# Why Child and Adolescent Psychiatrist are repulsed by public health and why they are so wrong

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# Conflict of interest

Consultant in statistics for most pharmaceutical companies

# Public Health

- Deal with health issues at the population level instead of patient's level
  - Health services (priorities, organization)
  - Prevention
  - Evaluation (medications, psychological treatments, integrative care)

  →Epidemiology, Biostatistics, Economics
- Specific problems in Mental Health?

# Why Child and Adolescent Psychiatrist are repulsed by Public Health?

- Strong clinical feeling of singular situations
- Public Health = Money / C&A Care # Money $\Rightarrow$ Public Health # C&A Care
- Spirit of Finesse versus Spirit of Geometry
- A problem of Superego?
- Less data than in other medical specialties
- Data are misleading / Public Health is unfair (Ugly Duckling Syndrome)
- Lack of a strong theoretical framework

  +: curiosity, need for culture,

  –: incommunicability, *lost in theory and care*

# Why they are so wrong

- If you want to be considered as a smart person, you have to speak the language of neurosciences
- If you want to be convincing, you have to speak the language of public health
- (If you want to deal well with your patients you have…)

→ *Public Health is a prerequisite for an effective advocacy of C&A psychiatry*

# Why they are so wrong

1. Should C&A Psychiatry be a Public Health Priority?

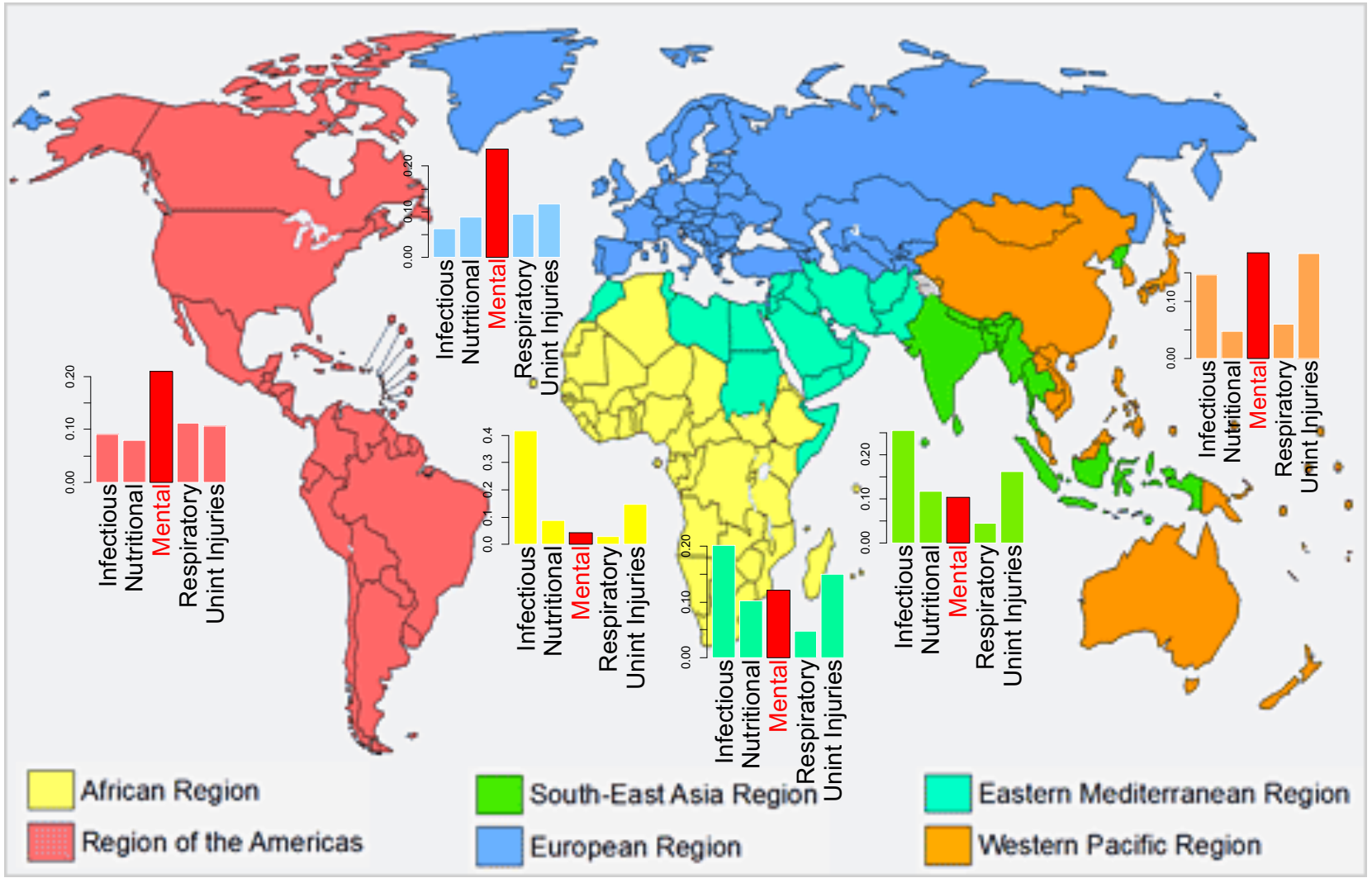
2. Health Service Organization

# Data *do* show that C&A Psychiatry should be a priority

- Public health problems are considered through their global level of "Burden of Disease"
- DALY (Disability Adjusted Life Year): "number of lost years due to ill health, disability or early death"
  - 16 y.o. adolescent commits suicide at 16 → 80 – 16 = 64 YLL = 64 DALYs lost
  - 7 y.o. child is diagnosed with ADHD → 25 × 0.014 = 0.35 DALY lost

# %DALYs due to M.H. problems: 5-14 years

WHO Burden of Disease Study 2014



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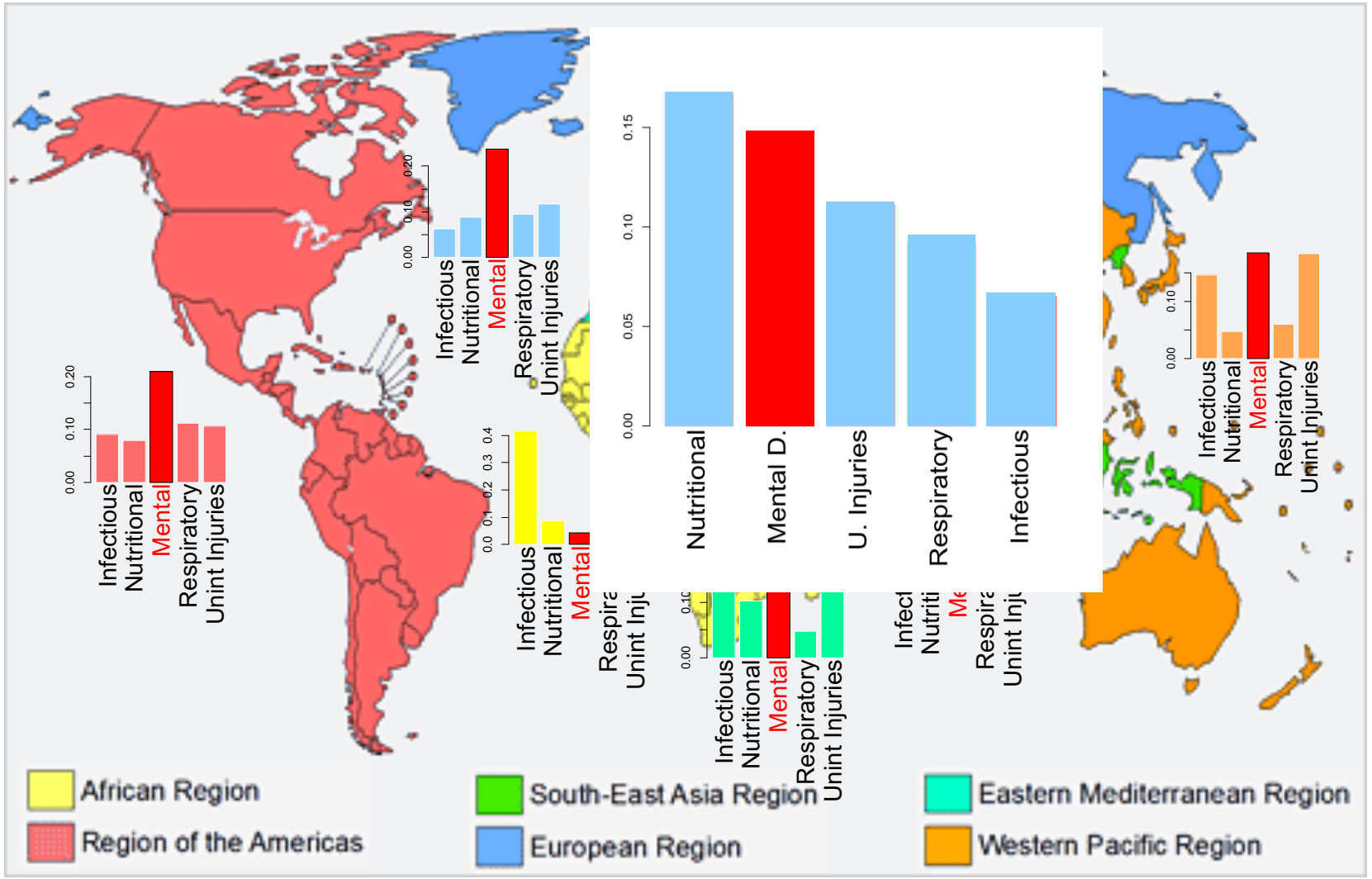

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- 7 y.o. child is diagnosed with ADHD → 25 × 0.014 = 0.35 DALY lost
  - Person 1: “is hyperactive and has difficulty concentrating, remembering things, and completing tasks.”
  - Person 2: “Chronic asthma”
  - *Who do you think is healthier overall (in terms of having fewer physical or mental limitations on what the person can do in life), the first or the second person?*
- What about the duration of ADHD? (CD?)
- What about care giver burden?

# Health Service Organization

- How many
  - C&A Psychiatrists
  - C&A Psychologists
  - Nurses
  - Social workers
  - Specialized teachers, special educators, …
  - Beds, …

  / 1000000 youths?

# Health Service Organization

- How many C&A Psych-Nurses-S.W.-Beds / 1000000 youths?
- What science says:

"49.5% lifetime prevalence of mental disorders in adolescents (13-18), 22.2% with severe impairment"

Merikangas, K. R. et al (2010). Lifetime Prevalence of Mental Disorders in U.S. Adolescents: Results from the National Comorbidity Survey Replication–Adolescent Supplement (NCS-A). *Journal of the American Academy of Child & Adolescent Psychiatry*, *49*(10), 980–989.

# Health Service Organization

- How many C&A Psych-Nurses-S.W.-Beds / 1000000 youths?
- “49.5% lifetime prevalence of mental disorders in adolescents (13-18), 22.2% with severe impairment”
- France:
  - 5 millions of adolescents 13-18
  - A given year: 400000 have a mental disorder
  - EBM: psychological treatment + …
  - Treatment volume: 35 hours/week, supervision, 10-30 sessions/patient
  - 9500 psychotherapists are needed → 10000 are available (in the country)

# Health Service Organization

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- *Optimal (EBM) care for youths who do need care are not sustainable*

# Health Service Organization: what can we propose?

- What is the problem, what are the solutions (1)
  - Prevalence of psychiatric disorders: psychiatric epidemiology is not what it is supposed to be
  - Patients come to see you / Epidemiologists go to see subjects
  - About impairment
  - What is a C&A psychiatric patient?
  - C&A Mental health versus C&A Psychiatry versus (Mental) Disability of C&A
  - → Who should be treated by Whom (with which Money)?
  - → Level 1, level 2, level 3, … bof
  - → We can take the lead (somatic medicine has the same problem)
  - → We have to accept not to take care of all youths

Diagnosis and need for treatment are not the same. RL Spitzer - Archives of general psychiatry, 1998

# Health Service Organization: what can we propose?

- What is the problem, what are the solutions (2)
  - Non pharmacological treatments are developed without taking costs and sustainability into account
  - → From Resources to Care (J.N Despland)
  - → Practice Based Evidence ("high-quality scientific evidence that is developed, refined, and implemented *first* in a variety of real-world settings.")

# Conclusion

- In medicine, the population-level analysis is a necessity, especially in C&A psychiatry
- Public Health is necessary for an effective advocacy of C&A psychiatry
- Get rid of the “Ugly Duckling Syndrome”, be fully actors of the evolution medicine
- Care is moving out of medical fold, we have to accompany it
- Statistics are not at the core of Public Health, group-level thinking *is*. C&A should thus naturally be involved in the game.