Chapter

The Impact of Covid-19 Pandemic on Community Psychiatric Services in Northern Italy

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Abstract

The Covid-19 pandemic, started brutally in February 2020 in Northern Italy (first European area hit by virus), has induced the most drastic and prolonged containment measures by a European government. The most affected areas of the Italian territory were Lombardy and Veneto. A severe and global lock-down was ordered for more than two months, with the closure of essential medical services among others. All health resources have been diverted to address the health crisis caused by the pandemic. During the lock-down, however, the only community medicine services that remained open were mental health services: psychiatry, the area of addictions, child neuropsychiatry. The community facilities have always provided services favoring, on the one hand, the maintenance of care and rehabilitation paths for patients in care, and on the other, allowing anyone who needs to have access to treatment. The operators were also involved at the forefront in the management of covid + patients and in the support paths for the management of the operators' stress. In this chapter, we want to describe the working conditions and the organizational responses of our services, referring to a large catchment area of the region most affected by covid-19.

Keywords: Covid-19, pandemic, mental health, psychiatric services organization, community psychiatry, post-traumatic stress, resilience, critical incident management

1. Introduction

The recent COVID-19 epidemic has created a serious and in many ways unexpected health and social emergency, imposing a drastic and immediate change in the lifestyles of the entire population. However, this emergency has had, and will have significant consequences on the psychosocial level, both direct and indirect. Among the direct consequences can be mentioned the trauma suffered by those who have fallen ill and have been hospitalized, or have been forced into prolonged isolation, and the stress and burnout of frontline health personnel (doctors and nurses of the ER services, infectious disease departments, intensive care units, sub-intensive care units, etc.). Among the indirect consequences we can mention the serious risk of unemployment and loss of personal and family income,

limitations to interpersonal contacts and work activities, complicated bereavement in the case of loved ones who have fallen ill and died, etc. This serious and complex psychosocial emergency poses new challenges to Mental Health Departments and professionals in this sector, and therefore requires the development and refinement of specific skills.

At the end of April 2020 (the so-called "first peak"), Italy entered the "phase 2" of the covid-19 pandemic [1]. Italy was one of the most affected western nations in the early phase of pandemic, in terms of number of positive cases and number of deaths. By April 30, 1354901 subjects had been tested, 205463 tested positive, with 27967 related deaths [2]. Italy was also the western country that has implemented the most aggressive and prolonged lockdown (even if internationally disputed), closing schools, workplaces, almost all the community health services being all the health resources diverted to acute hospital care services. The Lombardy region has been the hardest hit in all of Italy, with the most prolonged impact: by April 30 there were 75732 cases (out of 229880 cases tested), with 13772 deaths. Milan represents one of the Provinces most affected, with 19337 cases [3].

One of the issues that most worried health agencies in the first phases of pandemic was that of protecting weaker segments of the population, among these, those in need of psychiatric services. Although other segments of the population could have been protected by isolation, this response mode is not adequate for the specific fragile population of mental health patients. Since the lockdown in late February 2020, most hospital wards have been rapidly converted to the management of the Covid-19 epidemic, establishing intensive and sub intensive care units. ERs have also had to revolutionize their paths, becoming de facto hubs for Covid-19 case management. The specialist outpatient activities in the area have closed, both to allow the deployment of operators in emergency areas and to avoid exposure of the population. Only the mental health services continued their activity, moving most of the services remotely.

2. Mental health services under stress?

The management of psychiatry in Italy is community-based, based on homogeneous geographic districts of reference [4]. Multidisciplinary groups operate in these services (psychiatrists, psychologists, nurses, social workers, occupational therapists, rehabilitation counselors, auxiliary staff), in the complex path of taking charge (from acute emergency to long-term rehabilitation).

Within this context, ASST Melegnano and Martesana represents one of the largest Lombard territories, managing a population of more than 630000 inhabitants over a vast geographical area south of the city of Milan. The mental health services are characterized by two psychiatric wards for acute care (30 beds in total), with an average length of hospitalization in 2019 of 11.5 days, in a hospital network of 4 multispecialty units distributed throughout the territory. The offer of community services includes six psychiatric clinics and six addiction clinics, 3 residential rehabilitation facilities and 3 daytime rehabilitation facilities for the adult population. Several projects which specifically provide services for the younger population {16–24 years) are also active.

This rapid and drastic change in management style has imposed, at least until the beginning of "phase 2", to manage with home-based and non-hospital care of acute cases (mentioning work), developing a community triage in order to distinguish cases by their severity for hospital referral (compulsory admissions for suicidal risk, psychotic breakdowns). The management of access to services, as well as the recently described experience by a group of Italian colleagues working in a

mental health department geographically close to ours has involved the remodeling of a series of processes to protect and guarantee adequate services for healthcare workers and patients [5]. In agreement with the management, safeguard measures in community services have been progressively implemented which have envisaged:

1. closure of group rehabilitation services (day services),

2. blocking of access to residential structures,

3. phone calls and videoconference visits for deferred acute conditions and for monitoring and for requests for first visits and consultancy,

4. dedicated telephone counter for family members and health care workers under stress,

5. direct access to services only for situations related to the administration of therapies or for situations requiring direct evaluation.

The community teams also carried out the following activities:

1. monitoring of subjects with concomitant pathologies that can determine risk factors for covid-19 (hypertension, heart disease, diabetes, and chronic respiratory diseases),

2. education in infective risk prevention, through telephone calls, notices displayed outside the services, direct instructions to caregivers and patients.

In particular cases, services implemented home interventions aimed at supporting basic needs (nutrition, hygiene), with further and more stringent precautions (according to WHO indications). We gave a particular attention to young people (16–24 years), to whom specific lines of communication were dedicated which allowed remote operations to continue, creating virtual rehabilitative and re-socializing groups.

The two acute wards were involved both in the covid-19 screening phase (providing separate and isolated rooms for patients awaiting the outcome of the swab) and in the direct management of psychiatric patients with an infection in progress. In the two "hot" months of March through April we recorded only 2 active cases hospitalized in a dedicated psychiatric ward, and 3 psychiatric patients hospitalized in subintensive care units. At the same time, we almost halved total admissions, with a median hospitalization time of about 10 days [6]. Another group of Lombardy replicated the data [7] and a multicentric research involving a number of Mental Health Departments in northern and central Italy also replicated this finding [8]. Thus, the available data confirmed that psychiatric patients did not attend to acute psychiatric wards as usual; inference was made that they were shifted toward community services (which never closed even in the hard lockdown period). In the same period, available data did not show an increase of compulsory admissions, thus sustaining the hypothesis that community services responded well to population needs.

The management of the acute psychiatric wards involved the adoption of protective measures for psychiatric care workers and patients, who were constantly instructed in the measures of social distancing, hand hygiene, dressing of surgical masks. The hyper-social climate once characterizing the wards has been diminished, but this has allowed us to avoid the spread of any secondary infection.

The way we have been managing the crisis has allowed us to test the resilience of the community psychiatric services. Mental health community services proved capable of managing patients preliminarily reputed to be "difficult" in an innovative manner without weighing on emergency services, which, in turn, have been able to manage the covid-19 crisis with necessary equanimity required to maintain hospitalization times and quality of care at precovid levels [9]. In particular, we have noticed that innovations in the management of particular user groups (such as young people) during this time have been overwhelmingly appreciated for their effectiveness and must be further implemented. We have also the opportunity to implement a broader reflection on the adoption of protective behavior toward future pathogens without quitting our mission.

3. Health workers under stress?

The epidemic linked to the SARS-CoV-2 infection is causing an overload of commitment in the healthcare professions, not only physical (increased work shifts, reduced rest periods, increased care burden) but also emotional [10]. Emotional reactivity, typical of situations of massive and sudden stress, also has a clinical definition (and it could not be otherwise, in a world that "classifies" everything): the so-called Critical Incident Stress Syndrome (CISS), or critical incident [11, 12].

Why does this syndrome manifest itself, and how does it manifest itself?

Main point, we must remember that health workers are, also and first, human beings. Certainly, they are the bearers of technical and operational knowledge, relating to health management, significantly higher than that of the average human being. Nevertheless, this "superior" knowledge does not protect against emotional reactions, especially in extreme conditions. On the contrary, paradoxically it can also be harmful. In fact, healthcare workers do use distancing as the main defensive reaction, which can be quite ineffective: I, the technician, observe what happens from an external, neutral, "scientific" position; at the meantime, I forget that I am also directly involved as a human being in the same, if not greater, risks than the general population. This is the critical element: the awareness of being also a "normal people" suddenly and unexpectedly bursts when something breaks the delicate defensive balance of distancing. For example, the illness or death of someone who is dear and close to me, the death of too many patients on whom I have not been able to do anything, sometimes my own illness (which I had opposed in my clients) or even mine death (anticipated by the death of my colleagues). It is inevitable that my emotional world somehow resonates with what is happening around me, I am not an anaffective robot. Nevertheless, if I am not aware of this resonance and this reactivity, when these suddenly manifest themselves, I expose myself to a condition of crisis, and that is what happens in the CISS. The overload of work necessary to respond to the rapidly rising tide of requests related to my role and my profession does not allow me to reflect on myself and my emotions, in turn the rising tide of emotion is held back but only up to a critical point, then explosively emerges.

What follows is the development of pictures that range from a "banal" psychological imbalance (stress response syndrome) through the adaptation disorder to the full-blown and clinically demanding pictures of post-traumatic stress disorder. Which in turn can be structured in even more challenging situations such as a mood disorder or other. Certainly, the individual biopsychosocial characteristics (temperament and personality, vulnerability and resilience, protective factors

and risk factors) play a central role in tracing the path that the individual will take when exposed to a condition of massive stress, but the fact remains that all of us operators are exposed to an adaptation reaction which, if not managed well, can become a maladaptation reaction. A further element of risk is represented by the alteration of the usual routines, first that of sleep. We can never talk enough about the "restorative" role of sleep for the body in both physical and mental components. What is certain is that, subjected to excessive shifts, under tension, skipping rests and recoveries, even sleep is sacrificed. A non-restorative sleep, among other consequences, even in acute, involves significant alterations in cognitive functions, emotional control and immune function. And this leads to an increase in risk factors related to exposure to the new virus [13].

CISS is that reaction that occurs when the individual is exposed to an intense and acute traumatic event characterized by serious damage or risk of life for someone or events of serious accident/mass death, or, finally, for the concrete risk that the exposure to that event determines in the exposed subject serious consequences at the level of personal and professional functioning. As is objectively the case of the current CoViD-19 pandemic, especially in the areas of major outbreak. CISS is actually a practitioner's term used to reduce the stigma associated with the term PTSD [14], and most often refers to those who are employed in emergency service occupations exposed to stressful incidents. CISS is the response to the cumulative effect of stress: it occurs when people working with death, dying, or life-threatening injury on a regular basis have not had time to adequately "purge" these traumatic events in time to emotionally prepare for the next or have not properly addressed how much stress or trauma an incident has inflicted upon them. The most significant the stressful event is for the person, the greater stress reaction develops.

The most frequent indicators that we are facing a CISS are the following [15–17]:

1. activation of HPA axis (sleep disturbances, chest pains, gastrointestinal and appetite disorders, reduced sexual interest or changes in the menstrual cycle, headache, dizziness, muscle tremors, increased risk of infectious diseases);

2. emotional disturbances (development of thoughts of guilt and despair, irritability, anxiety, feelings of isolation, grief, anger, "hindsight");

3. cognitive symptoms (refusal/denial, loss of ability to concentrate, recurrent flashbacks/intrusive images of the event, short-term memory problems, difficulty making decisions)

4. behavioral manifestations (nervous breakdowns, loss of interest in work, substance or alcohol use, withdrawal from relationships, loss of interest in family life, compulsive need to always talk about what happened, increased risk of accidents) [18].

A lot of these manifestations have significant repercussions on the quality of health workers' work and therefore increase clinical risks. We have manage these issues adopting a correct stress management. Another important factor is that stress management has to be offered on site, in order to be less intrusive as possible in private life, the only moment of rest of health workers, and to be shared in the work group.

One of the first research conducted on a sample of 1500 Chinese doctors who found themselves engaged in Wuhan highlighted the progressive development of

an acute affective syndrome characterized by depression, anxiety and insomnia. The data underlines how the protection of health personnel cannot be limited only to PPE in various declinations, but must also take into consideration the protection of the psychological spheres, with adequate preventive interventions, damage reduction and functional recovery following the damage [19]. From then, a flourishing of works on the issue were published [20–22]. These researches obviously declines intervention models that can be used as a scheme for future training of the operators potentially involved.

We must not forget that there are also other elements not strictly related to the psycho(patho)logical sphere, but to the moral one: in fact, there are also moral wounds, linked to the condition of violation of one's own ethical and moral code having to make decisions in urgent conditions (**Table 1**). It is a term borrowed from the military law, where obedience to an order, for a superior strategic purpose, can be in contrast with one's own values. This induces a condition of psychological tension that can develop on two tracks: a picture of psychic suffering rather than a picture of individual growth, of maturation, of adaptive change. Which of the two paths the subject will take is certainly determined by individual differences but also by how individuals manage the moral dilemma, or by how the subject prepares before and receives support during and after the traumatic event. The sense of inadequacy arises precisely from the lack of preparation, not only technical but also moral and psychological, to face the new dramatic challenge of the pandemic. It is necessary that all health workers are prepared to face the moral and ethical dilemmas that the fight against the virus entails and will entail, and the sooner it is done, the better it will be for the subsequent psychological equilibrium. International research groups are already questioning themselves on these issues, offering interesting ideas for reflection [23].

• Organization
○ Feeling dejected because you work with insufficient resources (human or material), knowing that it is a situation that could have been avoided
○ Follow clinical decisions of others that you deem unethical, immoral or contrary to guidelines from recognized scientific societies
○ Having to choose which of two equally serious patients to treat, sacrificing one, due to the lack of sufficient treatment tools
○ Failure to report a clinical incident, a near miss, or episodes of pressure / threats on oneself, colleagues or patients
• Clinical culture
○ Intervening urgently in an emergency situation causing harm or death to patients, knowing it in advance but having no alternatives, or unintentionally
○ Changes in Ref. values with respect to the need or justification to adopt treatment plans or protocols that may threaten the integrity or life of patients
• Relationships
○ Giving clinical orders or establishing protocols of action that can result in the death of colleagues or patients
○ Endanger colleagues or patients due to their inexperience, indecision, or for tasks performed outside of their usual competences
○ Return home after a shift and learn that critical conditions for everyone's health have occurred in the facility where we have just finished working

Table 1.
Potential triggers for a "moral wound" induced by the CoViD-19 pandemic.

Critical incident stress management (CISM) techniques on site provide some specific preventive indications for those affected [24]:

- maintain physical activity
- have a frequent intake of nutritious foods, in small amounts
- use controlled humor
- adopt a positive self-statements communication style
- control breath, doing deep breathing as frequent as possible
- take breaks during work
- display controlled emotions: talk about one's own feeling with significant others

After the exposition to incident (stressful situation), in order to stop stress reaction, people should:

- engage in reasonable physical exercise (within 24 hr)
- get adequate rest
- eat good nutritious foods
- maintain normal schedule
- avoid boredom (involving in hobbies).
- talk about one's own feelings
- do not fight too hard against flashbacks and dreams
- attend mandatory defusing or debriefings if requested to do so.

CISM also suggests a specific family assistance project (psychoeducation). Actually, the effects of a traumatic critical incident vary significantly across individuals. Some people will feel little impact while others may experience significant trauma because of exposure to the same event. At times, family or others who care about the individual may have questions about what to expect and about the best ways to assist. Psychoeducative suggestions for family members include the following advice:

- individuals close to the affected person, being in the best position to detect and identify changes in behavior or demeanor of affected individual, should be trained to recognize the signs and symptoms of critical incident stress. They should also be advised that it is normal that most people may experience very few signs of CISS or none, while other do display a massive reaction
- they should be aware that support and open communication are valued tools when dealing with someone who has been involved in a traumatic critical incident. If the person wishes to discuss the incident, be empathetic and

participate in the discussion. An active listening and open communication concerning noticeable changes in demeanor or behavior following a traumatic critical incident, including any of the possible signs of critical incident stress, is encouraged. Anyhow, if the person do not wish, they should not press him to talk: if the individual chooses not to talk about the incident or his/her reaction, respect his/her decision.

- family members are trained to encourage exposed individuals to spend time with family and other individuals who can provide a source of quiet social support and a sense that life goes on.

A simplified description of the stages of the CISM are as follows [25–28]:

A. Pre-critical stage, adopting specific preventive interventions (training on traumatic reactions, Stress Inoculation Training, Psychoeducation)

B. Peri-critical stage, in two different interventions: Scene Support/Psychological First Aid (psychological first aid, immediate and direct support on the scene of the event), Defusing/Demobilization, Debriefing.

Defusing is a brief intervention - usually conducted by a psychologist - organized through group interviews, which is held on subjects exposed to a highly dramatic or traumatic event. As the word suggests, this intervention provides a brief and collective reworking of the meaning of the event. The goal is to reduce the emotional impact of a potentially traumatic event. The people who participate in the group interview have the opportunity to speak, in a non-judgmental way and in a protected relational context, about the facts concerning the incident, their thoughts and their emotional experience in relation to what occurred. Defusing is in some respects a reduced and modified version of the debriefing, allowing a more structured debriefing if it is necessary. If done correctly, defusing can help to reduce or allow remodeling the intensity of the emotional reactions inevitably generated by a difficult experience, and helps to reinforce the social support network of the people who have shared what has been experienced from contact with drama of the event. Demobilization is a particular form of critical post-intervention defusing which is carried out with groups or teams of rescuers - volunteers and/or professionals - at the end of relief operations of particular intensity, complexity or emotional importance (in the form of peer support). Debriefing is a structured and group psychological-clinical intervention, conducted by a psychologist expert in emergencies, which is held following a potentially traumatic event, in order to eliminate or alleviate the emotional consequences often generated by this type of experience.

C - Post-critical stage: multiple debriefing, individual and family support counseling, follow-ups, possible group or individual psychotraumatological care.

In some cases people exposed to traumatic events need to seek professional help: persisting (more than a month) symptoms and/or dysfunctions interfering with daily living.

The most recent model of CISM emphasize the usefulness of developing internal groups in order to face CISS as soon as possible [29], at the same time the earlier we intervene, the better is the outcome [30].

In our working reality (ASST Melegnano e della Martesana) the pandemic breakdown induced in health workers reactions of fear and distress never previously experienced in one's professional experience, both in intensity and in duration. The condition of psychological and emotional suffering has been reported

on several occasions, informally (direct communications, posts on social media, interviews in the press), and formally following institutional indications.

Specifically, the first request for help came from Intensive Care Units, hinging on three critical elements:

1. Unsustainable workloads

2. Very serious cases

3. Too many deaths.

The analysis of the demand immediately highlighted the extreme involvement of healthcare personnel (not only the ones involved in ER units) in relation to the emotional response and the need to organize immediate psychological support as a critical element. The management of the ASST has therefore given a mandate to the Clinical Psychology Unit of the Department of Mental Health and Addiction to organize a working group. Thirty-five expert psychologists were and are involved in this supportive group. They come from different social and health sectors of the hospital organization. A service was instituted to report a need/request for intervention via a dedicated email, providing the possibility of a rapid response 7 days a week through video calls (or telephone calls), to be more conveniently usable by healthcare personnel and not to give up communication without verbal of the emotions that the means of protection inevitably hide.

The intervention focused on health workers, as people in "trenches" exposed to exceptional job requests and heavy emotional stress, has the aim, first, to strengthen resilient responses to this unsettling situation and, later, to prevent a state of chronic stress that could arise in the phases following the emergency, with the onset of post-traumatic symptoms as before outlined.

The main problems identified by the analysis of requests for intervention can be summarized as follows.

Health workers found themselves having to work with a disease that does not have established protocols, each of them is being trained in the field, through continuous tests and feeling inadequate security mainly linked to the fluidity of the lines of behavior that are communicated day by day on the basis of the ever new emerging knowledge. Exposure to the inadequate availability of individual protections (especially in the early stages of the pandemic) and the risk of getting sick has certainly played a fundamental role in terms of stress; in particular, it has generated anguish with respect to being able to infect family members. The initial stages caught doctors and nurses unprepared and this condition generated feelings of inadequacy and helplessness; based on these feelings, anger reactions and acting out have often been reported.

Furthermore, Covid-19 patients require a lot of commitment and of resources in terms of energy. Only those who work on it in direct contact can perceive the real fatigue (physical but also psychic) experienced. The stressors have significantly increased compared to normal routine: put on and take off individual protective devices (hoping to have done it correctly), high number of infected and apparently always growing, never had in a normal hospital, returning home and all what this entails (including fear of infecting loved ones). Also, remaining only on the technical level, the difficulty in managing patients who ask "only" to be able to breathe well: they arrive with a frightening "hunger for air" caused by pneumonia, which does not allow them to speak … they cannot!

The world seems to have turned upside down by the social point of view: physical contacts, denied in everyday life by isolation measures, on the contrary

were maintained in the ward, being the only human contact between operators and patients. In this situation, on the other hand, Doctors and Nurses are unrecognizable to patients, because masks covers the entire face and becoming difficult to recognize and distinguish people... they all become the same. Some operators have decided to write their name on the gowns, others have even thought of making them personalized, with particular designs. In this way, patients also know whom they are relating to, personalizing the relationship that is being lost in these conditions of substantial isolation. Finally yet importantly, once the patients have entered Intensive Care Units or in any other acute ward, they lose every contact with their relatives.

Hospitals also had to reorganize themselves, changing the usual structure of the departments, changing the teams, revolutionizing the general organization. All this has led to further stress that impacts on staff resilience, increasingly put to the test by the events that take place in a dramatic way and seem never to stop. The nights, once upon a time, had a different rhythm inside the hospital, now this is no longer the case... The ordinary work that marked everyday life was upset by dramatic events that followed one another quickly and intensely, so much to expose health workers to conditions of very high Expressed Emotions.

According to the above considerations, the stresses most often highlighted by hospital colleagues concerned both the emotional state and feelings, but also the differences from the usual work with the patient that make relational contact unstructured.

Another issue that has greatly affected the daily commitment was the anguish of death, which is practically always present and which has certainly exposed operators to pouring on themselves the stories experienced by others. In this dynamic of projection and identification, the operators become children, parents and the sick, generating and structuring important worries, fears, anguish and anxiety.

Colleagues on the front line have often told us about the management of patients in their ward, before the advent of COVID19, in which the reports were characterized by the reading and careful consideration of non-verbal aspects, proxemics and proximity.

The current condition of human detachment has certainly created idiosyncrasies. They repeatedly tell us how they can hardly transfer their closeness to the patient and convey empathy in the act of taking care of the other.

3.1 Interventions proposed

The intervention model adopted by our working group, deriving from the previous professional experiences of the participants in the group itself, is that of Psychological First Aid (PFA) as proposed by Sphere and IASC [31, 32]. PFA represents a human and supportive response to another human being who is in pain and who may need help. The PFA plans to:

- offer practical assistance and support;
- collect needs and concerns;
- help people meet basic needs;
- listen to people, but do not force them to speak;
- offer comfort to people and help them stay calm;

- help people find information, services and social support;
- protect people from further harm;
- the first psychological support is indicated for people in difficulty who have recently been exposed to a serious critical event;
- it can be applied to both children and adults;
- people should not be forced to accept help they do not wish to receive, but they should be readily available for those who would like to be helped.

The activity of the group of psychologists was set up by structuring initial interventions aimed at recognizing one's emotions, trying to put into words and above all to normalize the brooding negative thoughts and overwhelming emotions. An attempt was made to reinforce the positive emotional resources that each individual operator described in the course of the video call interviews.

Although health workers are normally more "equipped" and have a higher stress tolerance threshold, for the first time they faced with the fact that they too are exposed to the same disease, they are afraid of contagion and of infecting, of failing to keep up with the pace. They were accustomed to live in contact with extreme situations but not massive in terms of numbers and temporal concentration. The current massive exposure to them imposes having to face sudden radical changes in the work routine, as said before. The lack of a certain timeline that suggests the end of this traumatic situation sustained psychic fatigue. The operators complain of not being able to separate private and working life: the two spheres, personal and professional, are united, the operator even at home thinks about the working reality, never disconnects. Normal and relationship habits have also changed. They feel guilty for being away from children and family. All the emotional patterns used before, today no longer work. Another thing that is happening is that they see their colleagues getting sick, dying. Everyone who gets sick or dies reminds them that they could be next. A looming threat they were not emotionally prepared for. Unpublished data of a survey we conducted on the working population of our hospital (311 respondents) showed that these are the main issues to face with: perception of high risk of exposition, uncertainty of protective devices efficacy, fear to be infected, fear to infect family members, development of obsessive behaviors. The same data were found in a more formal research in a catchment area near our one [33].

Our experience in working with health professionals who express the above issues showed that the most important need is to be welcome, listened to, and not left alone. Our intervention focused on helping to cope with uncertainty and on encouraging decompression, giving them the opportunity to think in the most appropriate way possible about what is really happening, sharing and dealing with the various new and stressful aspects, as well as than with the limits present in the situations that surround us. It is also emphasized that being tired, having a little anxiety, being a little worried makes sense and must be tolerated. Furthermore, it is essential and necessary to activate all the internal and relational resources that each of us has.

In the first stages of the project, requests for support were not numerous, but they progressively increased as the situation and all its implications became effectively aware of, even precisely those of the psychic discomfort that working in certain conditions entails. There is probably also a timing problem: perhaps the time to elaborate has not yet come, "there is no time" and those who help hardly ask for help.

Also because of this, we have decided to expand the offer of support to the relatives of the patients, relieving the staff of a part of the emotional burden that is often heavier than the work itself linked to the need to communicate with third parties. We then started listening to the stories of family members.

Also in these situations, a high expressed emotionality emerges. The contents are attributable above all to death anxieties, social distancing and isolation that does not allow people to join their loved ones during hospitalization or during and after death. Stress and anxiety are mainly attributable to the spasmodic waiting to receive information and in many situations, unfortunately, to the possibility of receiving so-called bad news. Even in the case of family members, the fear of getting sick and also that of infecting others in one's family is widely expressed (as, moreover, occurs in health workers); these aspects generate powerful feelings of guilt and to develop disturbing obsessive ruminations.

In these situations, the interventions carried out in a psychological key have as a premise the intention of being able to validate even very uncomfortable emotional contents and therefore to be able to channel experiences of stress and anguish in a dimension of better tolerance, favoring the structuring of adequate resources for new strategies of coping.

4. Conclusions

In conclusion, it is quite evident that the population, which at different levels and intensity unites both health workers and families, needs readjustments in the consolidated therapeutic approaches and ad hoc interventions on the COVID 19 situation.

From the point of view of mental health services, it was clear that, despite the fatigue and the re-organizational efforts, they were somewhat able to cope with the new requests imposed bay pandemic. The community services were able to offer valuable services to population and to patients already in charge. The mental health workers were also able to volunteer in first line services to help in Civd-19 medical management. All these efforts must be the basis of an adequate reorganization in order to favor a greater resilience of mental health services.

From the point of view of health workers (and general population), it is clear that we have to cope with a high risk of developing a significant psychological distress, which can shift toward more structured psychiatric diseases.

In actuality, clinical features emerging from the psychological counseling are similar to those of a Post-Traumatic Stress Disorder (PTSD). Certainly, we cannot forget that we cannot define the actual situations of emotional suffering described definitely as a post trauma, since the traumatization is daily and repeated along a continuum of events, which are much diversified in time and from each other. In addition, the psychic fatigue is sustained by the lack of a temporal line that suggests the end of this traumatic situation. The temporal element of stabilization of the dysfunctional response to stress is also missing, a parameter necessary to formalize the diagnosis of post-traumatic stress disorder. Certainly, however, we can witness all the predisposing elements of PTSD, which if not adequately managed can lead to an increase in this disorder in the future, as some research in the same field have shown in a wide spectrum of countries [34–37].

In fact, we need to think in terms of long-term stress in the evaluation of the operators who experience chronic contact with acute suffering, even if they seem to show a rather high tolerance threshold toward traumatic events. We must consider them at risk of developing at a short or long-term psychopathological disorders caused by vicarious traumatization. In the meantime, especially in this case,

we have to remember we are not only mental health workers but also colleagues and family members, so we are exposed to the same significant stress-producing variables. We are not neutral spectators or observers who arrive on a traumatic scene from which we have not been involved; it therefore becomes essential, to implement lucid and effective interventions, to have already structured for ourselves a planning of emotional management and reinforcement of resources. This can be managed with specific techniques, but above all with the sharing in a team of moments of reflection and discussion, useful to bring back into the right dimension what is faced daily.

At the moment we cannot predict both the potential course of the psychological imbalances described and the protective and preventive effect of the intervention offered, but certainly the operators and family members who have benefited from it have shown not only gratitude but also have partially modified the emotional response to the events they are exposed to. Which gives us hope for the proactive potential of our intervention.

Another issue that needs more studies on application and effects is that of telepsychiatry. The preliminary experiences of our group have shown how patients appreciated it and at least the sample of young subjects found it very useful [38]. Supporting our work, other evidences have highlighted how in a pandemic condition characterized by the coexistence of isolation measures and the need for support people find in the electronic medium a significant way to obtain response to health needs [39].

Conflict of interest

The authors declare no conflict of interest.

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