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▶ **To cite this version:**

Livia Velpry, Benoît Eyraud. Confinement and Psychiatric Care: A Comparison Between High-Security Units for Prisoners and for Difficult Patients in France. Culture, Medicine and Psychiatry, 2014, 38 (4), pp.550-577. 10.1007/s11013-014-9400-0 . halshs-01087019

HAL Id: halshs-01087019
https://shs.hal.science/halshs-01087019

Submitted on 15 Mar 2016

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Confinement and psychiatric care: a comparison between high-security units for prisoners and for difficult patients in France

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PRE-PRINT VERSION OF THE PAPER PUBLISHED IN CULTURE, MEDICINE AND PSYCHIATRY, 2014, PP.111-137

Abstract: This paper examines the uncertain meaning of confinement in psychiatric care practices. Investigating the recent expansion of high-security units in French public psychiatry, for patients with dangerous behavior (units for difficult patients) and for suffering prisoners (specially-equipped hospital units), we aim to understand psychiatry's use of confinement as part of its evolving mandate over suffering individuals with violent behavior. Although historically the epicenter of secure psychiatric care for dangerous individuals shifted from the asylum to the prison, a review of public reports and psychiatric literature demonstrates that psychiatrists' attempt to reclaim confinement as part of therapeutic practice underpinned the recent development of new units. Institutional-level analysis emphasizes psychiatry's enduring concern to subordinate social defense motives to a therapeutic rationale. Analyzing local professionals' justifications for these units in two emblematic hospitals, the paradoxical effects of a security-driven policy arise: they allowed the units' existence, yet prevented psychiatrists from defending a genuine therapeutic justification for confinement. Instead, professionals differentiate each unit's respective mission, underlining the concern for access to care and human dignity or defending the need for protection and safety from potentially dangerous patients. This process reveals the difficulty of defining confinement practices as care when autonomy is a core social value.

Keywords: Psychiatry, confinement, constraint, high-security units, care

Introduction

Over the past few decades, the rising number of individuals with mental health problems in prison has become an object of concern and public indignation, both in France and in numerous Western countries (Vacheret and Lafortune, 2011). Some researchers associate this rise with the transfer of a population previously hosted in psychiatric hospitals (Lamb and Weinberger, 1998; Harcourt, 2008). Others analyze this trend as a consequence of a "punitive turn", by which social problems are increasingly dealt with through incarceration. Using the case of US prisons as an example, American sociologists and anthropologists have suggested that the movement of mass incarceration observed since the 1970's is a crucial feature of contemporary American society and more broadly of Western societies (Carrier, 2010). These authors analyze this trend either as a way to manage poverty and racial issues (Wacquant, 2009), as the emergence of a "culture of control" through the new penology (Garland, 2001), or as a new technique of government (Simon, 2007). In France, a "turn toward security" has

been described as well (Mucchielli, 2007). Various studies in different national contexts emphasize the role that mental health care plays in this new governmentality and the moral economy it generates. Social scientists have documented psychiatrists' evolving mandate regarding the management of mental health problems in prison. Both in France (Le Bianic, 2011) and in the United Kingdom (Rose, 1998), authors underline the broadening of psychiatrists' role as experts for defining and assessing dangerousness. In the French case, Fernandez and Lézé (2011) also emphasize that prison psychiatrists insist on their humanitarian role in alleviating suffering, which some interpret as instituting compassion as "a moral disguise and an ethical counterpoint" to security-driven policies (Fassin, 2013). Lorna Rhodes' ethnography (2004) of mental health practices in Supermax prison in the United States has delved into the complex interplay between mental health care and custodial requirements, which places rationality as a major criterion for differentiating the two.

The widespread interest in prison-based psychiatry leads to analyze mainly psychiatric care as it relates to the custodial; current uses of confinement within psychiatry are seldom scrutinized (Velpry, Eyraud et al., 2014). This issue is central to an understanding of psychiatry's role in the current management of deviance and violent behavior. 18th century alienists' ambition to use confinement as a therapeutic intervention gave way to longstanding objections: psychiatry's special powers were analyzed as a mandate for social hygiene (Foucault, 1981), for total control over deviant behavior (Goffman, 1961) or for the management of social risks (Castel, 1983). As a result, confinement practices have become increasingly difficult to account for within a therapeutic model. These critics were influential in shaping psychiatric reform, which led to open the asylum (Busfield, 1986, Scull, 1985), and in shifting psychiatry's mandate from the dangerous to the suffering individual (Kleinman, 1988, Fenell, 2005).

Yet, confinement "remains a feature of the mental health system", as G. Moon observes in the UK (Moon, 2000, p. 248). In all Western countries, deprivation of liberty is legally authorized as involuntary commitment in response to an individual's dangerous state and/or incapacity to consent; seclusion rooms are a commonly used therapeutic intervention in hospital settings (Lendemeijer and Shortridge-Baggett, 1997). Lately, new high-security units have also appeared. In the UK, several types of secure units have been created since the mid 1970's, so that psychiatric hospitalization is now organized according to the security level (low, medium, high) (Bergman-Levy, et al., 2010). Meanwhile, in France, the development of new units for difficult patients (UMD) and specially equipped units (UHSA) has received massive funding relative to general mental health services budgets. These two types of units have multiplied recently, increasing greatly the capacity of high-security beds, while the overall ratio of beds per inhabitants slowly decreases (Coldefy, 2007). Often created in the wake of high-profile cases of murder involving people with mental health problems (Rose, 1998) and as a response to the "community-care backlash" (Wolff, 2002), these secure units are designed for individuals considered dangerous and in need of mental health care, with a variety of institutional profiles. Some are hospital patients, others are mentally disordered offenders, whether convicted and sentenced or not. In these situations of "fluid boundaries between care, surveillance and punishment" (Fernandez and Lézé, 2011), the signification attributed to confinement remains ambiguous.

This development re-opens questions on the specific mandate of treating dangerous individuals through confinement. Is it a continuation of its mandate of social control (Bodin, 2012, Conrad, 1982), in the sense that it ultimately involves restricting individuals' liberty? Is it to prevent recidivism and to avoid potential risks for society, as advocates of the "social defence theory" claim (Cartuyvels, Champetier, Wyvekens, 2010)? Or is it a way to make treatment possible, and to participate in a social process led by an ideal of psychiatric care, be it of emancipating the rational individual (Gauchet and Swain, 1980, Goldstein, 1987) or integrating the recovered individual (Davidson, 2012)? Nikolas Rose's analysis of the British case argues that the development of high-security units' contributes to psychiatrists' increasing involvement in the management of dangerous individual as a social problem, through the adoption of risk assessment techniques (Rose, 1998). In this article, we would like to show that the reintegration of confinement as an essential part of therapeutic practice is a major trend, but one whose meaning is still uncertain. Moreover, we argue that the meaning of such a reintegration depends on whether psychiatrists are able to define their use of confinement as alternative to the social demand put upon them, of protecting society against dangerous individuals.

To that effect, we examine the recent expansion of high-security units in French public psychiatry. The French case offers an interesting case study of these arrangements between confinement and care, since no specific institution was designed in France for criminals judged not responsible by reason of insanity, such as forensic hospitals. Until the beginning of 2000, specific units for "difficult patients" defined as presenting a highly dangerous state precluding hospitalization in a regular unit, were the only specified high-security units. In 2002, UHSAs were created for prisoners. Both use similar confinement practices and share striking spatial and architectural similarities; yet they rest on diverging justifications.

Through a brief historical overview of the two units' implementation, we will show how the epicenter of secure psychiatric care for dangerous individuals shifted from the asylum to the prison. Yet, both institutions were involved in the recent development of high-security units, underpinned, we argue, by the attempt by a group of psychiatrists to reclaim confinement as part of therapeutic practice. Finally, examining these entrepreneurs' response to critiques of participating in a security-oriented policy, we will point to the paradoxical effects of this policy. While it allowed for these units' funding and implementation, it also prevented the psychiatric community from defending a genuine therapeutic justification for confinement. Through this analysis, we aim to gain a comprehensive understanding of the current management of the problem of violence and illness in the French context. More broadly, our aim is to gain insight about the social construction of the role of confinement in the care.

Our research focuses on the two hospitals where these two types of units were created, Paul Guiraud Hospital in Villejuif, where the first UMD opened in 1910 and Le Vinatier Hospital in Lyon-Bron, where the first UHSA opened exactly a hundred years later [1]. Each of these

[1] This research is part of CONTRAST, a larger project focusing on the new regulations of coercion in treatment situations and funded by the Agence Nationale de la Recherche.

hospitals is in its own way emblematic of the history of public psychiatry in France. In addition, today, they both possess the two units. Data was collected in the two sites. On each site, we conducted twenty-five interviews with medical and management professionals who had been, or were involved in implementing and defining the functioning of these units. Wa gathered and analyzed regulation documents on each site. The existing professional and administrative literature regarding security units, violence and dangerous patients was also systematically analyzed.

1) Managing violent behavior: from the asylum to the prison

The ties between crime and madness have been longstanding and complex. Since the first part of the 19th century, these pervasive ties are regulated through a clear divide between on one side the criminals judged responsible for their actions, which are to be detained in the prison system, and on the other side the insane, judged irresponsible and treated in the asylum[2]. Such a distinction is not easily put into practice. Some patients in psychiatric institutions, while judged irresponsible, are considered at risk of committing acts of violence and thus require security measures. Conversely, some prisoners, considered responsible for criminal actions, nonetheless need psychiatric care. Since the creation of the first unit for difficult patients in 1901, this problematic population has been managed inside psychiatric institutions. Psychiatric reform and the high rates of incarceration have shifted public attention and psychiatry's focus to the need to address mental health problems in prison.

Difficult patient units as a response to violent behavior

In the first part of the 19th century, prison authorities and psychiatrists attempted a collaboration to treat the criminally insane. In 1870, in order to accommodate inmates who are insane but have been judged responsible and thus serve a sentence, a special asylum was built in the prison of Gaillon (Fau-Vincenti, 2011; Guignard, 2013). This unique experience ended in 1905, when the prison closed. The problem nonetheless persisted. The same year, an official Bulletin[3] acknowledges the presence of 'demi-fous' (half-mad prisoners) in prison. It emphasizes that these prisoners are responsible for their crimes, although their responsibility

[2] Over the course of the 18th century, alienists established themselves as a profession by seeking to differentiate the mad from the criminal (Castel, 1977, Foucault, 1972). The notion of irresponsibility for reason of insanity was introduced in 1810 in the French Penal Code (Guignard, 2005). Special hospital settings for the insane were created in 1838; the status under which patients were admitted was based on their incapacity to govern themselves (Eyraud, 2008). Inmates who were considered both insane and dangerous have been the object of concern since the beginning of psychiatry's history; they trigger persistent debates and policy propositions throughout the 19th century (Renneville, 2003). In 1902, French alienists distinguish between two categories of problematic patients in the asylum (Pactet et Colin, 1902). On the one hand are the 'criminels aliénés', or criminally insane patients, so named to emphasize the precedence of the criminal activities and the fact that they belongs in the prison, although they are in need of treatment. On the other hand, the 'aliénés criminels', or insane patients prone to criminal activities, within and outside of the asylum, are primarily in need of care and are the responsibility of alienists. There is considerable debate among professionals about the delimitation of these categories, especially regarding criminals who have been judged irresponsible by reason of insanity, as well as about the adequate setting where they should be confined and receive care.

[3] Circulaire du 12 décembre 1905, dite « Chaumié »

is diminished, but that they are in need of psychiatric care, for which prison authorities directly hire medical staff.

Asylum administrators and psychiatrists also explored specific responses for problematic patients, including the Unit for difficult patients (UMD), an experiment that would continue. The UMD is largely the result of psychiatrist Henri Colin's efforts to organize special care for disruptive mentally patients in the asylum at the start of the 20th century (Fau-Vincenti, 2011). In the recurring debate concerning the adequate treatment for the mentally ill who are also dangerous, Henri Colin, who was head psychiatrist for a few years in Gaillon, forcefully advocated for removing 'aliénés criminels', or insane prone to criminal activities, from the asylum to a special unit. In particular, he emphasized this as a way to protect and offer more freedom to the other patients treated in the asylum. The special unit was secured through high fences and strict rules of circulation. The therapeutic model was based on strong authoritarianism, on discipline and on forcing every patient to work (Colin, 1912). The first UMD opened in 1910 and was located in the Villejuif asylum, at the back of the hospital ground, next to the graveyard.

Although it was defined as an internal solution for dealing with the asylum population in need of both confinement and care, the scope of the unit would be much wider. From the start, State authorities mandated that Henri Colin to admit a number of criminals judged irresponsible by reason of insanity as well as prisoners in need of care but are considered too dangerous or too disruptive to be admitted in a regular hospital unit. A 1950 official Bulletin[4] planning the development of units for difficult patients divided such patients into three categories; the first is "agitated patients" who disturb hospital units, the two others include "anti-social unbalanced individuals" who have had, or could have "criminal reactions, generally with a forensic status". By the end of the 1990's, about a fifth of the patients admitted in UMDs were detainees (Kottler, et al., 1998). UMDs would remain the only formal high-security units for the population determined to be both insane and criminal. Three other units were created between 1947 and 1963, after which the number of beds in UMDs remains stable[5] until the middle of the 2000's, despite repeated recommendations that additional units be opened in several official reports (Zambrowski, 1986; Barres Fuchs, 1990; Massé, 1992).

Reducing psychiatric confinement and taking charge of mentally ill detainees

Evolving psychiatric practices explain in part the stagnating number of UMDs in the second half of the 20th century. Since the 1950's, within psychiatric institutions, the issue of violence as well as of coercion and confinement has been pushed into the background. By then most « unités de force », or secured units in the asylum, had disappeared. This was the case, for

[4] Circulaire n°109 du 5 juin 1950 relative aux Services spéciaux pour malades difficiles

[5] These units are located in Montfavet Hospital in 1947, in Sarreguemines Hospital in 1957, and in Cadillac Hospital in 1963. There were 400 beds for the whole country. The ratio is thus of 5 UMD beds for 1000 hospital beds in 1990, and reaches 9 p.1000 in 2000 after nearly half the hospital beds had closed.

example, in Le Vinatier (Eyraud, Moreau, 2013)[6]. As pharmaceuticals were introduced and new treatment models were developed, mental health policy focused on organizing community mental health care and transforming the hospital (Henckes, 2011), by opening it to the community and reducing considerably the number of beds. Mental health services undergo major transformations and units with closed doors are no longer the rule (Alezrah and Bobillo, 2004). The various Mental Health Plans place the emphasis on voluntary admission, an open-door policy and on extending the scope of treatment beyond mental illness to include mental health issues.

Such a policy destabilizes the existing balance between psychiatry and prison's mandate to deal with violent individuals. As early as the 1960's, French psychiatrists explained the rising incarceration rate as a response to the evolving therapeutic model of the psychiatric hospital. This was the case for example in Lyon, where a psychiatric unit[7] was created inside St Paul prison in 1957, with the help of Le Vinatier's psychiatrists. A few years later, a criminologist and a psychiatrist state their perception that drugs have increased prison's tolerance for dangerous patients, while psychiatry's reluctance for these patients rose:

> "In less than ten years, drugs have been allowed to transform health policy into criminological clinical work. We realized that it was much easier to bring the psychiatrist in to prison, with his bottle of chlorpromazine, than to send the mentally ill offender to the psychiatric hospital – which required maintaining a fortress inside a hospital that has not even finished taking down its fences and walls. Dangerousness used to be an eviction criterion for the prison administrator, when acute. It no longer automatically entails an admission to the psychiatric hospital." (M. Colin and J. Hochman, 1963)

Since the 1990's, along with the exploding incarceration rate, the prevalence of mental health problems in prison became a regular object of alarm and of criticism, in the psychiatric literature as well as in official reports. In the debates about mental health care in prison, psychiatrists have been under attack. Various actors, including within psychiatry, coincide is saying that as experts, they opt less often for irresponsibility than they used to (Protais, 2014); that in the hospital they are reluctant to admit prisoners; that the emphasis on community care

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[6] In later years, various planning and policy reports advocated for local closed units as a way to compensate the opening of the hospital as well as the decreased staffing. An official Bulletin in May 9th, 1974 on psychiatric care planning mentions « the opportunity of having small intensive care units, which could be closed if necessary » (Circulaire DGS/891/MS 1 du 9 mai 1974 relative à la mise en place de la sectorisation psychiatrique). Yet, only a few have persisted or actually been created in the 2000's.

[7] In the course of the 20th century and particularly after World War II, prisoners' access to mental health care was organized. At first, the Ministry of Justice opened local consultation centers in some prisons with mental health professionals working under the authority of the prison director. These experiments were established gradually as prison authorities and psychiatric services underwent various waves of reform (Circulaire AP 67-16 du 30 septembre 1967, règlement intérieur des CMPR du 28 mars 1977). A 1986 decree defines the comprehensive set of mental health care services in prison, including consultation as well as "day hospital" (Décret du 14 mars 1986 portant création des SMPR, arrêté du 14 décembre 1986). For details, see Senon (1998) and Rollin, Laurent et Brahmy (2005).

has led mental health services to "abandon the dangerous individuals" (Hyest and Cabanel, 2000). Among Western countries in the late 20th century this line of criticism is common (Vacheret and Lafortune, 2011) and builds on a longstanding preoccupation. As a result, in France, observers scrutinized and criticized the provision of health care in prison and specifically mental health.

Toward a new way to accommodate care and confinement

To address this concern, several studies were ordered on the status of prisoners' health (Gonin, 1993) as well as on their right of this population to equal access to health care. An important result of this process is the transfer of health care management to the health administration. Through a 1994 law, which promoted equal access to health care for prisoners like any other citizen[8], mental health care became independent from the authority of the Ministry of Justice. The entire medical staff, which formerly provided care as employees of the Prison Authority, was transferred to the Health authorities.

This administrative change amplified the public's concern for prisoners' health and admission to regular hospital units was facilitated, both judicially and organizationally. Meanwhile, hospital psychiatrists and administrations were preoccupied both by the potential dangerousness of these patients and by the lack of a custodial arrangement to prevent the risk of escape. As a result, the duration of prisoners' stay in the hospital unit were often shortened. While hospitalized in a regular unit, they tended to be systematically placed in seclusion rooms. Described by the Hospital Director as "a misappropriation of the therapeutic use of seclusion rooms" (Interview, Vinatier Hospital Director), such a confinement practice was criticized not only on humanitarian grounds but also on clinical ones. It thus led psychiatrists and administrators to reaffirm the distinction between confinement for custodial and therapeutic purpose, as the publication of the first clinical guidelines regarding the use of seclusion rooms showed in 1998 (HAS, 1998).

To assess both access and quality of psychiatric treatment for prisoners and suggest improvements, four official reports were ordered and published between 1999 and 2001 (Pradier, 1999; Mermaz and Floch, 2000; Hyest and Cabanel, 2000; Fatome, et al., 2001). All of them harshly criticized the care currently provided, stating for example that « prisoners don't have the same access to psychiatric care that the general population does » (Fatome, et al., 2001) and emphasized the dire need for adequate care, including hospitalization. They envisioned several alternatives. One report suggested using UMDs to hospitalize prisoners, and thus to increase the unit capacity (Mermaz and Floch, 2000). Another favored dedicated units for prisoners (Fatome, et al., 2001). In the end, a justice reform bill, passed on September 9, 2002, created "specially equipped units". At that time, these new units were not

[8] Loi du 18 janvier 1994 et Décret n° 94-929 du 27 octobre 1994 relatifs aux soins dispensés aux détenus par les établissements de santé, circulaire n° 45 du 8 décembre 1994 relative à la prise en charge sanitaire des détenus et à leur protection sociale.

defined; the text only specifies that they are to be dedicated to hospitalizing prisoners[9]. A hundred years after psychiatrist Henri Colin succeeded in opening the first UMD and less than ten years after the responsibility for health care for prisoners was transferred to Health authorities, the Ministry of Justice created a new type of units dedicated to prisoners.

2) Setting the agenda for high-security units: a new regulation of confinement and care

Ten more years passed before the first of these units actually opened. These years were be necessary to overcome reluctance in the psychiatric community. They were also used to elaborate therapeutic justifications within a wider dynamic. As we will see, psychiatrists attempted to reintegrate confinement for difficult patients within the boundaries of their clinical work. This includes secure units; a psychiatrist advocates for "their rehabilitation in psychiatry's therapeutic toolkit" (Castandet, 1991, p. 409).

The development of new secure units followed increasing civilian concern for prisoners' mental health. Undoubtedly, it challenged mental health policy's current guiding principles, which remain the opening of the hospital into the community. Over the course of the 2000's, a movement began to operate from within psychiatry, which led to the partial return of coercion practices and confinement settings within psychiatric care. The move was threefold. It involved the construction of violence as a problem in the hospital; the acknowledgement of a lack of clinical reflection regarding coercion; an effort by a few psychiatrists, most of all working in prison, in UMDs or as experts, to define a treatment specific to confined settings. This move takes hold, notably, from the perception of a rise in violence in hospital units and from the difficulty of managing coercion practices. Still widely rejected by the psychiatric community, this approach materialized in new units only with the support of the new security oriented politics.

A common concern: violence and secure care

Public concern regarding violence and dangerous patients in psychiatric hospitals was renewed in the 90's and 2000's. Psychiatrists incriminated the high occupancy rates due to the reduced number of beds, the fact that psychiatric nurses were more often female and that they no longer received specific training[10]. Various local studies were published in the psychiatric literature about "the dangerous mentally ill" (Thevenon, et al. 2000) or about the occurrence of violent events in psychiatric units (Esposito, 2000). Hospitals attempted to address security issues locally. In the Hospital Le Vinatier, a committee on "the management of patients' violent behavior" was established at the beginning of the 2000's. This initiative[11], as well as the two recommendations it advised, exemplified a national trend. First, the committee

[9] Psychiatric care in prison has developed mainly as outpatient care delivered in custody to a voluntary detainee. When hospitalization is needed, the prisoner is involuntarily committed and transferred to a regular hospital unit where he under medical authority; a strict distinction between patient and prisoner statuses is maintained.

[10] This concern develops in several directions. While concern is renewed about the danger posed by people suffering from mental illness, especially in its consequences on mental health professionals' workplace violence, public policies are equally concerned with the abuse patients experience in health care settings (Velpry, 2011).

[11]. An official report on patient's dangerousness (Lopez, et al., 2006) lists 7 such local initiatives.

advised establishing an "Observatory on violence", to identify cases and help design solutions[12].

Le Vinatier's committee also recommends creating a specific unit for patients with violent or dangerous behavior in the hospital, in order to improve the operations within regular, open units. In this, too, Le Vinatier's psychiatrists join in a broader effort to create new closed units in psychiatric hospitals and at regulating existing ones. As one psychiatrist explained: "A secured and closed unit: this is what allows for all the other units to be open" (Dubret, 2008, p. 550). In fact, despite mental health services reform, some psychiatric hospitals have maintained closed units, which specialize in providing a secure environment for difficult patients on site. Yet, the status of these units is ambiguous. Although they are known and used by surrounding hospitals, they are not explicitly singularized and never mentioned in mental health policy. They are also criticized for the lack of therapeutic improvement in their patients. According to the current head psychiatrist of the UMD in Lyon, "it was a place where patients stagnated" (Interview, Vinatier UMD head psychiatrist). Not only have these practices become less visible; they are not specifically regulated. Unofficial secure units are "considered internal affairs" (Interview, Vinatier UHSA former head psychiatrist) and they do not call for specific scrutiny or regulation.

Although there was still great reluctance in the psychiatric community with regard to closed units, psychiatrists began to formalize existing confinement practices, in order to respond to the rising concern for patients' rights[13]. Psychiatrists involved in the existing secured units began jointly to define their role as relief for regular units and to specify the treatment they provide in what they call Psychiatric Intensive Care Units (LeBihan, et al., 2009).

Facing the issue of dangerousness

In this process, it became necessary to review, and account for coercion practices, and to establish a clinical discourse regarding violence and danger in relation to mental health[14]. Yet, psychiatrists often underline the lack of clinical reflection regarding coercion and confinement practices. In 1998, a group of experts in charge of defining clinical guidelines underlined the lack of theoretical framework to justify coercion in care practices:

[12] In 2005, these local preoccupations will participate in creating a national "Observatory on violence" attached to the Department of Health, whose mission is to collect all the violent events happening in hospitals and to help prevent them. More broadly, in the perspective of designing a public policy regarding "Violence and Health" issues (Turz, 2006), a national committee will be dedicated to "Violence and mental health".

[13] The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) and a national independent authority, the General Inspection of Places of Deprivation of Liberty (CGLPL) regularly visit and publish reports regarding psychiatric detention (CPT, 2010; CGLPL, 2012).

[14] The danger posed by mental health patients has been abundantly discussed between criminologists and psychiatrists during most of the 20th century, especially in the relation of the latter to the justice system as experts (Protais, 2011). These discussions subsided in the 1970's.

> "To this day and despite the progress made in psychiatric treatment, seclusion for therapeutic purpose is both a frequent practice and generating persistent uncertainty as to its pertinence and the adequate action to be taken in this area" (HAS, 1998)

The same preoccupation appears in two psychiatrists' official report about the state of public psychiatry. They call for a clinical reflection specific to coercion and confinement:

> "It is imperative that professionals would debate over what clinical work can be attached to coercion and confinement." (Piel and Roelandt, 2001)

A group of psychiatrists working in prisons and in UMDs seized the issue of violence and danger in relation to mental health when they gathered to discuss the specificity of their clinical work in several meeting between 1993 and 2004, leading to common publications (Dormoy, 1995; Bourgeois, et al., 2004; Kottler and De Beaurepaire, 2005). While the first edited volume focused on the delivery of psychiatric care in custodial settings, the two others focused on the issue of dangerousness[15]. One reason for the meetings was the introduction of the notion of diminished responsibility in the 1992 Penal Code, which brought to the foreground the definition and assessment of dangerousness, in relation to recidivism (HAS, 2010). This led the group to attempt to claim responsibility and jurisdiction over the management of at least some dangerous individuals.

To establish their claim, these psychiatrists strongly asserted the correlation between criminality and mental illness. For example, a psychiatrist titles his paper: "Are the mentally ill more violent than ordinary citizens?" (Senon, et al., 2006), summarizing international research results to answer in the affirmative[16]. With respect to international epidemiological studies, as the first studies on the prevalence of mental health problems among French prisoners are published and discussed (Falissard and Rouillon, 2004), the correlation between criminality and mental illness and their roles in assessment of dangerousness is emphasized.

> "Recent epidemiological research has shown the frequency and importance of mental health problems in populations of violent individuals, whether incarcerated, hospitalized or living in the community. (…) Psychiatric comorbidity assessment is a major way to apprehend the dangerousness and recidivism potential for an individual, both for purposes of diagnosis and of prognosis" (De Beaurepaire, et al., p.2)

This opened the way for psychiatrists to establish themselves as experts regarding the definition and assessment of dangerousness in ways that are similar to what N. Rose described

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[15] Within the psychiatric community, this renewal is tied to the policy of "dehospitalization". In his introductory address at the 8th joint meeting of prison and UMD psychiatrists, the psychiatrist Bourgeois emphasizes the adverse consequences of opening the hospital to justify the choice of dangerousness as the annual theme: "The closing of psychiatric units and the reduced number of hospital beds, which are usually described as a progress for psychiatry, seem to correlate with a rise in criminal violence among the mentally ill." (De Beaurepaire, et al., 2004, 155)

[16] This attempt is reminiscent of the import of the US-risk literature in the UK, described by Rose (1998). They will also go toward risk and actuarial assessment of dangerousness, but later and more timidly (LeBianic, 2011)

in the UK (1998). In 2006, national experts set the terms of the debate in terms of risk (HAS, 2006).

Moreover, and more of our concern, in this process this group of psychiatrists participate in identifying a common clinical problem for psychiatrists working with difficult patients or prisoners. In 2005, the head psychiatrist of Villejuif's UMD and the head psychiatrist of prison care advocated for a common clinical reflection on psychiatric dangerousness (Kottler and De Beaurepaire, 2005).

Intensive care as « psychiatry with teeth »

In various joint publications in the 2000's, psychiatrists, mostly UMD and SMPR' heads defined closed units as offering a specific treatment, essentially characterized by the secured setting, tailored to the need of specific patients. They elaborated and began advocating for a setting-specific model of care, which they qualified as "intensive"[17]. A central feature of the intensive care model is the provision of a secure and therapeutic structure that regular units did not provide, either because of a lack of savoir-faire or a lack of means. Such a structure allows the staff to contain and master agitation and pathological violence, which refers to violence that is caused by mental health problems (Kottler, et al., 1998). The unit's "architecture and functioning has a moderating, structuring effect, independently of the effects of medication" (Kottler, 1997). Specifically, the unit's spatial configuration allows for a complete surveillance of the patients' behavior as well as for a total control of their circulation within the unit. The staff makes "interdictions" explicit and systematically sanctions "transgressions", thus enforcing a strict discipline in the unit. A comprehensive set of rules rigidly applies to all actors, patients and professionals, in the unit's day-to-day life: "respect of institutional rules is of great concern for us [professionals]. Their function is of an external law" (Kottler, 1997). For example, the right to communicate with the outside, including the family, and the right to receive visits is not only subject to medical authorization; it also requires a permit and happens under the surveillance of members of the mental health team. The day-to-day routine involves strict control over time spent inside and outside a patient's room, daytime activities and meals. The team immediately sanctions any act of non-compliance, most often through seclusion or through the deprivation of personal belongings (Desia and Robbe, 1998). The ability to exercise control and maintain order justifies these rules and sanctions, as well as the predominantly male composition of the teams. The reinforced medical and paramedical team that characterizes secure units is another element allowing for delivering such an intensive care (Le Bihan, et al., 2009).

Yet the unit's security features are fully integrated as part of the treatment. In a collective article, the head psychiatrists of all the existing UMDs, then the only high-security units,

[17] In addition to the secured units within the hospital being finally called "Intensive Care Psychiatric Units", seclusion rooms were renamed "Intensive care rooms". The same term is used in the 1986 decree defining UMDs. As early as 1991, psychiatrists from one of the then four UMDs described the evolution of the unit's therapeutic project as becoming "a place where intensive care is delivered to psychotic individuals who are often severely affected and, for most of them, in an acute state." (Castandet, 1991, 406).

asserted that, in addition to a "security architecture", treatment within secure units "borrows in an eclectic yet coherent manner from the most advanced techniques", citing psychotherapeutic models, chemotherapy, but also sociotherapy, hydrotherapy and electro-convulsive therapy (Kottler, et al. 1998). The therapeutic nature of the unit's security features can accommodate the two main psychiatric treatment models (Luhrman, 2000). Psychiatrists adopting a biological approach emphasized the possibility of close monitoring of medication. The setting, its security techniques along with the increased staffing also allow for prolonged breaks from medication and for testing new ones (Gaussarès and Poirel, 1991). Within a psychodynamic approach, the secure and disciplined framework is therapeutic in the sense that it helps limit and contain psychotic personality structures. In such a perspective, walls play a central role: "Inside, we are protected from the excitation of open space, which enters you and makes you lose your boundaries" (Interview, Vinatier UHSA former head psychiatrist). The Vinatier's UMD head psychiatrist, Dr Pagès, describes discipline as a key treatment feature of what he calls "psychiatry with teeth":

> "Because the patient undergoes a depersonalizing frustration, we need to establish a strong frame, very explicit, very educative, very rigid. We make everything explicit, we explain what is going to happen. The idea is that we need to present the patient with a structure that contains him, in an educational way." (Interview, Vinatier UMD head psychiatrist)

Confinement and seclusion here constitute the therapeutic context. They allow for the patient to experience a « relational reduction », thereby limiting his/her wants and thus frustrations.

> « We know that for a psychotic patient, not having to rely on his relational functioning, because everything is organized, because everyone wears pajamas, no one envies no anyone… The fact that nothing is refused to them because nothing is possible, this is very consoling for him [the psychotic patient]. It allows for his interpersonal relationship to function, in a quite artificial way, because there are no asperities. He will not have to compete with other patients, over anything. It makes his pathology less noisy, he will have less access to delusional preoccupations because things work well." (Interview, Vinatier UMD head psychiatrist).

Although the psychiatric community generally shares the idea that containment and coercion are a component of psychiatric care, a great majority diverges on the need for designing specific care for some patients because they are dangerous. Central to their reluctance, even among prison psychiatrists, is the concern for a blurring between punishment and treatment and the "confusion between what depends on the health care system and what depends on the penal system" (Dubret, 2008, p. 544), or between justice and psychiatry (Chabannes, 2004).

A political and administrative support for high-security units

Despite the renewed concern regarding patients with behavioral problems or at risk of being dangerous, both for the threat they posed and for their special needs, and despite psychiatrists' increasing sensitivity to the need for secure units, the orientation of mental health policy had not changed in the early 2000's. Mental health funds were still mainly devoted to developing services in the community. The decrees defining the UHSA had not been elaborated.

Likewise, the 2004 "Psychiatry and mental health" planning document emphasized the promotion of community and rehabilitation services and does not include any measure or funding for patients.

In the mid-2000's, several highly publicized crimes involving individuals with a history of mental illness heightened concern for the organization of mental health care. Within a few years, four official reports addressed the issue of dangerousness, mental illness and prison, either as an organizational matter or as a clinical problem (Sautereau et Lamothe, 2009). Each advocated for a different kind of special unit: "neither prison nor hospital" secure facilities for responsible and dangerous criminals (Burgelin, 2005, Lopez, et al., 2006); long term specially equipped units for mentally ill prisoners (Goujon et Gauthier, 2006); units of post-sentence preventive detention for persistently dangerous individuals (Garraud, 2006). In the meantime, between 2004 and 2009, various political decisions led to the actual construction of UHSAs and new UMDs. In 2007, almost five years after the law that created the Specially Equipped Units, Prison and Health authorities succeeded in planning the funding of a first set of units[18]. Less than two years later, hospital authorities decided to fund new Units for Difficult Patients. In Lyon, as in Villejuif, these political and administrative decisions led to the building of new secured units. They represent an economic opportunity for hospital managers, but also a success for the psychiatrists who had been insisting on the need for more secured units for years.

An economic opportunity

The Vinatier and Paul-Guiraud, as most French psychiatric hospitals, suffered financial hardships following the reduction of the number of beds, which still drives funding allocation, and had to constantly reduce staffing in the past years. In such a context, the Health administrations' offer to fund both the high-security units' construction and staff constitutes a welcomed development opportunity[19] for the hospital administration, both through increasing the budget and because it provides a use for the empty grounds of the hospital[20].

It is seized as such, as the hospital director stresses in the quote above, even though it involves adjusting the policy of openness and focus on community care. The new units are for example included in the 2000 "Urbanization and landscape planning program" (Plan d'urbanisation et paysage) designed by Le Vinatier's administrators to manage and improve the vast campus[21]

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[18] Circulaire DHOS du 16 juillet 2007.

[19] Le Vinatier and Villejuif are both vast hospitals situated in urban areas, where real estate pressure is high and the need to justify space occupation thus pressing. For hospitals located in more rural settings, though, the new security units can be an opportunity to avoid closure.

[20] Various funding plans in that period addressed the decay of old hospitals. They are defined along two rationales. One aim is to improve and renovate the hospital buildings and campus; the other is to comply with new requirements concerning norms of security and functioning. These new norms in health institutions concern fire hazards, health hazards, emergency care… (Ministère de la santé, 2007)

[21] Covering more than 100ha at the start of the 20th century, the land devoted to psychiatry has progressively been sold or used for other purposes. The estate's "sound management" (gestion avisée) is nonetheless one of the head of prison psychiatry, Dr. Lamothe's arguments when explaining the choice for implanting this first UHSA

of the former asylum, although this new plan's organizing principle is on fostering ties and circulation of the former asylum with the surroundings.

The success of the entrepreneurs of "psychiatry with teeth"

The hospital psychiatrists who supported "psychiatry with teeth" endorsed the shift by advocating for the need for secured units in psychiatric hospitals, which succeeded in making it acceptable to the medical community. In Le Vinatier, creating secured units actually represented a major change of strategy for a hospital that was the symbol of community-oriented mental health care until the 80's and which is proud to have hosted the first attempts at developing institutional psychotherapy in the 50's (Eyraud et Velpry, 2011). Because of his long-term engagement with mental health care in prison and of the close relationship he fostered with local prison authorities, psychiatrist Pierre Lamothe played a key role in the process of negotiating in favor of the unit, both with the national administration and with the medical community inside the hospital. Lamothe's engagement reaches beyond the local stakeholders. As a prominent speaker for a larger group of prison psychiatrists, he advocated for specialized hospital units for prisoners in the psychiatric literature and in discussions with Health authorities (Lamothe, 1997, 2011). Direct negotiations with both the Health and the Prison authorities led to the election in 2007 of his early project of developing a UHSA. In 2009, as part of the same dynamic, with the support of the hospital director, of the regional Health authorities' director[22], and of the head of the medical community, he convinced the hospital to host an UMD. In an interview, he stressed his involvement in the development of the hospital: "We have the advantage of fairly big hospital grounds, still localized in a urban area, we have acreage left, we also have the will" (Interview, Vinatier UHSA fomer head psychiatrist).

In Villejuif, the creation of the UHSA resulted from the same conjunction of administrative and psychiatric forces. The hospital's vice-director was preoccupied with developing the hospital grounds as 4 out of his 15 units were being relocated to the community. In collaboration with the hospital's administration and with the support of local politicians, the head of psychiatric services for the local prison lobbied the hospital's medical community in support of hosting one of the new UHSAs. She was joined in her efforts by the UMD's head psychiatrist, motivated by the prospect of being an important provider of secure care in the region. Thus, in 2013, both in le Vinatier in Lyon-Bron and in Paris-Villejuif, the hospital grounds would host both an UMD and a UHSA.

The implementation of new high-security units results from a political move started in the 90's and accelerated in the 2000's with the public scandal of a few high-profile cases and a

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in Le Vinatier (Lamothe, Projet de soin, 2007). He also underlined the importance of having local politicians' support, as is the case in Villejuif.

[22] The regional health authorities' director ordered a report regarding « treatment for potentially dangerous patients », which concluded with the need for a UMD for « difficult – and potentially dangerous – patients requiring long term specialized care ». They evaluated the local need to be 50 patients per year (Lombard, et al., 2008, p. 19).

political change in the government. Looking more closely at the social processes leading to these decisions, it appears that these units undoubtedly constituted an opportunity for psychiatric hospitals, they also resulted from the conjunction of an attempt at rehabilitating dangerousness as a clinical issue instigated by a group of psychiatrists and of rising concerns regarding the response to violence in mental health policy. In this regard, the creation of UHSA and the development of new UMDs are part of a process of specialization of a clinical practice for the "violent individual". The reintegration of practices of confinement and of coercion as integral parts of psychiatric treatment is the result of a move operated from within psychiatry. Supported by advocates of "psychiatry with teeth", it has to address the suspicion of being "security-driven".

3) Implementing secure units: the need to differentiate and circumscribe the role of confinement

"It was a time when you could not hear the discourse of care but only the discourse of security; it does have an impact." (Interview, Vinatier Hospital Director)

"We are not a unit for dangerous prisoners, no more than the UMD is a unit for dangerous patients" (Interview, Vinatier UHSA head psychiatrist)

In August 2007, President Sarkozy declared that a new hospital-prison in Le Vinatier will host sexual offenders at risk of recidivism. At a time when the criminally insane and the sex offender are the most prominent figures in public debates (Moreau and Protais, 2009), these new units are linked to dangerousness and custodial settings. Local actors are concerned that the project of the first UHSA, now well underway, will be stigmatized. A little more than a year later, in December 2008, President Sarkozy discloses substantial funding for the creation of high-security units. Among the other announcements are several measures aimed at ensuring society's and mental health professionals' security, in the face of the risk of violence and dangerous from individuals with mental health problems. Funding is dedicated to secure hospital grounds and buildings, from consolidating fences to controlling access. During the same period, a law is passed that institute post-sentence preventive detention for individuals assessed as at risk of recidivism[23].

<u>The suspicion of a shared "security ideology"</u>

"It is perfectly coherent to put them [the UHSA and the UMD] together if we overcome the ideological problem of having a section of "coerced care units'"

(Interview, Vinatier UHSA former head psychiatrist)

Reactions among psychiatrists to this whole set of measures is strong and soon extends to the public arena. Psychiatrists denounced the "security turn" and were careful to distinguish

[23] Or "*rétention de sûreté*", which provide that persons found guilty of sexual or particularly violent offenses could be detained after they have served their sentence, if they are found at risk of dangerousness or of recidivism.

themselves from such a position regarding mental illness and deviant behavior (Labouret, 2012). An association called 'La nuit sécuritaire' (The security night) was created to defend humanitarian values in psychiatry; it soon gathered participants and public visibility. In their calls and meetings, speakers rejected all forms of coercion and confinement in mental health care as backwards. The new secure units, UMDs and UHSAs, were specifically targeted. During the inauguration of the first UHSA in Lyon-Vinatier in May 2010, the association joined with other groups, including psychiatrist and care provider unions, to resist what they call a "security ideology". Their press release states:

> « The UHSA results from a rising tendency to criminalize behavior. Pretexting individual's responsibility, it leads to assimilate the mentally ill and the criminal. Rather than being the sign of a return to an outdated notion of the big confinement, it marks that medicine has shifted and is now at the service of the security ideology."

In such a context, the two high-security units tend to be confounded. Grouping them together feeds the suspicion that they are designed to protect society from dangerous individuals rather than offering care. Hospital unions and staff members are sensitive to the risk of assimilating psychiatry with security:

> "It is true that the project of UMD was intriguing at first. We wondered: "what need for an UMD in a psychiatric hospital, especially with the newly created UHSA". A first reaction was to say "Whoa, we are all security-oriented". I think this was what troubled most of the staff." (Interview, Vinatier UMD nurse in chief).

In Villejuif, the UHSA was similarly attached to the new measures of preventive detention and to the presidential discourse on security:

> "When we heard that the UHSA was [the then Ministry of Justice] Rachida Dati's project and the discourse of Anthony from Nicolas Sarkozy, a great deal of method was necessary to impose the UHSA to the rest of the hospital." (Interview, Villejuif Hospital director)

The risk of mixing security and care is also of particular concern within the UHSA, because prison staff is involved. Prison staff monitored entry into and exist from the UHSA; and were allowed to intervene within the unit when called by mental health staff. In Villejuif, prison staff came to train paramedics for the transfer of inmates from the prison to the hospital. They came "with machine guns and bullet-proof vests that scare off everybody". The new UHSA head psychiatrist commented that "we did not emphasize "care" enough. Paramedics are now traumatized; they think that every patient is a dangerous individual" (Interview, Villejuif UHSA head psychiatrist)[24].

Up to this point, there was some amount of confusion between the two units. Numerous actors did not really distinguish them. In Le Vinatier, the psychiatrist who will become chief psychiatrist of the new UMD did not understand, at that time, that it was different from the

[24] This is not only a concern for hospital staff. In a 2011 report on a visit of Le Vinatier's UHSA, the European Committee for the Prevention of Torture' recommended that prison staff be less involved in UHSA's functioning.

UHSA also underway. For a time, some administrative decisions and the ambition of the psychiatrists-entrepreneurs also increased the risk of confusion. Thus, when implementing a new law on hospital governance requiring the grouping of services along a spatial or a specialty rationale[25], the hospital administration and the head psychiatrists envisioned at first to place the two units under the same administrative and medical authority. The rationale was to facilitate staff mobility between the two units as well as to develop common training and reflection on "security and risk management protocols", according to the Vinatier's hospital director and UHSA's head psychiatrist. This suggestion is reinforced by the fact that these two units were so close spatially. The Villejuif hospital director recalled that the common ties of both units with forensic issues and psychiatric expertise were also considered. Beyond these administrative and institutional considerations, psychiatrists saw some clinical motives for grouping the units. The Villejuif UHSA's psychiatrist, in favor of the grouping, emphasizes the similarities in the population targeted:

> "People suffering psychologically with transgressive features, this is what characterizes all this population, of both the dangerous mentally ill and the prisoners." (Interview, Villejuif UHSA head psychiatrist)

As a matter of fact, beyond management incentive, the two units' therapeutic functioning is very similar. Patients spend a great amount of time locked in their rooms. The mental health teams are similarly overstaffed compared to regular hospital units. In both, a wide range of occupational therapy is provided at significant cost. The architecture of the units is also very close.

Distinguishing the mandate of high-security units: "humanitarian units" or "safe units"

> « UHSAs' are not a substitute for UMDs, whose specificity persists regarding patients that pose long term treatment difficulties » (Lombard, 2008)

Both the administration and the psychiatrists involved in prison or in UMDs then realized that they needed to establish a clear distinction between the activities of the new high-security units and what was understood as security-driven confinement. To do this implies that they circumscribed the role of confinement and put forth their specific mandate, one that is more important than the need to protect society.

A first step was to separate the units on an organizational level. The psychiatrists' union voted to pass a motion requesting separate chief psychiatrists for the two units. After having come forward to head both units, Pierre Lamothe himself later insisted, in interviews, that

[25] The law (Loi dite HPST, du 21 juillet 2009 portant réforme de l'hôpital et relative aux patients, à la santé et aux territoires) launched a massive reorganization of hospital governance. In French public psychiatry, the reform put an end to the *"secteur psychiatrique*" as organizing principle of the mental health system. This set of complementary mental health services provided for each territory was the core organizational principle of mental health services since the 60's.

separating them is crucial, "to display a section for coerced care would be disastrous", while stressing that this is an "ideological problem". Similarly, the Vinatier hospital director considered this decision to be most of all a delay, in order to avoid "superficial comparisons" and "confusions", as well as "being exposed to criticism". Thus, while the functional advantages and justifications of a grouping are obvious to all, psychiatrists as well as administrators recognized at the same time the political necessity of keeping them different. In both hospitals the UMD and the UHSA are separated in two distinct sections. One is called "medical and judiciary", grouping the UHSA with the mental health services delivered in prison, the other "intensive care", uniting the UMD with other secured units.

Even more than these differences in daily routines, local actors insisted on differences in the units' philosophy or symbolism. UMD mental health staff delineated an impervious boundary with prison practices to establish the unit's difference.

> "In the UMD, we know that we are not into the custodial, we are into the securization. Of course there is a deprivation of liberty, but it is for treatment. There are no Prison authorities, the patients are not incarcerated, they are in a specific care setting, which is the UMD." (Interview, Villejuif UMD head psychiatrist)

Furthermore, there is no external intervention to secure the unit: "If this [UMD's] model was one of 'security', I mean, there would be staff dedicated to security" (Interview, Villejuif UMD head psychiatrist).

Professionals integrate confinement and security measures in terms of the safe provision of care. Describing the actual unit's functioning, UMD staff, who are all mental health professionals, argue that they are in charge of both safety and care. They rely on the terms of UMDs' official mission, which is to apply "adequate intensive therapeutic protocols and specific safety measures"[26]. The dangerous state that characterizes admitted patients is defined in comparison to ordinary hospitalization; UMDs are designed for patients who cannot be dealt with in regular hospital units. Applying exceptional security measures is thus what distinguishes UMDs from general psychiatry. These measures constitute a specific therapeutic setting. They ensure the safety of the care provided, both for the mental health professionals and for the patients, while also allowing the patients to "get better", the notion referring to a pacified patient able to reintegrate and be treated in the regular units (Velpry, In press).

In order to justify and define the UHSA, actors insisted on the symmetry between prisoner patients and ordinary patients.

[26] Article R3222-1 du Code de Santé Publique créé par le décret n° 2011-847 du 18 juillet 2011 relatif aux droits et à la protection des personnes faisant l'objet de soins psychiatriques et aux modalités de leur prise en charge – art. 6

> "The project [of the UHSA] is not about security; it is a therapeutic project for individuals who are already confined, not a project to confine dangerous individuals" (Interview, Villejuif UHSA head psychiatrist).

As exemplified in the quote above, professionals insisted that the UHSA patient-prisoners are not dangerous, as they are in UMDs. Moreover, all the actors justified the UHSA's very existence by the imperative of providing access to voluntary hospitalization for prisoners; they stress that most of the patients are admitted voluntarily[27].

Professionals defined the UHSA as the third step in a comprehensive set of mental health services offered in prison, portraying it as an "ordinary hospital setting", except for it being situated inside prison and thus respecting prison rules.

> "The UHSA is a general psychiatric unit created for patients who happen to be prisoners; the idea thus is to host prisoners as we would do with any other patient" (Interview, Vinatier Hospital director)

The UHSA unit admits prisoners who need to be hospitalized to treat their mental health problems and who go back to prison when this need is no longer averred. Mental health teams thus attempt to maintain the same duration of stay as in the ordinary units in the hospital[28].

In the professionals' conception, psychiatry is nested within a custodial environment. For example, when describing the treatment area in the UHSA, the unit's chief psychiatrist portrays a normal caregiving situation, which is totally free from any form of constraint. Even the usual constraint practices, such as the use of the seclusion room, or involuntary commitment are considered separately from the confinement managed by prison authorities. This way, professionals are entirely free of security matters and thus discharged of the responsibility of confinement. In this way, confinement is located exclusively in a security perimeter, managed by the prison authorities. This stance rests on UHSA's official definition[29], which explicitly distinguishes between the security function and the treatment one. This division is made visible in the unit's statutory architectural design, where the treatment unit is enclosed in, yet separated from, a custodial space. Prison authorities thus endorse a confinement measure supervised by guards, while the mental health team provides care in a space they manage.

> « A prisoner remains a prisoner. The prisoner's criminal dangerousness and his dangerousness regarding his ability to escape remain the Prison authorities' responsibility" (Interview, Vinatier UHSA former head psychiatrist)

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[27] Until the creation of UHSAs, the only way for prisoners to be hospitalized was under the status of involuntary commitment, in regular hospitals. According to the date available, in 2010 and 2011, 51% and 53% of Le Vinatier's UHSA's admission were voluntary (UHSA, 2012). Data for Villejuif's UHSA was not available yet.

[28] Le Vinatier UHSA has a mean duration of stay between 46 days and 72 days, close to the 66 days mean duration of stay of the general hospital.

[29] Circulaire interministérielle DGOS/R4/PMJ2/2011/105 du 18 mars 2011 relative à l'ouverture et au fonctionnement des unités hospitalières spécialement aménagées (UHSA)

The rules that govern daily life in the units also mark a distinction between the two models. At first sight, the daily routine seems similar in the two units: it rests on a highly structured schedule and patients spend most of the time alone in their rooms. Yet, there are significant differences, which result in part from the distinct justifications for confinement. This appears in the organization of the collective moments. In the UHSA, a staff member systematically accompanies the inmate when he goes from one space to another, a rule that has been negotiated with prison authorities and is derived from prison rules. On the other hand, patients' supervision and control of patients in the UMD is derived from general disciplinary practices, which were in effect in the asylum for example. As such, if patients are also systematically accompanied when they leave or enter the "night division", they are mainly managed and controlled as a group.

The same division between custodial and therapeutic justifications for discipline explains differences in mundane personal tasks. In the UMD, all the tasks relating to personal care, such as maintaining hygiene (taking a shower), making one's bed or tidying one's room are mandatory. Similarly, meals are taken in the collective room in the UMD and the TV is located in the collective room and under staff supervision. All these moments are included in the therapeutic process, the patient's behavior being watched, evaluated and discussed in clinical meetings. In the UHSA, in contrast, the room is considered a privatized space, on the model of the prison cell. Meals are eaten individually in each room, which includes a private television. Washing oneself is left to the patient's discretion.

By describing these subtle, yet crucial differences in daily routine, it appears that the justification for the rules in the two units follow distinctive notions of confinement. Rules in the UHSA result from a compromise between hospital rules and prison regulations, both in the attempt to avoid escape and in the obligation to respect the prisoner's rights, notably to privacy. Rules in the UMD derive from hospital rules, which are reinforced and adapted to address the perception of an increased risk of troublesome behavior. This distinction is further strengthened by actors' strong claim on each unit's institutional functions.

By insisting on these differences, professionals maintain a strong qualitative difference in the meaning of confinement, which depends upon the status of the person as responsible or irresponsible. In other words, in both cases, therapeutic reasons are no longer used to justify confinement.

The scattering of "psychiatry with teeth" as a treatment model

UHSA staff is concerned with bringing a psychiatric treatment to prisoners comparable to that available to the general population; they do not pay attention to the "detail" – in the words of Le Vinatier hospital director – that they are in custody or, to say it differently, to their "criminal dangerousness". Conversely, UMD staff is driven by its role of alleviating the burden of ordinary hospital units, and does not consider the patient's responsibility status or the criminal acts he has committed.

In both cases, the staff defines the unit's institutional vocation based on motives external to psychiatric treatment. Confinement is exclusively left to the prison authorities' charge in the

UHSA, because the patient is a prisoner and thus responsible. Psychiatric care rests upon humanitarian concern and individuals' access to rights. In this process, psychiatrists do not seek to establish a link between the acts of violence that were punished and the mental health problems of their patients.

In the UMD, confinement is a prerequisite for intensive care, which is intended to restore the patient's capacity to consent to the treatment and to send him back to a general psychiatric unit. The importance given to the confinement is related to the concern for patients and hospital staff's safety and to the unit's specific position within the mental health system.

In both cases, the connection to these units' initial therapeutic justification, which was to offer a medical solution to the problem of violence and dangerousness, is loosened. In their attempt to address the critique of representing "security-driven psychiatry", they justify confinement as essentially "functional". Yet, this argument conflicts with the "vigorous care" psychiatrist entrepreneurs defined to account positively for their work in secure units. UMD and UHSA staffs thus accept to comply with public demand and to go toward a "service-providing psychiatry" (Interview, Vinatier UHSA former head psychiatrist).

Conclusion

In the past years, new highly secured psychiatric units have emerged in France, either for mentally ill prisoners or for dangerous patients. Critiques of these units – from within psychiatry or more generally activists, as well as social scientists – have treated them similarly as the result of a security turn in psychiatry. In order to examine such a critic and to gain a better understanding of coercive practices in psychiatry, we investigated the implementation of two types of high-security units, specially equipped hospital units on the one hand, and difficult patients units on the other, in two hospitals that are emblematical of French public psychiatry.

Retracing these units' institutional history, we outlined French public psychiatry's main orientations regarding the treatment of patients with troublesome or violent behavior. No specific institution, such as forensic hospitals or social defense units, was created to deal with these problems. Instead, units for difficult patients were created within the psychiatric institution, as a way to ensure hospitals' ability to deal with violent behavior. Changes in public psychiatry's evolutions, notably the dehospitalization policy, result in limiting the role of units for difficult patients, while more and more mentally ill offenders were incarcerated. Confronted with this situation, psychiatrist-entrepreneurs advocated for special units of a new type, which would operate under both prison and mental health authorities' management. Here again, the debate over the unit's characterization revealed the difficulty in defining a population through its violent or dangerous behavior. Rejecting the idea of a "penitentiary UMD", entrepreneurs of UHSA obtained that the new unit was designed for all the prisoners in need of care. Institutional-level analysis then emphasized psychiatry's enduring concern to subordinate social defence motives to a therapeutic rationale.

Examining the process that led to these two units' appearance on the political agenda, we draw two conclusions. First, we established that public emotion and the "security turn" in mental health policy were instrumental in the political decision of planning new UHSAs and

new UMDs. The presidential intervention undoubtedly accelerated and expanded the funding of these high-security units, whose implementation health authorities had not prioritized in their planning strategy. Secondly, we show how specialized psychiatrists seized the political focus on security as an opportunity. They took it to claim a clinical discourse regarding dangerous individuals, as well as to give more visibility to an existing dynamic of reincorporation of coercion in psychiatric care as "psychiatry with teeth". The therapeutic use of coercion and confinement is justified within a psychodynamic framework as helping "contain" the patient's psychic structure, as well as within a more behavioral model as teaching the patient to respect limits. Such an incorporation of coercion into care bears some resemblance to the notion of "caring through restraint" described with respect to other confined settings (Hejtmanek, 2010). Uncovering the complex dynamics that preceded these units' implementation thus brings another perspective. We found that the entrepreneurs of "psychiatry with teeth" refused to endorse the role of managing troublesome behavior; instead they maintain a strong transformative ambition in their definition of care. Although they might have played a "perilous game" of "surfing on the security wave", to paraphrase Dr. Lamothe; they still hold to a view of psychiatry as emancipating individuals, sometimes through a recourse to coercion and confinement.

Such an ambition was hindered as it collided with local actors' apprehensions. Professionals involved in the new high-security units were very careful to dissipate the suspicion of participating in psychiatry's supposed "security turn". In that effort, they did not embrace the notion of "psychiatry with teeth" that high-security units' entrepreneurs advocated for. Rather, professionals in each type of units more often differentiate their respective mission, underlining in one case the concern for access to care and human dignity, defending in the other the need for protection and safety from potentially dangerous patients. In UHSAs, psychiatrists deny having any involvement in the meaning of confinement. That their mission is delimited by their concern for equal access to care and for humanizing prisoners' living conditions is significant. Confinement practices are left to the responsibility of prison authorities, under the prison mandate. In UMDs, the meaning of confinement is not related to a therapeutic goal but as a result of a preoccupation for safety and discipline. Safe care justifies confinement. Yet, the "security-oriented" policy had an effect on these new high-security units. Instrumental in funding and implementing them, it also led the actors involved in this process to defend themselves from the security critique and to give up the definition of a specific treatment model for the dangerous. Paradoxically, these strategies lead psychiatrists to eliminate confinement's therapeutic meaning and seem to engage them in a form of risk management for violence and aggressiveness (Castel, 1983, Rose, 1998).

This analysis gives insight into the broader issue of the role of confinement as a way to deal with suffering individuals with violent behavior. In the past fifty years, balances between justice and psychiatry, as well as between the penal and the therapeutic uses of confinement have shifted. Penal recourse to confinement increased while therapeutic recourse was reduced quantitatively. The evolving definition of psychiatric care as well as new orientations in mental health, and penal policies all account for such a shift. In that sense, psychiatry participates in the changing social role of confinement. An interpretation of this changing role contends that it is security-oriented (Rose, 1998). Our analysis shows the persistence of

psychiatrists' concern for preserving care practices from a mission of protecting society from violent or dangerous individuals. They also underline the psychiatric community's reluctance to define and support a specifically therapeutic recourse to coercion practices. The history of the asylum and its critiques easily explain this reluctance. Yet, it seems to prevent a much-needed reflection on psychiatry's use of coercion, as well as on its specificity compared to other social domains. Ethnographies of psychiatric care in community settings have amply demonstrated the persistence and pervasiveness of coercion practices, even outside of confinement settings. Anthropologists have suggested a comprehensive analytical framework (Lovell, 1996), as well as called for ethical reflection (Brodwin, 2013). Attaching a therapeutic meaning to the use of confinement and coercion practices was a constitutive feature of psychiatry, one that allowed for contesting a more traditional use as a means of protecting society from deviant behavior. It seems that it needs to account more explicitly for a mandate that allows for using confinement and coercion as part of care practices.

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