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Public mental health outpatient service at the time of the COVID-19 pandemic: did we have any other choice?

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As of May 28, 33 072 deaths and 231 139 confirmed cases due to the COVID-19 epidemic make Italy one of the most affected countries in the world. 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. This has confirmed that mental health care services are considered as fundamental services to the community [1]. However, Italian Departments of Mental Health (DMHs), agreed by the management of local public health care services, recommended 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 [2].

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 low socioeconomic status and pre-existing severe psychiatric problems or learning difficulties) [3,4], was this the only most appropriate intervention that could be put in place for these young individuals? Were we sure that there were adequate technological supports throughout Italy to set up remote work and home care? Or could 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 severe mental disorders.

Additionally, several Italian psychiatrists (still in official speeches of prestigious scientific societies) asserted that during the pandemic, "psychiatric patients largely understood the need for social distancing, collaborated on it and did not cause problems". Are we sure this was not a deafening silence, especially for children and adolescents with Severe Mental Illness (SMI)? If access to outpatient services was not facilitated (but was often made difficult by the "material closing" of the doors), in the isolation of their rooms, without dedicated case management and specialized rehabilitative interventions, who could really intercept their suffering? Could emergency phone calls or video conferences be enough? Or perhaps it was another time delay of specific interventions that could not be further delayed (in particular, for young people with severe 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, together with unplanned school closure, mental health of adolescents and children

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impacts the risk of loneliness, symptoms' recurrence and academic achievement gaps [4], in a prevention total absence.

Italian DMHs also recommended the closure of day services and suggested that general psychiatric outpatient centers should be restricted to urgent visits (maintaining the centrality of the consultation with General Practitioners, especially by a phone triage and dedicated times) and to subjects who require daily administration of drugs or long-acting antipsychotics [2]. At the same time, they strongly advised home visits, when possible and safely. If the risk of infection had to be managed with caution in outpatient services, with what resourcefulness (and purposeful mood) did mental health professionals go to the patients' home, perhaps with poorly adequate protective devices? And how intense and effective were these interventions? All that was done, was patching up urgent patient requests, forgetting the crisis prevention. Italian CMHCs have decided to stop/postpone their activities rather than to ask themselves what really could be done for the patient, safely and proactively (especially for those individuals with SMI and the young ones with early severe psychopathology). As in public educational services, it was preferred to block that to seek a possible and feasible proactivity [5]. It was decided not to play the game. Did we have another choice? As De Gregori [6] wrote: "the player: you recognize him for courage, altruism and imagination".

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, especially for more vulnerable subgroups (as young people with SMI, early severe psychopathology and learning difficulties), so as not to further defer the no longer deferred.

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