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Patients Refused Admission to Psychiatric Hospitals in The Netherlands

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Summary. In The Netherlands unforeseen and unwanted effects of the "de jure" policy of the government are outpatient waiting lists and refusal of applications for admission to mental hospitals. A register of applications of six mental hospitals in the northern part of The Netherlands reveals that there are significant differences between admitted and refused patients with regard to juridical status, urgency, catchment area, referral source, age and type of problems.

Key words: Refused admission – Psychiatric hospitals

Introduction

At the present time in The Netherlands mental health care is undergoing an extensive revision. Current mental health care policy emphasizes a major shift from intramural to extramural care.

A decline in psychiatric hospitals admissions will result from intensified psychiatric care offered by non-residential provider agencies, an increase in sheltered housing and day-care capacity and an integral role in mental health care for the general practioner [16]. These measures are intended to bring costs under control and to remove the obstructions inherent in the present system.

Prompted largely by socio-economic considerations the Dutch Ministry of Welfare, Health and Cultural Affairs (WVC) announced in 1988 a new set of measures that should pave the way for a more function-oriented mental health care structure. The following proposals were made to realize this new structure: (a) budget cuts; (b) simplification of legislation; (c) measures to facilitate a more direct form of control, by placing more responsibility on the parties in contracts between patients and the provider of care agency and between the agency and the insurer; (d) the introduction of a kind of national health insurance and; (e) limiting the role of authorities in assuring a basic level of quality [17].

These measures will have far-reaching unpredictable consequences for the quality of care because it is as yet unclear what standards of quality will emerge from the negotiations between providers, insurers and consumers. In addition, up to now the government has not yet evaluated the effect of its "de jure" policy of deinstitutionalization systematically. Haveman [7] and Brook [3, 4] have shown that there is a discrepancy in the "de jure" policy and "de facto" situation in The Netherlands.

As mentioned above, one of the governmental goals has been to reduce the number of beds in mental hospitals. According to Giel [6], the Dutch mental health policy of deinstitutionalization is based on a confused blend of enlightened ideas and misconceptions of the political decision-makers. He feared that people with chronic mental illness would fall victim to the planned reduction of mental hospital beds from 1.5 to 1.1 per 1000 of the population. There are strong indications that his fear has already become reality. Alarmed by these warnings, the Minister of WVC recently has asked the Board of Hospital Facilities for advice whether to continue with its reduction plans or to stabilize the present number of beds in the mental hospitals.

Residential Mental Health Care in The Netherlands

Since the Second World War, in the Netherlands, as in many other countries, considerable changes have taken place in the treatment of psychiatric patients and in the clinical settings. Various new types of hospitals have come into being. In addition to the traditional General Mental Hospitals (MH), nowadays there are psychiatric departments of general hospitals (PAAZ), psychogeriatric nursing homes, clinics for various forms of addiction, institutions for mentally disturbed offenders (TBR) and psychiatric departments of universities (PUC).

The MH is a regional facility for multidisciplinary clinical care. Admission takes place at the request of a general practioner, a Regional Institution for Ambulatory Mental Health Care (RIAGG) or a private psychiatrist and is financed by the Exceptional Medical Ex-

penses Act (AWBZ). The MH offers around-the-clock clinical admission, outpatient care, partial hospitalization and resocialization. Optional services include child and youth, psychiatry, psychotherapeutic communities and forensic psychiatry.

Reductions of Beds, Outpatient Waiting Lists and Refused Applications for Hospitalization

Because of the reduction of beds, mental hospitals are under pressure to reduce admissions. Some of the consequences of the change in admission and discharge policy are becoming more clear now: a shorter length of stay, an increase of "revolving door" patients, an increase of referrals to other institutions etc. [3].

Other unforeseen and unwanted effects are the setting up of outpatient waiting lists and a tendency not to admit referred applicants. In The Netherlands both phenomena are relatively new and little attention has been paid to them.

The Medical Inspectorate of Mental Health (MIMH) has to monitor and where necessary to improve the quality of care according the Insanity Act and the Health Act.

In order to discover the number of patients refused admission the MIMH started in 1988 a register of both accepted and rejected applications for hospitalization. Furthermore, in 1989 a study has been started in which is investigated what has become of the patients refused admission. The data and findings reported here are based on the register.

Methods

On 1 January 1988 six psychiatric hospitals in the northern part of The Netherlands started a register of all applications for admission that were accepted or refused. At the time of application information was collected on all applicants' sex, nationality, date of birth, juridical status, catchment area, type of problems (somatic, psychiatric, social, behavioural), source of referral, urgency for admission according to the source of the referral, last known contact with a mental health service, medication, reasons to refuse an admission and date of admission or refusal. This article examines particularly the data of the applications that were refused from January to April 1988. Three types of applications were distinguished: (1) "immediate" admission-patients who were admitted on the day of application; (2) "delayed" admission-patients who were admitted within a period of 28 days; (3) "refused" admission-applications that were not accepted within a period of 28 days.

Results

From 1 January to 1 April 1988, 883 applications for admission were made; 528 patients were admitted the same day, 148 admissions were delayed and 207 applications were refused; the refusal rate, thus, was 23%. Because some applications were refused admission more than once, the actual number of persons refused admission is less than 207. Record linkage reveals that the 883 applications referred to 764 persons.

Table 1. Number of beds, immediate and delayed admissions and refused applications in six mental hospitals (MH); period 1 January–1 April 1988

	Number of beds		Immediate admission	Delayed admission	Refused admission	Total applications	(%)
PUC	123	(19)	79	13	32	124	(14)
MH-1	609	(±200)	38	7	84	129	(17)
MH-2	549	(62)	161	53	17	231	(26)
MH-3	395	(36)	80	24	27	131	(15)
MH-4	378	(48)	61	28	35	124	(14)
MH-5	571	(54)	109	23	12	144	(62)
Total	2625		528	148	207	883	(100)

[a] No. of beds available in admission wards in parentheses
PUC = Psychiatric University Clinic

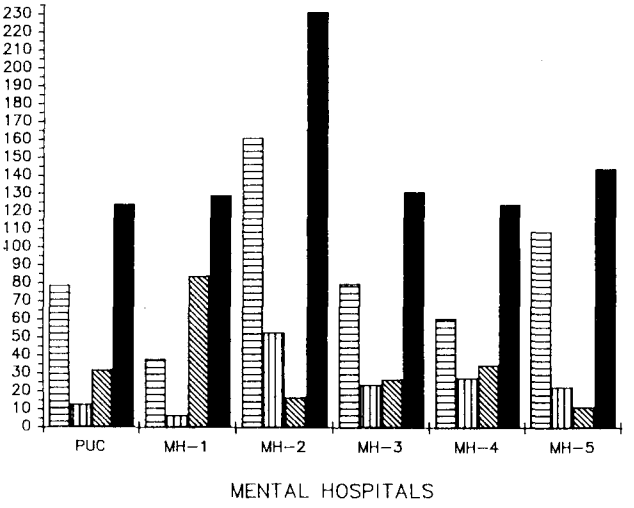

Fig. 1. Number of immediate and delayed admissions and refused applications in six mental hospitals (MH). ▤ Immediate admissions; ▥ Delayed admissions; ▧ Refused admissions; ■ Total applications

The six mental hospitals that participated in the registration differ in capacity. Five of them are MH with a mixed rural and urban catchment area and one is a PUC which serves a large municipality. The six MH together serve a catchment area of approximately one and a half million citizens [14].

Number of Admissions and Refused Applications

Table 1 shows the number of beds and the accepted and refused applications for hospitalization during the first 3 months of 1988 for each of the mental hospitals. This also is illustrated by Fig. 1.

There are remarkable differences between the mental hospitals with regard to the ratio of immediate, delayed and refused admissions. For example, in MH-5 76% and 16% of the applications led respectively to immediate and delayed admissions, 8% were refused. This in contrast to MH-1, where 65% of the applications were

Table 2. Reasons for refusal applications to be hospitalized in six mental hospitals (MH)

	PUC	MH-1	MH-2	MH-3	MH-4	MH-5	Total	(%)
Patient does not attend (includes cancelling)	1	16	8	7	12	5	49	(24)
Patient does not fit the admission criteria	5	9	–	8	4	4	30	(14)
Admission not needed anymore	4	14	2	1	1	–	22	(11)
Not beds available	13	8	3	–	2	1	27	(13)
Referral elsewhere	1	20	1	–	–	2	24	(12)
Other reasons	7	11	3	3	9	–	33	(16)
Not belonging to catchment area	1	6	–	8	7	–	22	(10)
Total	32	84	17	27	35	12	207	(100)

PUC = Psychiatric University Clinic

refused. The number of beds available in the admission wards of each of the mental hospitals may have influenced these different ratios. In Table 1 these figures are in parentheses. Many delayed admissions are probably caused by the limited capacity of admission wards, especially those that can be locked. Most of the 148 delayed admissions were placed on outpatient waiting lists for these locked wards. With regard to the waiting lists, on a census day (3 May 1989) each of the six hospitals had an outpatient waiting list with a total number of 22 patients.

A nationwide study of the National Board of Hospitals (NZR) showed that on a census day (1 April 1988) 419 patients were waiting for admission in 32 mental hospitals [18]. Of these 419 patients, 82% belonged to the corresponding catchment area of these mental hospitals. Because in The Netherlands mental hospitals are responsible for admission of citizens of their own catchment area, this shortage of beds confronts the referring agencies and the hospitals with great problems, but most of all affects the patients themselves. According to the mental hospitals themselves they are in need of more beds in locked admission wards, and of wards for long-stay and for elderly psychiatric patients.

Reasons for Refusal

The reasons for the 207 applications refused admission are presented in Table 2.

Twenty-seven applications did not result in an admission within 28 days because no beds were available. In contrast to these 27 patients who obviously had to be hospitalized, there were 20 applications that did not fit the admission (i.e. diagnostic) criteria. Clearly one cannot draw conclusions about the validity of this argument only from register data. Several studies have shown that factors other than those related to patients' needs influence the decision on hospitalization, such as a patient's sociodemographic and residential characteristics, clinical problems, diagnosis, the role of staffing patterns and community-based alternatives to psychiatric hospitalization [8, 11, 13, 15, 24].

Table 2 shows that 49 (24%) of the 207 applications did not attend the clinic following referral or application. Some of the factors involved may to be due restrictive clinic policies such as waiting lists [24] and elaborate intake procedures. Some factors, however, possibly relate to characteristics in the patients themselves [19].

Thus, several factors such as symptoms of the patient and such related factors as severity of psychopathology and dangerousness in combination with environmental

Table 3. Immediate, delayed and refused applications in six mental hospitals (MH), by sex, juridical status, medication, previous contact, urgency, and catchment area

	Immediate admission	Delayed admission	Refused admission
Sex			
– Male	253	63	110
– Female	277	85	97
Juridical status[a]			
– Voluntarily	448	137	192
– Involuntarily	73	11	15
Medicine use			
– Yes	244	62	77
– No	119	22	53
Previous contact			
No			
– Mental hospital	370	102	159
– Other services	444	97	144
Yes			
Mental hospital			
– < 1 month	77	18	20
– > 1 month	81	28	28
Other services			
– < 1 month	69	30	47
– > 1 month	15	21	16
Urgency[b]			
– Very urgent	266	5	34
– Urgent	233	12	81
– Not urgent	28	131	73
Catchment area[c]			
– Yes	455	107	154
– No	73	41	53

[a] $P < 0.05$
[b] $P < 0.001$
[c] $P < 0.01$

Table 4. Immediate, delayed and refused applications in six mental hospitals (MH), by referral source, age and type of problems

	Immediate admission	Delayed admission	Refused admission
Referral source[a]			
– General practitioner	113	11	61
– RIAGG	203	42	49
– Outpatient department of a mental hospital	70	24	14
– Mental hospital	48	17	20
– Self-referral	28	6	15
– Social geriatric services	18	26	5
– Other referral sources	45	22	43
Age (years)[a]			
– ≤ 20	14	4	22
– 21 ≤ 40	284	69	118
– 41 ≤ 60	162	32	55
– ≥ 61	68	43	12
Type of problems[b]			
Somatic problems			
– Physical complaints	25	17	20
– Brain disorder	6	16	4
Psychological problems			
– Fear	114	29	49
– Gloom	161	49	62
– Feeling ill at ease	96	30	26
Social problems			
– Problems with family or friends	108	35	40
– Sexual problems	7	1	12
– Problems at work or school	4	4	7
– Life events	29	7	13
– Other social problems	12	3	6
Problems in behaviour			
– Addiction	52	20	19
– Suicidal	193	26	66
– Aggressive	64	7	11
– Derailment	126	23	30
– Strange behaviour	135	25	30
– Self neglect	47	21	16

[a] $P < 0.001$
[b] $P < 0.01$

and institutional variables make the decision to hospitalize highly complex. Some of the register data confirm findings of the studies mentioned above; others raise questions. In the survey started in 1989 by the MIMH, more specific information will be gathered that perhaps can clarify these differences to some extent.

Other Variables of the Register

In the following, attention will be paid to some variables that are listed in Tables 3 and 4. The findings of studies concerned with similar issues will be discussed in the last section.

Using chi-square it appeared that the group of accepted applications differ significantly from those rejected, with regard to the variables juridical status ($P < 0.05$), urgency ($P < 0.001$), catchment area ($P < 0.01$), referral source ($P < 0.001$), age ($P < 0.001$) and type of problems ($P < 0.01$).

Table 3 shows that applications for females outnumber those of men (457 to 426). The variable sex does not significantly influence the number of admissions or refused applications. The percentage of male applications refused admission is higher than that of female (26% to 20%).

As to the juridical status it appeared that accepted applications differed from those rejected significantly ($P < 0.05$). Compared with the voluntary applications, significantly fewer involuntary patients were admitted. Although in The Netherlands mental hospitals have to admit all patients from their own catchment area, in particular those who are involuntary, 15 of them were refused admission.

An explanation could be the already-mentioned shortage of beds in the locked wards and related to this the fact that judical authorizations expire after 14 days.

The register also encompassed the variable "urgency to be hospitalized" according to the referral source. The category of accepted applications indicates the following relationships: the more urgent the application, the more likely admission will take place on the same day; and also, the less urgent, the more likely admission is delayed ($P < 0.001$). These figures indicate that in several cases the referral sources and the psychiatrists in the mental hospitals had a different view as to the necessity of clinical admission. In other words: the criteria they used did not matched. One hundred and fifteen patients (18%) for whom admission was urgent according to the referral source were not admitted within 28 days after application. In the survey of the MIMH special attention will be paid to this phenomenon.

This leads us to Table 4, in which the referral sources are specified. Thirty-three percent of the application made by general practitioners and 30% of the self-referrals did not result in admission. As already mentioned in discussing Table 2, a complex of various factors influence the decision to hospitalize ("pathway factors") and the actual admission. Most likely was admission after a referral by the outpatient department of a mental hospital or by social geriatric services (both 90%). Table 4 also encompasses the variable "type of problems". Most of the admissions were related to symptoms of gloom or had to be made immediately because of the danger of suicide. Still, 66 of the applications that were related to suicide were refused admission.

Discussion

In The Netherlands outpatient waiting lists and applications refused hospitalization in mental hospitals are phenomena to which little attention has been paid. Therefore the size of the problem is unknown. Knowledge of what has become of refused patients is also missing. The

study reported here was undertaken to get more data on the number and characteristics of patients refused admission by means of a register.

From 1 January to 1 April 1988, 883 applications for admission were made in six mental hospitals with a catchment area of about one and a half million people. Two hundred and seven applications were refused (23%). The refusal rate differed between the mental hospitals and may be due to the number of beds available in the locked admission wards. The register data also revealed that several patients did not attend and that various applications did not fit the admission criteria of the mental hospitals.

A remarkable finding was that 15 involuntarily patients were not admitted.

As to the admissions the following relationship was found: the more urgent the application, the more likely the admission will take place on the same day. In regard to the referring source, admissions were most often after referral by an outpatient department of a mental hospital or by social geriatric services and least frequently after referrals by general practioners or by patients themselves. In order to effect continuity of care the communication between referring agencies and mental hospitals has to be improved.

Waiting lists and restrictive or elaborate in-take procedures influence the admission rate. To some extent this can be considered to be a policy of the MH that can be modified. Some factors, however, may be related to characteristics in the patients themselves [19]. For example, Robin [21] found that reasons for non-attendance include various anxieties about the social effect and actual content of psychiatric treatment, as well as severe physical or mental illness preventing attendance. Whyte [25] showed that non-attenders had a personal or family pattern of occupational instability of court conviction, and were less likely than controls to suffer from the depressed phase of a manic-depressive psychosis. Those who failed to attend in the study of Robin were shown as likely to be neurotic or to have personality problems.

Mendel and Rapport [15] found that the decision-making process is influenced by administrative and organizational factors as well as by personal attitudes and professional backgrounds of mental health workers rather than by clinical considerations. In a replication of the study of Mendel and Rapport [15], Streiner et al. [24] found similar results. In both studies non-medical clinicians admitted fewer patients than medically trained staff, clinicians with over 3 years experience admitted fewer patients than less experienced clinicians, fewer patients were hospitalized when at least one outside resource existed. In contrast to Mendel and Rapport, Streiner et al. found that the severity of the patient's pathology was important if the clinicians were seeing a heterogeneous group of patients.

As to the latter, in a study of mental status and anamnestic factors, Johnson et al. [13] found that diagnoses of psychosis and personality disorder were related to hospitalization, while the diagnosis of neurosis was related to outpatient care. In addition, depressed and suicidal symptomatology was found to be related to inpatient treatment, while a previous history of either sexual maladjustment or stubbornness or retardation was found to be related to outpatient care.

In our study the percentage of male applications refused admission was higher than that of females (26% to 20%). This finding is opposite to that of Janzito et al. [12] who found that woman are less likely to be hospitalized. Janzito et al. [12] also found that age did not affect admission. The data in Table 4, however, reveal that the admitted patients differ significantly from those refused admission with regard to age ($P < 0.001$). In particular, persons under the age of 21 years are more often refused admission than those in older age groups. Although the absolute number of this younger age group is small, about 60% of them were not admitted. This finding raises the question as to whether these adolescents were referred to special mental hospitals for children and adolescents or that these data reveal a phenomenon that is new for The Netherlands, namely the emergence of a group of young Dutch adult chronic patients. In the United States several studies have shown that the mental hospitals and the general hospital emergency rooms, with their classic models of emergency intervention, are grossly inappropriate to their special needs and are reluctant to admit them. These studies show that many of them are homeless ("street-people") and receive no psychiatric service at all ("falling through the cracks") [10]. In the already-mentioned survey of the MIMH some of the referring agencies and several patients refused admission will be interviewed in order to obtain information on what has become of them. Our register data revealed that the admitted patients differed from those rejected significantly as to the juridical status. To what degree the existence of waitig lists and the postponement of admissions hampers the hospitalization of less "amenable" involuntarily patients more often than of the voluntary patients cannot be answered by register data exclusively. In addition to the group of involuntarily patients, there are five more types of patients who can be considered as less "amenable" according to Bregon and Dauzemon [1], those who require shelter, those who are difficult to treat, those who are dangerous, those with problems with the law, and those who do not fit age criteria.

Many studies have shown that a complex of factors influence the decision to hospitalize ("pathway factors") as well as the actual admission ("gatekeeper factors" [2, 23]. In a study of the outpatient waiting list, Simon [22] considered factors related to the participants of the intake transaction: the candidate-patient, his relatives, and the referring person on the one hand ("pathway factors"), and the official deciding whether and when the patient is to be seen and the psychiatrist in the institution, on the other (gatekeeper factors) [22]. As to the referral source, crucial in the intake procedure and the decision-making process appeared to be occupation, reputation, status, influence and power and forcefulness.

It seems as though the quality and the quality of the contacts between the referring persons and the mental hospital workers depends highly on the psychiatric expertise and skills the persons involved attribute to the

opposite party. Recently, findings of two Dutch studies indeed indicate that the success or failure of applications for hospitalization may be influenced by the concept the participants have of each other and of themselves [20, 22].

De Ridder and Visser [20] found that about 50% of the general practioners in their study felt capable of helping patients with psychosocial problems. Mental health workers differed in their opinion whether or not this is a task of the general practioner: 70% of the private psychiatrists thought not. In contrast, 75% of mental hospital workers were less restrictive. They also disagreed in regard to the competence of the general practitioner: 43% of the private psychiatrists thought general practioners are unable to meet psychosocial problems against 24% of the mental health workers.

In a study on aftercare of discharged mental patients Ten Horn et al. [9] found that 85% of the general practitioners said that psychosocial support is one of their tasks, while 75% of them felt they were in fact competent of performing that job. Of the mental health workers a corresponding 80% also saw a supporting role for general practioners, yet 50% thought they lacked the expertise. A remarkable finding was that 80% of the general practioners had the feeling that mental health workers were negative in their aftercare participation. The findings of the studies of De Ridder et al. and Ten Horn et al. indicate that the communication between the referring agencies and the mental hospitals has to be improved in order to effect continuity of care, and in particular the efficacy of the applications for admission in a mental hospital. This improvement is needed more in the light of the government's policy to emphasize the role of primary care and the non-professionals in mental health care.

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