

ANNEX VIII: THE NETHERLANDS

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Background

(1) What definitions of Intellectual Disability are typically used in your Member State? Is there an 'official' definition?

There are two standard definitions of intellectual disability in the Netherlands used in documentation, and papers.

Formulated by the American Association of Mental Retardation (AAMR) (Luckasson 2002).
 "Mental retardation is a disability characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. This disability originates before 18."(Luckasson 2002)

Formulated in the Diagnostic and Statistical Manual of Mental Disorders, fourth version (DSM-IV) (1994).

"Mental retardation: This disorder is characterized by significantly subaverage intellectual functioning (an IQ of approximately 70 or below) with onset before age 18 years and concurrent deficits of impairments in adaptive function.

Four degrees of severity can be specified, reflecting the level of intellectual impairment: Mild, Moderate, Severe, and Profound.

Mild Mental Retardation:	IQ level 50-55 to approximately 70
Moderate Mental Retardation:	IQ level 35-40 to 50-55
Severe Mental Retardation:	IQ level 20-25 to 35-40
Profound Mental Retardation:	IQ level below 20 or 25

Mental retardation, severity unspecified, can be used when there is a strong presumption of Mental Retardation but the person's intelligence is untestable by standard tests (e.g., with individuals too impaired or uncooperative, or with infants)".

In order to receive care people with ID need an indication for care, which will be provided by the Needs Assessment Body (in Dutch: Centrum Indicatiestelling Zorg, CIZ). The CIZ uses the following formulation to determine if a person has an intellectual disability.

The onset was before age 18 years, intellectual functioning is below average (IQ level below 70), and a person experiences permanent limitations regarding social skills.

Or

IQ level is below 85-90, and a person experiences behavioral problems, and or psychiatric problems (preferable diagnosed according to the DSM-IV).

(2) What is the historical context in which services have developed in your Member State?

In the fifties and sixties a “medical model” was applied. Intellectual disability was considered to be a disease or a disorder. Support of people with ID was considered to be part of health care. Institutional care was created with an emphasis on protection and care. Residential facilities were placed far from society in the woods or on the heather. Residential facilities looked like hospitals, with doctors, nurses and patients. The emphasis was on diagnostic research.

Under the influence of educationalists and psychologists the “medical model” was changed into a “development model”. People with ID were treated more and more like people with a handicap, but who were capable to learn. Children were placed into residential facilities, with the idea that they were better off in a residential facility than with their parents. In 1968 the Exceptional Medical Expenses Act (in Dutch: Algemene Wet Bijzondere Ziektekosten (AWBZ)) was introduced. Because of this law, residential facilities were financed completely by the government; this changed the admission to a residential facility from goodwill into a legal right. This development was besides the “development model” a reason for parents to place their children with ID into a residential facility. More people with ID were going to live in special situations, for example, in group homes.

The paradigm at the end of the eighties shifted towards a citizenship paradigm and “community care”, implying that people with ID have the same rights as everybody else to live in the community as full citizens. Residential facilities were replaced with more and more small-scaled and socially acceptable types of dwelling. People with ID were placed into the community. In this period extended support and the personal budget started. People with severe levels of ID, or with challenging behavior mostly remained in residential facilities. The citizenship paradigm led also to a shift from “community care” to “community support”, which implies that people with ID are supported by others in their daily life. Emphasis will be on supported living; supported learning, supported employment and supported leisure activities (Mans 1998; Van Genneep *et al.* 2003).

*(3) Are there specific legal rights afforded to people with intellectual disability?
Education, disability specific service provision, etc.
Situations where rights may be revoked on the basis of incapacity?*

People with ID have the same rights as any other citizen. In practice, however people with severe or profound levels of ID are considered not able to execute these rights, and are unable to give informed consent. There are two acts with respect to patients’ rights in health care, which also applies to people with ID (Frederiks 2004).

1) “The Medical Treatment Contracts Act” (in Dutch: Wet op de Geneeskundige BehandelingsOvereenkomst (WGBO)) describes the regulation for representation of persons who are unable to give informed consent (in Dutch: vertegenwoordigingsregeling). The aim of the WGBO is to make clear what the legal status of a patient is, or in this case of a person with ID, and to enhance it. The WGBO covers the protection of patients’ rights in health care and especially in the individual care relationship between a patient and a health care professional. People with ID, who are unable to give informed consent, have a legal guardian (parent or sibling). It is also possible that a formal representative is appointed to a person in order to represent a person with ID.

2) The main purpose of the “Compulsory Admissions in Psychiatric Hospitals Act” (in Dutch: Wet Bijzondere Opnemingen Psychiatrische Ziekenhuizen (BOPZ)) is to offer legal protection for patients who are involuntarily admitted to a psychiatric hospital. Although the law was originally designed for psychiatric patients, it also effects the legal position of people with ID. According to the BOPZ, it is only allowed to restrict clients in their freedom in case of danger of the client to himself or to others. There are still people with ID who are restricted in their freedom, especially those with challenging behaviour or with severe or profound levels of ID, or with autism.

In 2003 the “Equal Opportunities Act for the disabled and the chronically ill” (in Dutch: Wet gelijke behandeling gehandicapten en chronisch zieken (Wgbh/cz)) was introduced. In this act is described that discrimination on the basis of (intellectual) disability is forbidden. This act is applicable to work, occupation, vocational training, and public transport. Within the scope of community care, policy aims are to extend this Act to care and accommodation (Frederiks 2004).

(4) What is the estimated prevalence figure for intellectual disability in your Member State?

Both in terms of an estimated 1-3% of the population who have an IQ is less than 70, and in terms of known service users.

Is there any published material on prevalence studies?

In 1986, Maas *et al.* (1988) found a prevalence of 0.73-0.80% people with ID. When using the estimate of 0.76% persons, there were approximately 98,000 people with ID in 1986 in the Netherlands. The prevalence was expected to increase as a result of an increase of the size of the Dutch population, and as a result of an improved life expectancy of people with ID. Klerk (2002) estimated the prevalence for 2001, based on the study of Maas *et al.* (1988) the age distribution in 2001, and the available mortality rates of people with ID in residential centres. The estimated prevalence in 2001 for people with ID was about 103.000 people with ID, of which 53.000 were people with a severe level of ID. In a more recent study by Van Schroyensteen Lantman-de Valk *et al.* (2006b) a prevalence of 0.64-0.70% people with ID were found, which were approximately 111.000 people with ID in 2001 in the Netherlands. About 0.21-0.27% were living with family or on their own (van Schroyensteen Lantman de Valk *et al.* 2006b).

The number of older people with a severe level of ID is low, this is due to the fact that people with a severe level of ID die at younger age and their life-expectancy is lower compared to the general population (RIVM 2006).

(5) What databases/ sources are available in your Member State that might provide information on prevalence? Medical or social benefits; disability databases etc.

-National Case register (Landelijke Registratie voor Zorg (LRZ)): database consisting of people with ID in all residential centres in The Netherlands, containing data of, for example, date of birth, gender, level of ID, date of admission, date of discharge and date of death. Not available anymore since 2000.

-GP Information System (HIS). This is software, which general practitioners (GP) use to file, for example, background and medical information on their patients, and financial data on their practice. There are different HIS systems on the market.

Two networks of general practices in the Netherlands, using a HIS will be described (LINH and RNH). These two networks contain data on people with ID, who are registered at one of the participating GPs.

LINH (LINH 2006)

LINH is the Netherlands Information Network of General Practice. The LINH database holds longitudinal data on morbidity, prescribing, and referrals of about 350.000 individuals. Data are collected in a representative network of about 150 GPs, spread throughout the Netherlands.

LINH started in 1992 recording only referrals. It gradually developed into a system recording all patient contacts and all interventions, including diagnosis. Diagnoses are coded using the ICPC-codes (International Classification of Primary Care) (Lamberts and Wood 1987).

RNH (RNH 2006)

RNH is the Registration Network Family Practices, within the Maastricht University. The RNH database contains medical information on about 100.000 persons registered at 23 practices (56 GPs) in Limburg, the southern part of the Netherlands (Metsemakers *et al.* 1992). GPs file all relevant health problems on a so called problem list, which is an essential part of the medical

record. A relevant health problem is defined as “anything that has, does, or may require health care management, and has or could significantly affect a person’s physical or emotional well being” (Sandlow and Bashook 1978). Health problems are categorized according to ICPC-codes (International Classification of Primary Care) (Lamberts and Wood 1987).

-In development: Project of NIVEL: Monitor Participation of the Chronically Ill and Disabled, including a panel of people with intellectual disabilities. With this monitor NIVEL wants to collect data from a panel of 900 people with ID, both living in residential facilities as independent, on a continuous basis. The project focuses on data about social participation of people with ID, for example, about accommodation, employment, leisure, income, health care, and social contacts. The panel of 900 people with ID is expected to be complete in August 2006 (NIVEL 2006).

Service provision

(6) What is the criterion for eligibility for intellectual disability services?

The whole Dutch population is insured against exceptional medical expenses, based on the AWBZ. Based on this AWBZ people with ID are entitled to receive care when they are indicated for care. If a person with ID needs care, help or support, he or she can contact the Needs Assessment Body (in Dutch: Centrum Indicatiestelling Zorg, CIZ). A needs assessment advisor will provide a needs assessment decision (indication for care), and determines if a person needs care, the type of care, and the amount of care needed, taking the personal situation of a person with ID into account. Care can be funded in kind (care is provided directly by a residential facility) or in the form of a personal budget (PGB) (a person can purchase care). The CIZ forwards the needs assessment decision to the care liaison office (in Dutch: zorgkantoor). Care liaison offices are responsible for the implementation of the AWBZ act, and will decide on the PGB. With a PGB a person with ID can purchase help and support. A person with ID accounts for his/her expenses, and pays the money that has not been spent back to the health care liaison office. A person pays a personal contribution; the amount depends on his income. If a person needs more than 300 euros per day to buy the required care, the benefits will be changed into help in kind, unless a person wants to pay for the extra costs. A PGB is not mandatory; a person with ID is free to receive help through the usual home care systems or residential facilities (care in kind).

(7) What type of service provision is currently offered to adults with intellectual disability?
Educational, day service, residential, etc

There are several service provisions offered to people with ID, ranging from a few hours to 24 hours per day. As described before care is funded in kind or in the form of a PGB. A person can purchase care with a PGB in the following fields of the AWBZ: household care, personal care, nursing, supportive guidance, activating guidance, and short stays away from home. Treatment and long-term stay, for example in a residential facility are not included in the PGB.

In the following paragraphs several services that are provided to people with ID will be described.

Advice and / or treatment

There are several service providers who provide guidance and/or treatment to people with ID, for example, educationalists, psychologists, paramedics, and physicians. Other service providers are (specialized) home help, for household, ADL assistance, assistance for educational programme, etc.

Day care

There are several possibilities for people with ID with regard to day care. Up to the age of 22 years, they can go to a special school or receive assistance in a normal school. People with ID

from the age of 16 and older can visit a daycentre for adults. A daycentre provides meaningful activities during daytime, which are recreational or labour-like. Activities range from, for example: needlework, making toys, paintings, and cards, copy print, art, woodwork, etc. Another possibility for people with ID is to go to a social working place. A social working place provides work for people with ID, who can only work in an environment, which is adapted to their special needs. Supported employment is another possibility for people with ID to go to work. A supported employment service helps a person with ID to find a paid job and supports the person and his or her employer in doing his job.

Living arrangements

There are different types of living arrangements for people with ID. One type of living arrangements is a residential facility. People with ID who live in a residential facility receive 24-hour care. People are living in groups varying from 3-12 or more persons per house. A residential facility provides all aspects of life; medical care, psychological and psychiatric care, a place to live, work or activities during daytime, and support. Another option is living in a house with 10-20 people with ID, which is located on the ground of the residential facility or in a nearby municipality. People in this type of dwelling are more independent than residents of a residential facility. Another type of dwelling is living in group homes, located in the community, with 6-8 persons per home. People with ID who are reasonably independent are living in these group homes. They receive support and during the daytime they go to activities, receive education, or go to work or social working places. For people with a mild or moderate level of ID it is also possible to live independently with supported living services. People receive support or care when necessary. Most of them work during daytime. There are also other initiatives regarding living arrangements. For example, parents start together a group home, and purchase the necessary care with a PGB.

If people with ID are living with their parents or their family there is a possibility for parents to use respite care, during illness or holidays. People with ID can use respite care for a few days, a weekend or for a few weeks. There are also organized holidays for people with ID.

(8) What sources of income are available for people with intellectual disability?

Benefits – provide some index of national minimum wage as a reference point

People with ID have a right of their own income. There are different sources. Persons with severe or profound disabilities could receive benefits (for example, from a Disablement Assistance Act for Handicapped Young Persons (Wajong)). People with ID, with light to moderate level of disability who are capable of working, might receive an income from their work. Another possibility is that people with ID have property of their own, for example, from an inheritance. In the following paragraphs the Wajong, and general old age pension (in Dutch: Algemene Ouderdomswet (AOW)) will be described in more detail.

Disablement Assistance Act for Handicapped Young Persons (in Dutch: Wet arbeidsongeschiktheidsvoorziening jonggehandicapten (Wajong)) (MINSZW 2006)

The Wajong provides for a minimum benefit for young handicapped people.

A young handicapped person is entitled to Wajong benefit if he:

- has been at least 25% incapacitated for work;
- for an interrupted period of 52 weeks;
- the benefit starts not before a person becomes 18 years;
- a person is not older than 65 years of age;
- a person lives in the Netherlands.

The Wajong benefit depends on the degree of disability and the benefit basis. The basis for this Wajong benefit is the minimum (youth) wage, which was in January 2006, for a 18 year old person 26,62 euro per day, and gradual increases to 58.51 euro per day for persons 23 years and older. If the young handicapped person is so infirm that regular minding and care is essential,

benefit may be increased to a maximum of 100% of the basis. This does not apply if the person in question has been admitted to a residential facility and an insurer pays for the costs of this. If the (family) income of the young handicapped person is less than the applicable social minimum, he may be entitled to an allowance under the Supplementary Benefit acts (in Dutch: Toeslagenwet (TW)) and the person in question may also claim a partial benefit from the Act on Income for Older or Partially Disabled Employed Person (in Dutch: De wet Inkomensvoorziening Oudere en gedeeltelijk Arbeidsongeschikte Werkloze werknemers (IOAW)).

If a person is capable of working, for example with supported employment a person is stimulated to work. The income he earns with this work will be cut back from the Wajong benefit.

MEE is an organization for people with a disability, or a chronic disease and their parents or carers in order to support them in daily life. MEE can help them answering questions about education, accommodation, work, income, public transport, leisure time, and etcetera. MEE is independent of health providers or other authorities, and is funded by the government. People can use their service for free. MEE can assist a person with ID in applying for a Wajong benefit.

General Old Age Pension Act (AOW)

If a person with ID reaches the age of 65 the Wajong benefit stops. The AOW provides entitlement to old age pension for people who are aged 65 years and over. A single person receives 925.17 euro gross per month.

The minimum wage

The minimum wage for persons 23 years and older in the Netherlands is 1272.60 euro gross per month (15.271,20 euro gross per year) in March 2006.

(9) What health services are currently offered to adults with intellectual disability?

Primary care

People with ID have the same rights as any other person to use health services. In the Netherlands a GP is considered to be the gatekeeper in the Dutch health care system. People with ID who are living at home or in small-scaled facilities are registered with a GP and visit a GP if necessary. In practice a GP does not see very much people with ID. About 0.3% of the persons registered with a GP are people with ID. In a standard general practice this would be 7 to 8 people with ID (Van Schroyen Lantman De Valk and Metsmakers 2003). It was also found that people with ID had more health problems than people without ID. (van Schroyen Lantman De Valk *et al.* 2000; van Schroyen Lantman De Valk and Jabaaij 2006a) The combination of having not much practical experience, and in most cases the complex health problems of people with ID, and the difficulties of people with ID to communicate about their health problems, makes it necessary to create specialistic medical care for people with ID. People with ID living in residential facilities used to receive primary care from an AVG (see page 8) (Kramer, *et al.* (2004)).

In the old health care system in the Netherlands an agreement was made for GPs, they had the opportunity to double the normal charge for a person with ID, when a person with ID visits a GP. (in Dutch, Huisartsconvenant) People are working on a new agreement, which is applicable for the new health care system.

Specialistic medical care for people with ID

Since 2000 there is a specialist training for Physicians for people with Intellectual Disability (In Dutch: Arts voor Verstandelijk Gehandicapten (AVG)). A GP can refer a person with ID to this AVG. An AVG works in most cases in a residential facility. People with ID living in a residential facility visit in most cases an AVG instead of a GP. On the one hand the AVG will provide specialist care for people with multiple complex handicaps, serious psychiatric and behavioural disorders and psychogeriatric problems who will probably live in residential facilities in the future.

On the other hand much more emphasis will be laid on advising and consultative tasks for outpatients. Since July 2002 a GP has the opportunity to refer to an AVG. People with ID not living in a residential facility need an indication by CIZ (independent assessment organization) in order to qualify for compensation based on the AWBZ for visiting an AVG after referral of a GP (Kramer, *et al.* (2004)).

Outpatients' facilities

Another development concerning creating specialistic medical care for people with ID is the development of outpatients' facilities for people with ID. This initiative was created to solve problems that were difficult to solve by a GP. In these outpatients' facilities, an AVG is cooperating with and/or has the opportunity to consult paramedic and behavioral scientists, and is located either in hospitals or in service centers (Kramer, *et al.* (2004)).

Other specialistic medical care for people with ID

A GP and an AVG also have the opportunity to refer people with ID to specialists. For example, in case of challenging behavior to a psychiatrist.

In most residential facilities, a dentist has office hours, which are also visited by people with ID not living in a residential facility. Paramedics such as physiotherapist, occupational therapist, dietician, and speech therapist working in a residential facility generally completed postgraduate courses (e.g. Bobath therapy, sensomotory integration, TEACCH) in working with people with ID.

(10) Is there a body of research in your Member State on the health of adults with intellectual disability?

Cite main researchers and areas of research they investigate (not the specific studies themselves – just direct the reader to where the information can be found)

See RGO (Gezondheidsonderzoek 2005) for a state of affairs in 2004 with respect to medical and behavioral research on people with ID in the Netherlands.

Research about people with ID is cut up into pieces at different locations. A few university-affiliated programs will be described:

Prof.dr. H.M. Evenhuis

In April 2000 a Special Chair in "Intellectual Disability Medicine" was inaugurated at the department of General Practice at the Erasmus MC. The Chair is focused on two major research topics: 1) Perceptual disorders, and 2) Co-morbidity in children with severe multiple disabilities. Research projects running within the "Perceptual disorders" topic are; investigating visual acuity and hearing in adults with intellectual disabilities, investigating the prevalence of perceptual disorders, and which subgroups are at highest risk and the effectiveness of treatment. Within the topic "Co-morbidity in children with severe multiple disabilities" a large epidemiological study investigating nutritional and pulmonary problems around Rotterdam and Utrecht started (EUR 2006).

Dr. H.M.J. van Schrojenstein Lantman

Teaching undergraduate medical students on health in people with ID.

Research areas are; health of people with ID in primary care and health inequalities. She is involved in European project on Health Indicators for People with Intellectual Disabilities (Pomona).

Prof.dr. C. Vlaskamp

Teaching commitment: Remedial education in relation to the education and support of persons with severe mental limitations

A few recent research projects in which she was involved were; activities in day services for people with profound multiple disabilities, implementation of an education programme for multiple handicapped children in day care centra, moving towards independence? Evaluation of the mobility opportunities via education curriculum with children with profound intellectual and

multiple disabilities, and improving the quality of care for multiply handicapped children in residential care (Onderzoeksinformatie 2006).

Prof.dr. J.S. Reinders

Teaching and research commitments focus on normative aspects of health care for people with ID. Research topics are social integration, quality of life, independency / autonomy, and tracing genetic disorders. Reinders' focus is on theory and practice of ethics in health care for people with ID (sheerenloo 2006).

(11) Is there any data on life expectancy among this population in your Member State?

Few data are available on mortality rates for people with ID. The data found for mortality were based on a database from the period 1993-1995 consisting of people with ID in residential centres (National Case Register LRZ). There is no data available for people with ID who live with their parents / family or who live in semi residential centres. Mortality is found to be high at young age, than it decreases gradually, and as people become older mortality increases again. The age-specific mortality pattern of the Dutch population is comparable to that of the people with ID in residential centres, but the level of mortality is higher for people with ID. A relationship between mortality and level of intellectual disability was found. People with a severe / profound level of ID were found to die, on an average, at younger age, compared with people with a mild-to-moderate level of ID (Nidi 2006).

Maaskant *et al.* (2002) calculated mortality rates and life expectancy based on the same database as described above (LRZ), but looked at a five years period (1991-1995). In the database Maaskant *et al.* (2002) used, information was available for about 29.000 people with ID. They calculated age-specific life expectancy, which means the additional number of years a person of a certain age can expect to live. People with ID in Dutch residential centres have a shorter life expectancy than their peers without ID in the general population. It was found that 28% of the young children (0-4 years old) died within a period of five years. Less than 10% of the children between 5 and 19 years and less than 5% of those between 20 and 44 year died between 1991-1995. Mortality rates increased substantially after the age of 65 years old. It was calculated that 5-year-old children in residential centres can expect to live another 49 years, and a 35-year-old person, for example, can expect to live almost another 32 years. The life expectancy of people with Down's syndrome is shorter compared with people with ID with other aetiological diagnosis. It was found that 5-year old children with Down's syndrome in residential centres had a life expectancy of 46 years, and those aged 35 years had a life expectancy of 22 years. Mortality rates in people with Down's syndrome were much higher after the age of 45 years compared to the whole group. This could be explained due to the high prevalence of dementia in people with Down's syndrome over 40.

(12) Can you provide comparative information on the following for both people with intellectual disability and the general population – prevalence of epilepsy, forms of health promotion such as screening for blood pressure, blood cholesterol, breast screening, cervical screening, testicular cancer screening. Are there other forms of health promotion screening available to people with intellectual disability (such as medication use, oral hygiene, contraception etc.) and how is this information available – in written form, pictures, television adverts etc.

No information was available about the prevalence of epilepsy for people with ID.

Screening for Breast cancer

In the Netherlands, every two years all women between 50 and 75 years are invited for breast cancer screening based on their postal code, including women with ID. It is up to the person to decide whether or not to go.

Screening for Cervical screening

In the Netherlands, every five years all women between 30 and 60 years are invited for cervical screening based on their postal code. On the website of the NVAVG (www.nvavg.nl) a guideline is placed, regarding cervical screening in women with ID. The guidelines recommend that women with ID, who do not have sexual contact, do

not undergo a cervical screening. Except in case of gynaecological complaints, than a woman with ID needs to undergo a cervical screening, for medical reasons.

No information was found about how many women with ID use cervical or breast cancer screening.

There are different forms of health promotion available for people with ID, their parents or carers but it is scattered. A few websites will be mentioned which contain information for people with ID, regarding health promotion information on different topics.

<http://www.begrensdiefde.nl/>: Site with information about sexual education and about prevention, noting, and treatment of sexual abuse by people with ID.

<http://www.fvo.nl/>: The FvO is a parents association, and represents the interests of parents, relatives and people with ID.

<http://www.mee.nl/>: MEE is an organization for people with a disability, or a chronic disease and their parents or carers in order to support them in daily life.

<http://www.lkng.nl/>: Site with information for professionals and policy makers in health care for people with ID, and for people with ID, their parents, and carers.

<http://verstandelijk-gehandicaptten.startkabel.nl/>: Startpage or webportal with information about and for people with ID.

(13) Is there any disability specific training for health professionals – such as modules on undergraduate programmes etc? GP, Dental, Psychiatry -

Physicians for people with Intellectual Disability (AVG)

Since 2000 there is a specialist training for Physicians for people with Intellectual Disability (Arts voor Verstandelijk Gehandicaptten (AVG)). The training is a 3-years' practice based programme accommodated at the department of general practice of the Erasmus Mc in Rotterdam, every year about 12 persons are trained. "During the first and third year the trainee works in a residential facility for people with intellectual disabilities. Besides providing primary health care, in the third year the consulting tasks and advising skills are being emphasised in day care centres, group homes and in future outpatient clinics as well. Traineeships during the second year are meant for widening expertise in the field of etiologic diagnostics, hearing and visual impairments, motor disabilities, psychiatric disorders and ageing."

Undergraduate Medical Students

Maastricht University has an optional module for 2nd year undergraduates (medical students) on intellectual disability (ID). Aim of this module is to learn the student to communicate with people with ID, to learn about health aspects in a multidisciplinary program, including psychological, ethical and legislative aspects in a combination of presentations, contacts with an individual with ID, his family, carers and care system, self-study, writing a paper and giving presentations. Duration of this module is 6 weeks fulltime. From 2001 onwards, annually 10% of the year group follows this module. Nijmegen and Rotterdam also have optional modules.

As of 2006, junior doctors (last year undergraduate medical students) at the Maastricht University: can do their participation internship (18 weeks) in a centre for people with ID. There are about 5 places available. In the same year, students can do their scientific internship-also 18 weeks- on several projects in health in people with ID- at the Department of General Practice in Maastricht.

General practitioners

It is optional for GPs to fill in part of their external working period in a centre for people with ID in their 2nd year of training. The centre in Maastricht, and Nijmegen has each year one or more GPs in training.

In 2005, funded by the Netherlands Organisation for Health Research and Development a module for GPs was developed on health care in people with ID in cooperation with doctors, clients with ID and family/carers (Artsennet 2006).

Dental Care

In the Netherlands there is an association to improve dental health care for people with a disability (in Dutch: 'De Vereniging tot Bevordering der Tandheelkundige Gezondheidszorg voor Gehandicapten (VBTGG)'), who took the initiative in developing a 3-years' part-time postgraduate professional training in becoming a 'dentist in health care for people with a disability' (in Dutch: 'tandarts-gehandicaptenzorg' (TG)). Focus is not only on people with ID but also on physically disabled persons. Dentists will be educated on prevention, communication, eligibility for dental care and treatment and on how to solve specific problems that occur among people with a disability in the field of oral hygiene and dental treatment. This training focuses besides teaching dentists specific knowledge and skills, also on developing the right attitude of the dentists towards people with a disability. This postgraduate training started in 2004.

Psychologists

It is optional for psychologists to follow postgraduate courses with specific courses aimed at people with ID. Two organizations offering postgraduate courses will be described shortly. GTP PAO offers continuing education to university educated professionals in the Netherlands and Belgium who work in behavioural sciences, communication and human resource management (PAO 2006).

The RINO Noord-Holland is a Dutch national organisation for continuing education and training in the field of mental health (RINO 2006).

Nurse practitioner education

There is a pilot running, with a nurse practitioner in health care for people with ID. The results are not published yet.

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