support the development of the sector, for example in the context of the National Healthcare Project and the National Development Project for Social Services.

Despite the autonomy of municipalities in arranging services, a large number of municipalities have adopted central government recommendations on mental health and interventions promoting mental health for children. Efforts are under way to tackle regional disparities in service availability.

At the same time, population ageing and the need to encourage a longer working life have raised the profile of good mental health as integral to people's capacity to lead active and rewarding lives.

Reference

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COUNTRY PROFILE

French psychiatry

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Until very recently France was ranked second in the world in terms of the per capita provision of psychiatrists (nearly four times higher than that in the UK, for example), with, at its peak, about 13 500 psychiatrists for a general population of some 60 million.... There is also a marked geographical disparity: the population density of psychiatrists is 10 times higher in Paris than in the north-east of the country.

French psychiatry is currently facing a period of profound change, as many of what were considered its most specific characteristics and traditions have been called into question. It is therefore difficult to draw a profile of French psychiatry, because it has to take into account a radical splitting between, on the one hand, what is still the common profile of most French psychiatrists and, on the other, the new model imposed by stakeholders and policy makers who want French psychiatry to take on a more Anglo-Saxon profile, with evidence-based practice coming to the fore, for instance.

Staffing

In this context workforce issues are becoming a major concern for French psychiatrists. Until very recently France was ranked second in the world in terms of the per capita provision of psychiatrists (nearly four times higher than that in the UK, for example), with, at its peak, about 13 500 psychiatrists for a general population of some 60 million. Nevertheless, around 20% of public hospital positions remain vacant, which reflects a growing preference for private practice. There is also a marked geographical disparity: the population density of psychiatrists is 10 times higher in Paris than in the north-east of the country.

Most stakeholders wish to correct the French figure for psychiatrist density. There is a trend to reduce the number of all types of doctor to the European average, but psychiatry is particularly affected in this regard, and since 1990 the number of psychiatry students has dropped by 37%. Accordingly, the number of psychiatrists will be 40% lower in 2020. If there is no significant increase in the number of psychiatric students, or if psychiatrists' freedom to choose their type of practice is maintained, the present disparity in the provision of psychiatric resources will be exacerbated, and a large part of the French population will have very limited access to psychiatric services.

The same disparity also exists for allied professions: France has 58 000 nurses working in psychiatry. Their number is set to decrease with the recent termination of a specific psychiatric nursing diploma. There are also 35 000 psychologists and psychoanalysts, but for historical reasons they are still not officially considered health professionals (the idea was opposed by both medical and psychological organisations for ideological or economic reasons). The psychologist's role in both the public health sector and private practice is limited, because it is not recognised by the national social security system.

Education

In France, psychiatric specialisation follows a 4-year national diploma programme, which is open to students who have passed the 6-year general medicine programme. Access to medical schools is very tightly regulated. These training programmes are offered by at least one public university in each of the country's 12 regions. At the end of the programme for general medicine the number of positions available for each specialty is decided nationally; for psychiatry (including child and adolescent psychiatry) this number has been recently increased slightly, to 200. Medical students choose their specialisation in accordance with their rank in a national competitive examination at the end of the programme for general medicine.

The specialisation programme includes 4 years of residency training in psychiatric wards with at least 1 year in child psychiatry for future general psychiatrists and 1 year of general psychiatry for future child psychiatrists. Each student has to take a number of 'education units'; most are optional and particular to each university, but some are compulsory, including diagnosis and treatment using different techniques and theories. At most universities this allows prominence to be given to psychotherapeutic techniques and theory, especially psychodynamics and

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psychoanalysis. However, there is no specific training in any of the psychotherapeutic techniques, the specifics of training being left to each student to choose, through non-governmental scientific associations. Most of the psychiatric wards receiving residents give them supervision for their psychiatric practice rather than specific training in a particular psychotherapeutic technique. There is currently a debate concerning which psychotherapeutic techniques should be included within undergraduate training, and which of the scientific associations should be involved in it. The strength and diversity of French psychoanalytic movements (Freudian and Lacanian) add to the complexity of the problem.

Mental health policy and programmes

French psychiatry is also facing a crisis over the organisation of its public mental health services. This organisation is still very much based on *le secteur*, the division of the country in *géo-démographique zones* of 60 000–80 000 inhabitants for general psychiatry, and of 150 000–200 000 inhabitants for child and adolescent psychiatry. Within each sector a multi-disciplinary team is in charge of all the mental health needs of the population, from prevention through to rehabilitation and different treatment modalities (from ambulatory consultation to in-patient units or day care), under the direction of a psychiatrist. Private hospitals in psychiatry are not very numerous compared with other developed countries. They are generally used for less severe or less acute disorders and for patients of higher socio-economic status, even if in most cases they do not cost patients more because the national social security system reimburses much of the expense.

This sectoral model is valued by most public psychiatrists, who see it as well adapted to the treatment of patients with a psychosis, especially in reducing the burden of chronic psychosis. It has allowed the modernisation of hospital treatment, which was once limited to old asylums.

The problem is that the public service is required to take charge of an ever-growing range of problems, many of them worsened by the disengagement of social agencies with the end of the welfare state model. As a consequence, most of the *secteurs* are no longer able to give adequate attention to many psychiatric patients, either because of waiting lists for ambulatory early treatments or because of a drastic shortage of psychiatric beds (a reduction of 41% between 1987 and 1997, with the mean length of hospital stay dropping from 86 days in 1989 to 52 days in 1997). There has been a corresponding decrease in the medical supervision of psychiatric in-patient units and an increasing use of compulsory and urgent hospital admissions because they are becoming the only way to obtain a bed in overbooked public hospitals.

The future of the sectoral system is therefore being debated and new trends are emerging to try to improve its functioning:

- complementarities between the sectors need to be recognised to take into account the specific psychiatric needs of, for example, the homeless, elderly, emergencies, adolescents and young adults, and infants
- network strategies are needed for specific pathologies (sexual delinquency, schizophrenia, bipolarity, eating disorders, suicidality, etc.)
- rehabilitation programmes are required for the patient with chronic impairment in collaboration with specific social non-psychiatric public or private agencies
- better links with users and their associations are needed.

Legal issues

The French Mental Health Act gives priority to medical considerations and a limited role for judicial power in respect of compulsory hospitalisation. When things are working properly, priority is given to the psychiatric aspect of the hospitalisation needs of the patient. With the reduction in hospital resources and the growing need to protect users from medical abuse, this model has to be revised, at least in some respects. The Health Democracy Law passed in 2002 increased the power of users and of users' associations, and has given them the right to be informed and to have free access to their medical files.

Nevertheless, since 1992, under a new law governing compulsory hospitalisation (the French Mental Health Act of 1990, which replaced La Loi de 1838, written under the influence of Esquirol) involuntary hospitalisations have nearly doubled (even if these still represent no more than 13% of hospitalisations in psychiatry). At the same time, the number of mentally ill prisoners has never been so high, partly because of a growing tendency to limit the use of sentence reductions for psychiatric reasons.

To deal with both these problems and increasing public concern, special units for dangerous patients were recently developed, changing the type of relationship between psychiatric wards and penal institutions for these patients.

Scientific issues

Most French research and publications in psychiatry are based on clinical studies. Standardised research studies based on evidence-based methods are still relatively rare. For this reason French psychiatric literature has a low international impact factor. Linguistic considerations may account for some of this under-representation but most of it arises for both theoretical and material reasons.

The French psychiatric tradition values a global, humanistic approach rather than a symptom-focused

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one. It rejects theoretical reductionism and, as a consequence, is hesitant to adopt the methodological reductionism required by standardised evidence-based approaches. Many French psychiatrists consider that this type of approach is an artefact and does not account for psychiatric subjective reality. The same sort of ambivalence appears when one looks at nosographic issues: most French psychiatrists consider DSM–IV to be a purely research classification that is inadequate for clinical work, and which therefore serves to increase the split between research and clinical reality.

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French psychiatry is relatively under-resourced in terms of research. There is no specific research institute in psychiatry comparable to the Institute of Psychiatry in London. There are twice as many researchers at the Institute of Psychiatry as there are in all of France, despite the density of psychiatrists being, nationally, four times higher.

Epidemiological and outcome studies as well as aetiological research are thus relatively rare in all psychiatric fields. However, things are changing, with young psychiatrists placing a growing value on publication in international journals with a high impact factor (i.e. in English-language journals) for academic advancement. Genetic and cognitive work on schizophrenia, autism, eating disorders, bipolar disorders and borderline personality disorders is currently emerging but has yet to be published.

The abundant French-language literature contains valuable theoretical and clinical work on infant and adolescent mental health, bridges with social sciences, attachment and separation theory, developmental approaches in work with children and adolescents, the therapeutic alliance and community treatments. Much of this work adopts a psychodynamic perspective and refers to psychoanalytic or phenomenological psychopathology. Current leading topics are psychodynamic and cognitive approaches to schizophrenia and borderline personality disorders, and psychodynamic and systemic approaches to addiction, eating disorders and infant–mother interactions.

Professional organisations

Another specific feature of French psychiatry is that there is a division between psychiatric scientific organisations and the professional 'syndicate' bodies. Another uncommon feature is the number of these organisations. French psychiatry has nearly 40 active scientific associations and six specific syndicates. Syndicates are related to different types of practice, whereas the scientific associations were established on the basis of theoretical differences or are closely linked with one of the syndicates. The associations are of unequal importance: some have fewer than 100 members, whereas the larger ones have nearer 2000; some are of historical or symbolic value, but others are directly dependent on a syndicate; some issue a journal whereas others do not; some have only an annual scientific meeting, whereas others have monthly business or scientific meetings. None the less, all of them are federated on an equal basis in the French Federation of Psychiatry (FFP), which was created 10 years ago to try to overcome the weakness of such divided psychiatric scientific representation. International representation is still quite scattered, however. Six of the French scientific associations are members of the World Psychiatric Association (WPA) – the French Association of Psychiatry, the Psychiatric Evolution Society, the Medico-Psychological Society, the French Association of Psychiatrists of Private Practice, the Psychiatric Information Society (public sector psychiatrists) and the French Society of Expression Psychopathology – but it has been impossible to unify this representation under the FFP banner, and French psychiatrists are still rather under-represented in the WPA, as they are in most international and even European psychiatric societies.

SPECIAL PAPER

Earthquake in Pakistan and Kashmir: suggested plan for psychological trauma relief work

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On the morning of 8 October 2005, Pakistan and Pakistani-controlled Kashmir were hit by an earthquake that measured 7.6 on the Richter scale. Within 5 seconds, almost all buildings in two major cities of the north were destroyed: the capital of Pakistani-controlled Kashmir, Muzaffarabad, and Balakot, a picturesque mountain city. This was about 9 a.m. Children were in classrooms and mothers were doing household chores. Many men were in the fields. Therefore, when houses

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