Questions d'économie de la Santé

no 145 - August 2009

Fifty Years of Deinstitutionalisation Policy of Psychiatric Services in France: Persistent Inequalities in Terms of Resources and Organisation Between Psychiatric Sectors

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Fifty years after the mental health policy of deinstitutionalisation introduced psychiatric sectors in France, these elementary state-running psychiatric-care-delivering units are marked by considerable geographical disparities in the human and financial resources allocated, facilities and equipment capacity, and the degree of commitment to reaching the initial goals set in the policy.

To describe these disparities, a typology of adult psychiatry sectors was established using a three-factor classification: the allocation of facilities and personnel by number of inhabitants covered, the range of services and types of care delivered, and the way the services are used.

This typology goes beyond the clear distinction between adequate and under-resourced psychiatric sectors, and offers a more detailed analysis of the organisation and degree to which French sectorisation policy has been completed, notably in terms of providing and developing alternatives to inpatient facilities.

In comparison with other countries, French psychiatric provision can be considered as quantitatively substantial, notably in terms of facilities and human resources [WHO, 2005], and can equally be qualified as innovative. This latter point is demonstrated by the pioneering organisation of public hospitals into geographically sectored divisions: the 'psychiatric sectors'. The sector, initiated by the Ministry of Public Health circular of March 1960, constitutes the base unit in the delivery of public psychiatric care. For a specific geo-demographic zone, it provides and coordinates a comprehensive range of care and services necessary to the global coverage and continuity of care: prevention, care, aftercare and follow-up[1], and rehabilitation (*Cf.* Insert p. 2). Patient management and care coordination are ensured by multidisciplinary teams. With 815 general psychiatry sectors, one sector for 56,100 inhabitants aged over 20 on the average, the public psychiatric care supply in 2003 represented 80% of the psychiatric activity carried out by health establishments.

The sectorisation policy, largely influenced by the movement towards deinstitutionalisation recommended and supported by the World Health Organisation (WHO) in Europe since the beginning of the 1970s, was implemented in a number of other countries [Johnson, Thornicroft, 1993]. European policy, mainly elaborated in opposition to inpatient hospitalisation in specialised mental institutions, is based on the development of alternative care structures within or as close as possible to the general hospital, the home, the family and more generally to the patients' living area.

One major difference in France has been its deinstitutionalisation policy. Contrary

1 Translator's note: therapeutic facilities for patients transitioning between a hospitalisation and their return to home.

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The authors would like to thank Julie Chevalier and Isabelle Leroux for their collaboration.

The different medical services in adult psychiatry

[Coldefy, Bousquet (2002) ; Coldefy, Lepage (2007)]

Three different types of medical services in adult psychiatry can be distinguished, whether mobilised exclusively or not: ambulatory care (86% of the annual number of patients seen at least once during the year in 2003/67% received this type of care exclusively), inpatient care (25% of the annual number of patients/11.5% exclusively), and finally outpatient care (9% of the annual number of patients/1.5% exclusively). Over the last ten years, increased use of medical services concerns primarily ambulatory and outpatient care [Coldefy, 2007].

Ambulatory medical services deliver all forms of care outside hospitalisation. More often than not (76% of the number of annual ambulatory patients in 2003), patients are seen within the framework of community mental health centre consultations.

The community mental health centres (CMHCs) are reception and care coordination units. They organise all out-of-hospital actions effectuated by the health care teams and coordinate them with the hospital. Among those actions are prevention, diagnosis, interventions and treatments in the home or residential institutions other than the home (socio-medical structures, prisons, etc.). Certain CMHCs are equally capable of responding to psychiatric emergencies and are then known as 'permanent reception centres'.

Liaison psychiatry, concerns care or interventions in inpatient somatic wards, and constitutes the second main form of ambulatory care (20% of the annual number of patients in 2003). Ambulatory care activity also includes treatments and interventions in the home or substitute-for-home residential institutions (17.5% of the annual number of patients in 2003).

Inpatient medical services sconcern almost exclusively inpatient hospitalisation (97% of the annual number of inpatient patients). They are carried out in care centres where patients are under 24 hour surveillance and are reserved for acute situations and worst case patients requiring intensive care. Other forms of inpatient care are effectuated either within or outside the hospital structure, notably within the following types of structure:

- Rehabilitation units: medium stay units designed to provide continued active care and treatments necessary to rehabilitate patients after a phase of acute illness, in view of their return to autonomy;
- Hospitalisation at home (HAH): therapeutic care within the patient's home associated, if required, with housekeeping services necessitated by the patient's degree of dependency;
- Therapeutic apartments: care units outside the hospital made available to a few patients for a limited time period. Their aim is to enable the patient to live a normal life as far as possible but whose health status nevertheless requires daily visits from health professionals.
- Specially trained families: patients of all ages are placed in a host family when keeping or restoring them to their own homes is either not recommended or possible.

Outpatient medical services sare carried out in more or less medicalised structures without accommodation, with the exception of night hospitals. Among them can be found:

- day hospitals (40 % of the annual number of outpatients) deliver polyvalent and intensive care during the day, one or several days per week;
- night hospitals (5 % of the annual number of outpatient patients) involve therapeutic care at the end of the day, and medical surveillance during the night or even at the end of the week;
- day centres (59 % of the annual number of outpatients) provide therapeutic activities (support and group therapy) and occupational therapy aimed at rebuilding patients' autonomy and social rehabilitation;
- therapeutic workshops (4% of the annual number of outpatients) provide therapeutic (e.g. ergotherapy) and occupational activities (arts and crafts or sports) aimed at encouraging patients to exercise a professional or social activity.

Background

In 2002, the Cnamts* scientific council asked the Irdes to conduct research on psychiatric services. In a domain already subject to numerous studies, Irdes chose to analyse the impact of the disparities in the psychiatric care supply on the accessibility to and use of psychiatric care. The first part of the study, included in the current Questions d'économie de la santé, consisted in elaborating a typology of the adult psychiatric care supply in metropolitan France. A second experimental study on psychiatric ambulatory care was carried out in the Ile-de-France region among private psychiatrists and general practitioners [Coldefy *et al.*, to be published in 2009]. This research was based on various sources of information made available by the Directorate of Research, Studies, Assessment and Statistics (Drees) and the Regional nion of Health Insurance Funds in Ile-de-France.

to what was being done in other countries, rather than voice an outright opposition to inpatient psychiatric hospitalisation, sector policy advocated changes in order to eventually supersede it [George, Tourne, 1994], hospitalisation and its alternatives being a complementary unified combination of care supply and provision that today appears to prevail in Europe. This stance resulted in keeping psychiatric hospitals open, contrary to our European neighbours such as the United Kingdom or Italy. The second French specificity was to define each sector as geographical entities within which global psychiatric care can be provided in such a way as to avoid patients' segregation [Fourquet, Murard, 1980].

Even if the psychiatric sector constitutes an organisational and functional framework, the disparities in terms of resources (human, material, financial) and of levels of commitment to attain set goals caused the French 'sectorisation' policy to be only partially achieved. If disparities in resources have already been analysed fairly thoroughly [Coldefy, Bousquet, 2002; Alluard, Coldefy, 2005], disparities in levels of commitment have tended to be analysed at a local or regional level rather than at a national level [MNASM, 2005].

Today, sector policy is placed within a context of change with an expected 8% reduction in the density of psychiatrists in France by 2030, which is currently one of the highest densities in Europe [Attal-Toubert, Vanderschelden, 2009]. In parallel, psychiatric care use continues to increase [Coldefy, 2007], whereas the legitimate attributions of psychiatry and mental health respectively are being questioned [Ministry of Health, 2004]. Finally, with the adoption of the Hospital, Patients, Health and Territories Bill*,

health policy is extending the concept of organising care provision by territorial division to office-based care.

Our study aims at assessing the degree of completion of the psychiatric sectorisation policy. In this perspective a typology of metropolitan France adult psychiatry sectors according to care supply was elaborated. It is based on data taken from psychiatric sector annual reports, environmental data on the social and health care supply, and the population covered (*Cf.* Sources insert opposite and Methods insert p. 6). This typology classifies the sectors according to three factors: human and material resources allocation by population base, the range and types of care and services provided, and the use of psychiatric care.

For each variable or group of variables, psychiatric sector positioning is determined according to the quartile in which it belongs, and thus to the median[2]. In opting to analyse sector coverage by population base and the range and type of care provided, we complement previous studies on the sectorisation of psychiatric services by providing an additional insight. Former studies were mainly focused on the material and human resources within the psychiatric sector as compared with their stated activity.

Firstly, we present the factors that distinguish psychiatric sectors from each other and, secondly, we present the typology of sectors grouped into nine classes.

Significant differences in the allocation of facilities and personnel…

Resource allocation in terms of facilities and non-medical personnel constitutes the first distinguishing factor between psychiatric sectors. On the one hand, it concerns inpatient hospital bed capacity, and on the other, outpatient facilities for all types of care. Non-medical human resources (nurses, carers or socio-educational staff) are equally a determining factor. Psychiatric sectors incorporating general hospitals oppose those incorporating psychiatric hospitals as they are respectively under- and over-resourced than the median of psychiatric sectors. Furthermore, sectors whose level of allocation is lower than the median of psychiatric sectors achieve a lower use rate whether in inpatient or outpatient hospitalisation, and inversely for the sectors with better resource.

The second factor concerns resources in terms of psychiatrists and specialised personnel such as psychologists or socio-educational and rehabilitation staff (hereafter referred to as 'specialised personnel'). According to this factor, psychiatric sectors based in rural areas with an elderly population and numerous structures for disabled adults are understaffed in specialised personnel in comparison with Ile-de-France[3]-type sectors. The latter, with a great number of specialised personnel, are characterised by high accessibility to care which is provided by a significant proportion of community mental health centres open at least two nights a week after 6pm, emergency reception centres such as crisis centres or permanent reception centres, a low proportion of nurses working full-time in hospitalisation units and finally, a low level of activity oriented towards substitute-for-home residential institutions (such as retirement homes or prisons).

Sources

The analysis of disparities in the adult psychiatric care supply was effectuated from different sources of information that were relatively complex to handle or create:

- **data on adult psychiatry sectors**, of which the last available information dates back to 2003, issued from the periodic survey carried out by the Directorate of Research, Studies, Assessment and Statistics (Drees): psychiatric sector annual reports[a]. The study was essentially focused on facilities and personnel (bed capacity and/or number of places according to type of structure, number and full-time equivalent (FTE) for medical and non-medical personnel) and their activity (annual number of patients and days by type of care). For technical reasons the analysis is based on 794 adult sectors out of the 815 psychiatric sectors polled in 2003, that is 97.4 % of the total number;

- **data concerning the environment** in which the sector is established. This data describes:

  - resident population characteristics or its environment taken from the general population census of 1999 and includes: size of the population and households; population distribution according to age, socio-professional status, situation in terms of employment, level of education, age and type of housing[b].

  - lthe characteristics of the health and social services at departmental level: density of private practitioners (including private psychiatrists (from the Snir 2003, Eco-Santé Régions & Départements 2007) –, private psychologists (extracted from the Yellow Pages in February 2007), and psychiatric beds in private establishments subject to projected expenditures voted each year by Parliament (from the annual health establishment statistics of 2003); number of facilities for the elderly and disabled at departmental level (from the survey of socio-medical establishments 2001), and the number of beds in retirement homes (from the survey of residential homes for the elderly of 2003)[c].

a Before 1999, this survey was carried out by the Ministry of Health Service of Studies, Statistics and Information (Sesi). The last data collected in 2008 will not be available until the end of 2009.

b This data, initially collected at neighbourhood level (IRIS) by the Insee, were aggregated at psychiatric sector level in the framework of a Insee-Drees convention.

c The three latest surveys were produced by the Drees.

2 The median value is that which separates a population base into two equal parts. The quartiles separate a population base into four equal parts.

3 Translator's note: Paris and the surroundings suburbs.

T1

Descriptive statistics of the division of psychiatric sectors into 9 classes

Class characteristics

- 6 Ile-de-France-type sectors, well-resourced in medical personnel
- 2 Urban sectors, well-resourced in varied facilities
- 1 Rural sectors, well-resourced in non-medical personnel and facilities
- 3 Sectors averagely resourced in personnel and facilities
- 4 Sectors averagely resourced attached to regional hospitals
- 7 Atypical sectors without inpatient hospitalisation
- 8 Sectors under-resourced in personnel and alternative facilities
- 5 Sectors with serious medical demographic problems
- 9 Sectors under-resourced with high somatic orientation

	Very well-resourced sectors			Averagely-resourced sectors		Under-resourced sectors			
	Class 6	Class 2	Class 1	Class 3	Class 4	Class 7	Class 8	Class 5	Class 9
Number of sectors in the class	93	36	132	184	57	23	80	86	103
Percentage of the class within all sectors	11.8%	4.0%	16.7%	23.3%	7.2%	2.9%	10.1%	10.9%	13.0%
Equipement									
Average number of community mental health centres (CMHC)	1.5	2.4	3.7	2.9	2.9	2.2	1.8	2.3	2.3
Average number of day centres and therapeutic workshops	1.2	1.5	2.8	2.3	1.6	1.3	1.1	1.7	0.9
Places in day hospitals*	30.9	93.0	82.8	49.3	89.0	23.2	2.7	35.5	25.4
Places in night hospitals*	3.6	11.5	5.5	4.7	8.7	0.2	1.0	3.1	2.7
Places in crisis centres or permanent reception centres*	3.0	0.1	1.2	0.0	0.6	0.0	0.0	0.1	0.2
Inpatients beds*	104	317	241	172	166	316	112	98	54
Rate of beds theoretically occupied inpatient for over a year	22.5%	6.4%	22.5%	15.5%	6.4%	2.0%	13.2%	15.1%	27.5%
Number of inpatient beds, outside inpatient hospitalisation *	49.2	33.9	18.6	16.3	10.6	4.2	6.8	7.8	5.2
Personnel									
Full-time equivalents (FTE) for psychiatrists*	16.1	13.5	11.7	8.8	11.0	7.9	10.3	7.3	9.2
FTE for interns*	3.1	3.8	1.3	1.3	3.5	0.6	2.1	1.0	0.5
FTE for non-psychiatric doctors*	0.9	0.9	2.8	1.6	0.3	0.7	0.6	1.6	0.5
FTE for nurses*	99.3	137.8	171.7	114.1	109.4	50.6	74.5	94.8	54.0
FTE for psychologists*	8.9	6.6	7.4	5.3	5.8	5.3	5.0	4.5	5.1
FTE for rehabilitation-reeducation personnel*	4.7	1.6	1.9	1.5	1.2	0.5	1.4	1.4	1.6
FTE for socio-educational personnel *	7.3	6.8	7.3	4.6	4.5	2.8	3.7	4.0	2.9
FTE for carers*	40.5	56.3	69.9	42.3	31.4	22.7	26.4	25.8	16.8
Opening - Community									
Day centres, therapeutic workshops and CMHCs situated outside the hospital	95.4%	95.4%	87.8%	90.1%	83.8%	86.2%	87.5%	84.2%	87.8%
Bed or places outside the hospital	39.8%	30.0%	30.2%	24.9%	28.2%	74.4%	18.9%	31.2%	33.7%
Alternative places to inpatient hospitalisation (HTP)	37.8%	34.1%	31.7%	29.7%	41.3%	41.8%	8.5%	32.5%	37.4%
FTE for medical personnel working in HTP units	48.3%	53.9%	55.4%	61.1%	50.8%	25.9%	58.3%	61.5%	47.4%
FTE for nurses and managers working in HTP units	62.0%	63.0%	65.6%	69.0%	69.3%	24.2%	70.9%	68.1%	60.9%
FTE devoted to liaison psychiatry	6.5%	1.9%	4.2%	2.6%	4.3%	10.5%	3.8%	2.2%	7.8%
FTE devoted to emergency interventions	3.7%	2.9%	2.3%	2.7%	6.3%	7.1%	4.7%	3.1%	11.8%
Accessibility - Reception									
CMHCs open at least 2 days/week after 6pm	77.3%	54.7%	30.0%	29.9%	43.7%	24.2%	52.3%	37.0%	44.3%
CMHCs open all year round (including summer months)	97.3%	87.8%	87.3%	92.3%	74.0%	96.6%	94.9%	93.0%	87.7%
Day hospital open all year round (including summer months)	88.6%	63.4%	83.8%	81.6%	79.0%	81.1%	80.0%	89.2%	90.3%
Sectors in which all inpatients units are geographically situated within the sector	24.5%	38.9%	62.1%	42.9%	52.6%	30.4%	47.5%	69.8%	61.2%
Activity									
Total active patient list (annual number of patients)	1,578	1,361	1,813	1,438	1,514	1,227	1,448	1,374	1,485
Average duration of cumulated hospitalisation in the year (in days (d.))	42.1 d.	45.2 d.	49.3 d.	46.2 d.	39.9 d.	39.4 d.	42.8 d.	41.9 d.	34.2 d.
Rate of occupation of beds	90%	96%	92%	92%	92%	92%	90%	87%	88%

* for 100,000 inhabitants aged over 20.

Sources: Annual reports of psychiatry sectors, 2003, Drees; population census, 1999, Insee.

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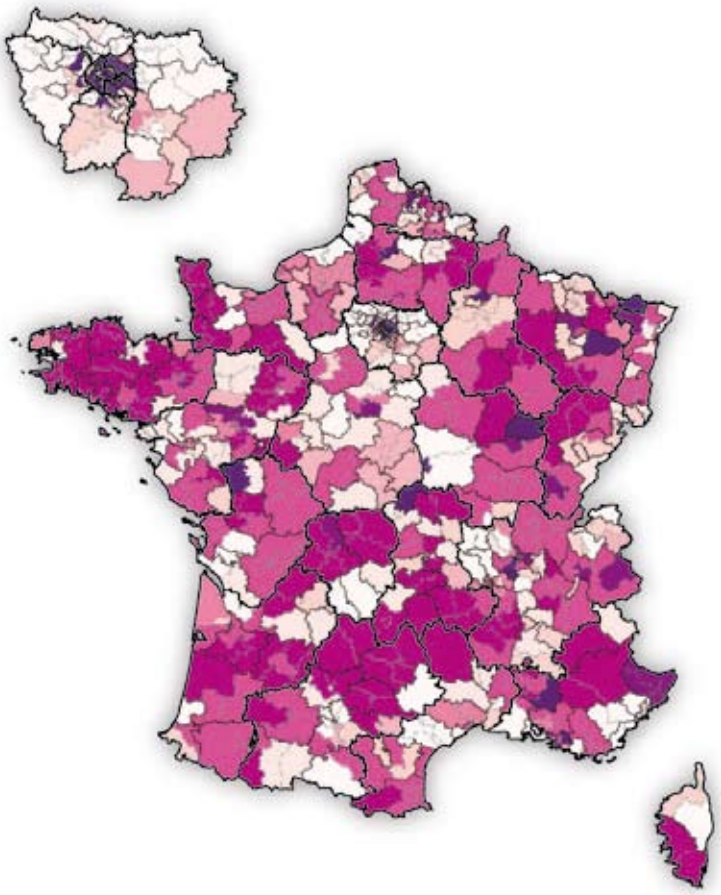
Typology of adult psychiatry sectors in 2003



Class characteristics and number of sectors

- 6 Ile-de-France-type sectors, well-resourced in medical personnel (93)
- 2 Urban sectors, well-resourced in varied facilities (36)
- 1 Rural sectors, well-resourced in non-medical personnel and facilities (132)
- 3 Sectors averagely resourced in personnel and facilities (184)
- 4 Sectors averagely resourced attached to regional hospitals (57)
- 7 Atypical sectors without inpatient hospitalisation (23)
- 8 Sectors under-resourced in personnel and alternative facilities (80)
- 5 Sectors with serious medical demographic problems (86)
- 9 Sectors under-resourced with high somatic orientation (103)

Geographical limits

- Sectors limits
- Limits of the health establishments
- Regional limits

Sources: Psychiatric sector annual reports, 2003, Drees ;
General population census, 1999, Insee;
surveys SAE 2003, ES 2001, EHPA 2003, Drees.

Exploitation and cartography: Irdes.

… and in response-time to emergencies and the development of alternatives to inpatient hospitalisation

The third factor distinguishes sectors according to level of ambulatory care activity and more particularly emergency care (liaison psychiatry towards somatic units and interventions in substitute-for-home residential institutions). It opposes psychiatric sectors attached to a psychiatric hospital with a low activity for ambulatory care to those attached to a general hospital with a high ambulatory activity given their liaising role.

A fourth factor differentiates psychiatric sectors with regard to the degree of commitment in developing alternatives to inpatient hospitalisation. Sectors with a low level of development of these alternatives are faced with a high use of ambulatory and inpatient services and thus mobilise a large percentage of their personnel. These sectors have little possibility of using inter-sector ambulatory services or outpatient care that would enable them to pool resources. They are located in regions where private sector psychiatry is limited.

In contrast, psychiatric sectors having developed alternatives to inpatient hospitalisation are equally those that have frequent use of inter-sector services for different types of treatment plans. They are established in regions with a high percentage of private psychiatric services.

The last factor opposes the different psychiatric sectors according to whether they declare having difficulty providing inpatient or outpatient hospitalisation.

Thus, the typology built up from these five discriminating factors provides a classification by nine types of psychiatric sectors. These sectors can be positioned along a gradient going from the best to the most poorly resourced in comparison with the French median. Table 1 (p. 4) presents the main descriptive statistics of these psychiatric sectors and map 1 (p. 5) illustrates their distribution across the national territory according to region and the type of health establishment to which they are connected.

Method

From the transformation of data to the typology

The comparison of the psychiatric sectors' care services is based on the construction of the following indicators:

- **resource allocation in personnel and facilities**, , by relating human resources (the number of full-time equivalents (FTE)) and allocated facilities (the number of structures, beds and/or available places according to their nature) to the population base aged 20 and over covered by the sector)[a];
- **the nature of care and services delivered** is broken down, on the one hand, in terms of accessibility (e.g. the percentage of beds and/or places outside the hospital perimeter; the number of days community mental health centres are open per week) and, on the other hand in terms of the range of care and services delivered (e.g.: the percentage of alternatives to inpatient hospitalisation related to the number of beds and places, the rate of diversification, the percentage of medical or non-medical FTE working full-time in hospital units);
- **use of care**: care use rate according to types of medical services (in numbers of days in relation to the population base); the duration of hospital stays (in numbers of days of inpatient hospitalisation in relation to the annual number of patients hospitalised full-time); the rate of occupation (in numbers of days of inpatient hospitalisation in relation to the number of inpatient hospital beds multiplied by the number of days in the year).

The continuous variables were transformed into quartiles so as, on the one hand, to analyse the variables of quantitative and qualitative supply conjointly and, on the other, to reveal the very well-resourced (quartile 4) and under-resourced (quartile 1) sectors.

The analysis is based on a Multiple Correspondence Analysis (MCA) associated with an Ascending Hierarchical Classification (AHC). To the MCA using the above-mentioned supply variables (active variables) is substituted the linear combinations (principle components) so as to reveal the similarities or differences between sectors on the basis of the active variables (factorial axes). The sector environment variables presented in the Sources insert (p. 3) as sub-sets of the above care supply variables are solely used in an illustrative manner. In the AHC, the sectors are divided into homogeneous classes in terms of care supply by founding the construction of classes on the factorial axes defined by the MCA.

a Legally, the psychiatric sectors cover populations aged 16 and over but adolescents are treated in the adult sectors as well as the infant-juvenile sectors. The availability of data detailed by age at a detailed geographical level obliged us to relate the indicators to the population aged 20 or over.

The well-resourced psychiatric sectors: a variety of alternatives to inpatient hospitalisation

SThe sectors characterised as being 'well-resourced' in comparison to the French median can be divided into three groups: classes 1, 2 and 6, that all have substantial material and human resource allocations. These classes, however, distinguish themselves by the nature of the personnel and the facilities developed, a more or less high level of activity, a highly contrasted geographic environment and, lastly, very different methods of organisation and care. These variations demonstrate diversified strategies in the application of the sectorisation policy.

Thus, in class 1, with average medical personnel resources, the alternatives to inpatient hospitalisation are relatively traditional (day hospital, day centre*, therapeutic workshop) and often developed within the hospital itself. These sectors are also more frequently developed in rural areas and often attached to private not for-profit hospitals. They are faced with a high percentage of care activity within residential homes because of the high number of social housing units for the elderly on their territory. Use rates of these sectors are high as is the average length of stay.

Inversely, class 2 psychiatric sectors benefit from a superior allocation in medical, psychiatric and non-psychiatric personnel. In relation to the number of patients seen at least once during the year, resources in personnel are clearly more favourable. Sectors in this class, frequently linked to a psychiatric hospital, have developed more alternatives to inpatient hospitalisation and have more frequently set up their structures outside the hospital perimeter. These sectors are in opposition to the previous sectors in that they are established in an urban environment, they have a large supply of private practitioners, and a low density of social and medico-social structures on their territory.

Class 6 is the most highly doted in medical personnel (psychiatrists and interns) and is an attractive sector for the profession. Psychologists and socio-educational staff are equally well-represented in these sectors but nursing staff and carers fall below the average and unfilled vacancies are frequent. These sectors have developed a wide range of alternatives to inpatient hospitalisation and particularly distinguish themselves in the number of emergency reception services. The limited number of ambulatory or outpatient structures is compensated for by high out-of-hours accessibility and centres created outside the hospital perimeter. These sectors are essentially situated in Paris and its surrounding suburbs; the dense urban tissue explaining the low overall number of these structures.

Psychiatric sectors in the median position: differences in the nature of outpatient medical services

Classes 3 and 4 of the typology are in a median position in terms of facilities and human resources. Psychiatric sectors in these two classes differentiate themselves essentially by the nature of outpatient medical services and the category of the structures to which they are attached. Class 3 sectors are essentially attached to psychiatric hospitals and are highly developed in terms of day centres and therapeutic workshops. In contrast, class 4 sectors are for the most part attached to regional university hospitals* and have privileged the development of day hospitalisation against other outpatient services. These sectors more frequently declare experiencing difficulties with same day hospital admissions and, except in emergency cases, waiting lists for a first consultation are long. At equivalent

resource allocation levels, the general or specialised status of the hospital seems to have an influence on the choice of therapeutic tools.

The under-resourced psychiatric sectors: strong disparities in terms of resources and the development of alternatives to inpatient care

Classes 5, 7, 8 and 9 of the typology, 'under-resourced', are disparate in organisational terms. If class 8 sectors appear to have a shortage of nursing, educational and social staff, their urban location allows them to attract psychiatrists, placing them in the average for medical staff. Resources in terms of facilities are low whatever their nature but the low number of community mental health centres (CMHC*) is compensated for by greater out-of-hours accessibility. The poor development of alternatives to inpatient hospitalisation in these sectors, however, prevents patients from benefitting from multiple and diversified services. Class 7 is fairly atypical. It distinguishes itself primarily by its lack of inpatient services as inpatient hospitalisation in these sectors is often managed through inter-sector cooperation. Classes 5 and 9 have in common their more frequent attachment to general hospitals but understaffing in both medical and non-medical personnel is higher in class 9 than in any of the other sectors. The same applies with regard to facilities. Whereas class 5 sectors fall within the median values in terms of bed capacity, inpatient and outpatient places and the development of alternatives to inpatient hospitalisation, class 9 sectors have few alternative supportive structures. This last class of sectors find themselves in an extremely critical situation. To this relative under-resourcing can be added a high degree of activity in emergency services and other somatic care units given they are situated within a general hospital structure. This additional activity mobilises a high number of their allocated staff, already reduced.

* * *

This typology enables us to account for the disparities in the general psychiatric care supply in metropolitan France. It contributes to the finer analysis of sector policy completion and organisation in France, and notably in the development of alternatives to inpatient hospitalisation by looking beyond the distinction between well-resourced and under-resourced sectors.

The observed disparities do not appear to be compensated for by a comprehensive care supply provided by the hospitals to which the sectors are attached. As can indeed be observed on map 1, these establishments are in the majority or exclusively composed of psychiatric sectors of the same type. It is thus extremely rare for a designated hospital to be composed of a variety of complementary sectors.

The sectorisation policy does not therefore appear to result in a homogeneous whole in terms of resource allocation and the balance between inpatient care and alternative supportive structures, even within a geodemographic area grouping together several psychiatric sectors as is the case for hospital bases.

In a recent report, Edouard Couty reasserts the position of the psychiatric sector with regard to proximity as the 'territorial base of mental health and psychiatry' [Couty, 2009]. Through the setting up of local cooperative groups for mental health, he proposes a significant reform in the organisation and financing of sectorised care which is equally supported by another report from the Sénat [Milon, 2009]. Psychiatric sectors would see their extra-hospital resources figure within the local cooperative group of which they are members whereas their intra-hospital resources would remain within the base hospital. It could be a decisive step in the completion of the sectorisation policy, or even its renewal through a more complete integration of other partners in mental health care that would be refocused on the 'community' rather than the hospital. This reform could nevertheless create a break in the continuity of care for patients alternating between inpatient hospitalisation and ambulatory care. This aspect is a cause of anxiety for certain professionals since continuity of care forms the basis of sectorised psychiatry.

The territorial approach which extends psychiatric care to office-based practice needs to be taken into account in the structuring of administrative data as demonstrate the elaboration of 'territorial medical projects', of territorialized 'quantified goals in terms of care supply', as well as the creation of future regional health agencies in the framework of the third Regional Strategic Health Plan*.

In this study however, mainly using psychiatric sector annual reports to describe psychiatric activity in France, presents certain limitations. In the present case, only state-run sectorised psychiatry is taken into account. Due to a lack of available data, information concerning activity supplied by psychiatric services in non-sectorised public hospitals (notably certain university hospitals) and private establishments (for-profit or non for-profit hospitals outside the sector) are excluded, as are those provided by private health professionals.

Finally, this research presents a great interest in the evaluation of territorial public health policy. The difficulties encountered in making existing administrative data bases 'speak' in a common territorial language is certainly questionable even if the psychiatric sector is considered as being the geographical unit in the organisation of psychiatric care in public hospitals. ♦

Further information

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Glossary

- **Annual health establishment statistics:** statistiques annuelles des établissements de santé (SAE)
- **[CHR] Regional hospital: c**entre hospitalier regional (CHR)
- **[CHRU] Regional teaching hospital:** centre hospitalier regional universitaire (CHRU)
- **[CMHC] Community mental health centres:** centre médico-psychologique (CMP)
- **[Cnamts] French National Health Insurance Fund for Salaried Workers:** Caisse nationale d'assurance maladie des travailleurs salariés
- **[FTE] Full-time equivalent: é**quivalent temps plein
- **Regional Union of Health Insurance Funds in Ile-de-France:** union régionale des caisses d'Assurance maladie d'Ile-de-France
- **Regional Strategic Health Plan:** Schémas régionaux d'organisation du territoire (Sros).
- **Regional university hospital:** CHRU hospital: centre hospitalier regional universitaire (CHRU)
- **Day centre:** centre d'accueil thérapeutique à temps partiel (CATTP)
- **Day hospital:** hôpital de jour
- **Deinstitutionalisation:** désinstitutionnalisation
- **Emergency and liaison psychiatry:** urgence et psychiatrie de liaison
- **General hospital:** centre hospitalier général
- **Hospitalisation at Home (HAH):** hospitalisation à domicile (HAD)
- **Hospital, Patients, Health and Territories Bill: Loi** Hôpital, patients, santé et territories (HPST)
- **Night hospital:** hôpital de nuit
- **Private for-profit hospital:** hôpital privé lucratif
- **Private not for-profit hospital:** hôpital privé psph
- **Psychiatric hospital:** hôpital psychiatrique
- **Psychiatric sector :** secteur de psychiatrie
- **Public hospital:** hôpital public
- **Rehabilitation centre:** centre de post-cure
- **Specially trained family:** accueil familial thérapeutique
- **Substitute-for-home (residential) institution:** institution substitutive au domicile
- **Therapeutic apartment:** appartement thérapeutique
- **Therapeutic workshop:** atelier thérapeutique (AT)

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IRDES • Site: www.irdes.fr Email : diffusion@irdes.fr
• Director of the publication: Chantal Cases • Technical senior editor: Anne Evans • Copy editing: Franck-Séverin Clérembault
• Translator: Véronique Dandeker • Layout compositer: Khadidja Ben Larbi
• ISSN : 1283-4769 • Diffusion by subscription: €60 per annum - Price of number: €6 - 10 to15 numbers per annum.ISSN : 1283-4769