Review
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COVID-19 Impact on the Italian Community-based System of Mental Health Care: Reflections and Lessons Learned for the Future

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Despite the unprecedented wave of research and publications sparked by the recent pandemic, only few studies have investigated the impact of COVID-19 on the Italian community-based system of mental health care. We aimed to summarize the available evidence from the literature also considering what we have learned from our daily clinical practice. As hospital care was restricted by COVID-19, although reducing their opening hours and activities, Community Mental Health Centers promoted continuity of care for at-risk populations, supporting them to cope with loneliness and hopelessness during quarantine and self-isolation. Ensuring continuity of care also remotely, via teleconsultation, lowered the risk of psychopathological decompensation and consequent need of hospitalization for mental health patients, with satisfaction expressed both by patients and mental health workers. Considering what we have learned from the pandemic, the organization and the activity of the Italian community-based system of mental health care would need to be implemented through 1) the promotion of a "territorial epidemiology" that makes mental health needs visible in terms of health care workers involved, 2) the increase of mental health resources in line with the other European high-income countries, 3) the formalization of structured initiatives of primary care and mental health cooperation, 4) the creation of youth mental health services following a multidimensional and multidisciplinary approach and encouraging family participation, 5) the promotion of day centers, to build competence and self-identity within a more participatory life, and programs geared to employment as valid models of recovery-oriented rehabilitation.

KEY WORDS: COVID-19; Community psychiatry; Italy.

INTRODUCTION

Italy was the first country to be hit by the 2019 coronavirus disease (COVID-19) in Europe. Italy was also the first country to impose on 9th March 2020 a nation-wide stay-at-home order, as an attempt to stop the coronavirus spread [1]. The Italian COVID-19 pandemic lockdown lasted for almost three months, until the 3rd of May, and confined over 60 million people inside their homes.

The regional structure of the Italian national health care service caused diverse regional responses to the emergency [2]. At the beginning of the pandemic, the emergence of many cases concentrated within a short period of time stretched hospitals to capacity. With particular regard to some regions, high pressure on hospital services have been also negatively affected by the insufficient support and poor integration with primary and community care services [3].

Social distancing and confinement measures promoted pervasive feelings of loneliness, hopelessness, despair in the general population, and led to marginalization and segregation [4]. Even during the post-lockdown pandemic

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phase, increased levels of stress and worry concerning personal health and economic consequences, combined with a reduction in alternative positive activities, impacted on people's lifestyle habits with particular regard to vulnerable subgroups [5,6].

Data from a cross-sectional study that we conducted on a representative sample of Italian adults reported that the national-level prevalence of depressive and anxiety symptoms doubled, getting to affect more than one third of the general population and the use of at least one psychotropic drug—mostly anxiolytics/benzodiazepines—increased by 20%. Feelings of hopelessness were more common among women and increased with increasing age [7].

Since 1978 (Law 180/1978), the Italian mental health care organization underwent a radical change, moving from a hospital-based to a community-based system of mental health care. Asylums, as "place of segregation and destruction where the real nature of social problems was concealed behind the alibi of psychiatric treatment and custody" [8], were abolished, psychiatric wards were developed in general hospitals, and a network of regional Mental Health Departments and corresponding Community Mental Health Centers (CMHC) was created. CMHC are based on the philosophy "that a patient should remain with his family and his community to the maximum extent possible in order to avoid alienation and de-habilitation, such as had occurred in state hospitals" [9]. These centers provide essential mental health care and individuals are supported in accessing social opportunities and in pursuing individualized rehabilitative plans, supported by a health budget approach.

According to the latest Mental Health Report issued by the Ministry of Health, Italy has a total of 134 Mental Health Departments with 1299 CMHC, 2760 residential care facilities and 328 psychiatric wards in general hospitals [10]. In line with regional regulations, CMCH are spread throughout the country and are generally open 5–7 days a week, 12 hours per day, with only few units remaining open 24/7.

Compared to hospital services that drastically decreased their activity, during COVID-19 Lockdown CMHC continued to operate offering continuity care and reducing emergency department pressure [11]. Services have been maintained for patients with clinically severe illness focusing on clinical monitoring and drug administration, while home interventions were only provided in urgent situations. From summer 2020, the majority of clinical and rehabilitation activities offered by CMHC gradually restarted at pre-COVID-19 levels, including the closed collaboration with third sector and user and family associations [12].

Despite the unprecedented wave of research and publications sparked by the recent pandemic [13], only few studies have investigated the impact of COVID-19 on the Italian community-based system of mental health care, both during the lockdown and post-lockdown pandemic phase. We aimed to summarize the available evidence from the literature trying to understand the importance and the need of a national mental health care system based on a community model considering what we have learned from this pandemic.

COVID-19 IMPACT ON CMHC

Five studies investigated COVID-19 impact on CMHC organization and activities (Table 1) [14-18].

During the COVID-19 lockdown (April 2020), an online survey was promoted by the Italian Society of Psychiatry to assess the pandemic impact on the activities of the Italian Mental Health Departments [14]. More than 50% of the Mental Health Departments returned completed questionnaires. Twenty-five percent of CMHC have reduced opening hours while 13% have been closed. A noticeable decrease (approx. −80%) has been registered in day hospitals' activity, semi-residential facilities within Mental Health Departments largely involved in clinical monitoring and treatment of subacute cases. An even greater reduction (approx. −85%) has been observed in the number of day centres, semi-residential facilities focusing on psycho-social and rehabilitation activities. Only residential care facilities, deputed to middle-long term rehabilitation, have remained almost fully operational, although with restrictions in new admissions and discharges. Almost all Mental Health Departments have set up remote mobile counselling activity both for general population and healthcare workers. Video calls have been adopted in more than two-thirds of patients while home interventions were only provided in urgent situations.

Data collected in Friuli Venezia Giulia Region, Northeast of Italy, during the first four months of 2020, confirmed that Mental Health Departments generally com-

Table 1. Studies that met inclusion criteria for narrative review

References	Results
COVID-19 impact on CMHC	
Carpiniello *et al.* 2020 [14]	25% of CMHC have reduced opening hours while 13% have been closed. Approx. −80% has been registered in day hospitals' activity, semi-residential facilities while, approx. −85% has been observed in the number of day centres. Only residential care facilities, deputed to middle-long term rehabilitation, have remained almost fully operational, although with restrictions in new admissions and discharges. Almost all MHDhave set up remote mobile counselling activity both for general population and healthcare workers. Video calls have been adopted in more than two-thirds of patients while home interventions were only provided in urgent situations.
Castelpietra *et al.* 2021 [15]	MHD generally complied with the indicators reported in the COVID-19 national operative recommendations reorganizing outpatient activities and home interventions. An increased use of telepsychiatry was registered in all regional MHD and group rehabilitations activities were promoted using remote devices.
Carnevali *et al.* 2020 [16]	A group of young patients included in a study conducted in a MHD of Milan, Lombardy region, North of Italy,felt supported by the remote psychological and rehabilitative early intervention program, both by video call individual interventions and remote group activities. The majority of respondents appreciated remote services and they would have liked to keep some activities even when emergency was over.
Mazziotti and Rutigliano 2021 [17]	Respondents held skeptical views about tele-mental health and did not feel sufficiently trained and satisfied.
Trabucco *et al.* 2021 [18]	A general degree of satisfaction was expressed by the majority of the mental health providers working in Liguria Region CMHC, Northwest of Italy, interviewed during the post-lockdown pandemic phase.
COVID-19 impact on CMHC patients	
Porcellana *et al.* 2020 [19]	A considerable proportion of participants reported symptoms of distress measured by the IES-R (34% mild, 32% moderate and 26% severe). The total score of the SRQ-20 was positive in almost 60% of outpatients, particularly in the female population. Anassociation between higher scores on SRQ-20 and diagnosis of affective and personality illness was also found.
Burrai *et al.* 2020 [20]	Patients living in residential care facilities scored lower on stress compared to healthy controls and higher on anxiety, perceived risk of getting infected by COVID-19 and worry about the emergency situation. Residents of psychiatric rehabilitation communities, compared to non-residential psychiatric patients who were forced to reduce their access to mental health care services, experienced greater support from mental health workers and peers, maintaining their typical levels of care.
COVID-19 impact on CMHC workers	
Magliano *et al.* 2022 [21]	More than 90% of respondents increased telephone contact with users. Around 70% of mental health professionals reported that pharmacological treatment plans were revised by CMHC staff according to new needs of care and almost 80% stated that they had been able to mediate between user needs and safe working procedures. The majority of the participants declared that they had gained strength among colleagues to face fear and they had discovered unexpected personal resources in users. Overall, 60% of participants stated that they found some positives in the COVID-19 experience.

COVID-19, 2019 coronavirus disease; CMHC, Community Mental Health Centers; MHD, Mental Health Departments; IES-R, Impact of Event-Scale Revised; SRQ-20, Self-report questionnaire.

plied with the indicators reported in the COVID-19 national operative recommendations reorganizing outpatient activities and home interventions [15]. An increased use of telepsychiatry was registered in all regional Mental Health Departments and group re-habilitations activities were promoted using remote devices.

In line with that, an interesting study was conducted in a Mental Health Department of Milan, Lombardy region, North of Italy, on a group of young patients joining an early intervention program [16]. They felt supported by the remote psychological and rehabilitative early intervention program, both by video call individual interventions and remote group activities. The majority of respondents appreciated remote services and they would have liked to keep some activities even when emergency was over.

COVID-19 pandemic creates an opportunity to overcome normative, technological, and cultural barriers to the use of online psychotherapy, showing the importance of adapting the therapeutic setting to both collective and individual needs. Despite initial concerns about its effectiveness and efficacy [17], a general degree of satisfaction was expressed by the majority of the mental health providers working in Liguria Region CMHC, Northwest of Italy, interviewed during the post-lockdown pandemic phase [18].

COVID-19 IMPACT ON CMHC PATIENTS

Two studies investigated the traumatic impact of COVID-19 lockdown in CMHC outpatients and in patients of residential care facilities, respectively (Table 1) [19,20].

With regard to the first study, a consecutive sample of CMHC patients was enrolled in Milan, Lombardy Region, the Italian region hit the hardest by the pandemic, to evaluate the relationship between COVID-19 emergency and clinical correlates [19]. A considerable proportion of participants reported symptoms of distress measured by the Impact of Event-Scale Revised (IES-R) (34% mild, 32% moderate and 26% severe). The total score of the Self-report questionnaire (SRQ-20), developed to investigate the general mental health state, was positive in almost 60% of outpatients, particularly in the female population, suggesting differences in coping strategies and response to stress, with an age between 45−65 years, mainly employed subjects forced to completely change their lifestyles. An association between higher scores on SRQ-20 and diagnosis of affective and personality illness was also found.

With regard to the second study, patients living in two residential care facilities located in Lazio Region, Central Italy, were enrolled and compared to healthy control subjects [20]. Psychiatric patients scored lower on stress compared to healthy controls and higher on anxiety, perceived risk of getting infected by COVID-19 and worry about the emergency situation. Residents of psychiatric rehabilitation communities, compared to non-residential psychiatric patients who were forced to reduce their access to mental health care services, experienced greater support from mental health workers and peers, maintaining their typical levels of care. This might explain lower score on stress subscale of the Depression, Anxiety and Stress-21 items (DASS-21). On the other hand, being forced to spend long hours together, residents of psychiatric rehabilitation communities were more likely to report feelings of apprehension, fear of infection transmission during close contacts and anxiety.

COVID-19 IMPACT ON CMHC WORKERS

Only one study investigated mental health professionals' view around positive changes in service organization and staff-user relationships during post-lockdown pandemic phase (Table 1) [21]. The online survey was conducted in the Mental Health Department of Trieste, north of Italy, listed by the World Health Organization as one of the most innovative and well-established community mental health system, and data were collected from February 15 to March 31, 2021. CMHC are open 24 hours a day, 7 days a week and cover most care needs including crisis management, mental illness prevention, pharmacological and rehabilitative interventions, and collaborate with many social cooperatives promoting recovery, social inclusion, and employment programs.

Results from the study revealed that more than 90% of respondents increased telephone contact with users providing them information about standard precautions for infection control. Around 70% of mental health professionals enrolled reported that pharmacological treatment plans were revised by CMHC staff according to new needs of care and almost 80% stated that they had been able to mediate between user needs and safe working procedures. Moreover, the majority of the participants declared that they had gained strength among colleagues to face fear and they had discovered unexpected personal resources in users. Overall, 60% of participants stated that they found some positives in the COVID-19 experience.

DISCUSSION

As hospital care was restricted by COVID-19, although reducing their opening hours and activities, CMHC promoted continuity of care for at-risk populations, supporting them to cope with loneliness and hopelessness during quarantine and self-isolation. As reported by our results, ensuring continuity of care also remotely, via teleconsultation, lowered the risk of psychopathological decompensation and consequent need of hospitalization for mental health patients, with satisfaction expressed both by patients and mental health workers [22].

Although only few studies have investigated the impact of COVID-19 on the Italian community-based system of mental health care, given the available scientific evidence and what we have learned from the daily clinical practice, some observations can be made.

The current pandemic confirmed the need of a national permanent mental health epidemiological observatory 1) to describe the mental health status of population estimating prevalence and incident rates and identifying risk factors by age group, 2) to predict groups of people at high

risk and 3) to control the distribution of disease, planning and testing early interventions to prevent and treat mental illness, giving information that health care providers need to allocate resources. More important, in a community-based system of mental health care a "territorial epidemiology" that makes mental health needs visible in terms of health care workers involved (general practitioners, social workers, psychiatric rehabilitation therapists, psychiatrics, psychologists) would be essential to promote the continuity of care outlined by the Law 180/1978 [23]. National statistics describing regional health care systems are not always based on shared operational definitions, they do not lead to common interpretation and do not capture the type and the quality of care provided by Italian mental health facilities. To date, the only nationwide study aimed to investigate the prevalence and socio-demographic correlates of common mental illness in Italy together with levels of disability, quality of life, the use of services and psychotropic medications, was conducted more than twenty years ago [24]. Solid evidence on the prevalence and impact of mental illness in representative samples of Italian adults and adolescents during post-pandemic time are therefore needed.

COVID-19 outbreak highlighted the lack of mental health resources. In 2009, while most European high-income countries spent around 10% of their budget for mental health, Italy spent about half that [25]. Afterwards, the percentage of total mental health expenditure in Italy had fallen to 3.5% (2015) and to 2.75% (2020) of the total health budget with a decrease of the amount of human staff capital in the public mental health service [26]. In an era characterized by a greater psychosocial vulnerability (e.g. early adolescent substance use, second-generation migrants) and the availability of evidence based costly therapeutic interventions (e.g. psychotherapies in personality disorders), this lack of resources hinders the continuity of mental health care and early interventions to at-risk individuals. The National Recovery and Resilience Plan (PNRR) presented by the Italian Government at the end of 2021, part of the Next Generation EU programme, namely the € 750 billion package that the European Union negotiated in response to the pandemic crisis, is developed around three strategic axes, 1) digitisation and innovation, 2) ecological transition, and 3) social inclusion, and six specific missions. Mission 5, "Inclusion and Cohesion", seeks to enhance employment opportunities, as well as social and territorial cohesion [27]. Its measures are designed to foster social inclusion and provide more support for people who are vulnerable, non-self-sufficient or live with disabilities. Mental health care, as part of PNRR Mission 5, needs to be recognized as a real public health priority pursuing the main goal of the Law 180/1978, namely that individuals with mental illness are treated the same way as individuals with other illness.

General practitioners (GPs) played a key role in the fight against the COVID-19 outbreak, helping block the viral transmission by monitoring subjects, reduce the increase of cases by treating patients and providing medical surveillance, and take care of the clinical and psychological well-being of patients [28]. As gatekeepers to secondary care, GPs play a central role as well in the process of care-seeking for people with mental illness. In Anglo-Saxon countries the Community mental health team, the Attached mental health professional and Consultation-liaison, were some of the models of joint working between GPs and mental health professionals mainly used [29]. In Italy, since the end of 1990s, the awareness of the importance of integration between primary care and mental health slowly grew and collaborative programmes were finally developed. The "G. Leggieri" Program started in 2000 in the Emilia- Romagna Region, northern of Italy, as an attempt to coordinate initiatives of primary care and mental health cooperation undertaken since 1980s, providing treatment of milder cases of common mental illness in primary care setting, while permitting CMHC to focus on more demanding cases [30]. This integrated stepped-care model makes easier the access of patients to mental health service, helps health care professionals to keep track of the patient's path, and enable GPs to actively cooperate with CMHC and work toward prompt back referral to primary care. As well described by the "G. Leggieri" Program, within a community-based system of mental health care, supporting management of common mental illness in primary care focusing CMHC activities towards severe patients, is needed to improve the quality of treatment personalizing the pathways of care.

From March 2020, rapid and severe public policies have been adopted to restrict population movements in order to help curb the epidemic, bringing on far-reaching consequences for children and adolescents. As reported by the literature, prolonged social isolation is a potential widespread risk factor to precipitate psychopatology, with

particular regard to anxiety and depressive symptoms [31]. In Italy, child and adolescent mental health services (CAMHS) are mainly organized to address childhood neurodevelopmental illness, such as language and learning disorders, together with autism, intellectual disability and attention deficit hyperactivity disorder, while CMHC focus on adult mental health (> 18 years). Although the critical 12−25 age range presents the highest incidence and prevalence of mental illness across the life spam and all the experts agree that early identification is the keystone to positively modified the natural course of vulnerabilities [32], both CAMHS and CMHC do not provide adequate responses. Therefore, youth mental health services able to bridge the current gap between CAMHS and CMHC following a multidimensional and multidisciplinary approach and encouraging family participation are urgently needed [33].

Equally important, psychiatric treatment and rehabilitation are separate complementary components of mental health care. From the one hand, no relevant pharmacological progress has been made in psychiatry since 1960s, from the other hand community residential facilities often provide inpatient care and long-stay residential services rather than focusing on rehabilitation [25]. As reported by the literature, day centers offer alternatives to individuals who are unable to maintain employment, providing social opportunities and creating intrinsic motivation to sustain and facilitate occupational engagement and to build competence and self-identity within a more participatory life, also giving relief to the patients' own families [34]. In parallel, a large segment of mental health patients wishes to work and consider working as the hallmark of recovery. Despite a wide diversification at the Italian regional level, sheltered workshops, training placements, individual placement and support, legislative quota system and temporary grants with public/private employers and social enterprises, are some of the available tools to CMHC to support employment programs. Despite the not-negligible economic impact of COVID-19 pandemic, as confirmed by the positive results obtained in recent regional experiences [35], programs geared to employment represent valid rehabilitation service models towards a recovery-oriented rehabilitation of mental health patients that must find space on the PNRR agenda.

CONCLUSIONS

The community-based system of mental health care developed in Italy since 1978 has withstood the COVID-19 impact promoting continuity of care and lowering the risk of psychopathological decompensation in mental health patients. Considering what we have learned from the pandemic, the organization and the activity of the Italian mental health care would need to be implemented through 1) the promotion of a "territorial epidemiology" that makes mental health needs visible in terms of health care workers involved; 2) the increase of mental health resources in line with European high-income countries; 3) the formalization of structured initiatives of primary care and mental health cooperation, providing treatment of milder cases of common mental illness in primary care setting, while permitting CMHC to focus on more demanding cases; 4) the creation of youth mental health services able to bridge the current gap between CAMHS and CMHC following a multidimensional and multidisciplinary approach and encouraging family participation; 5) the promotion of day centers, to build competence and self-identity within a more participatory life, and programs geared to employment as valid models of recovery-oriented rehabilitation.

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■ **Conflicts of Interest**

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