COUR DES COMPTES

Summary

of the Public thematic report

December 2011

Organisation of psychiatric care: Effects of the "Psychiatry and mental health" plan 2005-2010

Disclaimer

This summary is designed to aid the understanding and use of the Cour des Comptes report.

Only the report is legally binding on the Cour des Comptes.

The responses of government departments, councils and other organisations concerned are appended to the report.

Contents

Introduction

Psychological disorders are the third most frequent form of pathologies in France, following cancers and cardiovascular diseases. Psychiatric care is funded more than a million times a year in France, costing the French national health insurance system alone approximately €13 billion per year and representing approximately 7% of its total expenditure.

An additional, undefined amount is paid by other health insurance schemes, and, mainly in the case of social and medico-social care, notably by the State and the local authorities. The total economic and social cost of these pathologies is estimated at some €107 billion per year in France, which is similar to the amount seen in England for example.

Many reports have been written on this major public health issue in recent years, with generally similar recommendations. The French public authorities first introduced their "psychiatry and mental health" plan in 2005. The plan follows five main strategic lines divided into 12 operational objectives, broken down into 33 measures leading to 196 actions.

In 2011, the Cour des Comptes conducted a detailed survey with the aim of producing a status report and making the appropriate recommendations. This survey was limited to all forms of psychiatric care except those relating to Alzheimer's disease, other forms of dementia and developmental disorders such as the various forms of autism.

Approximately 40 psychiatric or penitentiary establishments and regional health boards were visited in eleven regions.

Throughout the survey, the Cour des Comptes remained in contact with the High Council of Public Health (HCSP), which itself produced a report evaluating the plan's implementation from a more medical point of view.

No legal definition of the public service role of psychiatry

A central finding is that the plan's implementation has been hindered by the lack of clarity regarding the geographical coordination of hospital and extra-hospital services; the legal basis of "psychiatric sectorisation" has, at the same time, gradually blurred. The regional health plans currently under development by the regional health boards will probably improve this situation, but this public service role was omitted from the "HPST" law of 2009 in spite of the plan. One of the Cour's principal recommendations (the list is appended to this summary) is that this role should be established.

In his reply appended to the report, the French Minister of Labour, Employment and Health accepts this recommendation and says that he will meet the specialist professionals in order to do define this role.

1 The unnecessary weight of full hospitalisation

This chapter examines the plan's impact upon the medical care and courses of treatment of patients, notably regarding the appropriate relationship between the players. This relationship is crucial both in order to ensure the relevance and the quality of care and in order to prevent and reduce interruptions in the courses of treatment. The care available is divided between full hospitalisation, hospitalisation alternatives and outpatient medical care provided by community extra-hospital establishments, combined with community practitioner consultations.

The number of hospital beds has continued to drop:

Number of beds	2001	2005	2010
Psychiatry	61,920	58,580	57,410
General	59,840	56,500	55,240
Children and adolescents	2,080	2,080	2,170

The fact that the beds available for full hospitalisation are apparently all filled is, however, mainly due to their use in inappropriate cases. The objective of encouraging extra-hospital care and freeing up some full-hospitalisation beds has not been achieved, although some progress has been made in this respect.

As the opinions of psychiatric care professionals are sometimes divided by competitive undercurrents, there is in fact no consensus regarding the 'fair use' of this form of medical care. The highly consensual way in which the plan has been drafted has hardly fostered agreement on this point.

Far from "decompartmentalising"(1) hospitalisation, certain measures or announcements after the plan was launched have heightened differences and misunderstandings instead, particularly concerning security and hospitalisation without consent. While remarkable progress has been made in some areas, some difficult situations remain. The Cour des Comptes has reported that some patients have been hospitalised unnecessarily, transferred unexpectedly as the establishment concerned

(1) The HCSP published the results of a related study conducted on its behalf by the CREDOC studies and research institute in 2011.

was full or had their care interrupted as a result of moving home, particularly in the case of people with no job security or prisoners. Alternatives to hospitalisation are still insufficient, and communication with the medico-social care bodies still shows some weaknesses. Care is highly likely to be less effective in these situations, and it is frequently costly.

Increase in staffing

The staffing situation must be qualified. The changes in medical-care establishment staff numbers are unclear: as the assessment methods have changed, the following data regarding the beginning and the end of the plan are barely comparable.

Human resources nevertheless increased under the plan, particularly in the extra-hospital environment. Their estimated full-time equivalent (FTE) is as follows:

	2005	2010
Salaried physicians	7,800	8,500
Medical care	96,000	97,400
Education & welfare	6,300	7,100
TOTAL	**110,100**	**113,000**
Hospital	1,300	1,550
Private practice	1,230	1,310

On 1 January 2011, there were 13,645 psychiatrists in metropolitan France, taking all forms of practice as a whole (39.5% in private or mixed practice, and 60.5% salaried), more than a third of whom work in the Ile-de-France region. In addition, there were 142 general practitioners able to provide psychiatric care, 96 of whom are salaried.

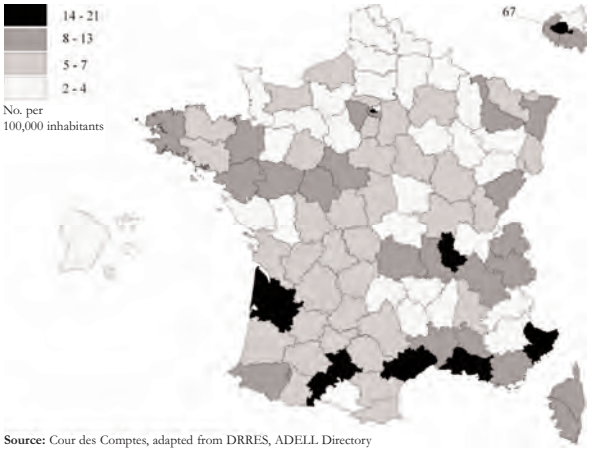
Whereas equal access to medical care is only possible if psychiatric care resources are properly distributed throughout France, 80% of all psychiatrists practise in towns with more than 50,000 inhabitants.

Psychiatric vacancies are difficult to fill in rural regions. The planned measures to attract psychiatrists to settle in such regions have not been implemented.

The plan has, in general, not addressed the problem of vacancies, representing one in five budget items (1,155 on 1 January 2009, a rate similar to most other medical specialisations).

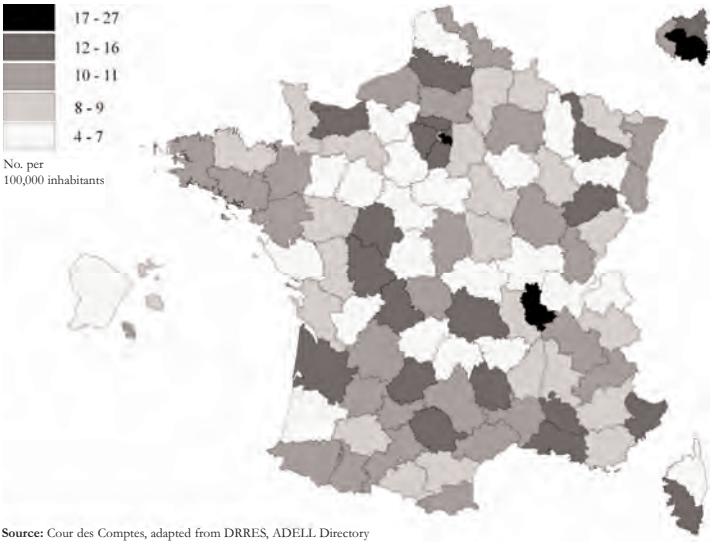
The report contains a dozen maps illustrating the disparities between regions or departments.

The geographical disparity in the number of private-practice psychiatrists per 100,000 inhabitants increased slightly between 2000 and 2010, with ten times more practitioners in some areas than in others.



Source: Cour des Comptes, adapted from DRRES, ADELL Directory

The same can be said of the psychiatrists employed by health care establishments. The number of such psychiatrists per 100,000 inhabitants were as follows as at 1 January 2010:



Source: Cour des Comptes, adapted from DRRES, ADELL Directory

The unnecessary weight of full hospitalisation

Additional training for nurses has mainly been provided through junior staff member mentoring. This measure has cost €46.7 million (as at mid-2011) and has been extended until the end of 2012 in order to make full use of the €75 million allocated to it.

Similarly, the measures designed to extend the length of psychiatrists' training to five years or to create a Masters degree in psychiatric research have not yet been implemented.

The measures intended to create a qualification for nursing training institutes and to restructure their courses have been abandoned.

2 "Health-Justice" scheme: unfinished progress

This chapter of the report analyses the main scheme devoted to a specific population. The "Health-Justice" scheme[2] is directed towards the prison population. Up to 40% of the approximately 65,000 prisoners in France receive care for psychiatric or addiction problems.

The combination of mental disorders and precariousness frequently makes both social and work rehabilitation and the stabilisation of medical conditions more difficult.

Any mistake is likely to result in the person being reincarcerated and their pathology worsening.

The twelve planned measures were implemented only partially, late or to an unknown extent. In 2010, the 173 French prisons concerned had the full-time equivalent of 157 psychiatrists organised into 26 Regional Medico-Psychiatric Departments (SMPR). Between 2005 and 2008, they received only €5 million of additional operating funding under the plan. On the other hand, €134.5 million (five times more than planned) was allocated to investments, mainly relating to security.

More Specially-Equipped Hospital Units (UHSA) than expected have therefore been funded. Each UHSA is built and managed within a psychiatric establishment, in compliance with both hospital and prison standards. Its external security is provided by the prison authorities.

Only one such unit had entered use by the end of 2010; the other 16, which generally contain 60 beds, will do so by the end of 2019.

It was necessary to give precedence to improving the premises, the renovation of which is a gradual process, and to securing them. On the other hand, less attention has been paid to ensuring that the courses of therapy are optimised, uninterrupted and lead to the patient's social rehabilitation.

Coordination difficulties still exist at several levels. The rapid social rehabilitation of some patients due for release is not possible, and some remain this way for some time.

Each year, some 8% of all consultations in prisons are cancelled at the last moment, either due to the patients or because staff responsible for internal transfers of detainees are not available.

(2) The French act of 5 July 2011 on the rights and protection of persons receiving psychiatric care was published after the Cour's survey was carried out; as a result, its implementation is not analysed.

"Health-Justice" scheme: unfinished progress

The resulting underutilisation is the full-time equivalent of dozens of psychiatrists.

This rate is as high as 54% in the Limousin region and 28% in the Nord-Pas-de-Calais region. According to the prison authorities, the schedules of psychiatric staff are not always appropriate. This is costly and adversely affects the care provided.

For the prison rehabilitation and probation service, the social stigmatisation of those awaiting trial, detainees and ex-detainees is worsened through "real difficulties (…) as a result, they cannot find stable accommodation, notably so that their medical care can be continued," emphasises the Ministry of Justice.

As the reports of the Controller-General of Places of Deprivation of Liberty make clear, the many instances of unsanitary conditions, promiscuity and staff and training shortages must be remedied.

A credible strategy that balances the sometimes conflicting requirements regarding personal protection and civil liberties has therefore been lacking.

The Ministry of Justice's strategic action plan 2010-2014 specifies actions that are more significant and better structured. In view of the objective of providing prison accommodation for 80,000 detainees in 2017, the psychiatric care facilities will be even more inadequate in the medium term if the time available for consultations is not optimised and the post-prison follow-up resources and their effectiveness are not improved.

In his reply, the French Minister of Justice has announced measures that implement the resulting recommendations.

Lack of internal audits and measures to combat fraud

The French Inspector-General for Social Affairs has written approximately twenty reports on psychiatric establishments since 2005. The lack of audits within the Ministry until 2010, on the other hand, has reduced its ability to monitor the plan's effectiveness, the associated risks and the reliability of the statistics.

In 2009, a check revealed that, in one region, each of the three most active psychiatrists had been reimbursed for an average of 63 consultations per day, whereas the national average was 11.5. No suitable indicators existed for detecting such abuses until now, but cases of medication-related fraud were punished. The French national health insurance fund (CNAM) has planned a battery of checks.

3 Insufficient supervision, adversely affecting key objectives

This chapter analyses the plan's method of supervision and its consequences, notably regarding its major objectives of increasing staffing, modernising real estate and increasing research.

The plan's supervision, which was initially sound, fell apart in the middle of 2007. This affected the distribution, control and monitoring of new resources—human, investment and research—even more because their funding was uneven. Whereas considerable funding was allocated to security, funds for job creation were barely noticeable and highly inadequate for research.

As many of the financial and statistical data are still provisional and being checked, a comprehensive report has not yet been produced. There are therefore still no indicators for monitoring the four psychiatric objectives of the 2004 law relating to public health policy, to which the plan relates.

The annual collection of data has been significantly improved, however, thanks to IT investments funded under the plan.

Subject to these considerable reservations, three aspects of the plan's financial contribution can be summarised as follows:

- Subsidies amounting to €540 million were paid in financial years 2005 to 2008, of which €36 million was paid by the State while the remainder was paid by the French national health insurance fund (CNAM);
- Since 2009, the national health insurance funde has paid €229 million per year to continue the plan's actions;
- Up to €1.8 billion will be allocated to real-estate and security investment between 2005 and 2017.

Half of the security-related investment will be funded by the French national health insurance system (via the 'FMESPP' public and private healthcare establishment modernisation fund), while the other half will be funded by the establishments themselves, either through internal reallocation or loans.

These three main aspects represented an annual increase of less than 2% of the resources, with regard to the €13 billion per year allocated to psychiatry by the French compulsory health insurance system.

This increase is less for psychiatry than for medicine, surgery, and obstetrics over the period of the plan; the plan's measures therefore seem to be funded through reallocation and not through additional funds.

Major real-estate programme, but late

Under the plan, 329 actions were scheduled for implementation by 2017 to compensate for shortcomings in the real-estate field, more than half of which have yet to be carried out:

Year of entering use	No. of actions
2005	1
2006	7
2007	19
2008	31
2009	39
2010	18
2011	91
2012	26
2013-2014	12
Later	58
Date unknown	27
Total	**329**
Abandoned projects	25

At this stage, these funded actions, which carried out among the hundreds of urgent necessary upgrades, have kept establishments, the condition of which varies greatly, in operational condition (sometimes after the deadline). The cost price per square metre was highly consistent.

In a third of the projects funded in this way, half of the funding was allocated to the former "specialist hospital centres" (CHS), which were the oldest establishments and were often highly dilapidated in areas.

The extra-hospital investment has, for its part, been restricted to 12% of the total. This level is less than was required by the change strategy promoting "decompartmentalisation", i.e. transparent services leading to better social rehabilitation.

Considerable effort has therefore been made to improve the quality and the security of the psychiatric hospital facilities, but it has not been possible to bring them up to the same level as the other healthcare facilities in every case.

This modernisation, which has focused too much on the full-hospitalisation units, has not been guided by a clear, appropriate strategy as insufficient attention has been paid to redirecting the methods of medical care towards eliminating or reducing the period of hospitalisation.

The French Minister of Labour and Health's reply announces a forthcoming inventory of hospital assets, along with measures to improve the implementation and the monitoring of real-estate related actions.

Psychiatric research remains the "poor relation" of health research. Insufficient epidemiological research, in particular, is carried out. The negative view stated in the plan as far back as 2005 regarding these issues still holds true.

The plan classified the human and social sciences field of research as being among those "that were underdeveloped and require top-priority support", but it specified and demanded nothing to remedy this weakness.

Solely the hospital programmes for clinical research (PHRC) have received new resources, which have been reallocated from other sectors: the national health insurance system has provided (mostly outside the plan) €12.3 million to 46 teams between 2006 and 2009 (more than one-third of which was for the "AP-HP" public hospital system of Paris and Sainte-Anne Hospital), and €3.4 million to 42 regional teams.

The French National Agency for Research has launched a call for a "neurological disease and psychiatry" project for 2008-2010, created a "mental health and addictions" working group and, for the first time, a "mental health and addiction" (SAMENTA) programme.

4 Territorial organisation

Chapter IV, lastly, covers the territorial organisation of psychiatric care: the "sectorisation" of psychiatry. This particular method of organising psychiatric care, which has been in use for half a century, has been gradually falling into disuse and resulted in a worrying lack of clarity regarding the organisational framework into which psychiatric care must now fit.

The plan's implementation has been set against a national strategy consisting in eliminating sectorisation and, with no credible sectoral organisation in the field, its natural continuation, resulting in extremely harmful confusion.

The 107 health-care territories could include a community level to ensure the sustainability of the sectors' achievements and overcome the sectors' weaknesses. This would help to ensure greater consistency in medical care facilities, based on benchmarks if not on standards.

At this stage, however, the plan has not resulted in sufficient growth in extra-hospital resources or a proportional reduction in full-hospitalisation capacity.

If this central objective is to be achieved, the French regional healthcare agencies (ARS) must plan their outpatient or part-time hospitalisation capacity according to the requirements, taking into account the poorly-defined public and private medical care providers, so that all patients are guaranteed of a range of community medical care.

At the end of 2011, the regional healthcare agencies defined their regional strategic health plans to comply with the organisational structures (medical care, prevention and medico-social care) and territorial health projects resulting from the work of the territory conferences. The various players' roles and modes of action should therefore be redefined and clarified as a matter of urgency.

The particular characteristics of psychiatry, which include the need to provide early medical care as well as to cater for the medico-social aspect and, in many cases, the need for social rehabilitation, therefore mean that a new public service role specific to the profession must be defined.

The French Minister of Higher Education's reply states various methods by which his department "will build on the Cour des Comptes' report in order to further support this discipline and increase the excellence of French research in this area."

Conclusion

The "psychiatry and mental health" plan, the core subject of the Cour's investigation, has unquestionably played a catalytic role in the field. In 2009, the French Ministry of Health assessed to what extent the plan's 33 measures and 196 actions had been implemented. A quarter of the actions did not focus on specific areas; their heterogeneity and that of the services provided did not allow meaningful national indicators to be produced.

No table contained information on the degree to which three-quarters of the other actions had been implemented, which varied greatly. The plan was therefore adversely affected by the methodology required by public health plan management being very poorly controlled. Under these conditions, it is difficult to weight the degree to which the plan has been implemented. The Cour nevertheless tried to weight the 33 measures in the following table.

This table also repeats that the objectives were all stated in terms of resources, and not of therapeutic results, as these can usually only be evaluated in the medium and long term.

The evaluation report produced by the High Council of Public Health (HCSP) in parallel with the Cour's survey confirms the Cour's observations and provides other case studies and assessments within its areas of specialisation.

With regard to the highly critical observation made in the plan in April 2005, real progress has certainly helped to significantly improve the situation, which was notable for the continued lack of alternative structures both upstream and downstream of hospitalisation.

Quite a few actions appear unfinished, however, and quite a few major inflection points are uncompleted.

As a result, more than 10,000 people remain in acute psychiatric care whereas their actual state of health would allow them to be more independent if they were provided with suitable medical care.

Psychiatric care must therefore be restructured around a more selective set of priorities and measures so that everyone can be treated with the dignity to which they entitled when they receive care in France, in accordance with the expectations of the patients, their families and medical care professionals.

It is now a matter of reorganising the medical care by increasing the coordination of community services while still maintaining the benefits of the care's sectorisation.

A policy of more actively redeploying hospital resources to extra-hospital structures must therefore be adopted.

This policy must take into account the national health insurance system's financial disequilibrium, which offers very little margin for manœuvre when allocating new resources.

The French Minister of Labour, Employment and Health's reply includes the announcement of a new plan relating to psychiatry and mental health and states that this plan, which is already under discussion, "can greatly draw on the Cour's chosen fields of improvement."

Table 1. Estimated degree of plan implementation 2005-2008

Measure	Abandoned	Low or uncertain	Moderate or variable	High	Completed
FIELD 1: DECOMPARTMENTALISED MEDICAL CARE					
1.1.1 General public campaigns					x
1.1.2 Promote mental health			x		
1.2.1 Break the isolation of GPs		x			
1.2.2 Outpatient, Med.-Psych. Centre and alternatives			x		
1.2.3 Adapt full hospitalisation			x		
1.2.4 Distribution of medical professionals	x				
1.2.5 Mental health networks		x			
1.3.1 Support services			x		
1.3.2 Mutual aid					x
1.3.3 Suitable housing or accommodation			x		
1.3.4 Protected work measures		x			
FIELD 2: PATIENTS, FAMILIES AND PROFESSIONALS					
2.1.1 Consultation with users and families			x		
2.1.2 Support for user and family associations					x
2.1.3 Expand CDHP skills	x				
2.1.4 Reform of hospitalisation without consent			x		
2.2.1 Initial and specialist training			x		
2.1.2 Increase investment				x	
FIELD 3: IMPROVE QUALITY AND INCREASE RESEARCH					
3.1.1 Develop good practices		x			
3.1.2 Promote proper medication use		x			
3.2.1 Gather medico-psychological information				x	
3.2.2 Information system on activity				x	
3.3.1 Clinical research on psychiatry			x		
3.3.2 Psychiatric and mental health epidemiology		x			
FIELD 4: IMPLEMENT ADDITIONAL, SPECIAL PROGRAMMES					
4.1.1 Medical care for depression			x		
4.1.2 Action strategy when faced with suicide			x		
4.2.1 Coordinated programmes for detainees				x	
4.2.2 Medical care for sexual aggressors			x		
4.3.1 Perinatal & medico-psychological collab.			x		
4.3.2 Children and adolescents				x	
4.4.1 People and precariousness				x	
4.4.2 Mental health of the elderly				x	
FIELD 5: IMPLEMENT, MONITOR AND EVALUATE THE PLAN					
5.1 National monitoring of the plan			x		
5.2 Regional approach				x	
Total	2	6	14	8	3

Source: Cour des Comptes

Recommendations

The 23 operational recommendations made by the Cour are intended to implement the four main strategic fields of improvement suggested in this report:

➧Firstly, a public service role directed towards all areas of psychiatry (instead of only hospitalisation without consent, as at present) should be defined and implemented;

This definition should retain the achievements of sectorisation and clarify the strategy. Such a role, and the contractual relationship it involves with its players, would make it easier to reorganise and structure the medical care offering. The "sector", provided it evolves, remains more of a solution than a problem.

➧Secondly, more effort should be made to reduce the geographical disparities, through redeployment due to the national health insurance system's financial constraints, by giving a higher priority to the community alternatives.

➧Thirdly, a reform of psychiatric care funding should be drafted and implemented. The plan's progress in the fields of computerisation and statistics should now enable this reform to be implemented without delay, benefiting the extra-hospital structures;

➧Lastly, the efficiency and efficacity of the medical care can only be increased if greater efforts are made in the research and epidemiological fields.

List of recommendations

Medical care

➧1. Continue to develop and widen the extra-hospital healthcare, medico-social care and social care offering, mainly so that the independence and social rehabilitation of patients are improved;

➧2. Evaluate performance, notably in terms of the waiting time for obtaining a specialist medical opinion or being admitted into a centre, and in terms of the fit-to-need of inappropriate full hospitalisation;

➧3. Add responsibility for locating, analysing and locally correcting any medical care interruptions and waiting times, regardless of their cause, to psychiatry's public service role;

➧4. Ensure that the establishments' organisational and internal management methods are revised so that it is easier to distinguish between the resources allocated to hospital and extra-hospital structures and reduce the degree of fungibility between the two;

➧5. Enhance the organisation and sustainability of emergency psychiatric services;

➧6. Harmonise the design, distribution and use of units for difficult patients;

➧7. Reform the funding of psychiatry via the national health insurance system, so that it is based on tariffs that take into account the psychiatric care's characteristics.

"Health-Justice" scheme

➧8. Publish the circulars concerning coordination between the prison authorities and the health-care professionals, taking into account article D.90 of the Code of Criminal Procedure in the health-justice protocols, and harmonise their implementation;

➧9. Develop standards and indicators for the care of patients under a court order, including at the post-penal stage, consolidating its medical and social coordination as provided for in the strategic action plan 2010-2014;

➧10. Ensure that all prison facilities in which medical care is provided meet the hospital standards introduced in 2011;

➧11. Improve the management of consultation time in prisons.

Supervision

➧12. Ensure better coordination of psychiatric policy at an inter-ministerial level, particularly between the Ministries of Justice and Health, including for patients under a court order, together with its follow-up based on reliable indicators;

➧13. Strengthen the supervision and national and regional monitoring of psychiatry;

➧14. Consolidate the funding and management of the French National Mission for Mental Health Support (MNASM) in accordance with the current regulations.

Indicators

➧15. Develop the epidemiological and statistical data sources so that psychiatric public-health indicators can be implemented, based on more rapid and better-coordinated data use, without identifying objectives with no tools for follow-up.

Funding

➧16. Make a clear distinction between durable non-renewable credit measures and new measures, and those funded through redeployment in the public health plans and their reports.

Human resources

➧17. Implement a medium-term initial and continuous training plan for all psychiatric players;

➧18. Increase the mentoring of newly-hired staff, offering the appropriate incentives;

➧19. Reduce the pay differentials between hospital and private practice (repeated recommendation).

Investment

➧20. Ensure that all establishments and departments welcoming the mentally ill comply with the national standards, including those within the prison system;

➧21. Prohibit the full payment of investment subsidies prior to completion, and ensure that their balance is paid solely when the subsidised equipment actually enters use.

Research

➧22. Ensure that all psychiatric research is coordinated at the cross-disciplinary level.

Territorial organisation

➧23. Define a psychiatry-specific community public service role in the French public health code, ensuring that all benefits of the sectoral policy are maintained;

➧24. Determine the conditions governing how each of the various potential psychiatric activities is authorised and operates;

➧25. Set up a consistent hierarchy linking the community care offering and the specialised bodies serving larger areas;

➧26. Generalise the mental health local councils, grouping together all psychiatric and general practice players and their partners, including the local authorities, for a given territory.