XVII. RECOMMENDATIONS

1. CULTURAL VARIANTS AND INVARIANTS OF RESULTS AND THEIR CONSEQUENCES

France was the mother of the world's asylums, in the name of freedom and human rights. It is in the name of these same rights that the issue today is to close down these concentrationary asylum structures. The harm, in terms of stigmatisation, has already been done. How can inspiration be drawn from those places that do not yet possess asylums, in order to further this fundamental progress for humanity ?

Everyone can see the hiatus between the soothing language used about insanity, mental illness and depression, and the potential for exclusion and marginalisation contained in each of these words. Today, if you are called "mad" or "insane", or even "mentally ill", you are excluded from the field of meaning and citizenship. This statement is so strong that it is at the same time necessary to establish "anti-exclusion" mental processes, since exclusion of the other person today could be your own exclusion tomorrow.

At the same time, the extraordinary semiotic and scientific field of mental health – its thousands of planners, exponents, university scholars, congresses – do only very little to alter perceptions. It is women's magazines, and the discovery of antidepressants, that have made for a major semantic change. But this was assuredly not with the conceptual tools that belong to psychiatry. These new definitions of the fields involved will cause an upheaval in society and lead to consequences in political terms.

Each time we intervene abroad, we should ask not only the question of the mental health policy, but also that of the mental health of politics.

If the French mental health policy, in line with WHO policy, aims to put the user in the centre of the care system, this will obviously have repercussions on the way communication is conducted with other countries, and the way mental health research is envisaged. That is to say, not a security-based conception of care, but a sort of health democracy conception. In this perspective, the comparative study of cultural and anthropological systems, of variations in the way things are termed, and of the ways in which the problem is catered for, comes into its own.

We have shifted the centre of gravity from wealth, economic power, and institutional and financial ways of thinking, to the study of human rituals, personal resources, the quest for symbolic and real efficiency in the combat against psychiatric disorders. The global village is 15% of human beings, no more : only the decision-makers.

Thus, finding a perspective is an asset that will enable us to work together. Not in the manner of those Australian and Canadian researchers, conducting studies in Mauritius and publishing results without informing those involved locally, whether ordinary people or scientists. This is a neo-colonialist situation that is intolerable for people who have not been colonialists in the past.

Indeed, the wealth of the West has brought us nothing in terms of mental health. Disorders are still widespread, and require a care system that is anthropologically clearly positioned. In the Indian Ocean, to move away from appeals for charity or blaming the former coloniser, there is a need to examine in what way the care system is also more or less efficient, like ours, which should dictate modesty to all concerned. It should also be noted that the intercultural approach is basically in line with what connects anthropology, sociology and psychiatry.

Working together deserves more than anathema and frontier marking, differentiating ready-made truths. The psychiatrist, a figure of social control, is face to face with the predatory attitude of the anthropologist that consists in describing suitably attractive medical phenomena that are never however assessed, and again with the triumphant sociological discourse turning in circles, which, like the psychiatric discourse is made up of the platitudes borrowed from popular or political discourse.

Faced with a shared problem, given different names and using partitioned fields of discourse, the work of research and co-operation obviously makes it necessary to move beyond frontiers and beyond oneself. WHO has indeed understood this : it has asked member states to integrate care provided by traditional practitioners into general mental health care structures and national programmes.

The general question is of course : is science still right for mankind, and in what way?

And the specific question : what are the consequences of this research ?

Results appear to diverge, as do the notions of "insanity", "mental illness" and "depression". Each country and each site has produced its recommendations, both particular and general, at once political, “WHO” coloured, and ethno-centric. We were astonished both by similarities and by differences between "insanity" ("madness"), "mental illness" and "depression". The following tables present the variants and invariants identified is the different sites, and the general recommendations arising from them.

In view of this, and of the scale of disorders, the scope for remedying them, the fact that the disorders described by epidemiological study have virtually no impact on mental representations with respect to "insanity", "mental illness" and "depression", the fact that this has virtually no effect on the stigmatisation process for the person who is “insane” (“mad”), “mentally ill” or “depressed”, the fact that conceptions are archaic but that the disorders are well an truly present, in view of all this, what can be the consequences in terms of research ?

De-partitioning has been fundamental and preponderant in this research. It made it possible to mobilise the teams and to implicate local authorities.

The task now is to work together to design mental health programmes and establish international co-operation that will take account of specific cultural features, working both ways.

TABLE 55 : CULTURAL INVARIANTS AND THEIR CONSEQUENCES

	INVARIANTS	***CONSEQUENCES***
Definition	✓ Every person has someone in his/her immediate circle who is “insane”, “mentally ill” or “depressive”. ✓ All violent acts are attributed to a “mentally ill” person, or to a lesser degree to an “insane” person. ✓ Physical causes are attributed to “mental illness”, and ambient misfortune is seen as the cause of depression.	➔ *Emphasise the importance of this phenomenon* ➔ *Inform, and dissociate violence from “insanity” and “mental illness”* ➔ *Implement meaningful communication with the press, psychiatry users, representatives of lay, unionist, political, religious and philosophical circles in society.*
Responsibility	Populations consider that : ✓ the person who is “insane” or “mentally ill” is not responsible or his/her acts or condition ✓ they should be treated even if they do not want it ✓ the relatives of an “insane” or “mentally ill” person suffer, so does a "depressive" person	➔ *Focus information on human and citizen rights rather than on stigmatisation* ➔ *Emphasise the need to take part in a subject’s care itinerary and focus on dialogue rather than on compulsory care* ➔ *Establish social and family mediation* ➔ *Take action to reduce the family burden.*
Cure	Populations consider that : ✓ cure is always possible for a “depressive” person ✓ cure is not possible on one’s own	➔ *Emphasise the prospects of cure, whatever the disorder* ➔ *Message of solidarity : a person cannot cure on his/her own.*

	INVARIANTS	*CONSEQUENCES*
Exclusion	✓ The majority of people would take in a person who is "insane", "mentally ill" or "depressive" if the person is under treatment or supervised ✓ The majority would take in a child who is "insane", "mentally ill" or "depressive" ✓ Everywhere people consider that exclusion from the working world is considerable	➔ *Highlight family protection. Emphasise assistance to families and creation of non-segragationary places of residence* ➔ *Assist in the integration of children into primary health care and specialised education* ➔ *Combat prejudice* ➔ *Establish programmes for work rehabilitation*
Resorting to care	✓ The general practitioner and the immediate circle are always the preferred recourse	➔ *Implicate GPs as a priority in the care offer, train and support them* ➔ *Emphasise the assistance of the circle of friends and relations in the field of lay care that may be as efficient as official care.*
Epidemiology of disorders	✓ There are mental disorders everywhere ✓ There is a prevalence gradient : anxiety disorders > depressive disorders > addiction > psychosis ✓ The distress associated with disorders is everywhere greater for depressive disorders	➔ *Develop awareness in the general public on mental disorders and the care offer* ➔ *Have depression recognised as a modern disease that is disabling and treatable*
	✓ Whether or not a person presents a disorder has little effect his/her representations of it	➔ *Everyone is concerned : use decision-makers to combat stigma (eg getting them to admit they have experienced a mental disorder some time in their lives)* ➔ *Establish solidarity structures for patients* ➔ *Design mental health programmes in collaboration with experts and users from outside the country.*

TABLE 56 : CULTURAL VARIANTS AND THEIR CONSEQUENCES

	VARIANTS	*CONSEQUENCES*
Definition	✓ Indian Ocean populations more frequently state they know a person who is "insane" ("mad") or "mentally ill". ✓ The French population more readily state they know a "depressive" person ✓ The words to define "insanity", "mental illness" and "depression" vary from country to country. ✓ The French population is more ready to consider that the person who is "insane" or "mentally ill" suffers ✓ The characteristics of "depression" are clear-cut and coherent in France	➔ *Ensure depressive disorders are better known* ➔ *Promote the concept of the human dimension in the potential suffering of a person who is "insane" or "mentally ill"* ➔ *Adapt communication to the cultural references of given populations.*
Exclusion	✓ Exclusion from family or society is less marked in Indian Ocean countries than in France	➔ *Establish solidarity structures for patients in France (homes, residential centres…)*
Resorting to care	✓ In the Indian Ocean people know places other than the psychiatric hospital providing care for a person who is "insane" or "mentally ill" : churches and missions. This is not the case in France, where the subject should be "compulsory admited" and "medicalised". ✓ Recourse is multiple (assistance and treatment)	➔ *Accept religious or lay solutions as an alternative and a complement to bio- medical care* ➔ *Promote multiple recourse; whatever their nature, results are cumulative. Mental health is above all solidarity and social support*
Epidemiology of disorders	✓ Prevalence of disorders is very variable from one country to another ✓ There is no target group. A slight increase among separated or divorced subjects and low-income groups, but everywhere numbers are small. Prevalence varies according to age groups. ✓ People with a disorder have a more marked feeling of being ill in Madagascar and Réunion.	➔ *Particular attention should be paid to people living alone, divorced, separated, or with low income, but avoiding overstigmatisation, since many of these present no disorder.* ➔ *No particular target group : avoid discrimination based on social data*

2. RECOMMENDATIONS FOR EACH SURVEY SITE

A. COMOROS, by Drs Laurent DENIZOT, Noëlle BARBIERA, Philippe LAKERMANCE

- Beyond the figures, both in terms of representations and in terms of epidemiology, it seems essential to underline once again the particular features characterising the Comoran people. They arise from centuries of history, custom, and ways of thinking that have shaped a society the durability of which resides in the community traditions, often via denial, always via adaptation. Taking care not to lapse into platitudes it is essential to recognise these realities, to analyse them and take them into account, so as to initiate a procedure reaching the individual and the group in its most sensitive dimension, its psychiatric health. This effort is crucial at a time when proposals are to be made to this country, which has virtually no psychiatric facilities, for collaboration in establishing a care policy.

- As has been seen, the Comoros site presents numerous particularities, which show up in the study results. In a country where psychiatry has no footing as yet, recommendations on how metal illness should be cared for should be cautious. It has been seen that care provided by churches, missions and communities are a very important resource for care provision for people who are insane, mentally ill or depressed, who are often confused in representations among the Comoran population. This active network should, in a sense for lack of something better, be used and reinforced, and should not be undermined.

- To provide more precise recommendations, assistance in the development of a national mental health programme should involve the following :

  - ✓ preserve local features, before any implementation of a mental health policy.
  - ✓ avoid creating a psychiatric structure that might foster asylum internment
  - ✓ complete the survey with a study of needs of people suffering from a mental handicap (children or adults). No receiving structure exists today, and the burden on families is very great.
  - ✓ encourage the training of local care agents, GPs, health officers etc via regional relay posts for the detection and treatment of the most frequent disorders (anxiety and depression), and also in the field of mental handicap.
  - ✓ promote inter-island exchanges from la Réunion.
  - ✓ conduct more in-depth study and further analysis of survey results, and in particular review survey methodology : do the results arise from specific features of this population, or are the questions, because of difficulties in translating concepts or representations, not suited to this type of population ?
  - ✓ Target other studies that would enable a better approach of the realities of mental health in this country.

B. MADAGASCAR by Dr Marcelin ANDRIANTSEHENO

Any health programme should start from the realities of the country in which it is to be established. This was behind the request filed five years ago by Madagascar representatives present at the first regional conference on mental health in the Indian Ocean (see part one).

Although it is not altogether possible to exclude the possibility of a bias in the Antanananarivo site, this survey, an integral part of the national Malagasy mental health programme, provides new information and confirms existing notions. Some conclusions followed by a number of recommendations can be reached :

- **Mental health is a public health problem,**
  - ✓ if reference is made to high prevalence of mental disorders : 1.35 higher than the average for the other sites, from Antananarivo (0.459/0.34) to 0.9 in Mahajanga (0.30/0.34).
  - ✓ this prevalence is likely to increase with the stress arising from spiralling poverty, uncontrolled urbanisation, loss of cultural markers, resulting from forced globalisation
  - ✓ the emotional and economic burden that such disorders entail for families and society.

- **Mental health is a public health priority, because there are tested and efficient means of coping with these problems :**
  - ✓ Primary prevention via education and awareness generated in the population which will achieve results by indirect pressure on politicians and local social authorities : combat against marginalisation, against the disintegration of the family nucleus (separation of the couple on account of work, rural exodus, forced emigration etc), against cultural disintegration, and against dehumanised relationships
  - ✓ Secondary prevention by reinforcing family, social and national solidarity
  - ✓ Curative treatment of disorders which can significantly improve prognosis (depression, alcohol addiction).

This survey shows that in Madagascar personal and family circles and resorting to religious bodies still constitute inexpensive and viable recourses in case of need.

Working with GPs (who need to be informed and trained) is an essential step, as they are the most readily available recourse, closest to the people.

Collaboration with traditional therapists is also essential, but it should be conducted outside ideological debate, artefacts of fashion, or commercial incentive. The main strength of traditional practice resides in their holistic approach, that is culturally and economically acceptable. Science should not destroy or seek to impress by overshadowing it, but should on the contrary contribute to identifying its essential components.

Several factors in fact condition the viability and the efficiency of the national mental health programme :

- ✓ its degree of community penetration
- ✓ its cultural acceptability: historically, Madagascar has always been hostile towards any sudden foreign intrusion, in particular if there are no "magical" beneficial effects
- ✓ its acceptability : cost, proximity, availability of "consumables" (medication) and care providers
- ✓ its ability to generate positive conditioning behaviours.

Finally, this research-action is the starting point for a more fruitful North-South scientific encounter. It would be a pity for it to end merely in a scientific prowess, or to the satisfaction of individual, collective or national ambition. It is after the survey that the real work begins : how can differences, anachronisms in lifestyle, and the experiences of the cultural groups taking part in the study be reconciled so as to rehabilitate psychiatry ?

After final review of the survey results by the co-ordination centre, final results will be delivered to the Malagasy health authorities. A working contract should be established with the Madagascar health ministry and ARESAME, who managed the survey, in order to establish a national mental health programme, of which they are a planned part.

C. MAURITIUS by Dr Siven MOTAY and Prem BURHOO

The survey of mental health in ***Mauritius*** was the first of its kind among epidemiological studies in the population. It gives a clearer idea of the representations connected with mental illnesses, the way they are seen and approached, the way they are cared for and the prevalence of different mental disorders. Thus the study has made it possible to assess the expectations of the population in terms of care and treatment. Within health care policy, it could contribute to promotion and development of mental health among the different partners involved in mental health matters (whether government or other).

Responses provided by the population to the questions aiming to collect first impressions regarding people who are “insane”, “mentally ill” or “depressive” are very surprising. One might have expected a large proportion of respondents to give a magico-religious explanation to mental illness. However the majority suggest an organic cause for "mental illness", cognitive damage for the “insane” person, or even environmental or social factors for "depression".

There was considerable reluctance after the pre-survey stage to adding the “depressive” theme to capture representations as to what differentiates “insane”, “mentally ill” and “depressive” people. Indeed, in all the representations regarding behaviours and conduct there is a marked gap in perception for the three categories. Respondents appeared to provide answers that were in agreement with the realities of psychiatric practice.

It should be noted that **regular consumption of alcoholic beverages has come to be seen as commonplace**. It should also be remarked that 60% of psychiatric hospital admissions are linked to alcohol. In general hospitals, half the admissions of men have some connection with excessive consumption of alcohol. At the time of the survey 51% of respondents considered regular consumption of alcoholic beverages to be “normal”. Thus its seems important to make the inhabitants of Mauritius aware of their consumption, since 6% of men are addicted, and 2% make harmful use. All this has implications not only in terms of health, but also in terms of social consequences such as violence (in the family, and dealings with the legal authority), accidents on the road and at work, economic repercussions (absenteeism, falls in working efficiency, loss of salary).

As regards **the role of the family,** a positive representation should be noted concerning the idea of taking a person with a mental illness into the family. This phenomenon has frequently be confirmed in hospital practice, where the majority of patients are cared for by their families after hospitalisation, and reintegration into the family circle goes well.

It should be noted that 22% of respondents present at least one mental disorder. It can be thought that very few people consult at the psychiatric hospital or in psychiatric consultations in general hospital for disorders of this type. Ongoing psychiatric consultation does not involve more than 10 000 people. Most will go to the GP or to heath care systems other than psychiatry. In the survey it can be noted that only 21% state they would turn to a psychiatrist. A notable proportion would resort to religious or magic-religious options, for 8% and 2% respectively.

From the above it can be seen that a large part of the population is affected by psychiatric disorders. The reasons are multifactorial : rapid change in the way society is run, changes in family structures, job insecurity, impoverishment of some strata of society that can lead to exclusion. It is essential to organise information campaigns to raise greater awareness in the population with respect to mental health, and to remove the stigmatisation of mental illness so as to bring people to consult in specialist facilities.

To initiate this de-stigmatisation, **present modes of care should be reoriented towards decentralisation of consultations to general hospitals and primary health care centres**. GPs should be made more aware of mental pathologies, and a multidisciplinary approach to the way they are cared for (doctors, psychologists, nurses, social workers, etc) should be promoted as near as possible to people's homes. This decentralisation process has begun, but the way in which patients are cared for needs improving both in terms of staffing numbers and in terms of structures.

Recommendation for Mauritius are as follows :

- ✓ raise awareness among the different partners regarding the promotion of mental health, and reinforce links with all partners working in mental health
- ✓ improve psychiatric care facilities
- ✓ increase numbers of staff qualified staff for this type of care
- ✓ train health personnel so that they are better able to identify mental disorders
- ✓ establish more structured psychiatric units in each regional hospital.

D. RÉUNION by Drs Laurent DENIZOT, Philippe LAKERMANCE, Patrick TRON and Noelle BARBIERA

- Initiate information campaigns among the population to combat stigmatisation of mental illness; provide better information on alternatives to hospitalisation, and reinforce community solidarity towards people with mental disorders.

- Pursue efforts in medical research and epidemiology via complementary studies, in particular on the subject of substance addiction and psychosis

- Develop and widen reflection on violence and social transgression, so as to combat harmful social representations that contribute considerably to compromising prospects of working towards open community psychiatry

- Reinforce and re-orient training facilities for health personnel, in particular GPs, who are essential in the detection and treatment of anxiety and mood disorders.

- Promote support for patient families (educational, moral and financial) as well as for staff in medico-social facilities

- Pursue collaboration with anthropologists and other human science professionals by way of interdisciplinary and trans-disciplinary collaboration. Encourage active, dynamic medical anthropology

- Collaborate with public health bodies (DRASS, ARH, CGSS, regional and municipal authorities, etc) so as to define and support their action

Regional co-operation

- By way of its history, its situation and its material wealth, ***Réunion*** has a well-established responsibility in scientific collaboration and medical co-operation with neighbouring islands in the Indian Ocean

- Priority should be given to establishing and using efficient tools (such as tele-medicine) – in the fields of research, training, resource bases, clinical and logistic support.

E. GUADELOUPE by Dr Michel EYNAUD

The implementation of any mental health policy in Guadeloupe should aim to :

- capitalise on the results of the survey so that needs and expectations of the population are taken into account in decisions in the field of health (planning, resource allocation, etc)
- gain better control over factors facilitating or hindering the use of care facilities, by adapting and improving such facilities
- improve overall screening for mental disorder
- pay particular attention to improving the identification and treatment of anxiety and depressive disorders
- diversify the way in which these disorders are cared for, reducing the share of hospitalisation and medication (diversification of places where care is provided, of therapeutic means and information on availability)
- develop networks and partnerships with GPs, health centres and medico-social centres in the area, which are the places first resorted to by the population
- promote a participatory model for community care, emphasising integration and quality of life within the context, including the socio-cultural context, rather than developing concentration type asylum structures
- attempt to influence the image of mental illness, still too strongly centred on the "insane" seen as dangerous, irresponsible, unfeeling and incurable, needing compulsory treatment
- combat stigmatisation which increases the difficulties patients have to cope with, making use of the tolerance of the population with respect to acute disorders or situations seen to be "crisis" states; or making use of the multiple meanings attributed to the term "depression", or the way that mental disorders are seen to be "reactive"
- reinforce support for families, facilitate the organisation of self-support groups and users associations
- implement further research action projects not only to gain better knowledge in the field of mental health problems, but also to lead on to genuine changes in the field, via the research process itself in that it entails contact between potential partners
- develop co-operation in the area of mental health with other French départements in the Americas (Guyane, Martinique), as well as with other Carribean states (Haïti, Cuba, San Domingo, Santa Lucia)making use of a community of influential factors, and the possibility of sharing experience and sharing and adapting methods
- make exchanges between sites taking part in the survey and constitute a wide data base which could be extremely fruitful.

A number of implementations have already taken place or are planned in Guadeloupe, prior to the development of all the lines of action listed above. The operations are listed according to target populations or partners involved.

Among professionals :

- presentation at the Information Psychiatrique congress in Fort-de-France in December 1999
- presentation at the "Rencontres de la Psychiatrie Guadeloupéenne" conference in Februiary 2000 in St Martin
- presentation at the Union Hospitalière workshop in April 2000 in St Martin
- presentation at the psychiatric workshop in Pointe-à-Pitre CHU in May 2000
- Mental Health in Guadeloupe conference in December 2000 within the health and well-being conference
- Drafting of a mental health section for the health directory issued to all participants in the above conference, and all health and social professionals in the network
- Publication in specialist journals : Information Psychiatrique nationally, ORS regionally
- Encounters organised between Guadeloupe teams (CHS, CHU) and Martinique teams (CHS for the establishment of co-operation between DFAs, and with Cuba and Haïti
- Establishment of a SROS giving priority to action in partnership, to de-hospitalisation, to diversification of the offer and to accessibility of care facilities.

Among GPs :

- professional workshop for GPs : detecting and treating anxiety and depressive disorders
- issue of brochures and information documents in the conference and workshop in December 2000
- EPU on the law of June 27th 1990

Among the general public :

- article in the local paper (France Antilles 30th September 2000)
- information campaign in audio-visual media at the time of the December 2000 conference
- partnership of the conference with the Carribean mental health film festival, projection of films, debates in the general public and in schools
- free access grand lecture-debate at the end of the festival "Folie et dépression en Guadeloupe, erreurs et vérités"
- issue of an information brochure on anxiety disorders and depressive disorders, and on Alzhéimer's disease
- issue of a brochure on the reorganisation of mental health in Guadeloupe : new sectors, names and addresses of CMPs
- support for user groups (in particular substance addicts)

This kind of research is necessary, since it contributes to altering the way numerous parties view mental health by making them aware of its realities, its diversity, its specific features and at the same time its universality. Indeed, the reality in the population is sometimes a long way from that viewed through institutional filters. Thus this sort of research enables a shift away from the structural logic, moving towards community integration.

By contributing to giving a hearing to the population, research-action on mental health in the general population also contributes to a culture of citizenship for all, and to reducing risks of exclusion which is always a threat for people suffering from psychiatric disorders.

F. MARSEILLE by Dr Dolorès BOISSINOT-TORRÈS and Laurence KURKDJIAN

This survey was set up by mental health professionals :

- within this field by way of their clinical function and experience
- outside the field by way of research and assessment tasks

It is an example of a practical implementation of the anthropological concept of evaluation as a ground-breaking practice. Can this approach be articulated with the relay or spokesman function of the anthropologist, who enables the expression of opinions and viewpoints that are not generally heard, and with the function of mediator, i.e. a function that is even more active in processes of change ?

After this work on evaluation and understanding of representations, what is to be done with the information derived ? Indeed, the negative view of mental care and patients is a considerable hindrance in their rehabilitation, as patients and families well know. :

- how can this image be changed ?
- how can the understandable reluctance of psychiatrists and all mental health care staff be overcome, when they feel the weight of these archaic representations on them, and hence adopt low-profile attitudes so as not to appear intrusive, persecuting and threatening to individual freedoms ?

This position, which can be termed ethical, is an essential part of clinical practice. Conversely, outside clinical practice and in the community, should not care providers have this essential relay function, related to the "bearer" concept of conveying information on the realities of care and pathologies? Is it not important, in the face of these opaque representations in which insanity, exclusion, and dangerousness are mingled, to widen possibilities for debate, information and discussion?

Over the years, links have already been created within the sectorisation policy, but this is a more active process, consisting in giving mental health and those implicated in it, a place in the community, so that they can play a full part, like others, in dialogue and exchange of information. Is this not a **mediator function, between the community and psychiatry**, psychiatry being itself a hybrid discipline between medicine and social and human sciences ?

Our research-action should look at once towards the users and towards psychiatry professionals, so that negative representations on either side can gradually progress and give way to transparency and dialogue which will help in rehabilitating people.

To conclude, emphasis should be put on the fact that at present, at a time when the future of psychiatry is threatened by prospects of budgetary and staffing restrictions, it is urgent to place mental health among public health concerns, so that users may one day themselves defend their care facilities. To achieve this, they need to know about them, and this is not yet the case. At a time when more and more missions are to be conducted with smaller and smaller means, is not the most important mission this mediator function in the social field, which will lead to a different positioning on the part of mental health care providers and care structures in the community, thus leading to changes in archaic representations endured by patients day to day, and enabling them to take their place as full citizens ?

G. PYRÉNÉES ORIENTALES by Dr Philippe MULLARD

The first results from the survey conducted over the *département* of Pyrénées Orientales as a whole, produce data showing and confirming present practice in the *département*, and other data that appear on the contrary not to be at all in line.

Without going into detail, two examples from these results can be used :

- The first is that **80% of the general population considers that hospitalisation is the most common mode of care in psychiatry**. This figure is in line with psychiatric practice in the département, where the organisation of all public psychiatric facilities is centred on the specialised hospital in the city of Thuir, coupled with a "grand project" approved by the Agence Régional d'Hospitalisation : construction on the same site of a new psychiatric hospital in the next 8 years. In addition, if psychiatric practice over the last 20 years is reviewed, no primary prevention action is found, and there is only a sporadic development of ambulatory facilities as alternatives to hospitalisation.

- **The second example is that 80% of the general population state they are prepared to take back a family member into their homes, provided they are receiving treatment or medico-social follow-up.** This shows there is strong solidarity within families, and strong expectations from community psychiatry, which would certainly enable a different outcome for the patients concerned, considerable progress in preventing exclusion, and probably a reduction in the suffering endured by the families.

This is quite out of line with practice in the area, where there is no talk on the part of professionals or policy decision-makers on stigmatisation, the revolving door syndrome (hospitalisation followed by discharge and abandonment once outside, therefore re-hospitalisation, and so forth), prevention of rejection phenomena, long-term accompaniment, etc.

We also need to consider themes that some will consider trivial, but which are realities in Pyrénées Orientales. This *département* on the southern fringes of France, that some of the Barcelona Catalans term as "North Catalonia", for 40 years preferred the "Republic" to Franco, as can well be understood, but the cost was the loss of Catalan identity. The civil society is thus caught between an impossible claim to being Catalan and belonging to the Languedoc Roussillon French region as a poor distant relative. Does this explain the tendency of the population to withdraw into itself, as can be observed in the way in which public mental health care is organised, i.e. a hospital-centred form of psychiatry, where the hospital claims veritable hegemony over mental health in the *département* ?

How then can the recommendations arising from the survey be broached ? We have shown that psychiatry as practised here is in the likeness of its geographical unit, withdrawn, with only easy-option projects lacking vision.

The fundamental recommendation would be to enable the area to come out of isolation and open up to the outside, so that with the help of others it can discover that in all European countries the issue over the last 20 years has been the closure of psychiatric hospitals and the development of community psychiatry !

H. NANTES by Dr Rachel BOCHER and Patrick METAYER

This epidemiological survey provides us with a valuable tool to bolster our reflection on the constitution of a mental health network involving several partners :

- the city of Nantes (public health authority
- Nantes CHU (psychiatric pole, psychiatric emergencies)
- Nantes-Habitat (rehabilitation, solidarity, housing)
- Office Central d'Hygiène Sociale
- Conseil Général of the département and DDASS

This network indeed intends to organise relations, articulation and co-operation between specific parties within the field of competence of each and in common agreement.

It should enable identification of relay persons, and implementation and exploitation of analyses and means. It will endeavour to ensure coherent and global action is undertaken for unsolved issues at hand.

To meet these objectives, in particular in terms of prevention (primary, secondary and tertiary) this research-action makes it possible to have a better picture of the demand of the Nantes population, to determine forms of assistance already in existence other than the psychiatric offer, to know how the people view specialised care structures, and if necessary to adjust them.

At the outset there appears to be a considerable gap between our determination to position CMPs (mental health centres) at the heart of the care structure in Nantes on the one hand, and on the other the fact that this type of care facility is not well known by the city's population, in comparison with other sites in metropolitan France. Yet despite this ignorance, most CMPs in Nantes are at saturation point despite redeployment of resources. This observation leads us to reconsider our task, in particular with respect to the need to develop articulation between public psychiatric facilities and the individual professional sector (GPs, psychologists, psychiatrists, psychoanalysts, etc)

Indeed, while psychiatry is sliding towards the "mental health" label, it seems important to pinpoint our limits, since psychiatry is not synonymous with mental health, it is only one party among many others.

It is indeed this research-action that should enable co-operation on the part of the different parties implicated in mental health, taking account of the limits of each.

The collected data, the figures, the percentages, (beyond their objective value) are above all a vehicle enabling an encounter among the various partners in this mental health network, an encounter the very nature of which contributes to consolidating this network.

I. SUD DES HAUTS DE SEINE by Drs Denis CHINO and Marie-Christine VELUT-CHINO

It is interesting to note for this site that :

- differences between “insanity” and “mental illness” are slight
- “insanity” and “mental illness” are associated with non-meaning, violence and danger
- attitudes towards the mentally ill are not negative
- the mentally ill are overall considered not to be responsible for their illness, and to suffer, but to suffer less than their families
- the population thinks that :
  - ✓ “an insane” or “mentally ill” person can be recognised from their behaviour
  - ✓ an “insane” or “mentally ill” person can be treated, but rarely completely cured
  - ✓ an “insane” or “mentally ill” person can return to the family on condition he/she is receiving treatment
  - ✓ care for the “insane” and “mentally ill” is provided in a psychiatric hospital, even if the hospital has not got a good reputation.

Following the first results, a day-long seminar was organised in the Centre Paul Guiraud in Villejuif, November 18th 1999, and in collaboration with UNAFAM[1] on May 26th 2000 in Sceaux. It emerged that the main recommendation that can be made, this being in line with the unanimous wish expressed that the “insane”, “mentally ill” or “depressive” person should return to his/her family on condition he/she is under treatment, is to rapidly implement “re-localisation” (re-positioning) of Hauts de Seine psychiatric sectors still attached to Val de Marne, via the Paul Guiraud hospital.

This recommendation can be aligned with the 2001-2005 project, in as far as four Hauts de Seine sectors have set up a care facility system for patients (inter-sector clinic and therapeutic “hotels” (hostels) which constitute a genuine alternative to the psychiatric hospital.

It can be hoped that this recommendation, which is indeed in line with Ile de France Schéma Régional d'Organisation Saniataire, will generate support from the various authorities, whether from the département, from the regional, or from national level, so that the means available to public psychiatry do not melt away as is the case at present in the Paul Guiraud hospital : it is the “mentally handicapped patient” who has “nothing to barter” who will always, in the end, find himself “without care and defenceless”[2].

[1] Families group

[2] Philippe Simonot *39 leçons d’économie contemporaine*, Editions Gallimard, Paris

J. VALLÉE DE LA LYS by Gladys MONDIÈRE and Dr Christian MÜLLER

Following the first analysis of results which still need a lot more consideration, some care orientations seem immediately possible, to be worked on in partnership with GPs and occupational doctors who are certainly very frequently confronted with these symptom patterns.

In terms of sector policy, the repercussions of the survey are considerable : on the one hand, in the field, directly via the very implementation of the survey, and on the other on account of the results. Thus the establishment of the survey methodology in the 10 communes in the sector made it possible to get a better picture of partnerships in formation. Indeed, to enable the student nurses to produce quality work, the project met them, and explained the issues at stake in terms of community action. Thus the Centre Communal d'Action Sociale in particular became involved, making premises, address files and useful contacts available.

So can psychiatry take an interest in something other than insanity hidden behind walls ? or else might insanity take on appearances one meets on the street corner ? or are psychiatrists going out into the streets ? These are underlying questions which led to lively debate leading up to the survey, in particular with municipal authority staff.

Further to this the Vallée de la Lys is a semi-rural and also industrial sector with a large proportion of working class people. To recruit working-class subjects contacts and acquaintances were made with companies and with practitioners in occupational medicine in the sector. Here again, questions of mental health and necessary partnership were subjects of debate. The issuing of results to the communes (districts) enabled full implication on the part of the Commission Santé Vallée de la Lys (health commission), which includes political and health partners for consideration of common projects in the geographical area (for instance one concerning the elderly).

With regard to results, **two tendencies** can be distinguished :

- **in terms of representations**, 80% of the population in the sector do not know any place other than the psychiatric hospital to care for an “insane” person, 60% for a person who is “mentally ill”. Work should mainly be on access to care, its “readability” (clear identification) within community health services, and thereby on representations.
- **in terms of symptom patterns**, the Vallée de la Lys is close to national statistics : one third of respondents state they have suffered a mental pathology. Depression and anxiety head the list at 44% and 46% respectively.

In fact, recognition of this distress, and work in close collaboration with GPs should enable an improvement in the way such distress is cared for, distress termed as “mental” and which should no longer be hidden away.

A discussion meeting with GPs should lead to decisions on practical action. Results from these contacts with GPs should certainly provide matter for consideration.

Finally, a special day seminar for issuing results to the population should make it possible to adjust priorities in terms of access to community health care.

K. LILLE HELLEMMES by G. TREBOUTTE, N. BRUYNOOGHE, H. BRICE, Drs J-L. ROELANDT, L. DEFROMONT and B. BRYDEN

General principles

The task will be to :

- foster lay care, solidarity, and moral and mental dis-internment
- implicate general practise strongly into mental health care
- train social workers in psychiatry, and psychiatrists in social work so that all have an impact on mental health

This is an ambitious programme. From now on staff will be made available to social bodies to facilitate introduction and acceptance of people with mental disorders by these bodies into social facilities. Mentally handicapped subjects will be helped by facilitation in relationships - specialised mental health workers, nurses, social workers – to assist them in their integration into society. This is the condition for psychiatric sectors to give way to mental health services integrated into the community and working to reduce exclusion arising from the social representations of insanity, mental illness and depression.

At local level :

- provide the population with **fair, objective information** on this survey
- contribute to **awareness** wherever and whenever possible, via artistic media or official channels, and experiences related by users
- develop a continuum of action on **promotion of mental health** in the sector; establish a person in charge of developing action, awareness-raising and prevention
- **give concrete explanations on mental disorders**, how they are cared for, their treatment and their consequences
- implement a wide-ranging campaign via local press, radio and television
- **combat social exclusion** by general measures, integrate people with mental disorders into a return-to-work programmes in sheltered situations, as is the case on the sector
- collaborate with mother and child health centres and occupational medicine
- **develop care networks with GPs,** pharmaceutical providers and self-employed (visiting) nurses
- increase representation in the social departments in the sector
- re-localise hospital beds still in psychiatric hospital within the Frontière$ project (art centre, residential care centre, hostel)
- continue to develop all structures involved in integration and de-stigmatisation
- **develop the alternative host family programme (**16 families planned) : following the survey, and using opinions of users and local elected representatives, posters and written proposals were drafted and issued to the population : responses are beginning to come in.
- Wherever possible integrate the family, people close, carers, municipal departments, family doctors into rehabilitation of subjects with long-standing disorders
- Make as many staff from the psychiatric sector as possible available for promoting mental health, via redeployment in social, medico-social and cultural bodies in the sector.

L. TOURCOING by Dr Catherine THEVENON-GIGNAC

The examination of overall results of the opinion survey leads us on the one hand to promote certain operations with a view to **mental health education** of the population, and on the other hand, on our own score, to incorporate into our activities some **recognition of user expectations and an effort to adapt to them**.

Education in mental health

At first sight, from responses provided, it would appear that the Tourcoing population has a **very restrictive picture of the care offer as a whole.** Resorting to hospital and medication is of course not the only offer in the Tourcoing psychiatric sector. Thus the question is to make our facilities better known, in particular those dealing with emergency and crisis situations that have been in existence for several months.

Another line of action concerns **a better knowledge of possibilities of intervention** in pathologies that seem hopeless, or even normal for respondents. Does the fact that people see depression and anxiety as being normal amount to saying that these disorders cannot be improved ? Does saying that mental illness is incurable mean that people see the place of the mentally ill as being the psychiatric hospital ?

Response to user expectations

Although there is general reluctance on the part of psychiatrists to play a part in the management of social harmony, in favour of the development of individual freedoms for users, there is a view that psychiatrists should be given the job of managing behaviours that are aggressive towards others.

To entrench in an attitude of defender of individual freedoms is likely in the end to increase incomprehension on the part of psychiatric users.

Reflection on the responses to be provided in the face of violent behaviour and situations of conflict by psychiatrists, specifying field of application and terms, would perhaps facilitate encounters with users who, after all, always have the option of imposing disrupters of democracy on psychiatric wards, in the form of compulsory hospitalisation of violent subjects.

The survey undoubtedly promoted values that are very precious to those working in mental health. Firstly, it promoted openings :

- **opening of minds** for those of us who only considered “Research” in a sterile world out of touch with life; also an opening up towards others
- **opening up towards partners**, our first guinea pigs, and then the relay for administering the questionnaires. Elected representatives, journalists, officials, from church or state… Each provided a unique experience, outside known pathways. There were surprises, good and bad, for some. Nobody was indifferent

- **opening up to users,** present or potential, of psychiatric facilities. We all too easily assume that they could be mistaken or wrong because they do not know us. Today the feeling is rather that not only do they know a lot, but also that they have other objectives and other strategies. And finally that we could learn more by questioning them further.

The survey also formed strong bonds among members of a team that previously suffered from an over-emphasised asylum-type hierarchy. Distributing tasks, exchanging information, finding solutions to material problems, being there morning, noon and night, moved us on from a pyramid-type functioning system to a rugby team function, at least for a time. The time spent together was valuable. But it was not just worthwhile as such, it also shows promise for the future.

It is indeed from the information drawn from the site results that we will be able to elaborate strategies for intervention and action, without running the risk of being too far wrong. It is from data provided by the public – the necessary third party in clinical studies and questionnaires to be used by professionals – that we will be able to validate or otherwise the impressions derived from our users and the ideas we can form, not for them, but with them.

XVIII CONCLUSIONS

1. MAIN RESULTS

A . THE POPULATION

Most people know someone in their immediate circle who is "insane" ("mad"), "mentally ill" or "depressive", but very few state they have been treated for "insanity" or "mental illness" (0.5%), while far more state they have been treated for "depression" (20%). A large proportion of people have already been in a psychiatric facility (visit, work or hospitalisation).

There is an increasing gradient in stated consumption of medication for nervous condition from Indian Ocean sites to French metropolitan sites**. In France, nearly 30% of respondents state they have already had medication for nervous conditions (mainly anxiolytics),** while there are only 5 to 10% in Indian Ocean sites. In France 5 –15% of respondents stated they had had "psychotherapy". In the Comoros, Madagascar and Mauritius resorting to religious and magical-religious offer is significant.

In France 80% of respondents only mention the psychiatric hospital as a facility for caring for "insane" or "mentally ill" people. There does not seem to be any possible alternative in people's minds. Among the 20% who can suggest another type of place, one in three (5% of the French sample) give the example of structures outside the hospital walls but connected with it (consultation centres, day centres etc), or else GP consultation. In case of problems with someone close who is "insane" or "mentally ill", they would first be sent to the psychiatrist or to the psychiatric hospital, and then to the GP.

In case of psychological problems, respondents would first seek help in their immediate circle, followed by the GP. Resorting to magical-religious offer is marked in the Comoros and Madagascar.

B. REPRESENTATIONS

"Insanity", "mental illness" and "depression" are explained by individual misfortune and ambient social distress.

Popular associations with the terms "insane", "mentally ill" and "depressive" are variable from one culture to another, but certain constant factors are found.

The representations of the person who is "mentally ill" – and, to a lesser degree, that of the person who is "insane" – carry the stigma of the potential dangerousness attributed to them both inside and outside the family. All violent, illegal acts (murder, rape, incest, aggression) are attributed to an "insane" (mad) person and even more markedly to someone who is "mentally ill". There are differences depending on sites – French metropolitan sites

more frequently provide responses on the side of exclusion (work, family, society) than do respondents in the French overseas *départements* or the Indian Ocean.

The vast majority of people interviewed think that "insane", "mentally ill" or "depressive" people are not responsible for their condition, nor for their acts; they consider they should be treated even against their will, and that they **are not conscious of their state**. **These are constant factors, whatever the culture. However the image of the suffering of the person who is "insane" or "mentally ill" varies from culture to culture, the denial of the suffering attributed to the "insane" and the "mentally ill" is more marked in French sites.** This is less true for the "depressive" person, where people are more likely to think that he/she is aware of his condition and suffers from it.

The image of the psychiatric hospital as the sole provider of care dominates in France and in Mauritius with regard to the "insane" and the "mentally ill". In addition, 80% of respondents think that the care provided there is essentially medication. In France, the population has little knowledge of care facilities other than hospitalisation. In the Comoros and Madagascar the alternatives to the psychiatric hospital mainly cited are first GPs and medical-religious offer (it should be noted that there are few or no psychiatric care facilities in these sites).

The psychiatric hospital is not considered to be an appropriate care facility for "depressive" people; three out of five respondents can suggest other care facilities for a "depressive" person. In France and Mauritius these are the home, the immediate circle, and then clinics and rest homes. In the Comoros and Madagascar the majority suggest church bodies and marabouts.

There is an international gradient concerning cure. In the Comoros and Madagascar people think an "insane" or "mentally ill" person can be cured. This representation of cure prospects decreases in the French DOM and French metropolitan sites, where few people think an "insane" or "mentally ill" person can be cured. **It is interesting to note the belief in the possibility of a cure is in reverse proportion to the offer in terms of psychiatric care : the less care facilities there are, the more likely prospects of cure are thought to be ! Conversely, everyone considers that a "depressive" person can be cured, this being true in all sites. And the large majority of respondents consider that an "insane", "mentally ill" or, to a lesser degree, a "depressive" person cannot cure on their own.**

C. TOLERANCE : THE FUNDAMENTAL AMBIGUITY

All respondents consider that the families of people who are "insane", "mentally ill" or "depressive" suffer.

The representations carry stigma : people think that the "insane" and the "mentally ill" are excluded from their families, but that they can be taken back if they are treated. Danger is the major preoccupation when people imagine themselves to be in the situation of taking in an "insane" or "mentally ill" person. For a "depressive" person, the change is marked, the danger shifting from others to the subject himself, to his suffering and the day-to-day burden that is increasingly difficult to bear. People state they would take in a someone close who is "mentally ill", "insane" or "depressive", but it is always a burden to the family; the family would resort to outside help if they feel that they or the subject are endangered. The notion of burden here too appears correlated with awareness of disorders : the burden exists only where one is aware, and one is more aware of another's illness than of one's own (denial is marked). It should be underlined that overall it is situations of emergency and crisis, where people are overwhelmed, that would trigger request for assistance. The sphere where exclusion is seen to be the most marked is that of work, even for a "depressive" person.

D. REPRESENTATIONS AND PROJECTIONS

The "insane" person is someone else, the "depressive" person can be oneself. Many respondents know an "insane" or "mentally ill" person in their immediate circle, but few define themselves as such. The descriptions of "insanity" and "mental illness" given by the population are very close to each other. "Depression" appears better accepted by respondents, who can see themselves as being depressive at some time. The concept of depression integrates a "clean", conscious, accepted and minor form of insanity, but it does not strictly cover the semiological psychiatric field, it is wider. Likewise, an "insane" or "mentally ill" person would be advised to go to the psychiatric hospital to obtain medication. But in the case of psychological problems, respondents would first seek help from those close to them, then the GP, resorting to magical-religious practice remaining marked in the Comoros and Madagascar.

E. PREVALENCE OF MENTAL DISORDERS

There are mental disorders everywhere, whatever the culture. Prevalence is high : **nearly one respondent in three presents at least one mental disorder at the time of the survey** (depressive and anxiety disorders, disorders related to drug and alcohol consumption, or psychotic-like syndrome).

Depressive disorders (major, minor or recurrent depressive episode, past or present, dysthymia) present an overall prevalence of 14% (1334 subjects), ranging from 7.5% in Pyrénées Orientals to 22% in Antananarivo (Comoros 4.7**%). The depressive episode is commoner in women.** Depressive disorders affect all age groups. Whatever the site, separated or divorced subjects present proportionally twice or three times more depressive episodes than people who are married, widowed or single; however these subjects are not very numerous in the samples.

Anxiety disorders also show high prevalence rates. Generalised anxiety concerns 11% (1017 subjects), ranging from 7.2% in Pyrénées Orientales to 13.9% in Tourcoing. **The prevalence of generalised anxiety is higher in women than in men**. These results are comparable to classic data in the literature. **The prevalence is the same whatever the age group and whatever the situation with regard to employment. Again, separated subjects have a higher prevalence than married subjects, but there are not many. The other anxiety disorders, post-traumatic stress disorder, agoraphobia, and compulsive obsessive disorder show very low prevalence rates >1%).**

Concerning **disorders related to addiction**, the MINI presents the same detection problems as all screening instruments of this type. The reliability of responses depends for a large part on the "sincerity" of the respondent at the time of the survey and on the cultural context (the weight of taboos for instance). **Alcohol-related disorders (abuse and harmful use)** represent an overall prevalence of 5%, ranging from 2.7% in Guadeloupe to 8.7% in Antananarivo. These disorders do not appear in the Comoros. **Whatever the site, it can be said that alcohol related pathologies are a male phenomenon**. **Disorders relating to drugs (abuse and harmful use) reach an overall prevalence of 2%** (from 0.3% in Mahajangha to 4.1% in Nantes). They do not appear in the Comoros. In France they range from 1% in the Vallée de la Lys to 4.1% in Nantes. They are more frequent in males under 35.

There is a hiatus between the mental disorders detected by standardised diagnostic questionnaire and the perceptions people have of them. In France, among those subjects identified as presenting a disorder (via the MINI), only 30% considered themselves to be ill. In the Comoros, Madagascar and

Mauritius, more people feel they are ill, one out of two presenting a disorder. Likewise, 25% of respondents stating they have never been treated for “insanity”, “mental illness” or “depression” present at least one disorder via the MINI.

Epidemiological data can have meaning and value only if they are viewed in context on the basis of anthropological data. Complementary anthropological studies are underway in certain sites.

Whatever the site, the consequences of disorders on work and daily life are considerable and constant. The hindrance felt in everyday life, work, and relationships with others is particularly strong among people presenting depressive disorders (60% associate the idea of hindrance). **This hindrance or difficulty associated with depressive disorders is independent of any socio-demographic criteria (gender, age, employment, income), i.e. it affects everyone in the same manner.**

At the same time, it can be noted that representations appear fixed : whatever the disorders present, representations associated with “depression” remain the same. In other words, and in contradiction with our hypotheses at the outset, whether or not a person has or has had depressive or anxiety disorders has little influence on representations the person has of depressive subjects (tolerance, compulsory care, suffering, exclusion).

Therapeutic recourse is varied and plural : Western medicine, religious or magical-religious offer, alternative medicine, psychotherapy, etc.
Whatever the mode of treatment, three out of four respondents consider their problems have improved.

2. DISCUSSION

This international research-action contributes to understanding of mental health issues, and makes it possible to develop the most appropriate responses according to the cultural context, via intercultural comparison.

Thus it can be noted that increase in wealth does not decrease mental pathologies. It is quite clear from the results that the emergence of disorders is not simply proportional to degrees of wealth or poverty, but is rather correlated to phenomena of adaptation, mutation and change, and to the way in which this takes place. Anxiety disorders in Antananarivo are partly linked to the daily search for food in a situation of extreme poverty. In Europe, these same disorders can be linked with the pace of productivity, to the development of “flexible” working hours, while being outside any objective situation of poverty or precariousness. Likewise, the link between situations of socio-economic precariousness and psychiatric symptoms is not automatic, even if it is obviously better to be rich and healthy than poor and ill.

This tidal wave of symptoms found in the course of the survey is so great that one can wonder what is actually covered by the famous 50% lifetime disorders in the American population and 30% disorders commonly found in present studies in the USA. Especially since, in opinion polls, 90% of French people consider and state themselves to be happy, and since, according to WHO, the French health system is the best in the world !
Suicide rates are high among citizens whose mental structures no longer have religion as a moral strait-jacket (taboos are gone), citizens who have less family, and whose families tend to be dislocated. This makes way for a new, very individualistic view of life, and new forms of solidarity. It is in fact these confidence-based relationships, these friends, these outsiders that seem to be more prominent in care for people with mental disorders. It is also these

outsiders that tell the person that things are not quite right in his head, when the person is not aware of it. And it works – in many cases, respondents in the survey consider that advice from people close to them, if it does not bring about a cure, at least it improves matters. This is true for all remedies, whether the GP who is always on the front line, medication, psychotherapy, religious recourse and so forth.

On the other hand, people would even so advise a friend or a family member who is "insane" or "mentally ill" to resort to the psychiatric hospital. But not the depressive person! In Madagascar and the Comoros people really think it is possible to treat without medication. Talking about "progress" in this sort of context requires caution. This progress should not be entrusted solely to "specialists", but should everywhere initiate a citizens' debate on any such notion of progress. The analysis can be more optimistic : how valid was the hypothesis that lay know-how, non-psychotherapeutic relationships, religions, alternative medicine can function as alternatives to psychiatric hospitalisation ? It no doubt is true, but disorders may disappear anyway over time, irrespective of the methods of care chosen by the individual, or chosen for him.

It could even be said that questions of mental health reflect contradictions in our cultural and economic system, and paradoxical situations arising from the fact that individuals have lost the pointers provided by the former major ideologies. For instance, we are told "you should not smoke", and tobacco is still being produced, "you should not drink" and alcohol is still produced, "you should not have mental disorders" and enormous quantities of psycho-tropic drugs are produced. The uneasiness that pervades civilisation is becoming more acute in the context of globalisation, where these contradictions are enhanced. Freud considered that psychiatry succeeds when it manages to convert pathological misfortune into normal misfortune. An then only philosophy, politics, religion and anthropology are left to "assist" there human beings who are unhappy but cured, or the reverse.

The role of WHO in questions of mental health can be important in avoiding relegating theses issues to the sole logic of adaptation. France, like other European countries, had an impact on whole sectors of the world during the colonial period. The exports of the asylum system has left marks that are still very visible today in professional practice and in representations. If something changes in the French system of psychiatry, this could accelerate things in these countries, so that they can avoid being bogged down in the institutional dead ends we have experienced for centuries and that we are only just managing to shake off. It is also a question of defending a social conception of mental health policies, in the face of what looks like a race to provide strictly technical, bio or psychotherapeutic responses centred on the symptom alone. France can contribute its particular experience, and via its political will, have a decisive influence.

However, it should also be recognised that colonialism has not succeeded in de-structuring social patterns, which in non-western societies apprehend the "insane" in a completely different manner, generally with a lesser degree of exclusion. Further to this, the "lack of means" feared in some countries encourages other to innovate and develop solutions for care of the mentally ill outside the classic psychiatric hospital structure inherited from colonisation (far too expensive in these context). Is this not an opportunity to be seized, an opportunity for balanced exchanges between cultures of exclusion and cultures of inclusion, between societies and organisations, between the Western world and the African world, between North and South ? If co-operation is to develop, it can only be completely bilateral and cross-bred. French psychiatric teams would have a lot to learn from work placements abroad, and vice versa – a sort of hybrid complementary training, in a spirit of humility and understanding.

Psychiatric professionals, alongside all their allies, specialised and non-specialised working for mental health, need to more clearly define these issues in the context of globalisation. They need to consider the place of psychiatry, which tends to replace the religious dimension when subjective and collective issues meet. This means that psychiatric practice needs to be clearly positioned as something other than a new "opium", aiming to adapt the subject to the laws that govern the world today. **This means moving from psychiatry that interprets to mental health policy that operates change.**

3. SOME PROVISIONAL CONCLUSIONS

From this first survey phase, and awaiting confirmation in the final phase for France

1. The notions of the “insane” and “mentally ill” person completely overlap for the population. Only medicalisation can provide an explanation for insanity or madness, by converting it into handicap, brain disease or genetic problems.
2. The “insane” or “mentally ill” person is someone else, the other person, who can only be treated by psychiatry using medication. This person is seen to be irresponsible and excluded. The “depressive” person is seen as being closer to self : he can be cared for at home with the help of people close, his friends and the GP, certainly not in a psychiatric hospital. Representations are massive and unvarying : gender, age, being ill, having known someone “insane”, “mentally ill” or “depressive”, or having psychiatric disorders oneself, have no effect.
3. There is a triple exclusion gradient :
   - from the “depressive” person to the “mentally ill” person to the “insane” person.
   - From “ family” to “society” to “work”
   - From Indian Ocean to DOM to French metropolitan sites
4. However, respondents think that a person who is “insane”, “mentally ill” or “depressive” can return to their family if they are receiving treatment This is an international invariant.
5. “Depression” is a concept that is becoming global, and it is in the process of upsetting traditional, archaic images of the “insane” or the “mentally ill”. It takes on the attributes of a person aware of his/her state and who can be cured. It is an acceptable psychiatric disorder for self and others, therefore it is seen to be less of an exclusion factor, although depressive subjects state they are excluded. This gives rise to even more negative representations of the “insane” person, and especially of the “mentally ill” person who receives all the negative attributes of the madman : murder, incest, rape, violence. Where the term “depressive” is not known by the population (in the Comoros and in particular in Madagascar) it is more frequently considered that an “insane” person can be cured, and that he/she is not excluded. It can therefore be wondered if there is not a confusion of the different notions prior to their differentiation. The fact that the “depressive” category was created in France (and perhaps in European countries, this will be seen in the second phase) could lead to greater rejection of “insane” and “mentally ill” people than was the case before.
6. Mental disorders are present in all survey sites, however with considerable variation (10% to 45.9%-. What is important is the multiplicty of types of recourse – medical, religious, family, psycho-therapeutical etc. - people concerned with their “non-normal” state say they have been stabilised or improved, whatever the type of recourse chosen. In the Indian Ocean, recourse is mainly magical-religious, but there is certainly systematic cultural and medical bi-therapy.

4. ANNEX

If the recommendations derived in the 12 sites are synthesised, the general consequences of the survey in terms of public health are as follows :

1. Change and develop the care system

- ✓ stop creating structures that perpetuate internment, exclusion and stigmatisation, or radically transform concentration-type hospitals
- ✓ train primary health care agents in diagnosing and caring for anxiety and depression (10 sites). Provide assistance in screening
- ✓ develop close collaboration with front line general practice (4 sites)
- ✓ preserve local particularities, in particular traditional practitioners (2 sites) and tolerate pluralism in care provision (results are cumulative)

2. Raise awareness in the population on the subject of mental health issues

- ✓ organise campaigns for the promotion of mental health (8 sites)
- ✓ combat negative perceptions (6 sites)
- ✓ give consideration to the problems of violence (3 sites)

3. Take action in the patient's environment

- ✓ Help families providing care for people suffering from mental disorders (8 sites)
- ✓ Combat precariousness, family breakdown, and promote solidarity (4 sites)
- ✓ Integrate users into decisions that concern them (3 sites)d

4. Promote research and inter-site, inter-island and inter-country exchanges

- ✓ acquire further anthropological and epidemiological data (5 sites)
- ✓ continue pluridisciplinary research operations (4 sites)
- ✓ establish telemedicine (2 sites).

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