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Treatment modalities for Depression in Health Establishments

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Psychiatric disorders and psychotropic medications cost 22.6 billion euros in 2011, representing 16% of total health expenditures for that year (CNAMTS, 2013). Depression is one of the most widespread psychiatric disorders in France affecting 3 million individuals (INPES, 2007). In cases of depression, individuals tend to consult their general practitioner first (21%), ahead of psychiatrists (13%) and psychologists (7%) in private practice. Even if the use of hospital care is relatively low in cases of depression (10 % of consultations -INPES, 2007), it is the main cause for seeking medical care in hospitals authorised to provide mental health services. Among the 1.5 million adults treated in hospital-based psychiatric units in France in 2011, almost one out of five was for depression.

If little was previously known concerning the treatment modalities available for these patients, the Medical Information Database for Psychiatry (Rim-P) instituted in 2007, used as the data source for this study, provides the missing information and a first national insight on the subject.

Psychiatric disorders and psychotropic medications cost 22.6 illion euros in 2011, representing 16% of total health expenditures for that year (CNAMTS, 2013). Among the 2.1 million adult patients hospitalised for psychiatric disorders or treated for a long-term psychiatric illness, over a third suffered from characterised depressive episodes[1]. Depression is one of the most widespread psychiatric disorders in France: its prevalence is estimated at between 5 and 12% of the population according to sources and the measurement tools used (Le Pape, Lecomte, 1999, Sapinho *et al.*, 2009; Morin, 2010) and affects over 3 million people (INPES, 2007). Whether an isolated episode or a recurrent disorder, depression can become a long-term chronic disorder. According to the National Institute for Health Prevention and Education (INPES, 2007), 60% of individuals that have previously suffered from a characterised depressive episode report having used healthcare services for mental health reasons. If visits to the general practitioner predominate for 21% of these patients, private psychiatrists and psychologists are in second place with 13 and 7%. Other health professionals combined represent 12% of consultations (therapists, nurses, physiotherapist- masseurs, social workers…) [Briffault *et al.*, 2010]. Even if the use of hospital-based care remains relatively low (around 10% of patients consulting), depression is the main cause for seeking medical care in hospitals authorised to deliver mental health care, a use

[1] The characteristics of a major depressive episode (EDC) are defined by the CIDI-SF (Composite International Diagnostic Interview – Short Form) and the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders 4th edition). It is identified by the presence of at least four symptoms (e g: at least two consecutive weeks feeling sad, weight loss of at least 5 kg, difficulty concentrating, etc.) of which at least one important symptom, and loss of interest in daily activities.

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rate that increases with the severity and chronicity of the disorder (INPES, 2007).

The most frequent principal diagnosis delivered to patients treated in hospital-based psychiatric units in 2011 was depressive episode and disorder. If little information was previously available concerning treatment modalities for these patients, the Medical Information Database for Psychiatry (*Recueil d'informations médicalisées en psychiatrie* - Rim-P), instituted in 2007, used as the data source in this study, provides the missing information and a first national insight on the subject.

Depression, leading cause for the use of hospital-based psychiatric care in 2011

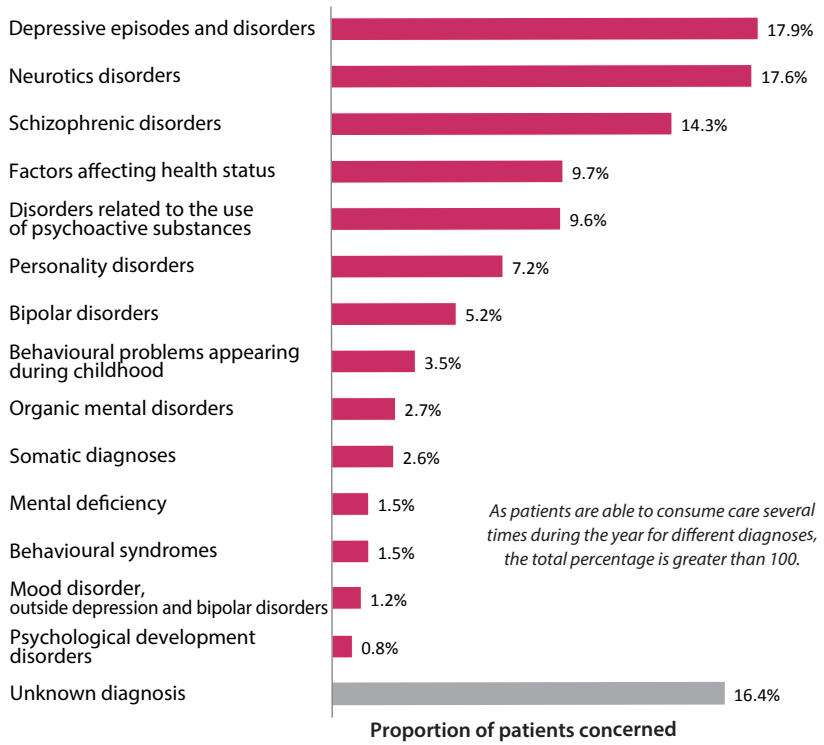
Over 1.5 million adults were treated in hospital based psychiatric units in France in 2011 (DREES, SAE 2011), of which 75% as out-patients on the basis of consultations with health professionals, interventions in hospital emergency services, home care etc. (DREES, 2012).

With almost 283,000[2] adult patients (aged 16 and over) treated for a depressive episode or disorder in 2011, representing almost 18% of the total active patient list (Source: Rim-P), depression is the main cause for seeking psychiatric care in French metropolitan hospitals (Graph 1). However, in terms of days or procedures, schizophrenic disorders represent almost 25% of hospitals' volume of activity against 15% for depression.

Depression covers a broad spectrum of different situations requiring variable treatment modalities according to degree of severity and a person's needs, as will be shown. The international disease classification (ICD 10th revision) qualifies depressive episodes and disorders as mild, moderate or severe (OMS, 2009). Among the patients treated for depression in hospitals in 2011, 37% suffered from a severe episode or disorder, 35% from a moderate episode or disorder, and 14% from a mild episode or disorder, and 14% from depressive episodes or disorders unspecified in terms of severity.

[2] Numbers not adjusted for missing health establishments

G1 **Principal diagnoses resulting in the use of hospital-based psychiatric care in 2011**



Reading: 17.9% of patients treated in a health establishment authorised to practice psychiatry in 2011 received a principle diagnosis of depressive episode or disorder.
Source: Rim-P 2011. **Scope:** metropolitan, individuals aged 16 or over.
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The use of hospital-based treatment for depression is higher among women

The prevalence of depression in the general population is higher among women (Morin, 2008, Sapinho *et al.*, 2009), as is the use of hospital-based treatment for depression with a 66% majority (Rim-P data). The use of hospital-based care for depression is also related to age, reaching a maximum use rate among the 51-55 year olds. There are no significant differences in use rate by gender within the different age brackets. These results remain stable according to degree of severity.

Treatment for depression is essentially delivered by outpatient services, except in cases of major depressive disorder

A patient treated in a public hospital authorized to deliver psychiatric care can be monitored in three ways: full time, part-time or as an out patient (Definitions insert p. 6). Certain patients are treated under one or other of these care options exclusively, but many combine several treatment modalities. The majority of forms of depression can be treated without hospitalisation, 62% of patients suffering from depression were treated by hospital outpatient services exclusively (essentially consultations) in 2011.

Hospitalisation can however be necessary in cases of severe depression, complex treatment requirements or in cases where a patient is in danger (risk of suicide, loss of autonomy, etc.) [HAS, 2002]. A third of patients treated for depression were hospitalised full-time in 2011. The use of hospital-based care increases with the degree of severity of the depressive episode; over half the patients diagnosed with a severe

Context

This study fits within the framework of research on the disparities in psychiatric care supply developed by IRDES. This first publication on depression is part of a research project financed by the DREES aimed at reviewing the current state of care provision for depression and schizophrenia in French health care establishments and its regional disparities. This project follows a feasibility study carried out for the DREES on the analysis of disparities in psychiatric care practices using the information system currently available (Coldefy *et al.*, 2012).

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depressive episode were hospitalised full-time at least once during the course of the year. For the majority of patients, hospitalisation is voluntary although it was observed that 3% of patients were hospitalised without consent (generally following a request by a third party).

Modalities of psychiatric care differ between public and private health establishments…

Several types of heath establishment authorised to deliver psychiatric care can receive individuals suffering from depression. According to *The Panorama of Health Establishment* (DREES, 2012), out of 588 health establishments delivering hospital-based psychiatric care in 2010, half were public sector facilities, representing two thirds of full-time hospital beds and four fifths of part-time hospital beds. The other half is evenly distributed between non-profit private hospitals (ESPIC) and private for-profit clinics. The majority of public and non-profit private hospitals with psychiatric units participate in the sectorisation of psychiatric services and provide full-time, part-time and outpatient care whereas private for-profit clinics essentially provide full-time and part-time hospitalisation. Out patient care for these patients is delivered by private office-based psychiatrists (outside the scope of this study *cf.* Sources and scope insert). This difference has an impact on hospital care provision. In public or non-profit private hospitals, for example, full hospitalisation constitutes the most comprehensive level of care that can be provided. In private for-profit facilities, full-time hospitalisation is often the only form of care as outpatient services are not provided other than by office-based practices. In this case, continuity of care is provided by professionals situated outside the hospital facility. Furthermore, very few private for-profit facilities are authorised to admit patients without their consent.

Accident and emergency reception and general interest missions associated with the sectorisation of psychiatric care also have an impact on patient populations and care delivery. Whether a hospital is specialised in the treatment of mental health disorders or not will also affect patients' care options and their access to care (proximity of emergency services and somatic care units).

… illustrated by a higher percentage of severe depressive disorders treated in private clinics

In France, 72% of patients treated for a depressive episode or disorder are cared for in public hospitals (against 82% patients in psychiatric care), 13% in non-profit private hospitals (*versus* 12%) and 15% in private for-profit facilities (*versus* 6%). The latter are specialised in the treatment of depression since the principal diagnosis for almost half the patients in private for-profit sector facilities was a depressive episode or disorder (45%), whereas in public or non-profit private hospitals[3] it represents between 17% and 21% of registered patients.

Three quarters of patients hospitalised full-time for depression in private for-profit facilities suffer from a severe disorder whereas the patient population in public or private non-profit hospitals is more

[3] For which a principal diagnosis was indicated

Source and scope

The Medical Information Database for Psychiatry (*Recueil d'informations médicalisées en psychiatrie* - Rim-P)

The Rim-P was introduced in 2007 in all health care establishments authorised to deliver psychiatric care. The fast development of this system over the last five years has made it possible to provide a first overview of psychiatric care practices in France and its diversity in health establishments and regions (Coldefy *et al.*, 2012).

In 2011, 95% of health establishments (552) uploaded their data to the Technical Agency for Information on Hospital Care (*Agence technique de l'information sur l'hospitalisation* - ATIH). In terms of activity, the comprehensiveness of this database is 98% for full and part-time hospitalisations, and 80% for outpatient services provided by medical-psychological centres (CMP), when we compare Rim-P data to those produced by the Annual Hospital Statistics (*Statistique annuelle des établissements de santé* - SAE).

The data presented here were not subject to statistical adjustments to correct the non-response of establishments that had not uploaded data to RIM-P. Consequently, population numbers are slightly under-estimated. They include all patients aged 16 and over treated in a health establishment in 2011. Outpatient care provision such as meetings, care provided by private practitioners in public hospitals, and therapeutic stays (socio-psycho-therapeutic activities in an unfamiliar environment for both patients and care teams) are excluded from the description of care practices.

Patients treated for depression were identified by the existence of at least one principal diagnosis for a depressive episode or recurrent depressive disorder (codes ICD-10: F32 and F33).

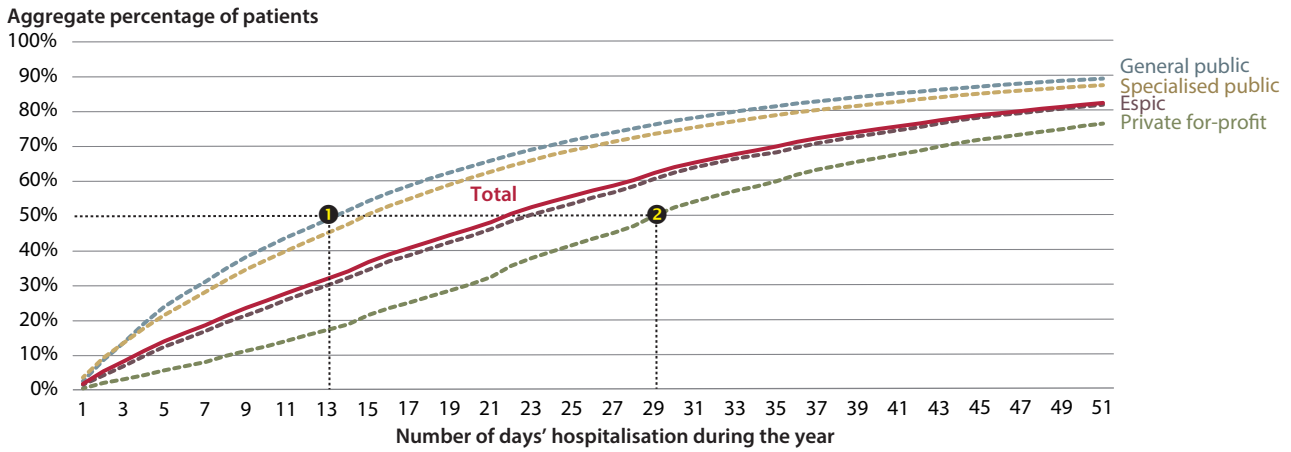
Scope of the analysis

The scope covered by the study concerns depression care management in health establishments authorised to practice psychiatric care in metropolitan France exclusively. Health establishments can be public, private non-profit (ESPIC) or private for-profit (private clinics) whether specialised in psychiatry or not. The majority of public and private non-profit establishments participate in the sectorisation of psychiatric care. Instituted by the circular of March 15th 1960, its aim is to ensure a given populations' mental health care by a same multidisciplinary team using a variety of practices in different locations: outpatient care, part-time or full-time care (Definitions insert p.6) in health sector structures located within or outside hospital grounds, in health establishments, medico-social centres or in the patient's home.

Care provided in medicine, surgery or obstetrics, office-based general practitioners, and private practice psychiatrists or psychologists are thus excluded from this study.

G2

Annual average number of days' hospitalisation for depression according to type of establishment



Reading: For 50% of patients hospitalised for depression in the general public sector, the number of days' hospitalisation during the year was less than 13 days, and 29 days in the private for-profit sector.

Source: Rim-P 2011. **Scope:** metropolitan, individuals aged 16 or over.

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heterogeneous. A considerable number of patients hospitalised full time for depressive episodes or disorders in the public or private non-profit sectors are treated for moderate to mild disorders (almost 40% against 22% in the private for-profit sector). Several explanations for this can be advanced: public sector admissions are frequently unscheduled; for an equivalent diagnosis, individuals' clinical and social situations can lead to hospitalisation even for disorders classed as relatively mild by ICD-10 (comorbidity, lack of family or social relationships, housing problems etc.). As Rim-P data provide little information on individuals' social and economic backgrounds, this hypothesis cannot be validated here. On the other hand, the higher percentage of patients aged less than 30 and 75 and over observed in public or private non-profit facilities could explain the hospitalisation of patients with mild or moderate disorders as these extremes on the age scale can lead to more complex situations. Different diagnostic coding procedures could also explain these differences.

Average duration of hospitalisations in psychiatric units more often related to hospital characteristics than the severity of the disorder

The average length of stay (ALOS) for patients suffering from depressive disorders was 27 days in 2011. However, in the field of psychiatry, the number of hospitalisation days per year (DAH) is preferred to the ALOS as it is more pertinent. Depression, like other psychiatric disorders, is a chronic illness requiring long-term treatment which can involve several hospital stays. The DAH observed for individuals suffering from depressive disorders was on average 32.8 days in 2011; it was higher for severe disorders (34.6 days on average).

These average values nevertheless hide considerable variations. For a quarter of patients the DAH is less than 10 days and for half it does not exceed 21 days (Graph 2). Inversely, 20% of patients have a DAH of over 45 days. The number of hospitalisation days varies according to type of health facility.

The lowest DAH is observed in non-specialised public hospitals (psychiatric services integrated into general or regional hospitals). It almost doubles in private for-profit facilities, even for an equivalent degree of severity. More generally, if the length of hospital stays for 30% of patients hospitalised in public facilities is less than or equal to seven days, in private for profit facilities, less than 10% of patients are hospitalised for less than seven days (Graph 2). The duration of hospital stays for depression thus appears to depend on the healthcare facility's status rather than the gravity of the disorder. Here again, it is difficult to control for individuals' social characteristics. A more in-depth investigation of several hypotheses is required. In public or private non-profit hospitals participating in the sectorisation of psychiatric services, full hospitalisation is part of the establishment's global internal care programme, and is coordinated with outpatient services before and after hospitalisation by the same care team, which makes it possible to reduce the duration of full hospitalisation. In private for-profit establishments, full hospitalisation (and its duration) is generally scheduled and therefore does not concern emergency admissions. Another factor advanced by the professionals is the availability of hospital beds and patient turn-over. In psychiatric services integrated in general hospitals, bed and place capacity as well as human resources have been identified as being under-resourced (Coldefy *et al.*, 2009) and are combined with a high patient turn-over because they are located in the vicinity of hospital emergency services. This situation can also accelerate hospital discharges in order to accommodate new patients.

Readmission rates in psychiatric care lower in establishments with a high volume of out-patient services

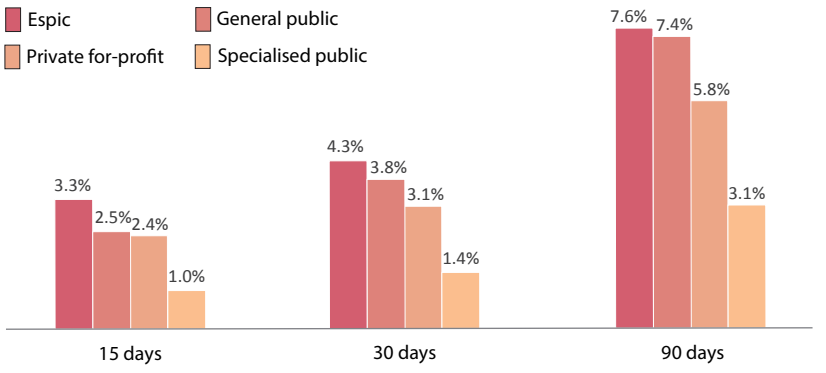
In medicine, surgery, obstetrics and odontology (MCO), readmission rate is used as a marker for poor quality care, meaning that the patient has suffered a relapse

following a premature or unprepared discharge from hospital. In psychiatric care, however, admissions can be voluntary and correspond to a sequential therapeutic hospitalisation strategy or the acceptance of a certain degree of risk on discharge. Considered on its own, this indicator cannot measure the quality of psychiatric care. On the other hand, crossed with data on the annual hospitalisation days, it highlights the differences in care provision between the different types of health establishment.

Whatever the lapse of time taken into account to calculate the readmission rate within a same establishment (15, 30 and 90 days), the rates are always higher in private non-profit establishments and psychiatric services attached to general hospitals (Graph 3). For the latter, the high readmission rates are related to the short DAH. The considerable mismatch between supply and demand in these establishments, notably due to the high use of emergency services, gives rise to shortfalls in hospital beds that can lead to discharging patients prematurely or without preparation to make room for new arrivals.

Inversely, the lowest readmission rates are observed in specialised public establishments and are associated with a low DAH. This result should be set against the resources available in the different types of establishment and the development of outpatient services that can help avoid certain readmissions. Graph 4 thus shows that patients treated for depression in specialised public establishments have on average access to a broader and denser spectrum of outpatient services than patients treated in other types of establishment. Medical consultations, meetings with caregivers, social situation monitoring, group therapy and home care are more frequently used by patients in these establishments. This observation confirms that outpatient follow-up care reduces the duration and frequency of hospital stays.

G3 **Readmission rate for patients treated for depression according to type of establishment**



Source: Rim-P 2011. **Score:** metropolitan, individuals aged 16 or over.

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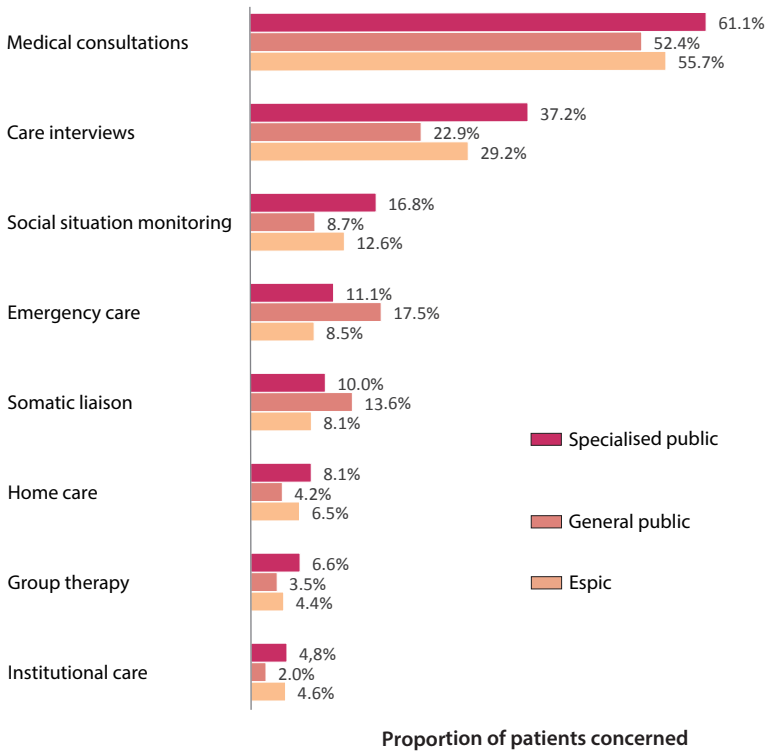
G4 **Outpatient care for depression according to type of establishment**
Excluding private for-profit establishments with no outpatient care provision



Reading: 61% of patients treated for depression in a public health establishment specialised in mental health care had at least one consultation with a doctor in 2011, 17% were monitored by social workers attached to the establishment to monitor their social situation.

Source: Rim-P 2011. **Score:** metropolitan, individuals aged 16 or over.

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* * *

This first insight into the care and treatment of depression in French health establishments reveals notable results needing deeper investigation in future studies. In 2011, depression was one of the main reasons for the consumption of psychiatric care in health establishments. There are significant differences in the care of depression between public and private establishments. The characteristics of care provision in these different establishments and their interaction with the environment play a major role in the variations observed. Similarly, part of this variability can be explained by the characteristics of the populations monitored in these establishments.

These first results deserve deeper investigation, combined with information on

the provision of care and the socio-economic environment of patients. The integration of these dimensions in the analysis of the determinants of care provision for patients suffering from depression in health establishments will complete this first overview.

However, to have a global view of psychiatric care supply in France and better understand the observed disparities, the scope of the analysis will need to be extended to include office-based care as general practitioners play a strategic role in this form of care (Dumesnil *et al.*, 2012). ♦

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Definitions

Clinical depression is a **characteristic mood disorder** resulting from the interaction of multiple psychological, biological and socio-environmental factors. It is distinct from feeling 'depressed' by the duration and intensity of symptoms, the suffering caused and its impact on daily living functions (Sapinho *et al.*, 2009, p.38). Depression is revealed by the **major depressive episode** which includes a feeling of sadness and a quasi-permanent loss of interest or pleasure in life for at least two consecutive weeks. A progressive scale distinguishes between **the isolated depressive episode** (ICD-10: F32), **recurrent depressive disorder** from two depressive episodes (ICD -10: F33) and **persistent mood disorders** (ICD-10: F34) [Passerieux, Hardy-Baley, 2008]. Depression is a long-term disorder with a high likelihood of recurrence (up to 80% throughout an entire life), with a risk of conditions becoming chronic (20% likelihood after 2 years) and whose intensity varies through time.

Psychiatric care practices

There are three main types of adult psychiatric care: outpatient care, full-time care and part-time care.

- **Outpatient care** is defined as all types of care provided outside the hospital context. In most cases, patients are monitored via consultations conducted in medico-psychological centres (CMP), the care coordination reception unit. Care provision can be individual or collective as in group therapies or therapeutic workshops. **Liaison psychiatry**; that is to say care or interventions in somatic hospital wards, constitute the second most common form of out-patient psychiatric care. It also includes home care or care provided in substitute-for-home residential institutions. .
- **Full-time care** almost exclusively consists of full hospitalisation in health establishments where patients are placed under 24 hour surveillance. It is reserved for patients with acute disorders or those requiring intensive care.
- **Part-time care** is provided in hospital establishments but does not involve full hospitalisation, with the exception of night hospitals that provide therapeutic care at the end of the day and medical surveillance during the night. The two main forms of care are provided by day hospitals and the part-time therapeutic activity centres.