

Reshaping Community Mental Health Services during the COVID-19 Epidemic - Report from the 59G21 Service in Lille, France

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ABSTRACT: The COVID-19 pandemic led to a rapid transformation of the health care system to cope with the risk of contamination and of developing a severe form of the infection. Although it is an international crisis, strategies have been decided nationally. In France, priority was given to hospital reorganization, especially intensive care units. Reorganization of primary health and mental health services took place with late and inadequate national guidelines or coordination. For mental health services, lack of visibility on the crisis impact on mental health, and difficulties in defining their place in the overall health strategy appeared as the main challenges to overcome. These rapid transformations impacted the whole organization of community mental health care. Any strategies developed must ensure that every person enjoys the highest attainable standard of physical and mental health. Using a systemic approach, it has been necessary to identify both status and risk factors of communities, and to implement appropriate and efficient health promotion and crisis resolution actions. These theoretical issues and their practical impact are discussed using the field strategy developed during the first 28 days of confinement by the 59G21 service in Lille, France.

KEYWORDS: COVID-19, mental health, community mental health services, organization and administration, risk assessment, human rights

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Introduction

Propagation of the virus responsible for the outbreak of pneumonia in December 2019 in Wuhan, China, was recognized as a Public Health Emergency of International Concern by the World Health Organization (WHO) on January 30, 2020.¹ Named COVID-19 in February 2020, its rapid spread around the world led the WHO to characterize it as a pandemic on March 11, 2020.² Following other European countries such as Italy and Spain, France decided on March 17, 2020 to confine the entire population.³ In the strategy set out by the French authorities, 2 distinct biological crises were targeted: contamination by COVID-19 and development of severe forms of infection.³ Whole population confinement and widespread use of barrier measures aimed at preventing contamination.³ To overcome severe forms, at-risk individuals were required to self-monitor and follow stricter confinement procedures.³

These new biological crises are followed by new psychosocial crises,^{4–6} due to the direct effects of the epidemic and confinement on mental and social health,⁷ but also to the indirect effects on employment or access to care and services. As is the case worldwide,⁸ the initial measures put in place in France were not inclusive of people living with disabilities. On the 16th day of confinement, adaptations for people living with disabilities and carers were introduced, but 28 days later they remain without clearly definition and are heterogeneously applied.⁹

Since the challenges raised by this epidemic affect the overall social organization and extend beyond the issue of mental

health problems, the concept of People Living With Psycho-Social Disabilities (PLWPSD) represents a more suited approach than focusing on mental disorders. This insufficient recognition of the needs of people living with disabilities from public policies and care⁸ increases health inequities, especially regarding the poor physical health of PLWPSD. The WHO estimates that in Europe, PLWPSD have a reduced life expectancy of 15 to 20 years compared to the general population.¹⁰ In France, a recent study also highlighted a gap of 13 to 16 years.¹¹ Reduced health literacy and access to health promotion, responsible for a less healthy lifestyle, are among the reasons for this gap.¹² Long-term use of psychotropic drugs is also identified as an influential factor in increasing cardiovascular and respiratory risks.^{13,14} Finally, many studies describe that PLWPSD get less prevention, have less access to and receive poorer quality care.¹² As a result, the poor physical health of PLWPSD has been regarded as a challenge for the organization of the health care system.^{10,12}

The COVID-19 epidemic adds a biological risk and puts a strain on health and social systems, already underperforming for those of us living with disabilities.^{10,12} In addition, recent studies highlight that PLWPSD could face a greater impact of the mental consequences of the epidemic, possibly related to common mechanisms between COVID-19 infection and possible biological components of mental health problems.¹⁵ This situation therefore raises fears, shared by professionals^{4,16} and users and survivors of psychiatry,¹⁷ going from increased inequities in care provision^{8,18} to lack of health coverage. In case of



overload, some care procedures limit access to emergency services for mental health problems,^{16,19} or base medical triage on factors more likely to target PLWPSD.²⁰ The situation has led authorities to condemn these inequities in treatment.^{16,21} This forces PLWPSD, carers, primary and mental health professionals to focus on prevention and advocacy within the health care system.

In France, stakeholders report that mental health was not part of early health directives.^{4,16} In this period, it has been necessary for mental health services to innovate in order to respond to the double challenge of continuing to provide mental health care and participating in the overall epidemic response. On the 15th day of confinement, health authorities released recommendations focusing on outpatient care for persons with a diagnosis of severe mental illness aiming at keeping them compliant with home confinement.²² Lack of national goals for improving the mental health of the population during the first 28 days of confinement is consistent with the overall lack of a mental health strategy at the national level. So far, field professionals have been responsible for this double stake of defining both goals and modalities of mental health strategies.

The French situation is similar to that of many countries worldwide where health is not conceived in a global way. In many countries, such as China²³ or Italy,²⁴ the lack of coordination between the mental and physical health systems has contributed to a loss of opportunity for PLWPSD. However, even beyond the care provided to PLWPSD, the integration of mental health into the care strategies of COVID-19 was pointed out as an essential element in the proper management of the epidemic.²⁵ Contrary to most cases,²⁶ this holistic thinking does not only concern mental health, but should be integrated into all public health strategies.^{27,28} The French experience in which the following strategy was developed is applicable to many health care systems worldwide. In this framework, coordination and communication between field stakeholders appears as an essential component of care.

The focus of this paper is from the perspective of a secondary care mental health service. It presents our initial analysis and the initiatives deployed during the first 28 days of confinement. This field report is based on day-to-day actions and follows more than 40 years of practicing community mental health care.²⁹ It could be used by other mental health services or policy-makers seeking to shape or reflect on their strategies, to organize healthcare in a different timeframe, or by those faced with similar situations in the future.

The municipalities of Mons-en-Barœul, Hellemmes, Lezennes, Ronchin, Faches-Thumesnil, and Lesquin

These 6 municipalities form a semi-urban area of 3251 inhabitants/km² (87 136 inhabitants; 26.8 km²). In this area, mental health care is organized according to the community mental health model developed by the WHO and Wonca,³⁰ noted that private mental health offer is almost non-existent. This is made possible by the specific French concept of “psychiatric sector”,

which entrusts a single service with responsibility for all public secondary mental health care in a given territory.²⁹ Known as “sector 59G21”, the service has evolved over more than 40 years, from a mental health asylum of 172 beds in 1983 to an almost outpatient-only service with an open ward of 10 beds located in proximity of a general hospital.²⁹

Access to mental health care is a top priority with more than 13 consultation sites scattered throughout the sector.³¹ In line with a community-based approach to health,³⁰ work is conducted in close partnership with primary care professionals (general practitioners, pharmacists, and community nurses) who remain the first professional providers of mental health. A psychosocial approach to health has been developed, in keeping with United Nations standards,³² in particular the 2006 Convention on the Rights of Persons with Disabilities. To this end, care pathways are organized within a comprehensive health approach, in partnership with health and social services. Autonomous social response capacity has been developed by recruiting social workers and developing a dedicated team based on the Assertive Community Treatment model.³³ In 2013, the service switched to a recovery-oriented approach,³¹ helping to structure its ability to support and develop informal care. Work is conducted in collaboration with 2 user-led mutual-help groups and health promotion actions are carried out, in tandem with a person expert by experience, to develop self-care. Health promotion initiatives are conducted in liaison with local elected officials.³¹

Measures taken to deal with the COVID-19 epidemic had a major impact on work modalities but not on the fabric of our system, which was already avoiding hospitalization in favor of home-based care. In fact, the service has been developing for more than 15 years a capacity to manage crisis situations at home, as well as a strong case management capacity. Lack of visibility on both the impact of the crisis on mental health and our role in the global health strategy, as well as adapting to an ever-transforming health system were the main initial challenges of the crisis.

Impact of the COVID-19 epidemic on local community mental health care

The strategy adopted to deal with the COVID-19 epidemic has reshaped the health care system. These modifications had a collateral impact on mental health care.⁴ Figure 1 shows our analysis of the reshaping of local community mental health, moving away from the organization promoted by the WHO and Wonca.³⁰

According to our initial analysis, all 5 layers of community mental health care are impacted:

Epidemic management strategy is accompanied by new demands for self-care

It concerns self-monitoring and barrier measures for physical health, but also mental health, in line with the WHO

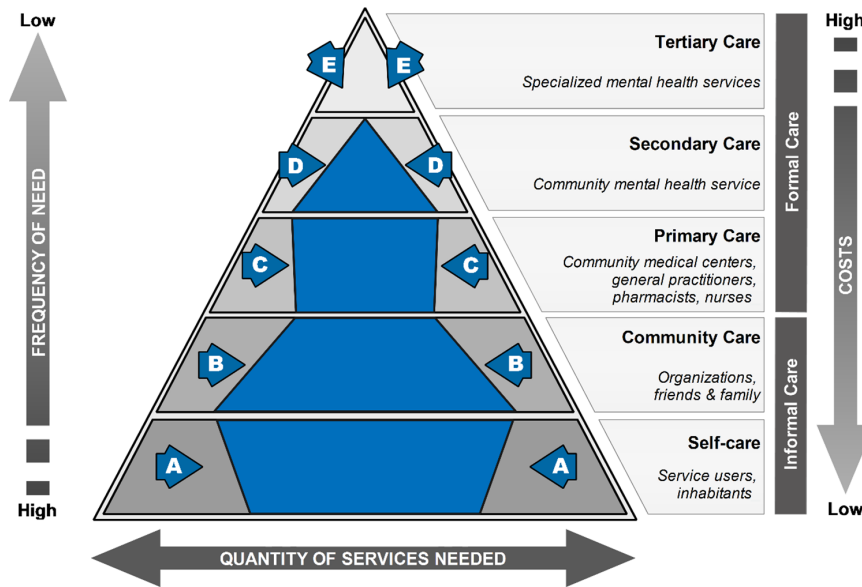


Figure 1. Impact of the COVID-19 epidemic on community mental health care in municipalities of the 59G21 service. The gray-scale diagram presents the theoretical community mental health organization promoted by the WHO and Wonca. The colored part shows the estimated state of community mental health following the COVID-19 epidemic. Each arrow represents the impact on each layer of healthcare and is individually described in the main text.

recommendations.⁶ Their difficult implementation highlights the lack of health promotion in the French healthcare system. While the need for self-care is increasing, confinement measures and their maladjustment to PLWPSD can limit coping skills for some people.³⁴ For others however, disability vanishes as they were already isolated by their experience of mental health problems. In France, confinement has also been accompanied by unprecedented social initiatives, such as a ban on housing eviction and the repossession of hotels to house homeless persons. The scientific consensus remains on the negative impact of confinement on self-care capacities.⁷ For informal care, the heterogeneity of situations highlights an increase in health inequities.

Health inequities arise in informal community care

While some people can rely on support in their households, others suffer from social isolation or being forced to remain in situations of domestic and gender-based violence.³⁵ Although communication has changed, confinement reduced the possibilities for friends support. For friends and families of PLWPSD, opportunities for home support were slow to be allowed.⁹ Organizations and mutual-help groups restructured with the use of digital tools and telephone support.³⁶ These new structures made it possible to continue community support during the confinement. They have also highlighted the impact of the digital gap, both in terms of telephony and internet access.³⁷

Incertitude of primary health care possibilities

The initial message was to avoid overloading primary health services.³⁸ To this end, pharmacists were given the opportunity to continue dispensing treatments beyond a prescription's validity period.³⁹ In case of overload, some emergency services

planned to limit access for persons with a mental health problem.¹⁹ Care provision by general practitioners was organized around teleconsulting and limited to urgent care. Primary care is closely connected to the mental health service, which can be reached anytime on a dedicated line. Contrary to expectations, their activity has been reported as falling by as much as 50%, indicating an overall drop in the population's access to basic healthcare.³⁸ On the twenty-second day of confinement, national measures were published regarding access to primary care for people with a chronic disease or a mental health problem in order to prevent increased morbidity.⁴⁰ This delay in response led to significant heterogeneity in the provision of primary mental health care. In addition, health professionals were considered at high risk of psychosocial complications,^{6,41} as well as biological contamination, especially for community nurses doing home visits.⁴²

Transformation of secondary mental health care

Day-to-day functioning of the service has been completely modified and reshaped using phone calls, teleconsultations, and home visits. Despite the epidemic, human resources have outstripped the collapsing demand for care. While the population's need for care is expected to increase, the disappearance of service demand has led to a shift in activity toward community outreach. It was difficult to anticipate the impact of the crisis on mental health, and the uncertainty led to blind management of the crisis without knowing how to adjust sensitivity thresholds. Indeed, many professionals predicted a worsening of the mental health problems of PLWPSD,⁴ which we did not observe during the first 4 weeks of confinement. The service gave specific attention to populations known to be at risk due to poor social conditions such as social isolation, domestic violence or deprivation of liberty.^{16,43} Increased access to care

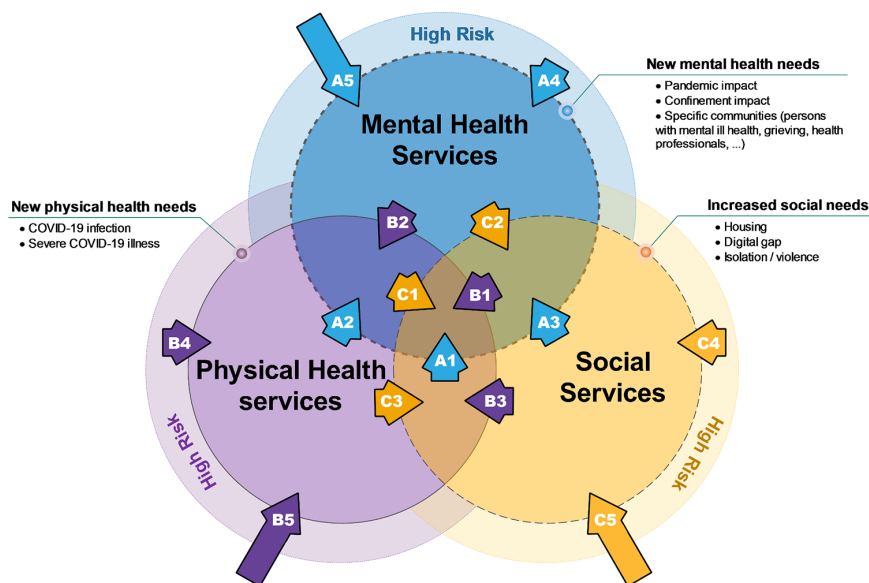


Figure 2. Interactions between the main physical, mental, and social systems.

should be organized for newly identified at-risk populations with little or no preceding access to secondary mental health services (health professionals,^{6,41} persons in grief, etc.).

Disappearance of tertiary mental health care

Specialized hospital mental health services were quickly closed and redirected to emergency management. In addition, access to electroconvulsive-therapy was interrupted due to a lack of available anesthetists.⁴ Some specialized psychiatrists remain available for supervision, but clinical interest is low without access to the specific resources these services offered.

Strategies for community mental health services during the COVID-19 epidemic

Core principles and motivations

The 59G21 service is built on a principle of respecting and promoting human rights.^{29,31} The goal is to ensure that every person enjoys the highest attainable standard of physical and mental health. It should be pursued from a perspective of social justice, aiming at health equity for all. Greater attention and resources must therefore be devoted to those most at risk or with the greatest health needs.³²

The WHO defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".⁴⁴ In France, the health system is built on sealed systems based on hospital models. This is especially true for physical, mental, and social aspects of health for which this division is also administrative.²⁹ Although some physical health hospitals provide mental health care, the majority are provided by specialized institutions.⁴⁵ Formal care is organized in 2 or 3 lines depending on medical specialties. General practitioners play a coordinating role between the systems, except for the social system which is organized apart from medicine.

The national confinement puts this system under strain through several crises. Firstly, the introduction of new biological crises in the form of COVID-19 contamination, and the development of severe forms of infection. Secondly, the introduction of new mental crises such as the consequences of confinement.⁷ Thirdly, the increase of pre-existing social crises, in particular the digital gap,³⁷ housing,⁴⁶ social isolation,⁷ or domestic violence.³⁵

While the hospital-centric system allows for the development of hyper-specialized care able to answer a reduced number of complex cases, it is struggling to cope with many simple cases. National⁴⁷ and international³² reports point out its inadequacy for pursuing the enjoyment of the highest attainable standard of health. This is particularly relevant for non-communicable diseases, including mental health problems, for which a recent WHO report recommends coordination by the Head of State rather than the Ministry of Health.⁴⁸ Thus, while the French system is performing well on specialized aspects of the COVID-19 epidemic like providing quality intensive care, it is struggling to promote health and provide community-based interventions for the population. Since an overhaul of the system in the midst of a crisis is not feasible, the chosen strategy must take these specificities into account.

The national response to the COVID-19 epidemic highlights main difficulties located at the interface and coordination between different systems. While scientific data does not permit pin-point identification of individuals at mental health risk,⁷ it appears clear that those most at risk for their overall health are at the confluence of physical, mental, and social crises. This approach is consistent with a cybernetic reasoning that the more complex the problem, the greater the risk of error.⁴⁹

Figure 2 presents a model of interactions between the main physical, mental, and social systems. Based on this model, several intervention targets can be identified, allowing the development of field actions.

Identification of risk factors and status

The mental health service must be able to offer care to people with health needs for which informal and primary care alone is insufficient. The service's prevention and treatment actions all rely on developing informal care and working in coordination with primary care and social services. Impact of the crisis on healthcare provision presented in Figure 1 limits resources, forcing health services to be able to prioritize targets for intervention and actions taken. To this end, part of the activity must be devoted to identifying each individual's status and risk factors. This is carried out through systematic telephone recontact of at-risk individuals.

Confinement has an uncertain impact on the health of PLWPSD.⁴ In addition, professional opinion favors an increase in the population's need for care.⁷ These elements suggest that the service should target a different population than it did before confinement. Lack of demand makes it impossible to rely on it to provide access to care for those who need it. For community outreach, it is therefore necessary to define a target population at higher risk. A large portion will consist of individuals who have used mental health services in the past year.^{4,22} In addition, individuals identified as being at risk, such as health professionals,^{6,41} people grieving, or deprived of liberty,^{16,43} are also included in the absence of an already existing specific strategy. Prospectively, analyses of crisis situations requiring the intervention of a mobile team or even hospitalization will help identify risk factors in order to continuously fine-tune the target population.

In contrast, risk factors for physical crises are clearly defined. COVID-19 infection status is based on a medical diagnosis and is conducted in coordination with general practitioners. Regarding the risk of contamination, lack of knowledge or respect of barrier measures, as well as exposure to an infected person, are identified risk factors. Risk factors for developing a severe form of infection include age,⁵⁰ medical conditions (most notably coronary heart disease, hypertension, diabetes, and chronic obstructive lung disease),^{50,51} smoking,^{50,51} and use of psychotropic drugs known to increase the risk of pneumonia.^{4,13,52} Benzodiazepines⁵² and antipsychotics¹³ are particularly targeted. High-risk treatments when associated with infection, such as lithium and clozapine, are also subject to systematic close monitoring.

For social crises, the risk factors sought are lack of decent housing⁴⁶ or access to telephone or internet,³⁷ social isolation,⁷ domestic violence,³⁵ and deprivation of liberty.^{16,43}

Targets and actions

Reducing mental health crises (A1-5). These actions form a community mental health service's specific activity. They are aimed at preventing mental health crises (A1-5), notably complex crises (A1-3). They target, as a priority, individuals in a situation of systemic vulnerability, that is, bio-psycho-social (A1), bio-psychological (A2) and bio-social (A3) crises, but also those at risk of mental crisis (A4), and ultimately the rest of the population

(A5). They rely on human contacts and increased access to care. All targeted individuals will receive information on global solutions proposed by the WHO,⁶ as well as individual support and guidance for appropriation and coping. For high-risk individuals, targeted strategies will be deployed,^{4,6,43} as well as involvement in resolving biological and social crises.

Avoiding the increasing complexity of mental crises (B1-2, C1-2). These actions are usual for a community mental health service and carried out in partnership with physical health and social services. They aim to avoid complex crises and target complex situations as a priority (B1, C1). For physical crises (B1-2), some actions are aimed at preventing contamination, such as information on barrier measures, or reduction and adaptation of risky psychotropic treatments with long half-life.^{13,52} Others aim to prevent severe forms, such as stopping, reducing and adapting risky psychotropic treatments with short half-life,^{4,13,52} or supporting smoking cessation.⁵¹ They are preceded by the identification of clinical signs evocative of a COVID-19 infection and referral to the primary care system. In the case of social crises, actions aim to support and maintain housing, provide access to telephones and the Internet, tackle isolation and take part in the strategy to reduce domestic violence.

Participating in the national strategy to fight COVID-19 (B3-5). These exceptional epidemic-motivated actions build on the usual actions of community mental health services to promote health and reduce physical morbidity. They aim to avoid contamination by COVID-19 or development of severe forms. They target individuals at high mental risk, particularly those in social crisis (B3), at high physical risk (B4), and ultimately the rest of the population (B5). They are preceded by the identification of clinical signs evocative of a COVID-19 infection and referral to the primary care system. They consist of information and support for barrier measures, maintained access to primary care, adaptation of psychotropic treatments if necessary,^{4,13,52} and support for smoking cessation.⁵¹

Participating in the crisis social response (C3-5). These actions extend those usually undertaken by community mental health services to address social determinants of health. They aim to prevent and resolve social crises and target individuals at high mental risk, particularly those in physical crisis regarding COVID-19 (C3), at high social risk (C4), and ultimately the rest of the population (B5). They aim to support and maintain housing,⁴⁶ provide access to telephones and the Internet,³⁷ tackle isolation,⁷ and take part in the strategy to reduce domestic violence.³⁵

Intervention targets thus defined allow the deployment and monitoring of field actions. They also make it possible to adapt operations to human resources and health constraints as the crisis unfolds. Table 1 presents a list of actions carried out by the 59G21 service during the first 4 weeks of confinement and their place in the model of Figure 2.

Table 1. Twenty-eight actions carried out by the 59G21 service during the first 28 days of confinement.

| ID | ACTIONS | GOALS | TARGET* |
|-----|--|--|--------------------------|
| 01. | Reorganization of the activity over the whole week instead of working days | Improve overall efficiency | All |
| 02. | Double the basic frequency of contacts | Improve overall efficiency | All |
| 03. | Bi-weekly meetings of management, doctors, psychologists and secretaries to adapt the organization of the service | Improve overall efficiency; Control communication | All |
| 04. | Information on the reorganization of the mental health service to all 3500 service users, using mail and text messages | Increased access to secondary mental health care | A1-5 |
| 05. | Information on the reorganization of the mental health service to primary care, social services and local elected officials | Increased access to secondary mental health care; Improved service coordination; Identification of risk factors and status | A1-5 |
| 06. | Social network coverage with daily activities | Supporting informal care; Preventing psychological crisis; Increased access to mental health care | A1-5 |
| 07. | Development and provision of a reliable information database on mental health promotion during the epidemic | Supporting informal care; Preventing psychological crisis; Increased access to mental health care | A1-5 |
| 08. | Outpatient care overhaul and dispatch of all non-urgent consultations | Reorganizing activity around crisis prevention and management | A1-5 |
| 09. | Increase in the workforce of night staff and development of its case management capacity | Prevent psychological crisis for at-risk individuals | A1-4 |
| 10. | Reorganization of the team of psychologists to ensure multi-weekly supports | Prevent psychological crisis for at-risk individuals | A1-4 |
| 11. | Reorganization of the team of psychomotor therapists toward remote stress and anxiety management | Prevent psychological crisis for at-risk individuals | A1-4 |
| 12. | Regarding the Assertive Community Treatment team, increased frequency of contact from a minimum of one every two days to three per day, for all service users | Prevent biological, psychological, and social crisis for at high risk individuals | A1-4 B1-4 C1-4 |
| 13. | Maintaining the opening of consultation centers and a physical reception capacity | Enabling access to care for people in social crisis, disabled or uninformed of reorganizations | A1 A3-4 |
| 14. | Procuring mobile phones to limit the digital gap | Reduce the digital gap; Prevent complexification of crises | A1, A3 B1, B3 C1-4 |
| 15. | Systematic assessment of the mental health of individuals infected with or in contact with COVID-19, adaptation of medication, and frequent mental health support during the physical crisis | Prevent complexification of biological of bio-social crises; Prevent severe forms of infection | A1-2 |
| 16. | Psychological support in dealing with confinement for people at physical, mental and social risk | Prevent complexification of social crises; Prevent psychological crises | A3-5 |
| 17. | Development of a mental crisis registry and weekly analysis of risk factors | Identify psychological crisis risk factors | A4 |
| 18. | Development of telephone and video consultation | Reduce risks of COVID-19 contamination | B1-5 |
| 19. | Limitation of mobility for serving professionals | Reduce risks of COVID-19 contamination | B1-5 |
| 20. | Organization of remote weekly operation meetings | Reduce risks of COVID-19 contamination; Systematically review operations of every team | B1-5 |
| 21. | Development of home-working and limitation of the number of people working at a minimum in order to ensure coordination of care and a physical response capacity | Reduce risks of COVID-19 contamination; Improved case-management capacity; Maintain accessibility of services | B1-3 |
| 22. | Systematic information on barrier measures and twice-weekly screening for COVID-19 symptoms in coordination with the general practitioner for all persons in mental crisis | Prevent complexification of psychological and psycho-social crises; Reduce risks of COVID-19 contamination | B1-2 |

(Continued)

Table 1. (Continued)

| ID | ACTIONS | GOALS | TARGET* |
|-----|---|---|---------|
| 23. | Collection and centralization of diagnoses of infected, suspected, and exposed individuals | Identification of biological risk and status; Prevent complexification of psychological and psycho-social crises | B1-2 |
| 24. | Restriction of home visits to Crisis and Assertive Community Treatment Teams | Prevent complexification of psychological and psycho-social crises; Reduce risks of COVID-19 contamination | B1-2 |
| 25. | Interventions take place at home rather than in consultation centers | Prevent complexification of psychological and psycho-social crises; Reduce risks of COVID-19 contamination | B1-2 |
| 26. | Identification of risk factors, including psychotropic medication, for severe forms of infection for all 3500 service users and monitoring of those most at risk | Reduce risks of COVID-19 contamination for at-risk individuals | B4 |
| 27. | Specific monitoring for individuals taking clozapine or lithium | Reduce complications of medication in case of infection | B4 |
| 28. | Contact with pharmacists and renewal of clozapine without biological control for individuals taking clozapine for more than a year without a history of hematological complications and with good mental health | Reduce risks of COVID-19 contamination for at-risk individuals | B4 |

*Targets code refer to elements from Figure 2.

Conclusion

The COVID-19 epidemic has led to a swift transformation of health systems, especially in the field of telecare, whose rapid development has enabled France to catch up. Health strategies should aim to provide the most resources to those with the greatest needs or risks of exclusion, in particular those at the confluence of several systems. This approach contrasts with international calls for the integration of mental health into advanced health strategies.²⁸ Lack of preparedness and organizational shortcomings lead to the development of solutions that build on existing local community resources. In this light, this experience makes it possible not only to propose a strategy for countries with a high economic status suffering from poorly organized care, but also for countries with a low economic status where similar management strategies are already being developed.⁵³ The next step will be to assess the impact on the health of the population of the various actions carried out. To this end, appropriate indicators need to be defined, most of which may need to be constructed.

The crisis has highlighted the lack of versatility of the French system and its limitations in adapting to provide the highest attainable standard of physical and mental health to the whole population. Yet this strategy also serves as an example of how lack of oversight allows field professionals to innovate quickly. Improvement of the healthcare system should build on positive aspects of this paradox between rigidity and innovation.

Health inequities, including the precarious situation of PLWPSD, have also become apparent to many. Thus, it appears essential for responses to health or social crises to acknowledge and address health and social inequities. The most at risk populations in the epidemic depend on socio-cultural contexts⁵⁴ and their identification must be based on the proximity of field actors

and local resources. To this end, field stakeholders must have the autonomy to innovate and define the modalities to achieve the mental health goals defined by the state, based on community-based care and pursuit of recovery and human rights.

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