

Mental Health in the Coronavirus Disease 2019 Emergency

The Italian Response

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IMPORTANCE This article briefly reports the experience of mental health services and the lessons learned during the coronavirus disease 2019 crisis. In particular, this report offers opportunities to build on experience gained in managing the coronavirus disease 2019 emergency in the Departments of Mental Health and Addiction (DMHAs) in Lombardy, the wealthiest Italian region, which has around 10 million inhabitants.

OBSERVATIONS Many challenges have occurred in the management of health services. In many hospitals, entire wards, including some psychiatric wards, have been reorganized to admit patients with coronavirus disease 2019, and many physicians and nurses have been diverted to wards managing patients with coronavirus disease 2019. Most day facilities for patients with psychiatric needs have been temporarily closed, whereas in residential facilities, patients who usually are free to come and go during the day have had to be confined in the facilities with very limited or no leave. These changes have produced considerable stresses on people with severe mental disorders. Many outpatient clinics have limited appointments to those with the most urgent cases, and home visits, a common practice in most DMHAs, have been drastically reduced with potentially detrimental consequences for patients' well-being. Another potential detrimental consequence of being forced stay at home has been an increase in the hours spent face to face with families with high amounts of conflict.

CONCLUSIONS AND RELEVANCE Departments of Mental Health need to be equipped with appropriate e-health technologies and procedures to cope with situations such as this. Additionally, there needs to be a rollout of interventions to mitigate the potentially harmful consequences of quarantine. Departments of Mental Health should be able to assume a leadership position in the psychosocial management of disasterlike situations, and this requires the acquisition of new skills, notably how to correctly inform the population about risk, train and disseminate effective preventive and management procedures for disasters, support health personnel and rescuers, and support those experiencing bereavement.

JAMA Psychiatry. 2020;77(10):1-3. doi:10.1001/jamapsychiatry.2020.1276
Published online April 28, 2020.

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Acceptance Date: April 1, 2020.

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The first Italian patient, a man aged 38 years, tested positive for coronavirus disease 2019 (COVID-19) on February 21, 2020.¹ Within a month, Italy, with a population of more than 60 million, had become the second country after China in the number of patients with COVID-19 and passed China in terms of reported deaths. By April 16, 2020, 159 107 people in Italy were known to have contracted the infection, of whom 19 996 had died.²

Our aim is to briefly report the experience of mental health services and the lessons learned during this crisis. In particular, we will build on our experience gained in managing the COVID-19 emergency in the Departments of Mental Health (DMHAs) in Lombardy, the wealthiest Italian region, with around 10 million inhabitants, which also had the largest number of COVID-19 cases in Italy, with 63 098 confirmed cases as of April 16, 2020.² Seven contributing authors (G.C., M.C., E.M., F. Spinogatti, F. Starace, G.T., and A.V.) lead DMHAs in the areas with the highest number of cases.

Italian Mental Health Services

Italy has a National Mental Health System divided into 134 DMHAs, 27 of which are in Lombardy. In 2017, the DMHAs provided care for 851 189 Italians.³ Mental health care is available to all, and most of the cost is covered by the National Mental Health System budget. In Italy, nearly 2400 residential facilities (RFs) with a mean of 13 beds have completely replaced former mental hospitals for long-term care, and they house 26 310 patients requiring long-term care. There are also 318 general hospital psychiatric wards (GHPWs) of similar size, with a total of 3981 beds, and there are also 22 accredited private hospitals, with a total of 1155 beds, covered by the National Mental Health System. This gives a total of around 10 acute beds per 100 000 adult population, as well as many day facilities, which are generally attached to community mental health centers.

COVID-19 and Management of Mental Health Services in Lombardy

In the 4 weeks after the epidemic started, important changes occurred in the management of DMHAs in Lombardy. In most hospitals, entire wards, including some GHPWs, have been reorganized to admit patients with COVID-19. In scenes reminiscent of a wartime emergency, many physicians and nurses, including in some cases those working in GHPWs, have been diverted to wards managing patients with COVID-19. Some managers of GHPWs have resisted change out of concern for the psychiatric care of their patients. Patients with psychiatric needs are also among those infected by the virus, and the need to adopt safe practices and isolate patients hospitalized in psychiatric wards in single rooms for 2 weeks if they contracted COVID-19 has proved particularly difficult.

However, the main organizational challenges have occurred in day facilities and RFs. Most day facilities have been temporarily closed, whereas in RFs, patients who had been free to come and go during the day have had to be confined in the facilities with very limited or no leave. These changes have produced considerable stresses on people with disabling mental illness. Many patients who were used to spending several hours a day in a day center have been forced to stay at home for days with few opportunities for interpersonal contact, while residents of RFs were suddenly forced to experience confinement more typical of an acute psychiatric ward. Other changes have affected many outpatient clinics, with national and regional rules limiting appointments to patients with the most urgent cases. Home visits, a common practice in most DMHAs, have been drastically reduced, with potentially detrimental consequences for patients' well-being. Another potential detrimental consequence of being forced stay at home has been an increase in the number of hours spent in face-to-face contact with relatives, in families with high levels of expressed emotion. Similar developments may be expected in other countries with predominantly community-based mental health services if the course of the pandemic in those countries follows the experience of Italy.

Infections and Deaths Among Health Personnel

The COVID-19 epidemic has caused a big toll among health personnel in Italy: as of April 16, 2020, 16 991 health personnel have been infected, and 127 physicians caring for patients with COVID-19 have died.² The number of health staff infected is twice as high as in China.⁴ The reasons for this very high proportion of health personnel infected are unclear and will need a proper, accurate investigation. Generally speaking, many personnel has been highly distressed by this unforeseen and complex situation, which has also been reported in a recent survey in China.⁴

Behavioral Changes in the Public

The sudden, massive restrictions caused by the epidemic have resulted in changes in the behavior of every resident that a month ago might have been considered the stuff of fiction. On the whole, Italians have rapidly adapted to the emergency measures, and compliance with restrictions to personal freedom and recommended changes in habits and schedules has been high (certainly higher than expected). According to official data,⁵ in the 10 days after the initiation of restrictions on March 11, 2020, there were 1 650 644 police assessments of people walking or driving, with 95.7% found to be compliant by showing there were compelling reasons to leave

Key Points

Question What are the psychiatric consequences of the coronavirus disease 2019 epidemic in Italy?

Findings This article reports the psychiatric outcomes of the coronavirus disease 2019 epidemic to date in Italy among patients with mental disorders and the general population.

Meaning A preparedness plan for mental health in possible new outbreaks should be developed.

their homes. We do not know whether the rate of violations among people with mental disorders in treatment has been higher or lower, which will be an area worth exploring in the near future; there are no similar data available from other countries in lockdown for a comparison of compliance with restrictive measures.

Populations at Risk

An unforeseen, disastrous consequence of the COVID-19 epidemic has been violent, destructive riots in 20 Italian jails involving as many as 6000 prisoners and resulting in the deaths of 12 prisoners (by overdose with drugs stolen from prison pharmacies) and injuries to 40 officers.⁶ The management of epidemics in high-security settings, such as prisons and detention centers, in which isolation of the affected population and adoption of other infection control measures require careful planning and are not easy to implement, will need special reflections, especially if many of those infected are security and health staff.

Addiction services are also affected, and in many areas, patients in methadone treatment have been given more than 1 dose at a time because of restrictions of movement, which may increase the risk of overdoses. We do not know the outcome of the restrictions on rates and patterns of substance use. Health care workers treating children and adolescents with attention-deficit/hyperactivity disorder or intellectual disabilities also report increasing problems among parents forced to manage these young individuals at home for extended periods, and the extent of any change in the rate of family violence has yet to be assessed.

Sadly, there is likely to be a new area of clinical activity: providing services for those bereaved because of COVID-19. As things stand, the isolation measures have meant that the relatives of many patients who have died have not been able to visit their deceased relatives during hospitalization or organize funerals because of the strong restriction on public gatherings of any kind.

Lessons for the Future

What are the main lessons for mental health services that can be learned from this unforeseen situation? The first lesson is that DMHAs need to be equipped with appropriate e-health technologies and procedures to cope with situations such as this one. For instance, DMHAs need to be able to manage online consultations, either by videolink or messaging service, for patients who are used to face-to-face consultations. Those online consultations will need to include arrangements for changes to medications, communication with people supporting patients living alone at home and those suddenly exposed to marked isolation, and counseling for patients living in households with high levels of conflict. The same applies to support to families who have children with attention-deficit/hyperactivity disorder.

der or intellectual disabilities. Means for e-mental health have been rapidly made available by DMHAs in some areas, but preparations need to be made for e-mental health to be implemented everywhere.

Connected to this, there needs to be a rollout of interventions to mitigate the potentially harmful consequences of quarantine.⁷ This is an area where self-help groups may play a pivotal role. It will be worth investigating whether in the next months we will record an increase in new contacts with DMHAs.

Another lesson is that DMHAs should be able to assume a leadership position in the psychosocial management of disasterlike situations; in Italy, very few if any DMHAs are equipped in terms of skills, knowledge, and training to intervene in natural or other disasters. This requires the acquisition of new skills. First is how to correctly inform the population about risk. While a shortage of information can be detrimental, we have faced an information overload about the epidemic and the consequences of this must be evaluated, even in terms of secondary traumatization and increase in posttraumatic stress disorder and stress reactions. Information overload has been characterized by contradictory information from national, regional, and local authorities; scientists with different backgrounds; and mass media, which presumably leads many people to fear the worst. Second, it is important to acquire skills in training and disseminating effective preventive and management procedures for disasters, including discouraging use of procedures of established ineffectiveness (eg, debriefing survivors of a disaster,^{8,9} which is often described as helpful in the media in Italy). Third, skills in supporting health personnel and rescuers, who are often highly distressed, is important. In some areas, DMHAs have done this, but again, effective strategies should be selected and disseminated. Finally, it is important to gain skills in supporting those who are bereaved.

Additionally, DMHAs should prepare plans for rapid reorganizations of inpatient stays and daily schedules in RFs in emergencies. Patients in these centers may be particularly distressed at the sudden introduction of restrictive measures.

Research Priorities

Although past epidemics, such as severe acute respiratory syndrome, Ebola virus disease, and Middle East respiratory syndrome, should have given us some understanding of how to respond, the speed and scale of this pandemic has taken the world by surprise, with differing responses in different countries adding to a sense of uncertainty and stress. Being able to measure respondents' stress levels and psychosocial adjustment is essential to both plan for the necessary psychosocial support during the recovery phase and prepare ourselves should this happen again. Therefore, learning from research findings will be essential.

It is possible to identify 7 population subgroups affected by the psychosocial consequences of the COVID-19 epidemic: (1) the general population affected by restrictive measures, (2) people subjected to quarantine because of contact with an individual with an infection, who themselves were not positive, (3) people positive for the virus who did not need hospital treatment and were isolated at home, (4) people positive for COVID-19 who were hospitalized and have recovered, (5) health care personnel coordinating or providing care during the pandemic, (6) relatives of persons who died, and (7) patients in treatment for mental disorders. It is important to understand the immediate and long-term outcome of COVID-19 pandemic in these 7 different groups, including stigma for those infected, to tailor support services to meet their unique needs. If we will do this, future emergencies will find us better prepared to cope.

ARTICLE INFORMATION

Published Online: April 28, 2020.

doi:10.1001/jamapsychiatry.2020.1276

Author Contributions: Drs Girolamo and Clerici had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Concept and design: All authors.

Acquisition, analysis, or interpretation of data: de Girolamo, Clerici, Starace, Tura.

Drafting of the manuscript: de Girolamo, Cerveri, Clerici, Spinogatti, Starace, Tura.

Critical revision of the manuscript for important intellectual content: Cerveri, Clerici, Monzani, Tura, Vita.

Statistical analysis: Tura.

Obtained funding: Tura.

Administrative, technical, or material support: de Girolamo, Starace, Tura.

Supervision: de Girolamo, Clerici, Tura, Vita.

Conflict of Interest Disclosures: None reported.

Additional Contributions: Matthew Large, MBBS, DMedSci, School of Psychiatry, University of New South Wales, and Prince of Wales Hospital Sydney, and Olav Nielssen, MBBS, MCRim, PhD, Faculty of Medicine and Health Sciences, Macquarie University, St Vincents Mental Health, provided valuable comments on the manuscript, uncompensated.

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