

# CERFI: From the Hospital to the City

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Assessment of the role that space plays in therapeutic processes and mental health tends to be reduced to the architecture of the hospital or clinical facilities. We believe that such analysis is, however, insufficient: the design of hospitals or clinical centers has always been part of broader projects, concerning not only the types of health care provision, but also their relation with the wider territory. The location of asylums outside the city, for instance, evidences a principle of segregation that is both therapeutic and architectural. In other words, conceptions of psychiatric care always carry an implicit thinking of space, which should be understood not only in terms of architecture, but also in terms of its urban and territorial context.

The institutional analysis movement in France provides a unique counter-example to this general trend, as space was considered key to the practice of psychiatric treatment. This became particularly evident with the emergence of CERFI (Centre d'Études, de Recherches et de Formation Institutionnelles). Bringing together urbanists, psychotherapists, educators and sociologists, the research produced by CERFI under the aegis of Félix Guattari carried an understanding of health care that was inseparable from thinking about the urban and the city, in medical, architectural, and (more broadly) social and political terms.

This paper will discuss the research on architecture, urbanism and psychiatry developed by CERFI, with a particular focus on Issue 6 of the journal *Recherches*, entitled 'Programming, architecture and psychiatry', which featured a collective reflection on the sectorisation of psychiatry by key figures in the theory of the sector and institutional psychotherapy. The paper begins by locating the sector proposal in line with the focus on space developed at Saint-Alban hospital and then at the La Borde clinic. In both cases the

understanding of space as an *active* therapeutic factor was vital, in the sense of providing heterogeneity of lived experiences and increased freedom of circulation. Finally, we will suggest how this renewed understanding of the relations between mental health and space grounded a paradigm shift from isolated hospitals to distributed activities of care, integrated within the city.

### **Saint-Alban and Geopsychiatry**

The institutional psychotherapy movement emerged at the end of World War II amid growing awareness among psychiatrists of the need to think about the hospital in relation to the community at large. At the center of this development was François Tosquelles. A psychiatrist, psychoanalyst, and left-wing militant, Tosquelles found himself in France after fleeing Franco's military rebellion and the outbreak of the Spanish Civil. In January 1940, he was invited by Paul Balvet to join the hospital of Saint-Alban in Lozère. Under his direction, Saint-Alban became at once a site of resistance and militancy in both political and medical terms. Wartime conditions accelerated what Tosquelles already suspected: that mental and social alienation were linked. Isolated in the mountains, the hospital's condition was extremely precarious, due not only to the scarcity of resources during the war, but also to its geographic and climatic surroundings.

In this context, Tosquelles began turning the hospital into a therapeutic and social community. Several procedures were put in place to break down fixed social relations emanating from medical power, and to empower patients through more active therapy and control over their environment. At the heart of this project was the idea that the hospital could no longer be dealt with as a passive instrument or as a stable geographical site. Rather, it was important to grasp its institutional and social dynamics as part of the context of treatment. Examples of these procedures were the elimination of uniforms for doctors and nurses and setting up collective activities and opportunities for social exchange, such as the intra-hospital therapeutic club (*Club Thérapeutique*), composed of caregivers, patients and personnel (or even patients alone). The club allowed the patients

to be in charge of their daily life and to participate in their own care, thus limiting dependence on caregivers and personnel and providing a sense of mutual accountability.<sup>1</sup> Other procedures were the creation of a journal published and edited by members of the patients' club, entitled *Trait-d'union Journal de Saint-Alban*, and theatrical activities, which typically took place in the bar. As Camille Robcis notes, "Tosquelles repeated throughout his work [that] the hospital – its architecture, its activities, its staff – constituted a *collectif soignant*, a "healing collective".<sup>2</sup> However, this modification of the hospital's spatial organisation, the amendment of the laws governing it, or the creation of a mechanism of empowerment were all part of a more significant and fundamental reassessment of psychiatric care seeking to move away from the idea of the hospital as a socially secluded environment, as it had been conceived up until that point.

This leads us to a key effect of Tosquelles' presence in Saint-Alban: 'One day, we tore down the walls of the compound. There was no longer a border between the hospital and the village of Saint-Alban. ... After the war, the liberation of the territory was also the liberation of the asylum'.<sup>3</sup> There can be few cases of the often-repeated claim of tearing down the walls of an institution being so literally realised. There were, however, several reasons for this tearing down of walls, some of them essentially pragmatic. The hospital of Saint-Alban was isolated in the mountains with about 600 patients;

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<sup>1</sup> The Therapeutic Club was a fundamental tool developed by Tosquelles. It was an associative structure, composed of caregivers and patients, that could take charge of activities in the institution. The therapeutic club was made possible by the circular of February 4, 1958, written by Tosquelles, which permitted (through a hospital committee) an association managed jointly by the patients and their caregivers to take charge of the daily life of a psychiatric sector. The Club did not simply manage the result of its work, like the revenues of the cafeteria; it also took charge of the occupational therapy registers, outings, solidarity funds, etc. See Marie-Odile Suppligieau, "Clubs thérapeutiques et « groupes d'entraide mutuelle » : héritage ou rupture?", *VST - Vie sociale et traitements* 95 (2007): 54-63.

<sup>2</sup> Camille Robcis, "François Tosquelles and the Psychiatric Revolution in Postwar France", *Constellations* 23(2) (2016), 218.

<sup>3</sup> Tosquelles, quoted in Robcis, Robcis, "François Tosquelles and the Psychiatric Revolution in Postwar France", *Constellations* 23(2) (2016), 218. Original quote from Bruno Coince, "Malades, médecins, infirmiers ... 'Qui guérissait qui?'" *Midi Libre*, December 3, 1991. Archives Lucien Bonnafé, IMEC, LBF 70 St Alban 95.

however, it was also close to a small village. For that reason, opening the walls to allow contact and trade with the village, and access to the mountains for the food and supplies, was of crucial importance for the fight against famine. Because of this, Saint-Alban was one of the few hospitals in which there were no deaths by starvation during the war. To put this in perspective, approximately 40,000 patients were thought to have died during the German occupation of France because of the reduction of supplies to psychiatric hospitals, as well as a policy of ‘soft extermination’ of the mentally ill endorsed by the Nazi State and seemingly approved by the Vichy Regime.<sup>4</sup>

The decision to tear down the walls of the hospital was more than a response to the contingencies of the war. The ‘breaking of the walls’ at Saint-Alban also occurred with regard to many of the internal partitions in the hospital, with the view to promoting a more flexible and less enclosed series of spaces. This can be seen in part as the fruit of Tosquelles’ early experiences with psychiatric reform in Spain, particularly the influence on him of the system of *comarcas* in Catalonia. Implemented by the regional government of Catalonia from 1911 to 1924 as part of a broad process of territorial reorganisation, the subdivision of the territory into different *comarcas* (districts) resulted in a series of initiatives to promote the decentralisation of psychiatric care away from the main cities, allowing patients to remain within the proximity of their families. In the words of one of the leading figures of this process, Vives I Casajoana, it was important to establish

a support network that is not centralized, one that is dispersed throughout the length and breadth of Catalonia with the intention of not removing patients from their families and their environment while at the same time satisfying the need for intermediate devices between hospital and social life, as well as the need to organize and form an effective service of nurses and social workers that would make possible that link and could follow the sick

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<sup>4</sup> Max Lafont, *L’extermination douce. La mort de 40 000 malades mentaux dans les hôpitaux psychiatriques en France, sous le régime de Vichy* (Paris: Editions de l’AREFPPI, 1987).

outside the hospital, to try to prevent the disease and its relapse.<sup>5</sup>

Allowing patients to live close to their natural environments would prevent further trauma and make reintegration easier. This approach had a lasting influence on Tosquelles, and preceded what came to be known later in France as sector psychiatry.<sup>6</sup> For Tosquelles and his colleagues, it was vital to oppose isolation and confinement with a more nuanced and integrated approach to mental health care, for example a diversification of strategies of care that included non-medical services and home visits (this was a frequent occurrence given the deep integration of the hospital in the village's daily life). To this broad range of activities and spatial understanding of care, the *Société du Gévaudan* – a professional group created by Bonnafé and Tosquelles and based in Saint-Alban – gave the name 'Geopsychiatry'.<sup>7</sup> Space did not merely refer to the site of therapy. In the sense of the hospital's architecture and (more importantly) of its relations with its surroundings, space became the object, and increasingly the means, of therapy.

### **La Borde Clinic**

Among those who trained at Saint-Alban was Jean Oury, who went on to be responsible for establishing the Cour-Cheverny Clinic (La Borde), another important case in which space was central to institutional psychiatric experimentation.<sup>8</sup> In 1952, Jean Oury invited Félix Guattari to help organise the clinic's activities. From Oury and

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<sup>5</sup> Salvador Vives I Casajoana, in Josep Ma Comelles, *La razon y la sinrazon*, (Barcelona: P.P.U., 1988), 110.

<sup>6</sup> See Robcis "François Tosquelles and the Psychiatric Revolution", 212-222.

<sup>7</sup> The *Société du Gévaudan* included both permanent and visiting doctors, nurses, members of the resistance and their families. See Françoise Dosse, *Gilles Deleuze and Félix Guattari: Intersecting Lives* (New York and Chichester: Columbia University Press, 2011), 41-42.

<sup>8</sup> Others who trained at (or sought refuge at) Saint-Alban were intellectual figures such as Frantz Fanon, Lucien Bonnafé, Georges Canguilhem, Georges Daumézon, Marius Bonnet, Paul Éluard and Jean Oury.

Guattari's perspective, institutions were ill and it was necessary to heal them. Oury coined the term 'pathoplastie' (pathoplastic) to name the particular illness affecting the institution and their pathological effect on patients.<sup>9</sup> Oury uses this term to distinguish the signs of individual pathology from the signs related to the hospital context. He developed the idea that a part of a patient's symptoms were directly linked to the atmosphere. Pathoplasty thus referred to the way in which disorders were constructed in correlation with the environment. For example, an environment in which patients were not accountable for their actions and had no autonomy or control over their daily lives had the pathological effect of a patient's lack of investment in their life. Intervention into these types of symptoms required intervening in the environment itself. For Oury and Guattari, therefore, an analysis of the institution was fundamental. As Oury put it: 'To treat the ill without treating the hospital is madness!' To this effect, Guattari developed the patient's club, an intra-hospital committee similar to the one in Saint-Alban. He also set up a series of organisational protocols with the primary goal of stimulating the autonomy of the patient, allowing them to regain a sense of responsibility and to 're-appropriate the meaning of their existence in an ethical and no longer technocratic perspective'.<sup>10</sup> These included workshops, drawing sessions, gardening and organising a newspaper.

For Oury and Guattari, the fabric and dynamics of La Borde's daily life were thought to offer analytical opportunities of diverse kinds. The scope of analysis was no longer limited to the privacy of the consulting room, but was extended to the whole of the institution. Specifically, this implied looking at the organisational and spatial dynamics of the institution to prevent the reinforcement of power structures, as well as to identify opportunities of treatment. Because of this, as in Saint-Alban, the spaces of the hospital were not seen as mere containers for different functions, but rather as active agents. The main guiding principles informing their thinking of space were the importance of guaranteeing that patients inhabited a heterogeneity

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<sup>9</sup> See, for example, Oury's seminars *L'aliénation* and *Séminaire de la Borde 1996/1997*. Jean Oury, *L'aliénation, Séminaire de Sainte-Anne* (Paris: Galilée, 2012); Jean Oury, *Séminaire de la Borde 1996/1997* (Nîmes: Champ social éditions Nîmes, 1998).

<sup>10</sup> Félix Guattari, "La Borde: a Clinic Unlike Any Other", *Chaosophy*, ed. Synchronè Lotringer, (Los Angeles: Semiotext(e) 1995 [orig. 1977]), 191.

of spaces, and as much as possible benefitted from freedom of circulation.

## Heterogeneity of Spaces

In a classic hospital, medication was given in specific places (for instance the patient's room). In contrast, at La Borde, medication was administered in different spaces and by different people. The reasons for this were twofold. Firstly, this allowed breaking the hierarchical differences between nurses and doctors that were inscribed in the specific functions performed by each and the specific spaces they each inhabited. Secondly, this use of different spaces made it possible to extend the therapeutic space to the entirety of the institution, as all its spaces were considered to be meaningful locations for analysis. Guattari, for instance, recounts the importance of administering medication in a multiplicity of spaces rather than in the same room or with the same people so as to avoid a rigid association between a place and an experience of being subject to (or subjected to) a passive role, in this case the act of being given medication. In this sense, the series of events and workshops that Guattari organised were key in providing a multiplicity of practices that allowed patients to discover new spaces and new ways to inhabit the clinic. As Oury explains:

It is a matter of working in a random field in which there can be unexpected, multireferential investments – as Tosquelles said – in a polyphonic dimension that cannot be programmed but which can indirectly manifest itself, if there are no structures that prevent this manifestation. The equipment cannot obtain this dialectical dimension. Our question is how to create a collective machine, a club – which is a part of it – that holds everyone accountable at all levels allowing for unexpected effects, interpretation effects.<sup>11</sup>

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<sup>11</sup> See interview with Jean Oury by Andréa Carvalho Mendes de Almeida, Danielle Melanie Breyton, Deborah Joan de Cardoso, Silvio Hotimsky and Susan Markusszower, “O Bom e o Mal Estar”, *Percurso* 44 (2010). Available at

In this context, as Oury's remarks make clear, architecture was a non-negligible therapeutic vector: "The hospital as a set of reference spaces! What does it mean that a patient goes every day, for months, to a dark space in an unfrequented service staircase? [...] And the window, a place of opening to the beyond, a jump to death, a traditional phobic object!"<sup>12</sup> Treating the patients thus required curing the institution itself, including its spaces, its programs, its organisational structure, its practices and modes of communication. All offered analytical possibilities and constituted the therapeutic impact of the institution seen as a whole.

It was in pursuit of this objective that Guattari and Oury set up a system called the grid.<sup>13</sup> The grid was a rotating schedule of *tasks* and *activities*, which ensured that people tried out a series of different things instead of just sticking to a repetitive routine. A sample grid from the 1960s included the *tasks* of dishwashing, housecleaning, kitchen and night shift duties, and waiting at table. *Activities* were things such as clubs, running the journal, or doing the laundry. The tasks were associated with 'disagreeability' and the activities with 'agreeability'. Tasks assured the minimal daily functioning of the clinic and therefore ought to be shared by everyone. The definition of tasks and activities worked as an indicator of what the majority of people inhabiting the institution deemed to be more or less pleasant. An example of this was the laundry, which several texts referred to as being a popular task. From the perspective of institutional analysis, this apparently unimportant aspect could open a window into something else that would otherwise go unnoticed. Unsurprisingly, the kitchen was key: "The kitchen then becomes a little opera scene: in it people talk, dance and play with all kinds of instruments, with water

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[http://revistapercurso.uol.com.br/index.php?app=artigo\\_view&ida=111&ori=entrev](http://revistapercurso.uol.com.br/index.php?app=artigo_view&ida=111&ori=entrev). [accessed November 1 2016].

<sup>12</sup> Jean Oury, "Architecture et Psychiatrie", *Recherches. 06 Programmation, architecture et psychiatrie* (1967), 272. [Our translation.]

<sup>13</sup> For a detailed explanation of the grid see Susana Caló, "The Grid", *Axiomatic Earth*, *Tecnosphere Issue*, *Anthropocene Curriculum & Campus*, House of World Cultures (HKW). Available at

<http://www.anthropocene-curriculum.org/pages/root/campus-2016/axiomatic-earth/the-grid/> [accessed November 1 2016].

and fire, dough and dustbins, relations of prestige and submission. As a place for the preparation of food, it is the center of exchange of material and indicative fluxes and provisions of every kind'.<sup>14</sup> Because of the grid, the previously unrecognised role played by certain spaces was now manifested at the level of the institution and were given weight in the process of analysis for the first time.

### **Freedom of Circulation**

For this heterogeneity of spaces to work therapeutically, the ways in which patients and staff circulated through hospitals had to change as well. The daily activities of the clinic had to allow patients to meet with caregivers, other patients, and even the outsiders who were occasionally invited to take part in hospital activities. This concern was central to the institutional analysis movement. As Delion remarks,

The heterogeneity of spaces, groups, therapeutic activities, and interstitial times ... is of great importance in the multiplication of possibilities of the palette. But if the patient cannot move freely so as to be able to take part in all of these 'transfers' – even partial, fragile, multiple – that heterogeneity is useless. And this is not only physical movement – rather a freedom of movement as encompassing the 'psychic'. This is why it is essential to put in place a system in which patients can easily choose their own path.<sup>15</sup>

If for Oury and Guattari the hospital environment should include a wide variety of spaces (both in terms of their 'atmosphere' and their function), this was also because in that way the wanderings of the

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<sup>14</sup> Félix Guattari, *Chaosmosis: An Ethico-Aesthetic Paradigm*, trans. Paul Bains and Julian Pefanis (Bloomington: Indiana University Press [Orig. 1992]), 69.

<sup>15</sup> Pierre Delion, "Thérapeutiques institutionnelles", *EM-Consulte, EMC-Psychiatrie*, 37-930-G-10 (2001). Available at:

<http://www.revue-institutions.com/articles/therapeutiquesinstitution.pdf>  
[accessed November 1 2016].

patients throughout the institution could act as a basis for therapeutic opportunities. As Oury contended, ‘A real encounter cannot be programmed. The path is made through walking, but if the path is already traced we always stay in the same place [...]. It is by chance that there may be an encounter, but it is not imposed’.<sup>16</sup> The purpose was one of ‘programming randomness’, to use Oury’s expression. This required facilitating the conditions for meetings and encounters without attempting to determine their content. Such freedom of circulation became a method of promoting unpredictable encounters among patients, doctors, nurses, support staff and visitors. In that way it also became a diagram of how the daily life of the hospital was organised, and how its relationship with the broader social sphere was imagined.

## CERFI

While working at La Borde, Guattari was also instrumental in creating the conditions for extending institutional analysis beyond psychiatric institutions by the foundation in 1965 of the FGERI (the *Fédération des Groupes d’Études et de Recherches Institutionnelles*). The FGERI was a network of psychiatrists, psychologists, educators, town planners, architects, economists, academics and others, dedicated to the analysis of the collective equipment of governance and institutional forms of oppression. Derived from the FGERI, the CERFI (Centre d’Études, de Recherches et de Formation Institutionnelles) took form in 1967 as a study center on institutional research that transposed the lines of enquiry raised in institutional analysis to urbanism and to the city.<sup>17</sup> Specifically, CERFI was created to receive research contracts from private organisations or the State, such as the research on the genealogy of public facilities (*équipement*

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<sup>16</sup> See interview to Jean Oury, *Percorso* 22 (2010).

<sup>17</sup> CERFI was originally founded in March 1967 with the aim of enabling FGERI to enter into research contracts with public or private bodies. For more on CERFI, read Stéphane Nadaud, “*Recherches* (1966-1982): histoire(s) d’une revue”, *La Revue des revues* 34 (2003): 47-76; François Fourquet, “Presentation. Histoire du CERFI”, *Recherches* 46 *L’accumulation du pouvoir* (1982): 47-72; Anne Querrien, “La Borde, Guattari and Left Movements in France, 1965–81”, *Deleuze Studies* 10(3) (2016): 395-416.

*collectif*) developed with Foucault and commissioned by the Ministry of Equipment.<sup>18</sup>

One particular issue of the interdisciplinary journal *Recherches* merits our attention: Issue no. 6, ‘Architecture–Programmation–Psychiatrie’. Compiled in 1967, it included contributions from members of FGERI and CERFI and leading figures of the institutional psychiatry movement, discussing psychiatric hospitals and their relations with the city and society. The issue presented a discussion about ‘programs and norms’ for psychiatric hospitals from the point of view of institutional psychotherapy and sector psychiatry, bringing together psychiatrists and city planners. Sector psychiatry in France refers to the organisation of public mental health in sectors defined as geographical areas. The idea of the sector emerged in the late 1950s in opposition to the nineteenth century asylum typologies, as well as to the modernist model of the hospital-village.<sup>19</sup> In essence, the sector followed the principle that treatment for mental illness ought to provide continuity of care, particularly between hospital and community treatment, and be as close as possible to the natural environment of the patient. It implied extra-hospital psychiatric services, such as day hospitals, ambulatory treatment, community and home consultations. The pragmatic reasons for this were clear, as Guattari stated in the introduction to the issue:

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<sup>18</sup> The CERFI research group on collective equipment included Michel Foucault, François Fourquet, Lion Murard, Françoise Paul-Lévy, Anne Querrien and Marie-Thérèse Vernet Stragiotti. Their work is documented in “Les équipements du pouvoir – villes, territoires et équipements collectifs”, *Recherches* 13, edited by François Fourquet and Lion Murard (December 1976); and “Généalogie du capital 2: L’idéal historique”, *Recherches* 14 (January 1974). On the collaboration between Michel Foucault and CERFI see Liane Mozère, “Foucault et le CERFI : instantanés et actualité”, *Le Portique* [on-line] (2004), 13-14. Available at: <http://leportique.revues.org/642> [accessed 1 November 2016].

<sup>19</sup> The promulgation of the circular on the sectorisation of psychiatry, in 15 March 1960, was the work of what became known as the ‘Groupe de Sèvres’. It operated for two years between 1957-1958, gathering together psychiatrists working in hospitals, psychoanalysts, and private psychiatrists such as Georges Daumézou and Lucien Bonnafé. The debates of the group mainly focused on sectorisation and the participation of nurses in psychotherapy.

It makes it possible to consider, in very different terms, the problems of prevention, the comprehensive support of patients – not limited to the hospitalization process – the relationships with families, social reintegration. [...] Merely establishing a relative proximity between the institutions of treatment and the habitat of the patients offers much more flexible possibilities. It thus makes it possible to contemplate, which is often necessary, stays of short duration, in varying frequencies, and trial releases, home visits, etc.<sup>20</sup>

### The Urban Hospital

One of the key texts in this special issue was a technical report entitled ‘Programme d’un hôpital psychiatrique urbain de moins de cent lits’ (Program for an urban psychiatric hospital with fewer than 100 beds) by Drs Guy Ferrand and Jean-Paul Roubier, members of CERFI.<sup>21</sup> This report developed a critique of the isolated hospital along nineteenth century lines, but also criticised the ‘hospital villages’ influenced by principles of modern urban planning and the Athens Charter.<sup>22</sup> Consisting of large-scale structures for 300–600 people, hospital villages were typically situated outside a main town, not unlike traditional asylums. However, as Guattari remarked in his introduction to the issue, despite being better equipped than traditional hospitals and offering better material conditions of hospitalisation and care, hospital villages still had the disadvantage of ‘being distant from the

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<sup>20</sup> Félix Guattari, “Presentation”, *Recherches 6 Programmation, architecture et psychiatrie* (1967), 5. [Our translation.]

<sup>21</sup> This results from the first commission ever received by the CERFI, from the Ministry of Social Affairs (Directorate of Sanitary and Social Equipment). The request was to develop a draft on ‘building standards applicable to psychiatric hospitals’ (See Guattari, “Presentation”, *Recherches 6, Programmation, architecture et psychiatrie* (1967), 3.

<sup>22</sup> Organised according to decentralised plans, with fluid circulations, they were subdivided into pavilions, each corresponding to a different function. In accordance to modern planning principles, they allowed for collective areas, vast green spaces, sunlight and natural ventilation.

usual *milieus* of social life'.<sup>23</sup> As an alternative to such institutions, Ferrand and Roubier proposed that psychiatric hospitals should consist of units with fewer than 100 beds and should be located within city areas. Like the *comarcas* that had been so influential for Tosquelles, they argued that these small-scale hospital units should be integrated with other care activities in each specific urban 'sector' (borough). This would prevent psychiatric care from being excluded from health at large. Seen in these terms, these units would be part of broader networks of part-time institutions, therapeutic workshops, day hospitals, home consultation systems, ambulatory treatment, drug rehabilitation programs, foster care units, visits to people's homes, etc. – and of course connected with the local neighborhoods, parks, squares and other public facilities of the city.

The principles of Ferrand and Roubier's proposal are tested in Nicole Sonolet's project 'Un centre de santé mentale urbain: proposition d'une expérience', also featured in Issue no. 6.<sup>24</sup> This project was the result of reflections following the construction of a psychiatric hospital by Sonolet in the 13th *arrondissement* in Paris and, as Sonolet wrote, following 'discussions with different doctors, social assistants, staff, patients and family members of patients'.<sup>25</sup> The proposal consisted of a basic model for an urban hospital, identifying the key technical, architectural and urban issues to be addressed. Of key relevance is how the project was designed to be one among many other medico-social facilities in the city. Two main design aspects are important to note. Firstly, the scheme promoted a strong relationship with the city by setting up a series of services on the external perimeter of the site, encouraging encounters between those inside and outside. The reason for this was to help the integration of patients and also to eliminate preconceived ideas about the psychiatric hospital among the local population. Such a configuration was in line with Ferrand and Roubier's idea of promoting stronger links between psychiatric care and the social life represented by the city:

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<sup>23</sup> Félix Guattari, "Presentation", *Recherches 6 Programmation, architecture et psychiatrie* (1967), 5. [Our translation.]

<sup>24</sup> Nicole Sonolet, "Un centre de santé mentale urbain: proposition d'une expérience", *Recherches 6 Programmation, architecture et psychiatrie* (1967): 137-155.

<sup>25</sup> *Ibid.*, 137.

In a psychiatric hospital, and mainly in an urban psychiatric hospital, the definition of the hospital structure should fit the idea of the participation of the realm of the hospital in the social equipment of the city. From the moment an urban institution is established, a real osmosis between its own equipment and that of the city should be implemented. The first therapeutic result is the permanent possibility of each hospitalized patient resuming contact with the real, outside of the artificial and unreal collectivity of the hospital.<sup>26</sup>

In accordance with this, the complex was designed to be accessible from all sides and the units could be independently accessed from the street level. The use of a courtyard typology makes it possible for us to imagine how such a speculative project could provide a model to negotiate very different urban settings. Here, too, the proposal for mixing distinct functions and programs – in particular the promotion of a close proximity between residential and institutional areas – was not only a critique of modern architecture, but more importantly a stand against the exclusion of madness from the collective life of the city.

Secondly, according to the author, the layout of the premises should maintain maximum flexibility in the use of spaces and the possibility of subsequent amendments, according to the needs that might emerge in the future. With this in mind, Sonolet suggested that some areas (interior or exterior) could be left empty to allow for the creation of new services or the expansion of local or existing ones. Not surprisingly, the design refers very closely to projects under development at the time, in the later stages of the modern movement, where the idea of a functional division of the city was being replaced

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<sup>26</sup> Guy Ferrand and Jean-Paul Roubier, “L’hôpital psychiatrique dans la cité : programme d’un hôpital psychiatrique urbain de moins de cent lits”, *Recherches 6 Programmation, architecture et psychiatrie* (1967), 84. [Our translation.]

by the design of large multifunctional complexes integrating a diversity of services and a variety of programs.<sup>27</sup>

On closer reading, what is significant is how the design does not so much involve a dispersion of healthcare facilities throughout the sector, but rather concentrates them into one single, programmatically diversified complex – albeit one smaller than the hospital village. It is less health care as part of the city, and more a hospital that mimics the heterogeneity of urban scenarios. More importantly, the design is indicative of a problematic reduction of sector psychiatry into spatial and quantitative formulas – such as the reduction in size and the calculation of hospitals in terms of bed units per capita – that, by themselves, are unable to address mental health issues. Such a simplification of the problem of ‘madness’ is part of the reason why the principles of sector psychiatry as implemented by the government were received as reactionary by several groups in the medical community, and in particular by the members of the CERFI.<sup>28</sup>

Indeed, there were several important differences between the original proposals that had found a space of problematisation in *Recherches* 6 and the sector policies officially promulgated in March 1960 by the State, resulting from a hasty and bureaucratised appropriation. Firstly, the State’s project was closer to a territorial distribution of ‘mental police stations’ oriented more towards control

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<sup>27</sup> Important references are the project for “The Free University of Berlin”, 1963, by Candilis, Josic and Woods; the project for the ‘reconstruction of Frankfurt Römerberg’, 1963, by the same authors; or even Le Corbusier’s “New Venice hospital” of 1964. It would be interesting to discuss the implications of presenting this unit as a single system of management, and considering whether small or more distributed units avoiding the mega-complex would not be more adequate for implementing the ideals of sector psychiatry.

<sup>28</sup> For instance, the rule of three beds per 1,000 inhabitants proposed by Ferrand and Roubier quickly became out of date in several areas with fast population growth, such as in Paris’s suburbs and satellite cities. Furthermore, many forms of psychiatric control and repression continue to exist regardless, or independently, of hospitals. See Issue 17 of *Recherches* edited by the CERFI: “Histoire de la de la psychiatrie de secteur, ou le secteur impossible?” *Recherches* 17.

than the actual improvement of mental health.<sup>29</sup> In administrative terms, the sector was implemented in a systematic way, something that was opposed by its proponents: it was geographically fixed to the point of creating immense bureaucratic difficulties.<sup>30</sup> In addition to this, for Daumézon, whereas the sector was implemented as a single psychiatrist that was assigned to a geographic location, the idea of the sector as proposed implied larger teams and collective work. Only by working collectively would the sector be able to incorporate its negotiations with different institutions into their programming of necessary interventions. For Daumézon this raised another problem: the lack of teams that could move from the setting of a hospital to a very different setting where they had to negotiate with local authorities, students or planners alike. In other words, the sector required a radical change in perspective, for which neither the State nor traditional psychiatrists were ready. As noted by Guattari: ‘Let us say that technocratic programming proposes a fixed plan once and for all, whereas continuous local programming, which is the very idea of an institutional programming, insists on an always possible and necessary intervention of collective interlocutors’.<sup>31</sup> Yet this never happened. The sector as implemented was not the sector as its proponents had imagined.

### **The City as Mental Health**

Leaving aside the detailed discussion of the shortcomings of the sector’s implementation by the State, we would like to highlight how the proposal for sector psychiatry (in its original intentions) reconfigured psychiatric care as an urban problem. The crucial reasons for this include the following. In economic terms, there are clear advantages in being close to home and other extra-hospital institutions (such as part-time institutions, therapeutic workshops, day hospitals, home-visits, ambulatory treatments or family placements),

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<sup>29</sup> Georges Daumézon, “Le Secteur Impossible?”, *Recherches* 17, ‘Histoire de la psychiatrie de secteur ou le secteur impossible ?’ (1975), 463. [Our translation.]

<sup>30</sup> Jean Oury, “Le Secteur Impossible?”, *Recherches* 17, ‘Histoire de la psychiatrie de secteur ou le secteur impossible ?’ (1975), 466. [Our translation.]

<sup>31</sup> Félix Guattari, “Le Secteur Impossible?”, *Recherches* 17, ‘Histoire de la psychiatrie de secteur ou le secteur impossible ?’ 1975), .431. [Our translation.]

as travel times and costs for both patients and medical staff are reduced. In recovery terms, this proximity facilitates the later stages of treatment, making home visits and hospital visits much easier. It also promotes autonomy and assists in the reintegration of patients into the community. Even more significantly, in thinking about psychiatric care at the scale of the borough, the proposal replaces a diagram in which madness implies social exclusion with one in which madness becomes a key element in the making of the city.

As we have shown, such a proposal follows on from the work on institutional psychotherapy and institutional analysis developed at Saint-Alban and La Borde and taken up by the CERFI. In this trajectory, space has become increasingly central to a collective effort that seeks to fight against social alienation without losing track of the therapeutic needs and specificities of mental health care. CERFI's approach to mental health and institutional analysis was, however, manifestly different from original proponents of sector psychiatry, such as Daumézon and Bonnafé. CERFI believed that psychiatry could not limit itself to the psychiatrist, nor was institutional analysis a domain of psychiatry only.

Regarding sector psychiatry in particular, Guattari argued that the teams managing each sector could not be based on psychiatric care only, and had to incorporate architects, planners or social scientists. What further distinguished CERFI was the idea that analysis could not be confined to a focus on the mental health institutions: it had to address social processes in their complexity (and therefore address other types of institutions). In articulating a vision of the hospital with a wide range of extra-hospital activities, therefore, the proposal of a psychiatry of sector opened the way for the removal of mental health care from the exclusive control of expert institutions, and located it at the intersection of a broader thinking of social services and public facilities, or more precisely, of *collective equipment*.<sup>32</sup>

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<sup>32</sup> We prefer the direct translation of *équipement collectif* as 'collective equipment' instead of the more common translation as public facilities, insofar as it maintains the focus on the relations between the equipment and a collective assemblage. Furthermore, the term 'public' necessarily limits the discussion of equipment to the State.

This shift from a unique focus on health facilities to a focus on the city at large is, in our view, the natural corollary to this trajectory, in which space became increasingly more central to psychiatric care. In Guattari's view, this trajectory culminated in the proposal of collective, interdisciplinary and self-managed teams of 'institutional programmers'.<sup>33</sup> Such a radical shift in the approach required to realise such a project is probably the best explanation for why its implementation by the State ultimately failed. Today, however, it is our task to analyse the conditions under which such an approach to the design of cities might be recovered.

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<sup>33</sup> Félix Guattari, "Le programmiste institutionnel comme analyseur de la libido sociale", *Recherches* 17, 'Histoire de la psychiatrie de secteur ou le secteur impossible?' (1975). [Our translation.]