Cour des comptes

CHILD PSYCHIATRY

Access to and provision of care to be reorganised

Communication to the Social Affairs Committee of the National Assembly

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Executive Summary

Psychological care provision not adapted to the needs of young people

In the member countries of the Organisation for Economic Co-operation and Development (OECD), about 13% of children and adolescents have at least one mental disorder, i.e. a condition that affects mental health and can take many different forms and expressions. Although the lack of data on the French situation makes it difficult to estimate the numbers involved, it can be estimated that around 1.6 million children and adolescents suffer from a mental disorder. As in other OECD countries, the Covid-19 epidemic has resulted in a significant increase in mental health problems in children from the age of 10 and in adolescents.

In recent years, between 750,000 and 850,000 children and adolescents have received child psychiatric care annually from specialised professionals in different forms (outpatient, partial and full hospitalisation). However, in the current state of the organisation of care, and in particular in child and adolescent medical-psychological centres (CMP-IJ), some of the patients treated only suffer from mild disorders, to the detriment of the care of children suffering from more severe disorders. Moreover, it is difficult to assess how organisation of the provision of care aligns with needs in the territories, as it is not possible to estimate the severity of the disorders. Although, as in adults, the mental disorders encountered in children and adolescents are diverse, they are distinguished by their non-stabilised, "developmental" and progressive nature, by the importance of social, economic and family risk factors and by the high frequency of comorbidities.

In terms of the supply of facilities, both outpatient and inpatient, France is in the middle of the pack among European countries and is marked by high regional inequalities. The policy of "shift to outpatient care", which aims to eliminate hospital beds in favour of care in CMP-IJ, has been applied indiscriminately to both the adult and child sectors: between 1986 and 2013, the number of beds decreased by 58%[1] while the population increased. The CMP-IJs have thus become the main place of care for children and adolescents suffering from psychological disorders. Furthermore, the crisis in medical demography, with the number of child psychiatrists falling by 34% between 2010 and 2022, makes access to child and adolescent psychological care even more difficult.

Expenditure on child-adolescent psychiatric care in healthcare institutions in 2019 is estimated at €1.8 billion and is concentrated in the public sector. The share associated with private for-profit institutions is residual. Expenditure on city psychiatry reimbursed by compulsory health insurance is fairly modest, whereas expenditure by social and medico-social institutions for the mental healthcare of children and adolescents represents a significant volume, estimated at over €1.06 billion.

An insufficiently graded care pathway and a saturated supply

The child psychiatry care pathway is based on a supply organised in child and adolescent "sectors": this health district includes one or more CMP-IJs, day hospital care and hospitalisation beds.

The duties assigned to the sector by the circular of 16 March 1972 are very broad: prevention, reception and referral, treatment of disorders, coordination between the various stakeholders in care, continuity of public service. They make them both first-level stakeholders

[1] From 5,380 to 2,239.

for local care and second-level stakeholders for the management of more severe disorders. Subsequent texts also entrust other professionals, particularly self-employed professionals, with part of the primary or local care, so that the role of each in the graded organisation of care is no longer clear.

Upstream of the pathway, the public authorities have tried to develop an approach to preventing psychological disorders in mothers and infants with the "1,000 first days" national project. Unfortunately, this effort is not as strongly pursued in schools, despite some occasional initiatives. Psychologists in the National Education system, particularly at secondary level, are still too much oriented towards school guidance, which distances them from the detection and guidance of young people with mental disorders.

In towns and cities, self-employed professionals, whether general practitioners or specialists, are still too unfamiliar with the characteristics of psychological disorders in children and adolescents and therefore do not yet play their role sufficiently as a gateway to the care system. Their training should be improved to enable them to better support patients and their families. Private psychiatrists are mainly serving an adult clientele and do not participate in the permanent care service. The demography of child psychiatrists, whose numbers are difficult to count, is unfavourable in the short term and will not enable them to fulfil their role as a specialist resource. On the other hand, psychologists, in large and growing numbers, are expected to gradually take a place in the care pathway.

In this context, the CMP-IJs, considered to be the "pivotal point" of the sector and the gateway to the care pathway, have been progressively overwhelmed by requests for information, advice, assessment and follow-up, ranging from mild to severe disorders. Their universal access, i.e. with no conditions and no advance payment for families, has the paradoxical effect that they are unable to fully carry out their task of monitoring the most severe psychological disorders: nearly 50% of their work consists of receiving patients for assessment and referral sessions who do not then benefit from long-term follow-up. Although important, this intake and assessment role limits their ability to follow up over time with the children who need it most.

In addition to existing structures (notably the adolescent centre, medical-psychological-pedagogical centres, maternal and child protection services, multidisciplinary health centres), an experiment in child and adolescent centres could help to ensure more effective front-line care. These structures could partly compensate for the current shortcomings of the front-line provision by supporting its structuring. These experiments could be extended to all children and young people and would aim to meet both somatic and mental healthcare needs and to limit disruptions in the care pathway.

In this renewed landscape, the CMP-IJs could progressively devote themselves to monitoring moderate to severe disorders, coordinating the pathways, in particular during hospitalisation, and fully assuming their role as centres of expertise, in particular with regard to self-employed professionals. It would be necessary to prioritise the creation of posts envisaged by the health foundations towards the CMP-IJs located in areas where there are too few front-line professionals to carry out their tasks.

In order to anticipate and limit the use of emergency services when a patient is in crisis, mobile and liaison teams should become a basic facility in each reference territory. Depending on the analysis of its needs, a limited number of crisis beds may be justified. Moreover, the imbalance between the tasks of public institutions providing permanent care with their emergency services and the reception of patients suffering from severe disorders on the one hand, and those of private institutions on the other, has become too marked. When granting authorisations for child psychiatry activities, the regional health agencies (ARS) should pay more attention to the sharing of permanent care tasks. The reform of these authorisations raised the age of care in child psychiatry from 16 to 18 years. This should lead to an increase in the number of child psychiatry beds, particularly for adolescents, by redeploying adult beds so that these patients can be accommodated.

A clear desire to improve the organisation of child and adolescent mental healthcare, but governance that is not very operational

The Ministry of Health has shown a clear commitment to increasing access to child and adolescent mental healthcare since 2018, including with the adoption of the Mental Health Roadmap. However, the latter does not set clear objectives, either in quantitative or qualitative terms, and does not provide for a timetable for its implementation. The adoption of "national objectives for child and adolescent mental health" with a precise timetable and indicators would allow an evaluation of the organisation of child psychiatric care. These objectives would help to better structure and plan this policy.

With regard to the implementation of the roadmap, the establishment of a ministerial delegate for mental health and psychiatry (DMSMP) has improved the clarity of the policy pursued, but its role and position must be more clearly defined. Its field of intervention, as far as child psychiatry is concerned, must be better identified. In the educational, health and social sectors, it must be cross-cutting. Its positioning should be interministerial, in order to provide it with a better identified steering function, and thus improve the effectiveness of the monitoring of the child psychiatry care policy. It should also be able to better involve representatives of the departments in their social responsibilities (maternal child protection, child welfare). The term "child psychiatry" should therefore be added to the title of the DMSMP and it should be given an interministerial title of "interministerial delegate for mental health, psychiatry and child psychiatry". This would pave the way for the appointment of delegates or correspondents for child and adolescent mental health in the other ministries concerned, such as national education, justice, solidarity and autonomy. The regional administrative organisation of child psychiatry also suffers from a lack of operational vision. Although the regional health agencies have equipped themselves with useful consultation tools for sharing views and experiences between local stakeholders with the adoption of territorial mental health projects (PTSM), their implementation is not objective. Indeed, the levers for steering policies on access to child psychiatry care are still too recent and too timid, as shown by the analysis of territorial mental health contracts (CTSM).

The funding of child psychiatry is under the same regime as that of psychiatry. The allocations are historically renewed from one year to the next without taking into account changes in activity and are hardly adapted to the local specificities of the institutions, with the exception of new measures and calls for projects. Although the reform resulting from the Social Security Financing Act (LFSS) for 2020 aimed to introduce more flexibility, it still has limitations in that it does not allow for the adaptation of funding to the activity of child psychiatry services.

The need to enhance the attractiveness of child and adolescent care professions to revitalise the sector

There are still shortcomings in the provision of child psychiatry care, both in terms of quantity and quality. The entire sector must therefore be revitalised, by improving the efficiency of the management of the policy on the supply of care, both in the central and regional administrations, and by reinforcing the attractiveness of the child and adolescent mental healthcare professions.

Children's doctors and paediatricians must be placed at the heart of the reception and referral of patients to improve the care pathway and its gradation. To this end, it is important to strengthen their initial and ongoing training in child psychology and psychiatry, particularly in the area of screening and referral.

The implementation of an attractiveness policy for child psychiatry is based on the enhancement of hospital and university courses, on the support of French research in the discipline and on a better recognition of the clinical practice in institutions and in private practice. Moreover, psychologists, who are essential stakeholders in the provision of child and adolescent mental healthcare, must be better integrated into the healthcare system. Lastly, it is important to clarify the function of advanced practice nurses, both in private practice and in institutions. Like psychologists, they are useful stakeholders for improvement, able to contribute to alleviate the pressure on the provision of child and adolescent mental healthcare.

Recommendations

1. Draw up an exhaustive inventory of the epidemiological situation of mental disorders in children and adolescents in France, in particular by extending the national study launched in 2022 to include adolescents and by making greater use of the medical and administrative databases. This inventory should be updated at least every ten years (*Ministry of Health and Prevention, CNAM, SPF*).
2. Strengthen the initial and ongoing training of practitioners who are to fulfil the role of the child's doctor (general practitioners and paediatricians) in child psychology and psychiatry, particularly in terms of screening and referral (*Ministry of Health and Prevention, Ministry of Higher Education, Research and Innovation*).
3. Build on the initial findings of the child and family centres experiments to extend them to adolescents, in conjunction with the current adolescent centres. In the meantime, continue to strengthen the resources of the CMP-IJs in under-resourced areas for their reception and assessment task, in line with the measures adopted at the end of 2022 (*Ministry of Health and Prevention, CNAM*).
4. Update the standard indicative equipment rate per relevant territory (covering public and private provision), which should include, in particular, a paediatric liaison team or crisis beds (observation beds), mobile teams and beds for the hospitalisation of 16 to 25 year-olds and open up reception capacities in medico-social institutions downstream of the hospital (*Ministry of Health and Prevention*).
5. Adopt "National objectives for child and adolescent mental health" with a precise timetable and indicators to evaluate the policy of organising child psychiatry care (*Ministry of Health and Prevention*).
6. Position the current ministerial delegate for mental health and psychiatry at the inter-ministerial level and name it thus: "Inter-ministerial delegate for mental health, psychiatry and child psychiatry" in order to identify child psychiatry explicitly in the field of the current mental health delegation and to reinforce its interministerial positioning (*Prime Minister, Ministry of Health and Prevention*).
7. Include a section for child and adolescent psychiatry in the territorial mental health project (PTSM) and include in the territorial mental health contracts (CTSM) quantified objectives, a timetable for the implementation of the planned actions and periodic evaluation indicators (*Ministry of Health and Prevention*).
8. Implement a policy to make child psychiatry more attractive by enhancing the value of hospital and university courses and by supporting French research in the field. To this end, it will be important to double the number of students trained in child psychiatry and to increase the recruitment of MCU-PHs (*Ministry of Health and Prevention, Ministry of Higher Education, Research and Innovation, CNAM*).
9. Strengthen the intervention of psychologists and advanced practice nurses in the child psychiatric care pathway as a complement to other professionals (*Ministry of Health and Prevention*).