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Facing Confinement, the Comfort of WhatsApp Groups in Mental Health Communities

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Mots clés
assessment, community mental health services, e-mental health, ethics, family therapy, health services research, knowledge exchange, post-traumatic stress disorder, qualitative, telepsychiatry

We read with great interest the Editorial of Vigo et al. on mental health of communities and found relevant the directions for future research.[1] The word "psychosocial support" was mentioned 6 times in the editorial. However, it is surprising that "social media" was not mentioned at all ($N = 0$). With the COVID-19 pandemic, the consequences of confinement were clear from the start, with the restriction of socializing and maintaining of social distancing.[2] However, communication within families continued to take place in one form or another.[1] It has been quite annoying how public health officials have been using the term "social distancing" when they really mean "physical distancing" which was the term that Vigo et al. used. Social distance is a well-known concept in the Social Sciences and is a negative dimension of the stigma that adversely effects psychiatric patients. Indeed, social media could reduce social distancing while maintaining physical distancing.

Nowadays many mobile technologies have been used widely as people depend on their cellphones for daily communication.[2] Furthermore, use of technology peaked during pandemic with expansion of cell phone applications and communication technologies as an interface between friends and family. WhatsApp is an instant messaging application that its most used in contexts of virtual communication between family members and helps to check on each other well-being.[3] Online social and psychological support strategies may mitigate the stress.[4,5]

We are illustrating how social media such as WhatsApp can be used to promote and maintain social interactions during the social isolation associated with COVID measures and we are using how this was used in one family as an example. In parallel to the collection of quantitative data on the frequency of use of messages, an exploratory qualitative research started to understand the content of the exchanges and the perceptions of family members with regard to WhatsApp. Beginning of the year 2020, curfew/quarantine was applied in most countries. The family includes 31 members spread over four continents: Europe, Africa, North America, the Pacific, and the Middle East region. The age varied from 13 to 89 years old. During the pandemic, 10 people lived alone and the others were either couples or a family. All of them gave their consent to allow analysis of data; 58% were women. No one was COVID-19 positive. The measurement period was from February to June 2020. Additionally, data were collected over 3 years: 2020, 2019, and 2018 in order to be able to compare the year of the pandemic with previous years. In a second step, the messages were classified according to their semantic contents.

Maximum number of messages was produced during the 31 March (Paris, Kinshasa, New York, Montreal, Dubai). We pooled and calculated the mean of the 2 first years, and we compared it to 2020. The message numbers were multiplied by 5 in March 2020, and by 4 in April and May with a

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steep decrease end of May after the beginning of deconfinement. Messages related to humor were multiplied by 8. Medical science by 3 and music and art by 5. Sport and politics did not change. At the end of the period, a message survey confirmed that WhatsApp helped. This is an example of a selected group that could not be used to make inference about any definable population. However, a population of family groups using WhatsApp could be easily studied in the future. Discussing the psychological impact of social isolation is needed, since this is an unprecedented situation with almost no record of its consequences in recent history. Social media use is crucial to help in measuring social support and the impact on mental health.

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The Impact of Community Treatment Orders on Substitute Decision Makers

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Mots clés

assertive community treatment, ethics, adult psychiatry

The recent CPA position paper—"Community Treatment Orders and Other Forms of Mandatory Outpatient Treatment"—reviews mandatory outpatient treatment for patients with serious and persistent mental illnesses and advocates for their use in specific clinical and legal contexts.[1]

More than 75 jurisdictions worldwide (including 9 Canadian provinces, most of the United States, Australia, England, Wales, New Zealand, Scotland, Sweden, Denmark, Norway, Switzerland) have enacted Community Treatment Order (CTO) legislation.[2] Although the specific legal frameworks for CTO enactment across Canadian provinces are not identical, most generally build upon the criteria for involuntary inpatient hospitalization (e.g., the individual is likely to cause harm to themselves or others or experience serious deterioration or physical impairment).[3] For example, in Ontario, a CTO can be implemented if the individual has been a patient in a psychiatric setting 2 or more times, equating to a 30 day or longer stay within the past 3 years, or if a previous CTO has been in effect.

An additional requirement involves identifying a substitute decision maker (SDM) to assume treatment-making capacity for the individual named in the CTO. The SDM is decided upon by the physician's reference a preestablished hierarchy of choices from the Health Care Consent Act. SDMs are typically represented as a partner or spouse, close

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