The WHO Recommendations and Mental Health in France: The real and tacit instrumentalisation of the instrument

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Project n° 0288848-2 co funded by the European Commission within the Sixth Framework Program
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Introduction

The aim of this report on the situation in France is to describe the modes whereby the WHO Mental Health recommendations are circulated and used. With a view to facilitating intra-European comparisons, the document entitled "Santé mentale: relever les défis, trouver des solutions" (Mental Health: meeting challenges, finding solutions) published in January 2005 was used by the members of this group as the key document, although other sources will also naturally be used. Since 2000, several commissions have held meetings, which have been attended by many experts and practitioners. The discussions which took place at these meetings have confirmed that many instances, experts, leaders in the field, etc. are actively participating these days in setting up a new paradigm: integrating psychiatry into mental health (see the previous Reports published by the French Health Team). This change of paradigm is very much in line with the WHO recommendations, which are outlined below:

WHO Mental Health Recommendations published in 2001:
- Treating mental disorders at primary care level
- Making psychotropic substances available
- Providing care locally within the community
- Educating the public at large
- Involving communities, families and users
- Adopting suitable policies, programs and legislation at national level
- Developing human resources
- Establishing links with other sectors
- Monitoring mental health in communities
- Supporting research

The WHO EUROPE European Ministerial Conference on Mental Health in Helsinki (Finland) in Janvier 2005: Meeting challenges, finding solutions,
1- Fostering awareness of the importance of mental wellbeing
2- Collectively combating stigma, discrimination and inequality, empowering and supporting people with mental health problems and their families so that they can participate actively in this process
3- Designing and implementing efficient integrated mental health systems covering aspects such as promotion, prevention, treatment and rehabilitation, and providing care and means of social reintegration
4- Responding to the need for a competent and efficient workforce in all these fields
5- Recognising the experience and knowledge of patients and their carers (members of their family) and using this knowledge to plan and set up appropriate services.
WHO Europe’s Mental Healthcare recommendations for Europe (the 2005 Helsinki Process)

1 – Instituting local services for treating and caring for people with mental health problems in the community.
2 – Setting up specialised teams to treat sensitive groups *in situ*. These services should be accessible day and night, all week round, and should be provided by a mobile multidisciplinary team.
3 – Providing residential services
4 – Providing emergency services (...) via mobile emergency or hospital-based teams.
5 – Conducting promotion, prevention and information activities.
6 – Forming links with primary health and general hospital wards
7 – Carrying out research and dispensing vocational training in community mental healthcare
8 – Forming intersectoral links with the various instances responsible for health, social protection, employment, housing, justice, education, leisure, etc.

The aim of this report is therefore to examine the relationships involved and the paths whereby these recommendations constituting supra-national tools are diffused and possibly used to draw up new mental health policies in France.

For this purpose, it is proposed to begin by describing the relationships between the World Health Organization and the various official French instances and organisations dealing with mental health. We will then discuss the level of awareness of the WHO recommendations and their appropriation by various players in the field of mental health in France. This analysis will be mainly based on recent official reports and interviews with some of the main protagonists, who are policy makers at national level.

As we will see, the policies recently defined in France were based on similar principles to those edicted by WHO. However, few explicit allusions were made to these recommendations, possibly because their influence is also tacit, however real it may be: all the experts consulted agreed that it is necessary to instigate a "political leap" and promote practices of specific (multidisciplinary, open) kinds. This is the underlying idea on which the present report was based. In line with J. Kindon, it amounts to saying that ideas and policies take parallel paths. This two-fold process of change does not make the policies any less effective.

1. **Strong institutional links**

The relationships between WHO International and WHO Europe and high-level decision-makers are mediated in France by the Ministry of Foreign Affairs (the Department of European and International Affairs) the International Bureau of the DGS ("Direction

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1 See Appendix 1 for an outline of the methods used.
Générale des Soins” – the General Healthcare Directorate) and the Ministry of Health. Until quite recently, the WHO “counterpart” for mental health in France was the Head of the Mental Health department of the DGS. What use do these governmental bodies make of the documents, recommendations and other papers produced? What knowledge produced by WHO is mobilised at the national level, and by whom?

Three levels can be distinguished in this respect (I.1). The stress will also be put on the contribution made by the WHOCC (the WHO Collaborating Centre) in Lille to the circulation of this knowledge (I.2)².

1.1 The three levels at which knowledge circulates

At the first level, there are applications for experts and expert reports (these are produced by the highest instance in the field of health, Institut National de Prevention et d’Education à la Santé - the National Institute for Prevention and Health Education, in particular), and the use made of specific kinds of data such as epidemiological and economic data, including those produced by WHO Collaborating Centre for research and training in mental health (the WHOCC Lille, France).

At the second level, the World Health Organization (WHO INT and WHO EURO) provides lobby groups (FNAPSY, UNAFAM) with policy-making support via the WHOCC (Lille, France), especially in matters pertaining to upholding rights, empowerment and the quality of services; see the 2005 Act entitled "Loi Handicap Psychique" in which psychiatric disabilities were officially recognized, which was instigated by "Groupes d’Entraide Mutuelle 2005" (mutual assistance groups), for example, and the integration of users and their families into quality assurance processes.

In actual practice, French national mental health policies may or may not be based on the WHO recommendations. But the main specificity of this institutional relationship, which is quite an organic one, is that the mental health-related activities (symposia, practical applications to public services, etc.) inspired by WHO both before and since 2005 have mostly been instigated by the WHOCC in Lille (France).

Prior to the 2005 Helsinki Ministerial Conference, for example, the 2001 French mental health plan entitled "Mental health: the users are central to a tool in need of renovation" was largely based on the Piel-Roelandt report submitted in July 2001, entitled "From psychiatry to mental health » and that by JL Roelandt entitled "The democratic approach

² See Appendix 2 for details about the work, missions and objectives of the WHOCC Lille, France.
to healthcare in the field of mental health: the role of the users and team-work in the community”.

The second report was an extension of the previous one submitted in July 2001. The approach proposed was two-fold: to introduce into the field of mental health the trend occurring in all the other fields of healthcare, whereby users were being placed at the centre of the healthcare system (part 1), and modes of exchange and cooperation were being developed among the various players (users, institutions, locally elected figures, etc.), especially by forming networks (part 2). This report contained a series of appendices giving examples of existing mental healthcare networks.

These two reports were strongly rooted in the philosophy described above and the WHO mental health recommendations, and this was reflected in the 2001 Plan, which gave the users a central role, integrated mental healthcare into primary healthcare systems, denounced stigmas, and promoted community services and the development of partnerships.

However, because of the change of government which occurred in 2002, this Plan was never applied and a new group was appointed to draw up a new report, which was eventually published with the title: "The Mental Health Plan 2005 –2008: Psychiatry and Mental Health". The fact that the durability of the underlying ideas, if not that of the resulting policies themselves, depends on the ups and down of political events confirms that the use made of these reports by the French government is mainly political rather than actually focusing on healthcare matters. While the above reports were being drawn up, the alliance between users’ associations (FNAPSY), family associations (UNAFAM), professionals in the healthcare and social fields (via the WHOCC in Lille, in particular) and locally elected figures was being strengthened. This four-fold partnership constitutes the cornerstone on which the potential application of the WHO recommendations for developing an intersectoral community-based system of mental healthcare depends.

Apart from these reports and the ministerial Plan, no close analyses seem to have been published so far on the links between WHO and mental healthcare policy in France. This might seem to suggest that WHO has little influence on mental healthcare policies in France. This conclusion needs to be modulated, however, because the WHOCC has been disseminating the WHO philosophy extremely actively and efficiently since the early

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3 JL Roelandt, the co-author and author of these reports, was already the Director of the WHO Collaborating Centre for research and training in mental health (France) at the time.

4 The National Fédération of users and ex-users of Psychiatric services

5 The National Union of Friends and Families of people with a mental health handicap

6 Roelandt JL, "Mental health: meeting the challenges and finding solutions in France" L'Information psychiatrique, April 2006, Volume 82, no.4, p.343-347
2000s. It therefore seemed to be worth briefly describing the position and the missions of this centre and the way it functions.

1.2 The World Health Organization’s Collaborating Centre for research and training in mental health (the WHOCC in Lille France)

The WHO’s French Collaborating Centre for research and training in mental health (the WHOCC in Lille) fulfills the WHO requirements for research and training in the field of mental health. This Centre, which works in collaboration with French public mental health establishments, hospitals, research centres and universities, was created in 1976 but has been particularly active since 2001. The Centre is periodically certified by WHO on the basis of a multi-annual programme. In 2005, Dr Jean-Luc Roelandt was reinstated as the Director of the Centre for a further period of 4 years by the World Health Organization, which designated the EPSM of the City of Lille as an official corresponding institution and the mental healthcare sector of the Public Mental Health Trust Lille Metropole : 59g21 as a Collaborating Centre in view of its good practices in line with the WHO recommendations.

The WHOCC in Lille manages many actions, skills, networks and programmes relating to orientations in mental health, in line with the research and training tools and guidelines published by the World Health Organization. In all these activities, it calls systematically on its four main partners, namely the associations of users (FNAPSY), families (UNAFAM), local elected officials (AMF, ESPT, etc.) and professional players.

The WHOCC works with the following French Ministry of Health departments: the DREES, DGS, DHOS, and DGAS and uses a network of highly qualified staff.

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7 The innovative mental healthcare tools gradually set up during the last 25 years or so at the Adult Psychiatry Ward in the eastern suburbs of Lille are an experiment on integrating mental healthcare into an urban community. They meet the recommendations of the World Health Organization (OMS 2001, 2004, 2005) which give priority to working within a community in partnership with all the intersectoral networks, including locally elected figures, users, their families and their helpers. The aim of this set of local services, which has been recognized by WHO as an example of good practice, is to provide patients with the best possible mental healthcare services while preventing stigmatization, discrimination and exclusion.

8 Mental healthcare priorities were redefined in 2005 by WHO Europe as follows: 1- Foster awareness 2- Collectively tackle stigma, and empower and support people with mental health problems and their families 3- Design and implement integrated mental health systems 4- Create a competent workforce 5- Recognize experience and knowledge of service users and carers.

9 The French Mayors’ Association

10 The Association of Elected Representatives responsible for Public Health and Territories

11 The Directorate for Research, Surveys, Assessments and Statistics
correspondents under the supervision of a national scientific board, the members of which share the same principles.

**The WHOCC in Lille pursues the following missions:**

1. Promoting and coordinating the participation of French research workers and University staff in the research and training activities it conducts in the framework of the WHO mental health programme.

2. Informing French authorities and specialists about the activities of WHO which are liable to be of interest to those developing French mental health programmes.

3. Informing the WHO Mental Health Division about any research and pilot projects carried out in France which are relevant to public health and it regulation.

4. Providing French mental health experts with a focal point assisting them with the management of their work as consultants, and mediating their relations with WHO.

5. Contributing to the production of French translations of technical documents published by WHO, especially those used to develop national mental health programmes, in collaboration with other Collaborating Centres in French-speaking countries, WHO Africa and the WHO Headquarters in Geneva.

6. Serving as the leading WHO European Collaborating in the War on Stigmas and as co-leader in the project to transform mental health services.

7. Facilitating and supporting the involvement of associations of users and carers in reforming mental health services at European level, in line with the WHO recommendations for Europe.

**The action programme** of the WHOCC in Lille focuses on 6 main topics, each of which includes research and training, information and networking activities.

1. Mental health in the population at large: images and reality.

2. Preventing suicide.


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12 The General Health Directorate

13 The Directorate in charge of Hospitalisation and the Organisation of Healthcare

14 The General Directorate in charge of Social Action
4. International and National networks focusing on innovative experiments in the field of mental health whereby psychiatric services are integrated into local communities.


6. The sociology of mental health.

Role and activities of the WHOCC:

At national level:

Every action is carried out systematically with the four main partners: the users, family carers elected political figures, and professional players from all the relevant sectors.

A - The main aims of the survey on "Mental Health in the Population at large: Perceptions and Realities" (SMPG), an international multi-centre action research project launched in 1997, are two-fold:

1. Describing mental representations of "madness", "mental disorders", "depression" and the various modes of assistance and care, and assessing the prevalence of the main psychiatric disorders among members of the general population aged more than 18.

2. Improving the awareness of healthcare, social, associative and political partners about mental health.

Since it was started in 1997, the SMPG survey has included 78 sites: 65 French and 13 international sites, at which 70 000 persons were interviewed, including:

- almost 58 000 individuals in France (2500 of whom were living in overseas departments)

- more than 11 500 individuals in all at the international sites.

B – Fighting stigmas: a campaign on “Accepting differences also includes people with mental health problems”. Coordinated the InformationWeek on Mental health (SISM) at national level. Participated in the INPES Depression Campaign. Prepared the Psycom 75 brochures.
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C – A National Network for the development of good practices in mental health in the framework of Urban Policy-making.

The aim of this network is first to draw up a list of present and future good practices, to reach a consensus and then to send this list to 45 urban sites, including mental health services. This project will be implemented by using networks and other active institutions (such as health workshops, WHO networks, the general Mental Health survey and various associations) to set up local mental health counselling services in which the inhabitants and local authorities are involved in the territories targeted.

- The creation and development of this network will require:
  - Observing and assessing the active tools and networks implanted in the territory targeted
  - Mutual exchange of ideas and proposals for relevant local actions
  - Developing and coordinating local Mental Health counselling systems
  - Developing indicators for monitoring ongoing actions

D – The first training course for peers working as carers (December 2008).

Setting up an action research project for designing a pilot scheme which is reproducible at national level, for recruiting users and ex-users at mental health departments to work as Peer Care Workers, as has been done in other countries (the USA, Canada, the UK, Australia), in collaboration with the municipality of Mons en Baroeul, the EPSM of the City of Lille, UNAFAM Nord, and the Self Help Connection (Dartmouth, Canada)
E- National research projects on "Dangerous states and mental health disorders":

- Examining 900 case studies on people convicted for murder or assassination
- A survey on "compulsory" hospitalisation in four French regions: Nord-Pas-de-Calais, Ile de France, Aquitaine and Provence-Alpes-Côte-d’Azur"

Type of knowledge: epidemiological knowledge, local groups of actors, statistics, the history of medico-legal problems, knowledge of the processes involved.

Practical aspects: assessing practices, drawing up action procedures, create a local observatory, etc.

F - Group for Cooperation on Mental Health matters in France: research and training in community mental health (with 17 public mental health establishments located all over France)

G- The Urban Mental Health vocational training programme: visiting comprehensive healthcare services and running theoretical courses. Organising vocational training courses and visits to professionals at national level.

Type of knowledge: epidemiological knowledge, management, communication, healthcare organisation

Practical aspects: vocational training professionals, elected political figures and territorial workers.

H- Organising international congresses on behalf of and with WHO and various French Governmental representatives:

- Lille 2004, "Mental health in France: images and reality"
- Nice 2007 "Stigmas! Fighting discrimination in the field of mental health"

Type of knowledge: all the types mentioned above

Practical aspects: all those mentioned above

At European level:

- Since 1999, the SMPG project has involved the cities of Trieste, Oviedo, Seville, Brussels, and Paris.
- In 2003: creation of the European INMCH network of good practices in mental health: training exchanges and twin town projects at European level (Italy, GB, Belgium, Greece, Albania, etc.), drawing up a mental health programme for Sardinia and providing Expertise in Bosnia.
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Type of knowledge: epidemiology, management, communication, healthcare organisation, network engineering.
Practical aspects: training professionals (healthcare workers, directors, managers, etc.) and decision-makers

- Since 2005: participated in the Helsinki conference as co-leader of the European WHO Collaborating Centres on the theme of stigmas (with the Edinburgh WHOCC) and co-leader on the theme of transforming mental health services (with the Trieste WHOCC).

- Participated in the European network against stigmas and discrimination. The circulation of knowledge: research and assessment tools.

- The ASPEN Anti-stigma project (a European Network)

- 2006-2011: the European project on "Knowledge and policy" involving 14 European research groups: www.knownpol.eu

- September 2008: organized a meeting in Lille between the main European users’ and carers’ associations under the aegis of WHO Europe, which was also supported by the European Union. Participated in the pilot committee of the European WHO EURO – UE project entitled "User Empowerment in Mental Health"

- October 2008: the Launching of the European Programme for reforming services, entitled "Effective responses to changing needs in mental health" WHO Europe, London) Member of the study group on indicators to good practices

- In December 2008: with the association "Local Elected, Public Health and Territories", the European Congress on cooperation between local political leaders and mental health professionals sponsored by WHO Europe and French Presidency of the European Union.

At international level:

- Took part in the Community Mental Health global forum organized by WHO International

- Took part in the MH Gap forum organized by WHO International

- The SMPG action research project was extended to include: Nouakchott, Algiers, Tangier, Tunis, Antananarivo, Mahajanga, Mauritius, Grande Comore, New Caledonia.

- Ongoing projects include the occupied Palestinian territories, Laos, the Seychelles
- The INDIGO International Study on Stigma and Discrimination Outcomes
- Took part in drawing up National Mental Health Plans for Madagascar and Mauritania
- Translation into French and adaptation of WHO documents
  - WHO AIMS 2005
  - Mental Health Guides (8 volumes) co-edited with the other French-speaking WHOCC (those in Geneva, Montreal and Casablanca)

2. Tracking references to WHO recommendations in official French Reports

In order to determine to what extent mental health policies refer explicitly to WHO recommendations, it was first proposed to look for traces of these recommendations in the Reports commissioned by the French Ministry of Health, which have ended up by serving as blueprints. In other words, these Reports are the main reference in France as far as mental health is concerned. It is worth noting in fact that most of Government-commissioned Reports end up by concluding that it is necessary to draw up appropriate laws.

As mentioned above\(^\text{15}\), the centralised nature of the policy-making activities in question gives them a Republican flavour, i.e., they are intended to be egalitarian. As all the players in the field know, however, when it comes to applying mental health policies all over France, the actual situation is far too variegated and unequal. In fact, in the case of France, the law of the country is the only tool capable of recognising the relevance of a recommendation and putting it into effect. The law therefore ensures a certain amount of rigour in this respect. However, this situation makes it difficult to introduce any innovations which have not been authorised at the central level, i.e., in Paris.

It is worth mentioning that one of the County Report recommendations which caused the greatest stir in paramedical circles was not inspired by WHO. This was about relaunching the idea of creating a psychiatric nursing diploma (at Master’s level) despite the need proclaimed elsewhere to abolish the distinction between medical and medico-social practices.

\(^{15}\) C. Maury et al, 2007.
Two recently published documents will now be analysed. As we will see, between the two dates of publication (February 2005 and January 2009), some changes occurred in terms of the authors’ references to WHO and the ideas expressed in this connection.

2.1 The 2005 and 2008 French Mental Health Plans: Psychiatry and Mental health

The document presenting the French Mental Health Plan published in February 2005 included five specific references to WHO.

Only one of these references was about recommendations for the organization of mental healthcare or the corresponding policies. This allusion was to the WHO recommendations on information campaigns (WHO, 2001). The other references were about epidemiological and economic information. The following quotation comes, for example, from a WHO Report dated 2001: "Depression is a condition which is frequently encountered in the general population. It is the fourth most common disease in terms of prevalence, and may well occupy the second place by 2020, after cardiovascular disease" (the 2001 WHO Report, p.9 in the Plan).

Generally speaking, no reference is made in this Plan to the organizational or policy-making recommendations, and the 2001 Report is the only one quoted. No subsequent WHO publications, such as the briefing papers for the Helsinki conference or the Guides published by WHO in 2004 (see the Reference section) are mentioned.

As mentioned in the latest Report (about to be published) by the French Health Team on WP 10, the drawing up and application of this Plan were speeded up by a dramatic event (the murder of two nurses in Pau by an ex-user). Far from what is advocated by the WHO philosophy, this tragedy has contributed to accentuating the safety aspects of the 2005-2008 mental Health Plan. However, the following two aspects in particular are much more in line with the WHO Europe recommendations:

Recognising mental health disabilities

The Act of 11th February 2005 recognizes disabilities resulting from mental disorders, which have been included for the first time in the French social code (which means that the specific needs of patients with these disorders are covered by the French health

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16See for example, "Alcohol and mental health", WHO EUR/04/5047810/B12 24, November 2004 and "Mental healthcare in local services", WHO EUR/04/5047810/B2 25, November 2004. See also "Promoting mental health and the prevention of psychiatric disorders", WHO EUR/04/5047810/B8 5, November 2004

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insurance system). Speaking about the aims of public action and the underlying philosophy, Mme D. Barres (DGAS) went straight to the point: "it’s a question of removing mental disability from the grasp of psychiatry" (at an interview in March 2009). The WHO definition has been adopted and advocated precisely for this purpose.

*Mutual Assistance and self helped Groups (GEM)*

The 2005 Act provided for the creation and funding of mutual assistance clubs or groups (Circular of 29th. August 2005). These Groups are integrative tools for combating isolation and protecting highly exposed persons from social exclusion. They should contribute more efficiently to helping people with mental health disorders. The great innovation here is the fact that these groups can be directly managed by the users. In 2009, there were approximately 240 GEMs in France. In her outline of the history, origins and development of these groups, Mme. Barres explained: "At the beginning, there was the example of the English Club Houses and the patients’ associations [in France]". In collaboration with the health agencies, these Groups were created on the basis of specifications submitted to the regional agency for social affaires and a pilot committee including representatives of all the partners involved. The General Councils and Departments do not participate in this scheme, which depends on "national solidarity; it is funded by the savings made by abolishing a public holiday (the Whitsun Monday)" 18.

The above two innovations were due more to an ongoing process which starts in the 2001 Piel and Roelandt and 2002 Roelandt reports and the 2001 Mental Health Plan than to a sudden move to support the WHO philosophy. In particular, they reflect the influence of the alliance between Users, Families, Professionals and Elected political figures mentioned above. This alliance supporting lobby groups relies strongly on the WHO recommendations. The fact that France is the European country which has allocated the largest sums to projects of this kind (30 million euros per year) is due to the conjunction between these various interests. The other reason is that the move to involve the users goes far beyond the field of mental health, and has become an important part of the general framework of public action (in the field of education, for example).

2.2 The Couty Commission’s Report

This Report, which was commissioned by the French Minister of Health Madame R. Bachelot, was published in January 2009. It was based on a broad consultation 19 and

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18 This is a recent governmental decision, which has given rise to some controversy. Transforming this public holiday into a normal working day means that the corresponding taxes/social contributions will be paid up, and this will provide the means of financing social measures in favour of disabled people and dependent populations.

19 Based on an approximate count, more than 130 persons were interviewed, including about 50 psychiatrists.
includes 26 recommendations. Although it is not possible to prove the existence of any direct links with the WHO recommendations, the Commission was probably well informed about them. When the Director of WHOCC in Lille (France) was interviewed for this purpose, he described the recommendations of WHO International and WHO Europe. In addition, he participated in the discussions at a special session on the theme of "Mental Health and Society". On the other hand, the WHOCC representative responsible for coordinating the campaign on "Accepting differences also includes mental health disorders" and the Mental Health Information Week was also interviewed by the Couty Commission. Lastly, it was at the initiative of the Director of WHOCC that the theme of "Experience acquired in Europe" was adopted for one of the discussion sessions, which provided an opportunity for the European WHO "counterparts", as they are called:

**Experience acquired in Europe: the Session held on 12th November 2008**

- Competence of the European Union in the field of health: Emmanuelle JEAN, Director-General for Health
- The European mental health pact and the relevant studies: Jurgën SCHEFTLEIN: European Community DG-SANCO
- Mental health in primary healthcare (WHO): Jean-Luc ROELANDT representing Benedetto Saraceno (Head of Mental Health at WHO International) and Matt Muijen (Head of Mental Health at WHO Europe)
- The role of users and their families, Anneke BOLLE, the Netherlands
- Professionals who have been users themselves, Kerstin Back MOLLER, Denmark
- Reforming the mental health system in England, Susannah HOWARD, The British NHS (a WHO Counterpart)
- Competences required by efficient mental health services, Peter RYAN, the British NHS
- The experience acquired in Trieste, Michèle ZANETTI

According to the Commission’s spokesman, E. Couty: "People should have heard about the WHO recommendations. Many of the professionals in the Commission know very little about the work of WHO, the directives, or what the international organisations are doing. Professionals with their heavy workloads don’t have time to look at what’s going on elsewhere; they are not sufficiently open to outside events...So unfortunately some of them did not turn up. Everybody attended the other sessions, but the attendance was much lower at that particular European session" (at an interview given on 19th. March, 2009).

Apart from the circulation of knowledge, the Couty Report refers several times to WHO data of various kinds, including epidemiological and economic data and considerations about the organisation of services and prevention. This 54-page report (which also contains 30 pages of appendices) includes 13 references to WHO. In this respect, it therefore differs considerably from the February 2005 Report on which the 2005-2008
Plan was based, which contained only 5 such references (4 of which related to epidemiological matters).

In addition, it was attempted in the Couty Report to relate the knowledge originating from WHO to the French context, as shown by this excerpt describing the high rates of mental disease: "According to WHO, mental diseases are the third most common types of disease and they are responsible for one quarter of all cases of ill health. In general medicine, they rank tenth after cardio-vascular diseases. They affect one person out of every five each year and one person out of every three in terms of the lifetime prevalence. WHO has included five mental diseases among the most worrying pathologies for the 21st century, since their contribution to the overall morbidity rates is liable to have increased by 50% between now and 2020 if suitable measures are not taken quickly. In France, psychiatric disorders are responsible for 12000 deaths by suicide annually not to mention the high mortality rates due to causes other than suicide (accidental deaths and those due to alcohol, smoking and drug abuse)" (the Couty Report, p.7)

As the E. Couty explained: "The WHO statistics mentioned in the Introduction are mainly there to show the extent of the problem at national and international level. They provide grounds for advocating that these problems need to be dealt with and that a law was needed to break down the barriers between the various sectors (the psychiatric, medical, medico-social sectors, etc.) and link them up together" (at an interview given on 19th. March, 2009).

Apart from these direct quotations, however, some of the recommendations put forward in the Couty Report (including some of the main ones in fact) seem to be directly although implicitly based on the WHO recommendations.

The Summary at the beginning of the Report outlines the main principles on which mental health policies should be based. The terms used here could well have been employed by the WHO Directors themselves:

"After examining all the issues involved in mental health and psychiatry, the members of the commission decided that the three basic principles liable to constitute an appropriate framework for innovative mental health policies should be set out in the first part of this report:

- Integrating mental health into public health policies, including the medical, social and medico-social aspects, which are all inseparable. The medical discipline of psychiatry should contribute along with the other disciplines to developing these policies;
- Renforcing the institutional role played by patients and their friends and families as fully-fledged players in the healthcare system along with the professional players.

- Making the assessment of structures, activities and practices an essential component of all mental healthcare and psychiatric practices (the Couty Report, p. 8).

On similar lines, the Report mentions the need to implement these principles and specifies in particular the steps which should be taken at the decentralized (territorial) level. It is recommended to provide for the following three levels at organisations:

- A local level on each territory corresponding to the present psychiatric sector (catering for both adults and young people), working hand in hand with the various players involved, such as local political figures, healthcare professionals, social workers, and those in charge of the housing and employment sectors. These players would all belong to a local group for cooperation in mental health (GLC); this level would also include a local deliberating mental health body depending on the GLC;

- a level dealing with public and private hospitalisation costs: the healthcare territory;

- a level focusing on regional and interregional specialisation and expertise (the Couty Report, p.8).

Lastly, the need for prevention is supported in this document in terms of the WHO system of classification:

"WHO has defined three levels of prevention. Primary prevention of mental disorders is intended to reduce the incidence of these disorders before the onset of the symptoms (...) Screening has been defined by WHO as part of prevention and denoted secondary prevention (...). Lastly, WHO has used the term tertiary prevention to refer to efforts to rehabilitate and reintegrate patients suffering from psychiatric disorders." (the Couty Report, p.46).

All in all, it can be concluded that for once an official French Report made considerable reference to statements published by WHO.

Although these recommendations did not explicitly mention WHO, they can certainly be mostly traced back to WHO. There are probably some good reasons why this source was not explicitly mentioned and why the experts seem to have agreed to adopting a common set of principles to which WHO had no claim as the author or sole executor.
It may well be, however, that those promoting this Report imagined that this discretion would make the Report more effective. In the context of France, keeping quiet about the international sources of principles and recommendations makes it possible to gain greater support for national objectives. Reformers can then present these principles and policies as if they are part of a democratic process, which seems a priori to be more legitimate than one launched by a far-away organisation which the French protagonists might tend to distrust, partly because they know nothing about how it functions. This obviously does not prevent practices adopted in France from looking very much like the application of international principles.

3. Other examples of WHO recommendations applied in France

In this section, it is proposed to describe two cases where WHO has influenced French mental health policies and practices. Comparisons between France and other European countries as far as mental health policy and coverage are concerned can be found in appendix 3.

The first example of a local urban health network which will be described in this section resulted from a move to involve towns more strongly in promoting health and to favour the development of local policies in this respect. The impact of this move launched at international level is rather fuzzy, however, as far as the field of mental health is concerned.

The second example is a map of current practices and organisations in France, in terms of the 6 criteria defining good practices adopted by the International Mental Health Collaborating Network. The members of this network are mental health departments which are strongly committed to applying the WHO recommendations. Two of the network’s founders are from the WHOCCs in Trieste and Lille (III.2). We will then discuss how the EU contributes to the interactions between knowledge and policy in the field of mental health.

3.1 The World Health Organization’s Urban Health Network in France: an effective tool?

This network was created in 1987 after the WHO Urban Health project was launched. According to WHO, cities provide a privileged place for testing and setting up health policies for all their inhabitants. As far as mental health is concerned, this initiative was obviously based on agenda 21, the Ottawa Charter, and the principle of health policies for all.
WHO has proposed to give priority to determining the factors affecting health, relying on the competences of the inhabitants and making them responsible for their own health. The idea is to promote partnerships and cooperation to reduce unequal access to health and protect the most vulnerable groups; this requires intersectoral collaboration between players and institutions. Commitment to this project depends on the determination of Mayors and Town Councils to giving health and quality of life priority on their agendas.

WHO has therefore been driving a move to promote the local development of general and international policies. As described by Professor B Mittelmarck\textsuperscript{20} at the 2005 WHO European Ministerial Conference on mental health in Helsinki, European action plans for promoting mental health should stress the need for means of forming official links with existing health promotion networks focusing on urban health, workplaces, educational establishments, hospitals and prisons. In France, some of these networks have already adopted mental health as a specific objective, whereas others have placed this topic under the heading of healthcare in general. It is difficult, however, to assess the efficiency of the WHO Urban Health project (see the map of urban health networks in appendix 4).

3.2 From the WHO recommendations to the actual organisation of psychiatric sectors in France

The criteria for good practices defined by the WHO International Mental Health Collaborating Network (IMHCN)\textsuperscript{21} based on the recommendations of the World Health Organization (WHO 2001, 2005) correspond exactly to the "sector" policy defined in France 40 years ago. These criteria feature in the psychiatric sector’s activity reports drawn up by the DRESS, based on proposals put forward by IRDES and the WHOCC in Lille (IRDES 1999, 2000). This report is submitted every 2 years by the psychiatric sectors. However, it was established upon analysing the French sectors’ 2000 and 2003 activity reports that the standard of a sector’s equipment (its structures and staff) and its practices do not depend on the sector (DRESS, 2005).

\textsuperscript{20} Promotion efficace de la santé mentale: bases factuelles and incidences politiques (Efficient mental health promotion: the factual bases and the political outcomes). Prof. Mitttelmark B. A report presented at the WHO European Ministerial Conference on mental health in 2005.

\textsuperscript{21} A network promoting good practices, whose international members belong to ONGs providing innovative locally integrated mental health services - www.imhcn.org
The WHO recommendations and mental health in France

Table 1: Comparison between 2002 and 2003, based on sector reports completed by the heads of departments (Source: DREES) – Percentage of French sectors satisfying the criteria of the International Mental Health Collaborating Network (IMHCN)

<table>
<thead>
<tr>
<th>CRITERIA for GOOD PRACTICES</th>
<th>2000</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>No confined hospital wards</td>
<td>27%</td>
<td>29%</td>
</tr>
<tr>
<td>More than 60% of the staff recruited from within the community (from outside the hospital)</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Permanent telephone availability (30% of calls answered by a member of the psychiatric staff)</td>
<td>69%</td>
<td>71%</td>
</tr>
<tr>
<td>Psychiatric wards always in touch with patients’ GPs</td>
<td>22%</td>
<td>21%</td>
</tr>
<tr>
<td>At least one monthly meeting with users’ and family associations</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>Responding to emergencies</td>
<td>85%</td>
<td>82%</td>
</tr>
</tbody>
</table>

In 2003, only 23 general psychiatric sectors out of 850 (amounting to 2.7%) fulfilled at least 5 of these 6 IMHCN criteria.

On the other hand, if we look at the seventh criterion (Table 2), it can be seen that the number of patients hospitalised for more than a year is directly correlated with the mean number of hospital beds per sector: the greater the number of patients hospitalised for more than a year, the greater the number of hospital beds available per sector becomes. All the patients therefore tend to have long hospital stays.

Table 2: Comparison between the number of patients hospitalised for more than a year and the number of beds – Percentage of the French sectors involved (Source: DREES, 2003 Psychiatric Sectors’ Activity Report)

<table>
<thead>
<tr>
<th>Number of patients hospitalised for more than a year</th>
<th>Mean number of beds in the sector</th>
<th>Percentages in 2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 patients</td>
<td>31</td>
<td>9.40 %</td>
</tr>
<tr>
<td>1 to 3 patients</td>
<td>33</td>
<td>13.10 %</td>
</tr>
<tr>
<td>4 to 10 patients</td>
<td>39</td>
<td>22.90 %</td>
</tr>
<tr>
<td>11 to 20 patients</td>
<td>52</td>
<td>20.00 %</td>
</tr>
<tr>
<td>&gt;= 20 patients</td>
<td>75</td>
<td>14.90 %</td>
</tr>
</tbody>
</table>

In France, 70% of the in-patient psychiatric wards are confined wards and the majority of the members of staff are not recruited from outside the hospital.

The above two tables show the wide range of practices existing in France as well as the gap between institutions’ practices and the WHO recommendations. This gap is particularly wide as far as the integration of psychiatry into the primary healthcare system and users’ participation are concerned. It is worth mentioning, however, that a
move is now occurring on these lines. The figures about to be published in the 2006 sector reports will shed further light on these trends.

3.3 In Europe: the case of the 2008 European Pact

In 2005, the Commission declared its intention to launch a Mental Health Pact at a high-level conference in June 2008. The preparatory meeting was attended by a single French representative, Mme Dominique Versini, who spoke in Defence of Children at a parallel session on HEALTHY CHILDREN AND YOUNG PEOPLE – LAYING THE FOUNDATION FOR MENTAL HEALTH AND WELLBEING. On the other hand, Mme Roselyne Bachelot-Narquin, the French Minister of Health and Social Protection, gave the closing address.

The purpose of the Pact is to stress the relevance of mental health to public health, productivity, learning, and social cohesion in the EU. The Pact signals willingness to work together on mental health, based on a common set of action principles. Implementation of the Pact will be driven by a series of thematic conferences in 2008 – 09 at which further action plans and the Commission’s Proposal for a 2009 Council Recommendation on Mental Health will be prepared.

The Pact focuses on five themes:

- Preventing Suicide and Depression
- Mental Health in Youth and Education
- Mental Health in Workplace Settings
- Mental Health and Elderly People
- Addressing Stigma and Combating Social Exclusion

The Pact also stresses the importance of action on four ‘horizontal’ levels: promoting mental wellbeing; preventing mental disorders; supporting people experiencing mental health problems; and improving the knowledge base.

According to E. Couty, as far as knowledge of the international kind is concerned, "The European Pact of June 2008 was a noteworthy event. It wasn’t a directive, but a declaration in favour of a more comprehensive approach to the treatment of patients, and for efficient cooperation between those responsible for the treatment and follow-up (those in the medico-social sector), and for the subsequent rehabilitation as well as

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22 EU HIGH-LEVEL CONFERENCE - “TOGETHER FOR MENTAL HEALTH AND WELLBEING” BRUSSELS, 13 JUNE 2008, 9H00-16H20. The programme of this conference can be consulted in the Appendix.
preventive efforts. Hospitals and sectors are at the heart of the system, but they can no longer go on working alone" (at an interview given on 19th. March, 2009).

The aims of promoting mental wellbeing, preventing mental disorders and improving the situation of people with mental health problems are in line with to the current EU social and economic policy objectives. Mental health is therefore a matter that concerns EU citizens and policy makers; it is also of direct relevance to the health, education, and social sectors as well as to places of work and communities.

Knowledge, experience and expertise are now being collected about the actions that could be taken to promote mental health, prevent mental disorders, and improve the quality of life of those suffering from mental health problems.

Two papers have been published:

- **Countering the stigmatisation and discrimination of people with mental health problems in Europe**, a document edited for the European Commission by David McDaid at the Health and Living Conditions Network of the European Observatory on the Social Situation and Demography (which is under the aegis of the Directorate-General for Employment, Social Affairs and Equal Opportunities). This document, which is generally referred to as "Stigma", does not mention the French initiatives, although these have been listed by WHOCC and widely diffused.

- **Mental Health in the EU: Key Facts, Figures, and Activities** A Background Paper provided by the SUPPORT-project. Many of the contributors to this volume have worked for WHO or the WHO CCs: Maarit Mukkala, STAKES, Dr. Eija Stengård, STAKES (WHOCC Finland), Paula Rowe, Scottish Development Centre for Mental Health (WHOCC Scotland), Dr Eva Jane-Llopis, was working for WHO.

Some French initiatives are mentioned in this document, “Protecting Children from Electricity”, with EDF-GDF (the French gas and electricity board) and "Actions to Prevent Relapses into Anxiety disorders and Depression (APRAND)". The “SCMHE” Project is also mentioned: the aim of this project supported by the Public Health Programme (2003-2008) is to develop and test a tool for monitoring the mental health of children of primary school age. This project is being managed by MGEN, France (a mutual association).

Two French projects dealing with children and one dealing with mental health at work have therefore been included. No French programmes focusing on healthcare, the organisation of services, etc., are mentioned in this document.
4. Synthesis

It is proposed as a conclusion to briefly outline the ideas and interpretations presented in this report, adopting the plan recommended by the coordinators for summarising national case studies.

To begin let’s noticed that in France there are:

- very few publication on « mental health », no scientific journal called « Mental Health … », no or very few academic -university training degree in Mental Health and very few continuous professional training in mental health.

- very few State, national, regional or local agency, office, bureau, organisation for « mental health » and in practice a still strong institutional psychiatric system with some Community Based local initiatives.

- The First « Mental Health » National plan was published in 2005.

- The first National promotion / information campaign on mental health (depression) supported by the government was launched in 2005

- They are no or very few explicit allusions at WHO national reports, laws, academic or professional training, university publications.

4.1 Institutional relationships

Relations between WHO and high-level decision-makers are mediated in France by the Ministry of Foreign Affairs’ Department of European and International Affairs and the Ministry of Health : the International Bureau of the DGS (The General Healthcare Directorate - monitoring). The responsible of the mental health bureau of the DGS was the WHO Counterpart in France until January 2009.

Applications are occasionally made to experts or organisations to obtain expertise and data it is the case for the INPES (National Institute for Health prevention and information) the HAS (High Authority in Health : regulation by guidelines).

Finally, WHO supports lobbies (FNAPSY users ngo, UNAFAM carers ngo) via WHOCC EPSM Lille Métropole, in particular.

The WHO CC Lille, France has formal and non formal - institutional multi level of governance. It provides: lobbies support (users, carers, local elected ngo) – Working groups – Conferences – Networking – Projects – Researches – Communication / information in mental health.

Very briefly we can underline two levels of knowledge circulation:
The WHO recommendations and mental health in France

- High level of governance: reports, experts, WHO economic and epidemic data – very poor and more for legitimation and flavour E. Couty 13.03.09: the WHO statistics are mainly there to show the extent of the problem (...) they provide grounds for advocating (...)

- Multilevel: Support for lobby groups Working groups, networking, meetings, conferences, Int. and nat. projects steering co. (Users and Carers NGO, National rehabilitation association, WHOCC for research and formation in MH Lille, France)

4.2 Contribution to the Helsinki Ministerial Conference 2005 (production)

The French “psychiatric” sectors constitute an example of integrated local services of the kind recommended by WHO. It is worth examining how this model directly influenced WHO.

The following official French representatives took part in the above conference:

- Dr Fabienne Debaux, Head of the Mental Health Bureau, which depends on the French Ministry for Health, Families and Solidarity

- Mme Evelyne Bonnafous, Deputy Head of the Bureau for specific populations, which depends on the Directorate for Hospital Care at the French Ministry for Health, Families and Solidarity

- Professeur Viviane Kovess, the Director of the MGEN Foundation 150 for Public Health

- M. Pierre Larcher, who works for the French Ministry for Health, Families and Solidarity

- Dr Alain Lefebvre, an Adviser on Social Affairs and Health at the French Embassy in Helsinki

France signed the official document produced at the Helsinki Ministerial Conference.

In addition:

- Presentation of the first national awareness campaign about mental health (non governemental initiatives): "Accepting differences..." designed and run by users (FNAPSY), users’ families (UNAFAM), mayors and local political figures (AMF) and professionals (WHOCC Lille, France).

- The psychiatric sector in the Eastern suburbs of Lille (59g21 EPSM Lille Métropole) was presented as an example of national policy implementation in a
psychiatric sector. Other mental health departments which founded the "Mental Health and Citizenship” - International Mental Health Collaborating Network (for the development of mental health services integrated and whole systems approach) representatives from Trieste, Stockholm, Monaghan and Birmingham talked at this conference.

The small but ever-increasing output to which WHOCC Lille, France - EPSM Lille Métropole contributes decisively (Training, information material, networking, data production, conference, working groups for eg. the WHO Euro EC Users Empowerement project...)

4.3 Impact of the Helsinki conference (Reception of information)

On the National Plan for « Mental health » 2005-2008 :

- Creation of mutual selfhelped groups (users, families ngo’sfunded by the governement)

- Recognition and Status of « mental health disorders handicap »

Two concrete results, in the continuity of the mission assigned by WHO in 2003 to Piel, Roelandt, Clery Melin with the users and families ngo for a plan of actions focused on the reorganisation of the mental health cares :

« Mental Health: the user at the heart of a system to reform »

- The First National information campain on Depression (WHO CC Scotland influence)

These are three long maturation processes “boosted” by the WHO Helsinki Conference, but the global direction of the plan is still institutional and psychiatry centred.

Our research has shown that these important steps forward have resulted from the combat and influence of families’ and users’ associations and the WHO recommendations defined in Helsinki, which were implicitly appropriated by the promoters of reforms.

Couty’s commission report 2009  "MH and psychiatry missions and organisations »

Some of the recommendations made in the Couty Report entitled "Mental health and psychiatric missions and organisations" about the organisation of healthcare and mental health policy, for example, are very similar to those published by WHO International and WHO Europe. Although the interviewer reported that most of the respondents (whether they were physicians or not) had never heard of these recommendations he added "that the European Pact of June 2008 was a noteworthy event".
WHO 2008 Baseline study participation (difficulty to gather information and not complete) – too soon to assess impact

4.4 Analytical reflections

The types of knowledge involved in the recommendations and the criteria for defining good practices are of three kinds:

a- Economic and scientific considerations relating to Evidence Based Medicine

These considerations pervade the many publications in which community mental health systems are compared with institutional systems. It is worth noting, however, that the authors of this literature are mostly from English-speaking countries. These comparisons, which are often made in terms of cost efficiency, have served as a basis for all the WHO reports. A similar pattern has occurred in France with the 2001 Piel & Roelandt and 2002 (vér) Roelandt reports. On the other hand, various European situations have been presented in a recent publication: Thornicroft G. & Tansella M. (2009).

b- Ideological considerations: Human Rights

Most protagonists are convinced that community-based healthcare practices are not only more effective and less expensive, but that they also comply more closely with the principles of human and civic rights[^23]. This corresponds to the concept of indirect costs which subtends and justifies the economic school of thought mentioned above. For example, integrated local intersectoral services help to reduce stigmas and thus improve access to healthcare. By preventing non-observance of treatment and long-term discrimination, services of this kind enhance the efficiency of the care dispensed. The earlier these disorders are dealt with on a regular, continuous basis, the better the prognosis will be and the less patients will be excluded and therefore in the long run, the lower the cost to the community will be (Référence).

c- Satisfying users and quality assurance procedures

The third kind of knowledge is that provided by users’ satisfaction surveys about the services from which they have benefited. These surveys come under the heading of certification and quality assurance procedures, along with the whole complex set of logistics and technical infrastructures involved. The 2010 version of the quality standards on which French health establishments’ certification procedures are based defines 13

[^23]: The Charter of psychiatric hospital patients in France

The cornerstone on which these associations have based their combat is preserving patients’ fundamental rights, as defined in the Mental Health Users’ Charter (FNAPSY and Hospital Board Chairmen’s speeches, 2001).
priorities (which are called "required priority practices"). The term "patient" features in five of these priorities, the last of which deals with the management of claims and complaints (High Health Authority, 2009).

4.5 A “transmission” process

France both receives and transmits WHO information. Although it is difficult to assess the legibility of the messages received and transmitted, considerable progress has been achieved during the last few years in the field of mental health in France.

France can also be said to be a "translator" of WHO recommendations and documents. For example, it handles the translation into French and the adaptation of documents to be distributed in Low and Medium Income Countries (LAMIC). Another key activity is vocational training (running vocational training courses in France at the national and international levels and sending French experts and trainers to other French-speaking countries), where France plays the two-fold role of translator and transmitter: "The French (psychiatric) sectors are a promising initiative which should be continued (...) Many countries have adopted this formula but they are now doing all sorts of other things as well" (an interview with E. Couty on 19th. March 2009)

Based on these analyses, it can be said that it is WHO which has provided the driving force rather than regulation properly speaking. This influence, however partial and limited it may be, is exerted at multiple levels of governance, which it is difficult to model. It is really a question of multi-level interactions, the results of which are extremely variable in terms of their effects on national policies.

Another reason worth mentioning is that as a regulatory instrument, the WHO recommendations do not really fit the French context unless they meet up with the interests (symbolic or otherwise) of a French group, lobby or school of thought. In that case, the French players’ strategy consists of furthering their own purposes by obtaining international recognition. The aim of this round-about approach is not to take part in drawing up a coherent philosophy in line with WHO, but rather to make a project, an idea or an innovation more acceptable in the eyes of the French psychiatric community.
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Annexe 1 : indication méthodologique

Le présent rapport est essentiellement basé sur :

- **Revue de littérature** sur la question de l’influence de l’OMS sur les politiques de santé mentale en France
- **Etude du premier plan Santé Mentale Français 2001** : l’usager au centre d’un dispositif à rénover
- **Etude du rapport de la commission Couty** (30 janvier 2009) : à noter qu’à l’initiative du CCOMS Lille, France des représentants de la CE et de l’OMS Europe ont été auditionnés.
- **Etude du « Pacte européen pour la santé mentale et le bien être »** Bruxelles, Juin 2008
- **Etude du travail du Centre Collaborateur OMS Français pour la santé mentale relais national de l’OMS Europe en France**
- **Interviews de divers acteurs de la santé mentale**
Annexe 2
Activités, Missions du CCOMS, Lille

Etude du travail du Centre Collaborateur OMS Français pour la santé mentale relais national de l’OMS Europe en France : Le Centre Collaborateur de l’Organisation Mondiale de la Santé pour la Santé Mentale (Lille, France)

Les centres collaborateurs de l’OMS sont des institutions, instituts de recherche, départements d’universités ou d’instituts universitaires qui sont désignés par le Directeur général pour mener des activités de soutien en faveur des programmes de l’Organisation. On en compte actuellement plus de 900 dans 99 Etats Membres qui travaillent avec l’OMS dans des domaines aussi variés que les soins infirmiers, la médecine du travail, les maladies transmissibles, la nutrition, la santé mentale, les maladies chroniques et les technologies sanitaires.

Historique des centres collaborateurs de l’OMS

L’idée d’utiliser des institutions nationales pour des visées internationales remonte à l’époque de la Société des Nations lorsque des laboratoires nationaux ont pour la première fois été désignés comme centres de référence pour la normalisation de produits biologiques. Dès sa création, l’OMS a désigné d’autres centres de référence, à commencer en 1947 par le Centre mondial de la grippe situé à Londres pour la surveillance épidémiologique mondiale. Dès 1949, la Deuxième Assemblée mondiale de la Santé a défini la politique (suivie depuis lors) en vertu de laquelle l’OMS ne doit pas envisager « la création, sous ses propres auspices, d’institutions internationales de recherche » et doit considérer que dans le domaine de la recherche en santé, il y a plus à gagner à appuyer, coordonner et utiliser les activités d’institutions existantes. Tous les centres collaborateurs de l’OMS, qu’ils portent sur la recherche (c’est le cas pour la plupart d’entre eux) ou non, ont été désignés dans le respect de cette politique, ce qui a incontestablement renforcé la participation nationale aux activités de l’Organisation.

Définition des centres collaborateurs de l’OMS

Un centre collaborateur de l’OMS est une institution désignée par le Directeur général de l’Organisation pour faire partie d’un réseau collaborateur interinstitutionnel mis en place par l’OMS pour apporter un soutien à ses programmes au niveau des pays, inter-pays, régional, interrégional et mondial. En conformité avec la politique de l’OMS et sa stratégie de coopération technique, le centre collaborateur doit aussi contribuer à renforcer les ressources des pays en termes d’information, de services, de recherche et de formation pour favoriser le développement sanitaire national. La désignation a lieu avec l’accord du responsable de l’établissement auquel l’institution est rattachée ou avec celui du directeur de l’institution, si elle est indépendante, et après consultation avec le gouvernement national. Au départ, une institution est désignée pour un mandat de
Les fonctions des centres collaborateurs de l’OMS sont multiples :

a. recueil, collationnement et diffusion d’informations ;

b. normalisation de la terminologie et de la nomenclature, des technologies, des moyens diagnostiques, des substances thérapeutiques et prophylactiques, et des méthodes et procédures ;

c. développement et application de technologies appropriées ;

d. fourniture de substances de référence et autres services ;

e. collaboration à des travaux de recherche mis au point sous la direction de l’Organisation, y compris les activités de planification, de réalisation, de

Exemples de désignations récentes:

- Le Centre de développement pédagogique pour les professions de santé de l’Université de Khartoum, au Soudan, a été désigné en janvier 2007 centre collaborateur de l’OMS pour le développement de la formation aux professions de santé. Il peut se targuer d’avoir fait avancer la cause des professionnels et des ressources humaines de la santé au Soudan et dans la région. En collaboration avec l’OMS, il a organisé plusieurs cours de formation pour le personnel médical et non médical. Il a notamment pour objectif principal de promouvoir des méthodes innovantes dans le domaine de la formation des professionnels de santé et de se pencher sur la gestion des ressources humaines en général.

- L’Institut de recherche national sur le SIDA (National AIDS Research Institute - NARI) situé à Pune en Inde a été désigné en début d’année 2007. Il a pour mission de mettre sur pied des initiatives de recherche qui soient en phase avec l’élaboration d’interventions et de politiques destinées à lutter contre la propagation de l’épidémie de VIH/SIDA. L’Institut étend ses activités dans différents domaines de recherche sur le VIH et le SIDA moyennant le développement de l’infrastructure, le renforcement des capacités et les programmes de recherche. En collaborant avec l’OMS, il assure une formation sur les techniques de laboratoire et sert de centre de référence pour le diagnostic de l’infection à VIH. Il fournit par ailleurs des orientations techniques sur la surveillance de la pharmacorésistance du VIH et diffuse des données.
surveillance et d’évaluation de travaux de recherche, et aussi promouvoir l’application des résultats de la recherche ;
f. formation, notamment dans le domaine de la recherche ; et
g. coordination d’activités menées par plusieurs institutions sur un sujet donné.

Les centres collaborateurs de l’OMS permettent à l’Organisation d’accomplir des activités qui entrent dans le cadre de son mandat et de profiter de ressources qui dépassent largement les siennes. Ainsi, l’OMS a accès à des centres de premier plan dans le monde et a des capacités institutionnelles propres à garantir la validité scientifique du travail sanitaire mondial. Grâce à ces réseaux mondiaux, l’Organisation peut exercer son rôle de leader pour modeler le programme de santé à l’échelon international.

En ce qui concerne les institutions, leur désignation en tant que centres collaborateurs de l’OMS leur permet d’accroître leur visibilité et d’acquérir une plus grande reconnaissance auprès des autorités nationales, tout en attirant l’attention du public sur les questions sanitaires auxquelles elles consacrent leurs activités. Elles ont ainsi plus de chances d’échanger des informations et d’établir une coopération technique avec d’autres institutions, notamment au niveau international, et de mobiliser des ressources supplémentaires – parfois importantes – auprès de partenaires financiers.

Les centres collaborateurs de l’OMS (CCOMS) ont pour rôle principal de fournir un appui stratégique à l’Organisation pour répondre à deux nécessités :

1. Mettre en œuvre les activités prescrites dans le cadre de l’OMS et les objectifs de son programme
2. Développer et renforcer les capacités pour la réalisation du dit programme dans les pays et les Régions.

Les centres collaborateurs de l’OMS sont encouragés à tisser des relations de travail avec d’autres institutions et centres nationaux reconnus par l’OMS, notamment en créant ou en rejoignant des réseaux de collaboration avec l’aide de l’OMS. Par l’intermédiaire de ces réseaux mondiaux, l’Organisation peut exercer sa prérogative, à savoir modeler le programme de santé à l’échelon internationale et passer de relations bilatérales à des réseaux multilatéraux.

Les domaines techniques auxquels se consacrent la grande partie des centres en 2008 sont les suivants : médecine du travail, risques pour la santé liés à l’environnement, choléra, soins infirmiers, santé mentale, maladies virales, procréation, santé buccodentaire, maladies parasitaires, lutte contre le tabagisme, salubrité alimentaire, cancer et classification des maladies.

La base de données des centres collaborateurs de l’OMS est accessible à l’adresse suivante http://www.who.int/whocc/
Le Centre Collaborateur français de l’Organisation Mondiale de la Santé pour la formation et la recherche en santé mentale (CCOMS, Lille France)


Le CCOMS (Lille, France) rassemble un réseau d’actions, de compétences, de programmes, en relation avec les orientations en santé mentale, les axes de recherche et de formation définis par l’Organisation Mondiale de la Santé. Il mène toutes ces actions de recherches, de réseaux, de communication, de formation en impliquant systématiquement les quatre partenaires de l’alliance : usagers (FNAPSY), familles (UNAFAM), élus (AMF, ESPT, autres) et professionnels.

Il travaille en lien avec les services du Ministère de la Santé : DREES, DGS, DHOS, DGAS et se fonde sur un réseau de personnes qualifiées, appuyé d’un conseil scientifique national rassemblé autour de valeurs communes :


26 Les priorités en santé mentale redéfinies en 2005 par l’OMS Europe sont : 1- Foster awareness 2- Collectively tackle stigma, and empower and support people with mental health problems and their families 3- Design and implement integrated mental health systems 4- Create a competent workforce 5- Recognize experience and knowledge of service users and carers.

27 Association des Maires de France

28 Association Elus Santé Publique et Territoires

29 Direction de la Recherche, des Études, de l’Évaluation et des Statistiques
La pleine participation des usagers à l’organisation et au développement de la qualité des services
La promotion de services de psychiatrie intégrés dans la Cité
La lutte contre la stigmatisation et la discrimination des personnes ayant des troubles psychiques
Le développement de réseaux de recherche, de formation, d’information en santé mentale
La valorisation, le partage et la diffusion des expériences innovantes en santé mentale
La participation des établissements hospitaliers à une recherche indépendante, menée par des professionnels et des acteurs de terrains
Le travail en réseau avec l’ensemble des partenaires oeuvrant dans le champ de la santé mentale, qu’ils appartiennent au domaine sanitaire et social ou à la société civile

Le CCOMS (Lille, France) s’est fixé les missions suivantes :

1. Promouvoir et coordonner la participation des équipes françaises de recherche et d’enseignement aux activités de recherche et de formation du programme de santé mentale de l’OMS.
2. Informer les autorités et spécialistes français des activités de l’OMS utiles au développement des programmes français de santé mentale.
3. Informer la division santé mentale de l’OMS des travaux et projets pilotes français, ayant trait à la santé publique et à la réglementation, pouvant être utiles à la conduite des programmes.
4. Constituer un point focal pour les experts français de santé mentale qui leur permette d’assurer un meilleur suivi de leur travail, quand ils accomplissent des missions de consultant, et faciliter leurs relations avec l’OMS.
6. Assurer le rôle de leader des Centres Collaborateurs européens de l’OMS sur le thème de la Lutte contre la Stigmatisation et de co-leader sur le thème de la transformation des services.
7. Faciliter et soutenir l’investissement des associations d’usagers, de familles et de proches dans la réforme des services de santé mentale, au niveau européen, selon les recommandations de l’OMS Europe.

30 Direction Générale de la Santé
31 Direction de l’Hospitalisation et de l’Organisation des Soins
32 Direction Générale de l’Action Sociale
Programme d’action du CCOMS (Lille, France)

Il s’articule autour de 6 pôles s’appuyant chacun sur des activités de recherche, de formation, d’information et de travail en réseau.

- Santé mentale en population générale : images et réalités.
- Prévention du suicide.
- Réseaux International et National d’expériences innovantes en santé mentale – pour des services de psychiatrie intégrés dans la Cité.
- Evaluation médico-économique des secteurs psychiatriques.
- Sociologie de la santé mentale.

Historique du CCOMS (Lille, France)

- **1976** Création du CCOMS, dans le cadre de l’unité INSERM 110 (épidémiologie psychiatrique) dirigée par le Dr Sadoun. Participation à la révision de la CIM X et coupes transversale sur la population des patients hospitalisés en psychiatrie / adulte.

- **1986** Fermeture de l’unité 110, maintien du CCOMS comme "structure flottante" INSERM. Traduction de documents. Participation à la révision de la CIM-10.

- **1990** Dr Nicole Quemada (épidémiologiste INSERM) désignée directrice. Développement d’enquêtes transversales, dans le cadre du programme d'intérêt commun DGS/INSERM. Développement de la version française WHO QOL : questionnaire d’évaluation de la qualité de vie. Développement des outils d’évaluation de la qualité des soins. **Outils développés, traduits, mais non utilisés en France.** Site français pour l’enquête internationale OMS « troubles psychologiques en médecine générale ». **Résultats cités dans différents rapports gouvernementaux mais impacts faibles au niveau des pratiques.**

- **1998** Pas de redésignation officielle, maintien tacite.

- **1999** Dr Jean-Luc Roelandt désigné directeur. Consolidation du statut, développement du travail en réseau, promotion de la politique OMS de psychiatrie communautaire au niveau national.

• **2005** Demande de reconduction formulée auprès de l’OMS.

• **2006** Reconduction du Centre pour 4 ans. Désignation comme CCOMS co-leader pour la transformation des services en Europe et co-leader pour la lutte contre la stigmatisation et la discrimination. En 2008 assignation de la mission de faciliter et soutenir l’investissement des associations d’usagers, de familles et de proches dans la réforme des services de santé mentale, au niveau européen, selon les recommandations de l’OMS Europe.

**Rôle et actions du CCOMS :**

**Au niveau national :**

Chaque action est menée systématiquement avec les quatre partenaires : usagers, familles-aidants, élus, professionnels (de tous les secteurs concernés)

**A - L’enquête " Santé Mentale en Population Générale : images et réalités" (SMPG), recherche-action internationale multicentrique, menée depuis 1997 a deux objectifs principaux :**

1- Décrire les représentations mentales liées à la "folie", "la maladie mentale", "la dépression" et aux différents modes d’aide et de soins, et estimer la prévalence des principaux troubles psychiques dans la population générale âgée de plus de 18 ans.

2- Sensibiliser les partenaires sanitaires, sociaux, associatifs et politiques à l’importance des problèmes de santé mentale dans la population générale.

Pour chaque site participant à l’enquête, les données sont recueillies par des enquêteurs formés, grâce à des questionnaires administrés au cours d’entretiens en face à face avec des personnes sollicitées dans la rue, anonymement, en respectant des quotas socio-démographiques (sexe, âge, CSP, niveau d’étude) de manière à constituer un échantillon aussi représentatif que possible de la population vivant sur la zone géographique concernée. Pour chaque personne interrogée, les questions explorent ses propres représentations ainsi que la présence de troubles mentaux actuels ou passé et les recours thérapeutiques et/ou aides utilisés.

Depuis son commencement en 1997, l’enquête SMPG a été réalisée sur 78 sites : 65 sites nationaux et 13 internationaux, soit plus de 70 000 personnes interrogées :

- Près de 58 000 individus en France (dont 2500 dans les DOM)
- Plus de 11 500 individus pour l’ensemble des sites internationaux.
Type de connaissances : représentations sociales, recours aux soins, épidémiologie, système de santé mentale.
Aspects pratiques : sensibilisation, formation information en santé mentale auprès des élus, des professionnels et de la population générale.

**B - Lutte contre la stigmatisation : campagne « Accepter les différences, ça vaut aussi pour les troubles psychiques », coordination de la Semaine d’Information en Santé Mentale (SISM) au niveau National. Participation à la Campagne INPES sur la Dépression. Plaquettes Psycom 75**

Type de connaissances : information sur les pathologies, les droits, les soins, les types de professionnels, les systèmes, les thérapies...
Aspects pratiques : sensibilisation population, formation information de tous les partenaires et de la population générale, prévention, accès aux soins, éviter les ruptures de soins, autonomie des usagers et facilitation des réseaux partenaires.

**C - Réseau National de collaboration pour le développement de bonnes pratiques en santé mentale dans le cadre de la Politique de la Ville**

L’objectif général de cette action est de renforcer, soutenir et développer la base Nationale d’un Réseau de Collaboration en Santé Mentale qui se fixe les objectifs suivants :

- La reconnaissance du rôle, de l’expérience et de l’expertise des usagers, de leur entourage et des élus locaux dans la planification et le développement des services
- La création de services de psychiatrie intégrés dans la Cité qui puissent répondre aux besoins en santé mentale de la population en accord avec la Politique de Ville et les acteurs de la vie la cité.
- Le redéploiement des grands hôpitaux psychiatriques par la création de services intégrés en partenariat avec les villes concernées
- La lutte contre l’exclusion, la discrimination et la stigmatisation des citoyens ayant des troubles psychiques.

Le but du Réseau National de Collaboration en Santé Mentale est de répondre aux besoins en terme d’information, de formation, de développement réseau et d’organisation des services de santé mentale qui s’engagent dans cette voie.

L’objectif est dans un premier temps de répertorier les bonnes pratiques actuelles ou à venir, de parvenir à un consensus puis de les étendre dans 45 sites urbains en associant les services de psychiatrie. La réalisation concrète de l’action consistera dans la mise en place de Conseils Locaux de Santé Mentale impliquant les habitants et collectivités dans les territoires ciblés en appui sur des réseaux et ressources déjà actifs : Ateliers Santé
La mise en place et le développement de ce réseau nécessitera :
- Une observation et diagnostic des dispositifs et des réseaux actifs sur le territoire ciblé
- Une réflexion mutuelle et des propositions d’actions locales adaptées
- Le développement et la coordination de Conseils Locaux de Santé Mentale
- Le développement d’indicateurs pour évaluation continue des actions

Type de connaissances : Sociologie politique, système de santé locaux, analyse des politiques publiques locales, rapport entre science médicale et décision politique (rapport technique – politique). Analyse des cultures professionnelles soignantes.
Aspects pratiques : développement réseaux, développement de politiques locales de santé, sensibilisation des décideurs.

D - Première formation de pairs-aidants (déc 2008)
Mise en place d’une recherche-action visant à l’élaboration d’un projet pilote reproductible au niveau national, pour l’embauche, au sein des services de santé mentale, d’usagers ou d’ex-usagers de la santé mentale, au titre de Travailleur Pair-Aidant (TPA) à partir d’expériences étrangères (Etats-Unis, Canada, Angleterre, Australie). En partenariat avec la mairie de Mons en Baroeul, l’EPSM Lille Métropole, l’UNAFAM Nord, et la Self Help Connection (Dartmouth, Canada)

Type de connaissances : expériences d’usagers, savoir profane, démocratie participative...
Aspects pratiques : culture professionnelle, destigmatisation, statut de l’expertise

E- Recherches nationales « Etats dangereux et troubles psychiques » :
- Étude sur 900 dossiers d’expertises de personnes incriminées dans des meurtres, assassins
- Protocole « Enquête sur les hospitalisations d’office dans quatre régions françaises : Nord-Pas-de-Calais, Ile de France, Aquitaine et Provence-Alpes-Côte-d’Azur»

Type de connaissances : épidémiologiques, systèmes locaux d’acteurs, statistiques, histoire des enjeux médico légaux, connaissance des processus
Aspects pratiques : évaluation des pratiques, élaboration de protocole d’action, observatoire local...
**F - Groupe de Coopération Sanitaire santé mentale France:** recherche et formation en santé mentale communautaire (17 établissements public de santé mentale sur tout le territoire national)

**G- Programme de formation Santé mentale dans la cité : visites de services intégrés et cours théoriques. Formations et visites des professionnels au niveau national.**

<table>
<thead>
<tr>
<th>Type de connaissances</th>
<th>Aspects pratiques</th>
</tr>
</thead>
<tbody>
<tr>
<td>épidémiologiques, management, épidémiologie, communication, organisation des soins</td>
<td>formation aux professionnels, élus et agents territoriaux.</td>
</tr>
</tbody>
</table>

**H- Organisation de Congrès Internationaux parrainage et participation OMS et différents représentants du gouvernement :**

- Lille 2004 « Images et réalités de la santé mentale en France »
- Nice 2007 « Stigma ! : Vaincre les discriminations en santé mentale »

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<thead>
<tr>
<th>Type de connaissances</th>
<th>Aspects pratiques</th>
</tr>
</thead>
<tbody>
<tr>
<td>tous types suscités</td>
<td>tous types suscités</td>
</tr>
</tbody>
</table>

**Au niveau européen :**

- Depuis 1999, recherche action SMPG : Trieste, Oviedo, Séville, Bruxelles, Paros.
- 2003, INMCH, réseau de bonnes pratiques européen en santé mentale : visites croisées de formation au niveau européen (Italie, GB, Belgique, Grèce, Albanie...) et jumelages mise en place du programme de santé mentale de Sardaigne, Expertise en Bosnie.

<table>
<thead>
<tr>
<th>Type de connaissances</th>
<th>Aspects pratiques</th>
</tr>
</thead>
<tbody>
<tr>
<td>épidémiologiques, management, épidémiologie, communication, organisation des soins, ingénierie de réseaux</td>
<td>formation aux professionnels (soignants, directeurs, managers...) et aux décideurs</td>
</tr>
</tbody>
</table>

- Depuis 2005 : Participation à la conférence d'Helsinki, co-leader des Centres Collaborateurs européens de l'OMS sur le thème de la lutte contre la stigmatisation (avec le CCOMS Edinburg) et co-leader sur le thème de la transformation des services (avec le CCOMS Trieste).
- Septembre 2008 : organisation à Lille d’une réunion des principales associations européennes d’usagers et d’aidants sous l’égide de l’OMS Europe et avec l’UE. Participation au comité de pilotage du projet européen OMS EURO – UE : User Empowerement in Mental Health
- Octobre 2008 : Lancement du Programme Européen pour la réforme des services « Réponses effectives au changement des besoins en santé mentale » OMS Europe, Londres) Membre du groupe de travail sur les indicateurs de bonnes pratiques

**Au niveau international :**

- Participation au Community mental health global forum. OMS International
- Participation au projet MH Gap. OMS International
- Recherche internationale INDIGO International Study on Stigma and Discrimination Outcomes
- Projet ASPEN Anti stigma project European Network
- Participation au Plan national de santé mentale pour Madagascar et pour la Mauritanie
- Traductions et adaptation des documents de l’OMS en français
  - WHO AIMS 2005
  - Guides pour la santé mentale, 8 tomes, avec les ccoms francophones- Genève, Montréal, Casablanca
  - Participation aux séminaire de lancement du Global Forum Juin 2007 et mhGAP octobre 2008
ANNEXE 3

Quelques résultats clés pour situer la France :

Politiques de santé mentale

- After 2005:
  - Austria, Belgium, Bosnia and Herzegovina (Federation of Bosnia and Herzegovina and Republika Srpska), Bulgaria, Croatia, Cyprus, Denmark, France, Germany, Ireland, Israel, Italy, Lithuania, Norway, Poland, Portugal, Romania, Russian Federation, Serbia, Spain (Catalonia, Extremadura, Galicia and Murcia), Switzerland, the former Yugoslav Republic of Macedonia, Turkey, United Kingdom (Scotland)

- 1999-2004:
  - Albania, Czech Republic, Finland, Greece, Hungary, Latvia, Luxembourg, Montenegro, Netherlands, Slovakia, Slovenia, Spain (Castilla y León), United Kingdom (England and Wales), Uzbekistan

- Before 1998:
  - Malta, Sweden

- No policy:
  - Azerbaijan, Estonia, Georgia, Moldova

Législation en santé mentale

- After 2005:
  - Austria, Belgium, Bulgaria, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Ireland, Italy, Latvia, Lithuania, Montenegro, Norway, Poland, Slovakia, Spain (Castilla y León), the former Yugoslav Republic of Macedonia, United Kingdom (England and Wales)

- 1999-2004:
  - Azerbaijan, Bosnia and Herzegovina (Federation of Bosnia and Herzegovina and Republika Srpska), Croatia, Cyprus, Greece, Israel, Netherlands, Portugal, Romania, Russian Federation, Spain, Spain (Catalonia, Extremadura and Murcia), Sweden, Turkey, United Kingdom (Scotland), Uzbekistan

- Before 1998:
  - Albania, Hungary, Malta, Moldova, Slovenia, Spain (Galicia)

- Draft law prepared and submitted to the Ministry of Health in 2004:
  - Serbia

- Information not available:
  - Luxembourg, Switzerland

Source: Europe 2008 Policies and Practices for mental health in Europe – meeting the challenges
Ce tableau compare à partir de quelques indicateurs (source OMS EUROPE 2008) les systèmes psychiatriques de plusieurs pays européens. On retiendra pour contextualiser ces données dans trois pays que :


- Le Royaume Uni a investi massivement dans les soins communautaires et a fermé 112 des 126 hôpitaux du Royaume depuis 20 ans. Les équipes de psychiatrie de proximité soignent dans la Cité et l’intégration est menée de concert avec les services sociaux, ce qui explique le faible taux d’admissions dans les hôpitaux.

- La France, selon ces indicateurs, n’a pas mis en place efficacement la politique de secteur prônée depuis cinquante ans. Elle dépense quasiment autant qu’au Royaume Uni pour un système qui n’a pas encore choisi clairement son organisation. Les soins et les budgets sont encore très hospitalo-centrés et les inégalités territoriales majeures, faute d’une politique effective de soins et de prévention de proximité dans la Cité.

<table>
<thead>
<tr>
<th>Pays</th>
<th>Psychiatres</th>
<th>Lits</th>
<th>Admissions</th>
<th>Taux de suicide</th>
<th>Budget Santé Mentale / Santé Générale</th>
</tr>
</thead>
<tbody>
<tr>
<td>France</td>
<td>22</td>
<td>100</td>
<td>1000</td>
<td>16.32</td>
<td>12</td>
</tr>
<tr>
<td>Italie</td>
<td>9</td>
<td>5</td>
<td>800</td>
<td>5.98</td>
<td>5</td>
</tr>
<tr>
<td>Royaume Uni</td>
<td>12</td>
<td>20</td>
<td>300</td>
<td>6.38</td>
<td>14</td>
</tr>
<tr>
<td>Belgique</td>
<td>22</td>
<td>150</td>
<td>900</td>
<td>19.6</td>
<td>?</td>
</tr>
<tr>
<td>Allemagne</td>
<td>9</td>
<td>80</td>
<td>1300</td>
<td>11.0</td>
<td>11</td>
</tr>
<tr>
<td>Suède</td>
<td>23</td>
<td>60</td>
<td>1200</td>
<td>12.0</td>
<td>10</td>
</tr>
<tr>
<td>Spain (Galicia)</td>
<td>6</td>
<td>5</td>
<td>180</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Roumanie</td>
<td>5</td>
<td>80</td>
<td>1300</td>
<td>12.0</td>
<td>3</td>
</tr>
<tr>
<td>Grèce</td>
<td>16</td>
<td>20</td>
<td>400</td>
<td>3.0</td>
<td>?</td>
</tr>
</tbody>
</table>

Source : Europe 2008 Policies and Practices for mental health in Europe – meeting the challenges
ANNEXE 4
Réseau des Villes – Santé en 2006

Les villes adhérentes
Réseau Français des Villes-Santé

(Actualisation décembre 2006)