5

Deinstitutionalization in France

At the end of the Second World War, France's prospects for expanding mental health care were similar to those of the United States, if, perhaps, a little dimmer. The war had devastated the mental health system under the Vichy regime: Between 40,000 and 45,000 psychiatric patients died of famine, which nearly halved the population living in asylums (from about 100,000 before the war). Although the population residing in psychiatric institutions rose over the next few years, very little political and policy attention was paid to the ailing system. Hospitals were at the brink of closure (Bouhallier 2021). By the time American legislators were making an explicit congressional commitment to expanding the public mental health outpatient system in 1963, French policy-makers had only developed a loose set of suggestions for local officials to consider in a 1960 administrative circular.

Yet this initially insignificant administrative circular has more recently gained mythical status as the founding text of one of the world's largest public mental health systems (see Figure 1.1). The document was the first to formally propose the concept of "sectorization," in which the state would supply diverse care services across geographically delimited catchment areas (each of them a "sector"). Although the concept was not immediately implemented, it eventually became the cornerstone of the "French way" of deinstitutionalizing the mentally ill in the second half of the 20th century (Demay and Demay 1982). This alternative approach, however, has received little attention from international analysts. In this chapter, I offer an English-language discussion of the political-economic development of the French case, finding that the mobilization of workers against deinstitutionalization pressures induced policy-makers to instead expand mental health services.

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As I theorize in Chapter 1, a coalition of public mental health workers and their managers was crucial to this expansion of services. An independent and unified organization of the public psychiatrists who supervised hospital personnel – the Trade Union of Psychiatric Hospital Physicians (Syndicat des médecins des hôpitaux psychiatriques; that is, the Syndicat) – served as a critical conduit for public workers' petitions.[1] But that coalition did not form until well after the administrative circular was published. As in the previous chapter, I trace three supply-side policy feedback cycles. Figures 5.1–5.3 illustrate each cycle in turn, and Table 5.2 at the end of this chapter formalizes how the evidence meets methodological expectations.

THE FIRST FEEDBACK LOOP: THE LIMITED DEVELOPMENT OF MENTAL HEALTH SECTORS

Most observers trace the origins of psychiatric sectorization in France to an administrative circular issued in 1960. For confirmation, look no further than the title of a recent 469-page government evaluation report: "Organization and Functioning of Psychiatric Care Resources, 60 Years after the Circular of March 15, 1960" (Lopez and Turan-Pelletier 2017). But the circular, though intellectually significant for its novel proposals, was hardly landmark legislation. Nonetheless, any analysis of the French approach to deinstitutionalization, and its consequently extensive system of state-funded outpatient and inpatient psychiatric care, must begin with this "revolutionary" text (Bauduret 2002). While its authority may be exaggerated, indeed mythical, the circular marks the first time that public managers successfully persuaded government authorities to allocate new funds to the mental health sector in the postwar period. Its

[1] In the language of postwar French health policy, the Syndicat's members were often "*médecins-chefs*" or "*chefs de service*" (and later, "*chefs de secteur*"), a role likened to the "boss" of a "medical fiefdom" (de Pouvourville 1986, 408; Gay 2011, 19; and discussed in personal communication). In general, these physicians could influence the scale and distribution of the health care workforce by requesting additional staff for their specialty area through a national recruitment system. In psychiatric establishments, furthermore, their managerial responsibilities and authority increased, as *médecins-chefs* directed entire hospitals (and sectors). Although nonmedical hospital directors began to emerge in general health care in this period, *médecins-chefs* in psychiatry carried on the roles described in Chapter 3 and retained substantial control over staff through the 1980s (Ayme 1995, 407; Mossé and Tchobanian 1999, 149). This chapter, then, continues to follow the Syndicat as the primary representative of public psychiatric managers as deinstitutionalization unfolded.

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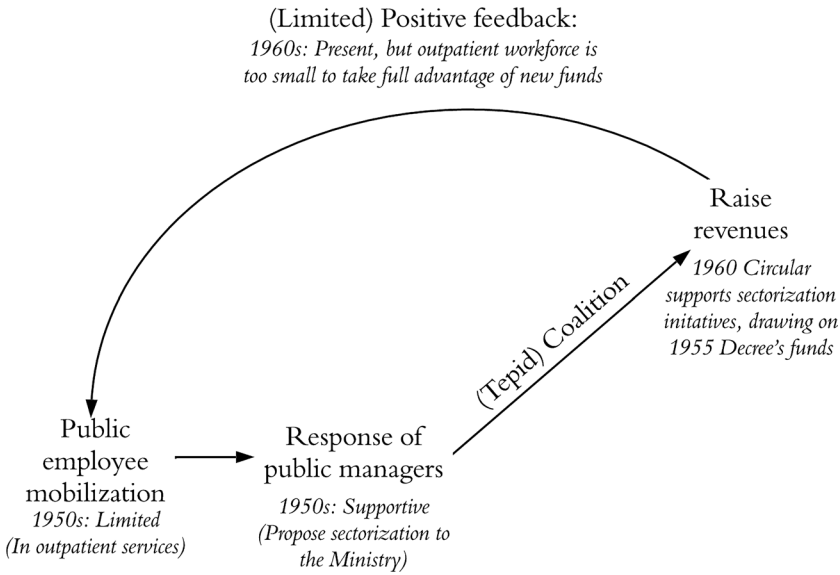


FIGURE 5.1 First supply-side policy feedback loop, postwar French mental health care

full implementation, however, was delayed. As this first (stunted) feedback loop will show, the absence of a coalition between public managers and workers slowed the take-up of funds in outpatient services (see Figure 5.1). Without a robust mental health workforce advocating for more resources for the mental health sector, a generous set of financial supports were left unused for more than a decade.

Public Managers without Public Workers: The Tepid Origins of Sectorization

At the close of the Second World War, both public psychiatric managers and workers had the legal right to organize. Represented by the Syndicat, managers had begun to develop an independent political voice on matters of mental health policy. The Communist-affiliated General Confederation of Labor (Confédération générale du travail, or CGT) and its more independent offshoot, Workers' Force (Force ouvrière, hereafter FO), had begun to organize workers in mental hospitals as well (Bouhallier 2021). But because outpatient services were limited at this time, worker organization remained more limited in that setting, too. As a result, a formal coalition between managers and workers on outpatient public mental

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health services had not yet formed, and this weakened the overall support for expanding and rebuilding psychiatric care after the war.

The relative novelty of the Syndicat, which had only just formed in 1946, also weakened the organization on several fronts. By the late 1940s, a rival group – the Trade Union of Nervous System Psychiatrists (Syndicat des médecins français spécialistes du système nerveux) – had formed to represent private practitioners and neurologists. Moreover, its members voted to affiliate with the Confederation of French Medical Trade Unions (Confédération des syndicats médicaux français, or CSMF), France's powerful medical association that also favored private practice. These private practitioners jockeyed for attention from the Ministry of Health and Social Affairs (hereafter the Ministry), which in turn offered them spots on its advisory councils. In 1949, the Ministry even appointed the founder of the Trade Union of Nervous System Psychiatrists, Dr. Georges Heuyer, as the president of the reformed "Commission on Mental Health" (hereafter the Commission), a consultation body that had until then been reserved for public psychiatrists ("Séance du 24 mai 1949" in AN 19950173/1, 2). In the words of one prominent public psychiatrist, Dr. Georges Daumezon, the move rendered relations between his Syndicat and the Ministry "practically broken" (cited in Ayme 1995, 41).

The Administrative Circular of 1960 Makes Funds Available, If Indirectly, for New Mental Health "Sectors"

Nearly a decade passed without much policy change in public mental health until a personnel change at the Ministry opened a window of opportunity for the Syndicat. A group of bureaucrats sympathetic to the expansion of public mental health services appointed one of its leading members, Dr. Hubert Mignot, as "Technical Counselor" to the Ministry's Bureau of Psychiatry. Dr. Mignot used the opportunity to promote the Syndicat's vision for mental health reform, a concept called "sectorization" that had first appeared in a memo released by the Syndicat in 1947 (Ayme 1995, 51–52; Henckes 2007, 786). Over the following years, the proposals in this 1947 memo had filtered into the Ministry through reports written by members of the Syndicat sitting on the Commission.[2]

[2] See, for example, Lauzier and Godeau 1948 in AN 19950173/1. Note that the Ministry expressed serious reservations about this proposition at the time, such that its authorization of the sectors would have been unlikely without the Syndicat's advocacy for them ("Section technique: Séance du 19 octobre 1948," in AN 19950173/1).

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The Commission's 1955 report on psychiatric hospitals, for example, is particularly illustrative. In the report, the authors advocated for the expansion of government-financed mental health care services (especially outpatient services).[3] They argued that this expansion would equitably distribute mental health services across the territory, a policy frame that Lynch (2020) has shown to be especially potent in France. Drawing on these ideas, the bureaucrats of the Ministry's Bureau of Psychiatry drafted an administrative circular with suggestions for local officials on how to develop their public mental health system. Local authorities were to take stock of their psychiatric resources and design a program in line with the Ministry's new mental health policy vision set out in the circular. With the intention of "separating the patient from his family and his environment as little as possible," a team of mental health professionals would care for the needs of a catchment area of about 67,000 persons.[4] Each of the French *départements* (subnational units) would constitute an overarching "sector," which would coordinate these teams and their catchment areas ("subsectors," *sous-secteurs*).[5] It would be up to the chief psychiatrist for each sector, in conjunction with the director of the local health office, to determine the specific arrangement of services, in accordance, the Ministry presupposed, with population needs (1960 circular, 9). Those *départements* that lacked a chief psychiatrist (a not infrequent occurrence) would assign that task to another official, namely the *département*'s health director.

The 1960 administrative circular recommended, but did not require, that each sector include several types of services. Although expanding hospital capacity was at the top of the list (French officials were painfully embarrassed that the supply of beds in their country lagged far behind the World Health Organization standard at the time),[6] the authors of the French circular also recommended establishing services in each sector that resembled

[3] The 1955 "Rapport sur l'équipement psychiatrique, d'un territoire dépourvu de toute formation spécialisée" was discussed at multiple meetings, for example, December 19, 1955; February 28, 1956; October 27, 1959; October 27, 1959; and November 29, 1959 (AN 19950173/1).

[4] Circulaire du 15 mars 1960 relative au programme d'organisation et d'équipement des départements en matière de lutte contre les maladies mentales. Ministère de la santé publique et de la population, Direction générale de la santé publique (7e bureau), 2–3; hereafter "1960 circular."

[5] I simply will use the term "sector" to refer to subsectors from now on, as policy-makers and professionals began to do over the following decades.

[6] France had 2.1 compared to the WHO-recommended 3 beds per 1,000 population (1960 circular, 6; Ayme 1995, 261).

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those promoted by their American counterparts advocating community mental health: an outpatient mental hygiene center, preferably integrated into a community center that served other social needs (*centre polyvalent*); a day hospital (a service directly inspired by the United States and other countries); a rehabilitation center; and a protected employment workshop.

Moreover, the circular remained agnostic as to whether these services should be public or private, perhaps a response to the protests of private and academic neuropsychiatrists, who disliked its approach.[7] In fact, the circular implied that nonprofit organizations would jump at the opportunity to enter this newly created market: "Day hospitals, re-habilitation centers, protected employment workshops are projects that above all will interest private, not-for-profit organizations, acting in conjunction with mental hygiene physicians at psychiatric hospitals." Nonetheless, the circular continued, "nothing prevents interested local public authorities from pursuing such projects themselves" (1960 circular, 8). Moreover, the circular envisioned the sector as a sort of private–public partnership, whereby private clinical psychiatrists and neuropsychiatrists based in universities could "harmonize" their services with public and not-for-profit actors (11–12).

How did this simple, unbinding document jump-start the first feedback loop and eventually gain mythical status as the founding document of contemporary French mental health policy? Part of the answer lies in its obscure funding source. To support the implementation of its proposals, especially the non-hospital services, the Ministry suggested that actors draw on the public monies made available by the Decree of May 20, 1955 (1960 circular, 1). This earlier document expanded the availability of central government funds for mental hygiene dispensaries from a mere 20 percent to a whopping 80 percent of operational costs, extending the mandate of another policy produced in 1954.[8] Following the enactment

[7] See, for example, the debate between Drs. Heuyer, representing the private and academic psychiatrists, and Bonnafé, representing public psychiatrists, in the "Procès-verbal de la séance du 29 novembre 1955" (AN 19950173/1, 3; also Henckes 2011a, 172). Note that not all in the *Syndicat* immediately supported the sectorization policy. An article written in the early 1960s in *l'Information psychiatrique* "Contre le secteur," attests this reality. However, by the mid 1960s, more than 80 percent of the attendees at an affiliated scientific conference (*les Journées nationales de l'Évolution psychiatrique*, 1965–67) approved a White Paper adopting the sectorization policy (Leguay 2002).

[8] Décret 55-571 du 20 mai 1955 sur la prophylaxie des maladies mentales, pris dans le cadre des pouvoirs spéciaux accordés au Gouvernment par la loi du 2 avril 1955, *Journal officiel de la République française*, 5068–69; Loi 54-439 du 15 avril 1954 sur le traitement des alcooliques dangereux pour autrui, *Journal officiel de la République française*, 3827–29.

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of a law targeting the treatment of alcoholism, the Ministry had developed the dispensary program to tend to the unwelcome disruptions of various "social ills" (*fléaux sociaux*). Indeed, much of the Ministry's initial attention given to mental health was motivated by the special case of alcoholism, but it soon expanded the definition of "social ills" to encompass many other conditions treated in psychiatric hospitals, such as psychosis.[9] Several addendum documents also released in 1955 made it clear that the funds could serve multiple purposes.[10]

Limited Feedback and the "Long Sleep" of French Mental Health Services

Yet the funds allocated by the 1955 decree – though generous and relatively unconstrained during the booming *Trente Glorieuses* (1945–75) – would not be tapped to implement the 1960 circular for over a decade. Indeed, few sectors were established in the 1960s (Benamouzig 2005, 103; Coffin 2005, 238). A needs assessment produced in the following decade noted that fewer than half of the anticipated sectors and their associated administrative infrastructure had been developed.[11] Some analysts have even referred to this period as the "long sleep" of French mental health services (Murard and Fourquet 1975, 195). Looking back on this period, the policy-maker Jean-François Bauduret lamented that "public psychiatry has lost [more than a decade] and has passed up a historic opportunity to rapidly reform itself thanks to a favorable economic context and a flexible and effective financial mechanism" (Bauduret 2002, 2).

The political dynamics of the first feedback loop explain this delay. Although public managers conceptualized sectorization and secured

[9] For documentation of the Ministry's interest in alcoholism, see the records of the Commission des maladies mentales (Archives Nationales) from the early 1960s.

[10] Décret 55-687 du 21 mai 1955 portant règlement d'administration publique pour la détérmination de la part des départements et des communes dans les dépenses d'aide sociale, *Journal officiel de la République française*, 5219–20, Annexe; Circulaire 133 du 4 octobre 1955, Application du Décret 55-571 du 20 mai 1955 Dispensaires d'hygiène mentale (Direction de l'hygiène sociale, 2e Bureau), *Bulletin du Ministère de la santé publique et de la population*, 1955, 395–96.

[11] A letter from the Ministry, dated 1975, claims that only 371 sectors had signed agreements to confirm their status (*conventions de secteur*), of the 737 planned sectors. Moreover, not all sectors had a chief psychiatrist (only 607, according to the letter), only 93 had complied with the expected departmental commitments (*règlements départementaux de lutte contre les maladies mentales, l'alcoolisme, and les toxicomanies*), and only 73 had established the requisite mental health councils (see Mamelet letter in AN 19910084/30/Documents de travail/Sectorisation).

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some financial resources for it, the public mental health workforce in non-hospital services remained too small in the 1960s to exert significant pressure on government to increase expenditures on the sectors. Note that hospital workers did mobilize to protect their employment in the period immediately following the Second World War. Bouhallier (2021), for example, shows how the CGT and FO unions representing employees of psychiatric hospitals in the Seine *département* resisted closures by setting up "defense committees." Moreover, he finds that the support of public psychiatrists for the unions' efforts "undoubtedly influenced" policy-makers, who ultimately conceded. But, for the most part, hospital workers in this period were demanding support from more established funding streams, such as Social Security (see Table 5.1). Employment in the non-hospital sectorized services remained too small to generate robust demand for funds in those alternative settings. It was not until the second feedback loop that the number of workers in outpatient services grew, putting pressure on managers and the Ministry to use the funds made available in 1955 and expand the sectors as suggested by the 1960 circular.

Until then, the 1960 circular remained a marginal document. Many reformers would have preferred a more substantial commitment to public psychiatry from government, perhaps made via order, decree, or even legislation. Instead, they received an unpublished set of guidelines, with some suggested, but undelivered, funds from the 1955 decree. Those funds would prove to be crucial to the expansion of public mental health services. In some ways, the (unintended) founding document of French sectorization is not the Circular of May 15, 1960, but the Decree of May 20, 1955, because of its attached funding resources. Nevertheless, over the following decade neither document was of immediate consequence.

THE SECOND FEEDBACK LOOP: THE EXPANSION OF THE MENTAL HEALTH SECTORS

It was not until the student and labor protests of May 1968 that the situation changed for the politics of mental health care in France. The student and labor activism of that political moment motivated the Syndicat to participate in solidarity movements. When public managers launched an extended administrative strike at the peak of the 1968 protests, government leaders made several concessions that would expand the pipeline of public mental health workers in both inpatient and outpatient settings and augment the administrative and political levers available to public

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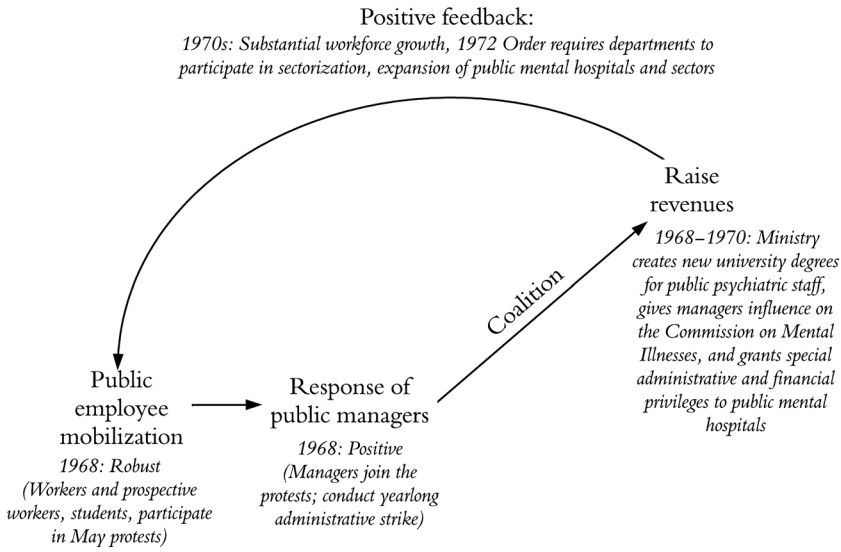


FIGURE 5.2 Second supply-side policy feedback loop, postwar French mental health care

psychiatrists. The subsequent growth of the public mental health workforce, in turn, urged the Syndicat to use these new policy levers to raise revenues for the sectors, positively feeding resources back into the public mental health infrastructure (see Figure 5.2).

1968 Aligns Public Psychiatric Workers and Managers

Prospective Workers Mobilize

The protests of May 1968, though pivotal to the expansion of the public psychiatric workforce in France, remain ingrained in the memories of those outside of mental health as well. Social and economic unrest over the conflict in Algeria, America's growing international influence (especially in Vietnam, a portion of former French Indochina), and labor issues bubbled up as France embarked on its nascent Fifth Republic (Capdevielle and Mouriaux 1988). At the same time, the postwar baby boomers now filled university classrooms, prompting the construction of additional institutions of higher education, the most iconic of which was the University of Nanterre, in the Paris suburbs. In Tilly's (1986, 347) characterization, this "assembly plant for standardized education" offered little in the way of university and research facilities, and even less in the way of future employment prospects.

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It is not surprising, then, that it was at Nanterre on May 2, 1968, that the student protests first took hold, before spreading across the Parisian region and throughout the rest of France. The students would be joined by major trade unions, including the CGT and an emerging Socialist affiliate, the French Democratic Confederation of Labor (Confédération française démocratique du travail, hereafter CFDT), and eventually, by an unprecedented number of white-collar workers and employees of high-technology industries too. By May 13, the anniversary of the Algerian rebellion that returned President Charles de Gaulle to power, an estimated 700,000 marchers were protesting in the streets of Paris (Tilly 1986, 343–47).

Pundits often say that little came of this, the largest demonstration in French history. With an angry declaration of "reform, yes, but chaos, no" (*la réforme oui, la chienlit non*), de Gaulle responded by attempting to reorganize government and its leadership. The following year, he invited French voters to reaffirm their commitment to democratic "participation" via a referendum, even though its purposes and promises remained unclear, not to mention mocked by the public. The referendum was the political disaster that ended a two-year struggle by de Gaulle to reassume power. His replacement, Georges Pompidou (who had served as prime minister under de Gaulle), chose to interpret the referendum as a conservative endorsement for decentralization and local government, hardly the radical revolution championed by the protestors (Gourevitch 1980).

Managers Join the Protests

Nevertheless, these events had important implications for the politics of public mental health care in France: A labor–management coalition formed. Initially, the Syndicat distanced itself from the protests, questioning whether its interests would benefit from the generalized chaos (Ayme 1995, 158). Some – including the Syndicat's most celebrated radical, the institutional psychotherapist Dr. François Tosquelles – entirely refrained from taking part.[12] But as the protests/strikes continued, the Syndicat realized the opportunity they afforded. On May 17, the leadership released a press release to "denounce the government repression of student demonstrations." Criticizing first the "archaic structures of education" that had given rise to the protests, the statement then quickly

[12] His experience of the Spanish Civil War had made him leery of violent protest, so Tosquelles remained at his home in Melun for the duration of the events of 1968 (Ayme 1995, 156).

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returned to its political priorities: "in doing so, [the Syndicat] also denounces the notorious insufficiencies of public health institutions, and of mental health institutions in particular" (Ayme 1995, 159).

The Syndicat's declaration of solidarity with students and workers – broad enough to protect their political independence but militant enough to demonstrate their support – initiated the beginning of a yearlong strike of all administrative duties. While the members of the Syndicat continued their clinical work as physicians, caring for the medical needs of their patients, it was in their capacity as supervisors that they supported the students. Ceasing "all administrative activities" (*tout acte administratif*), they also assembled a national strike committee in charge of organizing local protests that would give the strike a "spectacular and grassroots" (*spectaculaire et populaire*) character. A protest along the Champs-Elysées to the Ministry of Health would amplify their voice further in Paris (Ayme 1995, 182).

Why did the Syndicat agree to form a coalition with workers? Why did it view this moment as a political opportunity? In brief, long-standing challenges to the regulation of hospital psychiatrists' employment could be solved by expanding the public mental health workforce as a whole. To fully understand the Syndicat's involvement in the 1968 protests, one must turn back to a decade earlier, to the law that paved the way for full-time public hospital employment in France. The Law of December 30, 1958, is better known as the "Debré Reform," named for its author, Dr. Robert Debré, a prominent pediatrician from an influential conservative political family. It sought to "rationalize" the country's complex hospital system, boost its research productivity, and promote fairer employment for minorities by offering salaried teaching positions in hospitals located near universities.[13] To top up their salaries, physician-researchers (*universitaires*) at academic medical centers (*Centres hospitaliers universitaires*, hereafter *CHU*) could receive additional payments from patients seeking private consultations, a provision that protected the private practice so closely guarded by the CSMF (CHU Réseau 2008; Rodwin 1982). *Universitaires* could take their public sector salary but still spend significant time attending to privately paying patients in lieu of their other clinical, teaching, and research responsibilities at public hospitals. In other words, the 1958 Debré Reform allowed physicians employed by public (university) hospitals to accept private top-up payments from patients.

[13] As a Jewish family, the Debrés were particularly concerned with the residual anti-Semitism of the Second World War (Dutton 2008; Immergut 1992).

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Importantly, the 1958 Debré Reform excluded psychiatric hospitals, largely to satisfy the preferences of the Syndicat (Ayme 1995). At the time, a young physician interested in a psychiatric career first would need to obtain a graduate certificate (*Certificat d'études supérieures*, hereafter *CES*) in neuropsychiatry, a discipline that combined neurology and psychiatry, before completing their training in a psychiatric hospital. By contrast, those interested in neurological careers would gain their supplemental training at elite universities and later go on to private practice. At the time of the law's enactment in 1958, the Syndicat expressed concern that merging psychiatric hospitals with *CHU*s could bias students toward neurological careers by limiting their training to the university environment. Training in public psychiatric hospitals would, they feared, become obsolete.[14] Few students would learn about the "specificity" of psychiatry, a notion that helped to both build loyalty to their profession and fill vacant positions at mental hospitals.[15] Participating in the 1958 reform effectively meant surrendering this important staff pipeline, and so this carve-out for psychiatric hospitals was obtained. In short, the 1958 Debré Reform made an exception for psychiatry, so that the discipline would not lose too many students to more lucrative careers in neurology (based in university hospitals).

By the late 1960s, the "double remuneration" problem fostered by the Debré Reform had become a contentious policy issue, one that could be resolved in part by taking advantage of the student protests in 1968. The government decided to "complete" the Debré Reform by definitively splitting private and public hospitals, forbidding those physicians in public, salaried positions from taking any private patients. To encourage young physicians to pursue salaried careers, it expanded the number of positions available at *CHU*s. Thus the incentive formed for the Syndicat: By 1968, the government was willing to spend more money on public university hospital employment to end the use of private payment in that setting.

For mental health workers, both the 1968 student protests and the government's willingness to expand public medical employment offered a unique opportunity to create new degrees and positions in both

[14] Note that public psychiatrists also viewed training in university hospitals as "incomplete," precisely because these hospitals did not treat many patients with severe or chronic conditions, contributing to a rival understanding of "mental illness" in that setting. Thanks go to François Chapireau for this point, raised in personal correspondence in August 2023.

[15] Much of Henckes's (2007) analysis centers on the importance of this notion in the development of the French psychiatric profession.

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mental hospitals and outpatient sectorized services. The Trade Union of Psychiatric Trainees (Syndicat des psychiatres en formation) advocated for the creation of a separate *CES* in psychiatry, which would definitively prevent them from competing with neurologists in the existing joint program (neuropsychiatry, see Ayme 1995). A similar mobilization supported the efforts of CEMÉA (Centres d'entraînement aux méthodes d'éducation active), the group responsible for the continuing education of social workers, nurses, and other social professions.[16] Although a state-sanctioned nursing degree (*Infirmier d'hôpital d'État*) had existed since 1920, and a special designation for psychiatric nurses (*Infirmiers psychiatriques*) was added in 1955, CEMÉA had sought to establish a more specialized *Infirmier de secteur psychiatrique* (*ISP*) degree following the circular of 1960. This degree would allow for employment growth in the sector as a whole, not only in the hospital. In sum, mental health workers and their managers seized the moment to propose multiple new training pipelines that would encourage workforce growth in public psychiatry.

The 1968 Agreements Expand the Public Mental Health Workforce

It would not be long before the Syndicat's participation in the strike began to yield concessions, the first of which was a new university degree that would significantly expand the mental health workforce. To appease students' requests, legislators enacted a major reform of the university system in November 1968. In December, Education Minister Edgar Faure ordered the creation of a separate *CES* in psychiatry. This, however, was not enough for the protestors. The prestige of this new *CES* relative to the status quo was unclear, and no efforts had been made to accommodate psychiatric nurses' demands for their own *CES*. The strike continued. It was not until May 1969 that the *CES* for sectorized psychiatric nurses (*ISP*s) was granted, nor until September of that year that the government strengthened, via decree, the *CES* for psychiatric physicians.[17]

[16] Note that interest in psychiatric work among young '68 protesters is also a reflection of the sociocultural changes of the era. As Henckes (2011b, 175) writes, these professionals were "the avant-garde of a new and rising middle class that promoted human sciences and cultural progressivism throughout society."

[17] See Ayme (1995, 168) and with reference to: Loi 68-978 du 12 novembre 1968 sur l'enseignement supérieur (Loi Faure), Arrêté du 12 mai 1969, Décret du 29 septembre 1969.

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These new degrees would boost the pipeline of incoming mental health psychiatrists and nurses. The prestige of the new *CES* remained a significant sticking point. A clause in the decree allowed the *universitaires* to teach in psychiatric hospitals. "It is this last clause that has enraged psychiatric hospital physicians, who had become leery after the many years of domination of their discipline by CHU neuropsychiatrists," reported a 1969 article in *Combat*, a leftist newspaper.[18]

Underlying what Health Minister Robert Boulin called a "doctrinal and emotional" conflict was, of course, an awareness of how these initiatives would impact employment trends.[19] Under the current (1958) law, psychiatrists with research and teaching aspirations had two employment options: the *CHU*, which gave them access to lucrative privately paying patients, or the public psychiatric hospital, where patients were far less affluent and thus these psychiatrists were largely restricted to their salary. The clause in conflict could incentivize psychiatrists to have it both ways (accept private payment in *CHU*s and teach in public psychiatric hospitals), with the effect of depleting psychiatric hospitals of full-time doctors. To express their opposition to the continued "parachuting" of the university physicians out of public psychiatric hospitals, the Syndicat prolonged the strike.[20]

By November 1969, the government had had enough. In a press conference, Health Minister Boulin announced a second concession. To end the strike and resolve the conflict, he would reestablish the Commission on Mental Illnesses, which had been disbanded in 1964. With painstaking attention to maintaining a balance of power, bureaucrats in the Ministry sought to appoint representatives on each side of this public/private dispute. The nomination of the president presented a particular challenge: "It has been customary," the Director General of Public Health, Pierre Boulenger, wrote to Boulin, "that the President alternate between a university physician and a hospital physician." Weighing different options, Boulenger opted to appoint the well-liked hospital psychiatrist Dr. Henri Ey to the presidency and appointed Professor Théophile Kammerer to the vice presidency.[21]

The decision to appoint Henri Ey, "despite his age," to preside over the Commission reveals the desperation of the Ministry. Now in retirement,

[18] "Le conflit en psychiatrie: formation d'une commission des maladies mentales," *Combat*, November 7, 1969.

[19] Ibid.

[20] "Le conflit en psychiatrie;" "Création d'une commission de la santé mentale," *Informations médicales*, November 17, 1969.

[21] Although the civil servants were careful in their appointments, the final composition of the Commission favored the *Syndicat* slightly, perhaps in order to repair relations with

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Dr. Ey's age should have prevented his involvement in government affairs (he was four years past the age limit for public service). Moreover, his ill health made it more difficult for him to participate. But Ey was a unifying figure; once a president of the Syndicat, Ey had maintained an active neurological research portfolio during his career. The appointment of Professor Kammerer, a university psychiatrist with strong ties to the private sector, as his deputy would help to assuage any concerns regarding Ey's lingering loyalty to the Syndicat, of which he was once president (Garrabé 2005).

Although the appointments of Ey and Kammerer would smooth some tensions over the leadership of the Commission, the question of its membership was just as contentious. Particularly "delicate," as Boulenger put it, was the question of representation by members of the Syndicat.[22] Although Boulenger favored the participation of both para-medical staff (social workers, psychologists, nurses) and nonmedical staff (national public servants, hospital administrators), he worried that "if one admits them all, high-level debates would become but quarrels of influence."[23] He suggested, then, extending ex officio (*à titre de droit*) appointments only to select members, while those with a "special competence in mental hygiene" would be appointed in merely "a personal capacity" (*à titre personnel*). Later that year, the Ministry published an order nominating 44 members to the new Commission, nearly all of whom (41) were appointed in this less formal capacity. Only those organizations who had played a prominent role in the former commission were offered ex officio status: the National Committee for the Prevention of Alcoholism (Comité nationale de défense contre l'alcoolisme), the Autonomous Trade Union of Social Workers in Departmental Services (Syndicat national autonome des assistants sociaux des services départementaux), and the Trade Union of Psychiatric Hospital Physicians (Syndicat des médecins des hôpitaux psychiatriques).[24] The strike ended shortly after this announcement.

the strikers. Not only was it presided by Ey, a former president of the trade union, but, in addition, the only physician with an ex officio appointment was Ayme, the current president of the trade union. Moreover, public hospital psychiatrists composed nearly a third of the Commission (14 of 44 members). The ex officio presence of Leclerc as the representative of the social workers' union, furthermore, helped to amplify the voice of other public psychiatric workers as well ("Note pour Monsieur le Ministre" in AN 19910084/28/Réponses à la lettre du 27 mai, 3).

[22] "Note pour Monsieur le Ministre" in AN 19910084/28/Réponses à la lettre du 27 mai, 5.

[23] "Note pour Monsieur le Ministre" in AN 19910084/28/Réponses à la lettre du 27 mai, 5.

[24] Arrêté du 25 novembre 1970: Commission des maladies mentales du conseil permanent d'hygiène sociale, *Journal officiel de la République française*, December 24, 1970.

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Even then, the effects of the Syndicat's mobilization carried into the following year. In 1970, legislators finally enacted a third concession: the Second Debré Reform.[25] By formally splitting public and private hospitals, it forbade all public, salaried physicians from accepting privately paying patients. The public designation was extended to psychiatric hospitals, but in order to preserve the "specificity" promised to psychiatric doctors and nurses, a separate hospital category was created: the Specialized Hospital Center (*Centre Hospitalier Spécialisé*, or *CHS*).[26] To accommodate the projected growth in the workforce, the positions of assistant and adjunct *CHS* physicians were added (Leguay 2002, 11; Ayme 1995). This new designation gave mental hospitals significantly more authority over staff training and the distribution of financial resources. This latitude would make it easier for psychiatric hospital administrators to expand sectorized employment, and therefore services, in the coming decade.[27]

Positive Feedback Continues to Expand the Mental Health Workforce and Sectors

The effects of the 1968 protests and the resulting empowerment of mental health workers were evident at both national and local levels. Consider the Syndicat's strategic use of the Commission on Mental Illnesses to rewrite the terms of sectorization in favor of public mental health workers, exemplifying their use of the "brokerage" mechanism. Following the workforce expansions just initiated (and additional agitation by the hospital psychiatrists, who launched a second strike between May and October 1971), the Commission turned to other mental health policy issues by organizing seven different thematic working groups. One group devoted itself entirely to sectorization, another to personnel (AN 19910084/28 and 29). Now that the Syndicat had ensured that few private or university psychiatrists would serve on these subcommissions,

[25] Loi 70-1318 du 31 décembre 1970 portant réforme hospitalière, *Journal officiel de la République française*, January 3, 1971, 67–73.

[26] Neurology departments remained attached to *CHU*s. In addition, sectors were "consecrated" as training sites for psychiatric medical students, which helped to build loyalty to the concept (Henckes 2007, 628).

[27] Moreover, the law introduced the concept of a national plan (*carte sanitaire*) that would determine the distribution of hospital beds and equipment throughout the territory. The idea cohered well with the territorial logic of psychiatric sectorization (Jaeger in Reynaud et al. 1994; Leguay 2002; Wilsford 1991).

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their public hospital representatives redesigned the Ministry's objectives for the sector. With the help of the Commission, the Ministry released several new documents. The most authoritative was the Order of March 14, 1972, which now required *départements* to participate in sectorization. It was followed by a circular on adult psychiatry that reminded local authorities of the central government funds available (from the May 1955 "social ills" decree) to support the policy.[28]

Most importantly, these documents signaled a shift in tone emblematic of this policy feedback loop. The new circular differed from its predecessor in that it emphasized staff – not buildings – as the core resource of sectorized psychiatry: "Each sector is entrusted to a chief psychiatrist, responsible for a *team* of doctors, social workers, psychologists, nurses, etc." (emphasis in the original).[29] Moreover, the document's annex, "Guidelines Concerning the Sector Team," included an expansive list of professions that should be included in the sector teams: physicians, nurses, social workers, psychologists, even teachers and rehabilitative therapists. This interdisciplinary team would be necessary to "multiply" outpatient services. *Département*-level and hospital administrators were invited to draft a timetable to prepare for the "essential" (*indispensables*) appointments.[30] Over the next two years, a flurry of additional documents and guidelines followed, the last of which concluded that "the years 1972–1973 represented an important stage in the development of French mental health policy."[31]

Throughout the 1970s, medical employment exploded, particularly in psychiatry. As more psychiatrists gained the new *CES* and began new positions as adjunct or assistant *CHS* physicians, they contributed to a ballooning of the number of medical staff at psychiatric hospitals. While the number of psychiatrists in France had hovered around 1,000 in the 1950s, by the 1970s their numbers had reached 13,000 (Cléry-Melin

[28] Arrêté du 14 mars 1972, Modalités du règlement départemental de lutte contre les maladies mentales, l'alcoolisme et les toxicomanies (Arrêté du 14 mars 1972), *Journal officiel de la République française*, April 21, 1972, 4206–7; Circulaire 431 du 14 mars 1972 relative au règlement départemental de lutte contre les maladies mentales, l'alcoolisme et les toxicomanies (Ministère de la santé publique et de la sécurité sociale, Direction générale de la santé, Sous-direction de la protection sanitaire, Direction des hôpitaux), *Journal officiel de la République française*, April 21, 1972.

[29] Circulaire 431 du 14 mars 1972, 1.

[30] Ibid., 7.

[31] Circulaire DGS/891/MS 1 du 9 mai 1974 relative à la mise en place de la sectorisation psychiatrique (Ministère de la santé publique et de la sécurité sociale, Direction générale de la santé, Direction de la protection sanitaire), May 9, 1974, 2; see also Circulaire DGS/2030/MS 1 du 12 décembre 1972, Circulaire DGS/1262/MS 1 du 6 juillet 1973, Circulaire DGS/78/MS 1 du 15 janvier 1974 cited in the same.

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2002, 796). Similarly, the new *CES* in sectorized nursing generated a steady pipeline of new staff into the growing sectors, as well as of allied mental health providers such as social workers.

As the number of medical degrees and positions proliferated, so too did the trade unions that represented them. The communist union CGT had close ties to public psychiatry through the Syndicat; in its earliest years, many members had been sympathetic to the Communist Party. However, upon its creation in 1964, a union with closer ties to the Socialists, the CFDT, garnered broad appeal among public sector workers, too. Workers who preferred the CGT but rejected the influence of the Communist Party in it, sought representation from the union's offshoot: FO. Unaffiliated trade unions also sprouted during this period. These included the unconventional Trade Union of Psychiatry (Syndicat de la psychiatrie), in which medical professionals advocated "for psychiatry, not psychiatrists" (USP 2021). Motivated to win higher wages, obtain stronger employment protections, and expand their ranks, these trade unions pressured hospital psychiatrists and local administrators to take advantage of sectorization. The availability of the generous May 1955 "social ills" funds – not yet affected by the emerging oil crisis – made it easy to satisfy these pressures. The long-ignored funding mechanism now became central to the maintenance of expanded mental health services (Bauduret 2002).

The national policy changes of this time period were most vividly experienced at the local level. In fact, studies documenting how mental health workers advocated for the expansion of sectorization in individual *départements* has become a rich area of research in recent years.[32] In his study of CGT activists at Le Vinatier hospital and sector in Rhône, Alfandari uncovers a wealth of archival evidence showing how workers advocated for funding increases, staffing diversification and expansion, and secure training and employment schemes in the wake of the post-1968 policy changes. Protecting the sector's public status was also crucial to workers: A joint CGT–CFDT leaflet of 1973 empathically decried "*NON*" to a proposal that would allow private sector organizations to manage some or all sectorized services (reproduced in Alfandari 2017, 91). These efforts are what prompted the local union's then general secretary to claim "'it's thanks to the CGT' that the sector now exists" in an interview years later (quoted in Alfandari 2017, 90).

[32] See, for example, Alfandari 2018, Guérin 2011, and the study as part of Gaspard Bouhallier's doctoral thesis, Lumière University, Lyon 2, currently underway at the time of writing.

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Local public managers were responsive to such protests, and here, too, acted as brokers between workers and policy-makers. In his study of sectorization in Angers, Vincent Guérin (2011) offers an example that illustrates how public managers took advantage of the generous "social ills" funds to placate their expanding staff. In January 1972, the personnel of the public psychiatric hospital in Sainte-Gemmes-sur-Loire went on strike. The group of protestors, composed mostly of nurses, sought to expand their workforce. In a coauthored report, the *département*'s seven chief psychiatrists (one for each sector) offered their support of the strike, denouncing the fact that it took two protest movements (the first in 1968 and now this one in 1972) to persuade authorities to hire more personnel. To this, they added that the events "could have been avoided if the doctors had been listened to" (Guérin 2011, 498). The timing of the strike, just prior to the collapse of the *Trente Glorieuses*, was fortuitous. The Ministry had just published the March 1972 order and circular, casting renewed attention on the May 1955 funds for social ills. Local authorities quickly complied with strikers' demands, announcing "a happy solution to the conflict through the adoption of exceptional measures and financial means" (Guérin 2011, 498).

The more that policy-makers turned to this financial tool to placate workers, the more the workforce grew. Consider what occurred in Angers over the following decade. Between 1970 and 1977, the number of nurses, caregivers, and social workers (*personnel soignant*) grew from 744 to 992, an increase of more than 30 percent. During this time, the mental health service also added two chief psychiatrists and consequently two medical secretaries. The number of hospital interns almost doubled (from 17 to 31). Spending on nurses alone tripled, taking up an expanding proportion of the *départements*' medical budget (Guérin 2011, 525–26).[33] Moreover, this personnel boom continued even as the number of inpatients was plummeting, from 1,959 to 1,242 (Guérin 2011, 615, table 1).

The second feedback loop therefore demonstrates how intensification of worker demands, engendered by the events of May 1968, prompted public managers to expand the workforce and, by extension, support the expansion of psychiatric sectors. Their proliferation helped to further deinstitutionalization, as they allowed hospitals to more quickly

[33] Nurse expenditures increased from around 32 million to 92 million francs during this period. Accounting for the high inflation of the time, these amounts are roughly equivalent to $56 million to $86 million contemporary USD (per INSEE 2023; OECD 2023).

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discharge long-stay patients. The coincidence of this period with the *Trente Glorieuses* allowed for the "happy" disbursement of government funds at the local level. Moreover, this economic boom would soon come to an end. The third and final feedback loop shows how the empowered public mental health sector confronted economic crisis.

THE THIRD FEEDBACK LOOP: LONG-TERM, LOCKED-IN FINANCING FOR THE MENTAL HEALTH SECTORS

By the end of the 1970s, public mental health workers and managers discovered that the disbursement of government funds had become decidedly less "happy." In fact, it was downright strained. The oil crisis, combined with a maturing welfare state, put stress on nearly every dimension of the French economy, including the mental health sectors. The election of President Valéry Giscard d'Estaing in 1974 signaled a shift in electoral preferences toward economic conservatism, but it was his prime ministers, Jacques Chirac and especially the economist Raymond Barre, who sought aggressively to reduce government spending in health care through the early 1980s. Hospitals, which comprised more than half of the state's health insurance spending, were a top concern. Significant cost-containment measures followed.[34] When the hospital association claimed that one especially tough motion was illegal, it received a letter from Prime Minister Barre himself buttressing the governments' commitments (Ayme 1995, 340–41).

Mental health care was no exception; if anything, it was more of a target for budgetary cutbacks since its patients tended to lack political influence. Moreover, the 1955 funds for psychiatric sectors remained unstable and insufficient, as the costs of psychiatric hospitals, now inflated by rising numbers of psychiatrists, nurses, and social workers, were increasing. Spending on the sectors became more constrained, and the government announced a target to eliminate 40,000 psychiatric beds (Coffin 2005, 241; Leguay 2002, 14–15). That more young psychiatrists were entering private office practice facilitated this objective and increased public psychiatry's competition from the private sector.

Public mental health workers and managers in France remained united, unlike their counterparts in America, who experienced this period of

[34] In 1975, the government began to experiment with a fixed hospital spending growth rate (*taux directeur*) and, in 1978, with global budgeting. The circular of March 29, 1978, set the *taux directeur* at 9.5 percent – a stringent cap when, at the time, the general inflation rate was 17 percent and inflation in health spending was 24 percent (Ayme 1995, 281–82; Leguay 2002, 13–15).

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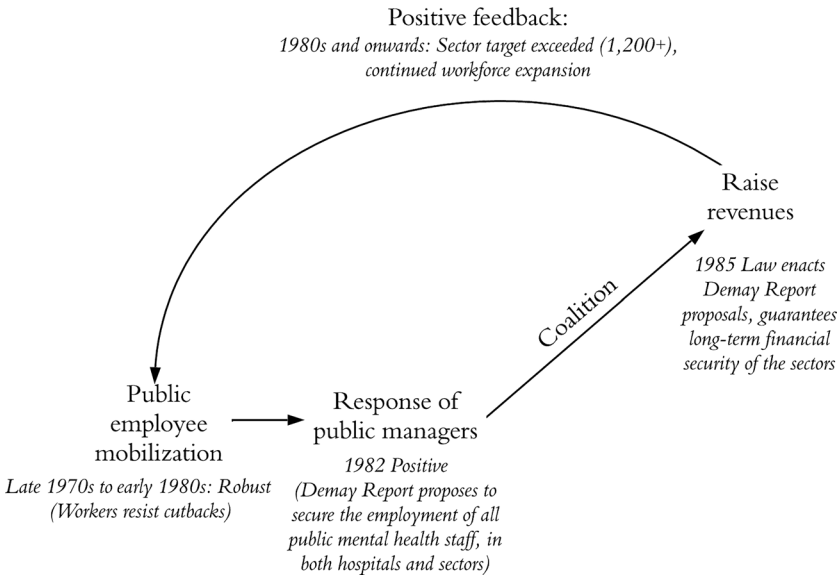


FIGURE 5.3 Third supply-side policy feedback loop, postwar French mental health care

economic retrenchment unaligned. In this third and final feedback loop, this coalition pressured local authorities to maintain sector funding at high levels. Although pressures to cut funds and deinstitutionalize *à l'américaine* by closing hospitals were high, workers and managers jointly stood by a proposal to deinstitutionalize the "French way." In 1985, the government capitulated by securing long-term financing for all public mental health workers and, by extension, for both inpatient and outpatient care. That decision, in turn, has continued to strengthen the power of the public mental health workforce over subsequent decades. The following pages and Figure 5.3 document this positive feedback and Table 5.1 offers a guide to the mental health financing changes it produced.

Public Mental Health Workers and Managers Resist Cutbacks at the Local Level

Despite pressures to reduce financial support for psychiatric hospitals and services, public psychiatry workers in the sectors continued to demand revenue increases from their managers. President Giscard d'Estaing's reforms to health insurance (*assurance maladie*) had slowed, but not halted, hiring in psychiatric services (Ayme 1995, 281–82). Still profiting

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TABLE 5.1 *Timeline of psychiatric sector financing in France, key dates*

	The "Sector"			
	Hospital/inpatient services		Non-hospital/outpatient services	
	Payer	*Personnel status*	*Payer*	*Personnel status*
1960–83	Social Security fee-for-service (nondiscretionary)	Social Security (stable)	*Double financement*: state funds for "social ills" and *départements* (discretionary)	DDASS (less stable)
1983–85	Social Security fee-for-service (nondiscretionary)	Social Security (stable)	State funds for "social ills" only (discretionary)	DDASS (less stable)
1985 to present	Social Security global budgeting (nondiscretionary)	Social Security (stable)	Social Security global budgeting (nondiscretionary)	Social Security (stable)

Note: DDASS = Direction départementale des affaires sanitaires et sociales.

from the May 1955 funds for social ills, the sectors remained jointly financed by local health offices (commonly referred to as the Direction départementale des affaires sanitaires et sociales hereafter DDASS) and discretionary central government funds (simply referred to as the State, *l'État*). Moreover, the financial responsibilities of DDASS had lowered to just 17 percent of costs. Observers have remarked that this arrangement, by then referred to as double financing (*double financement*), was "particularly 'heretical,' but of unparalleled efficiency in developing a dynamic public health policy" (Bauduret 2002).

The Managers' Demay Report Proposes a "French" Approach to Psychiatric Deinstitutionalization, with Protections for Public Workers

In 1982, an important window of opportunity opened for public managers to further exert their influence. The defeat of Valéry Giscard d'Estaing by François Mitterrand, a Socialist, ended 23 years of governance by parties of the Right. With Mitterrand's election, the Socialist Party sought to finally implement the "Common Program" (*Programme commun*), a set of Keynesian domestic policies jointly adopted by the Socialist and Communist parties in 1972. When the Socialists released their platform in advance of the election, they had promised to develop

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sectorization.[35] What is more, shortly after the election, the new Health Minister, Communist Jack Ralite, personally attended the Syndicat's conference in Sotteville-lès-Rouen (October 1981). "Far from suppressing jobs," he declared, "psychiatry must create them."[36]

Proposing that more sectors should be created to support an even smaller catchment area (50,000 people), he concluded with an invitation to the author of a new report:

> For this reason, I entrust to Dr. Jean Demay, known to all for the work he has undertaken in the field of public service psychiatry, a mission of reflection, a mission of invention, to renew psychiatry the French way.[37]

The opportunity to directly influence government policy was welcomed with enthusiasm by the Syndicat and public mental health workers. "We could only rejoice at the Minister's speech," the labor leader Dr. Ayme reflected; "It even went beyond what we had ever dared to claim in terms of the size of the population served by sectors." As for the choice of Dr. Demay, it "deprived us of a member of the union hall in exchange for a reliable and fraternal technical adviser" (Ayme 1995, 375). The next issue of *Vie sociale et traitements* (1981, number 137), the principal journal of sectoral workers, published Ralite's speech in full as its special feature. Mental health workers thus applauded the new government and the auspicious opportunities it offered them (Ayme 1995; Jaeger 1989, 22; Leguay 2002, 15).

Throughout Demay's report, the preferences of public psychiatrists superseded those of private psychiatrists. Typically, the president of the Commission on Mental Illnesses would expect to author a government-mandated report on mental health such as this one. But the Commission presidency had recently rotated to a private psychiatrist, Professor Kammerer. By instead choosing Dr. Demay as the report's author, Minister Ralite ensured that the report would take a public sector approach to mental health provision. For most of the 1970s, Demay had led the Commission's subcommittee on sectorization.[38] Long interested in formalizing the sectorization project into law, he organized a three-day colloquium in 1977 to develop the idea (Leguay 2002, 15). Moreover, the addition of

[35] The platform also promised to reform commitment procedures, which remained unchanged since 1838. The Syndicat was less pleased about this; see Club socialiste du livre 1980 in Jaeger (1989, 21).

[36] Jack Ralite, "Déclaration sur la santé mentale" (Sotteville-les-Rouen, October 12, 1981), www.cemea.asso.fr/IMG/pdf/jack_ralite.pdf.

[37] Ibid.

[38] See AN 19910084/28/Groupe de travail secteur.

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his wife, Dr. Marie Demay, a pediatric psychiatrist in the public sector, as coauthor of the report contributed further to its public sector orientation (Demay and Demay 1982; Faraggi and Dayot 2016; Leguay 2002, 15).

Contrasting "the French way" of deinstitutionalizing with the British, American, and Italian experiences (see Box 5.1), the Demays (and, by extension, the Syndicat) proposed anchoring their envisioned sectorization project in "public sectoral establishments" (*établissements publics de secteur*). These broadly defined community establishments would assume the responsibilities – and with them, the sustained, stable payment mechanisms – historically associated with mental hospitals. To justify this approach, the Demays looked to their country's long tradition of "great public services, recognized for the importance of their role and the quality of their personnel" (Demay and Demay 1982, 5). This emphasis on personnel reveals much about the agenda driving the report, another tool for brokerage.

Box 5.1 1982 Demay Report Comparative Assessment of the Various "Ways" (*voies*) to Deinstitutionalize

Emphasizing worker protections and service expansions, the 1982 Demay Report proposed a "French way" (*une voie française*) to deinstitutionalize that would differ from that pursued elsewhere:

The English way (*la voie anglaise*): Anti-psychiatry and non-hospital therapeutic communities … led to very remarkable [community-based] projects. But what became of the movement to close the classic psychiatric hospitals? It seems that the movement, which was very active in the early 1970s, lost its momentum in the context of the economic crisis … asylums were recreated elsewhere.

The American way (*la voie américaine*): Kennedy's speech (1963) and the social changes of the 1960s and 1970s enabled the mass closure of psychiatric hospitals and creation of community mental health centers. But here also the economic crisis, the abandonment of some former hospital patients, and the [subsequent] violence among some of them obstructed the deinstitutionalization movement. Meanwhile, mental health care appeared to spread into society at large, leading to the insensible psychiatricization of other areas, such as education, law, and prisons.

The Italian way (*la voie italienne*): The radical Law 180 was effective in 4 out of 20 regions, where either the Basaglia movement or sectorization had set up alternatives outside the hospital. Elsewhere, the abandonment of patients, the resistance or sabotage of professional lobbies, and the anguish of families, may perhaps lead to a reform of the law – risking, however, the re-institutionalization of patients in the old psychiatric hospitals.

Source: Demay and Demay (1982, 32)

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For many years, sectoral workers had relied on the May 1955 social ills funds to obtain the high revenues necessary for their employment, but the instability of this mechanism prompted a more ambitious agenda: the "unification of personnel statuses" (*unification du statut des personnels*). The segregated financing of psychiatric hospitals (statutorily covered by Social Security) and non-hospital sectoral services (discretionarily covered by the May 1955 social ills funds) had produced two classes of mental health workers: those with positions inside the hospital whose employment could rely on stable Social Security revenues and those positions outside the hospital whose employment depended on the fluctuating social ills funds. (The timeline in Table 5.1 helps to illustrate this division.) While the Syndicat had begun to actively support the unification agenda in the late 1970s, it was through the Demay Report that the managers found an opportunity to communicate those demands to policy-makers most directly (Ayme 1995). By transferring all sectoral services to Social Security, the new establishments would lead to the "disappearance of the current inequalities produced by differences in the authority responsible for payment … in particular regarding the cases of certain nurses, social workers, psychologists, [and] medical staff" (Demay and Demay 1982, 21). The report was released in July 1982, and in 1983 *Vie Sociale et Traitements* released a full special issue (number 146) celebrating the recommendation. This widespread optimism would, however, soon turn sour in the face of Mitterrand-era austerity measures.

Positive Feedback Develops Legal Protections for Mental Health Sectors, Despite the "Turn to Austerity"

Economic pressures to reduce mental health expenditures reached a tipping point in 1983. The Common Program had failed so spectacularly to meet the standards of the European Monetary System that Mitterrand scrapped the agenda altogether.[39] In a landmark shift known as the "*tournant de la rigueur*" (turn to austerity), the president's branch of the Socialist Party turned away from the Communist and more radical wings of their governing coalition (Levy 1999; Vail 2010). Moreover, the government's tone toward mental health changed substantially. When outlining policy goals in the Ninth Economic Plan (1984–88), Mitterrand

[39] The expansionary policies and expensive nationalization measures had deepened the national deficit and reinforced the high inflation rate, while higher taxes had alienated business elites. The franc was devalued three times (OEA 1983).

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unveiled a massive reduction target for psychiatric beds that rivaled the aggressiveness of the Reagan and Thatcher administrations abroad: the suppression of 13,000 beds and the conversion of another 28,000 (Commissariat général du Plan 1982; see also Biarez 2004, 517; Coffin 2005, 240; Jaeger 1989, 22). Here was a classic case of crisis-induced deinstitutionalization.[40]

The Syndicat-supported Demay Report would play an important role in protecting mental health workers from Mitterrand's turn to austerity, but at first the Ministry ignored the report. Mitterrand reconfigured his Cabinet, now appointing Edmond Hervé to the Health Ministry. The Commission did not meet for several months. "Rumors emanating from the cabinet suggested that the [new] minister was in favor of this 'hibernation,'" Dr. Ayme (1995, 344) remembers. Moreover, when the Commission eventually convened, the presiding civil servants made no mention of the Demay Report (Jaeger 1989, 22).

Instead, the Ministry privileged the recommendations of another document. Commissioned under the austerity of the previous Barre government and hence published shortly before the Demay Report, the Gallois–Taïb Report (1981, 44–47) had proposed reducing psychiatric services by integrating them into the general hospital system. Although it too denounced the system of "*double financement*," the Gallois–Taib report argued that the problem could be resolved by relying more on the private, not public, sector. The marginalization of the Demay Report, as Denis Leguay (2002, 17) commented, was "like a sort of burial of the Sotteville speech [by Health Minister Jack Ralite]. Was it too ambitious, [too] costly in terms of human resources?"

Moreover, the laws of January 19, 1983, and January 3, 1984, applied three additional austerity measures to the hospital system by (1) extending the global budget to all *CHU* hospitals, hence (2) formally imposing a fixed hospital spending growth rate (*taux directeur*), and (3) terminating the system of "*double financement*" that allowed both the State and the *départements* to jointly finance services (Safon 2017). The first two reforms, intended for the *CHU*s, did not trouble mental health workers as much as the third. Individual social services (a hospice, a

[40] Hospital care was unpopular among some workers, particularly the more radical psychiatrists and psychiatric interns affiliated with the Trade Union of Psychiatry. An open letter to President Mitterrand, published in *Vie sociale et traitements* in 1981, advocated for greater commitments to community care in lieu of hospital care. Syndicat de la psychiatrie, "Lettre ouverte à François Mitterrand, Président de la République," *Vie sociale et traitements* 136 (1981), 42.

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rehabilitation center, a clinic) would now receive payments either from DDASS or from the State, but not both. This change gave each payer greater discretion over the services they would choose to fund, prompting the adage "whoever pays, decides" (*qui finance, décide*) and preventing services from using second payers as reinforcements (Reynaud et al. 1994, 255–56). In the area of mental health, the State became responsible for all non-hospital sectoral services, as Table 5.1 shows (Ayme 1995, 247; Bauduret 2002; Leguay 2002, 143). This decision depleted spending on sectoral services by almost a fifth (the 17 percent of costs that had been typically covered by DDASS).[41]

There are different interpretations of what happened next. State policy-makers claimed that the Ministry of Finance never transferred the DDASS funds to the State and refused to finance any spending increases, in order to pressure the Ministry of Health to eventually charge the bill to the Social Security system (Bauduret 2002). Alternatively, mental health professionals rebuked the State's "forgetfulness" as yet another blanket austerity measure (Ayme 1995; Jaeger 1989, 23–25). Regardless of the intent behind policy-makers' forgetfulness, the end result was that the government had reduced financial support for community psychiatry.

It did not take long for mental health workers to respond. With nearly 85 percent of mental health spending going to personnel, the new budgetary reductions forced prefects of the *départements* to terminate contracts, reduce shifts, and forego replacements for outgoing personnel.[42] On June 28, 1985 the Syndicat, the Trade Union of Psychiatry, and the CGT Federation of the Île-de-France (Paris) region, organized a protest in front of the Ministry of Health in Paris (Ayme 1995, 418). At its meeting the next day, the Commission denounced the situation as "perfectly intolerable." The "unilateral decisions" taken by the government had resulted in the "disruption of the entire health care system, challenging jobs and relationships, imposing drastic decisions for budgetary reasons alone, ignoring both needs and technical requirements" (quoted in Ayme 1995, 418).

Upon hearing the statement, the coalition of managers and workers organized an even larger protest on September 20, following it with significant media attention. Hundreds of psychiatrists, psychologists,

[41] Monetary estimates of the DDASS deficit vary from about $91 million contemporary USD (Bauduret 2002) to $160 million contemporary USD (Ayme 1995, 399; Jaeger 1989, 25; per INSEE 2023; OECD 2023).

[42] See CFDT statement in Jean-Paul Bossuat, "La psychiatrie à gauche, Vaugrigneuse, les 18, 19, 20 novembre 1981," *Vie sociale et traitements*, 140 (1982), 23–28; see also Ayme (1995); Jaeger (1989, 23–24).

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psychometricians, nurses, and social workers protested in front of the ministries responsible for resolving the budgetary "error" (Ayme 1995, 418). In that month's issue of *Vie sociale et traitements*, the CGT, the FO, and the Trade Union of Psychiatry published statements condemning the lack of funds.[43]

That same issue of the journal also explored ways in which the situation could be used to mental health workers' advantage. They had been eyeing the development of global budgeting for several years.[44] Although they were critical of the government's use of the global budget as a tool for austerity, some wondered whether a guaranteed global budget would offer non-hospital sectoral services more stability than the billing per episode that had been in place, especially when "episodes" in community care included relatively inexpensive services such as a group workshop or a short outpatient clinic visit. In a piece entitled "What the Global Budget Could Be," Jacques Ladsous, a special needs educator, reflected on the demerits of the fee-for-service system for mental health care and, in particular, its susceptibility to further retrenchment: "All it takes is to suddenly define 'a day' in a more precise way … and to demonstrate that a certain number of days were counted unduly. It would be enough, for example, to reduce the notion of 'a day' to the notion of 'accommodation.'"[45]

In short, some mental health workers warmed to global budgeting as payment system that gave them more flexibility than the current fee-for-service system. Although the global budget could be reduced from year to year, the fee-for-service system could undergo more specific and restrictive regulatory changes that would make delivering comprehensive psychiatric services more difficult.

The Ministry seemed to have picked up on some workers' openness toward global budgeting as an opportunity to resolve the "financial stalemate" (*impasse financière*, Bauduret 2002). It returned to the Demay Report, using it now as a template for new legislation that would satisfy both mental health workers and, ironically, the government's austerity program. Here the "adaptive expectations" mechanism discussed in Chapter 1 appears to have been at work. Although this mechanism is perhaps the most difficult to document in the two previous feedback

[43] "Des positions syndicales," *Vie sociale et traitements* 154 (1984), 45–46.
[44] The first full issue on the topic appeared in 1979 (number 125).
[45] Jacques Ladsous, "Ce que pourrait être un budget global," *Vie sociale et traitements* 127 (1980), 21.

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loops described in this chapter (where only archival and other historical documents are available), I was able to assess its relevance to the third feedback loop by interviewing a former civil servant at the Ministry's Bureau of Psychiatry and lead author of the reforms. The senior official told me that he had drawn on the Demay Report in part because he knew that the prefects feared, above all, the labor protests ("*mouvements sociaux*") that often came with implementation. The Ministry had long been aware of this concern, having tracked the labor agitation on the ground for at least the last decade.[46] The law that was subsequently proposed, and passed, on December 31, 1985, extended global budgeting to all *CHS* (the public psychiatric hospitals) and included sectorized services as part of that reform.[47] The laws thus "legalized" the sectors by guaranteeing their statutory coverage by Social Security, and in doing so, upgraded the status of sectoral workers outside the hospital (see the last row of Table 5.1).

Through mass mobilization and the strategic use of the Demay Report, therefore, public workers and their organized managers gained a significant concession from a fiscally strained government. The protection and expansion of the public mental health sector was the product of workers' pressure on their managers to expand revenues and protect their employment – pressures that had grown over time and reached their tipping point during this third feedback loop. An independently organized and unified group of public managers, the Syndicat, communicated these demands to government clearly and unequivocally.

Including sectoral services in the *CHS* global budget had important implications for deinstitutionalization. Hospitals had little incentive to increase their inpatient activity. Rather, the prospective global payment encouraged them to re-deploy care to the community setting early and often (Leguay 2002, 21). The result was the accelerated development of diverse, non-hospital sectoral services. By 1989, the country had developed more than 1,000 (Jaeger 1989, 30). Today, France's 1,232 sectors not only meet but in fact exceed the Syndicat's original target (1,200, Chevreul et al. 2015, 147). Their success stands in stark contrast to the intentions and operations of their counterparts in America, presented in Chapter 4.

[46] For example, the Commission's archives on sectorization implementation included newspaper clippings from the *F.O. hebdomadaire* (see the October 16, 1976 "Difficultés en psychiatrie et dans les cliniques" in AN 19910084/30).

[47] Loi 85-1468 du 31 décembre 1985 relative à la sectorisation psychiatrique, *Journal officiel de la République française*, January 1, 1986, 7–9.

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ALTERNATIVE EXPLANATIONS

I argue in this chapter that the presence of a coalition between public sector workers (e.g., medical interns, nurses, and social workers represented by a wide range of trade unions) and managers (independently represented by the Syndicat) in France produced positive policy feedbacks that gradually increased mental health care services and the overall strength of its workforce. Here I consider three sets of alternative explanations, which are in some ways inversions of the three alternatives explored in the previous chapter on the United States.

Alternative Explanation 1: An Absent Social Movement?

Apart from the 1968 student and labor movement, which benefited the expansion of the public mental health workforce, other social movements are absent from the story of psychiatric deinstitutionalization in France. Public pressure to deinstitutionalize, therefore, seemed limited, in mirror opposition to the American case, where pro-deinstitutionalization sentiment gained strength.

Why is this? The strength of the public mental health workforce, once again, appears to be part of the explanation. If American public mental health workers were not sufficiently powerful to respond to the attacks of those critical of public psychiatry, French workers were just the opposite. A review of the historical evidence suggests that French mental health workers managed to both anticipate and suppress public criticism in ways that ultimately facilitated the expansion of their service.

"Anti-psychiatry" in fact held little sway in France (Henckes 2007, 22). Certainly, France is famous for producing academics who drew on psychiatry and psychoanalysis for their social critiques.[48] But many, if not most, of these thinkers – Michel Foucault, Gilles Deleuze, Félix Guattari, Jacques Lacan, and even the postcolonial theorist Frantz Fanon – positioned themselves more as users, not necessarily critics, of psychoanalytic thought and practice. How society controlled madness, many believed, illuminated numerous questions about the social order. "We are careful not to demand the abolition of these [psychiatric] hospitals," explained a nuanced letter cosigned by Deleuze, Lacan, and others,

[48] As Goldstein (1987) writes in her preface, French bookstores can house entire sections devoted to "anti-psychiatry."

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published in *Le Monde*.[49] Only a few radical offshoots of those critics (e.g., the Foucauldian-inspired Asylum Information Group, or Groupe information asiles) seriously engaged the question of whether the entire psychiatric system should be overturned.[50] In broader public discourse, that question never quite materialized.

Public psychiatrists, for their part, preempted it with a coherent response. In the mid 20th century, many psychiatrists were themselves deeply critical of the social control functions of the psychiatric institution. For example, in a series of writing produced in the 1970s, Henri Ey and his colleagues expressed their shock at being considered "jailers" in the country where Philippe Pinel famously freed the mentally ill from their chains (Coffin 2005, 240). For reasons such as this one, public psychiatrists developed their "institutional psychotherapy" method (described in Chapter 3) to promote more social forms of treatment – but from within the walls of the public mental hospital.[51] Thinkers such as Guattari and Fanon trained precisely at the hospital where "institutional psychotherapy" first emerged (St. Alban), rendering them even more likely to support this method. It helped to lay the intellectual foundation for the sectorization policy, which some even framed as a form of antipsychiatry itself (Martin 2004).

To be sure, psychiatrists were not immune to criticism after institutional psychotherapy developed, including from some of their own coalition partners. At a conference of the Syndicat in 1974, a collective of nurses and other mental health professionals presented a 310-page report

[49] Marie-Claire Boons, Guy Clastres, Denise Demoy, Françoise Dolto, Laurence Friedmann, Francis Hofstein, Irène Kotsonis, Jacques Lacan, Lucien Melèse, Jeanine Mouchonnat, Michèle Montrelay, Philippe Rufenacht, François Raux-Filio, Christian Simatos, Bernard This, Radmilla Zygouris, Gilles Deleuze, "Correspondance: l'Antipsychiatrie," *Le Monde*, March 12, 1971.

[50] Furthermore, it was not until decades later that this group would make a dent in French mental health policy. Advocacy by the Asylum Information Group before the French Constitutional Court contributed to the passage of a 2011 law guaranteeing systematic judicial reviews of involuntary care after a predetermined period of hospitalization (15, then 12, days; see Barnard 2019b). Compare this late and limited liberalization of commitment practices in France to its much earlier and more substantial counterpart in the United States, where activists faced less opposition (described in Chapter 4).

[51] From a cross-national standpoint, mental health care systems appear to reinforce certain psychotherapeutic philosophies, and vice versa. Where public funding for mental health care is generous, as in France and Norway, psychiatrists have tended to develop and emphasize the social dimension of care. Where public funding for mental health care is limited, as in the United States and Sweden, psychiatrists have tended to emphasize a biomedical tradition. By applying a comparative, historical, and political-economic lens to mental health care, this book can help to explain how such complementarities came about.

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exposing psychiatrists' demagoguery. (That these groups formed alliances in politics does not mean that they always got along in the workplace.) Soon thereafter, the public accused the Syndicat, with its historical ties to the French Communist Party, of sympathizing with Soviet psychiatry and its full range of horrors. At its 1978 conference in Deauville, the Syndicat developed a broad public relations strategy to respond to these critiques. The 300 participants assembled to recast the union as both a scientific and a labor organization and to formulate a coherent intellectual response to their critics that justified the protection of public psychiatric services (Ayme 1995, 326–27). The papers presented emphasized the therapeutic justification for public psychiatry, extending and rejuvenating the concept of sectorization to refute its harshest critics. Through a series of promotional events and press – both in France and overseas – they worked to distance themselves from the Soviet Union and authoritarian approaches to psychiatry as a whole.[52]

With the exception of the collective just described, however, mental health workers generally contributed to efforts to refute anti-psychiatric critiques. Union activists combined an intellectual reframing of anti-psychiatry with cunning mobilization strategies. Drawing on both archival sources and oral histories, Alfandari (2017, 2018) examines how CGT militants defined themselves as both political leftists who opposed the authoritarian "asylum" and loyal employees of the publicly funded sectors. Meanwhile, Bouhallier (2021) has discovered archival evidence that unions actively mobilized patients and their families to contest hospital closures in the postwar period. In other words, the unions representing mental health workers played a direct role in amplifying client demand for services and support for the psychiatric establishment. Together, public psychiatric workers and managers reinforced a mental health policy paradigm that made little room for anti-psychiatric critiques.[53]

Alternative Explanation 2: The Central Authority of *l'État*

Over the second half of the 20th century, France's powerful and centralized *État* (State) appeared to become even more so. Gaullist public policy

[52] See, for example, Ayme's (1995, 240, 277) discussion of the Mexico conference and writings of journalist Claire Brisset (daughter of Syndicat member Dr. Charles Brisset): "L'Association mondiale de psychiatrie renouvelle sa condemnation des pratiques abusives," *Le Monde*, July 9–10, 1977; "Psychiatrie et politique," *Le Monde*, August 27, 1977.

[53] This political sociology resembles closely what Bergeron (1999) has theorized and described in the case of French substance abuse policy.

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adopted a top-down, *dirigiste* approach to managing the economy, which a commanding bureaucracy implemented. This approach may have advantaged the French public mental health workforce, which unlike its American counterparts faced fewer institutional veto points that checked its influence. Personal accounts of how the 1960 administrative circular came to be illustrate this pattern. The bureaucrats' influence was notable. Their Parisian office, Dr. Ayme's memoir recalls, "was the control tower for all of psychiatry in France and its overseas territories" (Ayme 1995, 52). Once the Syndicat gained the ears of the bureaucrats, though, these policy-makers were "conquered by the idea of the sector" (Daumezon in Murard and Fourquet 1975, 185).

Recall, though, that State bureaucrats were unsuccessful at implementing sectorization policy during the first feedback loop. Even if the Ministry did come to support the policy in the 1960s, the fact remains that few sectors developed at the height of *dirigisme*. This "long sleep" lasted until 1968. At that point, managers and workers allied to expand public employment opportunities in public psychiatry as a whole. Only afterwards did sectors proliferate.

State enthusiasm for sectorization then cooled during the second feedback loop, just as services expanded. While health care cost containment was becoming a priority in Paris, *départements* were turning to the "social ills" funds to increase mental health care expenditures. This conflict between national and subnational levels of government belies stereotypes of France's unitary government structure. The reality is more complicated. Mental health workers and managers lobbied across a range of local institutions and their representatives, including elected officials on departmental councils (*conseils généraux*, or *conseils départementaux* as of 2015), mayors heading municipalities, as well as local labor dispute settlement and planning bodies (e.g., *commissions paritaires départementales*, *comités techniques*).

The incentives of policy-makers in these local institutions differed from those of their counterparts in Paris. Public psychiatric services were "a bit like the mine of the region, the big company around which the village economy revolved."[54] Local leaders were concerned about maintaining local employment and could exploit central funds to do so. Moreover, left partisans have historically been very responsive to local public sector trade unions, granting them much more power in some

[54] Thanks go to Gaspard Bouhaillier for this language, cited from personal correspondence in December 2023.

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regions compared to others (Vincent 2016), and even compared to the national level. Indeed, unions in France have less direct influence on national policy than their counterparts in textbook corporatist countries such as Germany. But again, local incentives differ, in ways that in the 1970s benefited local mental health workers.[55]

The financial strain and austerity policies of the 1980s made the State even more committed to cost containment during the third feedback loop (Bauduret 2002). It attempted, but did not fully succeed, to make drastic cuts to psychiatric services. Rather, the State agreed to a compromise proposed by the coalition itself. The following section will consider to what extent this compromise was part of the broader economic plans of that decade; however, it is unlikely that sectors would have gained national attention had they not already become staples of local economies in the previous decade. In some ways, sectors had developed against the prerogatives of the otherwise powerful *État*.

Alternative Explanation 3: The Role of Public Employment in the French Political Economy

French policy-makers have often expanded public employment for strategic political and economic reasons. After 1968, the new public sector positions would help to satisfy young protestors' demands for employment. In the 1980s, the Mitterrand government restricted public employee wages to achieve the fiscal austerity and internal devaluation required by the European Monetary System, while also adhering to the Socialist government's political commitment to Keynesian-style full employment. To compensate for the high unemployment of this period (exacerbated by the restructuring and industrial sector layoffs that followed the oil shocks), French policy-makers expanded public – albeit low-paid – employment (see Di Carlo 2023, also confirmed in personal communication). To what extent can these political strategies explain the expansion of public mental health employment? To what extent did the advocacy of the welfare workforce, especially in mental health care, shape those outcomes?

[55] This local-level activity in fact accords with another prominent public policy approach in France at that time. For example, and as mentioned earlier in this chapter, President Georges Pompidou, developed a robust localist agenda that formed the basis of later efforts to "de-concentrate" French social services (Cole 2008). Although these services were managed and organized in Paris, significant local activity would determine their distribution on the ground.

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Not all segments of the public sector workforce benefited equally from these targeted expansions.[56] Perhaps the most illustrative contrast comes from disability policy, a close cousin of mental health care but, in this case, also its competitor. Over the latter half of the 20th century, services for people with physical disabilities developed a private, not-for-profit, and targeted character, never gaining the full Social Security coverage that the public and universal mental health sectors did (Barnard 2019a, 766). Had French policy-makers sought to expand public employment irrespective of workers' demands, one would expect similar policy outcomes in the disability sector as in mental health care. But that did not occur.

This divergence is partly attributable to the strength of public mental health professionals, who in effect feared losing their clients to another social sector. Note that the cards were stacked against them. In 1975, an association representing the families of people with mental illness managed to get a law passed that encouraged the transfer of residents of mental hospitals into the not-for-profit "*médico-social*" sector.[57] But two articles of this law were particularly troubling to public psychiatric workers. Article 46 established separate services for the care of "dependent adults with chronic medical needs," and Article 47 promised a decree detailing the conditions under which the State would cover "the expenses incurred in establishments receiving mentally ill persons whose condition no longer requires care in a psychiatric hospital but does require temporary medical supervision."[58]

The public mental health workforce responded by actively opposing those provisions, and they succeeded. Scholarly accounts point

[56] By some accounts, the French form of neoliberalism may even have hit hardest in the public sector labor force, where the size of the state declined over the long term (Prasad 2006, 235).

[57] UNAFAM (then shorthand for Union de familles de malades mentaux et de leurs associations, or the Union of Families of the Mentally Ill and their Associates) was the major representative of people with severe and chronic conditions in France at this time. It was founded in 1963, sixteen years earlier than its counterpart NAMI (then the National Alliance for the Mentally Ill) was founded in the United States. This earlier start allowed UNAFAM to participate in the overall trajectory of deinstitutionalization more than NAMI, though the record of its success is mixed. Note also that UNAFAM and NAMI originated as parents' associations and hence held policy positions that may have differed from those of the mentally ill themselves (see Chapter 1). In recent years, NAMI has made efforts to shift its focus from families to people with mental illness.

[58] Loi 75-534 du 30 juin 1975 d'orientation en faveur des handicapés and Loi 75-535 du 30 juin 1975 relative aux institutions sociales et médico-sociales, *Journal officiel de la République française*, July 1, 1975, 6596–6607.

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unequivocally to how powerful public psychiatrists, in particular, shaped this outcome (Barnard 2019a, 2019b; Henckes 2007, 2011a, 2011b). The profession would play an important role in defining the disabled, as doctors have in other countries (Stone 1984). But notice that French psychiatrists had specific economic interests at stake. Debates from the Syndicat's 1978 Deauville conference – one already sensitive to employee demands – reveal the managers' concerns about the potential for service competition (as opposed to the eligibility criteria of insurance benefits). One important paper proposed adding "intermediary structures," a public sector alternative to those proposed in the 1975 disability law, to the sectors.[59] In particular, "therapeutic apartments" would shift patients from the hospital setting to a less medicalized, more community-oriented one.[60] These facilities were anchored firmly in the public sectorization system and offered more job opportunities for their sectorized employees than for themselves. (Such services are far less medicalized, and thus less dependent on physicians, than hospitals and outpatient clinics.) By the end of the 1978 conference, the Syndicat had passed several new resolutions. They denounced the disability law's "serious risks of developing a network of institutions parallel to the public service" and renewed "its demands for 'a financial tool' that would be adapted to the situation" (Ayme 1995, 328). To date, those resolutions have been largely reflected in public policy: The comprehensive set of mental health sectors gained stable Social Security coverage in 1985, while disability services remain privately provided and less generously funded.

This 1985 law, it should be added, achieved goals different from those of French macroeconomics at that time. Although the Mitterrand government prioritized young people entering the labor market for the first time, the 1985 law that legalized mental health sectors primarily affected those already employed. In fact, it did more to strengthen existing public sector jobs (by converting *département*-run outpatient care into more stably financed services) than expand them. This outcome, too, was the direct result of the advocacy of the welfare workforce. The Mitterrand government may have sought to expand public employment overall, but

[59] See Dameron and Reverzy paper in Ayme (1995, 328).

[60] The group even debated whether the hospital was necessary to the sector at all. While some argued that sectorization, as originally conceptualized by Bonnafé, did require hospital care; others argued against that idea. See the Berthelier–Constant–Karavokyros debates in Ayme (1995, 328).

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in mental health care it did so according to the specific terms set forth by the public labor–management coalition in that sector.

Certainly, not all has been positive in French mental health care since 1985. Coordination with the disability sector, ironically, has become a challenge. Austerity measures have made it difficult for outpatient services to meet demand, especially for psychotherapy. They have also incentivized staff flight to the private sector, not unlike the "YAVIS" phenomenon described in the previous chapter did in the United States (Bauduret 2022).[61] Although the overall financial structure and universality of the French mental health system has not been seriously challenged, it is notable that these strains began to appear as psychiatric management fragmented. At least four other unions of hospital and sector psychiatrists have emerged (Karavokyros 2010). Moreover, public managers trained in medicine, previously represented exclusively by the Syndicat, are less the norm now than before. The 2010 creation of regional health agencies (*agences régionale de santé*), as Tartour (2021) has highlighted, deepened the fragmentation of the mental health care administration as well. These divisions may make coalition formation and continued advocacy for service expansion more difficult for mental health workers, even if their primary employment protections have long been secured.

In comparative perspective, though, the "French way" of deinstitutionalizing psychiatric services produced higher levels of public mental health care than in many other countries. One cannot explain this contemporary outcome without acknowledging the historical role of the welfare workforce. A coalition of workers and independently organized, unified managers advocated to develop, expand, and ultimately sustain mental health sectors, the diversified set of services that would complement institutional care. That public mental health care withstood austerity, though, is not unique to France. The next chapter shows how a similar pattern shaped the expansion of services in Norway and its absence facilitated their decline in Sweden, as they did in the United States. This shadow case comparison of two otherwise generous social democratic welfare states can assess whether and how the argument presented in this book generalizes to other countries.

[61] In fact, financing psychotherapy is a major mental health care policy challenge across the affluent democracies. The YAVIS phenomenon helps to explain why. But in addition, policy-makers have been reluctant to fund a technique with higher labor costs and less scientific backing than psychopharmaceuticals and other biomedical alternatives. Conflicts over who can provide talk therapy have also impeded public coverage (as has been the case in France).

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TABLE 5.2 *Within-case process-tracing tests, France*

Empirical questions (and type of process-tracing test, Van Evera 1997; Bennett 2010)	Evidence	Interpretation
Core theoretical argument 1: Public sector workers and managers express the same preferences for public service maintenance and expansion.		
1.A. Do workers mobilize in favor of public service maintenance and expansion? (Hoop test)	Mobilization at the local level, for example, in the Seine *département* during the first feedback loop (hospitals only); 1968 protests at the national level and subsequent mobilization at the local level, for example, Rhône, Angers, during the second feedback loop (sector-wide); mobilization in the early 1980s during the third feedback loop (sector-wide).	Yes, public psychiatric workers (in both hospitals and sector-wide) regularly mobilized in favor of public service maintenance and expansion throughout deinstitutionalization.
1.B. Does an independent and united organization of public sector managers allow them to express a preference for public service maintenance and expansion? (Hoop test)	Role of Syndicat in Debré Reforms (1958, 1970) and Demay Report (1982).	Yes, an independent and united organization of public psychiatric managers allowed them to express (and defend) their opinions separately from the private sector.
1.C. Do workers and managers form a coalition? (Hoop test)	Joint statements and mobilization at national level (1968, 1985) and in *départements* (e.g., Seine in the first feedback loop, Angers in the second feedback loop).	Yes, public sector workers and managers formed coalitions at the national and local levels during deinstitutionalization.

(*continued*)

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TABLE 5.2 (*continued*)

Empirical questions (and type of process-tracing test, Van Evera 1997; Bennett 2010)	Evidence	Interpretation
Core theoretical argument 2: The coalition of public sector workers and managers procures concessions from policy-makers by way of the following causal mechanisms:		
2.A. Brokerage: Do public managers use the privileged tools at their disposal to secure and expand the delivery of public services? (Smoking-gun test)	Role of public managers on the Commission on Mental Illnesses/Health, in departmental councils (e.g., Angers example), and in the Demay Report.	Yes, public managers brokered the demands of workers (and advocated for their own) throughout deinstitutionalization.
2.B. Adaptive expectations: Do policy-makers make concessions because they fear retribution from the coalition? (Smoking-gun test)	Rationale stated by senior French civil servant in interview for the 1985 legislation; see also the statements and actions of Boulin and Boulenger in 1969 and local authorities in Angers in 1972.	Policy-makers expressly feared retribution from workers during the third feedback loop. Statements and actions of policy-makers during the second feedback loop, as well as the evidence in 1.C and 2.A., implies that a coalition with managers augmented that threat.
Core theoretical argument 3: Positive feedback reinforces the coalition, relaunching the feedback cycle.		
3.A. Does the public sector workforce expand as funds for public services increase? (Hoop test)	Expansion after the 1968–72 national policy changes, and continued growth as workers begin to leverage "social ills" funds at the local level.	Yes, the public sector psychiatric workforce expanded over successive feedback loops.

3.B. Do workforce mobilizations become more robust as funds expand? (Hoop test)	Limited mobilization in the first feedback loop, followed by more robust mobilization at the local level in the second feedback loop, culminating in the national protests in the third feedback loop.	Yes, the mobilization of public sector psychiatric workers became more robust over successive feedback loops.
Alternative explanations:		
Alt.A. Did the absence of a pro-deinstitutionalization movement in France independently lead to the expansion of public mental health care?	Both public psychiatric managers and workers actively refuted anti-psychiatric critiques in favor of protecting public revenues for their services. (Passes a doubly-decisive test standard)	No, the absence of a pro-deinstitutionalization movement was at least in part the result of worker–manager advocacy in mental health care.
Alt.B. Did the powerful and centralized French State independently lead to the expansion of public mental health care?	The timeline of sectoral development does not align with the timeline of the State's prerogatives. (Passes a hoop test standard)	No, the nature of the French State did not over-determine the success of the labor–management coalition in this policy area.
Alt.C. Did French policy goals independently lead to the expansion of public mental health care employment?	A comparison between the mental health and disability sectors reveals that policy-makers protected and expanded public services in the former more than in the latter, in part because of the advocacy of mental health professionals. (Passes a smoking-gun test standard)	No, employment in public mental health care did not increase simply because increasing public employment overall was a national policy goal.

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