THE FOUCAULT EFFECT

STUDIES IN GOVERNMENTALITY

WITH TWO LECTURES BY AND AN INTERVIEW WITH
MICHEL FOUCAULT

Edited by
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From dangerousness to risk

Robert Castel

In this chapter I would like to put forward a line of reflection on the preventive strategies of social administration which are currently being developed, most notably in the United States and France, and which seem to me to depart in a profoundly innovatory way from the traditions of mental medicine and social work.

To begin by putting it very schematically, the innovation is this. The new strategies dissolve the notion of a *subject* or a concrete individual, and put in its place a combinatory of *factors*, the factors of risk. Such a transformation, if this is indeed what is taking place, carries important practical implications. The essential component of intervention no longer takes the form of the direct face-to-face relationship between the carer and the cared, the helper and the helped, the professional and the client. It comes instead to reside in the establishing of *flows of population* based on the collation of a range of abstract factors deemed liable to produce risk in general. This displacement completely upsets the existing equilibrium between the respective viewpoints of the specialized professional and the administrator charged with defining and putting into operation the new sanitary policy. The specialists find themselves now cast in a subordinate role, while managerial policy formation is allowed to develop into a completely autonomous force, totally beyond the surveillance of the operative on the ground who is now reduced to a mere executant.

Furthermore, these practical implications may also have a political significance to the extent that, as I shall try at any rate to suggest, these new formulae for administering populations fall within the emerging framework of a plan of governability appropriate to the needs of 'advanced industrial' (or, as one prefers, to 'post-industrial' or 'post-modern') societies.

Like all important transformations, this one presupposes a slow preceding evolution of practices which, at a certain moment, passes a threshold and takes on the character of a mutation. Thus, the whole of modern medicine has been engaged in a gradual drift towards the point where the multiplication of systems of health checks makes the individualized interview between practitioner and client almost dispensable. The examination of the patient tends to become the examination of

the patient's records as compiled in varying situations by diverse professionals and specialists interconnected solely through the circulation of individual dossiers. This is what Balint has called 'the collusion of anonymity'. The site of diagnostic synthesis is no longer that of the concrete relationship with a sick person, but a relationship constituted among the different expert assessments which make up the patient's dossier. Already here there is the shift from presence to memory, from the gaze to the objective accumulation of facts. The resulting situation might, if one chooses, be called a crisis of clinical medicine, a crisis affecting the personalized relation between professional and client; or it might be called a transition from a clinic of the subject to an 'epidemiological' clinic, a system of multifarious but exactly localized expertise which supplants the old doctor–patient relation. This certainly does not mean the end of the doctor, but it does definitely mark a profound transformation in medical practice.

Over the past twenty years or so, this redefinition of the medical mandate has been fuelling discussion of the evolution of medicine and the quest for solutions or palliatives to its negative side-effects (Balint groups, group medicine, attempts to revalorize general practice, etc.). In addition, the very precise objective conditions on which this whole evolution depends have themselves been studied often enough: the increasingly 'scientific' direction in which technologies of care have been evolving; the growing importance of the hospital as the privileged site of emergence and exercise of a technically advanced medicine; and so on. In mental medicine, however, the discussion has not progressed quite as far: it is still assumed that the crucial practical issues are those relating to the therapeutic relationship, whether they are seen in terms – as most of the professionals who operate it tend to think – of improving it, adapting it to more complex situations by enriching it with new resources, or else in terms of criticizing the non-therapeutic social functions, for example of repression or control, which denature it. It may be, however, that this problematic, while not completely outdated, is no longer able to keep pace with the most recent innovations currently transforming the field of mental medicine. This at least is what I would like to suggest, although I shall confine myself here to giving an outline of the route which over the last hundred years has led to the replacement of the notion of *dangerousness*, formerly used to designate the privileged target of preventive medical strategies, by the notion of *risk*.[1]

From dangerousness to risk: what does that signify historically, theoretically and practically?

THE PARADOXES OF DANGEROUSNESS

For classical psychiatry, 'risk' meant essentially the danger embodied in the mentally ill person capable of violent and unpredictable action. Dangerousness is a rather mysterious and deeply paradoxical notion, since it implies at once the affirmation of a quality immanent to the subject (he or she is dangerous), and a mere probability, a quantum of uncertainty, given that the proof of the danger can only be provided after the fact, should the threatened action actually occur. Strictly speaking, there can only ever be *imputations of dangerousness*, postulating the *hypothesis* of a more or less probable relationship between certain *present* symptoms and a certain act *to come*. Even where what one is talking about is a risk of recidivism, there still always exists a coefficient of uncertainty separating the diagnosis of dangerousness from the reality of the act. To say, for example, that someone is 'a monomaniac' or 'an instinctive pervert' already involves postulating a risk, one which in a paradoxical manner is supposed to dwell 'in' the subject even though it will often not yet have manifested itself in any act. Hence the special *unpredictability* attributed to the pathological act: all insane persons, even those who appear calm, carry a threat, but one whose realization still remains a matter of chance. 'Harmless today, they may become dangerous tomorrow.'[2] Faced with this besetting paradox of classical mental medicine, psychiatrists generally opted for the all-out prudence of preventive interventionism. When in doubt it is better to act, since, even if unfounded intervention is an error, it is one that will certainly never be known to be such; whereas if one abstains from intervening and the threatened act should still materialize, the mistake is obvious and the psychiatrist is exposed to blame. Hence the comment of one nineteenth-century alienist on reading one of those periodic news items smugly headlined in the newspapers, narrating the outburst of one such unpredictable act of violence: 'If we did not wait until lunatics committed some serious crime before we committed them, we would not have to deplore such accidents every day.'[3]

But is it possible to develop on this basis a fully-fledged policy for prevention? Only in a very crude way, since one could only hope to prevent violent acts committed by those whom one has already diagnosed as dangerous. Hence the double limitation arising from the fallibility of such diagnoses on the one hand, and the fact that they can only be carried out on individual patients one by one, on the other. This was why classical psychiatry was only able to make use of the correspondingly crude preventive technologies of confinement and sterilization. To confine signified to neutralize, if possible in advance, an individual deemed dangerous. In this sense it is not an exaggeration to say that the

principal laws on compulsory confinement, such as the law of 1838 in France and the law of 1904 in Italy, are preventative laws, since, at the alarm signalled by the perception of a pathological symptom by the persons around him or her, the sick person is subject to forcible transplantation into a new environment, the asylum, where he or she will be systematically prevented from fulfilling the threat carried inside.

However, even apart from the moral or political reservations one might have about this strategy, it must be noted that *technically* it is not very satisfactory, since it has an arbitrary element which considerably limits its possible application. One cannot confine masses of people just out of simple suspicion of their dangerousness, if only for the reason that the economic cost would be colossal and out of all proportion to the risks prevented. Thus in a country like France the number of mentally ill persons confined in institutions has levelled off at around 100,000, which may seem a lot but at the same time is very few if one considers the number of dangers needing to be 'prevented'. These limits to confinement have become increasingly obvious as, through a line of development starting with monomania and 'madness without delirium', and progressively tracing the elaboration of a whole protean pathology of will and instinct, dangerousness turns into more and more of a polyvalent entity credited with unfathomable causes and unpredictable ways of manifesting itself. All those abnormal individuals, 'too lucid for the asylum, too irresponsible to imprison: are they not, above all, too harmful to be left at liberty?'[4] How, then, are they to be disposed of?

The more alert among the psychiatrists very soon realized the trap into which they risked falling through their propensity to treat dangerousness as an internal quality of the subject. Thus, as early as the middle of the nineteenth century the French psychiatrist Morel (better known as the discoverer of degeneracy) proposed a 'hygienic and prophylactic point of view' based on assessment of the *frequency* of mental illnesses and other abnormalities among the most disadvantaged strata of the population, and related this frequency to the living conditions of the subproletariat – malnutrition, alcoholism, housing conditions, sexual promiscuity, etc. In doing this, Morel was already arguing in terms of *objective risks*: that is to say, statistical correlations between series of phenomena. At the level of practices, he also suggested that the public authorities undertake a special surveillance of those population groups which might by this stage already have been termed 'populations at risk', those located (of course) at the bottom of the social ladder.[5] Morel was, incidentally, reactivating here the tradition of medical hygiene which had flourished in France in the late eighteenth century but from which alienism had distanced itself by concentrating the main part of its activities within the asylum.

But Morel was not able to go very far in this direction towards a

genuinely preventive perspective, since he did not have at his disposal the specific techniques to achieve this. For him, to intervene still means to enter into contact with and take complete responsibility for particular individuals. Thus he talks of 'generalized moral treatment' as designating the new preventive practices he aims to promote, as though it were sufficient to extend and proliferate the same existing form of action, moral treatment, which at that time was established as the mandatory form of therapy for individual patients. He does draw the essential distinction between 'defensive prophylaxis' (internment) and 'preventive prophylaxis', but he is obliged to restrict the latter to:

> trying to modify the intellectual, physical and moral conditions of those who, on various grounds, have been separated from the rest of men; it must, before returning them to the social milieu, so to speak equip them against themselves, so as to reduce the rate of relapses.[6]

In other words, this 'preventive prophylaxis' is in practice still only applied to populations which undergo traditional confinement. For want of an adequate technology of intervention, Morel is unable to profit from his distinctly modern intuitions.

To be exact, one does find the emergence, in continuity from Morel and the discovery of degeneration, of the possibility of another kind of preventive strategy which culminates in the eugenic policies of the early twentieth century. Eugenics also starts to reason in terms of risks rather than dangers; the goal of an intervention made in the name of preservation of the race is much less to treat a particular individual than to prevent the threat he or she carries from being transmitted to descendants. Accordingly, the prophylactic measure of sterilization can be applied in a much more widespread and resolute preventive manner than confinement, since it can suppress future risks, on the basis of a much broader range of indications than those of mental illness strictly defined. Thus in 1914 a voice as authoritative as that of the President of the American Psychiatric Association declared:

> that a radical cure of the evils incident to the dependent mentally defective classes would be effected if every feeble-minded person, every imbecile, every habitual criminal, every manifestly weak-minded person, and every confirmed inebriate were sterilized, is a self-evident proposition. By this means we could practically, if not absolutely, arrest, in a decade or two, the reproduction of mentally defective persons, as surely as we could stamp out smallpox absolutely if every person in the world could be vaccinated.[7]

Indeed we often fail to remember that eugenic practices were widespread during the first third of this century, and that even in a country as supposedly 'liberal' as the United States special laws imposing sterilization for a wide range of deficient persons were enacted in almost

all states.[8] But the interventions of eugenics were braked by the crisis affecting the 'scientific' basis which was held to justify them. Such interventions rely on the postulate that the hereditary character of the risks to be prevented, and of their mode of transmission, is scientifically established: something which in the majority of cases is far from having been proven. And then the monstrously grotesque version provided by Nazism helped both morally and politically to discredit eugenic techniques which, but for this tragic episode, would doubtless have had a fine future ahead of them. Besides, it was a French doctor who, as early as 1918, was so far as I know the first person to propose the setting up of an 'Institute for Euthanasia where those degenerates tired of life will be painlessly put to death by means of nitrous oxide or laughing gas'.[9]

But if the preventive path followed by eugenics thus finds itself (definitively or provisionally) discredited, how will it be possible to prevent without being forced to confine? There is a risk here of reverting to Morel's position: recognizing the need to act directly on the conditions liable to produce risk, but lacking the techniques with which to instrumentalize this requirement. A century after Morel, this ambiguity still characterizes the whole American tradition of preventive psychiatry founded on the works of Gerald Caplan.[10] Here again the question is one of *widening the intervention of the psychiatrist*, if need be by giving him or her new roles to play, making the psychiatrist into an adviser to ruling politicians or an auxiliary to administrative 'decision makers'. Take for example this programmatic text:

> The mental health specialist offers consultation to legislators and administrators and collaborates with other citizens in influencing governmental agencies to change laws and regulations. Social action includes efforts to modify general attitudes and behavior of community members by communication through the educational system, the mass media and through interaction between the professional and lay communities.[11]

On this basis, Caplan defines a first meaning of prevention, 'primary prevention', which is in fact a whole programme of political intervention.

But what is there that especially qualifies the psychiatrist to assume these new functions? What connection is there between the competence he or she can claim and that which is for instance needed to reform environmental policy or the school system? The specialist in mental medicine who, in Caplan's words, 'offers consultation' in these fields, runs a high risk of seeing his competence challenged, or at least of encountering strong competition from numerous other specialists, many of whom may seem better qualified than him. And so the hopes and fears which developed around an 'expansionist' psychiatry, and sometimes gave rise to denunciations of the risks of 'psychiatric imperialism', are

doubtless somewhat exaggerated, at least at this level. They credit psychiatrists with quite exaggerated powers, in view of the actual position they occupy in society and the uncertain character of their knowledge: they represent psychiatrists as being able to intervent in a wide range of specifically social problems, despite the random social provenance of their classically individual clientele. Doubtless they can attempt to make their traditional therapeutic role a little more flexible. But they cannot variegate at indefinitely so long as they remain constricted by the relational character of their practice.

THE NEW SPACE OF RISK

The limitations are removed if one breaks this *direct* relation with the assisted subject which characterizes classical forms of treatment not only in psychiatry but in all the social work and care professions. In so doing, one makes an overt dissociation of the technical role of the practitioner from the managerial role of the administrator.

Such a shift becomes possible as soon as *the notion of risk is made autonomous from that of danger*. A risk does not arise from the presence of particular precise danger embodied in a concrete individual or group. It is the effect of a combination of abstract *factors* which render more or less probable the occurrence of undesirable modes of behaviour.

For example, in 1976 a general system for the detection of childhood abnormalities began to be installed in France, entitled the GAMIN (automated maternal and infantile management) system.[12] This involves making *all* infants subject to systematic examination (three examinations, in fact: at a few days, a few months and two years of age). These examinations detect all possible abnormalities of child and mother, whether physical, psychological or social. Among the kinds of data thus collected are: certain illnesses of the mother; psychological deficiencies; but also social characteristics such as the fact of being an unmarried mother, a minor, of foreign nationality, etc. These items of information can then be collated, thus grouping together types of factor which are totally heterogeneous. For instance, one may happen to be born of an unmarried mother who is less than seventeen years old, or more than forty, who has had a certain type of illness, or previous difficult pregnancies, who is a farmworker or a student, and so forth.

The presence of some, or of a certain number, of these factors of risk sets off an automatic alert. That is to say, a specialist, a social worker for example, will be sent to visit the family to confirm or disconfirm the *real* presence of a danger, on the basis of the *probabilistic and abstract* existence of

risks. One does not *start from* a conflictual situation observable in experience, rather one *deduces* it from a general definition of the dangers one wishes to prevent.

These preventive policies thus promote a *new mode of surveillance*: that of systematic predetection. This is a form of surveillance, in the sense that the intended objective is that of anticipating and preventing the emergence of some undesirable event: illness, abnormality, deviant behaviour, etc. But this surveillance dispenses with actual presence, contract, the reciprocal relationship of watcher and watched, guardian and ward, carer and cared. This form of copresence, if only in the sublimated form of the observing gaze, was a requisite of all the classic disciplinary, benevolent and therapeutic techniques (cf. the model of the panopticon as analyzed by Michel Foucault).[13] Even in their most collective, impersonal and repressive forms, in barracks, factories, prisons, boarding schools and psychiatric hospitals, operations designed to detect and correct deviant behaviour retained this reliance on presence 'in the flesh' and, in short, on a certain form of individualization.

But now surveillance can be practised without any contact with, or even any immediate representation of, the subjects under scrutiny. Doubtless the police have long kept their secret files. But the logic of such subterranean dossiers now attains the sophisticated and proudly proclaimed form of 'scientific' predetection.

It seems to me that one has a real mutation here, one that is capable of giving an extraordinary scope to the new technologies of surveillance. To intervene no longer means, or at least not to begin with, taking as one's target a given individual, in order to correct, punish or care for him or her (however one cares to interpret these latter forms of intervention – positively, according to the tradition of charitable, albeit muscular philanthropy, or negatively in line with the anti-respressive critical school of thought). There is, in fact, no longer a relation of immediacy with a subject *because there is no longer a subject*. What the new preventive policies primarily address is no longer individuals but factors, statistical correlations of heterogeneous elements. They deconstruct the concrete subject of intervention, and reconstruct a combination of factors liable to produce risk. Their primary aim is not to confront a concrete dangerous situation, but to anticipate all the possible forms of irruption of danger. 'Prevention' in effect promotes suspicion to the dignified scientific rank of a calculus of probabilities. To be suspected, it is no longer necessary to manifest symptoms of dangerousness or abnormality, it is enough to display whatever characteristics the specialists responsible for the definition of preventive policy have constituted as risk factors. A conception of prevention which restricted itself to predicting the occurrence of a particular act appears archaic and artisanal in comparison with one which

claims to *construct* the objective conditions of emergence of danger, so as then to *deduce* from them the new modalities of intervention.

In brief, this generalized space of risk factors stands in the same relation to the concrete space of dangerousness as the generalized space of non-Euclidean geometries has to the three-dimensional space of Euclidean geometry; and this abstracting generalization which indicates the shift from dangerousness to risk entails a potentially infinite multiplication of the possibilities for intervention. For what situation is there of which one can be certain that it harbours no risk, no uncontrollable or unpredictable chance feature?

The modern ideologies of prevention are overarched by a grandiose technocratic rationalizing dream of absolute control of the accidental, understood as the irruption of the unpredictable. In the name of this myth of absolute eradication of risk, they construct a mass of new risks which constitute so many new targets for preventive intervention. Not just those dangers that lie hidden away inside the subject, consequences of his or her weakness of will, irrational desires or unpredictable liberty, but also the exogenous dangers, the exterior hazards and temptations from which the subject has not learnt to defend himself or herself, alcohol, tobacco, bad eating habits, road accidents, various kinds of negligence and pollution, meteorological hazards, etc.[14] Thus, a vast hygienist utopia plays on the alternate registers of fear and security, inducing a delirium of rationality, an absolute reign of calculative reason and a no less absolute prerogative of its agents, planners and technocrats, administrators of happiness for a life to which nothing happens. This hyper-rationalism is at the same time a thoroughgoing pragmatism, in that it pretends to eradicate risk as though one were pulling up weeds. Yet throughout the multiple current expressions of this tranquil preventive conscience (so hypertrophied at the moment in France, if one looks at all the massive national preventive campaigns), one finds not a trace of any reflection on the social and human cost of this new witch-hunt. For instance, there are the *iatrogenic aspects of prevention*, which in fact are always operative even when it is consumption of such 'suspect' products as alcohol or tobacco which is under attack.

PRACTICAL AND POLITICAL IMPLICATIONS

Even if one sets on one side the issue of these general implications, it is possible to begin to draw a certain number of practical and prosaic consequences. I shall limit myself here to two which seem to me to be particularly important.

The separation of diagnosis and treatment, and the transformation of the caring function into an activity of expertise

Whether one thinks this a good or a bad thing, the tradition of mental medicine, and more broadly of social work and assistance in general, has until now been characterized by an aspiration to provide as complete as possible a service of care for the populations for which it had responsibility.

For psychiatry, this aspiration was initially realized in the clear, simple form of internment: to be diagnosed as mentally ill amounted to being placed in a special institution or asylum, where the way a person was taken charge of was so total that it often continued for life. But in modern psychiatry, in its community-based mode of operation, this globalized vocation is taken over by the essential notion of *continuity of care*: a single medico-social team, notwithstanding the diversity of sites in which it operates, must provide the complete range of interventions needed by a given individual, from prevention to after-care. This is fundamental to the doctrine of the 'sector' which is official mental health policy in France, and to the Community Mental Health Centers movement in the United States. One might add that even psychoanalysis is not altogether foreign to this tradition, since, as we know, it follows the client over many years through the various episodes of the cure and punctuates his or her life with the rhythm of its sessions, thus in its own way providing a continuity of care.

Today, this *continuous regime of assistance* has certainly not come to an end, but it no longer represents a quasi-exclusive model of medico-psychological practice. In a growing number of situations, medico-psychological assessment functions as an *activity of expertise* which serves to *label* an individual, to constitute for him or her a *profile* which will place him or her on a *career*. But to actually take the individual into some kind of care does not necessarily form a part of this continuity of assessment.

Such, for example, is the logic of the important law 'in favour of handicapped persons' which was passed in France in 1975 and affects around two million individuals.[15] A diagnosis of handicap makes it possible to allocate subjects to various special trajectories, but these are not necessarily medical ones. For example, a handicapped person may be placed in a sheltered workshop or a Centre for Help through Employment (Centre d'aide par le Travail: CAT): that is to say, an establishment which has nothing medical about it, where the handicapped person is not so much 'cared for' as invited to work in a less competitive way than in ordinary productive enterprises. One can call this 'demedicalization' or 'depsychiatrization' if one likes, but it is of a kind in which treatment is replaced by a practice of *administrative assignation* which often intervenes

on the basis of a medico-psychological diagnosis. In France this law is encountering increasingly determined opposition from a majority of practitioners who realize that it carries a fatal threat to their professions. Nevertheless, the intervention of the practitioner remains an essential part of the functioning of the process, since it is the practitioner's expert assessment which seals the destiny of the handicapped individual. But this expertise no longer serves the same end: while remaining indispensable as an evaluation, it can become superfluous to the process of supervision. In other words, there are a growing number of subjects who continue to have to be *seen* by specialists of medico-psychological knowledge whose intervention remains necessary for assessment of their abilities (or disabilities). But individuals who are *seen* in this way no longer have to be *treated* by these same specialists. We have gone beyond the problematic of treatment (or, in critical nomenclature, that of repression and control). We are situated in a perspective of *autonomized management* of populations conducted on the basis of differential profiles of those populations established by means of medico-psychological diagnoses which function as pure expertises. Undoubtedly we have yet to take in the full moment of this mutation.

The total subordination of technicians to administrators

Conflict between administrators and practitioners is itself an old tradition of the mental health and social work professions. Indeed it is a leitmotif of the whole professional literature to regard administrative exigencies as the principal obstacle to the deployment of a therapeutic or caring activity worthy of the name: the administrator is always refusing the practitioner the resources needed for his or her work, obstructing initiatives by niggling regulations, imposing functions of control and repression, etc.

But in the classical system this conflict of viewpoints was acted out between two almost equal partners, or at least it left room for negotiation, compromise and even alliance on the basis of a division of responsibilities. One could set out to seduce or neutralize an administrator, to outflank or exploit a regulation, to influence or intimidate a manager, etc. Moreover, from the beginnings of psychiatry until today, policy for mental health has been the product of a confused interaction (or, if one prefers, a dialectical relation) between the respective contributions of practitioners and administrators. In the elaboration of policies, one can in spite of the disparities between different historical eras and geographical regions identify four common phases which follow on from one another with such regularity that one is entitled to conclude that it amounts to a genuine constitutive logic.[16]

An initial phase is dominated by the operators on the ground. Practitioners confronted with day-to-day problems gradually devise through trial and error a new formula for organizing the domain they have charge of. Thus one has the 'invention' of the asylum in France at the start of the nineteenth century, set against the background of the old *hôpital général*, and the geographical sectorization of the care of problem populations after the Second World War: to begin with these are more or less improvised reactions to concrete situations, which afterwards become progressively systematized.

During a second phase, which in fact starts very early on, these professionals make advances to the administrative and political authorities to request the officialization of their formula. Esquirol writes his famous 1819 report to the Minister of the Interior on the condition of hospitals for the insane and the reforms they require. In the post-war United States the modernizing professionals of the National Institute of Mental Health, and in France the progressive wing of the psychiatric profession of the 1950s, form their respective alliances with the Democrat administration and the progressive administrators at the Ministry of Health.

After a series of comings and goings, a shuttle operation which proceeds through mutual adjustments and compromises and may extend over years or even decades, an official decision is finally taken which definitively establishes the new mental health policy. This happens with the French 1838 law and 1960 ministerial circular on sectorization, and with the 1963 USA Community Mental Health Centers and Retardation Act, backed by the full authority of President Kennedy himself. On these administrative and medical foundations, a new formula for the management of problem populations is elaborated. The care of the mentally ill and other deviant persons no longer poses problems *of principle*; it is inscribed in a coherent scheme of administration constituting what is termed a policy.[17]

There then begins a fourth phase, generally marked by the disillusion of the professionals. There are cries of betrayal, charges that their humanist intentions have been distorted for the sake of bureaucratic or even repressive criteria. They denounce administrative sabotage, the ill-will of ministries, the denial of necessary resources. But the professionals tend to forget that a law does not actually need to be applied according to the letter in order for it to fulfil its essential function: that of providing conditions for the coherent management of a thorny problem at the administrative, juridical, institutional and financial levels of provision. They also forget that, even if they have been let down and their intentions distorted, their practice has furnished an essential element in the construction of the system.

Such has been the structure, schematically outlined and looked at in its political dimension, of the practitioner–administrator relationship up until now. Certain recent critiques of psychiatry have undoubtedly distorted the issue by treating mental health professionals as mere agents of state power. There is absolutely no question that these professionals are equipped with an official mandate, but this mandate is held on the basis of a practice which is not itself a straightforward instrumentalization of administrative–political decisions. The proof of this is that certain of these agents have been able to make use of their powers to redirect their mandate and effect a subversion of the previous juridical function, working on the basis of advances achieved in their own practice. The contribution of the Italian democratic psychiatry movement has provided just such an example, with their action culminating in 1978 in the passage by the Italian parliament of the famous Law 180,[18] in the history of which I think one would not have too much difficulty in recognizing the four phases identified above.

There is no doubt that this complex, conflict-ridden relationship is in the course of breaking up, with the coming of the new preventive technologies. Administration acquires an almost complete autonomy because it has virtually absolute control of the new technology. The operative on the ground now becomes a simple auxiliary to a manager whom he or she supplies with information derived from the activity of diagnosis expertise described above. These items of information are then stockpiled, processed and distributed along channels completely disconnected from those of professional practice, using in particular the medium of computerized data handling.

Here there is the source of a fundamental disequilibrium. The relation which directly connected the fact of possessing a knowledge of a subject and the possibility of intervening upon him or her (for better or for worse) is shattered. Practitioners are made completely subordinate to objectives of management policy. They no longer control the usage of the data they produce. The manager becomes the genuine 'decision maker'. The manager holds all the cards and controls the game. Among other consequences, this means an end to the possibility of those strategies of struggle developed over the last twenty or so years by progressive mental health operatives in Italy and, to a lesser degree, elsewhere.

TOWARDS A POST-DISCIPLINARY ORDER?

Finally one can wonder whether these trends do not inaugurate a set of new management strategies of a kind specific to 'neo-liberal' societies. New forms of control are appearing in these societies which work neither

through repression nor through the welfare interventionism which grew up especially during the 1960s (with, in the field of psychiatry, the sectorization policy in France and the Community Mental Health Centers in the USA: here it was, in a nutshell, a question of covering the maximum amount of ground, reaching the maximum number of people, through the deployment of a unified apparatus linked to the machinery of the state). In place of these older practices, or rather alongside them, we are witnessing the development of differential modes of treatment of populations, which aim to maximize the returns on doing what is profitable and to marginalize the unprofitable. Instead of segregating and eliminating undesirable elements from the social body, or reintegrating them more or less forcibly through corrective or therapeutic interventions, the emerging tendency is to assign different social destinies to individuals in line with their varying capacity to live up to the requirements of competitiveness and profitability. Taken to its extreme, this yields the model of a 'dual' or 'two-speed' society recently proposed by certain French ideologists: the coexistence of hyper-competitive sectors obedient to the harshest requirements of economic rationality, and marginal activities that provide a refuge (or a dump) for those unable to take part in the circuits of intensive exchange. In one sense this 'dual' society already exists in the form of unemployment, marginalized youth, the unofficial economy. But until now these processes of disqualification and reclassification have gone on in a blind fashion. They have been uncontrolled effects of the mechanisms of economic competition, underemployment, adaptation or non-adaptation to new jobs, the dysfunctioning of the educational system, etc. The attempts which have been made to reprogramme these processes are more addressed to infrastructures than to people: industrial concentration, new investment sectors, closures of non-competitive concerns, etc. – leaving their personnel to adjust as well they may, which often means not particularly well, to these 'objective' exigencies.

But one has to ask whether, in the future, it may not become *technologically feasible* to programme populations themselves, on the basis of an assessment of their performances and, especially, of their possible deficiencies. Already this is what is being done with the handicapped, who are guided on to special careers in what is termed sheltered employment. But exactly the same could, for example, be done with the exceptionally gifted, who after all are only sufferers from a handicap of excess and could be guided and 'treated' to prepare them for careers in social functions which require very developed or specific aptitudes. In a more general sense, it would be possible thus to objectivize absolutely any type of difference, establishing on the basis of such a factorial definition a differential population profile. This is, thanks to the computer, techni-

cally possible. The rest – that is to say, the act of assigning a special destiny to certain categories defined in this way – is a matter of political will.

The fact that there has so far been no politically scandalous utilization made of these possibilities is not enough to allow complete peace of mind. In present circumstances for the majority of industrialized countries, among which Reagan's United States represents an extreme case, the crisis of the Keynesian state is causing not just a standstill but a contraction of welfare policies whose growth seemed until a few years ago inscribed in the course of history. Thus it has become extremely problematic in advanced capitalist societies to promote generalized welfare as a response to the penalties of economic development and political organization of society; but this does not mean that one reverts to *laissez-faire*.

In this conjuncture, the interventionist technologies which make it possible to *guide* and *assign* individuals without having to assume their custody could well prove to be a decisive resource. Traditional social policies have always respected, even if viewing with suspicion, what might be called a certain naturalness of the social: individuals are inscribed within territories, they belong to concrete groups, they have attachments, heritages, roots. Sometimes repressive, but progressively more and more welfare oriented in their character, social policies have until now worked upon this primary social material, canalizing untamed energies, pruning back the more bushy entanglements, weeding out here and there, occasionally transplanting. But all these measures, more corrective and reparative than preventive in function, shared a conception of individuals as previously assigned to some place within the geography of the social.

The profiling flows of population from a combination of characteristics whose collection depends on an epidemiological method suggests a rather different image of the social: that of a homogenized space composed of circuits laid out in advance, which individuals are invited or encouraged to tackle, depending on their abilities. (In this way, marginality itself, instead of remaining an unexplored or rebellious territory, can become an organized zone within the social, towards which those persons will be directed who are incapable of following more competitive pathways.)

More the projection of an order than an imposition of order on the given, this way of thinking is no longer obsessed with discipline; it is obsessed with efficiency. Its chief artisan is no longer the practitioner on the ground, who intervenes in order to fill a gap or prevent one from appearing, but the administrator who plans out trajectories and sees to it that human profiles match up to them. The extreme image here would be

one of a system of prevention perfect enough to dispense with both repression and assistance, thanks to its capability to forward-plan social trajectories from a 'scientific' evaluation of individual abilities. This is of course only an extreme possibility, what one might call a myth, but it is a myth whose logic is already at work in the most recent decisions taken in the name of the prevention of risks.

NOTES

1. I have attempted a more systematic explanation of this new problematic in *La Gestion des risques*, Paris, 1981, especially chapter 3, 'La gestion prévisionnelle'.
2. Doctors Constant, Lunier and Dumesnil, *Rapport général à Monsieur le Ministre de l'Intérieur sur le service des alienes en 1874,* Paris, 1878, p. 67.
3. L. Lunier, 'Revue medicale des journaux judiciaires', *Annales medico-psychologiques*, vol. VIII, 1848, p. 259. The *Annales* had a regular section of these items, accompanied by 'reflections' that underline at once the discomfort of the psychiatrist faced with this situation, and the need for preventive vigilance.
4. P. Seriex and L. Libert, *Les lettres de cachet 'prisonniers de famille' et 'placements volontaires'*, Ghent, 1912, p. 12.
5. Cf. Morel's letter to the Departmental Prefect of Seine-Inférieur to solicit his aid in 'penetrating the interior of families, looking closely at the manners of life of inhabitants of a locality, getting acquainted with their physical and moral hygiene'. 'This is', he says (and one can understand his point), 'a delicate mission which can only suitably be carried out under the patronage of authority. I do not believe that one can otherwise succeed in establishing the statistics of this populous Department and thus providing the authorities with useful documents on the causes of the increase in lunacy and the most appropriate prophylactic and hygienic means of preventing so great an infirmity.' (Letter reproduced in *Le neo-restraint*, Paris, 1857, p. 103.)
6. B. Morel, *Traité des dégénérescences physiques, intellectuelles et morales de l'espèce humaine*, Paris, 1857, p. 691.
7. Carlos F. Macdonald, Presidential Address, *American Journal of Insanity*, July, 1914, p. 9.
8. For example, the law enacted in Missouri in 1923.
9. Dr Binet-Sangle, *Le Haras humain*, Paris, 1918, p. 142.
10. Gerald Caplan, *Principles of Preventive Psychiatry*, Boston, 1960.
11. *Ibid*., p. 59.
12. In the United States, President Nixon sought advice as early as 1969 from the Secretary for Health, Education and Welfare on a report he had commissioned which proposed that 'the Government should have mass testing done on all 6–8 year old children . . . to detect [those] who have violent and homicidal tendencies'. Subjects with 'delinquent tendencies' would undergo 'corrective treatment' ranging from psychological counselling and day-care centres to compulsory enrolment in special camps. The minister replied, through the mouth of the Director of the National Institute of Mental Health, that the required detection technologies were not sufficiently

advanced for their results to be credible (quoted by Peter Schrag and Diane Divosky, *The Myth of the Hyperactive Child*, Harmondsworth, 1981). Where systematic tests are practised in the United States at present, they apply to limited groups perceived as carrying special risks. It seems that France's 'advanced' position in these matters results from the centralized structure of power, which makes readily possible the planned national implementation of administrative decisions. I should add that in June 1981 (the date is not fortuitious; it falls one month after the change of Presidential majority in France), a government commission on 'Computerization and liberties' gave a hostile verdict on the GAMIN system. But its condemnation applied only to the threat to individual liberties posed by breach of confidentiality in the system's procedures, and not to the technological apparatus itself.

13. Michel Foucault, *Discipline and Punish*, especially part III, chapter 3.
14. A conference was recently held on preventing the effects of earthquakes on the Cote d'Azur, at which serious indignation was expressed that this problem had not yet been accorded the attention it merited. One can see here how the *mise en scene* of a 'risk' which is after all perhaps perfectly real, but totally random in its effects, unpredictable in its occurrence and uncontrollable in source, can create a piece of machinery which for its part can also have a perfectly real existence, prompting the creation of a corps of experts, modifying norms and costs of construction work, influencing flows of tourism, and so on. Not to speak of the culture of fear, or at least of anxiety, provoked by this habit of digging up endless new kinds of risk in the name of a mythological representation of absolute security. But it is true that a culture of anxiety secretes a developing market for remedies for anxiety, just as the cultivation of insecurity justifies a muscular security policy.
15. The law of 30 June 1975 'in favour of handicapped persons' institutes new committees at Department level, one for children and one for adults, before which are brought the cases of the entirety of persons seeking, or for whom someone is seeking, a financial benefit and/or placement in a specialized institution. They work on dossiers built up by subordinate specialist technical committees. Representatives of the various administrative agencies are in the majority on the departmental committees, whereas the technicians are the majority on the specialized committees. The departmental committees have power of decision in questions concerning handicap. As the then Minister of Health, Mme Simone Veil, put it during the debate on the law in the Senate: 'In future those persons will be considered handicapped who are recognized as being such by the departmental committees proposed in Article 4 of the Bill, for minors, and Article 11, for adults' (*Journal Officiel*, 4 April 1975).
16. I have tried to demonstrate this for the 1838 law and the policy of the sector in France in *L'Ordre psychiatrique*, and for the American Community Mental Health and Retardation Act of 1963 in *The Psychiatric Society*, co-authored with Françoise Castel and Ann Lovell, 1982.
17. For example, the 1838 law removed the contradiction between the impossibility of juridical internment of mentally ill persons regarded as dangerous, since they were penally irresponsible, and the necessity of doing so to safeguard public order. The new medical legitimacy provided under the rubric of 'therapeutic isolation' allows for a sequestration which is as rigorous as imprisonment but justified henceforth by a therapeutic end. The insane person is provided with a civil and legal status, he or she is assigned a place in a 'special establishment', and even the financial details of his or her

custody are provided for in the framework of the law. But this complete apparatus, which henceforth makes possible a rational administration of madness, had been made possible by transformations of hospital practice extending over more than thirty years, starting with Pinel at Bicêtre and then Salpêtrière, and snowballing thereafter.

18. The Law 180 among other things provides for the closure of existing psychiatric hospitals, prohibits the building of new ones and stipulates that acute psychiatric crises must be treated in small care units integrated in the general medical hospitals.