

## **The WHO in Belgium: cross-level networking**

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# Table of contents

Introduction	1
1. Institutional context	2
2. The main actors: a divided network, an occasional community	3
<i>2.1. Introduction</i>	3
<i>2.2. Identification of several key actors</i>	3
<i>2.3. The WHO in Belgium: the technocratic temptation</i>	5
3. Belgium's contribution	8
4. Reception	9
5. Analysis	12
7. Conclusion	15
Bibliography	17
Appendixes	19

## INTRODUCTION

On 23<sup>rd</sup> January 2009, a young 20-year-old man, dressed in disguise, burst into a crèche and stabbed several babies and an employee. He killed three people. Very quickly, the press started asking questions about his psychological profile, making a link between his “Joker”<sup>1</sup> makeup and a possible state of schizophrenia. Several days later, the parents, who had been concerned about his state, revealed that they had already unsuccessfully attempted to have him interned. The doctor had not deemed it necessary, preferring to prescribe him drugs at home.

This digression via this “critical episode” is interesting for more than one reason. First of all, by sparking widespread public debate, this event helped to reveal numerous stakes supported by the actors in the sector. By questioning psychiatry’s ability to prevent this type of drama, the press helped to emphasise the existing tension between a law-and-order role that we are attempting to assign to psychiatry, and a therapeutic objective that the practitioners intend to defend. By defending themselves, numerous practitioners, universities or users’ associations spoke out, linking the drama to a lack of prevention policies, the problems of under-financing, the need to redesign healthcare organisations, to involve the users, etc.: numerous stakes at the centre of normally more discreet debates, in which the actors sometimes position themselves by calling on the WHO, the Helsinki plan or, more rarely, the European green paper. It would appear that this is the only form of existence – retranslated into the sectoral stakes – of these supranational instruments. At least for the moment. Indeed, and this is a second interesting point, faced with this debate, the Minister of Health and Social Affairs announced the creation of an emergency psychiatric service and rumour had it, among the initiated, that she intended to lead a global reflection on the organisation of mental healthcare in Belgium. For the promoters of Helsinki in Belgium, it was perhaps an opportunity to air their analysis and feasibility studies on the implementation of the Helsinki plan, which had gone unheeded until then. Indeed, in Belgium, the Helsinki process had had no direct repercussions on a legislative level, it had not led to the implementation of projects or concrete policies, and it had not aroused any important specific debate. The WHO’s various recommendations only seem to exist as being retranslated into the present stakes and, from this point of view, the approaching debate on the organisation of healthcare could have been a great opportunity to improve our knowledge of how these tools function. After presenting the institutional context, the key actors, and their work, we shall see that the description of the reception of Helsinki in Belgium seems to suggest slow, long-term changes.

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<sup>1</sup> The “Joker” is a fictional character in the “Batman” comic strip and the film version.

## 1. Institutional context

Understanding the reception of the WHO recommendations in Belgium involves understanding the country's sociopolitical organisation. Belgium is structured into two different philosophical and linguistic communities. The distribution of competences is relatively complex and, as we shall see, can have consequences in terms of acceptance and the implementation of international knowledge. Since the organisation of the sector has already been widely presented in the main lines of the preceding reports, we shall only refer to it succinctly and refer the reader to the O1 report. A graphic representation, from this first report, is also available in the appendix (p.20) to help the reader understand the organisation of the mental health sector in Wallonia.

In Belgium, the competences in terms of mental health are distributed between three levels of power:

- The **Federal Government** is mainly in charge of hospitals, the health insurance system and the organic laws organising the health sector.
- As for the **Regional Governments**, they are essentially in charge of ambulatory care.
- As for the **Communities**, they are mainly competent in terms of promoting health and preventive medicine.

As for other domains of public action, an organ was created to co-ordinate the general policy in terms of health: the "Interministerial Public Health Conference". Grouping together the ministers from the various levels of power, this conference is planned on a twice-yearly basis. However, it seems that its reach should be nuanced, since the great co-ordination difficulties involved bear witness to the inability of this conference to reach a protocol agreement on an area that is nevertheless the subject of consensus: the creation of health networks. The representation of countries in international organisations is therefore governed by a co-operation agreement<sup>2</sup> between these three entities. Among other things, this provides for a horizontal dialogue between the various levels to allow information to circulate, agreements to be reached on the stance in Belgium and on its representatives among these authorities. As regards the latter, plans have been made for priority to be given at the level of the power most concerned and each entity can be represented.

As regards mental health, the level of power most involved in international activities such as those of the WHO and the European Community seem to be at the federal level. Given

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<sup>2</sup> M.B. 19.11.1994. Co-operation framework agreement between the Federal State, the Communities and the Regions relating to the representations of the Kingdom of Belgium among international organisations pursuing activities relating to mixed competences.

the complexity of the institutional mental health organisation in Belgium, we have chosen to only study the French-speaking part of the country as regards matters for which the regional and community powers are competent.

## **2. The main actors: a divided network, a occasional community**

### **2.1 Introduction**

First of all, by searching through the numerous documents produced on this issue, whether legislative, informative, official or not, we have endeavoured to identify the main people associated with the WHO or the European Commission. This initial phase was completed with a series of questions asked during our interviews, the aim of which was to attempt to pinpoint an interknowledge network working on the subject of the implementation of international standards in Belgian public action.

The analysis of the biographical backgrounds reveals that many of these people hold a variety of positions, making it difficult to differentiate between different levels of public action: international – national – local. The most active people seem to be simultaneously or successively involved in academic, scientific, or clinical careers at the WHO, in local projects, or in associations.

The relationships between these people also seem to be more sporadic than permanent and depend on circumstances offering, for instance, a joint research contract, or more simply, WHO activities: *"We can't speak of communities, there isn't any "movement", it's more divided up"*<sup>3</sup>.

### **2.2 Identification of several key actors**

In Belgium, one of the main people in charge of relations with the WHO as regards mental health, is the "National Counterpart", a post allocated by ministerial decision. It was under this title that he was able to follow the activities of the WHO and was involved in the Helsinki process and the "Mental Health: facing the challenges, building solutions" report. A doctor in psychology, and defender of an "evidence-based" policy during his doctoral thesis, he worked on a pilot project conducted by the Federal Public Service (FPS) Health, Safety of the Food Chain and the Environment (that we shall refer to from now on, for greater ease, as "FPS Health"). This collaboration allowed him to apply for the

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<sup>3</sup> Co-president of the WHO Collaborating Centre.

post of head of the psychiatric care unit. He occupied this position until last year, when he became assistant director of the FPS.

At the same time, in the same institution, FPS Health, there was a head of the international relations department. She was the main point of contact for international organisations such as the WHO and the European Union. After having worked on research, this psychologist worked for the WHO Collaborating Centres and as an advisor to the ministry.

Another key person was an economist, advisor to the Federal Minister of Health and Social Affairs. Her position is interesting insofar as she was required to monitor the Interministerial Conference, the organ likely to co-ordinate a policy in response to the Declaration of Helsinki.

At the level of the WHO Collaborating Centre – hereafter referred to as the “CCOMS” –, there is mainly:

- A psychiatrist and former professor from the “Université Libre de Bruxelles” (ULB). He was the “National counterpart” for Belgium at the WHO and was involved in numerous policies regarding mental health in Belgium at all levels. For instance – and this is of interest to our work – he was an expert for the “Conseil National des Etablissements Hospitaliers” (CNEH), an organ which was responsible for the reform of mental health policies in Belgium, and he is involved in a “dialogue platform”, a structure that aims to co-ordinate mental health care territorially and which is involved in the pilot projects that we have chosen to study in the second orientation.
- The second co-president of the Collaborating Centre since its creation in 1979 is also a psychiatrist and was a professor at the “Katholieke Universiteit Leuven” (KUL). He was an expert in mental health for the director-general of the WHO in Geneva. Just like his French-speaking counterpart, he works, or worked, for numerous structures such as the “Conseil National des Etablissements Hospitaliers” or an NGO. He also held the post of “National counterpart” until the end of the 1990s.

These four people were involved in the Declaration of Helsinki at the side of the Minister of Health, the members of his cabinet and another member of the Collaborating Centre who was a leader for a “Mental Health Europe” project which, as we shall see, is an NGO that played a significant role in the Belgian participation at the Helsinki conference. This organisation groups together numerous associations of patients or families of patients and benefits from privileged access among European authorities.

While the last person to whom we referred, and the professor from KUL figure in the “Mental Health: Facing the challenges, finding solutions” report as observers and members of the Collaborating Centre, the first co-president of CCOMS was present in Helsinki as a member of the Belgian delegation supporting the Minister of Health.

Reported as present in Helsinki by the text from the conference – which another participant denied – the Minister of Health signed the declaration. It is interesting to note that several representatives of the Flemish Region were present, as permitted by the above-mentioned framework agreement, while no other representative from the Walloon Region or the French-speaking community was there.

### **2.3 The WHO in Belgium, the technocratic temptation**

The two main relays of the WHO in Belgium are the “National counterpart” on the one hand, and the WHO Collaborating Centre on the other hand. While this may involve the same people – for instance, this was the case for the professor of psychiatry at KUL who was both co-president of the CCOMS and the “National counterpart” – this was not the case for the Helsinki process. Nevertheless, these people know each other and can, if necessary, collaborate. Before tackling the terms of their co-operation, it is interesting to begin by describing what the work of these two relays involves.

Formally known as the “WHO ‘Health and Psychosocial Factors’ Collaborating Centre”, this flexible interuniversity structure unites two opposing teams as regards the linguistic communities and Belgian denominations. Composed of the Université Libre de Bruxelles’ (ULB) “Laboratoire de psychologie médicale, alcoologie et toxicomanie”, the French-speaking institution depending on the liberal pillar, on the one hand, and a psychiatry department at the Katholiek Universiteit Leuven (KUL), a Dutch-speaking university depending on the Catholic pillar, on the other hand, the collaborating centre seems to have been composed in a functional manner in the Belgian institutional landscape.

The professor from Louvain, and founding member, tells us the story. After training and placements abroad, especially in Geneva where the headquarters of the WHO is based, he returned to Belgium, where care is mainly given in homes, with the desire to develop the innovative ideas he had discovered. Following his stay in Geneva, he maintained relations with the WHO. A specialist in the elderly, he was in the habit of collaborating with a professor in health from ULB, who specialised in paedopsychiatry. In the 1970s,

these two professors formed excellent relations with their new Minister in charge, who was quick to surround himself with experts in order to proceed with his policy: "He had already asked for an opinion left, right and centre in order to help his policy progress. He immediately saw Sand, Professor of Public Health at ULB, a specialist in child psychiatry, and myself, who wasn't at all a public health specialist at this time, though relatively committed to mental health". It is seemingly with nostalgia that he describes a minister taking clear-cut decisions on the basis of expert advice: "He had a highly pragmatic view of things [...] when he was convinced, he get ahead: "I can't wait for the State's normal course of operations", "there must be fundamental changes"".

It was also in the 1970s that a trip to the WHO led to the creation of the Collaborating Centre. Accompanied by his two experts, the minister flew off to the WHO's annual ministerial conference, an institution where the psychosocial conceptions of health had not yet been developed, in sharp contrast with the political project supported by the minister and the two experts: "We discussed this here in Brussels in his cabinet but [during the meeting]: he said "there isn't anyone speaking about psychosocial issues here"". Having defended his approach, the minister returned with a draft collaboration agreement, supported by the couple of French-speaking/Dutch-speaking experts, allowing a federal policy that was differentiated according to the communities: "De Saeger<sup>4</sup> called us and said: "You are an astonishing couple, French-speaking, Flemish, and you succeed in working together. This is a relief because, for a minister, it is always very difficult to get ULB and KUL – which are opposed and contrasted – to work together, and this makes my job easier. I would like you to continue giving me an opinion on mental health and I'm delighted about it." This is what De Saeger said and it was prophetic: "I need a centre that is Federal (the word didn't exist)<sup>5</sup>, but I also need two teams who work together well with no Flemish / French-speaking division. You have to work together but it must be a collaborative piece of work with two wings, two teams that collaborate fully from a Belgian point of view and that at other moments, can work on projects linked to Wallonia or Flanders without there being any sabotage. They must continue to work together while continuing *to fully collaborate with the WHO.*"

Since then, the collaborating centre continues to be driven by this double dynamic. This may even have been reinforced with the move to a Federal State and the increased decentralisation of the competences to communities and regions. In this respect, it is interesting to note that when asked the question, a young researcher who has been working for the CCOMS for the past few years is unable to give concrete details about the activities achieved owing to the high level of differentiation between the two community wings: "*I'm not aware of everything that was achieved; it's important to point out as well*

<sup>4</sup> Flemish Christian-Democrat Minister. He held the post of Minister of Health from 1973 to 1977.

<sup>5</sup> Constitutionally, Belgium became a federal state in 1993, thus bringing to an end a long process that had begun approximately three decades earlier.



*that CCOMS was organised into two wings: French-speaking and Flemish. Except for a few projects developed in collaboration as requested by the Federal Government, everyone was working alone and had different activities. [...] [The projects are financed] either by the Federal Government, whereby the two wings are involved as for Helsinki and one or two internal projects, I think. The majority of the others [are financed] by French-speaking or Flemish regional or community authorities, etc. [However], the vocation even at the beginning, I think it's important to point out, the idea was to put together the lifeblood of several universities in order to work together on joint projects."*

With the goal of driving a double dynamic – confirmed by the researchers and set out in the statutes – aimed at communicating data from practices in Belgium to the WHO, and communicating to Belgium the knowledge from the WHO, the CCOMS team admits that it has found it difficult to meet this goal in a satisfactory manner. In this respect, as for many others, the complexity of dividing up the competences is called into question: *"It's impossible to provide complete epidemiological data. Either we have it for the whole of Belgium with no differentiation between the regions and communities, which is impossible to compare, or we have it from one side and not the other."* The centre's activity by far exceeds the implementation of WHO standards and constitutes a structure of expertise for the authorities on numerous themes, including the prevention and promotion of health. Thus, for instance, the French-speaking wing carried out research entitled "Well-being and Health at Work. Priorities for Brussels-Capital". Carried out at the instigation of the Minister of Health and the French-speaking Community Commission of the Brussels-Capital Region, the results were presented in June 2008. When reading the report, it is interesting to note that from the outset, the Declaration of Helsinki is cited in order to legitimize the importance of policies in a network for the promotion of health at work. Hence, numerous expert reports conducted by the various university institutions upon the request of political cabinets also constitute a way of structuring public action through international recommendations, when the latter have been reappropriated. Their exact influence is however very difficult to measure owing to the great number of these works and the variable and undetermined effect on public action.

The other position that allows a link to be formed between the WHO and Belgium is that of the "National Counterpart". This person is the Government's official link to the WHO; this post is allocated by ministerial decision and was held until 2000 by the professor from Louvain, co-president of the CCOMS. He envisaged his role as *"a facilitator to set up a good policy in terms of mental health"*. However, he described the aim of his activities essentially as a means to raise awareness and *"to stimulate the authorities [...] [in order to] maintain mental health on the political agenda"*. Indeed, while he insists on the fact that we cannot speak of pressure by the WHO on the Government, he describes his work essentially as relaying information. His essential task was to attend and participate in meetings organised by the WHO where he relayed the position of Belgium, and to organise, in return, meetings in Belgium to keep the sector informed: *"That's what we*

*stimulate, they are aware of that. I also organised a study day to explain the points of action to all those in charge of mental health in Belgium. I asked David McDaid<sup>6</sup> from the London School of Economics if we could present a session on the subject. It's also to inform the sector and it's up to him to use that or not, it's not up to us. The various political heads are aware, I was in London. I asked the various cabinets responsible for health: "What do you think of these documents, have you got any remarks?"*

As regards the argumentation developed, as testified by the presence of David McDaid, it is interesting to note that the economic data holds a significant place alongside an argument in terms of public health dealing with care issues. The use of this economic data also illustrates this promotion activity as regards the authorities: "If we use the economy it is to show that the investment in mental health is a real investment. It costs money in the short term but you gain money in the long term. That's more or less the idea, but especially on the level of prevention and the promotion of mental health, and it's the same logic in the 'green paper', [even if] the emphasis is particularly on promotion and prevention, it's normal, because they are only the competences of the European Commission."

The "National Counterpart" and those at the CCOMS know each other very well. The CCOMS strongly depends on its key figures, especially to obtain research contracts. We shall come back to this point in the fifth and sixth chapters, which will further illustrate the importance of the relations with the ministers in charge of public health for these people, and this tendency towards technocratic management, which will be dealt with in the penultimate chapter.

### 3. Belgium's contribution

During a study day on suicide among the elderly organised at the Senate on 17<sup>th</sup> December 2004, the Minister of Health stated: "In 2001, the World Report on Worldwide Mental Health was presented in Belgium: "Mental health: new conception, new hopes". This was followed by the European conference relating to stress and depression. In January 2005, an interministerial conference on mental health took place at the instigation of the WHO. The Federal State of Belgium played a key role in this process, especially on the theme of suicide." In November of that year, we held the preparatory meeting in Brussels with a view to reaching a consensual text. Some details still have to be debated between European ministers in Helsinki, but overall, we can be proud of having been the kingpin in this important stage in the evolution of mental health in our European region. Based on the observation that [...] suicide leads to more deaths than road accidents, Belgium explicitly asked for the theme of suicide to be a main concern

<sup>6</sup> David McDaid is an economist at the "London School of Economics and Political Science". A specialist in mental health, he regularly collaborates with the WHO. <http://www.lse.ac.uk/collections/PSSRU/staff/mcDaid.htm>

within the framework of the new declaration and action plan that should be adopted in Helsinki.”<sup>7</sup>

Largely criticised as regards its real reach, the suicide plan implemented by the Federal Minister for Health is nevertheless of interest to us. The extract of the speech above, clearly links the WHO to the policy developed in Belgium. In 2001, mental health year, Belgium presided over the Council of Europe. Subsequently, a conference entitled “Problems linked to stress and depression: European approaches”, among others, was organised in collaboration with the European Union and the WHO in Brussels. The European Commission was delighted with this collaboration<sup>8</sup> which it proposed to continue in the future. Following this, from 2002 until 2004, the NGO “Mental Health Europe” led a study project on the prevention of suicide in Europe. This study was carried out in collaboration with the international relations department of FPS Health, which financed it, and the WHO’s European network. This work led to a meeting in March 2004 prior to the Helsinki Conference. Exclusively dedicated to suicide and bringing together experts and representatives from 36 countries in the WHO’s European region, this conference led to several recommendations before being debated in Helsinki in order to be integrated into the action plan.

At the same time, a reflection was conducted in Belgium on the subject and the minister stated his intention to co-ordinate a policy between the different levels of power on several occasions. Announced in Helsinki as a participant in the conference, according to a member of the delegation, he finally did not attend, which “*showed his lack of interest in the problem*”. It is true that the timidity of the measures taken by this minister regarding suicide was underlined on many occasions, with the minister arguing of the distribution of competences entrusting the responsibility of prevention and promotion to the federated entities, but also focusing the major part of his policy on the problem of care networks.

## 4. Reception

At first view, the Helsinki process may seem to have had a considerable effect on the Belgian policy considering the number of references to the action plan among the official documents defining the major political orientations in the sector. More troubling and deceptive was the decision to create a pilot project putting into operation a care network – a recommendation that was part of the Helsinki action plan – taken in 2005, a few weeks after the WHO conference. The general policy note of the minister presenting the project refers to the WHO and its 2001 report in the introduction. Reference is also made

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<sup>7</sup> [www.rudydemotte.be/communiqués\\_asp/discoursomsfr.doc](http://www.rudydemotte.be/communiqués_asp/discoursomsfr.doc)

<sup>8</sup> Conclusions of the Council of 15 November 2001 relating to the fight against problems linked to stress and depression (2002/C 6/01).

to numerous other documents dealing in particular with the question of care networks. However, the attaché to the minister's cabinet, in charge of following up the Interministerial Conference, points out: *"But the Belgian reports are not a reaction to European reports. But, obviously, these two things go together and just as well. It's clear that with Europe, we have felt the pressure"*. Answering a question on the link between these policies implemented for several years and the WHO, the person immediately spoke about the pressures at European level. While the WHO seems to be a resource that is much more used to establish reforms in the sector, the pressure seems to be coming from Europe: *"At a political level, it's Europe. I don't think that Europe plays a direct role as regards the institutions. There are no regulations obliging them to do anything. But there is a political pressure on the institutions. When they tell us: you have to organise your institution differently, your mental health, then yes."*

An examination of political literature – statements of intent, expert reports, opinions from consultative organs, etc. – rapidly reveals the centrality of a few major themes. It is even more interesting to note that these themes did not arrive all of a sudden in the political arena after 2005 but, on the contrary, had been key areas for reflection in the sector for many years in some cases. Hence the emergence of a new mental health concept conceptualising a broadening of the care, no longer limited to curative care to meet new needs or, more generally, the importance of mental health in global health, an idea expressed by the slogan "no health without mental health", are themes that regularly reappear to justify the need for reforms in the sector. The involvement of the user, intersectoral co-operation, and the promotion of a biopsychosocial holistic approach are also points that are often reappropriated in texts<sup>9</sup> dealing with policies concerning the setting up of networks or the status of those involved on a therapeutic level. Hence, the central theme of de-institutionalisation and setting up networks is not new; it is part of a reflection that has been conducted in the sector since the 1990s.

Following Helsinki, the Minister of Health, ordered the WHO Collaborating Centre, via his public service, FPS Health, to carry out a feasibility study of the implementation of the plan in Belgium. The work was conducted by a multidisciplinary team including psychiatrists, politologists and sociologists, and organised into two major parts. The first one consisted of an inventory of all the actions carried out in Belgium by all levels of power in the field of mental health. According to its authors, the resulting report has never been used, its results being the property of the sponsor. The second part consisted of a series of "validation seminars" whose confirmed objective was to reach a consensus, on the basis of the results of the first part, among a panel of experts, practitioners, and heads from various regions and structures, on the strengths and weaknesses of mental

<sup>9</sup> As an example, readers can consult the "Note politique relative à la santé mentale" by the Minister of Health and Social Welfare, Rudy Demotte, in May 2005 or the numerous advisory notes from the CNEH or the Conseil Supérieur d'Hygiène. More often than not, these texts more or less concern the question of care networks.

health policies in Belgium. Like the majority of people encountered, the various participants emphasised the complexity of distributing the competences in Belgium. As regards expanding mental health to numerous problems requiring global and intersectoral action, this distribution of competences appears to be both a strength and a weakness for the authors of the report and the participants. The multitude of places for discussion and local co-ordination projects involving actors from this institutional organisation seems to be an advantage for them owing to the local innovations it allows, but there are also problems of coherence in the global policy in terms of mental health.

According to the general opinion of WHO promoters in Belgium, and others too, while there are still things to be done, globally, Belgium is not the most concerned by Helsinki: *"In the recommendations, there are many different things, there are some that are very close to those that exist in Belgium and other very different ones. Of course, the elements that are the closest to the way in which we function in Belgium are easier to implement, exist already or, for some things, let's say in Belgium, we are more advanced than the requirements of the Declaration of Helsinki. But in other domains, we are far off, very far off, and there are things which, in order to be applied in Belgium, would require a huge upheaval in policy management or in the very political culture of Belgium, these are really fundamental things. Of course, like in Belgium, we have function by compromise, everything concerning providing possibilities to develop things on a local scale, which are the Helsinki recommendations, focusing on patient needs, integrating a large number of actors, families, etc., these are things that aren't difficult to set up in Belgium because we are already in this process of dialogue, horizontality in a certain way, everything regarding the preservation of the freedom of the actors are elements that can be found in Helsinki and in Belgium. [...] Where it's difficult, is when you have to exceed the local level, step outside your segment, there, the partners become more difficult to implement, the generalisation of projects and I would say that the biggest disadvantage of this way of functioning, is in terms of means. [...] If you want to set up a major national plan for something, it's going to be difficult to do, we're going to have to count on small local powers".*

Focusing on operating through compromise – which we shall come back to in the last, more analytical part – it is interesting to note that the main shortcoming found by the CCOMS researchers is the difficulty of reaching a global policy. This is the only answer we received when we asked to make a negative assessment of the situation in Belgium compared with WHO standards.

Reinvested in a differentiated way, the Helsinki standards and the problem of their implementation reveal the relative autonomy of the different levels of power.

Federal: The central policy in terms of mental health implemented by this level of power was defined by the previous minister. Contrary to the other levels of power, reference

was made to the WHO several times or, more specifically, to Helsinki. However, these references were integrated into policy projects that had already begun some years ago such as – and interestingly enough – therapeutic projects: a pilot project aimed at developing a model for care networks. At the centre of what is currently happening in the sector.

**French-speaking community:** The policy in terms of preventive medicine and the promotion of health is defined every five years by a five-year programme. Looking at the major priorities, this is proposed by an advisory board composed of actors in the field and experts: the “Conseil Supérieur de Promotion de la Santé”. This plan must then be operationalized by a governmental decision. The latest five-year programme, for 2003 to 2008 and extended owing to elections, provides for a focus on mental health. This priority was not retained by the current minister. Neither the Declaration of Helsinki, nor the green paper led to a specific repercussion on the policy implemented by this level of power. In an even more surprising way, a specialist in public health, and member of the “Conseil Supérieur” stated: “I’ve never heard of Helsinki”.

**The Walloon Region:** The Walloon Region did not implement any particular policy after the Declaration of Helsinki arguing, among other things, that it was not particularly concerned by its contents which mainly concerned issues of health promotion and prevention, competences of the French-speaking Community, the Region being in charge of curative aspects through the ambulatory sector.

The promoters also refer to this important differentiation in the field of mental health in Belgium. The source of a way of functioning through compromise, we shall see in the following chapters how it can also explain why Helsinki has not led to a specific policy in Belgium, though this does not mean that these standards have not been effective. The importance of interorganisational actors will therefore be stressed.

## 5. Analysis

The Belgian political system is characterised by the structuring of civil society into pillars. Traditionally, there are three “pillars”: Catholic, Liberal and Socialist. Constituted according to an ideological basis, the pillars are veritable “vertical conglomerates” (Vrancken, 2002) which, among other things, include political parties, unions, teaching networks, mutual benefit societies, youth movements, and care networks. It is often said of these pillars that they are equipped to support their members “from the cradle to the grave” (Faniel, 2004). Added to a top-down system of supplying services for the State that subsidises them – which explains the high level of unionization in Belgium, with the unions taking care of managing unemployment benefit, for instance – is a bottom-up political representation of the members. Thus, the pillars play a preponderant role in

political life by participating in negotiations at the level of decision-making organs. In concrete terms, the presence of pillars can be seen through the existence of numerous advisory organs in the various sectors. One of the main ones in health is the “Conseil National des Etablissement Hospitalier” (CNEH) which includes the various federations of hospital institutions grouped together on the basis of the pillars. These particularities participate in the act of functioning through compromise – the “Belgian compromise” (Kuty, 2005)

The analysis of decision-making as regards therapeutic projects<sup>10</sup> shows the weight of these advisory organs. Reacting to the de-institutionalisation policies of the 1990s, the CNEH took the leadership of the reform by working on the development of care networks in which hospitals would keep an important curative role. As the CNEH’s numerous advisory notes suggest, it is not unlikely that the recommendations and data from the WHO constituted a resource for the conception of these care networks. However, as the analysis of this case shows, with the numerous loops constituted by the Government’s requests for advice from the CNEH, or other advisory organs and the work of the Interministerial Conference, decision-making in Belgium in terms of health as in other sectors, is never or rarely unilateral but the result of a compromise. Hence the existence of numerous pilot projects, the proliferation of procedural policies that the authors of CCOMS emphasise as strengths and weaknesses.

The failure to act on a federal level in relation to Helsinki can certainly be explained by the change of government since the elections in June 2007 and the community crisis, followed by the economic crisis which, since then, has taken up much of the authorities’ attention. However, it would have been surprising, in Belgium, even in the case of an extraordinary political activity due to the drama in Termonde, to witness the approval or the implementation of a public action programme in response to the Declaration of Helsinki by a political cabinet or governmental agency.

However, the federal minister, his cabinet and his public service was not completely deprived of the capacity to take initiative. The importance for the members of CCOMS and this small network of people linked to the WHO, to have good relations with the minister is, in this case, particularly interesting. The conditions in which CCOMS was created bears witness to this. First of all, we can see from the manner in which one of the founders tells us of its creation, in the background, this temptation to manage the sector technocratically, where a minister makes his informed decisions according to several well-advised scientists. As Jacob and Genard assessed (2004), this management model is perhaps typical of an era – the “Trente Glorieuses” – in which a programming process<sup>11</sup> was supported by a State which held the majority of expertise. However, the

<sup>10</sup> VRANCKEN (D.), SCHOENAERS (F.), MELOTTE (A.), 2009

<sup>11</sup> Regarding the history of the mental health sector in Belgium and the programming process with the development of the Welfare State in the 20<sup>th</sup> century, see DE MUNCK et al. (2003).



technocratic temptation remains, even if the circumstances no longer seem to allow it. The career of a civil servant linked with the WHO, such as it was related to us by one of his colleagues was, in this case, exemplary. Too proactive and too directive, he was dismissed from his post *"because he did not facilitate things"*. On the other hand, the correct attitude to adopt, as recommended by this same person is just as interesting: *"I am a facilitator, I can make the most of a network of expertise but only if I'm asked to. I won't impose anything, I'll wait until I'm asked. You have to be grown up about it."* However, we should not be mistaken by this passive attitude, however directive; he nevertheless frequented the political cabinets in order to "interest" them in a reform: *"To work properly, you have to be in a political cabinet. But beware of changes in ministers. We've 'had it' in the current state of affairs. Now Demotte (the former minister) can no longer commit himself"*. The situation in the coming sector could have been a chance to verify our hypotheses. However, the reforms in progress and the implementation of care networks provide information on the manner in which decisions are taken in Belgium. Governmental action seems to reside in the requests for advice or operationalization in different advisory organs with a view to establishing a policy in which the latter are involved. Seen from this angle, the political power in Belgium seems especially to be a "mobilising power" (Kuty, 2004).

The ineffectiveness of these recommendations can also be explained by another factor. According to several heads, including the cabinet's advisor who follows the Interministerial Conference, the main problem indicated by international organisations is the excessive number of hospitalised patients in Belgium. *"Every time, we got the reaction that we psychiatrise too much, we've too many beds. We're singled out on a European level: what are you doing here? It's the WHO, it's also the Helsinki report... There are plenty of activities on a European level where we were told we had to change every time"*. And yet, in response to these orders, we know that the CNEH participated in the implementation of care networks in which the hospitals would have a concrete role. The theme of de-institutionalisation is very sensitive in Belgium and in this climate of rationalisation – since the State is sensitive to economic arguments –, the lifeblood of the sector can be even more attentive.

However, we should not deduce that because the Declaration of Helsinki has not led to any specific policy that it has not had any effect. This remark must, however, be aligned with the nature of this instrument constituted by Helsinki. The Helsinki promoters encountered do, indeed, share the opinion that it would be useful for the WHO or the European Union to have a more directive approach based on the distribution of indicators allowing a more direct assessment of public action evolutions in mental health. The result of a compromise, according to them, the Declaration of Helsinki reveals its shortcomings through its imprecision: *"There are many utopias in Helsinki. We'll never get there. It's formulated in far too vast a way. It's often too much of a 'slogan', it's not operational. There are much more revealing indicators to see whether we are progressing"*.



In this sense, the Declaration of Helsinki does not constitute a clear guide for action. While it creates the adherence of the majority of actors, they nevertheless do not grasp the direct usefulness or exact reach of it. While they often emphasise that they are not against what is being done in Belgium, the Helsinki plan is no less a resource for action: *"We've already spoken about it among colleagues, we have already said several times that we need to hold a meeting to see what we can do about Helsinki. There are already a fair number of activities associated with these recommendations but we need to think about what we can do about it"*. In this more imprecise case, or concerning other more directive points, such as reducing the number of hospitalised patients, the WHO recommendations do not seem to provide univocal action guidelines but rather a form of support, a resource for the search for "possible worlds" (Callon et al., 2001).

## 6. Conclusion

The analysis of the relations between Belgium and the WHO suggest that we should move away from a hierarchical political model with a "top-down" influence. Providing resources for the definition of new policies and a certain legitimacy to maintain these issues on the agenda, the resulting influence seems to occur through far more sinuous and slow routes, requiring an intense activity of translation into local sectoral stakes. On the other hand, the European Union seems to provide less cognitive resources than pressures for change.

Several observations allow us to establish this fact. First of all, the people associated with the WHO all spontaneously stress the profound consensual nature of such declarations. The toing and froing ensured by the "National Counterpart" between the WHO and the Government is also interesting in this matter. The WHO does not seem to be able to adopt an overly directive attitude as a former WHO expert explicitly asserts: *"In this case, the minister might reply: 'They're not going to tell us how to organise our care'."* Secondly, the participation of Belgium in the Declaration of Helsinki is also enlightening. Although there has been no wide-scale policy, according to the actors in the sector, the conferences held in 2001 have, nevertheless, had a minimum effect of putting the issue of suicide on the political agenda. Taking advantage of the dynamics created between a number of actors linked to the WHO, Belgium will hold a stance on the matter at the Helsinki Conference.

Deprived of legal constraints, the WHO seems to exist in Belgium through a network (Thatcher, Le Gales, 1995) of actors that relay information among the various actors in the sector. This small interknowledge community manages to collaborate at various levels according to the current climate and moments which open up – or not – the doors of the ministerial cabinets. Dependent on relations with the competent ministers, this network is also led by heterogeneous dynamics according to which community they belong. Founded by uniting members of philosophical and different linguistic communities, they

nevertheless manage to affect actors at numerous levels. Since they hold a variety of positions at a national and international level but also in local projects, they can also be the relays of knowledge produced and distributed by the WHO, even in concrete practices. We must therefore take an interest in these local projects, which reappropriate these recommendations through associations or external actors. Whether they are therapeutic projects, users' associations or pressure groups, the analysis of this reappropriation and the dynamics which convey the information to more global positions through advisory organs or assessment mechanisms, is likely to enrich our understanding of the role of knowledge in the reconfigurations of public action. The study of these "strange loops" (Lascoumes, 1994) will thus fall under the scope of a perspective that takes into account the role played by all the "stakeholders" without, however, focusing on the political elites alone and the highest spheres of the State in accordance with the approach in terms of public action (Musselin, 2005; Commaille, 2004). Hence, this approach is likely to clarify the role of the "brokers" or the "marginal secant" (Crozier, Friedberg, 1977) of these people situated at the intersection of several social systems, but also the integration of this knowledge in local public action systems (Lascoumes, 1996).

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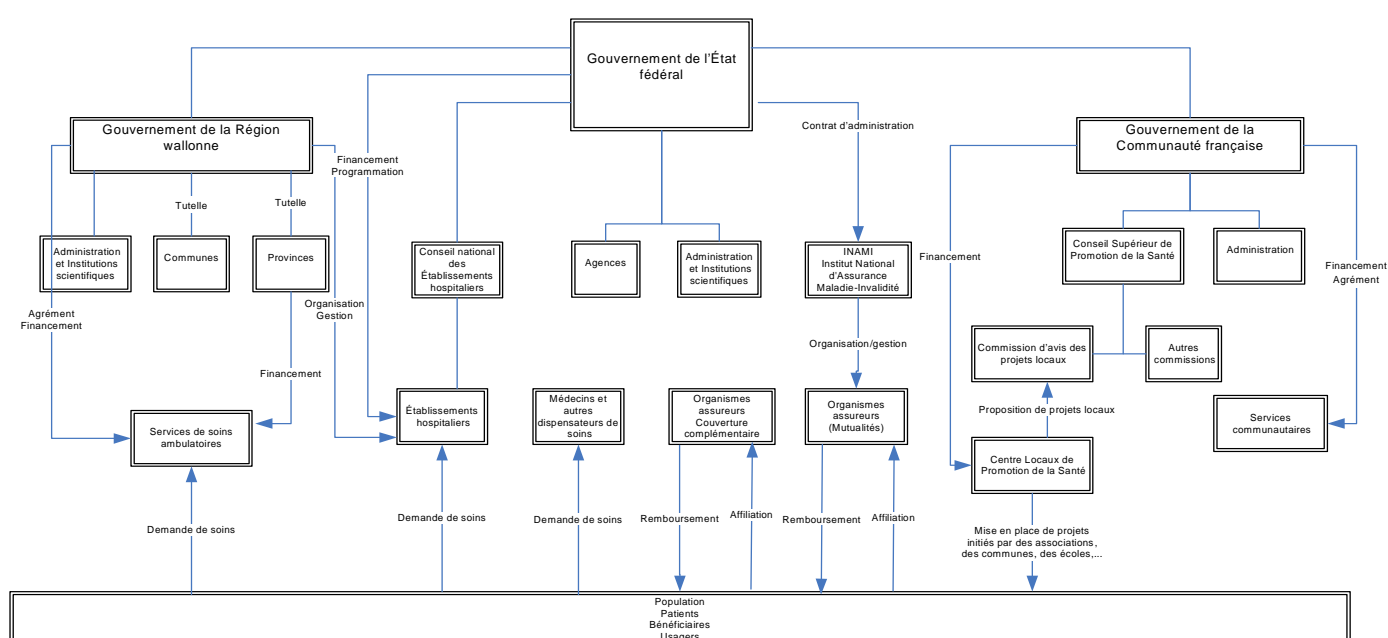
Speech by the Minister of Health, Rudy Demotte, at the "Journée d'étude organisée par Christel Geerts au Sénat [sur] le suicide chez les personnes âgées". [www.rudydemotte.be/communiqués.asp/discoursomsfr.doc](http://www.rudydemotte.be/communiqués.asp/discoursomsfr.doc) (Consulté le 13/02/09)

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## Appendix 1: Organisation of the mental health sector in Wallonia

### Health Sector in the Walloon Region Secteur de la Santé en Région wallonne



## Appendix 2: Methodological note

The majority of the present report is based on a double methodology. Initially, we studied the legislation and the debates held at the Senate and the Chamber of Representatives. For this purpose, we used the following official search engines:

[http://www.just.fgov.be/index\\_fr.htm](http://www.just.fgov.be/index_fr.htm)

<http://www.dekamer.be/kvvcr/index.cfm?language=fr>

[http://www.senate.be/www/?Mival=/index\\_senate&LANG=fr](http://www.senate.be/www/?Mival=/index_senate&LANG=fr)

This documentary research was completed by a second one among the numerous research reports and opinions published by advisory boards, universities or NGOs involved in mental health.

Secondly, we conducted a series of semi-directive interviews with key actors. These were completed by those conducted during the preceding phases, when the theme of international relations was dealt with. The research we conducted is therefore based on a qualitative and inductive methodology.

The following list includes the interviews used for this report:

CCOMS	Co-president	Interview
CCOMS	Researcher	Interview
Cabinet	Attaché	Interview
FPS "Health"	Assistant Director – "National Counterpart"	Interview
French-speaking Community	Academic member of the "Conseil Supérieur de Promotion de la Santé"	Interview
Institut Wallon de Santé Mentale	Director	Interview
Psytoyens – Federation of users' associations in mental health	President – Co-ordinator of and participant in the CCOMS "validation seminars" – Head of "participation".	Focus Group