

Psychiatry: organization and continuity of care at the time of confinement

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To prepare for the discussion, here is a paper written in April 2020 based on my initial empirical investigations in a psychiatric facility. This paper was written with Pierre Robicquet (Cermes3) and published on the CSO website (<https://www.sciencespo.fr/cso/fr/content/psychiatrie-organisation-et-continue-des-soins-lheure-du-confinement.html>). My presentation on the day of the panel will provide more recent elements on the adaptations that followed in psychiatric institutions throughout May 2020 and June 2021. In particular, I will emphasize on the elements of change that are already appearing to be sustainable as well as the effects that the Covid-19 crisis is having on the way psychiatry and mental health are treated in the media and political discourses.

The Covid-19 epidemic has taken psychiatric actors by surprise, while numerous alerts on the lack of human and budgetary means had been relayed in the press for several months in France. Five weeks after the beginning of the containment, this text aims at documenting how the actors in public psychiatry responded to the requirements of protection of the patients in front of Covid-19. We question the modalities of adaptation of the care offer in psychiatry, and its effects on the organization of the sector.

Psychiatric sector refers to the specific territorial and administrative organization of mental health care in France. The founding project inscribed in the first circular of March 15, 1960 is based on the opening of traditional care institutions and the accompaniment of patients in an ordinary environment. A sector is made up of inpatient and outpatient services designed to meet the care needs (prevention, treatment and aftercare) of the population living in a given territory. Within the framework of the sanitary crisis and in accordance with the (considered late) instructions of the Ministry of Health, these care services took measures in order to "guarantee the continuity of care" and "protect the patients and the professionals from the propagation of Covid-19". It appears from our fieldwork - and as is often the case in psychiatry - that the arrangements implemented vary locally, according to territorial arrangements and professional cultures.

THE CHARACTERISTICS OF A POPULATION "AT RISK"

What are the risks specific to the population followed in psychiatry and perceived by care professionals? Although the patient population is relatively young, the people followed in psychiatry present a worse state of health compared to the general population. Diabetes, obesity, hypertension and heart problems, chronic obstructive pulmonary disease (COPD) are very common comorbidities among people living with a mental disorder and make them particularly vulnerable to infection with Covid-19.

In normal circumstances, the somatic health status of psychiatric patients represents a public health issue that is unequally addressed by professionals. The Covid-19 health crisis seems to have modified the hierarchy between psychological and somatic priorities in the service of protecting patients against the risk of infection. As emergency care was subject to an increased logic of sorting, professionals feared that their patients would suffer a double misfortune, since

their somatic vulnerabilities would be compounded by the stigmatization suffered by those followed in psychiatry.

REORGANIZING CARE AND HOUSING IN THE PSYCHIATRIC HOSPITAL

With the Covid-19 crisis, the need to free up hospital beds is primarily a health issue and seems to be better accepted by professionals than when it is based solely on management logic. Following this approach, the early discharge of certain patients encouraged reorganization within the units, the reception of new patients during confinement and reduced promiscuity.

The principle of sectorization was, for a time, suspended in favor of “cohorting”, applied more or less strictly depending on the establishment. The units coordinated among themselves to distribute the patients according to their Covid-19 profile, and less strictly according to their residency. As elsewhere, visits were suspended, short-term outings were prohibited and most of the therapeutic activities were stopped.

Despite the instructions to preserve the units as a place of care, the hospital function of accommodation and assistance to the most precarious seems to be reinforced in times of crisis. If patients who have been able to be housed at home or by their families are discharged as a priority - often with little guarantee as to the quality or safety of these accommodation options - some of the most precarious patients are still hospitalized. Some patients without a permanent solution, but well known in their sector, were also temporarily accommodated by medical-social structures thanks to pre-existing partnerships. The criteria for decision-making and usual referral methods in psychiatry have evolved to adapt to the health risks linked to the Covid-19 epidemic. With them, the roles of the actors and their institutions have been affected - sometimes against previous trends of rationalization and specialization of the activity.

CONSULTATIONS AND DRUG TREATMENTS

In order to "maintain the link" and "reach out to patients", professionals offered partial care to known patients. In outpatient clinics (medical-psychological center, day hospital), face-to-face therapeutic activities, which are often carried out in groups, were quickly suspended to avoid contact. Fearing the isolation of patients living with a psychic disability, most of the care teams, usually reluctant to teleconsulting, undertook to communicate with their patients by phone. The psychiatrists contacted told us that there was great heterogeneity in the implementation of these consultations, and some of them expressed ambivalence about the capacity of this tool to allow for follow-up care. While the majority of professionals felt that this system allowed them to keep in touch, they nevertheless specified that patients did not take advantage of it in a uniform manner and tended to decline calls, preferring to wait for a return to normalcy.

Another part of the medical work consists in making sure that prescriptions are renewed and that medication is taken - a break in treatment being one of the first causes of relapse and psychological decompensation. The consultations that have been maintained in person concern the securing of treatment (neuroleptic injections and pillboxes making). A complementary strategy aimed at organizing the transmission of information with the local pharmacies. In the context of the development of clinical pharmacy activities, these practices already existed formally; in other areas, the health crisis acted as a trigger for initiating new cooperation.

As in other specialties, psychiatric professionals have observed a sharp decline in the demand for care. From an organizational point of view, this decrease can be interpreted as an indication

that the sector is functioning well, able to meet the requirements of patient identification, remote monitoring and prescription renewal. In our field, however, this reorganization of the supply of care raises several questions for professionals about their role with patients and their ability to anticipate the heterogeneous needs of a population. It will be necessary to analyze, after the crisis, the extent to which these arrangements will have made it possible to maintain continuity of care and in what forms they are perpetuated in the organizations.

WHAT ABOUT NETWORK DYNAMICS?

The changes observed within the sectors seem to redraw the relational and territorial network in which they are inserted. On the one hand, the usual central work of accompanying and integrating patients with medico-social and social partners has suddenly stopped. On the other hand, certain cooperative relationships have been strengthened. The context has encouraged cooperation between establishments belonging to the same hospital grouping, through crisis cells that have been meeting very regularly since the end of February. Psychiatric facilities coordinated with general hospitals to make accommodations and patient transfers possible. Locally, arrangements were also made with general practitioners to allow the follow-up of certain patients. In the same way as with pharmacies, these exchanges are sometimes based on already existing links or are inaugurated during the crisis.

These initial data raise several questions. First of all, the link between the solutions found during the crisis and previous and future operating methods. Do the organizational innovations reveal network dynamics, or are they merely compensations for already obvious structural weaknesses? Will these relationships withstand the end of the crisis or were they a one-off mode of cooperation to meet exceptional needs? What degree of formalization would be necessary to establish them over time? Another set of questions concerns the effectiveness of the organization of care in the sector. The context of the health crisis has revealed both the strengths and the tensions of this organization of care. The distribution of patients by territory has made it possible to identify very early on, and effectively, the active file that requires continuity of care. But the dehospitalization measures that accompanied sectorization also show the already well known limits, concerning the lack of accommodation places and the weakness of the care offer in town. Finally, this very particular situation leads us to reexamine the role that actors attribute to their institutions.