General practitioners are bearing an increasing burden of the care of common mental disorders in France

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ABSTRACT

Introduction: In France, general practice is playing an increasing role in the management of common mental disorders. This is due to a variety of factors, among which the way general practice and specialised mental health services have evolved over time.

Methods: A description of the status quo in France, with a comparison between France, the UK and the Netherlands. A review of reasons for the present position.

Results: the general practitioner (GP) is often the only medical carer to be contated in cases of psychological distress and over 80% of psychotropic medications are prescribed in this setting. Although most common forms of mental disorder can be managed at the primary care level, GPs need to be able to refer patients rapidly to specialised mental health services. Yet there are delays for consultations with both private and public psychiatrists along with difficulties in finding beds for full-time hospitalisation. The situation is predicted to get worse with the reduction in the number of psychiatrists and GPs forecasted for the coming years. 'Psychiatric sectorisation' has led to a substantial development of community mental health care services, yet this has not compensated fully for the reduction in full-time hospital beds. Furthermore, community mental health care services remain relatively isolated from other community health services with very limited exchanges with general practice.

Conclusions: GPs report an urgent need for training in mental health. Along with improving their ability to accurately detect and treat mental disorders, it is crucial also to improve communication between GPs and psychiatrists and increase shared case-management. Structural changes are also necessary to ensure a quicker and easier access to specialised mental health care services.

General practice in France is increasingly at the forefront for the management of common mental disorders (mainly anxiety and depression). This is due to a variety of factors linked mainly to the way general practice and psychiatry have evolved over time, a lack of coordinated care between generalist and specialist physicians and a of communication between general practice and community specialised mental health care. After describing the current situation of general practice as well as specialised psychiatric services, this paper will examine how general practice fits in to mental health care in France and the options the general practitioner (GP) has to choose from when managing mental illness.

French general practice

General practice in France contrasts to that in many other European countries. Firstly, France has one of the highest numbers of GPs per head of population (Eurostat, 2003). Yet projections predict a 25% reduction in the number of GPs by 2025 (CARMF, 2006). As for all health care facilities in France, there are huge geographical disparities with a lack of physicians practicing in the rural areas and the North and a concentration of physicians in the Paris area and the Mediterranean urban zones (DREES, 2002; Imai et al., 2000; Vigneron, 2000). This results from the freedom of choice to set up practice almost anywhere irrespective of the density of physicians in the area.

In France, GPs work as private practitioners on a fee for service basis with patients being paid back fully or partly by the state insurance system. GPs work mainly alone with no ancillary staff and with little contact with other GPs and specialists. Patients were until recently free to consult directly any GP or specialist (private or public) as often as wanted. Since July 2005, every citizen is encouraged to register with a specific physician (in 98% of cases a GP is chosen), responsible for coordinating care and referring patients to specialists (Assurance Maladie, 2005). This measure is hoped to reduce the amount of "shopping around" done by patients and overbooking of costly specialist services by patients with erroneously "self-diagnosed" disorders. Visits to most specialists without referral from the coordinating doctor are financially sanctioned.

Although direct visits to specialists have decreased dramatically (Caisse Nationale de l'Assurance Maladie, 2006), this new legislation has substantially increased GPs' workload. Furthermore, patients being allowed to choose a GP or a specialist as coordinating physician and change at will, GPs have not been given a clear gate-keeping role restricting access to specialists as in the UK for example. They are regularly faced with the dilemma of complying with patients' demands which is in their interest and ethical considerations. The main

differences between the organisation of general practice in France and in two contrasting European countries, the UK and the Netherlands, is shown in Table 1.

In France, as elsewhere (Goldberg & Huxley, 1992), the GP is often the first and only medical professional to be contacted in the case of mental illness (Lepine et al., 1997). It is now widely acknowledged that GPs play a key role in the early identification of mental disorders and for severe cases in reducing the delay to appropriate treatment. Furthermore over 80% of all psychotropic medication prescriptions emanate from general practice (Baumann et al., 2001; Briot, 2006). Mental illness accounts for approximately one third of all health problems presented to the GP (Lecrubier et al., 1995; Norton et al., 2004) and is likely to increase hand in hand with the increase of common mental disorders in the general population.

Yet, GPs report that they have very little time to deal with psychological problems which already account for longer consultation times (Breuil-Genier & Goffette, avril 2006; Labarthe, juin 2004) than the 15 minute average (Ustun & Von Korff, 1995). Despite recent changes introducing additional fees for specific procedures (CNAM, 2006), the type of consultation and the corresponding amount of time required are not taken into account meaning a fixed rate is charged whatever the length of the consultation. GPs report a lack of initial training in mental health and over two-thirds of them state a need for continuous medical education training specifically in case-detection and psychotherapy (Verger, 2006). Prescribing psychotropic medication often remains the only immediate solution. It is a safe “refuge” for GPs faced alone with complex clinical pictures and pushed to the limits of their medical competences (Haxaire, 2006).

It is widely acknowledged that French GPs, as elsewhere, recognise approximately half of cases of psychiatric disorder among their patients (Lecrubier et al., 1995; Norton et al., 2004), as diagnosis is often made difficult by comorbid physical illness and patients presenting with somatic symptoms only. It has been shown that half of cases of major depression go unnoticed (Lecrubier et al., 1995) and less than half receive adequate treatment (Lepine et al., 1997). Improving GPs’ ability to establishing accurate psychiatric diagnoses and offer adequate treatment is important (Briot, 2006) just as is easy and rapid access to specialised care.

Specialised mental health care services

In France, there are a variety of different mental health services: the public hospital sector - offering inpatient beds in psychiatric hospitals and general hospitals, part-time (day or night)

outpatient places, consultations and ambulatory mental health care - private and semi-private psychiatric clinics and private psychiatric practices.

In 2004, France counted 14 000 psychiatrists, that is 22 for 100 000 inhabitants, which is the highest density of psychiatrists in Europe (European Commission, 2004). 47% of psychiatrists are private. However, 49% of psychiatric establishments and 73% of psychiatric beds are in the public sector (Coldefy, novembre 2005). There are strong regional disparities with the highest density of psychiatrists found in urban centres (especially those with teaching hospitals) and in the southern part of the country. A large number of posts for psychiatrists in the state health system's hospitals lie vacant, especially in the rural areas and in northern France (Verdoux & Tignol, 2003).

Since the 1960s, state hospital services are organised into geographic 'sectors' each covering a population of approximately 70 000. The aim of this "politique de secteur" is to limit full-time hospitalisation and develop a variety of structures in the community such as out-of-hospital consultation and day care centres, therapeutic workshop centres and home-visits, as well as continuity of care with the same mental health care team (Guilmin, janvier 2000; Reynaud et al., 1999). It is also to develop coordinated mental health care involving primarily GPs. Although the extension of psychiatric hospital care into the community has been substantial, there are huge disparities between sectors in the transition from hospital care to ambulatory care leading to different specialised care models in different areas (Guilmin, janvier 2000). Table 1 shows the main differences between the organisation of specialised mental health care services in France and two contrasting European countries.

Since the 1990s, there have been further large reductions in the number of psychiatric hospital beds and in the mean duration of stay (Reynaud et al., 1999; Verdoux & Tignol, 2003), leading to frequent readmissions after discharge of patients not sufficiently stabilised. These cuts were meant to be compensated for by an even greater development of ambulatory care. Although this varies form one sector to another, it has overall been insufficient, with less than 10% of total mental health expenditure used on public sector community care (DREES, 2002).

Forecasted reductions in the number of psychiatrists

Owing to the drastic reduction in the number of medical students since the 1980s (numerus clausus), the number of psychiatrists should decrease by nearly 40% over the next two

decades. This should theoretically be sufficient to ensure France's mental health needs (Piel & Roelandt, 2001) as it will be comparable to that of other European countries. However, there are already huge disparities in staff and bed resources from one sector to another and inequalities in access to care are likely to worsen, especially if private psychiatry remains unregulated with the possibility of setting up practice anywhere (Verdoux & Tignol, 2003). Moreover, a large number of private practitioners are principally practicing psychoanalytically orientated psychotherapy (Lafitte et al., 1996).

The un-bridged gap between general practice and specialised mental health services

Let alone the time constraints of the fee-for-service system, French GPs are confronted with difficulties in accessing specialised care that have worsened with the above-mentioned changes.

The GPs in Verdoux et al's study report long yet similar delays for booking consultations with both public and private psychiatrists for patients with an early onset of schizophrenia. GPs obtained a consultation with a psychiatrist, whether private or public, in less than two weeks for only 40% of patients (Verdoux et al., 2006). Delays can be expected to be even longer for less severe non-psychotic disorders and to increase in coming years with the forecasted drop in the number of psychiatrists.

The long appointment delay for consulting private psychiatrists can be explained partly by the fact that most patients are seen on a very frequent basis for psychoanalytical therapy only (Lafitte et al., 1996; Réseau de Promotion pour la Santé Mentale 78, 2003). Private psychiatrists very rarely offer alternative therapies (Lafitte et al., 1996). They see many patients with personal problems or sub-threshold symptoms only, leaving little time for new patients with definite psychiatric disorders (Chapireau, novembre 2006; Réseau de Promotion pour la Santé Mentale 78, 2003).

Despite similar consultation delays, GPs are more likely to refer patients with early onset schizophrenia to private psychiatrists (Verdoux et al., 2006). It is likely that this applies even more so to patients with common disorders. Yet, private psychiatrists often charge rates beyond what is covered by the national health insurance, requiring patients with no additional private health insurance to pay the difference. When offering psychoanalytic therapy, the entire fee is often to be paid by the patient as part of the treatment process. Patients managed in the public 'sector' whether in full-time hospitalisation or ambulatory care tend to cumulate other medical and social problems: physical health problems, unemployment, marital problems and poor functioning. This 'patient environment' may no doubt make GPs reluctant

to contact public sector psychiatrists for their patients (Chapireau, novembre 2006). GPs most often choose to manage patients in the early stages of mental disorder in general practice. The reluctance to refer them to a psychiatrist comes not only from the long consultation delay but from the complex procedure for booking a consultation. In order to actually be given an appointment it is often the GP who contacts the psychiatrist: for many GPs this involves ringing the psychiatrist and leaving a message on an answer phone (most private psychiatrists work alone with no secretary), being rung back by the psychiatrist, fixing the appointment and then contacting the patient again.

Advising a patient to visit a psychologist can sometimes avoid the stigma attached to seeing a psychiatrist and reduce the length of time necessary to convince the patient to consult. As is the case for private psychiatrists, psychologists offer mainly psychoanalytical therapy. However consultations are never refunded which explains in part why GP patient referral is limited (Verdoux et al., 2006). French psychologists see mainly children and adolescents; the small proportion of adults consulting them tends to have perturbed personal and professional lives rather than clear-cut psychiatric disorders, coupled with a high level of education (Chapireau, novembre 2006).
Psychotherapies are offered at large in France as there is no convention regulating training and access to the profession (today anybody is entitled to offer psychotherapy). Increasing access to psychotherapies, by structuring the profession (setting official rules for being labelled as a 'psychotherapist') and examining how the costs could be covered by the national health insurance system, is currently under discussion (Clery-Melin et al., 2003).

When requiring in-patient hospital care for a patient, both private clinics and public psychiatric hospitals pose problems. Private clinics often charge beyond what is covered by the national health insurance. Regarding hospital services, GPs are often confronted with difficulties in obtaining rapid full-time admission for a patient due to the reduction in hospital beds, a quicker "way in" being sometimes through the emergency services. Furthermore, a patient will preferentially be placed in the sector corresponding to his place of residence. As mentioned above, there are huge disparities between sectors in the offer and quality of care, as well as the theoretical approach to care. Although in theory the rules of 'sectorisation' do not apply to the patient who can choose to be treated by a team other than the one in charge of the catchment area (Reynaud et al., 1999; Verdoux & Tignol, 2003), it is well-known that the choice of the sector is very rarely left up to the patient (Reynaud et al., 1999).

Public psychiatric care has remained relatively isolated with respect to other health care services. Firstly, there are very few psychiatric services in general hospitals and secondly, although the extension of psychiatric care out of the hospital into the community has been substantial, it remains relatively isolated from other community health care services. This has led to a lack of exchanges with other actors of the health care system (Reynaud et al., 1999). GPs for example, report no or very infrequent contacts with their local mental health care teams although the vast majority know at least one private psychiatrist or psychiatrist of the sector's mental health care team (Verdoux et al., 2006). Furthermore GPs report a lack of feedback from psychiatrists regarding the diagnosis and treatment of patients they have referred (Réseau de Promotion pour la Santé Mentale 78, 2003; Verdoux et al., 2006). They also consider that irrespective of the diagnosis, the relationship with psychiatrists is difficult (Verger, 2006), even more so than with other specialists (Réseau de Promotion pour la Santé Mentale 78, 2003). Coordinated care and shared case-management will only be achievable if communication between GPs and psychiatrists is improved.

Conclusion

The current trends in medical demography and the lack of coordinated care between GPs and psychiatrists, means that GPs are likely to become increasingly isolated in the management of common mental disorders. The French authorities are well aware of the "time-bomb" related to mental illness which will be increasingly difficult to cope with given the reduction in offer of specialised mental health care (Plan Psychiatrie et Santé Mentale 2005-2008).

As is the case for all drug consumption, France has one of the highest psychotropic drug consumption levels in Europe (Alonso et al., 2004; Ohayon & Lader, 2002; Tylee et al., 1999), with over three quarters of prescriptions emanating from general practice (Briot, 2006). A recent report points to the need to increase GPs' ability to accurately identify cases of psychiatric disorder and offer adequate treatment (Briot, 2006). Increasing access to psychotherapies has also been highlighted as a priority (Clery-Melin et al., 2003). The central role of general practice in the management of mental illness is clearly recognised. Yet, let alone improving accurate GP case-identification and treatment, developing communication and shared case-management between GPs and psychiatrists with better access to specialised care is crucial for France to tackle this growing public health problem.

2500 words

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