support from the law-enforcement agencies to facilitate the movement of these patients to the treatment centers. Moreover, treatment-seeking will remain low despite the lifting of restrictions unless the safety concerns of this group are addressed adequately.

In a binary logistic regression model, number of days since last use of alcohol (odds ratio, 0.90 [95% confidence interval, 0.84–0.97], $P = 0.007$) was the only variable independently associated (inverse association) with attempt to seek alcohol during the lockdown period.

There is a need to address barriers to help-seeking going ahead as we continue to deal with COVID-19 in the coming months. A contingency plan should be put in place to ensure continuity of care for persons with alcohol use disorder in such extraordinary situations.

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E-mental health options in the COVID-19 pandemic and beyond

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According to the United Nations, there is a high risk that the COVID-19 crisis will evolve into a mental health crisis if no immediate action is taken.[1] Potential causes of psychological distress during the pandemic are many, including fear of infection and consequences of physical and social distancing (e.g., loneliness) or economic turmoil (e.g., job loss). The United Nations recommends the widespread availability and use of mental health care and psychosocial support as a means to minimize the psychological consequences of the COVID-19 crisis.[1] However, mental health care is often underfunded and structurally poorly prepared for the challenges ahead. Currently, there are also unique challenges to contact-based mental health services, such as risk of infection (or fear thereof) in inpatient settings or in community initiatives (e.g., self-help groups). Thus, the transmissibility of COVID-19 via direct contact hinders many forms of traditional treatment options in mental health care.

To date, there is common agreement that e-mental health provides valuable options for mental health care during the pandemic.[1–4] E-mental health encompasses the use of digital technologies to deliver, support, or enhance mental health services.[5] For example, during the pandemic in China, e-mental health options (e.g., online psychological counseling, online mental health education, and online psychological self-help interventions) were widely used.[2] In Germany, reimbursement possibilities for recently deregulated video consultations have been expanded in response to the COVID-19 outbreak. Thus, the pandemic may accelerate regulatory processes required for e-mental health services. As a quick emergency response, governments worldwide should expand the legal frameworks required for the application and reimbursement of e-mental health options.

The COVID-19 crisis does not only lead to short-term psychological difficulties, but negative long-term mental health consequences are also expected.[1] In light of the growing demand and expected economic turmoil, which may limit resources, sustainable, innovative, and cost-effective solutions in mental health care are needed in the long term. The current crisis provides an opportunity to align mental health-care policies with the current state of knowledge regarding the effectiveness of e-mental health options.[6] National health policy-makers should further accelerate e-mental health options. To meet this aim, sustainable policy measures are needed that include adequate funding and reimbursement strategies, but also high standards of usability and rigorous quality control for e-mental health products. Importantly, not all available e-mental health options must necessarily be implemented or reimbursed. For example, thus far, the evidence for the effectiveness of standalone apps in mental health care is rather limited.[7] Adequately funded research is needed to assess how the applicability and effectiveness of e-mental health options in routine practice and future crises can be further improved, taking into account users' perspectives.[8,9] Many mental health professionals are gaining firsthand experience with e-mental health options in the current pandemic, which may positively influence attitudes towards their use in clinical practice. Specific training of mental health professionals will be necessary to meet quality standards for safe and effective use of e-mental health options. In sum, we support current calls for the upscaling of e-mental health options in the face of the COVID-19 crisis. Additionally, sustainable policy solutions, training capacities, and adequate research funding are imperative to ensuring the long-term uptake, acceptance, and quality of e-mental health options.

Disclosure statement

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Mental health services in Italy during the COVID-19 pandemic

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To date, very little is known about the way in which mental health systems worldwide are facing the current COVID-19 global health emergency.[1–3] Italy was the first Western country to be severely affected by the COVID-19 pandemic, and only local reports relating to Italian psychiatric services have been published so far.[4–7] In this short report, we present preliminary data emerging from a survey conducted by the Italian Society of Psychiatry to study the impact of the current emergency on the functioning of the Italian Departments of Mental Health (MHD), comprising community mental health centers (CMHC), residential facilities (RF), and psychiatric wards in general hospitals (GHPW).

Between 1 and 11 April 2020, all heads of the MHD received a 40-item multiple-choice questionnaire focused on CMHC, and a 30-item questionnaire on GHPW. Responses were analyzed according to geographical area and to the rates of COVID-19 cases per 1000 inhabitants in the reference area. To date, 71 questionnaires have been returned from the 134 Italian MHD (52.9%) and 107 from the 318 (33.6%) GHPW.

A total of 14% of CMHC have been closed and approximately 25% have reduced their hours of access. A decrease has been registered (approximately –78%) in the number of operational day hospitals, which are largely involved in the clinical monitoring and treatment of subacute but not severe cases, whilst an even greater reduction (–85%) has been observed in the number of operational day centers focusing on psychosocial and rehabilitation activities. Only RF, units specifically deputed to medium to long-term rehabilitation, have remained almost fully operational. The routine mode of operation in CMHC has changed substantially. Urgent psychiatric consultations, both on-site and at home, are continuing as usual, in the same way as interventions for compulsory treatments, psychiatric prison consultations, and on-site and home administration of long-acting injectable antipsychotics; however, all other activities have been affected by a significant decrease. Indeed, scheduled psychiatric consultations, both at home and on-site, have only gone ahead for selected cases, being replaced in approximately 75% of cases by scheduled remote contact, mainly phone calls (100% of MHD), videocalls (67%), or emails (19%), with 41% of units adopting all these means of contact. All other activities have been affected by a significant decrease, including psychiatric consultations for general hospitals (approximately −25%), individual psychotherapies (approximately −60%), group psychotherapies and psychosocial interventions (approximately −90% and –95%), and monitoring of cases manifested in RF (−40%) and among offenders affected by mental disorders assigned by the Court to CMCH (−40%). COVID+ cases have been registered among both staff members (52% of CHMC) and facility users (52% of CHMC), although slightly lower rates have been reported for residents living in RF (less than 40% of RF). As expected, a significantly higher number of cases have been reported in the northern Italian regions (i.e., areas featuring the highest rates of infection). Finally, a limited number of CMHC (21%) have reported cases of increased aggressiveness or violence, either towards the self or others, among community patients, with 8.6% constituting severe cases.

Major issues in the supply of personal protective equipment for staff members have been reported, particularly for infrared thermometers, high-protection masks, safety glasses, and disposable gloves. A certain reduction in the number of GHPW wards (−13%) has been observed, largely due to conversion into general COVID-19 units for positive patients, as well as in the number of beds available (approximately –30%) due to a need to increase the distance between patients and to set up isolation rooms. An overall reduction of admissions has been registered (87% of GHPW), partly due to a restriction of scheduled admissions (64% of GHPW). Only 8% of GHPW have reported an increase in compulsory admissions. The vast majority of GHPW have continued to guarantee psychiatric consultations for emergency rooms and medical and surgical units, with psychiatric consultations for COVID-19 units being performed in approximately one-fifth of GHPW. Mood disorders, psychoses, anxiety disorders, and attempted suicides represent the most frequent reasons for consultations. Only 8% of wards have registered an increased rate of violence towards the self or others among inpatients. Fifty percent of GHPW have reported the availability of swabs for patients, although only 20% of these are able to request swabs on both admission and discharge. Approximately 60% of GHPW have reported the admission of symptomatic, COVID+ psychiatric patients to general COVID-19 units, whilst severely ill and non-collaborative COVID+ patients are generally admitted to specific COVID-19 GHPW, or to purpose-adapted isolated areas of the wards. Indeed, although the Italian MHD has effectively succeeded in facing the challenges manifested and has implemented a widespread use of telepsychiatry, numerous issues related in particular to psychosocial interventions and family support will need to be addressed in the future should the current operational restrictions continue.

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