

EARLY INTERVENTION IN THE REAL WORLD

What is a “Maison des Adolescents”? A history of integrated youth health care services in France

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Aim: Since 1999, the development of more than 100 “Maisons des Adolescents” (MDAs) has enabled young persons to gain access to specific care in integrated youth-friendly facilities in France. To contribute to the development and standardization of international youth-friendly health care services, this review provides insight into the French MDA facilities.

Methods: This socio-historical analysis includes a systematic review of articles referring to the MDAs (selection through title and/or abstract), ministry reports and newspaper articles, from 1999 to 2018.

Results: If the various medical programmes of MDAs depend on the priorities of local teams rather as well as on official regulations, all MDAs offer the following essential services: a “Health and Prevention Space” open daily; multidisciplinary consultations; a mobile team visiting youth hospitalized in medical units; a mobile team able to meet adolescents at their homes; an open centre for art workshops; refresher and remedial courses for school work; network meetings and parent support groups. The MDAs from the start addressed an age group (young people aged 11–21 years) rather than an illness. They thus provide primary prevention for adolescents according to the World Health Organization definition of health as “a state of complete physical, mental and social well-being.” This medical and political movement was shaped by the epistemological background of its first leaders.

Conclusion: Although more cohort studies to evaluate their early interventions would be useful, the success of the MDA network is already widely acknowledged by users, professionals and policy makers.

KEYWORDS

access to health care, France, integrated youth health care services, Maison des Adolescents, primary prevention for adolescents

1 | INTRODUCTION

To contribute to the development and standardization of international youth-friendly health care services (Hetrick et al., 2017), this paper provides insight into the French “Maison des Adolescents” (MDA) facilities.

Since the first MDA opened in 1999 in the city of Le Havre, these facilities have improved the access to care of adolescents with physical, psychological or social problems. In 2002, a review of studies concluded that French adolescents were in an overall good state of health, but affected by several critical health issues: eating disorders (*overweight, obesity, bulimia, anorexia nervosa*), addictions, suicide,

chronic illnesses, sex-related risks (*unwanted pregnancies, sexually transmitted diseases*) and risk-taking behaviours (Pommereau, 2002). In 2003, the French Ministry for Health, Family and Handicapped Persons, planning for the upcoming Conference for Family, commissioned a report on what the 5 million French adolescents needed to help them reach adulthood successfully (Rufo & Joyeux, 2004). At that time, a wider implementation of MDAs was considered necessary because adolescents were not using the existing array of facilities designed for children and adults (Marcelli, 2011). Although the first guidelines did not specify the age range of adolescents (Cahier des charges des Maisons des Adolescents, 2010), the target population was clarified: young people aged 11 to 21 years, a range that local

MDAs can choose to extend to 25 years (Valls, 2016). Activity reports rapidly showed the success of these services, due to their relatively low cost and the presence of multidisciplinary professionals (Amara & Naves, 2013). On average, an MDA welcomes 700 to 1000 young people each year (most coming two or three times) and 150 to 250 parents (Amara & Naves, 2013).

2 | ONE MODEL, DIVERSE LOCAL EXPERTISE

2.1 | National guidelines for the Maisons des Adolescents

MDAs are multidisciplinary centres responsible for the harmonization of all activities of all those working with adolescents (Cottin, 2016; Rufo & Joyeux, 2004). At a local level, they offer the following essential services:

- A “Health and Prevention Space,” open daily, provides early, immediate and unconditional listening, information and training to adolescents and their parents. This service is also open to an array of professionals (general practitioners, teachers, lawyers, members of associations or social workers) who are considered key partners who work vigilantly with adolescents to promote early health care (Barraband, 2015; Ferron, Pottier, & Berges, 2011).
- A mobile team, visiting youth hospitalized in medical units.
- A mobile team able to meet adolescents at their homes, schools or at various organizations.
- An open centre for art workshops (cooking, painting, singing, expressive writing, meditation, sports and more) (Viardot, Rizzi, Lachal, & Moro, 2016).
- Multidisciplinary consultations (psychological, family, transcultural, gynaecological, paediatric, legal).
- Refresher and remedial courses for school work.
- Network meetings: to ensure that adolescents receive holistic care, covering all their needs, professionals from health, social, educational and legal services work in a network open to other institutions (schools, clubs and other associations) (Cottin & Dujardin, 2010). Networking is seen as a way to share knowledge and practices, while building friendly relationships to strengthen the effectiveness of the ambulatory care network (Cailleau & Dutray, 2006). The close bonds between MDA professionals and social workers enable them to jointly design medical and social follow-up for adolescents in distress for social, familial or economic reasons. Moreover, MDA professionals provide emotional support to social workers frequently exhausted by their responsibilities (Barraband, 2015).
- Parent support groups, first opened in 2004 and widely implemented since 2010.

A steering committee, headed by a trained leader, supervises MDA operations, their alignment with public policies and the efficiency of its network. At a regional level, a committee harmonizes the delivery of care of each MDA and mediates discussions between

MDA professionals and local authorities. It also monitors the public health of adolescents and fills the gaps between care needs and delivery across territorial lines.

2.2 | Standardization is not a priority

Since 2007, MDA development has responded both to policy-makers' requests (Versini, 2007) and to the demand of psychiatrists arguing that existing data on adolescent distress and their increased help-seeking behaviour show the need for greater governmental involvement (Moro, 2012). From the beginning, the medical programmes of MDAs depended on the priorities of local teams (Podlipski & Gerardin, 2011) rather than on official regulations. Thus, in 2009, the charter of the French National Association of Maisons des Adolescents (ANMDA) confirmed that standardization of MDAs appears impossible: “Without hegemony, the framework of MDAs relies on the existing array of facilities provided by every territory. [...] In this sense, MDAs might be considered managers, in a process of sharing common tools” (ANMDA, 2009). This statement also sought to appease concerns from local public psychiatric departments. Since the 1960s, 77% of mental health care in France has been provided by public community centres designed either for children or for adults, with full and universal cost-free coverage (Les Comptes de la Sécurité Sociale, 2014). Thus, the spread of MDAs reconfigured the populations and missions of these public mental health centres and threatened their governmental funding (Cosseron, 2011). As early as 2003, Rufo and Joyeux (2004) praised the first MDA experiments, already underway in cities including Le Havre, Marseille and Bordeaux. By 2008, 69 new MDAs had been funded by the government and “adolescence” was endorsed as a distinct age requiring specific care (de Fleurian & Genvresse, 2011). Between 2005 and 2010, the government spent 12.6 M€ and had 102 MDAs in operation. Although the initial plan was to establish one MDA for each of the 101 French districts, each existing MDA ended up determining its own geographical catchment area according to local needs and population density. In 2010, 92% of the French population had access to an MDA, although 17 districts remained uncovered (DGCS & DGOS, 2011). Funding sources remained diverse; in 2013, each MDA received a total of 185 to 950 K€ from 10 to 30 different funders and had catchment populations of 250 000 to 1.3 M inhabitants. Nonetheless, the only secure, sustainable funding remains that provided by the Regional Health Agencies, as reported by Amara and Naves (2013), who also estimated some of the savings provided by an average MDA with a mean budget of 400 K€. Mediation in a group home for adolescents, under pressure because of a difficult teenager could save 25 K€ by preventing sick leaves and postponement of admissions. Reception, listening and ambulatory care of an adolescent with anorexia nervosa could prevent hospitalization (750€/day for 4 months, 112 K€. The same services to prevent a suicide attempt that would be followed by 1 week of hospitalization would economize 7 K€.

2.3 | Examples of specific therapies and institutions

The accessibility of MDAs depends on three priorities: geographic proximity, opening schedules suitable for teenagers and a welcoming

team (Benoit, 2017) able to listen to adolescents' multiple reasons of seeking help and their multiple ways of expressing their unease (Boë, Lestideau, Papanicolaou, Moulay, & Wernoth, 2012). Although face-to-face psychoanalytically oriented talk-therapy is most common, counselling psychologists call for flexible settings capable of meeting the moving demands of youth (Perier, Benoit, & Moro, 2012). Ferron et al. (2011) analysed the diverse motives for consultation in their MDA in the Tarn-et-Garonne district: 24% of the teenagers came seeking understanding and support, 22% for psychological distress, 13% for health problems, 9% for family difficulties, 8% for school-related problems, 5% for housing issues, 4% for questions related to the law and their legal rights, 4% for activities and 2% for professional questions, while 9% did not specify a reason. Overall, 13% had only a single welcome interview; 23% received information including contacts, and addresses; 38% came several times for repeated support and 26% began regular care at the MDA (Ferron et al., 2011).

Different MDAs have gained experience dealing with specific problems or disorders, depending on their location, history and local partners. The team of "Casita," the MDA of Bobigny, a Paris suburb, is well-known for its expertise in addiction, migrants' access to care and post-traumatic stress disorder. Bobigny's population is young (28% younger than 20 years); 19% are migrants or belong to ethnic minorities, the unemployment rate is 17% and the violent death and poverty rates are high (Moro, 2006). Other MDAs (Strasbourg, Nîmes) have begun addressing newer issues, related to the terrorist acts that have struck France.

Another example is the Maison de Solenn, in central Paris, designed to provide care for teenagers with eating disorders or chronic illness (Vincent, 2007). It received substantial funding from well-known families whose daughters had anorexia nervosa. Other specific issues it addresses include anxiety-based school refusal (Benoit, Barreteau, & Moro, 2015), international adoption (Benoit, Harf, Sarmiento, Skandrani, & Moro, in press) and unaccompanied foreign minors (Radjack, Hieron, Woestelandt, & Moro, 2015). Four paediatricians and an endocrinologist perform 3000 somatic consultations a year there. It has 10 hospitalization beds intended for adolescents with chronic disease flares, eating disorders and other somatic complaints (eg, pubertal delay, menstrual disorders, headaches and sexually transmitted infections) (Lefèvre, Blanchet, Cosson, Mimoun, & Ferrand, 2008). Analysis of profiles of 200 young patients seeking help for obesity revealed 53% had a low socioeconomic status, 70% lived with only one parent, a third had been exposed to violence (in the family, at school or due to urban violence), and 9% of those older than 16 years had dropped out of school. The Maison de Solenn allows integrated care addressing the various personal or family psychological and social characteristics observed in eating disorders (Lefèvre, Bertrand, Vachey, & Moro, 2011). A parents' support group, focused on eating disorders, is moderated jointly by a parent with long caregiver experience and a counselling psychologist (Giraud & Moro, 2014). With an entire floor dedicated to high-quality art workshop space, the cultural care programmes (Soins Culturels) prioritizes creative engagement by young people as individuals and promotes positive action and responsibility (Moseley, 2007).

3 | MAISONS DES ADOLESCENTS VS EARLY INTERVENTION YOUTH-FRIENDLY SERVICES: HISTORICAL DISTINCTIONS

3.1 | Deal with immediate issues rather than refine the detection of long-term conditions

What historically distinguishes MDAs from services designed for early intervention? First, the 2003 report, in some sense a foundational document, stressed a vision of adolescence as a crisis that eventually passes, thus defining health as not a mere medical matter, but as a perpetually moving balance of the individual (Rufo & Joyeux, 2004). This document does not mention mental handicaps as a risk for young people, should they not receive early psychiatric care. When mentioned, impairments are innate or acquired (visual, motor or mental) resulting in problems that exist before—and are exacerbated by—adolescence. The report does mention both psychosis and autism among the less prevalent disorders (0.1%), without describing their life-long consequences. Thus, professionals working in an MDA are not specifically trained to detect and address the first symptoms of lifelong psychiatric disorders as early as possible. Their main mission is to handle adolescents' behavioural and depressive symptoms, seen as both highly risky and of short duration (leading for instance to a suicide crisis) (Moro, 2012).

Second, the report underlines the role of parents as useful in reporting alerts and helpful partners for the professionals in dealing with these short-term crises. Parents and society, however, also appear responsible in many ways for adolescents' unease: high divorce rates, child neglect, overly invasive parenting, ever lengthening higher education, high youth unemployment—all of these are issues that might explain adolescents' difficulties in becoming autonomous. Thus, the Maison des Adolescents—literally "the home of teenagers"—were created from the beginning as homey spaces where young people and their families would feel welcomed (Gilloots, 2006). The welcoming atmosphere is understood as a therapeutic tool (Paris, 2012; Poitou et al., 2012), and the homey habitat designed to enable teenagers to experience fulfilling group encounters respectful of their privacy (Pripis, Andrieux, Mille, & Duriez, 2011). Although a place called a "psychiatry unit" can generate stigma, "home" is a label intended to restore adolescents' confidence (Poitou et al., 2012). According to Barraband, highly specialized services often overlook the complexity of the individual as a whole person. Often designed to ensure efficiency, they can convert an adolescent's help-seeking pathway into a disjointed assortment of unconnected professionals (Barraband, 2015).

3.2 | Address the well-being of an entire age category rather than target an at-risk population

While international mental health care models have only recently moved from a medical-centred approach to a wider movement addressing a population based on its young age (McGorry, Bates, & Birchwood, 2013), the MDAs from the start addressed an age group rather than an illness (Benoit, 2016). Their objective was not to provide a "medicalized adolescent medicine" (Cottin, 2008) but primary

prevention for adolescents according to the World Health Organization (WHO) definition of health: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1946). This preventive goal—to help adolescents become full-fledged adults—has been explicitly supported by French policy makers through the development of the MDA network (Carlotti, 2013). Returning to school, experiencing fulfilling relationships to others, envisioning one's aspirations for life, improving parenting skills—these are all seen as successful endpoints, just as better health is. Strongly influenced by Winnicott's parent–infant relationship theory, most MDA professionals see their work as a therapeutic holding of the adolescent and its family (Benoit, Smadja, Benyamin, & Moro, 2011; Poitou et al., 2012). In contrast, historically, the Australian early intervention research programme was developed to provide young people with evaluated facilities, in a context of insufficient public services (Brijnath & Antoniadis, 2016; Yung & McGorry, 1996). Further studies shedding light on the lower quality of life of young people with at-risk mental states (ARMS), independent of any transition to psychosis (Fusar-Poli et al., 2015; Lin et al., 2011), highlighted the need to enlarge the target population from the ARMS category to all youth. This evidence-based approach, aimed above all at reducing transition rates, was remodelled into the promotion of government-funded mental health care services supporting youth mental health and well-being (Coughlan et al., 2013). In France, the pre-existing public community centres and the creation of MDAs were already based on the universal cost-free health care coverage. This, and a professional norm against involuntary commitment of young people for an unduly early diagnosis, might together account for the scarce use of standardized early detection of psychosis in France (Benoit, Moro, Falissard, & Henckes, 2017).

4 | CRITICISM AND LATEST PROPOSALS FOR YOUTH MENTAL HEALTH IN FRANCE

Some authors argue that specific settings designed to contain adolescent crises might be a way to deny and naturalize a generation conflict. Thus, our society might deny its young citizens' longings by medicalizing them (Benoist et al., 2011; Huerre, 2011). According to Rechtman, "listening" to adolescents should not be regarded as therapy. Their urge to speak may reveal a contemporary social norm of self-narrative rather than an aspiration to disclose one's private life (Rechtman, 2004). Although adolescents are welcome to become involved in running these MDAs intended to welcome them, MDAs are far from co-designed by teens. Adolescent participation appears limited to attending support groups and collective workshops. According to Marcelli, the more distressed adolescents are, the less likely they will ask for help, and the more likely they are to discourage, through constant opposition, those who would like to help them (Marcelli, 2011). Consequently, care should be available before the teenagers ask for it, and professionals should be trained to uncover signs of unease hidden by physical or mood complaints. Teenagers are described as errant and unreliable patients who need a unique, simple, accessible service, situated in the city centre (Rufo & Joyeux, 2004). In 1999, the first MDA in Le Havre, scheduled broad opening hours to

conform to their understanding of adolescents as inclined to immediate and unpredictable changes. Staff were surprised to note that teenagers attended pre-booked appointments, if they were scheduled within 2 weeks (Fuseau, 2015). In 2011, other authors argued that MDAs needed be better regulated by the government to optimize the care provided, prioritize needs and adapt their aims and activities to new societal issues (Lida-Pulik, Enjolras, & Isserlis, 2011). MDA guidelines were updated in 2016 to address these points (Cottin, 2016). As mentioned above, governmental funding of MDAs relies on local and regional health agencies, which treat MDAs as long-term societal investment than intermediate-term research evidence. This might account for the low number of randomized cohort trials thus far undertaken. Accordingly, despite its dynamic array of youth-friendly services, France lags behind in epidemiological data collection and in evaluation of therapeutic methods. Influential psychiatrists, such as Marcelli, argue that the overall good health status of teenagers has already been proved and that the key requirements are to provide professionals with psychoanalytic supervision and to further improve their teamwork inside and outside MDAs (Marcelli, 2011). This view is contradicted by psychiatrists from the public health field, who argue that the time has come to distinguish the meanings of "well-being," "mental health" and "mental disability" (Falissard, Monégat, & Harper, 2017). Others contend that in a context of scarce economic resources and universal health insurance coverage, psychiatrists ought to be delineating relevant medical priorities and attempting to detect adolescents' mental disorders earlier (Falissard, 2016). Simultaneously, a recent report on the "Well-Being and Health of Youth," co-written for the Ministry of Education by the psychiatrist directing the Maison de Solenn, recommended a distinctive political choice: the consecration of well-being as both a right and as a duty to oneself and of psychological support as a preventive tool (Moro & Brison, 2016). If the upcoming "Pass Santé Jeunes" (Pass for Youth Health) project is approved by the legislature, youth aged between 11 and 21 years might be eligible for direct access to 10 free sessions with a psychologist in private practice.

5 | CONCLUSION

The development of the "Maisons des Adolescents" has enabled young people to gain access to specific care in integrated youth-friendly facilities. This medical and political movement was shaped by the epistemological background of its first leaders. Although cohort studies to evaluate their early interventions would be useful, the success of the MDA network is already widely acknowledged by users, professionals and policy makers.

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