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► **To cite this version:**

Aline Sarradon-Eck, Cyril Farnarier, Takeo David Hymans. Caring on the margins of the healthcare system. *Anthropology and Medicine*, 2014, 21 (2), pp.251-263. 10.1080/13648470.2014.924299 . hal-02151612

HAL Id: hal-02151612

<https://hal.science/hal-02151612v1>

Submitted on 22 Feb 2024

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Caring on the margins of the healthcare system

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(Received 16 April 2014; final version received 12 May 2014)

This paper addresses the working practices of a mobile mental health outreach team in a large French city, one that ‘targets’ homeless people with severe psychiatric disorders who are considered ‘hard to reach’ by the public health authorities and medical services. Analysis of the team’s work – where acts of curing and caring are closely tied – reveals the importance of moving beyond a polarized vision of *cure* and *care*. The paper departs from much of the literature on the medicalization of social problems by arguing that medicalization is not only a means of social control, but has ethical value as well. In examining the practices of frontline health workers, it aims to show that integrating the methods and theoretical approaches of social work in medical practice is necessary to address the specific problems of homeless people, to enable health professionals to pursue medical cures, and to challenge the shortcomings of public policy.

Keywords: street work; mentally ill homeless; France; medicalization

Introduction

The medico-social care of homeless persons is often analysed in terms of the medicalization of social issues, or how social problems come to be framed in medical terms (Fassin 2000; Conrad 1992). But ‘although some homeless people were also mentally ill, most people were not and had become homeless because of decreased low-income housing, declining real wages, unemployment, and cuts in government benefits’ (Mathieu 1993, 170). In other words, medicalizing the cause of homelessness removes attention from broader political economic processes (Snow et al. 1986; Lyon-Callo 2000). The medicalization of homelessness, critical anthropologists have further argued, confines and controls homeless persons and justifies their removal from public spaces (Mathieu 1993). Health policies thus become a ‘type of medical social control’ (Conrad 1979), obscuring the fight against social exclusion and the desire for social change (Nguyen 2012).¹

This paper approaches the issue in a different way. We recognize the medicalization of homelessness as a ‘total social fact’ (Mauss 1950) and propose examining its impact on the practices of frontline health workers. Our fieldwork focuses on the working practices of a mobile mental health outreach team, one that ‘targets’ homeless people with severe psychiatric disorders who are considered ‘hard to reach’ by public health authorities and medical services. For numerous reasons, this population does not make effective use of available medico-social services, often leading care providers to conclude that they

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are not seeking help. The outreach team aims to engage this population by providing somatic and psychiatric care as well as access to their basic social rights (including housing). The programme's approach can be described as a 'continuum of care' (Tsemberis and Elfenbein 1999) with parallels in many contemporary societies.

The Equipe Mobile Psychiatrie-Précarité (EMPP, 'psychiatry and precariousness mobile team') operates outside of traditional psychiatric facilities (hospitals and community mental health centres) and the French system of psychiatric 'sectors'.² It thereby resembles what Anne Lovell (1996, 1997) calls 'interstitials' – with 'the targeting of a homeless population with severe mental disorders. . . [forcing this type of service] to operate on the margins of formal organisations' (Lovell 1996, 56). The focus on the homeless also requires services to be 'nomadic' to work in the urban non-places where the homeless live (Lovell 1996).

One could interpret the support provided by the professionals of this hospital without walls as 'a process whereby more and more of everyday life has come under medical domination, influence and supervision' (Zola 1983, 295). But medicalization is not only a form of social control; it also has ethical value that is not the exclusive preserve of care workers whose work the sociology of care has done so much to bring back into view. We argue that this hospital mobile team – which dispenses acts of curing while attempting to persuade mentally ill homeless persons to enter treatment (sometimes with coercive methods) – provides forms of caring for a vulnerable population. Attentiveness to detail (the meaning of care according to Laugier 2013) leads team members to tackle social problems at the individual and local levels by combining medical and social work approaches. As for the question of medicalization, our aim is to show that the flexibility needed to handle the problems of the mentally ill homeless and the shortcomings of current public policy necessitate the *socialization of medical work*. By this we mean the integration of the methods and theoretical approaches of social work within medical or paramedical practice (Farnarier 2009).

Methods

This paper draws on ethnographic fieldwork by anthropologists (18 months by the first author, February 2011 to September 2012; 12 months by the second author, September 2011 to September 2012). The EMPP we observed is a hospital unit and a part of the mental health services provided by the city's public hospitals. At the time of fieldwork, the team consisted of five doctors (two psychiatrists, a public health physician, a GP and a psychiatric intern), two social workers, two nurses, a secretary, a coordinator, six peer workers and two anthropologists (working on action research to evaluate the programme).³

The mobile team's programme of medico-social care has two main objectives: (1) to reach out to the mentally ill homeless and help them engage health and social services; and (2) to provide 'psychiatric rehabilitation care', including looking for ways to get people off the streets and into a place they can call home. As a hospital unit, the team provides psychiatric and physical consultations (on the street, but also in emergency shelters and in an office), obtains in-patient admissions, prescribes medication (sometimes delivering daily dosages), adjusts medication levels, assesses side-effects, and at times provides rudimentary medical care. Team members also focus on social work, helping the mentally ill homeless access social security benefits, health insurance, emergency shelters, permanent housing, residence cards, etc.

Although unusual in the social sciences, the position of researchers as team members and employees of the observed team, while complex, is not untenable. The stance of the ‘involved’ anthropologist (Fassin 1998) requires both closeness in action and analytical distance, including significant reflexivity in both data analysis and in disclosing and disseminating research findings (Farnarier 2014). It is one form of ‘critical anthropology’ so designated by Vidal (2014).

We pursued participant observation of all the activities of the mobile mental health outreach team in a single French city, including key moments such as team meetings, interactions between professionals, and discussions with the programme’s institutional partners. We conducted in-depth interviews with staff (including those who had left the team) as well as with some ‘clients’. By closely following the team in its daily work, we were able to gain insight into each member’s understandings of the aims and roles of this hospital without walls.

Our observations and analysis of the team’s professional practices led us to frame them in terms of *cure* and *care*. These concepts are difficult to translate into French and were not used by the team members to talk about their work. Instead, our analysis uses a theoretical framework inspired by the work of Annemarie Mol (2008). Mol suggests that ‘good care’ is not necessarily equivalent to patient ‘choice’ or ‘autonomy’, both central in biomedical ethics (Orfali 2003). Re-examining the notion of ‘good care’, Mol shows that other principles prevail in the act of caring, such as ‘tenacity’, ‘inventiveness’ and ‘concern’ (Mol 2008). Mol moreover points to the lacunas involved in opposing *cure* to *care*, which pervades the sociology of care; she argues that the act of curing and that of ‘taking care of’ are interconnected and that care is not only confined to the sphere of lay activities. Practices of care are not entirely free of the influences of technique, economic considerations, and power, while the practices of cure include both devotion and generosity (Mol, Moser, and Pols 2010).

This paper first examines how homelessness has been medicalized in French public policy, and the ideologies that underlie specific health responses to precariousness. It then turns to how the mobile mental health team adapts its work to patient and social problems, and how the team addresses the lack of requests for healthcare from the mentally ill homeless through its outreach work. We analyse the team’s practices as a hybrid of social and medical work, where practices of care are used to cure the mentally ill homeless. We end with two particularly instructive instances of the ‘socialization of medical work’.

‘Targeting’ a population on the margins of society

French policy shifted in 1993 when the government decriminalized homelessness and opted for a strategy of care through the creation of mobile outreach teams. The new approach was a political and a humanitarian choice, anchored in a government action plan to tackle the growing population of highly marginalized people without access to fundamental human rights (such as healthcare) and the prominence of ‘la question SDF (*sans domicile fixe*)’ or ‘homeless issue’ (Damon 2008). Framing marginalized populations as victims opened the door to experimental projects (such as the *Samusocial*,⁴ a street-based mobile outreach service in Paris) that rapidly became tools of government action, thus officializing the notion of ‘social emergency’ (Rullac 2008; Cefai and Gardella 2011). At the same time, public health approaches in many French cities – employing mobile teams with peer support workers, based on the principle of ‘harm reduction’ – encouraged strategies to meet drug users ‘where they are’.

The first mobile mental health outreach team was created in France in 1998 (Marquès 2010).⁵ Its main aims were to reach out to homeless people suffering from psychiatric disorders, to encourage them to accept care, to act as an intermediary between other existing services, and to support frontline workers. A 2005 ministerial circular⁶ established such teams nationwide, and by 2010 there were 126 EMPP in France (Mercuel and Querimi 2011). Although their aims were clearly defined from the outset, a certain amount of leeway was left for each team to create their own intervention models (Marquès 2010).

The EMPP observed by the first two authors developed a model based on 'street work', with healthcare professionals meeting homeless persons where they live on the streets, in parks, train stations and other public places. The team works in the centre of a city of 1 million people, whose homeless population over a 12-months period is estimated at 12,600.⁷ Social workers and citizens in the city report a shortage of shelters and unhealthy conditions in the largest one. Three general emergency shelters provide 650 beds (600 for men and 50 for women), while smaller emergency shelters cater to specific groups (youths, drug addicts and women with young children). There are also seven kinds of soup kitchens, although half operate only in winter. Based on these statistics and prevalence rates estimated by epidemiological research,⁸ team staff estimate that there are between 2400 and 3000 homeless people suffering from severe psychiatric disorders in this city.

The team's 'target' population consists of the long-term⁹ adult homeless who suffer from severe psychiatric disorders (mostly schizophrenia)¹⁰ and who are not receiving (or have never received) medical treatment. Half are French nationals, mainly with immigrant backgrounds. The other half – in the country both legally and illegally – are mostly from the European Union and Africa. Regardless of their nationality, the majority do not have access to financial means or basic social rights. Most of the time, they have distant or no contact at all with family members.

The mentally ill homeless are further marginalized in their access to healthcare. Although the French health system is free,¹¹ the mentally ill homeless make use of it less frequently than those suffering from physical ill health (Kovess and Mangin Lazarus 2001). At best, they use the clinics set up by NGOs and the drop-in services run by the district and the city. At worst, they go or are taken drunk to emergency departments where they are often poorly received due to the 'resistance' of medical staff to work with people whom they consider 'lost causes', who use the hospital as a hotel (Fournier and Mercier 1995).

The mentally ill homeless are clearly a population of 'highly marginalized'¹² individuals, excluded not from society so much as from the liberal economic model (Lovell 1992), from social protection and the 'grand project of social democracy' (Damon 2008, 56). 'A typical figure of exclusion' (Damon 2008, 62), the homeless in France emerged as a social policy issue in the 1990s. The government's targeting of this population through the creation of EMPPs also marked the beginning of the patient category policy, which targeted persons identified by specialized institutions (in this case psychiatric hospitals) and defined by their social status (homelessness) and disease (psychiatric disorder). The sociologist A. Marquès (2010, 105) argues that the psychiatric classification of the phenomenon (people with psychiatric disorders living on the streets) is not just 'the definition of a social problem, but the definition of its solution'. While the targeting of specific populations can have beneficial effects for their health, it can maintain or even reinforce their stigmatization – which explains why some refuse the term homeless¹³ or prefer the label 'drug user' to 'mad'.

Outreach work: care or cure?

Team members (psychiatrists, GP, psychiatric intern, social workers, nurses, peer workers) work in pairs and walk pre-defined city-centre areas used by the homeless. Efforts to identify homeless persons who show signs of suffering from mental or somatic illness are part of the team's 'street clinic'.¹⁴ 'Contact' with the homeless takes place on the street and often continues in outdoor cafés over coffee or a sandwich. Staff also give out soap, clothes or sleeping bags if asked and if resources permit.

Street workers emphasize the value of the time spent '*building a bond*' with homeless individuals. This includes ordinary conversation, sometimes crouched down next to the person, and plenty of waiting to give the homeless time to ask for help or to accept the help that is offered. Gilbert's story is illustrative. The team saw Gilbert regularly over several months at the spot where he begged. At every meeting he refused all offers of help until one time, just as the team was about to leave, he asked to meet a social worker. Over the next few weeks the team organized the support necessary for Gilbert to regain access to his basic social rights and financial entitlements that he had lost due to his isolation and ill health, and helped him to accept both somatic and mental healthcare.

Team members are particularly attentive to how they refer to homeless persons. Each person is called by their title (Mr, Mrs) followed by their surname or first name, or sometimes by a made-up name when their real identity is unknown. When referred to as a group, team members use the term '*street people*'. Both the word '*registered*' and the administrative term '*beneficiary*' imply that a person is receiving care; the term '*patient*', though rarely used by professionals in the team, is used when a person is hospitalized or during consultations. All of these terms suggest that the homeless person has acquired the 'ordinary' status of an ill person and is receiving treatment – implying social inclusion. The term 'user' – though commonly used by two of the peer workers to designate 'patients who see psychiatrists' (the more accepted term being '*users of psychiatric services*') – is not used by the team as it does not fit a population largely excluded from the healthcare system. The terms 'consumer' or 'client' are no more used by team members than by French healthcare professionals more generally, due to their connotation as uniquely commercial terms in French society.¹⁵ This is in contrast to Anglo-American societies where the word 'client' introduces the idea that the care recipient has the power to make his own choices (Mol, Moser, and Pols 2010, 9). In an American psychiatric service not unlike the EMPP we observed, Lovell and Cohn (1998, 12) witnessed a similar attention to terminology: 'they referred to clients as "members" to emphasize their participatory rights'. Culturally situated differences aside, the care taken to name this population helps to give it a social identity, which in the context of social disqualification (Paugam 2009) is a form of 'caring about'.

The street clinic also involves acts of curing: psychiatric evaluation and treatment (the prescribing and distributing of medication and the assessing of side-effects) as well as physical care. Consultations take place where the homeless live (on the pavement and benches, in doorways, etc.). Repeated contact enables team members to keep an eye on the physical and mental state of homeless persons and to intervene quickly if their health deteriorates. In that event, or in other dangerous situations,¹⁶ they propose taking the person to a hospital. If the person refuses, team members employ coercion to take him/her in an ambulance to a psychiatric emergency room for involuntary hospitalization.¹⁷ Such involuntary treatment gives rise to a dilemma – one between patient choice (the first principle of biomedical ethics) and the moral and legal obligation to assist individuals in danger. As Velpy (2008) has shown, biopsychiatric ideology resolves this dilemma by justifying constraint as a way to achieve autonomy, while Paul Brodwin (2013, 173) has

argued in a related context that the recourse to constraint — a clinical tool from a psychiatric viewpoint — is ideologically justified as ‘morally heroic’. Indeed, EMPP physicians justify their decisions by their role ‘to keep people alive’ (GP). In contrast, social workers and peer workers are more reluctant but accept taking part in involuntary hospitalization.

Seen professionally, the efficacy of psychiatric treatment (such as involuntary hospitalization) depends on the quality of the interpersonal bond built up over time. In other words, the cure work provided by the mental health outreach team is made possible by the care work preceding or accompanying acts of cure. As we suggest in the following sections, integrating the methods and theoretical approaches of social work in medical practice often enables health professionals to pursue medical cure.

Another objective of street work is to better understand the conditions of life on the streets to help the homeless anticipate the dangers they face.¹⁸ Over time, team members have acquired detailed knowledge of the street and its inhabitants, and have learned to read signs invisible to passers-by: clothes in a bin near a public bench, a mattress rolled under a doorway, a pile of plastic bags — all indicating that somebody has ‘lived’ there. Peer workers who have lived on the streets play a crucial role in building this specialist understanding. They pass on their knowledge of survival strategies and safe places, and reveal the ‘codes’ and ‘language’ of the street, which helps other team members understand what they see and hear.¹⁹ Peer workers also help to pick up on the movements of certain groups of homeless persons and the pressures they are facing (from police on their begging sites or from other homeless). While they work, team members inform passers-by and shopkeepers of what they are trying to do and encourage them to help watch out for homeless individuals. In doing so, they hope to change the public’s negative image of the homeless.

From an interpersonal relationship to a therapeutic relationship²⁰

Once homeless people have been located on the streets, the next step is to ‘enter into contact’ with them. This can be difficult as they are not a captive population and are often not seeking medical or even social help.

To reach out to someone means to go up and introduce yourself. They are not looking for help. They don’t want anything from you. It’s up to you to go and see them . . . you choose the people you are going to see . . . in the end it is you that is asking them to help you get to know them and not the other way round. (Psychiatrist)

According to psychiatrists, ‘asking for help means creating a bond’ (Furtos and Morcellet 2000). If there is no initial demand for help, creating a bond through regular contact is the only way to encourage future requests for help.

Among team members, the ‘outreach’ of street work is essentially about creating relationships: ‘*this work is all about bonding with others*’. It begins with building a sense of community. It is vital to the homeless person that he feels he matters to someone, and that someone cares about him. Team members often say, ‘*if you need anything, you know that we are here*’ or ‘*we’ll be back later to see you*’. There is clearly a practice of ‘caring about’, borne out by the vocabulary the team uses: ‘watch over’, ‘protect’, ‘look after’. It is also about restoring dignity lost during a long process of social disqualification (Paugam 2009).

When a bond is established with one or more members of the team, regular ‘follow up’ work ensues. This includes watching over physical and mental health and regularly

repeating information using helping relationship techniques such as empathetic understanding, reformulation and reassurance ('*you do have skills*', '*there are people who support you*'). The helping relationship defined by Carl Rogers is widely taught in social-work training courses in France, although not in medical schools.

When dealing with individuals described by the team as '*dislocated, ambivalent, ambiguous and disorganized mentally and behaviourally*' (GP), street workers say they have to use '*imagination*' and '*creativity*' to establish contact and to create bonds (this is also true of Anglo-American teams, see Anthony and Hunter 2004).

There is an intuitive and an experimental side to this work. You get it wrong, what you did didn't work, never mind [laughter] . . . in any case no one else has tried. You have this chance to experiment all the time like a juggler or tightrope walker [laughter]. And when faced with a difficult situation you know you have to use your own abilities, your social skills . . . your non-medical skills. (GP)

This apparent improvisation²¹ is the ethos of care as described by Mol, Moser, and Pols (2010, 14): 'try again, try something a bit different, be attentive'. This, of course, is not exclusively confined to street work, but shows the equal recognition given to extra-professional skills (acquired through experience or in other areas of everyday life) and medical or medico-social competence (acquired through training) (Farnarier 2009).

Team members sometimes have to transgress 'good practice' to '*establish contact*'. Offering cigarettes is often an effective way to establish contact with a homeless person. Less frequently, alcohol is bought for an individual to make him stay long enough for other members of the team to come and administer care. These transgressions, however, are only part of what makes the carer–patient relationships observed in this team so singular. The EMPP's situational context – so different from the hospital environment – enormously influences this relationship:

It's a team where there isn't this idea of 'you have to keep your distance with the patients', that you get within the hospital system . . . we are close to the patients. We greet them with a kiss on the cheek, we use '*tu*' rather than '*vous*' with them, we touch them and joke with them. We drink coffee and smoke cigarettes and eat together. . . . It is, I think, really different because in a hospital it is all about therapeutic activities; staff go to the cinema or prepare a meal with the patients: this is considered a therapeutic thing . . . whereas we actually share things with them. It's not about 'I'm going to help cure him if I do this thing with him', it's 'we are sharing in it together and it is part of a broader sense of recovery where carers share experiences with users' . . . we do it because it is important to share and carers get as much out of it as the user. (Psychiatric intern)

This interview extract reveals the desire to redress the balance in the carer–patient relationship. Therapeutic relationships are inevitably unequal but this can be lessened by the conviviality (sharing a meal for example) and the reciprocity that are part of the social relationship between carer and patient (Girard et al. 2006). We observed people who have received care showing gratitude to team members. Receiving thanks through words, gestures or gifts is a common part of a GP or hospital doctor's life. It becomes all the more touching when the thanks come from those who have nothing: offering to prepare lunch for staff, inviting a team member to a restaurant with the money from a first benefit cheque, the giving of small handmade gifts, etc. Team members are part of this reciprocal exchange. When a homeless person thanked the psychiatrist at the end of the consultation, the psychiatrist replied '*don't thank me, it's me who should be thanking you*'.

Team members stated that it is difficult to build relationships of trust with homeless persons as the harsh conditions of life on the streets lead to distrust of others. This distrust is magnified when the person suffers from persecutory delusions, a frequent symptom of psychotic disorders, which the mentally ill homeless often suffer. Many of those targeted by the team have also received some form of psychiatric care in the past and generally have painful memories of it (particularly of involuntary hospitalization). Despite these difficulties, we observed that relationships of trust could be built between homeless people and team members. In these relationships, one of the keys is to expand trust beyond dyadic relationships. This is achieved through trust transitivity, or the extension of trust to a third party or system from a person already deemed trustworthy (Mangematin 2004).

We can observe the fruits of this trust transitivity in the street networks of the homeless. Trust can help to identify others in need, to locate persons who have gone missing, or to convince sick persons to accept care. Operating by 'word of mouth', these networks act as intermediaries, facilitating the identification and referral of new people to the team by other homeless. When a team member meets a new person, it is vital that they build the relationship to 'encourage' (Marquès 2010) the person to extend his trust to the team as a whole. Meeting regularly is, amongst other things, about renewing a person's trust in a care system adapted to his needs, the system itself being unable to demonstrate this ability (sometimes due to painful past experience). 'This is one of the main reasons why individuals at access points normally go to great pains to show themselves to be trustworthy: they provide the link between personal and system trust' (Giddens 1990, 115).

'Support' as cure

As understood by the team, 'support' for the homeless is 'to do things with them, not for them'. Support work aims to promote autonomy, which not only has value in its own right but is also the therapeutic rationale of psychiatry (Velpry 2008). In the team's work, support can mean physically accompanying a homeless person to care services (consultations with a specialist, to the hospital). For a hospitalized person, it can entail consolidating a trusting relationship by regularly visiting them, bringing necessary items (clothes, soap, tobacco) and following up on entitlement applications – things that could just as easily be done by a family member. Support is also about accompanying the homeless in everyday activities such as meetings with their legal guardian, completing administrative formalities (for ID papers, social security benefits, at the employment centre or bank, etc.) or going to buy shoes or glasses. Such support is often essential to ensure that homeless persons have access to non-urgent medical care. For instance, a peer worker spent more than three days (due to delays, bureaucratic hurdles and unfamiliarity with legislation) helping a woman open a bank account, which was necessary to obtain health insurance that would pay for the opioid substitution treatment and the physical care she needed.

Helping people back into housing implies different kinds of support, such as help with moving and buying furniture, connecting the electricity, arranging for pest control, etc. In the eyes of all team members, such support work creates opportunities for therapeutic dialogue. It also reinforces the confidence between carer and patient necessary for the therapeutic relationship (the 'therapeutic alliance' in psychiatric language). All professionals in the team participate in this support work. For example, doctors and nurses can team up with social workers and peer workers to help an individual to move into stable housing or simply to prepare a meal.

We see this support work as a form of ‘taking care of’ that includes forms of ‘care giving’ and ‘caring about’ that go unrecognized in the French healthcare system – a system that places all value on medical interventions to cure specific physical or mental symptoms and illnesses. When, for instance, professional members of the team accompany homeless persons to the emergency department for somatic or mental healthcare, they often feel marginalized within their ‘own’ institution. Team members indeed admitted that ‘*we are always unwelcome*’ in emergency departments or psychiatric emergency rooms.

They explained this absence of recognition for their work, particularly from physicians, with the social stigma attached to the people they look after. ‘*For physicians, you are right on the edge of the margin which means that you are not even a professional*’ (GP). The street-dwelling homeless are side-lined in emergency departments where they are often poorly treated (Emanuelli, Tartière and Laruelle 2004). This is sometimes due to their disturbing behaviour, the embarrassment they cause, or the extra work they represent (dirtiness, fleas, yelling, etc.). But it is also because they point to the inadequacies of emergency department staff (Ogien 1986; Fournier and Mercier 1995): ‘*[you feel] a reticence straightaway, as in “we can’t do anything for him”*’ (GP). The doctors and nurses in the team recounted numerous instances of how their positions in the hospital hierarchy, and even their status as ‘colleagues’ working for the same public hospital, was contested. What we see here is a form of symbolic contagion from the stigma (Goffmann 1963) that surrounds the homeless people they look after.

The kind of support provided by team members – based on the cultivation of long-term relationships – is not perceived as care and remains invisible. The support that facilitates the later work of emergency department staff also goes unrecognized. Homeless persons will not be better welcomed upon arrival, no effort will be made to keep them in hospital if they want to leave, and prescribed treatments will not be better adapted to their situation (for example, prescription for Heparin injections to be administered *at home*).

We observed that the invisibility of street work leads psychiatric professionals to undervalue the work of the EMPP. The numerous jokes about the team that circulate in the psychiatric services reveal that its work is seen as ‘*doing nothing*’, or worse, as a form of ‘*cleaning up the streets*’ (just taking homeless people suffering from severe psychiatric disorders to the emergency ward). Both statements underline the invisibility of the team’s contributions and reveal a real misunderstanding of outreach work. An exchange between a senior emergency aid doctor and the team’s intern psychiatrist, which took place as the young physician and one of the authors accompanied a patient to the emergency department for involuntary hospitalization, illustrates this misreading of the team’s work. The patient was very dirty and was protesting loudly, eliciting negative comments from staff.

Senior doctor: You [the outreach team] do a great job. You do it with a great heart. But the problem is that there is nothing behind it!

Psychiatrist intern: Think again! There are a lot of things!

Senior doctor: Maybe, but we don’t see them.

Psychiatrist intern: It’s a real shame that you don’t know what we do behind [hospitalization].

Many hospital staff are also confused about the EMPP’s role, misunderstanding its work as the ‘rounding up’ of mentally ill patients who abscond from hospital. As theorists of care have often emphasized, care work and care workers are undervalued (Tronto 1993). It is this devalorization alongside care work’s inherent invisibility and its association with the private sphere that explains the lack of recognition for the team’s work.

But the reactions of emergency department staff can also be read as a critique of the medicalization of homelessness. For instance, we heard emergency doctors say, '*We can do nothing for him, it's his choice of lifestyle*'. Team members (especially physicians) often felt isolated in the public hospital when colleagues disagreed with their decision to involuntarily admit a patient. In response to the critique of medicalization and the lack of recognition for their work, team members try to sensitize somatic and psychiatric service staff to the living conditions of the homeless, their effect on health, and the constraints that living on the street impose on providing healthcare (lack of compliance, inability to rest, etc.). Team members thus also aimed to change the social representation of homelessness – as a peer worker said, to '*make the invisibles visible*'.

Conclusion

This paper's ethnographic portrait of a new form of mental healthcare practice seems to us useful for thinking about the medicalization of homelessness in another way. We hope to have shown that the mobile outreach team's objectives go beyond the immediate improvement of the health of homeless persons. Instead, it seeks to change their environment, to give them back their place as citizens in society by enabling them to regain access to their human rights (to housing, to social protection, to civil rights, and to culture), to allow them to rediscover their autonomy by reducing the psychiatric symptoms they suffer, and to help them rebuild a social identity free of stigma. Above all, the practices of this hospital without walls are forms of 'care giving' and 'caring about' that fight social exclusion.

The mobile mental health outreach team focuses on vulnerable and marginalized persons with medical and social problems and tries to provide practical solutions to improve their health and reduce their psychiatric symptoms. The aim is not to cure people suffering from chronic illness but to improve their quality of life by helping them access treatment, amongst other things. This way of working requires each team member to have both the medical and social skills necessary to ensure that the mentally ill homeless receive both the cure and the care that they need. Within the 'logic of care' (Mol 2008), acts of 'curing' and of 'caring about' overlap and imply each other; in the team's work, care practices are employed for cure purposes and vice versa. For example, the creation of interpersonal relationships – built on attention, concern and reciprocity – is intended to ensure the homeless person's access to healthcare services, often including admission to hospital and/or the prescription of medication. But hospitalization and medication are just two parts of the long process of recovery and of improving the quality of one's life, the other vital aspects being the re-accessing of basic social and civil rights and the receiving of support to rebuild a positive social identity. This is why the team and the practices described in this paper are a form of the 'socialisation of medical work' (Farnier 2009), which conforms to the logic of care.

Acknowledgements

The authors would like to thank Asha Last who translated the first original French version of this paper into English. The authors would also like to thank the Center for Social Science and Global Health for funding the open access version of this article.

Funding

This work was supported by the French Agence Régionale de Santé of Provence-Alpes-Côte-d'Azur [COSA 156568]; The University of Amsterdam's Centre for Social Science; Global Health supported the open access publication.

Conflict of interest

No.

Notes

1. In particular the Don Quichotte movement during the winter of 2006–2007 refused the emergency response as it only provided immediate short-term housing rather than a long-term solution to a chronic social problem (Rullac 2008).
2. Since 1960, the French government's 'sectorization' policy has been based on well-defined catchment areas. Each sector, comprising approximately 70,000 inhabitants, is run by a multi-disciplinary team that provides preventive as well as palliative and rehabilitative care as close to home as possible.
3. This EMPP has more staff than other mobile mental health outreach teams because the team manager, a charismatic psychiatrist, has managed to attain special government funding.
4. The NGO *Samusocial* (*Service d'Aide Mobile d'Urgence Sociale*, mobile emergency assistance service) was founded by Dr Xavier Emanuelli, the co-founder of Médecins Sans Frontières. *Samusocial* mobile teams, made up of a nurse, a social worker and a driver, seek out homeless persons on the street.
5. Mobile teams were created in the USA in the 1980s to address the failings of the American psychiatric system, both to ensure continuity of care for the homeless suffering from severe psychiatric disorders and to 'clean up' certain areas of major cities (Lovell 1996).
6. Circulaire DHOS/O2/DGS/6C/DGAS/1A/1B no 2005-521.
7. A doubtful 2011 calculation by the city council and the Regional Health Agency counted individuals present at visited locations (homeless shelters, day centres and low-threshold health centres) then subtracted those already encountered elsewhere. The city's largest low-threshold health centre was not included; nor were the many homeless persons who do not use available services. While a counting programme using capture–recapture methods was recently entrusted to a university public health laboratory, it should be noted that France has no reliable statistics on the numbers of homeless.
8. Since the late 1980s, several studies have highlighted the high prevalence of severe psychiatric disorders – between 30 and 50% – among homeless people (Koegel, Burnam, and Farr 1988; Laporte, Le Méner, and Chauvin 2010).
9. A third have been living on the streets for more than 10 years.
10. These people also have addiction or somatic co-morbidities as a result of their psychiatric disorders and the harsh conditions of life on the streets.
11. Through 'universal health coverage' (AMU) for French people and long-term residents, and 'state medical support' (AME) for those residing irregularly in the country.
12. For the limitations and arbitrariness of the notion of exclusion as applied to the homeless, see Damon (2008).
13. Like the case of Fred who insisted that he did not live on the streets because he lived in his car.
14. Words used by EMPP members are in italics.
15. Furthermore, considering the practice of medicine as a commercial activity is illegal. But the term 'client' is sometimes used to denote a person belonging to the target population.
16. In another paper we describe the self-endangering behaviours of the mentally ill homeless that lead to decisions of involuntary treatment (Sarradon-Eck and Farnarier 2014).
17. The mobile mental health outreach team makes about a dozen involuntary hospitalizations per year.
18. Hypothermia, dehydration, and also violence (physical and sexual aggression, rape), which is highest among the homeless suffering from mental health problems (Lovell, Cook, and Velprey 2008).
19. For example, the different sites and tactics used when begging and the alcohol consumption required to cope with the shame, etc.
20. By therapeutic relationship we mean the healthcare professional's influence on the success of the prescribed treatment, whether it be chemotherapy or psychotherapy.
21. Apparent because staff have a quite limited set of tried and tested skills to deal with different situations.

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