

Foreign reports

The organisation of general psychiatric care in France and the development of the 'Secteur'

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The beginnings of the secteur

In 1945 general psychiatric care in France was still mainly centred on large public and private institutions built, for the most part, in the 19th century and which had embodied, as their basic philosophy, the isolation and detention of the mentally ill.

The concept of treatment based on segregation and isolationism had, however, been increasingly criticised during the inter-war period. It was a question of finding a formula whereby care for the mentally ill could be provided both inside and outside an institutional setting, of reconciling the need to treat preselected groups in hospital with the need to promote prevention, selection and assessment on an out-patient basis.

In 1922 Edouard Toulouse introduced the first 'service libre' (informal treatment) in the form of an out-patient clinic at the Henri Rousselle Hospital in Paris. Toulouse had long conducted a vigorous anti-asylum campaign and it was with the help of the radical senator, Henri Rousselle, that his idea of establishing a centre for the prophylaxis, treatment and after-care of the mentally ill became a reality. For Toulouse, prevention took place upstream and downstream of hospitalisation. The success of this experiment prompted the government to issue a circular in 1937 instructing the préfets to set up out-patient clinics for the early detection and prevention of mental illness, thus extending the concept of 'service libre' (Cayla, 1985).

However, it took a World War and German occupation, when 40,000 mental patients died in French asylums, to bring about a determined national and political resolve to open up the asylums and formulate a policy of treating the mentally ill in their normal social environment. A series of 'Journées psychiatriques nationales', held between 1945 and 1947, worked out the basic principles of the secteur. In 1952, Georges Daumezon, a reforming hospital

psychiatrist, proposed that a pilot scheme based on these principles should be tried out in the département of the Seine. In 1954, similar experiments were attempted in Paris – in the XIIIth arrondissement – and in the provinces.

To promote and extend these facilities, a decree (no. 55–571 of 20 May 1955) entrusted the detection and prevention of mental handicap and illness and also the treatment of alcoholism to special clinics, the cost of which would be shared by the central government and the département.

A circular issued by the Ministry of Health on 15 March 1960 first defined on a national scale the aims and structure of the emergent psychiatric secteur. Each département was to be subdivided into geographical secteurs and each secteur, comprising 67,000 inhabitants, was to establish a network of public out-patient psychiatric services to complement in-patient services. This policy also embodied a profound change in the attitudes of society towards mental health care. "L'esprit du secteur, c'est d'abord le refus de la ségrégation du malade mental, le refus de son exclusion . . . L'objectif, c'est de l'aider à garder sa place dans la communauté des hommes et lui permettre, dans toute la mesure du possible, d'y restaurer son autonomie" (Mignot, quoted in Postel, 1987).

The circular stated the aims of the new psychiatric services: treatment of mental illness to be started as soon as possible as a result of early detection; after-care was to be provided in order to avoid the risk of relapse; the patient was to be kept as far as possible in his family and social surroundings.

The old monolithic asylum system soon began to disintegrate and from 1965, the population in the mental hospitals declined at a dramatic rate. Sainte Anne, in Paris, saw in the space of 15 years a reduction of almost 50% in its in-patients. Some psychiatric hospitals built in the early '60s were never to be fully occupied. The initial norm of three psychiatric

beds per 1000 inhabitants was soon seen to be excessive and quickly reduced to one bed or even a fraction of a bed per 1000 inhabitants (Postel, 1987).

The closed isolationist mental hospital received its coup de grâce in 1968 when the law of 31 July of that year (article 25) integrated psychiatric hospitals into the general hospital system. Psychiatrists working in these hospitals came within the statute regulating all hospital doctors, although their appointment remained in the hands of the Minister of Health. This was to ensure their independence *vis à vis* the préfets; the psychiatrist's relationship with the préfet could be stormy and troubled, especially in the matter of compulsory hospital orders. It was therefore imperative to safeguard the professional liberty of the psychiatrist by having all such appointments made centrally.

Throughout the 1960s, the secteur had consolidated its position and a decree and a circular of 14 March 1972 was able to redefine its main aims. These were to make the hospital services bisexual; to emphasise the need for prevention and after-care as well as treatment; and to increase the fight against alcoholism and drug abuse.

The limitations of the secteur

During the 1970s the secteur began to show certain weaknesses. Adolescents fell between two stools – not eligible for the specialised psychiatric services offered to children and ill-catered for in the adult services. Few medico-social teams knew how to provide satisfactory therapy for them, particularly if their mental conditions were related to incipient delinquency or to drug abuse.

Indeed, the treatment of drug addicts, in any age group, posed particular problems to the psychiatrists working in the secteur. The law of 31 December 1970 relating to drug abuse enabled psychiatric treatment to be considered by the judiciary as an alternative to penal sanction. However, many psychiatrists were reluctant to accept drug addicts who had been directed to undergo treatment but had not expressed any wish to rid themselves of their addiction. Faced with this the magistrates were increasingly obliged to impose a penal sanction for drug dependence. According to a report published by the Ministry of Justice entitled 'Stupéfiants et justice pénale, enquête pour l'année 1981,' the growing use of repressive measures by the magistracy in the 1970s was a direct result of the absence of a mental health alternative in the secteur. However, rare successes were achieved by one or two teams, notably at Joinville and at Champigny, in creating specific and effective therapeutic measures for the drug addict (Postel, 1987).

Alcoholics had been left outside the mainstream of the secteur services, particularly if they did not

present any major psychiatric disorder. They had been consigned to special consultations by the law of 15 April 1954 and by the circular of 23 November 1970. This provision was confirmed by the circular of July 1975 which encouraged the creation of special centres devoted to the diagnosis and treatment of alcoholism (consultations d'hygiène alimentaire or CHA). Some of these centres had been integrated into the secteur but many remained outside. Alcoholics who were also delinquent were shunned by the CHA and secteur alike (Postel, 1987). If criminally responsible, they were sentenced, often to a term of imprisonment. If not deemed criminally responsible, article 64 (Penal Code) would be invoked and they would be admitted to a psychiatric hospital. Many delinquent alcoholics belonged to no geographical secteur, being immigrants, of no fixed abode, or generally on the fringes of society. They thus escaped all possibility of treatment.

Finally, there were the elderly, not necessarily senile, who were insufficiently catered for by the secteur services. Domiciliary services were too often in short supply. A few secteurs, like the XIII arrondissement in Paris, made efforts to face up to this problem but in many secteurs, the absence of preventative assistance and psychological support had often led to the removal of the elderly person to a home or hospital.

The secteur was also wanting in its response to emergencies. The concept of psychiatrists intervening quickly at the patient's home had been promoted by Sérieux in his 'Rapport sur l'assistance des aliénés en France, en Allemagne, en Italie et en Suisse' (1903). Yet the usual response was still hospitalisation. A circular issued on 15 June 1979 laid down guidelines for the secteur's response to emergencies. Each département was to set up, for a number of secteurs, a permanent centre to receive calls for help; a psychiatrist was to visit the scene of the crisis; arrangements were also to be made for transporting and receiving the patient at this centre. But little extra financial assistance was forthcoming so that few secteur teams benefited from the existence of these centres.

The law of 25 July 1985 and the law of 31 December 1985

The election of a socialist President and government in 1981 gave optimism about new initiatives in the field of mental health. However, economic restraints delayed the much-hoped for impetus in developing the psychiatric secteur. The changes that did occur in the first three years were directed mainly at sorting out pay and conditions of hospital medical staff rather than instituting alternatives to hospitalisation.

In July and December 1985, major legislation reached the Statute book and the secteur now

achieved statutory recognition. These laws set out in detail the aims, administrative organisation and financing of the psychiatric secteur and constituted a blueprint for mental health care in France.

In France, all psychiatric services, in-patient and out-patient, in a given secteur, would be grouped around a hospital and share a global budget. It was hoped that this would put an end to the pre-existing administrative dichotomy between in-patient services financed by the hospital and out-patient services financed by the département. Also financial considerations would force the balance of care in favour of the less costly out-patient services and so facilitate new measures aimed at preventing mental disorder and at treating and reintegrating the patient in the community. It was envisaged that there would be a shift of emphasis from the provision of beds in psychiatric hospitals to the provision of day hospitals, night hospitals, temporary hostels, therapeutic centres, sheltered workshops, domiciliary services, emergency centres, and after-care clinics. This unification of psychiatric services was to extend to those services which dealt with alcoholism and drug dependence. A multidisciplinary team would serve and have access to these unified services.

Within the secteur, there would be three main categories of services; the general psychiatric services which would respond to the needs of the population over 16 years of age; the 'infanto-juvénile' services which would cater to the needs of children and adolescents and often cover several secteurs; and the prison psychiatric services which would serve the needs of the prison population within a given area, again covering several secteurs. The four special inter-regional units for difficult psychiatric patients – at Cadillac, Montfavet, Sarreguemines and Villejuif – were not to form part of the secteur services.

To assist in planning the services of the newly unified secteur, the 'conseil départemental de santé mentale' (CDSM) was to replace the former 'conseil de santé mentale de secteur' created in 1972, the latter's purely consultative and local role having proved ineffective. The CDSM was to consist of 38 members including representatives of the central government, local government councils, health insurance agencies (i.e. 'caisses d'assurance maladie'), and mental health staff, six to be hospital psychiatrists. It was to be given wider powers than its predecessor. The 'commissaire de la République' (the préfet under a new name) was to be obliged to consult the CDSM on the number and boundaries of the psychiatric secteurs in the département and on the scale and provision of in-patient and out-patient services. The commissaire de la République could also seek the advice of the CDSM on the organisation, co-ordination and collaboration of psychiatric services and to programmes of study, medical, statistical or otherwise.

While recognising that the CDSM could be useful in highlighting deficiencies in secteur services, some psychiatrists feared that its advice could be overridden by the regional commissions and national government departments, and become another 'talking shop' delaying the practical implementation of services.

A thumbnail sketch of the work of the general psychiatric secteur in 1987

The Ministry of Health carried out an exhaustive inquiry into the workload of the general psychiatric secteurs in 1987; 61% of the general psychiatric secteurs had attached themselves to a psychiatric hospital (centre hospitalier spécialisé (CHS)), 31% to a general or regional hospital (HG) and 8% to a private hospital which had a public function (HPP).

Each general psychiatric secteur served, on average, 69,400 inhabitants and in 1987 each secteur, on average, dealt with 937 patients, more than half (57%) on an out-patient basis. The corresponding figure for 1985 was 51%. The decrease in in-patient care was reflected in fewer psychiatric hospital beds – an average reduction in each secteur from 112 beds in 1985 to 106 beds in 1987 – and a shorter average length of stay in hospital – a fall from 83 days in 1985 to 78 days in 1987.

Full-time hospitalisation was losing ground to part-time hospitalisation, as provided by day hospitals and night hospitals. Patients admitted to day hospitals had increased in France from 21,300 in 1985, to 27,248 in 1987. More day places in more secteurs had made this possible. A similar upward progression was noted in patients admitted to night hospitals, the 1987 figure of 5200 patients showing a 11% increase on the 1985 figure.

Other out-patient facilities which showed signs of development were the 'centre médico-psychologique', the 'appartement thérapeutique', the therapeutic family placement and the therapeutic workshop.

The statistical profile of a general psychiatric secteur, as expressed in averages, may be sketched as follows:

| 1987 | Average per Secteur |
|---|---------------------|
| Total population | 69,380 |
| No. of full-time hospital psychiatrists | 2.8 |
| No. of part-time hospital psychiatrists | 0.3 |
| All other medical staff | 5.6 |
| No. of beds available for full-time hospital care | 106 |
| No. of patients receiving full-time hospital care | 89 |
| No. of day hospital places | 11.9 |
| No. of night hospital beds | 2.2 |
| No. of after-care beds | 1.1 |

| | |
|---|-------|
| No. of beds in therapeutic apartments | 0.8 |
| No. of places in therapeutic family placements | 2.6 |
| Patients treated as in-patients | 221 |
| Patients treated as both in-patients and out-patients | 178 |
| Patients treated as out-patients | 538 |
| Total | 937 |
| No. of medical consultations | 2,694 |
| No. of domiciliary visits | 2,004 |

The secteur reassessed

The swing away from in-patient treatment to out-patient care has therefore been maintained but the general psychiatric services continue to be dominated by the hospital (Postel, 1987; Zambrowski, 1989). The secteur has not been able to throw off its 'hospitalo-centrisme'. Its administrative and financial structures are, by definition, attached to a designated hospital and the development of alternatives to hospitalisation has taken place in the shadow of this powerful establishment. The attitudes of the administrative and medical staff have also required reorientation. As Jeanson suggests in 'La psychiatrie au tournant' (1987), medical staff have had to face a big challenge in conceiving the psychiatric hospital as 'un lieu de soins et non pas un lieu de vie'.

The secteur has also had to battle against the centralist tendencies of French administrative and financial controls. The CDSM is a consultative body with no real powers in policy making. Similarly, the 'Conseil général' has no effective voice in determining mental health policy. The concept of a decentralised general psychiatric secteur is thus in the hands of the hospital administration and the commissaire de la République, both of whom are responsible and accountable to central government ministries.

The 'global' budget has proved disappointing. It has hardly been sufficient for financing the needs of the hospital alone; consequently, out-patient and community services have had to be content with a diminishing portion.

Another threat is posed by the shortage of qualified staff, doctors, nurses and other specialists. Vacancies have to be left unfilled and the shortfall in the number of psychiatrists being trained is causing deep concern.

Zambrowski (1989) gave prominence to other weaknesses in the provision of general psychiatric care. One was the development of private psychiatric care which, in France, accounts for 11% of total psychiatric hospital capacity. In 8% of general psychiatric secteurs, the private hospital with a public function was the cornerstone of in-patient and out-patient services in that secteur. However, there were many more small private psychiatric hospitals/clinics which did not occupy such a strategic position and these private psychiatric establishments also needed to develop alternatives to in-patient care. Hitherto, they had not been given the legal power or the financial support to do so. Zambrowski advocated revision of certain official decrees, notably that of 9 March 1956, so that the private psychiatric hospital could set up day hospitals, night hospitals, after-care centres, etc. in the same way as public psychiatric hospitals. He recommended increased cooperation between private and public psychiatry with more flexible arrangements allowing private psychiatrists to work in public institutions and vice versa. He also proposed a radical restructuring of public psychiatry in France with updating of the aims and the general psychiatric services which would guarantee to the patient or his family a real choice of treatment and care. He argued general hospitals should extend their facilities for treatment by redeployment of the resources of the psychiatric hospital. Indeed, the number of beds should be drastically reduced and space and staff released for a variety of other purposes. There seems agreement that general psychiatric care should continue to move away from hospitalisation in psychiatric institutions and head in the direction of more flexible systems of care in the general hospital and in the community.

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A full list of references is available on request to Mrs Gwynne Lloyd.