From asylum to "secteur" and beyond: the rhetoric of the "psychiatric crisis" in France and the case of "Units for difficult patients"

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Introduction

While French public psychiatry on the whole has dealt with a long-lasting crisis involving a redefinition of community mental health care, and the doctor/patient relationship, specialized hospitalization units for difficult patients (UMDs) are experiencing a crisis of a different kind: they need to reform their functioning to fit with what "taking care of the dangerous mentally ill" means today.

Based on research of such a structure, I will look at the imaginative processes that the resolution of this latter crisis involves. I argue that through the description of two processes -- turning old tools into new ones, negotiating a position toward the regular hospitalization units -- we can learn more about the current state and evolution of French psychiatry's model and norms.

I will first briefly present the overall context of French psychiatric care today. I will then discuss how the staff of an UMD reframes dangerousness and has adapted its functioning to make it a "modern" institution. In a last part, the paper explores the paradoxical relationship these units have with community psychiatry by focusing on two core components of its functioning, "having time" and "being numerous".

How are the "units for difficult patients" back on the scene of modern psychiatry?

In 2008, a young man left the hospital unit where he was involuntarily committed, and randomly killed a student in the street. A few days later, while visiting a psychiatric hospital, the French President Nicolas Sarkozy announced a set of measures that were designed, in his words, "to avoid this drama from happening again". These measures, along with the ones that were introduced after the killing of two nurses in a psychiatric hospital by a former patient in the year 2002, aimed at protecting society from the risk of violent and unpredictable acts committed by people with mental illness. On the one side, security in regular hospital settings was reinforced, especially regarding involuntary committed patients. On the other, the development of closed units designed for individuals with mental illness and presenting a risk of dangerousness was planned.

Many psychiatrists strongly criticized this whole set of measures. In their argument, to promote security and closed units amounted to going backwards by emphasizing psychiatry's role in protecting society from the dangerousness of mental patients instead of focusing on the provision of good community care, meant to prevent such events from occurring. Critics of these measures were drawing on the rhetoric of the "crisis of psychiatry", a recurring one in the past decades in France[1].

The French organization of public mental health care is called "secteur". This name refers to a comprehensive organization of psychiatric care where all the services (hospitalization, community mental health centers, day-treatment programs, supported housing and rehabilitation programs) are integrated and managed by one head psychiatrist. Each set of services is designed to serve all the individuals who reside in a given territory who need mental health care. Historically, this model was developed in the second half of the 20th century and was rooted in a critique of the asylum as a model of care, similar to those in other Western countries[2].

Following the tragic events of 2008, the main unions of public psychiatrists argued that the focus should be on the deinstitutionalization process and its consequences, namely the implementation or reform of "the secteur". In these debates, "the secteur" is used in ways that are sometimes contradictory. On one side, it is the site of the many problems identified today in French psychiatric care. The most commonly evoked are the shortened duration of hospitalization and the lack of hospital beds, as well as the understaffing of both hospital unit and community services. Also criticized are the fact that this organization of care was implemented very slowly and unevenly - on key aspects such as the coverage of the territory -, as well as the fact that, even today, it designates quite heterogeneous practices. On the other side, when studying the debates about French psychiatric care, it appears that the term "secteur" has also become what a French historian of psychiatry calls a "key-concept"[3], in the sense that it is used constantly as a reference of "good care", while there is no real consensus about its definition. At best, a number of values are commonly attached to "the secteur", values which are considered as endangered today. These values are its public nature and more specifically the intervention of the state in mental health care, which have been strongly defended since its beginnings. Values also include the free access to, and continuity of care, as well as the comprehensive array of services[4]. Thus, when discussing the crisis of psychiatry today, the "secteur" is both criticized for not functioning well and praised as an ideal care model.

Yet, the political answer to these events was not to address the possible problems of the "secteur"; rather it emphasized the failure of psychiatry regarding its mission to protect society from risk. It also identified this 'protection' as synonymous with the confinement of dangerous mentally ill individuals by

[1] Coffin J. C., "La psychiatrie par temps de crise", *Etudes*, 2009

[2] Both humanism and psychoanalysis were strong influences for the psychiatrists involved in sectorization. Among the specificities of the French "secteur" has been the concern to reform the hospital rather than to reject it

[3] Coffin, *op.cit.*

[4] Coffin, *op. cit.*

removing them from life in society. This confinement was to be achieved in psychiatric units defined as "experts" in dangerousness.

Units specifically designed for dangerous mentally ill patients have existed in France since the beginning of the 20th century. They are called "units for difficult patients" (UMD). Among the measures announced to address "difficult patients" was the decision to double the capacity of these units. There are currently five such units in France, representing 400 patients. Only 10 percent are women. According to the 1986 text that officially named and defined theses units, they are designed for involuntary committed patients who present "a dangerousness which requires care in special settings". Although they also receive forensic patients, at various stages of the judiciary process (awaiting legal expertise, irresponsible for reasons of insanity, partially responsible and awaiting trial) and some inmates needing psychiatric hospitalization and considered dangerous, most (80%) of the inpatients come from a regular hospitalization unit where they have been violent, usually toward the staff, and are considered unmanageable. Upon admission, the referring unit is under obligation to take back the patient when he is discharged.

When these units were designed, they were modeled after the asylum, then the main mode of psychiatric care. With its functioning based on discipline, closure and control, they seem to have been relatively unaffected by the development of "the secteur" and its new norms. Yet, when the decision was made to double their capacity following the events just mentioned, they were advocated for by their supporters as offering a "modern intervention" specialized in one area of psychiatric care: dealing with the dangerous mentally ill. The development of units specifically designed for dangerous individuals can thus be understood either as the comeback of an old and backward management of mental illness, or as the opportunity for a targeted and specialized intervention. How can these units be both backwards and modern? How are they compatible with the rhetoric of "the secteur" as a model of care? These are the two questions I would like to explore using data from fieldwork I have been conducting over the past few months.

What is outdated, what is up-to-date?

<u>An old-fashioned institution…</u>

The "unit for difficult patients" where I am currently conducting fieldwork was the first of its kind to be created, a hundred years ago. It is constituted by a group of five wards enclosed by a high wired fence situated on the premises of a psychiatric hospital. Each ward has its own garden and is secured by a fence. Inside the ward, the spatial configuration and the daily routine ensures a strict control of the staff in terms of both the circulation and the behaviors of the patients, who are permanently under direct surveillance. The right to communicate with the outside, including with family and to receive

visits, is subject to hospital authorization and monitoring. The daily routine plays a central role in the control of the patients. Here is how a psychiatrist describes a typical day on a ward, which supports my observations elsewhere in the unit:

"On the ward, the life rhythm is very ritualized. Patients are in their [locked] rooms from 7.30 pm to 7.30 am. Then they get out for the obligatory shower, then they eat, they take their meds, then they stay in the dayroom for two hours, then they take their meds again, they eat. After that comes the nap, for three hours, in their room, locked, then they get out, take their meds, eat." (UMD's psychiatrist)

In this very controlling environment, the treatment model is explicitly based on discipline and behavioral adjustment. What is expected of the patient is that he complies with the rules imposed by the staff, which includes following the daily routines and taking medication. Another central component is for the patient to recognize and criticize the acts of violence that justified his admission. In return, the level of control and restriction will be lowered. At any time, though, a deviation or a resistance will result in an increased level of control. The use of the seclusion room and of physical restraints is a common response to "inappropriate" behaviors. These "inappropriate" behaviors include a wide range of 'deviance': insulting people or physically assaulting them as well as not properly waiting in line to take one's medication or stealing cigarettes from other patients.

The logic of the treatment process appears in the circulation between wards for male patients. Recently admitted patients enter the first ward, where they spend the first two weeks in a seclusion room, under observation. During their whole stay in the first ward, they wear hospital clothes, eat with plastic spoons and keep no personal belongings in the room. As soon as the patient presents no behavioral issues and complies with the treatment, he is admitted to the second ward, where he will be allowed some personal clothes and belongings, eats with regular forks and sometimes participates in activities. When considered "stabilized", the patient will enter the third ward in order to get used to – and tested in – an environment that is much more similar to the hospital unit he will eventually return to.

<u>… working on new areas of expertise</u>

This description could lead to envision the "unit for difficult patient" uniquely as a site of direct discipline and control, thereby assimilating it to "old-fashioned" means and goals. Yet, other elements contrast with this vision and lead toward the definition of the UMD as an up-to-date psychiatric unit. For example, when defining the treatment process, care providers, and particularly psychiatrists, rely on at least two other dimensions besides the behavioral one, which is clearly dominant. The first is the development of an expertise in pharmacology. Psychiatrists, and particularly recently appointed ones, aim to find an adequate medication for the patient as one goal of the stay at the UMD. The setting is considered particularly appropriate to pharmacological exploration for various reasons. The extended duration of the patient's stay allows the psychiatrists for more trials and errors of different molecules

with a longer period to observe their effects. The possibility of a close monitoring, through sufficient staffing, allows trying medication with potentially dangerous side effects more easily than in a regular hospital unit. Lastly, the practice of stopping medication and starting anew with a different treatment (in what is called "therapeutic windows") is facilitated by the same staffing policy as well as by the controlling environment. The type of patients is also considered appropriate for the development of a pharmacological expertise; a common view among psychiatrists is that the unit receives a lot of pharmaco-resistant patients, who are more likely to commit violent acts as a reaction to their persistent delusions. In the unit I observed, the chief psychiatrist thus hired a pharmacologist to review the patient's medication charts and adjust the treatment strategy. The indication of electroconvulsive therapy as well as the prescription of clozapine, both of which are not commonly used in regular hospital units because of the close monitoring they require, are here commonly discussed and tried.
Aside from pharmacology, another dimension of expertise is stressed by the UMD's staff: the ability to effectively contain and master violence or agitation. The claim to expertise is based on the *savoir-faire* developed by the staff in dealing with such patients over the course of years rather than on specific technical skills.

Depending on which aspect is underlined, the UMD could be portrayed either as a site of "old-fashioned" control, here to isolate and "master" recalcitrant and unmanageable patients, or as a specialized site offering pharmacological expertise as well as specialized behavioral interventions, targeted at clinically challenging patients who present pharmaco-resistance or unusual agitation.
Each one of these options stands in a different relation with the community care model I have described as "the secteur" (and which includes hospitalization). In the first option, the UMDs' therapeutic work, centered on discipline and expecting a behavioral adjustment, bears a strong contrast with the therapeutic work done in the community which rests on the (ideal) goal of establishing a long-term "trust relationship" through which patient and care providers negotiate an acceptable management of the problem identified as the illness (Velpry, 2008a). In this negotiation, the care providers have to continuously redefine the limits of their intervention and decide whether they should "do in the place of", "do for", or "do with" the patient (Velpry, 2008b). This process also implies some risk-taking, in order to assess the patient's capacity to manage. As it appears in the following quote by a UMD psychiatrist, this common clinical practice in community settings is absent in the UMD:
"It is a place where the answer [to a deviant behavior] is always an increase in the level of constraint. It is never the other way around. You never take risk." (psychiatrist)
It is more difficult to determine how the UMD could stand as an "expert unit" in relation to the "secteur". The creation of specialized units – for certain types of patients or pathologies has long been considered to contradict the inclusive conception of "the secteur". First, one should note that a feature of the unit's functioning makes this claim to expertise possible: the fact that they are able to select the

patients they admit among the incoming demands, and that they are assured of the patient's return in his regular unit when discharged. This gives the unit the possibility of influencing the profile of the patients and therefore the definition of their clinical mission. It is also a crucial difference with regular units whose catchments area is territorial.

If we leave the discussion of the models of care to turn to the practices of care in the UMD, the light shed on the relationship toward community care setting will be more paradoxical.

Time and numbers

When conducting observations in the unit and discussing with both staff and patients, having time and being numerous appear like two essential components. They are recurrently and commonly mentioned to characterize the UMD in contrast with other units but also to describe the conditions of possibility for the work to be done.

<u>The means to discipline</u>

"The temporality is different [from a regular hospitalization unit]. Even in a closed ward, you need beds [for new admissions]. Your temporality is different. You don't have time ahead of you. There is a movement. (…) [in the UMD] you have time. You have all your time. The patient bends first, not the institution. There comes a time when they realize that. You feel when they shift" (psychiatrist working at the UMD).

In the UMD, "having time" refers to the fact that the duration of hospitalization can be as long as is required. The current mean duration of hospitalization in the unit is 9 months, which is much longer than in a regular hospital unit. More important than the actual duration, though, is the fact that there is no preestablished limit to the stay in the UMD and that the only criteria for discharge is the patient's clinical assessment. After the patient has been admitted, every six months, experts will clinically assess his current state and decide whether he can be discharged. At any time between two assessments, the psychiatrist or the patient can ask for a new assessment. This decision is supposed to rest solely on the expert's assessment of the patient and his/her clinical evolution and not on external considerations about the management of the unit and of resources. By contrast, in regular hospital units, staff is often asked to secure free beds because of the pressure to admit other patients.

Time thus becomes an asset for the staff in the power relationship they engage in with the patient. As one nurse puts it, "*Time is on our side*". This means that they [the institution] are not pressured and will wait as long as is necessary for the patient to fold and comply. This is reinforced by the fact that the decision of discharge is not taken by the staff in charge of the patient but by an expert committee.

Patients are also very aware of the time leverage. In my discussions with them, it was common to hear that being rejected by the commission meant "*taking it for six more months*". When committed in the UMD, "regular time" is suspended and the rhythm is given by the accumulation of 6-months periods[5].

"Being numerous" qualifies a central staffing policy in the unit: at any time during the day, the threshold is a minimum of four staff members – nurse or auxiliary – present in each 20-patient units, five in the admission ward. When a patient has to be accompanied somewhere, inside the ward – to a seclusion room for example – or outside of the ward, two staff members have to go with him. This policy is strictly respected. During discussions with the nurses and psychiatrists, it is justified by the necessity to ensure "containment". When described by the staff, this "containment" is understood literally – meaning in the commonsensical sense – as the possibility to react quickly to any threat of a violent act and physically contain the patient. It is also used more diffusely as a way to 'make an impression upon the patients' and discourage them to try and repeat deviant acts. Less frequently, a clinical dimension is attached to the term, like when a nurse refers to the necessity "to contain the shattering of personality due to psychosis". The 'containment' that is obtained through having a sufficient staffing thus has two possible frames: it can be construed as a direct disciplinary mean as well as a more elaborate clinical tool.

<u>Do you have to be dangerous to get better care?</u>

"Psychiatrist 1(from the regular unit): It will be a change, to go back to the unit. We will offer you a reassuring structure so that you don't feel like you are going from all to nothing. But you know the unit, there is a lot of circulation, people coming and going.

Patient: Yes, here we are well taken care of ("cocoonés"). One can ask for advice, when one is not well there are people to talk to. In Sainte-Anne [the regular hospital's name], the staff has more work to do, there is a lot of coming and going, it is more difficult to talk. Here one can talk easily while taking care of the garden, planting tomatoes, one can talk while playing games."

"UMD's psychiatris: And to receive the patient and ease the transition, do you have means, like seclusion rooms?

Psychiatrist 1: We have one seclusion room, 25 beds, it is rarely empty. We work in a constant understaffing; of course we don't have the means."

Turning back to regular hospitalization units and community settings, "having time" and "being numerous" also appear central in discourses about the crisis of psychiatry, but because of their lack. Shortened duration of hospitalization and understaffing is a common complaint. The first is a consequence of the drastic reduction of hospital beds, driven by financial arguments rather than

[5] The level of security and control, as well as the discharge procedure are two elements that differentiate hospitalization in the UMD from involuntary commitment in a regular hospital unit.

clinical ones. In the second, psychiatry joins other medical specialties being confronted with a general reduction of hospital staffing. The argument is that the conditions are not met for the staff to provide a care that would fit an ideal model of the "secteur".

Referring to this same model, care providers in the UMD are able to argue that they can give adequate or "real" therapeutic work, precisely because they have sufficient staff and because they are not pressured to discharge for non-clinical motives. This is illustrated in the two exchanges above observed during the meeting following a decision of discharge. Both the patient, in the first quote, and the psychiatrist, in the second, acknowledge that the gap in the means available.

The multifaceted meanings of time and numbers

In the UMD, "having time and being numerous" thus have three meanings which do not always coincide. First, in the UMD, these components (time and numbers) are abundant compared to regular hospitalization units. This regimen of exception is justified by the "special dangerousness" of the patients. In this sense, "having time and being numerous" manifests the distinction[6] of the UMD from other, more common, units.

Second, these two components are valuable and central tools in a therapeutic model that is based on control and restraint as well as on behavioral adjustments. Here, time and numbers are what defines the specificity of the psychiatric work conducted in the unit.

Lastly and maybe most interestingly because of the paradox it creates, having time and being numerous are currently the demanded means to do "good work" in regular community settings. Thus, having these components makes it possible for the UMD to stand as a "Deluxe community care".

Time and numbers participate in the distinction of UMD from regular community care in paradoxical ways; on the one side they are justified by its "special task" (dangerousness) and on the other side their presence defines the UMD in reference to community care "values". They are also incorporated in conflicting care models: a behavioral one, based on direct power relationship and one based on accessing autonomy.

Conclusion

The crisis that the "units for difficult patients" have to resolve today in France reframes an old tension in psychiatry, one which involves its social functions of protecting society and caring for the mentally ill. In the new frame, to be modern means both to distinguish itself from regular hospital units and to build an area of medical expertise. It is thus paradoxical that these units also appear at the same time to be the only ones with the capacity to achieve the model of "the secteur".

On a more political angle, the fact that more financial means – through having time and being in numbers – are devoted to this structure is significant because of the increased attention put on

[6] I am referring here to Bourdieu's use of the term.

individuals labeled as dangerous and mentally ill. This should be linked with the definition in France, in the past ten years, of a new category: "the psychically impaired". Designed for individuals receiving mental health care, this category gives access to benefits and compensations and focuses on community-based mental health services. The new economy of psychiatric care thus comprises on one side, "psychically impaired" individuals expected to live in the community and dangerous mentally ill ones for which confinement is required.

Finally, examining the multiple dimensions of time in a place of exception such as the "units for difficult patients", we can shed a more complex light on this notion in community settings: time is what care providers always lack to do a "good work". In this sense, time is what allows for more humanity. But time is also what gives power to the care provider over the patient.