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Leaving the walls of mental health institutions

From ideals in texts to the uncertainties of practice

Sortir des institutions en santé mentale. De l'idéal des textes aux incertitudes de la pratique

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Résumés

English Français
This article offers first of all an analysis of the representation of the person suffering from mental disability or mental disorders which is found in the call for deinstitutionalisation aired by the Committee on the Rights of Persons with Disabilities (United Nations). It then shows how this anthropology, which is at the same time demanding and perfectly in sync with the ideals of a society in which personal autonomy is the right and the duty of each individual, is practically negotiated on the field of a mental health residential facility which provides support for its patients when they leave the institution at the end of their stay. The paper takes as empirical object a central feature of this process, the "partner-meetings" and the conversations taking place between the patient and other actors. The paper shows that, far from the abstraction of juridical texts, the care providers' perception of the patient as a partner is a fragile process. The partnership is always conditioned, for the care providers, by an absence of worries about the persons' (in)abilities to look after themselves, and by a demonstration of the latter's desire for and capacities for autonomy. In these negotiations, the patient in mental healthcare is always potentially, but never completely, the partner in the process of leaving the institution.

Cet article propose d'abord une analyse de la représentation de la personne souffrant de handicap ou de troubles mentaux telle qu'elle existe dans l'appel à la désinstitutionnalisation lancé par le Comité des droits des personnes handicapées (ONU). Il montre ensuite comment cette anthropologie, exigeante et parfaitement en phase avec les idéaux d'une société où l'autonomie individuelle est un droit et un devoir de chacun, est négociée en pratique sur le terrain d'un établissement de santé mentale qui accompagne les sorties de l'institution de leurs patients au terme de leur séjour. Il prend pour objet empirique un dispositif central de ce processus, les "réunions-partenaires" et les échanges qui s'y tiennent entre le patient et d'autres acteurs. Le chapitre montre que, loin de l'abstraction des textes juridiques, la perception par les soignants du patient comme un partenaire est un processus fragile. Le partenariat est toujours conditionné au

fait que les soignants soient non pas inquiets par l'incapacité d'une personne à se prendre en charge, mais rassurés par la démonstration de son appétence et de ses compétences pour l'autonomie. Dans ces négociations, le patient en santé mentale est toujours potentiellement, mais jamais totalement le partenaire de sa sortie de l'institution.

Entrées d'index

Mots-clés : psychiatrie, santé mentale, sortie de l'institution, patient-partenaire, autonomie
Keywords: Psychiatry, Mental Health, Leaving The Institution, Patient-Partner, Autonomy

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Texte intégral

1. Introduction

1 In the domains of disability and mental health, the pair "institution-deinstitutionalisation" crystalises the criticisms and the hopes, the tensions and the demands, to the point of becoming a central element in the controversies over what is or isn't a good way of intervening on (or with) another person. These controversies are played out differently depending on whether they take place at the general or even abstract level of international juridical texts, or at the particular and concrete level of the functioning of an institution, where decisions are to be taken concerning the future of a very specific patient. This chapter aims to bring these two levels face to face.

2 First of all, we will come back to some key elements regarding the position of the Committee on the Rights of Persons with Disabilities (United Nations) vis-à-vis the Convention on the Rights of Persons with Disabilities (CRPD) and its article 19, in which it claims to read an invitation for a complete deinstitutionalisation in order to foster the autonomy and full participation in the community of persons with disabilities. We will insist on the fact that, to justify this uncompromising position, the Committee mobilises a demanding anthropology of the person with a disability, which it endows in indistinguishable manner with a desire for autonomy and the capacities to achieve this desire. This point is all the more interesting insofar as neither the Convention nor the Committee take into account potential distinctions between persons with motor disabilities, those affected by an intellectual disability and those experiencing psychiatric illness – they are all grouped together under the category label "persons with disabilities."

3 Secondly, we will see how the question of leaving the institution is concretely dealt with in an open psychiatric establishment based on short-stays (6 months maximum), whose therapeutic project precisely consists of, in lockstep with this demanding anthropology, positioning the patient as a "partner" and turning them into an actor in the process of leaving the institution, which is at the same time always wished for but occasionally feared for the risks it generates. Through an analysis of the conversations in several "partner-meetings" which include the patient and other healthcare actors, we will see that in practice this partner status is continuously negotiated, fragile and contingent, because conditioned to the fact that the care providers consider the situation of the person leaving the institution as being more reassuring than worrying.

2. Leaving the institution in theory: Willing and competent persons

2.1. The Committee on the Rights of Persons with Disabilities, a radical interpreter of the Convention for the Rights of Persons with Disabilities?

4 On September 9, 2022, the United Nations' Committee on the Rights of Persons with Disabilities published its "Guidelines for deinstitutionalisation, including in emergencies" (thus referring to the lockdowns implemented following the COVID-19 pandemic). This body is the official interpreter of the Convention on the Rights of Persons with Disabilities and the fifty or so articles enshrining the rights of persons with disabilities, and its guidelines complete the statements of another text initially published in 2017 and whose notoriety no longer needs to be demonstrated: General comment No.5.

5 In this General comment, the Committee delivers an uncompromising critique of institutions and institutionalising as a whole on the basis of a strong interpretation of the CRPD's article 19 (see the contribution by Rosemary Kayess in this issue). This article stipulates that the "States Parties to the present Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community." For the signatory States, it is a question of ensuring that (1) "Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement"; (2) "Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community"; (3) "Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs."

6 For several authors (inter alia Appelbaum, 2019), the radicalness of the interpretation of this article (in which it will be noted that the term "deinstitutionalisation" does not appear) is due in part to the composition of the committee, which includes numerous critics of the medical model of disability, and then due to its working method, which aims, theoretically at least, to give voice to vulnerable actors (Payet, Giuliani & Laforgue, 2008). The guidelines are thus presented as the outcome of a participatory process having brought together over 500 persons with disabilities, including people who consider themselves as "survivors of institutional placement." But in what ways is this interpretation so singular?

7 Its most obvious feature, and the one most discussed in particular in the juridical literature, concerns a what might be termed radical criticism of institutions or institutionalisation per se, as this reading redefines any institutional form as a restriction of individual freedom of choice and as a form of segregation (Hachez & Marquis, 2024). General comment No.5 in fact indicates that for there to be any meaning to talking about the autonomy of persons with disabilities, it is necessary that they "are provided with all necessary means to enable them to exercise choice and control over their lives and make all decisions concerning their lives" (2017: 16). Yet, the framework propitious for autonomy of life must exclude "any form of institutionalisation," that is to say any imposition of specific life conditions. The institutional landscape as such here redefined does not stop at the walls of the buildings: "Neither large-scale institutions with more than a hundred residents nor smaller group homes with five to eight individuals, nor even individual homes can be

called independent living arrangements if they have other defining elements of institutions or institutionalization." Amongst these elements are included the sharing of services, lack of control over day-to-day decisions, the imposition of a routine which does not take preferences into account, participation in identical activities, the supervision of life conditions, and a "paternalistic approach" to service provision.

8 The directives published in September 2022 again put the boot in: institutionalisation is "a discriminatory practice," "a deprivation of liberty based on disability," "in contradiction with the right of persons with disabilities to live independently and be included in the community," which "must never be considered as a form of protection of persons with disabilities, nor as a 'choice'," – in short, a practice which "nothing justifies being perpetuated." For the first time, following abuses established by the Committee's investigations, the mental health institutions (amongst which, "psychiatric institutions," "prison psychiatric wards" or "rehabilitation centres others than those community-based"[1]) are notably cited as organising "a detention based solely on disability or in conjunction with other reasons such as 'care' or 'treatment'" (2022: 14). This denunciation also concerns situations where the persons are undergoing personal crises, which is also, in the eyes of the Committee, no reason for institutionalisation. Identified with any form of constraint (from imposing a routine to the absence of a choice of cohabitants, and taking in any form of treatment, medical or otherwise), the institution(alisation) is also considered in this nonetheless singular sector as always being part of the problem, and never of the solution.

2.2. The practical anthropology of a complete deinstitutionalisation: The rights and duties of an autonomous life

9 To establish a foundation for its critique of the institution, the Committee leans on a strong version of the social model of disability, which refers to autonomy as a personal issue (see Winance, 2016). In this constructivist perspective, there is almost never any reference to the materiality of a disability, considered to be the result of the maladjustment of the environment to the specificities of the person (Kayess & French, 2008). In it, moreover, "impairment" is spoken of much more rarely than "disability," which means that motor, mental or psychiatric disabilities are considered and addressed in indistinguishable fashion.[2] A tension appears, therefore.

10 On the one hand, this model claims to be nominalist, concrete and refuses any form of totalisation: there is no such thing as "persons with disabilities," but solely human beings endowed with specificities, which only generate difficulties from the moment they are not acknowledged and taken into account. Because disability is no longer a deficiency with regard to a norm but instead a clue to the infinite diversity of the forms of human lives, each person is considered as unique, and the holder of a right to see the social environment adapt to their proper way of functioning, irreducible to that of their neighbour (from which springs the proscription of any regulation, constraint or routine). On the other hand, if only through the performative effect of drafting texts with legal significance, persons with disabilities, now part of the shared humanity, are, in the General comments and the guidelines, addressed as an abstract and indistinguishable categorical totality. Further still, they are *all endowed indiscriminately* with certain common characteristics which are not subjects for discussion, but without which the ethical position of the Committee would have no basis.

11 The characteristics which persons with disabilities are invested with are of two types. First of all, they concern the desire or the wish to lead a form of life marked by autonomy: whatever their specific characteristics, each person wishes to be in control of their lives, or at the very least participate in the decisions which concern them, and therefore could not flourish in an institutionalised system; each person wishes to have a

place of their own and refuses to have imposed on them a routine they have not chosen or to share services, each person wants to participate in life in society and refuses to be segregated on the basis of their disability or with a view to treating it. Then, these characteristics concern the capacities (which must be legally recognised) allowing them to realise this desire for autonomy: each person develops (or can develop) a life project; each person is best placed to know what is good for them; each person is able to express these wishes (in the event that the environment is capable of receiving the message).

12 Together, these axioms of desires and capacities form what could be termed a "practical anthropology" of the person with a disability (Marquis, 2015), expressed here in juridical terms. The issue here is not to discuss the reality or the pertinence of this practical anthropology, which for that matter has numerous supporters in the social sciences (for the recent focus of the French-speaking sociology on individual capacities, see Genard & Cantelli (2008) and Genard (2013), as well as, more generally, the intellectual Disability Studies movement and the successive issues of the journal *Disability studies Quarterly*). Like that of the child (see Ehrenberg & Marquis, 2023), the practical anthropology of the person with a disability is intrinsically moral and evolves over time. The "person with a disability" is nowadays one of the key figures around whom are most clearly crystalised the tensions of the moral environment of a society where autonomy is regarded as a common condition (Ehrenberg, 2010, 2020). In such an environment, despite our infinite differences, autonomy is a wish *and* a capacity supposedly shared by all. In addition, what was previously perceived as a disability should better be read as a symbol of diversity, even as a personal potential, a hidden asset which is only asking to be revealed in a suitable environment. From a sociological viewpoint, the "full participation" of persons with disabilities in society endorsed by the Convention and the Committee thus also implies their participation in the collective ideals of a society where autonomy is regarded as a common condition: for them as for everyone, a life which is worth being lived implies being able to be yourself, being able to be active, and being able to be properly socialised and integrated (Marquis, 2022a). The practical anthropology of the person with a disability which underpins the Committee's reading demonstrates very well that, here once again, desiring and being able to be autonomous is not only a person's right, it is also a collective expectation regarding them.

2.3. Deinstitutionalisation: For mental health as well?

13 In what follows in this chapter, we will see how this practical anthropology is negotiated on a specific terrain over which the CRPD and the Committee indiscriminately extend their jurisdiction: persons suffering from mental disorders housed in mental health institutions, which the Committee is urging, as we have seen, be closed down, in the same way as the others. How does the Committee see, in concrete terms, the process of deinstitutionalisation, in particular in mental health? In the Guidelines (2022), the Committee offers various recommendations, relatively vague and general. Amongst them, that "people leaving the institution are respected as decision makers, with support if required, in respect of all aspects of leaving the institution." They should also "be provided with adequate time and opportunities to prepare physically and emotionally for living in the community, with States parties ensuring that all persons have an individualized plan in place according to their will and preferences."

14 As such, these broad considerations will certainly in principle gain support from many in the domains of disability and mental health, as they also will beyond them. But there is a very strong likelihood that in the eyes of certain stakeholders they will trigger questions, even concerns, as to the ways it is possible to implement them. One of the obstacles frequently raised, which we will not look into within the scope of this article, of course pertains to the financial sustainability of these individualised provisions of

care. Another concerns the impact on informal caregivers (see Kittay, 2024). We will here discuss a third obstacle, in other words the capacity of the persons to meet the requirements of this demanding "practical anthropology."

15 In law and psychiatry, several academic voices have been raised to request that the Committee's radical viewpoint, judged "impracticable" or even harmful to the persons concerned (Appelbaum, 2016, 2019), be replaced by a more "realistic" approach, in particular as regards the assumption of universal legal capacity (Dawson, 2015). These works, some of which draw on John Talbott's criticism of the "disasters" of past deinstitutionalization (2004 [1979]), highlight problematic cases of aged people suffering from complete dementia, or of persons in an acute crisis of psychotic decompensation. In doing so, they doubtless have little difficulty in demonstrating the limits of the Committee's approach (or that of the CRPD) in situations where the person concerned is totally absent from themselves and risks putting themselves in danger if the principles of a radical deinstitutionalisation were applied to them. It is as much a question of "protecting" them as a question of "rendering them capable" (Eyraud, 2013).

16 Nevertheless, the issue of the capacity of persons with (intellectual) disabilities to meet the demands of this practical anthropology is far from being confined to extreme cases. It especially irrigates the "day-to-day of psychiatry" (Velpry, 2008a) in that this latter domain is progressively attempting to put into practice the principles of a deinstitutionalisation which encourages, where possible, ambulatory care (Coldefy, 2016). In fact, we will see that, from the perspective of the care providing teams responsible for supporting this process, it frequently happens that the people who are nevertheless designated "stabilised" (in that they have not been in a crisis condition since a certain time), and who are led either by choice or by obligation to exit the institution, do not necessarily meet the axioms discussed earlier in terms of the desires for and the capacities for autonomy, which generates concerns that leaving the institution leads to more dangers than potential benefits. How, in practice, when a person leaves the institution, are the decisions negotiated and how is the support provision arranged, in particular in the mental health sector where, owing to manifestations of the pathology, the presuppositions adopted by the practical anthropology on which the Committee's position is founded are frequently undermined?

3. The Gîte d'étape, an institution preparing for exiting it

17 The fieldwork upon which the analysis rests has been conducted in a French psychiatric institution, which we will call the Gîte d'Etape. 6 months of observation (including witnessing some fifteen cycles of "partner-meetings," cf. infra) and some thirty interviews with the care providers and the patients were carried out in 2015-2016. Located in the Paris suburbs, this care facility organises "time-out residencies" of a maximum of 6 months (in theory at least) based on systemic therapy for adults affected by mental health disorders, many of whom receive AAH (adult with disability allowance).[3] "Time-out" refers to the fact that these patients, most of whom already have a long psychiatric history, are considered as being in a therapeutic dead-end by former care providers who are often the ones sending the patient to the Gîte d'Etape. It is an open institution with a capacity of around 70 beds: the patients can come and go as they please, with the sole obligation of sleeping there overnight and taking part in certain therapeutic or collective activities.

18 The care providers working there are unfamiliar with the debates concerning deinstitutionalisation (which they rather associate with the anti-psychiatry of the second half of the twentieth century), and even less with the CRPD's system. They consider the institutional care they practice as a solution which is certainly imperfect, but in itself already a huge improvement in comparison with the psychiatric asylum

model acting as a deterrent, or even in comparison with the hospital, presented as a solution of last resort which often merely fosters or even aggravates the person's difficulties. Deinstitutionalisation is therefore not an aspiration or a political demand, and the institution (which is their place of work and their employer) is an entity considered to be protective (as a legacy of institutional psychotherapy) which is less in need of revolutionising than it is of reforming. Nevertheless, as it is an establishment offering fixed-term stays, the question of "exiting the institution" is raised practically as soon as the patient arrives. Each of them for that matter receives, on their arrival, a diary in which they are straightaway requested to note, visibly, the (theoretical) date of the exit, towards which the whole stay is geared. The patients frequently know this date by heart and promptly mention it in their presentations of themselves.

3.1. The "partner-meetings": A theoretical partnership

19 Whilst it does not refer to the CPRD or to other legal obligations, the Gîte d'Etape's therapeutic project is no less shaped by principles which are close to them in that they place the person, their capacities and their wishes at the heart of the support process. It thus conforms to the ideals of the empowerment, the participation and the rehabilitation of the persons involved by means of valuing their capabilities. The development of a partnership is the spearhead of this investment in the patient, not as an individual *on whom* one acts, but as a partner *with whom* one acts, in a dynamic which is more contractual than institutional (here in the meaning the Committee gives to this dimension). The institution's charter in fact specifies that…

> …the admitted patient is an actor in their stay, a fully-fledged partner, the holder of their experience-based expertise, equivalent to other forms of expertise. We lean on their specific and environmental competences. We provide them with support so that they might rediscover their agency and we enable them to embark on the road to recovery they have chosen. (Excerpt from the website, consulted in August, 2023)

20 This partnership with the patient is supposed to manifest itself in numerous terminological cues aiming to highlight what could be termed the "deinstitution in the institution": patients can come and go as they please, they are treated as if they are "in a hotel" by a "hospitality staff" (and not by maintenance personnel), they eat in a "restaurant" (and not in a canteen), their appearance often does not differ from that of the care givers, since the latter do not wear uniforms), everybody respectfully and symmetrically addresses each other (using the "Vous" form in French), the corridors are fitted out in a "lounge" style (furnishings, musical instruments, art exhibitions, ambient music, etc.) and emphasise relaxation, care consultations are re-termed "meetings," etc. Concerning the therapeutic aspect, the touchstone of this partnership system is the sequence of "partner-meetings" (PM) held monthly (in other words around 6 meetings per patient) which constitutes the spinal column of the stay and which the patient must attend.

21 In keeping with the systemic perspective according to which the issue at stake is not the patient but the tangle of relationships which needs to be loosened with the assistance of the persons involved, each meeting brings together, around the patient and their situation, the stakeholders, the significant people, in other words most often members of the family or friends, caregivers from the institution or "the local primary care sector" (the French form of the territorial organisation of psychiatry) attending to the patient, people who interact with the patient about administrative issues. There are no clear rules or restrictions as to selecting the participants. The patient is asked to provide the names of the people they consider important, but this list, when it exists, is often amended by the caregivers, and the attendance in any case proves to be very variable from one situation to another.

22 Each PM lasts for about an hour and is routinely presided over by a systemic therapist presented as independent of the institution. The architecture of the site has been though through with these key moments in mind: the meetings take place very close to the reception – and thus near the entrance door – in small rooms situated on either side of a corridor with a "lounge" style. Each room is intended to be pleasant and light-filled thanks to patio doors overlooking the green spaces of the institution frequented by the patients. It is fitted out with simple but comfortable furniture – chairs arranged around a coffee table, a board to note down ideas. Coffee and biscuits are served on a tray. The atmosphere looked for is that of a shared work moment, a collegial brainstorming or a progress report – a meeting between partners.

23 For the observer, these PMs are first of all often very muddled moments, owing to the very unequal level of attendance, but also of information, of memory, of the attention of the stakeholders, who sometimes have very different interpretative frameworks and interests. In this respect, they offer a mirror to the complexity of the landscape and the at times extreme fragmentation of the careers of people in psychiatry. It is not uncommon that a significant part of the meeting is taken up with trying to understand who is doing what, or to even more or less come to some agreement over what is being discussed. Nor is it uncommon that the patient is (along with the institution's special needs professionals) the best informed about the parameters of the situation.

24 In taking an interactionist perspective, one can see these meetings as configurations behind closed doors in which each participant expresses themselves or keeps their head down, employs tactics and stratagems, carries out modifications, adds to or clears up misunderstandings, to argue for a reading of the situation or to obtain "something," which always requires minimal cooperation on the part of the other participants. They are above all elements of a negotiated order (Strauss, 1981; Ogien, 1989). These spaces-times also often have the appearance of a theatrical, even dramatic, performance, because they alternate between moments of tension and of relaxation, they witness expressions of reassurance and of concern, they are riddled with reversals, and oblige some or others to clarify their expectations and the representations or "feelings" which underpin their position taking.

3.2. An apparently evident, but in reality fragile, partner status

25 Whilst, in compliance with systemic therapy, these exchanges are supposed to focus on the situations and the relationships rather than on the persons, the fact is that in practice, the subject or the object of the majority of the sentences remains the patient themselves, their condition or its evolution, their wishes or their problems, their plans or their troubles, and above all their near future. The issue is what will become of them. On the invitation of the systemic therapist, the "expectations" and the "fears" of the caregivers and family members are also talked about of course – but they in their turn also have as their object the patient, to whom people speak directly in the second person, but who is also talked about in the third person in their presence in all of the meetings observed.

26 From the first exchanges between the patient and the systemic therapist which open the meeting on the latter's initiative (for example: "So, Sir, how are you feeling since the last time?," or: "Good, well today, we will see what you can provide the sociologist with for his investigation into autonomy!," etc.), the dynamic established for the patient is thus one they experiment in most of the transactions with the caregivers: talking about themselves, assessing themselves and being assessed (see Bloor, McKeganey & Fonkert, 2018). The asymmetry of the positions thereby never disappears, and the patients are acutely aware that they are at the same time playing for higher stakes in these moments than the other participants (the issues are personal for them whilst they are work-related for the majority of the other participants) and that they nonetheless have less levers than the others to influence their outcome.

27 As soon as the patient alludes to this asymmetric reading during the meetings, the caregivers systematically look to undermine this perspective, in reminding the patient of their theoretical position as a partner *inter pares*. The opening to the second partner-meeting held with Jacqueline, aged 66, describes very well this difference of perspective. Jacqueline is one of the institution's oldest patients. Her stay began a little less than two months previously. It was instigated by her primary care psychiatrist (the psychiatrist who attends to her outside the institution), owing to repeated stays at a psychiatric hospital following the death of her husband and whose stabilising effects seem to fade rapidly when the patient returns home. Present at her second partner-meeting are the members of the Gîte d'Etape team attending to her, as well as the primary care psychiatrist. Neither of Jacqueline's two children, including her daughter, who will probably become her trustee, are present, officially due to busy schedules, but also more probably to tensions with Jacqueline over the management of her possessions.

28 Before the start of the meeting, Jacqueline, elegantly dressed and made-up but clearly stressed, had positioned herself at the entrance to the room, where she welcomes each participant by thanking them for attending. The meeting begins with a cup of coffee and the standard pleasantries.

> *Systemic therapist*: So, how are things going, Madam?
>
> *Jacqueline*: I feel fine. But it's true that I freaked out because of the anniversary of my husband's death, but it's fine, don't worry, I feel great, I am back to myself again.
>
> *Systemic therapist*: And at the Gîte d'Etape (GE), have you found your feet?
>
> *Jacqueline (addressing the caregivers)*: It's not for me to say, I think.
>
> *Several participants take mild offence and one of them says*: But no, it's you who should feel that.
>
> *Jacqueline*: Fine, if I could say one thing, I am making progress, but I find that I sleep too long.
>
> *Systemic therapist*: And how much is too long?
>
> *Jacqueline*: Well, I sleep from 21.00 to 07.35, and then I have a nap at 13.15 until the women from the hospitality staff arrive to wake me up. But I have to say that I do the activities all the same.
>
> *Nurse at the GE*: Yes, and you like doing them, you are invested and it's a real pleasure to have you.
>
> *Special needs worker at the GE*: Because, what you are describing is just a good night's sleep, in fact.
>
> *Jacqueline*: But I told myself that all the same it was my fault if I got up late, because I watch the TV too late in the evening.
>
> *Everyone downplays it and the nurse at the GE says*: But no, 07.30 isn't too late!
>
> *Systemic therapist*: You should see my children (laughter).
>
> *Special needs worker at the GE*: And me, you should see me in the morning!
>
> *Jacqueline*: At the hospital, they allow me to have my breakfast in my pyjamas. Here, it's not the case, and it's good, that, it forces us to look after ourselves, but I have to say that here I find it difficult to get dressed for breakfast. And this morning, it was even more difficult because during the night I was freaking out about the PM.
>
> *Special needs worker at the GE*: Really! But why? After all, it's something to help you!!

Jacqueline: I don't know what to expect. I'm so scared of talking nonsense, of speaking, and that after there are consequences.

Special needs worker at the GE: but no, it's really a safe environment here.

Systemic therapist: OK, can we take stock of this first period by starting with the beginning?

29 The exchange which gets this partner-meeting started seems to be the reverse of what is classically observed in patient-caregiver interactions in psychiatry: here, it is the patient who problematises, even pathologizes, their behaviour, looks for flaws and reasons to be concerned at the same time as being reassuring, whilst establishing expert knowledge on the side of her professional interlocutors ("It's not for me to say"). The caregivers, for their part, de-pathologize and play the similarity card or, one might say, that of "shared humanity" (Boltanski & Thévenot, 1991), including by accentuating the normal nature of the patient's behaviour and even taking themselves as examples, as the exchange concerning sleep demonstrates. This excerpt thus seems to perfectly illustrate the participatory aspiration of the "partner-patient" concept valued both by the caregivers and by the international texts.

30 Nevertheless, this dynamic is, in practice, extremely fragile and contingent. Jacqueline herself will see her status as a partner falter over the course of the reunion due to the mentioning, by the external psychiatrist, of her previous relapses, which did not bode well, and this being the case whilst Jacqueline does not perceive the risks which the caregivers want her to read in them (see Marquis, 2024). Generally, the outcome of these meetings, the mood in which they will end, the participants' levels of satisfaction and the impression the exchanges will leave on them are difficult to predict. In fact, a reunion beginning auspiciously and which opens with confidence in the fact that "It's going fine" or that the patient's plan is on track, can turn dramatically in the light of new elements introduced by the participants, if other people respond to also express their concerns. Similarly, a situation judged worrying during a previous meeting can be read in another way depending on the dynamic of the interaction (for example in accordance with the condition of the patients and the ways in which they recount things) or the absence of a participant who had at one time maintained a circumspect reading. What was judged problematic might no longer be mentioned or even considered normal or reassuring from one meeting to the next, and vice-versa.

31 What does this contingency bear witness to? Establishing the patient as a partner and, above all, sustaining this status are actually processes that have, for the caregivers, prerequisites. These prerequisites require that the patient meets certain criteria, without which it will not be possible, from the caregivers point of view, to engage in a partnership. These criteria are very close to the axioms of practical anthropology referred to earlier: a patient will constitute a reassuring partner if they outline a plan involving a greater yet reasonable form of autonomy and if they evince the competences necessary to carry it out successfully (or in any case to not mishandle it), such as the ability to read the situation correctly, to not place themselves in danger, to appeal to others when necessary. The major difference lies in the fact that in the legal texts mentioned earlier, these competences are quite simply presupposed, whilst here they are problematised and subjected to evaluation. To better understand the nature of these processes, the reasons why the caregivers insist on them, and the expectations (sometimes paradoxical) that they have of the patients, we will present and analyse two contrasting situations, that of Jeff and that of Jean-Pierre.

4. When the patient worries: Jeff's partner-meeting

32 Jeff is a 35 year-old patient at the end of his stay at the Gîte d'Etape. He has a son aged five, Victor, currently placed in a foster family and for whom he has supervised

visiting rights. Jeff began a relationship a month ago with another patient over the course of their stay, and has a plan to live with her. The excerpts transcribed below are taken from the fifth and penultimate partner-meeting, at which are present the members of the GE team attending to Jeff, Jeff's father, a social worker and a primary care psychiatrist – but not Silvia, Jeff's partner, who seems not to have been invited. The mood amongst the family and the caregivers is one of perplexity. After having pursued the plan of an apartment, Jeff has very recently announced that he no longer wants this solution, without for all that clearly investing in another, which irritates and concerns the institution's team. As if responding to an emergency felt by several participants, the meeting opens straightaway with the "solutions" to be implemented immediately at the end of the stay.

> *Systemic therapist*: So, what's the news?
>
> *Social worker at the GE*: Ehm, the latest news is that we have asked for a transition centre,[4] and not an apartment, so that there is no risk of isolation. And then, because Sir, after having wanted an apartment, has changed his mind a little, hey, Sir… And so, now, we are waiting, we are a bit hanging on their decision, and whether or not there is a place. So, that is where we are, hey, Sir?
>
> [*Jeff stays silent, staring fixedly in front of him*]
>
> *Systemic therapist* [*to the father and to Jeff*]: And what is the plan B, if we have to wait a long time? Have you already thought about it in the family?
>
> *Jeff*: I will have to stay in my father's apartment whilst waiting for that to unblock…
>
> *Father*: But I am in the Czech Republic for work!
>
> *Systemic therapist*: What would reassure you, knowing that solitude can be highly problematic?
>
> *Father*: Ehrm, that he is supported, anyway, that he is supervised, but me, I cannot look after him.
>
> […]
>
> *Systemic therapist*: [What Sir would need is] a nice crisis centre, as it were. A refuge. Are there any, in the primary care sector? In care homes, for example?
>
> *Primary care social worker*: Yes, there are. I am for it, there are solutions, but the problem is that everything needs to be scheduled! It doesn't happen by clicking your fingers, and I would like it if we were very sure what we were looking for.

33 A form of apprehensiveness tinged with annoyance is expressed directly by some of the participants. Jeff's change of mind has derailed a patiently constructed plan. Even more worryingly, Jeff doesn't seem in a particular hurry to leave the Gîte d'Etape, meaning there is a risk of the situation getting bogged down. "We can't do anything unless we know what he wants," sighs the primary care social worker after the meeting. Because of his apparent lack of interest as regards the practical implications of this unexpected change of mind, Jeff does not seem to be a reliable and reassuring partner. He is creating a breach in the practical anthropology mentioned earlier. As we will see, solitude in fact constitutes a significant risk, at the very least from the perspective of the caregivers. As Jeff doesn't seem himself, "to be self-supporting from within" (to make use of a phrase by Martucelli, 2002), he must be the object of "support," even of "supervision," in the words of Jeff's father (the caregivers preferring the terms "framework," "structuring" and "propping up"). To the accommodation problem is quickly added that of filling his days (together they form the two themes most frequently raised in the PMs), and thus occupying himself.

> *Primary care psychiatrist*: OK, but [whatever the accommodation] he will in any case have to fill his days.

Special needs worker at the GE: But Sir, you want to do the activities, even so?

Jeff: Yes, why not.

Special needs worker at the GE: It's for you, hey, to break the solitude.

Jeff: But for that, don't worry, Silvia could come to my father's place.

Father: But I don't want her to move in!

Systemic therapist: And so, for you Sir, your girlfriend and your father's apartment, would that be enough to make you happy?

Jeff: Yeah.

Father: Me, I think the same way as your psychiatrist, that it's really better when you have activities, otherwise, when you get depressed, it's difficult for everyone. The week before, you had a massive dose of depression before redoing your meds injection. You also said you were thinking a lot about your mother, but after the injection, you had a good week.

[…]

Systemic therapist: It remains the case that apparently, the people around you think that you have need of support…

Special needs worker at the GE: And the GEM?[5] To go and have a chat, without specially doing compulsory activities, you can do as you wish, but amongst other people… to be socialised, huh, but really, we are not forcing you to do anything.

[…]

Systemic therapist: And so, your father's apartment and the GEM, does that seem like a good idea?

Primary care social worker: Ehrm, but you also have to manage your everyday life, prepare your food, do the cleaning, we'll have to see, right?

Special needs worker at the GE: There are the SAVS[6] which offer a series of aids.

Jeff: But the shopping and the cleaning, that's fine, the cooking as well, the grub, I can do all of that. It's the solitude that's the problem. But that, my girlfriend will be there.

[*long gap in the conversation*]

Systemic therapist: And you [to the primary care psychiatrist], might that reassure you?

Primary care psychiatrist: As far as it goes, my point of view is that it is necessary to provide something offering support. And a GEM, I don't really think so. The minimum, and I insist, the minimum is that Sir does take his treatment, and so that involves coming to the CMP,[7] with in addition a self-employed nurse at the weekend, that's the minimum. Because after the day centre, if that doesn't work, the next step, it's the hospital.

34 We are witnessing here a situation which is the complete opposite to that which opened the PM with Jacqueline: what the father and the caregivers are attempting to do is to make sure that Jeff shares their frame of reference, and in particular their worries, whilst Jeff looks to be reassuring – in a way which triggers even more apprehension on the part of the caregivers and his father. For them, Jeff is quite simply not worried enough. In what follows in the discussion *(infra)*, the father explains this lack of awareness by blaming the institution's offer of a liminal position for Jeff and the other patients, which may give them the false impression that "it will be fine." The opposition between the comfort, the framework and the protection offered by this institutional stay on the one hand, and on the other the "real life" that does nobody any favours or the "outside," where you have to count on yourself is an argument frequently used as a

reminder to patients who cause concern by their lack of concern, or who confidently express a desire for autonomy which they do not, from the viewpoint of the caregivers or the family, appear to be capable of assuming.

> *Father*: Me, I think that here [at the GE], there is important work that is being done, but I also think that you are a little too much cocooned; you should see what it means to prepare your own food yourself. And for several days, so you understand. That's why a transition centre, or something like that, is a good avenue, to test… And you, you would also benefit from it to talk more with other people who have the same type of life as you have.
>
> *Special needs worker at the GE*: What is difficult for us, is that here, you don't really take part in the activities, so, in terms of wanting, it's hard to identify what would make you happy. So, for me, if you say that horse riding would make you want to get up in the morning, then go for it!
>
> *Jeff*: What interests me, is looking after animals.
>
> *Father*: Yes, but when you are all on your own, it's difficult to motivate yourself, to do things. Your problem, is that you just stay in the realms of wanting.
>
> *Primary care psychiatrist*: All these activities, they have to be on your initiative, and which we cannot do on your behalf. In my opinion, to structure you there has to be an activity which isn't compulsory, but which doesn't depend on your motivation, for example going to the CATTP,[8] where you can see a little bit how you are progressing. We can try and find something you like. And yes, it's as much for us as it is for you, because I don't feel like not keeping an eye on you anymore and say "oh everything will be fine."
>
> *Father*: What do you think?
>
> *Jeff*: The CMP, no way, in any event.

35 In this excerpt we find a language feature very frequently observed in the meetings (and in other fields of psychiatry, see Beliard et al., 2015; Marquis, 2022b): the double reminder given to the patient that, on the one hand, "it has to come *from* them" and correspond to authentic wishes, and on the other hand that "it is *for* them" (in this instance that following the instructions – activities, medical treatment, etc. – is in their strict interest). At all costs it is necessary, to use the language of the caregivers, that the patient demonstrates that they are willing to do what they are expected to do, otherwise they fear that there is no reliable patient compliance. That is why they all want to find out what "interests" Jeff, whilst reminding him that he is not "obliged." The psychiatrist's expression (a "non-obligatory" activity, but which "doesn't depend on motivation") concentrates all the paradox of wanting to situate all of the impetus in some kind of "true desires" of the patient, while at the same time, it is however stated for that matter that one cannot truly count on these desires alone.

> *Special needs worker at the GE*: Does that make you happy, the idea of getting your accommodation?
>
> *Jeff*: Yes, that's fine.
>
> *Special needs worker at the GE*: Leaving the GE, that's not a problem for you?
>
> *Jeff*: It's no problem for me.
>
> *Special needs worker at the GE*: Because you are confident about it?
>
> *Jeff*: Yes, I'm confident, I feel good there. In any case, my girlfriend is leaving on the 13th [of the following month] so it makes no sense to extend it…
>
> *Primary care psychiatrist*: But it's always the same. When everything is going well, everything is fine. But afterwards, when it's not going well it can go all over the place. I repeat that we have already had experiences where Sir is all by himself at home, and the major worry, is the loneliness, and also the vulnerability in terms of keeping bad company which pushes Sir to consume substances. And I am not

> even talking about big anxiety attacks. But we know that last time, it ended in a hospitalisation. So, Sir, if we want to avoid another hospitalisation, we have to avoid that and put something else in its place. Because even serial hospitalisation, it hasn't gone well. So, it is better to provide too much care than too little. For me the goal is to avoid another hospitalisation…
>
> *Jeff yawns ostentatiously, then says*: Getting back Victor (his son), that would help me.
>
> *Father*: But you cannot take care of the child for one night, because you fall asleep before he does!
>
> *Jeff*: But that's the meds; when I reduce them, it will be better.
>
> *Primary care psychiatrist*: But precisely, reducing them, that's exactly what you mustn't do, you've seen very well what happens!

36 Faced with Jeff's aloofness, as distrustful as it is serene, regarding the issues as they are perceived by the other participants, the external psychiatric doctor picks up on another very frequently mobilised argument: in the past, other endeavours have ended in very painful failures, hence the need for a redoubling of prudence and to no longer move forward on automatic pilot. Faced with a patient who expresses his confidence and articulates ambitions he is perhaps incapable of assuming, the caregivers who have been attending him for a long time assume the role of the memory of former disasters from which it has at times been difficult for him to recover. In recalling these events and their consequences, the caregivers hope to find a minimal common ground with Jeff as to the fact that one cannot run the risk of stimulating a relapse owing to a lack of caution, and that everything must be done to avoid a(nother) hospitalisation. But Jeff progressively closes in on himself as the discussion progresses, no longer responding other than to say "yeah," "as you wish," "if you say so," "we'll see."

> *Systemic therapist*: OK, how can we do this apart from "we'll see"?
>
> *Jeff*: We will see! I don't want to think about what might happen.
>
> *Primary care psychiatrist*: You are right to enjoy life, when you don't know what the future will bring, but experience shows that instead you have four-month cycles, and consequently plans have to be put in place.

37 Everyone wholeheartedly agrees on the need for a framework, apart from Jeff, who closes his eyes, and the meeting is brought to a close, the time allocated to it having passed.

38 The exchanges show the extent to which the pair "worrying-reassuring" dominates the caregivers frame of reference. Jeff's situation worries the caregivers because he doesn't provide the necessary assurances on either of the two levels of practical anthropology mentioned above. On the level of desires, Jeff is perceived as indecisive (he changes the plan) and indifferent (Jeff doesn't seem invested, says "as you wish," concerns himself with criteria deemed secondary, such as the duration of a bus ride, whilst the other participants are worried about aspects which to them seem far more urgent). On the level of competences, Jeff does not convince the caregivers that he is capable of looking after himself (and even less of taking care of others). He further worries them because they perceive as an incapacity his inability to understand his incapacity and the consequences that could give rise to. For the caregivers, trusting in the confidence he expresses would amount to supporting Jeff potentially endangering himself. Despite an inevitable exit from the Gîte d'Etape, for the caregivers the conditions have not been met in order to move towards "less care" and "less institution" (for example, towards ambulatory services or day care institutions), as that would paradoxically risk leading to "more institution," in other words a hospitalisation, perhaps enforced after a relapse (hence the requests for a framework, support, a structure, etc.). Jeff is thus not, in this partner-meeting, a partner equal to the others because his remarks are doubted, and it is considered that they cannot from the outset

be counted on (see Velpry, 2008b). The present Jeff in the meeting is not, in the interaction, entitled to talk about the Jeff of the future.

39 In reality, to be a full partner here and now, the patient must demonstrate that they will in the future remain a partner and an actor in their care pathway. Yet, the particularity of mental illness in comparison with other ailments is precisely to shatter the self-evident nature of the permanence of self: "the life of the (former) patient in psychiatry is a life essentially vulnerable, fragile, lived under the perpetual threat of relapse" (Marquis, 2022b), which caregivers willingly remind patients who, like Jeff, display a confidence judged too high as to the fact that "we'll see, it will be fine, this time." For a patient to be considered reassuring by the caregivers in the process of exiting the institution, it is in reality required that they assume a subtle, if not paradoxical, reflexive position. This is what we will see in decrypting the last partner-meeting of Jean-Pierre, another of the Gîte d'Etape's patients.

5. When the patients reassures: Jean-Pierre's partner-meeting

40 On the face of it, Jean-Pierre's situation strongly resembles that of Jeff. Jean-Pierre is also at the end of his stay (the PM considered here is his last one), after having come to the institution, like Jeff, following a therapeutic impasse situation from the perspective of the primary care provision teams. Again like Jeff, Jean-Pierre is affected primarily by bipolar disorders, and has also presented other symptoms closer to the psychosis spectrum (imaging himself speaking directly to famous figures or metaphysical beings). Jean-Pierre has also begun a relationship with another of the institution's patients, Laetitia, and they are very rapidly planning to move in together in this blended family context (they both have children from earlier relationships). But the comparison ends there, and the caregivers have a very different assessment of this situation.

41 From the point of view of the care providing team, Jean-Pierre's stay is in fact unanimously considered a success (including in its imperfections). If the members of personnel have for a few weeks already been saying, in team meetings and to Jean-Pierre himself, that "they are going to miss him," it is certainly because Jean-Pierre is a person whose manner is easy and pleasant in every way, but also because he has assumed the role of a patient who gives meaning to the therapeutic and social work – work which is often considered thankless, uncertain or invisible. In the case of Jean-Pierre, the impact of the stay at the Gîte d'Etape is obvious to all, including himself, and is concluding in the much awaited apotheosis: the patient is leaving the institution in better condition that he arrived, the therapeutic and relational "knots" have been loosened and, above all, one can have reasonable faith that these changes seem to have been embedded lastingly.

42 Jean-Pierre's last partner-meeting is attended by members of the Gîte d'Etape team and several external carers, Jean-Pierre's parents, but also his partner. For scheduling reasons, the partner-meeting takes place on December 24, and the participants kiss one another for the occasion. The Christmas (midday) meal is taking place at the same time in the institution's '"restaurant" very close by, with the seasonal sounds and the smells emerging from it. To the social worker's apologies, regretting that Jean-Pierre will have to forego this pleasant moment, he replies, before the reunion commences, "I prefer the PM to the Christmas meal, it is more important," which triggers several light-hearted comments amongst the caregivers on the fact that Jean-Pierre is a "perfect patient" and that they wouldn't have expected any less from him.

> *Systemic therapist*: So, here we are! It's a big step. You will soon return to your apartment full-time. You were already doing that at the weekends. And you have had a ruling to have the right to see your child. The planets are aligning, hey! But you have never exercised this right in an autonomous way, neither one nor the other, right?

Jean-Pierre: No, but we have asked for assistance, educational assistance. And I think that is smart, it's a good idea to allow us to see how the children develop.

Systemic therapist: And so, you might say that you are en route to a new, well arranged life! In any case, I see that you are asking the right questions. And the parents, what do they think of it all?

Mother: Hah, well, we are happy with it, the apartment is pretty large, as well…

Jean-Pierre: We have discussed the allocation of the bedrooms, and the children will get to know each other this weekend.

Laetitia: We will have a "pre-Christmas" to give the presents.

Primary care psychiatrist: It's a really great idea.

Special needs worker at the GE: and it's really good you have discussed the allocation.

Jean-Pierre: We have found some sofa beds at good prices. So, we will take it gently, we have the time to get prepared for the children.

Special needs worker at the GE: Ha, you are spoiling them, hey, bravo, that's really good to hear.

43 The mood is one of self-satisfied congratulations and encouragements to keep on going as they are. Unlike Jeff, Jean-Pierre reassures because he and his partner have a clear plan and because they "'ask the right questions." The demonstration of competences does not end there. After this opening, there follows a conversation about Jean-Pierre and Laetitias' respective children, as well as their former partners and various related ongoing rulings. The discussion is extremely technical and complex, and Jean-Pierre on several occasions corrects various imprecisions in the remarks made by other participants. "Hah, you no longer have any need of me, then, very good!," jokes the social worker. There follows a sequence in which those involved, anyway and as if it was necessary, go over the remaining worries, but which do not, in this case, call into question the general positive interpretation. The attitude adopted by Jean-Pierre and Laetitia is one of the major reasons for this.

Systemic therapist: And you, the primary carers, are you confident?

Primary care social worker: Seeing them like that, yes… but it is true that there is a long history behind it.

Jean-Pierre: There won't be, finally, any more break with the healthcare, right, I will remain in the primary care sector for my psychiatric care; I'll have the CMP, a psychotherapist, and my partner will also be checked by her psychiatrist. We will continue with the care.

Laetitia: Each one their pathology, their doctor and their sector.

Special needs worker at the GE: Sir will leave on January 29, and Madam is here up to March 22.

Laetitia: I haven't thought too much if I will stay until the end, but I say to myself I might as well make the most of it, as I had a slight fear over the paperwork, the court, the MDPH,[9] the CAF,[10] I have a lot of paperwork to fill in, so I might perhaps make the most of here.

Special needs worker at the GE: But in any event, we are not abandoning you, eh, we will support you and then we will forward your file…

Laetitia: Ha, here, it's a little like a cocoon. We have to leave the nest, we know very well that it cannot last eternally.

Systemic therapist (to Laetitia): And you, what worries you about this new life with Sir?

Laetitia: [*long gap*] I don't know, I can't answer your question, sorry…

Social worker at the GE: There is always the fear of being left to your own devices, but now you are no longer all on your own.

Laetitia: Jean-Pierre reassures me a lot, he has made me feel a lot better about things. He's the type of person I needed, rather than someone violent [which was the case of her previous partner]. It's true that sometimes he shouts, that terrifies me, and so I get flustered.

Systemic therapist: Maybe that's what you are a little afraid of, the repetition in relation to previous situations?

Primary care social worker: Yes, but that's normal, not everything in life goes swimmingly, little tensions, they always happen.

Laetitia: Yes, and I manage to defend myself a bit more, now when there are tensions. I have a psychiatrist, and I will ask for a psychologist for a therapy, because I need that after my difficult background.

Primary care psychiatrist: Hah, that is a very good idea, too much is better than too little.

Laetitia: I should also say that I am scared that Jean-Pierre will abandon me a little when he is with his son.

Systemic therapist: It's very good to open up about your fears rather than shutting them away inside you, you have to talk about your feelings and discuss them together. Communication is absolutely essential, it's a bit like the fitness centre of relationships.

Jean-Pierre: In any case, the trial month went very well.

Laetitia: But there is no reason that it would go badly.

Systemic therapist: And the caregivers don't seem stressed, which is generally rather a good sign!

Primary care social worker: It just needs relearning the daily life with the children.

Laetitia: Hah, yes, that is absolutely true.

Social worker at the GE: But you know, it's normal that not everything is easy, it's not easy for anyone, right, it's learning to take care of your partner and his children.

Systemic therapist: But yes, it's a big first, that shouldn't be overlooked.

44 Jean-Pierre and Laetitia produce language features which, in the caregivers' view, were lacking in Jeff's situation: they are sure of their choices, they take into account the past to approach the future, they grasp the importance of the continuity of care, whose effects they recognise, are aware of the division between the protected institutional environment and the exterior, establish their priorities and employ the resources at their disposal. They are reassuring because measured, reasonable, reliable and far-sighted. Consequently, when they anyway voice fears, it can be observed that, here, the caregivers look to reassure them, where they had looked to worry Jeff. The caregivers thus expect of a patient leaving the institution that they express what might be termed a "correct concern," neither too large because that would mean they are not grasping the measure of their autonomy, nor, as in the case of Jeff, too little, because that would mean the endangering of their autonomy.

45 As the following excerpt shows, Jean-Pierre fulfils this function very well. On the one hand, he offers assurances as to the fact that he is doing *really* better, which implies recognising the previous difficulties which are objectified as the outcome for example of a "delusion" and in which he no longer recognises himself. But, at the same time, Jean-Pierre also provides assurances as to the fact that he is aware that there are no and there

never will be any certainties, that nothing can be taken for granted, and that he shares the caregivers principal concern, that is to say avoiding a relapse, even if that involves sacrifices and discomfort. Finally, Jean-Pierre also offers assurances of safety: the fact that he shares the caregivers' reading and relevance system is not feigned, but the result of a genuine realisation (if not a conversion), which is, for the caregivers, an essential indication that the crisis has passed and a stabilisation has occurred.

> *Jean-Pierre*: Since I have been here, I have found again an autonomy, even with my father it's going better, I sense a stronger connection.
>
> *Systemic therapist*: But you are saying that to make us happy, ha-ha!
>
> *Jean-Pierre*: No, not at all, that changes many things. I don't know if it is because of the psychotherapy with Mr. Sanchez [the Gîte d'Etape psychologist] but I have changed in any case thanks to the sophrology and the psychotherapy exercises.
>
> *Father*: Me, I am very happy to see him take his life back in hand, finally.
>
> *Jean-Pierre*: And I also take things less to heart, I am more tolerant, calmer, more relaxed, I don't know how to say it.
>
> *Special needs worker at the GE*: You are happier, no?
>
> *Jean-Pierre*: That's how I feel it. I no longer get worried sick about things, I no longer carry out personal investigations, I let myself slip into real life, [...].
>
> *Mother*: Me. I find him really well stabilised.
>
> *Jean-Pierre*: I've all the same still personal problems with one medicine, and it tires me as well, it's a really heavy treatment, but I've realised that I didn't have a choice and it was for my benefit. For that matter, that reminds me that I have to take it [*Jean-Pierre takes his medicine with a sip of water in front of everybody*].
>
> *Special needs worker at the GE*: In any case you have always taken it seriously.
>
> [...]
>
> *Jean-Pierre*: But this medicine discomfits me, I know it helps me, but there are downsides which make me suffer. But no worries, OK, I want to and I will continue my treatment. The Largactil is a neuroleptic for my hallucinations, for my maniac side when I have episodes. At least, that's it, right, have I got it right?
>
> *Primary care psychiatrist*: Yes, that's it, you describe it well, you have a treatment which protects you. With also the Depakine and the Abilify.
>
> *Father*: Hah, you are taking Depakine now? I remember that you didn't want to at the beginning.
>
> *Jean-Pierre*: Yes, but I was in my delirium. Ha-ha, the previous doctor. I really gave him a hard time with my stories of the glass of milk and my crazy ravings.
>
> *Mother*: And even in terms of memory, it's going better, I would say.
>
> *Jean-Pierre*: That's thanks to the relaxation.
>
> *Systemic therapist*: Me, I wonder all the same, what is the difference between today and the first time you went under? And how about if it doesn't work out with Laetitia, have you thought about that?
>
> *Jean-Pierre*: Today, there is the medical supervision, and above all the fact that I have accepted, and that I have understood that if something is not going well, I need to talk about it straightaway with the doctor. Another thing which has changed for me, is that I no longer give everything without expecting anything in return. Before I gave everything, my car, my bank card, but that's over now.
>
> *Mother*: That period then, that wasn't the responsible Jean-Pierre we have now. I no longer recognised him. Now, when we think back, we can have a good laugh about it, but it wasn't easy.

[…]

Jean-Pierre: In any case, even if I wanted to give Laetitia a diamond, you have the property curator to give me an earbashing, ha-ha. And it's the thought which counts, [*to Laetitia*] you don't need a diamond, right?

[*Jean-Pierre and Laetitia start bickering in front of everyone*]

Special needs worker at the GE: Hah, there you go, a normal couple, that's what we like to see *(laughs)*!

Jean-Pierre: I also feel more autonomous, before I was doing nothing.

Primary care psychiatrist: Of course, we will continue to support you, but I really think you are on form, at ease, serene. I have the impression that there is less risk than before of toppling over.

Jean-Pierre: I have talked about it with Laetitia, I said that you have to be attentive for the signs, when I put on my dark glasses for example. We will be a sentinel for each other […] a prop. Now I know how to avoid it when I sense it's going to tip over.

Systemic therapist (announcing the end of the meeting): Good, so all that remains is to live, you might say.

46 One cannot fail to be struck, in this last excerpt, by the fact that in response to the assurances given by Jean-Pierre, the reassured caregivers reassure in their turn, in putting aside the pathological register and taking on that of normal, ordinary life: a "happy" person in a "normal couple" for whom it "only remains to live." It bears repeating: it is not the elements which are reported (the number of hours of sleep for Jacqueline, relationship tensions for Jean-Pierre and Laetitia, previous psychic crises in the three situations focused on, a patient's non-compliance with one of the institution's rules, etc.) which in themselves generate a positive or a negative evaluation, a normalising or a pathologizing reading, reassuring or worrying for the caregivers, but rather the attitude of the patient in their regard and the position they take in an overall configuration of proximity or distance regarding the expectations of practical anthropology. The same facts can give rise to different interpretations depending on the situation – which does not mean that they are random.

6. Discussion

47 The work of caregivers in psychiatry constitutes what Florent Champy (2015) terms a prudential practice. Confronted with a new situation (in this instance, a patient), they can neither content themselves with applying knowledges, for example scientific or drawn from previous experiences, nor disregard these very same knowledges. Each new situation is uncertain, and must push them to take risks or take a gamble. This tension is exacerbated by the manner in which the normative environment of a society where autonomy is regarded as a common condition, materialised in the practical anthropology discussed above in the ideal of hidden potential, redefines good care: a good caregiver should always think that a patient is capable of more or of better, that it always worthwhile trying, and never condemn them to the status quo. They should offer treatment which is "as short as possible, but as long as necessary," as stated by a text specifying the role of mobile teams in the Belgian "Psy107" reform of mental healthcare favouring ambulatory services and deinstitutionalisation (SSSP, 2017: 2). Good care is of the order of the upward slope, towards less support props and more autonomy, but never the institutional dead-end-street. Nevertheless, caregivers also include in their ethical and therapeutic mandate the fact of never, from their point of view, doing harm to a person *even in spite of themselves*, for example of not showing sufficient caution and in risking heading straight towards a new cycle of relapse and hospitalisation (without talking here of questions of legal liability which caregivers sometimes evoke

(Marquis & Pesesse, 2021)). Never would the care team of the GE agree, unless with a heavy heart and in considering that it constituted a professional failure, to leave to fend for themselves patients with regard to whom they are not reassured, even if that is what these patients are requesting.

48 In short, the Gîte d'Etape caregivers who must provide support for the patients leaving the institution in theory share, as does the establishment which employs them, the practical anthropology which provides the basis for the position adopted by the Committee on the Rights of Persons with Disabilities. In theory, it is expected of each patient that they express a desire for autonomy and less institution. In theory, each person is considered to possess the capacities necessary to pursue their goals, which the terminology of partnership bears witness to. Whilst this terminology appears self-evident, its grammar is much less so. At what point and according to what criteria is a patient really treated as a partner? The exchanges analysed here have first of all shed light on the fragility and the contingency of the position of partner. Within an actual meeting, this continually negotiated status can be accorded, then challenged, whilst being dependent on a more general configuration of assessment. Three discussion points can be highlighted.

49 First of all, in this process of problematising desires for and capacities for autonomy (considered in the legal texts as evident), the status of partner is never definitively refused, but always considered as a potentiality. Whilst it is not possible, for the concerned caregivers, to consider Jeff as a partner here and now, nothing prevents him from becoming one in the future: Jeff is not seen as a lost cause, and the current condition in no way erodes the moral conviction that Jeff could meet the practical anthropology criteria of the autonomous person, for example on condition that he manages to identify what is really necessary for him, or that he understands the importance of avoiding any relapse. Simply, he is not yet ready, and additional therapeutic work is required to reveal this hidden potential. Conversely, the partner status is never definitively accorded. If Jean-Pierre seems to be the ideal patient-partner in the eyes of the caregivers, everyone knows very well that it is possible that he may lose this status in the future, for example owing to a future crisis – nothing will ever thus be completely "normal." As a patient in mental health having had crisis periods during which he was, at least for a moment, no longer himself, Jean-Piere remains a partner in the leaving the institution process for as long as he demonstrates his correct concern and his awareness of the fact that he could, at any moment, risk losing this status in the event of a relapse.

50 Then, the excerpts demonstrate the way in which the presuppositions of practical anthropology are expressed in expectations on the part of the caregivers. But these expectations are difficult to read or may even appear contradictory for the patients called upon to leave the institution. Patients must agree to be both an actor in and the object of the discussion. They must share the frame of reference and anxieties of the caregivers, but not reduce themselves to them. They must desire a maximum of autonomy, but accept that the caregivers continue to intervene on them. They must believe in themselves, but call on expertise when necessary. They must develop ambitious but reasonable plans. They must not determine their future in the light of their past (often painful), but keep in their minds the memory of this past and what it could presage for the future. It "just remains for them to live," but they have to remain on the look-out. They must hope for the best, but expect the worst. In these oscillations, the expectations are formulated in terms of degrees or of the right amount: it's a question of wanting autonomy but not too much, being confident in your capacities but not too confident, invested in your plan but not too much. The patients observed at the Gîte d'Etape spend a considerable amount of time investigating the correct measure expected (knowing that it is itself variable) and conforming to it.

51 Finally, the analysis shows that whilst, in the abstraction of texts, the axioms of a desire for autonomy and the capacity to pursue this goal are essentially formal criteria which are not defined or problematised more beforehand, in the practice of mental healthcare they take a much more substantial form. In fact, it is not *just any form* of

autonomy, not just any plan or declarations of wanting that will be valued, encouraged and considered as reassuring, but solely those which seem reasonable in the eyes of the caregivers, inasmuch as they do not generate too large a risk. Similarly, when it is a question of pursuing their pathway to autonomy on leaving the institution, not all forms of capacity are equal for the caregivers. The most valued is certainly serious reflexive awareness of your strengths and of your chances, but also and above all of your limits and risks, on the part of a patient who knows that they must establish themselves as a look-out post of their own condition, must never drop their guard and appeal for help when necessary. In short, a reassuring patient-partner is one who first and foremost remains a patient in psychiatry, whilst acting as if they could no longer be one.

52 What feedback could we offer, in conclusion to this analysis, regarding the presence of this demanding practical anthropology in key juridical texts and in certain interpretations made of them? There would be no sense in mobilising the elements here present to contest their relevance, even if they point towards a discrepancy between a solid ideal and a fragile and contingent reality. In fact, this representation of the autonomous person is a more moral than an empirical consideration. It serves to guide practices, and is adopted even by caregivers confronted with its limits, in the same way as they take on board the idea that, ideally, less institution is always better – even if in practice that cannot always be the case. The partner-meetings crystalise a fundamental practical tension of societies where autonomy is regarded as a common condition, and which can be written simply in the following way: is autonomy an always-already-there (potentially still unexplored), or is it dependent on specific parameters, or on the intervention of other persons? Nevertheless, there is obvious value in gaining a better grasp of the concrete implications of this moral representation or of this normative aspiration, in particular when they are expressed in generalising manner, for example in legal texts. In many ways, autonomy is no less normative than other ideals and, as this study shows, in this respect generates expectations which weigh heavily on the shoulders of the persons concerned.

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Notes

1 General Comment No.5 also enjoining the States Parties to refrain from any softening of institutionalisation: "nor should there be developed any modes of 'satellite' accommodation, by which is meant accommodation having the appearance of autonomous accommodation (individual apartments or houses) but which are connected to an institution" (General Comment No.5/49).

2 It is nevertheless to be noted that this undifferentiation is not limitlessly extensible and that, paradoxically, the reference to a form of physicality or of corporeality does not disappear completely, as disabilities of a purely social or economic order do not appear to be part of the CRDP landscape or that of its interpretation by the Committee.

3 The presentation of the institution and of the case of Jacqueline (cf. *infra*) picks up aspects published in Marquis (2024). The research methodology is more fully described in Marquis (2022a).

4 A form of both individual and collective social housing accommodating people on low incomes.

5 Mutual self-help groups: associations based on peer-support, see Troisoeufs (2009).

6 The social life support service is a medico-social measure created for adults with disabilities but living autonomously (independent housing, social housing apartment, etc.).

7 The medico-psychological centre is a public health facility, the spearhead of the sector's policy, which offers medico-psychological and social consultations to anybody with psychological disorders.

8 The part-time therapy centre (PTTC) is public health facility offering therapeutic support actions, principally through activities and occupations.

9 Regional home for people with disabilities, which in particular grants the adults with disabilities allowance (AAH) as well as the disability compensation allowance (PCH).

10 Family Allowances Fund.

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