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LETTER TO THE EDITOR

COVID-19 epidemic and public mental health care in Italy: ethical considerations

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We read with great interest the commentary by Mezzina and colleagues entitled "Mental health at the age of coronavirus: time for change" [1], specifically discussing the infection impact on mental health and on mental health services. This is a poorly considered topic in the current public debate on management of the COVID-19 pandemic, especially when examined together with the relevant changing of the most public outpatient activities in the Community Mental Health Centers (CMHCs) due to the epidemic.

As of June 6th, 234,801 confirmed cases and 33,846 deaths due to the COVID-19 infection make Italy one of the most affected countries in the world. Italian public mental health services are traditionally organized according to a community-based model of care, which provides a wide range of interventions from long-term rehabilitation to acute emergency treatment, distributed across outpatient and inpatient centers [2]. On 7th March 2020, the national authority for welfare ordered a block on all but urgent outpatient services (i.e. dialysis, chemiotherapy), while maintaining mental health-care activities. Although this confirmed that psychiatric services are considered as fundamental services to the community [3], Italian Departments of Mental Health (DMHs), agreed by the management of public local healthcare agencies, recommended (and still continue to recommend) closure of second-level outpatient programs (e.g. for eating disorders, early psychosis, autism spectrum disorders, severe learning disorders), suggesting to implement phone calls and video conference-based visits only for emergencies or specific urgent patient requests.

Considering how much COVID-19-induced social isolation and unplanned school closure (extended until next September in Italy) may affect mental health of children and adolescents (especially for more vulnerable subgroups, as those with pre-existing psychiatric problems or learning difficulties) [4], was this the only and most appropriate intervention that could be put in place for these young individuals? Are there adequate technological supports throughout Italy to set up remote work and home care? Or did this increase the national disparities between users of the most technological areas and users without such possibilities, the latter often living within families with a low socioeconomic status? In this social fragmentation, the area of marginalization/abandonment may be further extended, increasing up the risk of worsening mental disorders. Finally, if access to outpatient services was not facilitated (but often made difficult by the "material closing" of the doors), in the isolation of their room, without specialized rehabilitative interventions and dedicated case management, who could intercept their suffering? Could emergency phone calls or video conferences be enough (especially for young people with Severe Mental Illness [SMI])? Or is it another time delay of specific interventions that cannot be further delayed (specifically for young individuals with early psychopathology)? And what about families and caregivers? With what support have we decided to sustain them? By depriving them of rehabilitation time and replacing it with the Internet connection? In this perspective, mental health of children and adolescents even more impacts the risk of loneliness, in addiction with academic achievement gaps.

All that was done was patching up urgent patient requests. Nothing was structured in the direction of preventing psychopathological relapses. Italian DMHs (similarly to the school service) decided to stop/postpone their activities

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rather than to ask themselves what really could be done for the patient, safely and proactively. They decided not to play the game. Was an alternative choice possible and practicable? As De Gregori [5] wrote: "a player: you distinguish him for courage, altruism and creativity".

Therefore, we strongly suggest that Italian medical, educational and institutional authorities should implement as soon as possible strategic plans for a progressive re-start of mental health outpatient activities and routine therapeutic-rehabilitation interventions (as well as a re-start of school/educational services), especially for more vulnerable subgroups (e.g. young people with SMI, early severe psychopathology and learning difficulties), so as not to further defer the no longer deferred.

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Compliance with ethical standards

Conflict of interest The authors declare to have no conflict of interest and no competing interests.

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