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SPECIAL ISSUE

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The current state of adult mental health care in France

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Abstract Since the 1960s, French public mental health services are organised in "sectors", each sector catering for a mean population of 54,000 inhabitants. Although this organisation was aimed at insuring equal access to care whatever the place of residence, there are still huge disparities in number of staff and bed resources from one sector to another. The reduction in the number of hospital beds started later in France than in most other European countries, and was really effective in the 1990s. In 2000, there were 9.4 beds for 10,000 inhabitants aged over 20 years. Hospital-based care has still an overwhelming importance, and is associated with a marked underdevelopment of community services and lack of sheltered housing for the most disabled patients. With more than 13,000 registered psychiatrists in France, the density of psychiatrists is one of the highest in the world. However, French psychiatry has currently to face a structural crisis due to the reduction in public health budgets, as well as to the reduction of 30% in the number of French psychiatrists over the next two decades. The numerous national programmes aimed at renovating French mental health services, published over the last decade, have not yet kept their promises.

Key words french psychiatry · mental health services · mental health professionals

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Introduction

Generalities about the health care system, and about the mental health legislation

The total number of inhabitants in France is 63 millions. The current organisation of French public mental health care is based upon a structure implemented in the 1960s. Public adult mental health services are organised according to 839 catchment areas, called "sectors", each catering for a mean population of 54,000 inhabitants aged over 20 years. The primary aims of this organization were to promote the development of prevention and community care, and to ensure that any subject living in France may have easy access to a mental health service and may be treated by an identified team [1]. The rule of sectorisation does not—theoretically—apply to the patient, who can choose to be treated by another team than that in charge of his/her catchment area. French patients can freely consult a public or private psychiatrist without GP referral, since psychiatrists are among the remaining few specialists with direct access according to the new law that regulates access to specialists, operation as from July 2005.

Compulsory admissions can be decided upon according to two modalities. "*Hospitalisation à la demande d'un tiers*" (requested by a third party, i.e. by any person "feeling concerned" for the patient's health) is based upon a medical decision and concerns persons with a mental state "requiring urgent treatment and permanent medical supervision". The request of hospitalisation has to be certified by two medical doctors. The second modality, "*Hospitalisation d'office*" (committed hospitalisation) is decided by a state administrator ("*Préfet*") for patients "threatening the public order or the safety of persons". There is no fixed duration of compulsory admissions, but a medical report confirming that hospitalisation is still required has to be provided after 24 h, then after 15 days, then monthly.

Welfare characteristics and funding modalities of the health system

Total French health expenditure was 10.5% of GDP in 2003 [2]. Mental health disorders are the second most costly group of diseases, accounting for 9.4% of the total health expenditure [3]. The cost of full-time psychiatric hospitalisations represents 80% of mental health expenditure [4]. Regional agencies are in charge of regulating and controlling the hospital health budget at a regional level, in accordance with priorities defined at a national level. The national health insurance system, called "*Sécurité Sociale*" (Social Security) was established immediately after World War II.

Psychiatric treatment is free if the patient is suffering from a chronic or severe mental illness (except for housing costs during full-time hospitalisation, which can be covered by private insurances) or if he/she is financially severely deprived. Outpatient psychiatric treatment, provided in mental hospitals or Community Mental Health Centres (CMHCs) is free of charge. The cost of private psychiatric treatment is funded in part by the social security; the remaining part can be funded by private insurances. There is currently no limit in the number of private psychiatric consultations covered by the social security. Psychoanalytic treatment by private psychoanalysts is most often not covered, as well as psychotherapy provided by private psychologists is not (yet) covered by the social security.

Role of professional societies

There are several psychiatric professional societies, but there is no legal obligation for psychiatrists to register to any of them. The only legal obligation for psychiatrists (and for all French practitioners) is to register and to pay yearly fees to the "*Conseil de l'Ordre des Médecins*", an elected national medical agency aimed at regulating and controlling medical practice. In order to identify an association representative of the largest number of French psychiatrists, the Minister of Health promoted in 1992 the development of the French Federation of Psychiatry aimed at gathering professional associations (Fédération Française de Psychiatrie, FFP, http://www.psydoc-fr.broca.inserm.fr/FFP/FFP.html). The associations are free to become a member of the FFP or not. The FFP has contributed to organise consensus conferences.

Training of psychiatrists

Training in psychiatry starts after 6 years of general medical studies. The choice of the speciality and of the university residency programme are dependent on the rank obtained at a national examination regulating access to all medical specialities, general practice being considered as a speciality since 2004. The number of residency positions in psychiatry in each university is hence regulated at a national level. In 2005, 300 residency positions in psychiatry were available in France (out of a total of 4,803 positions for all medical specialties, including 2,400 for training in general practice). This represents a major increase, as there were only 176 psychiatric positions in 2001. Duration of training is 4 years, including at least 1 year of training in a child and adolescent psychiatric department, and at least 6 months of training in a university department of psychiatry. At the end of the 4-year training period, the title of Medical Doctor specialised in psychiatry is granted after having defended a medical thesis on clinical or research work. There are only two official qualifications in subspecialties, adult psychiatry and child psychiatry. Education in psychiatry can be completed by a 1-year complementary training period in addiction, pharmacology, forensic medicine or geriatric psychiatry.

Research infrastructures

The under-development of French psychiatric research has been recognized in a large number of consecutive reports, including the last Mental Health Plan [4], but the subsequent proposals aimed at changing this situation have had so far only a moderate impact. Medical research in general, and psychiatric research in particular, is almost exclusively carried out in research units officially designated for a duration of 4 years after a national assessment procedure. This designation can be made by the Minister of National Education, Universities and Research, as well as by national research agencies, such as the National Institute of Health and Medical Research (INSERM) or the Centre National de la Recherche Scientifique (CNRS). The number of research units involved in psychiatric research is still markedly low, although this number has slightly increased after the creation in 2000 of an INSERM committee aimed at promoting creation of INSERM research units devoted to psychiatry. If INSERM units including psychiatric research as part of their research activities are counted, there now are around 10 designated units. Funding of these units by the University, INSERM or CNRS is usually modest, hence the main interest of the designation is to favour funding through grant applications. The Ministry of Health is promoting regular research grants through the *Mission Interministérielle de Lutte contre la Drogue et la Toxicomanie* (MILDT) for research on substance use disorders, and through the *Mission Recherche* (MiRe) for research in social psychiatry. Other grant programmes are most often not specifically aimed at funding psychiatric research, and psychiatric projects have to compete with other specialty projects, such as for example in the grant programme "Neurosciences, Neurology and Psychiatry" promoted in 2005 by the recently created "*Agence Nationale pour la Recher-*

che" (ANR). Applications for research projects in psychiatry made in the framework of the national programme of hospital research grants (*Programmes Hospitaliers de Recherche Clinique*) have been encouraged in the recent years, and they are also in competition with other specialty projects. There are very few private sources of funding, with the exception of the *Fondation pour la Recherche Médicale* (FRM), a charity that has regularly developed research grant programmes for psychiatric research.

Roles and characteristics of self-help organizations and NGOs active in the mental health field

Over the last decade, users and family associations have gained a growing position in the organisation of health care in general. Their role has been openly acknowledged and specified in the recent laws, and members of users' associations are now part of hospital management boards, of hospital committee on patient's rights, and of committees in charge of mental health planning at regional level. They also participate in national consensus conferences. The *Fédération Nationale des Associations d'(ex-) Patients-Psy* (http://www.fnappsy.org) is the main users' association, while the *Union Nationale des Amis et Familles de Malades Mentaux*, established in 1963, and now counting 12,000 members (http://www.unafam.org) is the main association of patients' relatives. According to the most recent mental health plan, users' associations should receive about 600,000 € of annual funding from the Ministry of Health [4].

The role of NGOs like *Médecins du Monde* (http://www.medecinsdumonde.org) is mainly concentrated on the development of medical facilities able to improve the access to care for severely deprived subjects, such as psychiatric consultation for homeless people.

Structure (input) data

Information on mental health facilities and mental health professionals were drawn from statistics provided by the Ministry of Health (http://www.sante.gouv.fr) [5, 6] and from the last official Mental Health Programme [4].

Mental hospitals

In 2000, in Francethere were 43,173 public adult psychiatric beds, i.e. 9.4 beds per 10,000 inhabitants aged over 20 years. The reduction in the number of hospital beds started later in France than in most other European countries, and became really effective in the 1990s, and it was mainly motivated by the need of cost reduction. This number has decreased by 49% since 1987 (84,000 beds at this time). Most (98%) adult psychiatry sectors have beds, with a mean number of 54 for each sector; half sectors have between 35 and 65 beds, and only 6% have more than 100 beds (compared to 54% in 1987). Most hospital rooms are single (61%) or double (26%), but there are still 13% of rooms hosting three or more patients.

Two out of three beds are located in mental hospitals. As a large number of mental hospitals built during the 19th century are located in rural areas outside the main cities, the beds are not physically located in the geographical area of the corresponding sector in 50% of cases. Although child and adolescent psychiatry is outside the scope of this paper, a complete appraisal of the state of adult psychiatry has also to take into account the very low number of beds (N = 1,604) in child and adolescent psychiatric sectors. Only one child and adolescent psychiatric sector out of three has no bed, and the 121 sectors with beds have a mean of 13 beds for these specific age group. As a consequence of the limited number of beds, adolescents and even children are frequently hospitalised in adult psychiatry wards.

Acute inpatient facilities

The distinction between beds located in acute inpatient facilities and other inpatient units is difficult, since acute, medium or long-stay facilities are not clearly distinguished in most mental hospitals, and mixed populations are yet often admitted to the same ward. Hence statistics are available for all psychiatric beds considered jointly.

General hospital psychiatric units

Thirty percent of public hospital beds (i.e. around 15,000) are located in general hospitals. The lack of integration of psychiatric care in the community, with very few psychiatric units within general hospitals, has been regularly stressed [7], and it has been highlighted that this is a factor particularly contributing to an increase of stigma for mental disorders [8].

Private inpatient facilities

There are approximately 10,000 private beds in France, representing less than one-fifth of all psychiatric beds. The stay in private inpatient facilities is reimbursed by the Social Security.

Other acute inpatient facilities

As another example of the scarcity of community facilities, there are very few crisis centres; these are available in only 5% of sectors, with a total number of 172 places (mean number by centre: 5). "*Home hospitalisation*" for acutely ill patients has been developed by a limited number of sectors (5%), for a total number of 437 places.

Non-hospital residential facilities

There are 86,000 places in non-hospital Residential Facilities (RFs), including 11,000 places in "*Maisons d'Accueil Spécialisées*" (specialised sheltered houses) for severely disabled patients [8]. There are 2,600 places for adults in "therapeutic families". One-third of adult psychiatric sectors is equipped with this kind of RF, with a mean of 9 places. A quarter of adult sectors have "therapeutic apartments" (mean number: 9 places), defined as community facilities aimed at fostering patients' rehabilitation with intense nursing supervision, and requiring a high level of staff resources. Half sectors use "sheltered apartments" managed by private non-profit associations, with a lower level of staff resources.

Outpatient facilities

There are 2,200 Community Mental Health Centres (CMCHs). All sectors of adult psychiatry have set up at least one CMHC, 97% have at least one CMHC open 5 days a week, and 71% at least 2. Most CMCHs are located in separated facilities, 15% are combined with a day-hospital, and 28% with a day-centre.

Day-hospitals are 1,218, totalising 13,900 places and a mean number of 17. Most adult psychiatry sectors (83%) have at least 1 day-hospital, and 87% of them are open over all the year. More than half (58%) are located outside the hospital premises, with a mean distance of 31 km (0–300 km).

Finally, there are 1,056 day-centres. In contrast with day-hospitals, where the patient is supposed to stay for the all day, these facilities are aimed at providing time-limited care through focused activities. Adult psychiatric sectors have largely developed day-centres, since the percentage of sectors equipped with such facilities has increased from 41% in 1989 to 78% in 2000. Also in contrast with the large percentage of day-hospitals still located in the premises of mental hospitals, day-centres, more clearly oriented toward community care, are largely (91%) located outside hospitals.

The personnel

Table 1 shows the numbers and rates of professionals working in public mental health services and drawn from a national survey of all public mental health services carried out in 2000 [5].

Psychiatrists and psychologists

In January 2004, there were 13,765 psychiatrists in France, representing 13% of specialists [6]. They had a mean age of 50 years, and 23% were women. The density of psychiatrists (23 per 100,000 inhabitants) is one of the highest in the world. However, the number of psychiatrists should decrease by 30% over the next two decades, down to approximately 8,000 psychiatrists in 2020 [9]. They are fairly distributed between private practice (48%) and public services (45.6%), the other working in private institutions.

Table 1 Number and rates of public psychiatry professionals in 2000 [5]

	Mean number per sector		Rate for 100,000 inhabitants	
	Child	Adult	0–19 years	≥20 years
Psychiatrists	4.9	4.8	9.6	8.9
Registrars	0.8	0.9	1.6	1.7
Other practitioners	0.1	0.5	0.1	0.9
Total medical staff	5.8	6.2	11.5	11.5
Psychologists	6.6	2.5	12.8	4.7
Nurses	15.3	48.4	31.1	89.4
Chief nurses	2.6	5.4	5.3	9.9
Psychomotricians	2.9	0.2	6.0	0.4
Ergotherapists	0.1	0.6	0.1	1
Orthophonists	2.8	0	5.6	0
Social workers	8	2.8	16.1	5.4
Others[1]	10.4	19.8	21.1	36.4
Total non-medical staff	48.4	79.8	99.8	147.4

Public psychiatrists have to choose to work in adult or in child and adolescent sectors, with the possibility to change from one area to another during their career, just by moving from one type of sector to another. Although private psychiatrists may choose to treat only adults or only child and adolescent patients, there is often an overlap between these two kinds of clinical practice. Hence, if is not possible to assess the exact number of adult psychiatrists and child and adolescent psychiatrists in France.

There are 35,000 psychologists in France, of whom 5,000 are working in psychiatric facilities.

Nurses and other professionals

In France there are 58,000 nurses working in the area of mental heath. The former diploma of "psychiatric nurse", which selectively enabled access to work restricted to psychiatric institutions, has been cancelled in 1992, and all nurses receive now a training in general nursing. Then all nurses have to undergo a training in psychiatric services, but no specialisation in psychiatry is possible during their general training. Information on other professionals is given in Table 1.

Variation in the availability of facilities across different country areas

There are huge regional variation in the availability of mental health services and their organization. The number of inhabitants by adult psychiatry sector ranges from 20,000 to 170,000 aged over 20 years, the number of beds ranges from 55 to 115 per 100,000 inhabitants, and the numbers of psychiatrists and

nurses ranges from 4 to 17 and 30 to 150 per 100,000 inhabitants, respectively. The density of psychiatrists varies from 12 to 36 per 100,000 at the region level and from 9 to 90 per 100,000 at the "département" level (a "département" is the major French administrative geographical area).

There is no legal regulation limiting the number of psychiatrists allowed to set up a private practice in a given area, hence psychiatrists are concentrated in the South of France and in the largest cities (excluding the most deprived suburbs), with one out of four private psychiatrists practising in inner Paris. By contrast, a large number of positions of public psychiatrists lie vacant in public hospitals in rural areas and in Northern France (9% of all full-time and 14% of all part-time posts).

Process data

Even these data are drawn from statistics provided by the Ministry of Health [5, 10] and from the last Mental Health Programme [4].

Rate of users of public mental health services

In 2000, 1,151,000 subjects were treated by public mental health services (mean number by sector = 1,387, range 80–5,600), corresponding to a 62% increase compared to 1989. The rate of subjects aged over 20 years in contact with public mental health services was 26 per 1,000 (sector range: 9–70; regional range: 22–34). Women were slightly over-represented (54%), as well as subjects aged 25–44 (43%), the age distribution of the patients being similar to that of the general population. Nearly half (43%) were treated for the first time by a given sector (but may have had previous contact with another sector), and a quarter (25%) of patients were seen only once over the year.

Hospital admission and stay

In 2000, 306,000 persons have been admitted or have stayed in different types of psychiatric facilities. The mean percentage of admitted patients among those in contact with public mental health services was 27% (sector range: 0–59%). Compared to 1989, there was a 20% increase in the number of admission, but a marked decrease in the percentage (36% in 1989). The mean duration of stay per year (continuous or not) was 45 days (86 in 1989), ranging from 24 to more than 55 from one region to another. Home hospitalisation was provided to 1,200 patients, with a mean duration of 3 months.

Although the number of subjects staying for more than 1 year is low (4%, regional range: 2–7%), 25% of public beds were occupied by these patients. As previously mentioned, long-stay units are not clearly identified in a large number of mental hospitals, and adult persons with autism, or with chronic psychotic disorders, are often hospitalised in acute wards because of the lack of alternative RFs for disabled adults with mental disorders.

Activity of RFs

Psychiatric institutions funded by the social security are in charge of treating people with mental disorders, while social services funded by state social agencies of each "département" have to care for people with disabilities due to psychiatric or somatic problems. Medico-social institutions have the dual authority, and are funded both by the social security and the state social agencies. Only statistics on activity provided by non-hospital residential facilities managed by public mental health structures have been found by the author. In 2000, only 1.4% of patients treated by public health structures were concerned ("therapeutic family" n = 3,100; "therapeutic apartment" n = 1,800).

Activity data of outpatient facilities

In 2000, there have been 980,0000 outpatients, corresponding to 85% of all patients treated by public mental health services (sector range: 54–100%). This proportion was lower (75%) in 1989. Nearly two out of three (65%) subjects were only treated as outpatients. Among the subjects with ambulatory follow-up, 70% were seen in CMCHs. The mean number of consultations per patient was 8 per year, a number stable since 12 years in spite of the increase in the number of outpatients. Domiciliary visits were performed for 17% of patients, corresponding to 120,000 patients visited at home (mean number: 11 per year) and 79,000 visited in residential settings or in jail (mean number: 8 per year).

Part-time care involved 125,000 (11%) patients (sector range: 0–43%), corresponding to a 50% increase since 1989. More patients (N = 66,000, mean number 23 days) were treated in day centres compared to day hospitals (n = 48,000, mean number 58 days).

Compulsory treatment

The proportion of compulsory admissions on the total of hospital admissions is 13% and has considerably increased over the last decade (+86% from 1992 to 2001), probably as a consequence of the change in the law in 1990. There are each year around 62,000 "*Hospitalisation à la demande d'un tiers*" (hospitalisation requested by a third party) and 6,000 "*Hospitalisation d'office*" (committed hospitalisation).

Quality of care studies

Although several consensus conferences on psychiatric issues have been organised in France, leading to guidelines and recommendations broadly diffused to mental health professionals, in particular through the website of the "Haute Autorité de Santé", the national agency in charge of the elaboration of professionals recommendations and evaluation of quality of care (http//:www.has-sante.fr). Few studies have investigated their impact on practices. The only example is provided by studies exploring on national representative samples the impact of the consensus conference on treatment of schizophrenia organised in 2004, that showed that French psychiatrists have slightly decreased coprescription of neuroleptics after the diffusion of recommendations drawn from this conference [11, 12]. A national audit has been organised to assess use of physical constraint in mental hospitals [13] leading to recommendations for implementation of specifically designed rooms, that are now available in a large number of acute wards. A few studies have been carried out on specific issues in small samples [14–16]. If studies sponsored by drug companies were excluded, we are not aware of other studies carried out in adult mental health services. As our search was limited to information available on official websites and research papers published in journals referenced in international database, we cannot exclude that such studies, if any, may have been published elsewhere. This scarcity of studies should shortly change, since assessment of professional practices has been made obligatory since July 2005 for all practitioners by the national agency "Haute Autorité de Santé".

Users' satisfaction studies

If studies sponsored by drug companies are excluded, we did not find studies carried out in French mental health services on that issue. As our search was limited to information available on official websites and research papers published in peer-reviewed journals, we cannot exclude that such studies, if any, may have been published elsewhere.

Discussion

Most public psychiatrists and mental health planners would agree on the fact that French psychiatry is currently facing a major crisis. In spite of the massive closure of beds that took place over the last 15 years, hospital care has still an overwhelming place, with a marked under-development of community treatment and lack of sheltered housing for the most disabled [8, 17]. Hence, most French mental hospitals have now major difficulties to find beds for acutely ill patients: only 35% of sectors were able to find a bed within 24 h for these patients in 2000 [5], and the situation has dramatically worsen in several regions since this period. Another major drawback is due to the fact that a large proportion of public mental health professionals are reluctant to adapt the sector organisation to the societal changes that have occurred over the last 30 years. The public health principles offering guarantee of universal access to care as well as continuity of care have obviously to be preserved. However, the principle stating that all psychiatric teams should have a similar and general competence in mental health care has limited the development of tertiary structures specialised in the assessment and treatment of specific mental health disorders. There are currently few "intersectorial" structures, with the exception, for example, of health facilities for persons with substance abuse. The sectorial organisation, at least that based upon catchment areas of relatively limited size, should be rapidly reconsidered. There is currently an ongoing large reform in the funding procedures for French public hospitals ("Hospital 2007 Programme"), shifting to global yearly funding by regional agencies to funding based upon the actual activity of the hospital, and eventually, of each department of the hospital. Hence, gathering of small departments into bigger ones is currently "encouraged" by hospital administrations in order to facilitate this new hospital financial management. Hence, particularly in urban areas, the co-existence within big hospitals of numerous psychiatric sectors (and their corresponding numerous chiefs) will soon become an obsolete organisation replaced by few big departments (and few chiefs). This reform only motivated by health cost reductions may (hopefully) allow for a better organisation of public mental health services, favouring in particular the development of specialised units within these big departments. The probable larger size of the future catchment areas may also favour the implementation of local networks with private and public health professionals involved in mental health care, as suggested by some pilot experiences.

However, several other questions are still waiting for reassuring answers. How will the public mental health services adjust to the massive reduction in the number of psychiatrists over the next years? Will other health professionals such as general practitioners and psychologists accept and have the adequate training to ensure psychiatric care no longer provided by psychiatrists? Will the universities assuring initial training of psychologists and general practitioners, and continuous medical education, have the resources to adjust for these changes? Will the Social Security be preserved, or will the health expenditures be progressively shifted to private insurances? Will free care be still possible for the more disabled or more deprived patients with mental disorders?

Consecutive reports [8, 17] and several national programmes aimed at renovating the French mental health structures have been published over the last decade [18], without noticeable impact. Regarding the new programme aired in 2005 by the Minister of Health [4], the only possible comment is similar to that we did in a previous paper [19] regarding another programme launched in 2001 [20] and never applied: it is to be hoped that these worthy propositions will be followed by future changes.

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