Myths of Mental Health

revelations from the French system for the United States

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ABSTRACT Drawing on an analysis of the French mental health system, this essay examines four presumptions about mental health care dominant in the United States: (1) the required abolition of the hospital for psychiatric deinstitutionalization; (2) the substitutability of public and private financing; (3) the importance of a "dangerousness" criterion for involuntary commitment procedures; and (4) the need for an ever-expanding scope of care. These claims hold little weight when subjected to comparative scrutiny, and the essay closes by discussing the implications of these revelations for US mental health care policy and ethics.

Mental health systems face competing imperatives to respect patient autonomy, ensure access to long-term comprehensive treatment, and also control costs. In the United States, the system has tilted towards incentivizing private health care providers to deliver voluntary, community-based care. Although some analysts have criticized aspects of this approach, US-based policymakers, researchers, and practitioners tend to view deviations from established policy pat-

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terns with suspicion (see, for example, Dudek et al. 2015 in response to Sisti, Segal, and Emanuel 2015). But other countries have struck a different balance. In fact, comparative analysis of mental health policy demonstrates how the proposed solutions to these competing imperatives are specific to the history, economy, politics, and culture that produced them. Questioning their universality, then, could help to address some of the most heated debates in the field.

In 2015, we set out to gain a deeper understanding of the guiding principles of mental health care in the United States by conducting a comprehensive comparative analysis of mental health services in France, which fundamentally challenged how we viewed its American counterpart. Although we each focused on different aspects (Barnard on the ground-level process through which people with mental illness accessed care, Perera on the system's political and historical origins), we teamed up to conduct interviews, share documents, and compare field notes. In this essay, we report on important lessons learned from the French mental health system, which provides a valuable counter example to conventional wisdom about psychiatric services in the US. We identify four common ethical and policy myths about mental healthcare in the US that are challenged by the French system: (1) the required abolition of the hospital for psychiatric deinstitutionalization; (2) the substitutability of public and private financing; (3) the importance of a "dangerousness" criterion for involuntary commitment procedures; and (4) the need for an ever-expanding scope of care. When subjected to comparative scrutiny, these claims hold little weight (see Table 1 for a guide).

Background: The US Mental Health System

Like many countries, the US closed many of its psychiatric hospitals during the period of deinstitutionalization, which began roughly in the mid-1950s and continues today. Across the West, the postwar expansion of social welfare programs first prompted public asylums to depopulate. A wave of advocacy for the rights of patients in asylums, meanwhile, brought global attention to the abuses they experienced. Meanwhile, pharmaceutical companies promoted the use of psychotropic medications for patients returning to the community, reducing reliance on institutional oversight and constraints. A period of retrenchment in the late 1970s and '80s accelerated the rapid closure of many state psychiatric hospitals across the US.

In fact, between 1972 and 1990, the number of state and county psychiatric beds in the US declined by 70% (Fisher, Geller, and Pandiani 2009). Although reform-minded policymakers like President Kennedy (1963) promoted a "bold new approach" that sought to replace these hospitals with a network of 1,200 Community Mental Health Centers, or CMHCs, only a fraction of these centers was funded and constructed as originally envisioned. Today, the majority of psychiatric inpatient care is provided in other settings, such as general hospi-

TABLE 1 *Myths of mental health care policy in the US*

Myth	*Basis for myth*	*Factors that challenge myth*	*Alternative approach in France*
Deinstitutionalization requires closing hospitals.	Widespread closures of state and county mental hospitals coincided with the community mental health movement in the late twentieth century.	Community mental health was never funded as reformers intended, and the hospitals that remained often were unable to integrate their inpatient services with outpatient services.	Hospitals coordinate a network of mental health "sectors" that include a range of inpatient and outpatient services. A single psychiatric team manages and delivers both inpatient and outpatient care for a given patient caseload.
Private financing can fully replace public financing.	As public mental health care spending declines, the movement for mental health "parity" has encouraged private insurance plans to provide mental health benefits on par with medical and surgical benefits.	Private insurance companies can be unwilling to finance the high costs of long-term, comprehensive mental health care treatment. As a result, many private providers do not serve people with severe mental illness and limited resources.	The complete sectorization system depends on public funds, such that most of the care that it provides is free to users at point of service.
Strict commitment standards encourage voluntary treatment.	Civil rights mobilizations in the 1960s and '70s demanded new procedural protections and strict criteria that curtailed involuntary hospitalization.	Access to voluntary inpatient care is limited, and instead rates of short-term involuntary hospitalization are high.	To avoid using involuntary care, the sectorization system promotes the continuity of care. The high supply of psychiatric beds facilitates voluntary admissions.
Mental health systems must constantly expand in scope.	In response to social demands, American psychiatric nosology frequently revises diagnostic criteria. These expansions the widen the continuum of "mental health."	Psychiatric resources are diluted, such that they are redirected away from severe mental illness and toward other social problems.	Public psychiatry continues to focus on people with severe mental illness and resists pressures to address other, nonmedical social problems.

tals, private psychiatric hospitals, Veterans Administrations medical centers, and correctional facilities (SAMHSA 2019a). The latter are often a last resort that compensates for the lack of long-term psychiatric care capacity across the US health-care system.

On the whole, the supply of psychiatric services in the US is much lower than in other countries, in part because financial arrangements do little to incentivize their construction and maintenance. Consider the benefit structure of the health system's core insurers, who have replaced the American states as core funders of mental health care (Frank and Glied 2006; on what follows, see Garfield 2011; Rice et al. 2013). First is Medicaid, a joint state-federal public insurance program financed by general taxes. As an insurance program for the poor and disabled, it takes on a greater burden of mental health spending than of health care in general. Over a quarter of mental health spending is attributed to this program (Mark et al. 2016). Still, federal law restricts Medicaid payments for services provided in "institutions for mental disease" (IMDs, generally defined as having more than 16 psychiatric beds) to adults ages 21 to 64 (Zur, Musumeci, and Garfield 2017). Next is Medicare, the public insurance for the aged and the disabled. Although this program only covers about 16% of the population, it plays a large role in the determination of market prices and care standards. Its poor reimbursement of psychiatric services, therefore, sets a low standard for other payers. Finally, private health insurers cover about two-thirds of the population. Until the recent (and fragile) passage of the Affordable Care Act in 2010, no minimum basket of benefits was required of these private insurers. The new law requires some new health plans to cover mental health services at "parity" (at the same rate as other specialty health-care services), but regulations concerning this provision are difficult to implement at the state level (see, for example, Dixon 2009; Garfield, Lave, and Donahue 2010).

Other social insurers and discretionary funds fail to compensate for the deficiencies of mental health care coverage in the health system. For example, the disability insurance program (Social Security Insurance) discourages public inpatient psychiatry by denying benefits to individuals living in public institutions. The block-grant structure of the CMHC program has prevented its expansion. Overall, the proportion of health spending directed towards mental health and substance abuse in the US has fallen from 9.3% in 1986 to 7.4% in 2014 (Mark et al. 2016).

The limitations of public mental health financing mean that private providers are dominant, especially in outpatient care but also in inpatient and involuntary services. Accessibility is limited. Private psychiatrists are significantly less likely to take insurance than other private physicians (Bishop et al. 2014). Less affluent Americans are more likely to find themselves in prisons or homeless shelters than in psychiatric hospitals: psychiatric conditions affect about half of incarcerated individuals and about a quarter of chronically homeless individuals (Culhane

2008; James and Glaze 2006). Psychiatric conditions also affect inmates of French carceral institutions, albeit at a much lower rate. According to a recent government report, 3.8% of inmates have schizophrenia and are in need of treatment, while 17.9% suffer from depression (four times that of the general population). All told, only about one-third of Americans with mental health problems receive treatment (Cunningham 2009).

Other features of the US mental health system bear mentioning. Observers have criticized the system roundly and repeatedly for shifting its emphasis away from people with severe, chronic mental illnesses, such as schizophrenia, since deinstitutionalization (Steering Committee 1980). The country's restrictive involuntary treatment laws have facilitated this shift, even as legal mandates have become an increasingly central route into scarce inpatient beds (SAMHSA 2019b). Instead, the rise of private sector alternatives now delivers less-intensive services, such as short-term counseling and outpatient medication dispensation, to an ever-expanding swathe of the population. Evidence supporting the efficacy of this form of treatment is limited (Mechanic 2014; Mojtabai and Jorm 2015).

Comparative Analysis: The US and France

Not all countries, though, have approached the tradeoffs inherent to mental health care in the same way. Using the methods of comparative social science, we identified the French mental health system as an instructive alternative to the American one (Gerring 2014). As the sections following this one will show, several aspects of the French mental health system differ sharply from the American one. Juxtaposing extremely different cases protects against the selection bias associated with studying outcomes on one end of the spectrum alone (Geddes 1990; Gerring 2014). It also throws unique aspects of each case into sharp relief. The comparison therefore allows us to discover a fuller range of possible policy and ethical solutions to challenges faced in the US.

Before we examine the differences in France, it is important to emphasize that they arose from similar conditions to those of the US. Another reason that we selected France, then, is because its initial experience of deinstitutionalization shared many characteristics with the US. Like their American counterparts, French policymakers in the 1950s and '60s constructed community-oriented social and medical programs, which then faced significant fiscal strain in the 1970s and '80s.

While Erving Goffman, Thomas Szasz, and the civil liberties movement critiqued institutional psychiatric power in America, Michel Foucault, Gilles Deleuze, Félix Guattari, and the *Groupe information asiles* (GIA, Asylum Information Group) movement did the same in France. What is more, the first psychotropic medication (chlorpromazine) was developed by a French pharmaceutical company (Rhône Poulenc) in 1952, with immediate effects on hospital practice

in its home country (Scull 1977). The result of these experiences is that contemporary French observers, too, have rejected hospital-based long-term psychiatric care as an inappropriate and antiquated approach in most instances and moved toward a community-oriented approach.

Although American rates of uninsured individuals and per capita health spending tower far above those of other affluent countries, including France's (about 9% in the US, compared to virtually none in France; and $9,364 per capita in the US, compared to $4,620 per capita in France; see Mossialos, Djordjevic, and Osborn 2017), France nonetheless shares many of its structural features: a combination of employer and employee payroll taxes, income tax, and general taxes fund the insurance system, which includes both public and private payers. Although the breadth of public coverage differs (100% of French residents; about 40% American residents), voluntary, employer-sponsored, and competitive payers are central to both systems (insuring or co-insuring over 95% of the French residents and more than half of US residents). Out-of-pocket spending also accounts for a similar share of total health expenditures (8.5% in France, 11% in the US). Relative to other countries, general health care provision in France and America is largely private and fee-for service, and gatekeeping is minimal (Mossialos, Djordjevic, and Osborn 2017). The differences between the two countries' mental health systems are thus largely the result of deliberate policy choices, rather than a by-product of health system organization or historical accident.

The observations we will report are supported by a range of recent and archival sources of data and documentary evidence, complemented by ethnographic fieldwork conducted in 2015–2016. Perera conducted a full review of all relevant trade press and government documents relating to mental health policy-making prior to and during deinstitutionalization (from the mid-19th century to about 1985), collected at the French National Archives, the National Library of France, and the Henri Ey Medical Library at the Sainte-Anne Hospital Center. Barnard interviewed nearly 200 French mental health professionals and policymakers and carried out observations in clinics, benefit offices, emergency rooms, and courts to understand how policy translated into practice. Now synthesized, our comparative analysis of French and American mental health care systems challenges four fundamental beliefs about mental health policy in the US.

Four Myths Challenged

Myth 1: Deinstitutionalization Requires Closing Hospitals

Reformers often justified the rapid decline of US state and mental hospitals in the name of expanding community care (though this promised remains unfulfilled). They presumed, as many still do, that psychiatric deinstitutionalization necessitates wholesale hospital closures and not just reducing the number of beds. Underpinning this belief is the logic that rejecting institutional care will increase

the supply of community-based care. This presumably destigmatizes mental health care by promoting the social inclusion of those with a mental illness, reduces overall mental health expenditures by diverting patients away from costly psychiatric hospitals, and forecloses the possibility of institutional abuse (Steering Committee 1980).

Yet the pursuit of psychiatric deinstitutionalization in France did not include widespread hospital closures. In fact, even though France has closed two-thirds of public hospital beds since the 1970s, it continues to have three times as many psychiatric beds as the US (OECD 2017; WHO 2011). But psychiatric institutions are not simply bed centers in France. Hospitals (usually specializing in psychiatry) coordinate and oversee a network of 1,200 psychiatric "sectors" over geographic catchment areas of up to 70,000 people. Each sector must provide multidisciplinary mental health care and should be responsive to the specific needs of the local population. Nonetheless, the vast majority of sectors include a public psychiatric outpatient center (*centre médico-psychologique*) that provides ambulatory treatment. Other services include rehabilitation programs, day hospitals, and crisis centers. Crucially, under the sectorization policy, clinicians often work across multiple facilities and treatment settings. This ensures patients have the same psychiatrist as they traverse treatment settings from inpatient hospitalization to ambulatory and outpatient care.

In addition to psychiatric services, psychiatric hospitals also can organize and coordinate a range of *services médico-sociaux*—comprehensive health and social services that provide housing, educational support, professional training, and sheltered workshops. One study estimated that France spends about €3 billion on these services (Chevreul et al. 2013; data is from 2007). The degree of coordination between public psychiatric services and these public or not-for-profit medical-social services varies, partly because of a cleavage between services for people with disabilities and those with mental illness and partly because of the budgetary competition between them (Barnard 2019; Chevreul et al. 2015).

The complementarity between hospital and outpatient care is not unique to France. Data from the WHO *Mental Health Atlas*, a comprehensive international survey of mental health services, show a direct positive association between the supply of inpatient and outpatient care in the 15 advanced economies that first deinstitutionalized, and hence set global expectations in this area (Perera 2020).[1] The data thus suggest that an expanded supply of some types of specialized psychiatric services is associated with an expanded supply of others, both inside and outside the hospital. In keeping with this trend, countries on the low end of the supply spectrum, like the US, provide both little inpatient care and little outpatient care. Contrary to the presumptions of mental health thought leaders

[1] The link between community and hospital psychiatry remained positive, even when "non-hospital residential facilities," which combine nonmedical social care with overnight care, were included in either category.

and policymakers in the US and around the world (WHO 2014), hospital and community care appear as complements not substitutes—but further research is needed to confirm and understand this trend.

The French mental health system offers some preliminary insights and directions for future inquiry. It suggests, for instance, that the boundaries between community and institutional care are permeable. Hospital administrators and staff have been advocates for intermediary facilities, such as rehabilitation centers or day hospitals, which offer distinct services from outpatient clinics. The French system also suggests that the structure of payment can reinforce the symbiotic relationship between hospital and community care. The fee-for-service model often employed in American mental health care incentivizes clinicians to provide acute interventions, instead of interventions that address the long-term medical and social needs of patients with chronic illnesses. In France, a global budget gives hospital administrators the incentive and latitude to develop comprehensive, balanced care systems, provided by a single care team. A global budget can coordinate and bundle services, as well as include otherwise difficult to reimburse nonmedical services and social supports (such as phone calls to disability services, court visits, and patient-clinician relationship-building activities). As a result, psychiatric hospitals serve an important administrative hub for community services.

Myth 2: Private Financing Can Fully Replace Public Financing

Underpinning the structure of mental health payment and services in France is a second and significant dimension of difference: robust public financing. In the past, the total amount of spending on public mental health services in France has amounted to over €8.8 billion per year (Lopez and Turan-Pelletier 2017). Behavioral health analysts tend to view private and public financing as interchangeable. Either one, they believe, will expand capacity in equal measure. This notion has propelled the American movement to aspire toward mental health "parity," in which private insurance plans provide mental health benefits on par with medical and surgical benefits. This movement has gained limited success, and both public and private mental health care financing remain limited. The French mental health system advances a very different approach.

France spends about twice as much on mental health as the US proportionally (see Lopez and Turan-Pelletier 2017; Mark et al. 2016). Driving this divergence is the publicly funded sectorization system. Sectorized outpatient care is free at point of service, while sectorized inpatient care requires a small copayment (about €20, reimbursable by sickness funds). Outside of the sectorization system, statutory health insurance coverage of psychiatric care is abundant as well. For example, policyholders (all French residents) with chronic psychiatric conditions qualify for full reimbursement of preset copayments (Service-Public.Fr 2020). As a result of this financial generosity, the major government agency for health statistics rates access to psychiatrists higher than access to pediatricians, and in ur-

ban areas, higher than access to ophthalmologists and gynecologists (Castell and Dennevault 2017).

An overlooked implication of mental health economics helps to explain why the generosity of the French mental health system depends on public funds. The mental health market is different from the general health market. Government usually pays for mental health services, even when the rest of the health sector is privately financed. In fact, when comparing the relationship between public spending and hospital bed supply (an indicator of overall care supply) in OECD countries, the extent of public general health financing accounts for just 6% of the general bed supply. In contrast, the extent of public mental health financing accounts for almost 40% of the psychiatric bed supply (Perera 2019). In other words, more government spending is associated with more mental health care, but not more general health care.

The public sector is important to behavioral health because clients rarely have the means to afford their own care. Psychiatric disabilities inhibit workforce entry, limiting the income available to cover private and out-of-pocket health care costs.[2] Moreover, long-term mental health treatment requires different, often more complex resources than other health care. Many interviewees in France emphasized the importance of public provision for people with serious mental illness, particularly when they have co-occurring addiction or criminal justice involvement. Private providers are less likely to accept these patients. In addition, private payers are more willing to pay for pharmaceuticals than for long-term, labor-intensive services for marginalized people. Substantial public financing of behavioral health services is hence necessary, and its absence in the US helps to explain the limited supply of American psychiatric services to people with the most severe conditions.

Myth 3: Strict Commitment Standards Encourage Voluntary Treatment

Since 1838, France has followed a two-track system for involuntary care. One pathway permits involuntary hospitalization if the patient needs "immediate care" and is "unable to consent" to it. The other track permits involuntary hospitalization if a "state representative" (usually, the police) requests it, and if a psychiatrist agrees the patient's mental illness leads to a "serious disturbance of the public order" or "compromises the security of others." Although the criteria are looser than those in the US—compare the "need for immediate care" criterion with the "danger to self" or "danger to others" criteria in most American states—it has not necessarily led to more involuntary care.

Prior to deinstitutionalization and the creation of the sector system, nearly all patients in French asylums were there involuntary (Eyraud and Moreau 2013).

[2] The French system of social protection also attempts to remedy this problem; in fact, one report identified the country's policies for integrating people with psychiatric conditions into the workforce as some of the strongest among Western countries (Economist Intelligence Unit 2015).

Yet over the following decades, the use of civil commitments plummeted: in 1965, 86% of patients in French psychiatric hospitals were there under legal constraint, but by 1997, only 26% were (Joly 1997; Lopez and Turan-Pelletier 2017). By 1990, nearly 90% of new entries into hospitals were voluntary. Unlike the US, legal activism had little to do with this outcome. French advocates of mental health reform in the 1960s and '70s rarely couched their programs in terms of patients' "rights." Rather, the sector system allowed clinicians to develop long-term relationships with patients via continuous and intensive monitoring, and hence made the use of legally enforced treatment much less common than in the US (see SAMHSA 1985).

French psychiatry has actively resisted a shift in its role from providing medical assistance to managing social risks on behalf of the state. When a discharged psychiatric patient committed a murder in 2008, President Sarkozy responded by calling for more long-term, high-security detentions. Yet Barnard found that psychiatrists in both outpatient and emergency services continue to exercise their discretion in this area, by focusing on people with an identifiable and treatable mental illness. They continue to reduce pressure to try to manage people whose disruptive or deviant behavior has attracted the ire of the authorities but which cannot be traced to a diagnosable pathology. An aggressive but targeted use of involuntary treatment also helped psychiatrists divert many patients from potential incarceration. Judges still largely defer to the evaluations of psychiatrists, despite the introduction of mandatory judicial hearings for all hospitalized patients in 2011.

The proportion of involuntary hospitalizations started to creep back up in the 1990s and has accelerated in recent years (Sheridan Rains et al. 2019). Clinicians blamed both increasing economic insecurity and longer wait times for beds. Fewer psychiatric beds obligated them to wait until patients' conditions were so bad that they were no longer able to consent when a psychiatrist finally proposed hospitalization. Research in England found a similar relationship between bed closures and the absolute number of involuntary admissions (Allison, Bastiampillai, and Fuller 2017). While at least some states in the US also have seen an increase in involuntary hospitalizations (MHSUDS 2016), there has been almost no government leadership to regulate or reduce the use of involuntary treatment (Morris 2020). The French parliament, on the other hand, has repeatedly investigated and legislated in response to these trends (Robilard and Jacquat 2017).

As several French psychiatrists reminded readers of an American journal, "many nations have struck a balance different from the U.S. between the interests of people with severe mental illness in receiving treatment and their liberty and autonomy interests" (Gourevitch et al. 2013, 609). The French system recognizes that access to long-term, quality mental health care and social support are civil rights. Furthermore, it suggests that a well-funded mental health system, rather than applying strict legal criteria, may be the best way to reduce involuntary treatment.

Myth 4: Mental Health Systems Must Constantly Expand in Scope

French policymakers designed the public sectorization system to make it even more accessible than the already universalistic general health system. In the words of a 2016 report, "the sector, as a public service, is obligated to provide care to all people seeking it" (Laforcade 2016, 88). One might think that the broad accessibility of this system would increase the number of users with less severe diagnoses and thus divert resources from more severe cases. After all, such mission creep has been evident for a long time in the US, where the mental health system is far less accessible (Mechanic 2014). As early as the 1970s, for example, CMHCs were expanding their mission to include services for less severe mental health conditions, both in response to federal directives and in an attempt to expand their revenues, while under-serving former state hospital patients (see Gillon 2000; Comptroller General 1977).

Historically, however, the French sectors have prioritized caring for the sickest and most vulnerable individuals—above all, people with psychosis—who need holistic, team-based support not usually available in private practice. Public providers hence have resisted pressures by some advocates and politicians to address "mental health" more generally. When a public awareness campaign encouraged people to seek treatment for depression, for instance, psychiatrists accused the government of promoting pharmaceutical companies by expanding the market for medications (Briffault, Morvan, and Du Roscoät 2010). French clinicians also have been concerned about how de-stigmatization campaigns might unintentionally create demand for psychiatric services, and hence detract from the sectors' core mission (Benoit et al. 2019).

Nonetheless, the proportion of the French population seeking care from a sector has doubled since the 1980s (from 1.7% to 3.4%, see Lopez and Turan-Pelletier 2017). As a result, sectors now must make choices about which patients to prioritize. Barnard's ethnographic research finds that sectors continue to devote the vast majority of their resources to people deemed as "real mentally ill." Inclusion in this category does not depend solely on an International Disease Classification (ICD) diagnosis, despite the expectation that staff assign one to each patient in the sector. Instead, sector-based psychiatric professionals identify patients who needed the services that only the sector can provide: long-term, team-based medical care that coordinates with social support services. With nearly 50% more psychiatrists per capita than the US, French public sector psychiatrists play a much more expansive—and, as they indicated in interviews, fulfilling—role in supporting patients than simply prescribing medications, increasingly the sole responsibility left to their American counterparts (Torrey, Griesemer, and Carpenter-Song 2017).

National professional and policy developments reflect the priorities of the sector, as well. The proliferation of new diagnostic categories in the 1980 *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)* was a major turning point in

American psychiatry (Horwitz 2001), but it provoked little interest in France. Unlike its American counterpart, the French psychiatric profession has largely not sought to claim jurisdiction over new diseases and social domains. As the managers of well-funded sectors, psychiatrists enjoy a stable position and, with their role in public hospitals, a relatively prestigious one. The successful reforms to the system made in the 1960s have also insulated them from the critiques that have led American psychiatry to repeated overhauls of its diagnostic system.

The focus of French psychiatry hence remains on the "real mentally ill." Policymakers tend to follow suit. For example, the National Plan for Mental Health and Psychiatry (2011) made "fighting against the over-medicalization of poor well-being and social problems, notably by adjusting the consumption of psychotropic medications" a policy priority (*Direction générale de la santé* 2012, 28). The sector system, combined with a strong professional ethos attentive to the most severe cases, supports a more focused allocation of resources in France than in the US.

Implications for the United States

To be sure, the French mental health system is imperfect. Among the most prominent critiques is that the sector system has fallen short of its stated goals. Although the system intends to provide equal access to services across the country, differences across sectors can produce wide regional disparities in care (Coldefy and La Neindre 2014). Some analysts have expressed concerns that the hospital remains too central to mental health care provision, even if it does help to coordinate and develop non-hospital services (Lopez and Turan-Pelletier 2017). This objection suggests that policymakers should neither fully reject nor overemphasize institutional care—and that the perfect pitch is challenging to maintain. Nonetheless, it is revealing that almost no one in France has suggested closing hospital beds to the same extent as in the US.

Another key set of challenges concerns the relationship between the public mental health system and other sets of institutions. The French mental health system has developed autonomously from the rest of the health system, resulting in fragmented care at best and poor access to somatic care at worst (Gandré and Coldefy 2020). As in the US, where recent White House statements have proposed increasing psychiatric hospitalization rates to reverse trends in mass gun violence, policymakers in France have tried to instrumentalize the psychiatric system to control social disorder (Blake 2018). This was most striking in a call from the Minister of the Interior to mobilize psychiatric hospitals against the "terrorist menace" (Gourion 2017). Finally, the system faces pressures to address the social problems created by retrenchment elsewhere in welfare state, with caseloads of both public and private practitioners continuing to go up. This expansion of the patient population makes it difficult to continue to concentrate resources on the most severe patients.

Nonetheless the French comparison challenges several dogmas that have been at the heart of US mental health policy at least since the 1960s. First, allocating funds to inpatient care does not necessarily reduce community care—on the contrary, the latter may benefit from the injection of additional resources into the system. This is because hospital and community care can be complements, not substitutes. Second, maintaining and expanding public financing is critical to maintaining and expanding services. Proposals to lift the Medicaid ban on payments to "institutions for mental disease" (IMDs) and repeal Medicare's 190-day lifetime limit on inpatient psychiatric care might offer one way of doing so. Third, both the historical trajectory of France and recent research suggest that greater inpatient resources may actually reduce the need for involuntary hospitalization and treatment (Gandré et al. 2017). Psychiatry should keep as its core mission treating pathology, not dangerousness and deviance. Fourth, while the US has focused on "treatment gaps" and a "disturbingly low" use of services (Kessler et al. 2008, 201), France has paid more attention to the question of where the medicalization of social and personal problems should, in fact, stop. Efforts to encourage care through public awareness campaigns and screening must be supported by treatment resources on the other end.

The world often looks to the US for innovation in treatment and research of mental health conditions. Many French clinicians we spoke with are interested in programs like Housing First, Clubhouses, early intervention in preventing or treating psychotic syndromes, and Assertive Community Treatment, which are more or less developed across parts of the US. However, at the macroscopic policy levels of organization and financing, the US would do well to learn from other countries.

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