

## **“I found some positives in this experience”: staff views on positive changes in the mental health services of Trieste and Gorizia, Italy during the first year of pandemic.**

### **Introduzione**

Fin dalle prime fasi della diffusione a livello mondiale, numerose ricerche hanno documentato l'impatto del COVID-19 sulla salute mentale, evidenziando un incremento dei disturbi psichici nella popolazione generale (Richter et al., 2021; Lange 2021; Singh et al. 2021) ed effetti negativi sui SSM (Lange, 2021; Hossain et al., 2020). A livello di prestazioni erogate, sono state evidenziate contrazione dei posti letto e dei ricoveri ospedalieri, riduzione delle attività territoriali e prolungata chiusura delle strutture residenziali (De Girolamo et al., 2020; Carpinello et al., 2020; Rains et al., 2021). Negli utenti dei SSM sono stati documentati peggioramenti clinici, un aumento dell'isolamento sociale e della solitudine (Gillard et al., 2021) e una maggiore difficoltà di accesso alle cure, psichiatriche e non (Rains et al., 2021). Negli operatori dei SSM sono stati evidenziati stress e burnout (Rapisarda et al., 2021) anche legati ai cambiamenti rapidi nelle modalità di lavoro, alle preoccupazioni per i rischi di contagio e alle difficoltà di garantire livelli accettabili di cura alle persone con disturbi mentali gravi, più emarginate e con meno risorse familiari ed economiche (Johnson et al., 2021).

Mentre diversi studi hanno documentato gli effetti negativi del COVID-19 sulla salute mentale delle persone e sui servizi che se ne occupano, i potenziali effetti positivi della pandemia sull'organizzazione e le pratiche di questi servizi, sulle persone che li frequentano e sugli operatori che vi lavorano, sono stati quasi del tutto inesplorati. La presenza di studi prioritariamente centrati sulle difficoltà (Johnson et al., 2021; D'Avanzo et al., 2020; Rains et al., 2020; Gillard et al., 2020) può aver portato a sottovalutare il ruolo che i meccanismi adattativi possono aver esercitato sui SSM, modificando positivamente relazioni e pratiche. I dati disponibili evidenziano che il dover far fronte alla pandemia ha portato in alcuni ad un aumento della collaborazione tra gli operatori della SM e tra questi e il personale di altri dipartimenti, a una diminuzione della burocrazia e a un approccio alle cure più flessibile (Bommersbach et al., 2021; Johnson et al., 2021; Guan et al., 2021) e talvolta alla percezione dello staff che quanto stesse accadendo avrebbe potuto portare a qualcosa di utile (D'Avanzo et al., 2020). Il ricorso a piattaforme di videocomunicazione si è rivelato una modalità di lavoro capace di garantire supporto psicologico e adeguate valutazioni cliniche, riducendo i tempi per gli spostamenti e permettendo una maggiore partecipazione dello staff alle riunioni (Johnson et al., 2021; D'avanzo et al., 2020; Rains et al., 2021). Nelle persone più isolate che frequentano i SSM, la generalizzata riduzione della vita di relazione sembra in alcuni casi aver

portato a maggiore empatia e accettazione sociale nei loro confronti e a una ridotta emarginazione. In alcuni utenti, la polarizzazione sulla pandemia ha avuto l'effetto di distrarli dalle loro condizioni pre-esistenti portando a una riduzione dei sintomi (Rains et al., 2021). In altri utenti, sembra aver facilitato nuove modalità di coping e di commessione con la comunità (Gillart et al., 2020).

Tuttavia, gli studi disponibili sono stati condotti spesso utilizzando metodologie qualitative, di difficile replicazione in condizioni di routine, o mediante l'uso di questionari costruiti ad hoc ma non sufficientemente validati. Inoltre, la maggior parte degli studi sono stati condotti nei primi mesi della pandemia, quando i meccanismi di reazione al COVID erano probabilmente centrati su reazioni emotive iniziali che verosimilmente hanno lasciato il campo a strategie di coping più *problem-oriented* nei mesi successivi (Lazarus & Folkman, 1984). È possibile che la prolungata necessità di far fronte al COVID-19 abbia facilitato da parte degli operatori della salute mentale lo sviluppo di modalità organizzative e di intervento nuove, rimodulando il senso del lavoro e dando nuovo valore alla relazione con gli utenti e con le loro famiglie. Conoscere questi dati può essere utile sia per comprendere in una prospettiva più equilibrata l'impatto del COVID sui SSM che per pianificare servizi in era post COVID più rispondenti ai bisogni delle persone e maggiormente *empowerment-oriented*.

L'Italia è stato uno dei paesi europei più colpiti nel primo anno di pandemia, con 95.000 morti e 2.800.000 contagiati (Ministero della Salute, 2021; il Gazzettino, 2021). Durante il primo lockdown (marzo-maggio 2020), le prestazioni erogate dai DSM sono calate complessivamente del 30%, mentre i ricoveri ordinari e obbligatori sono calati del 50% e del 70%, rispettivamente (Carpiniello et al., 2020; Saponaro et al., 2020). Nei DSM più orientati in senso comunitario, a fronte del calo dei ricoveri, l'assistenza territoriale non ha subito sostanziali riduzioni (Castel Pietra et al., 2021), suggerendo che questi servizi abbiano retto meglio di altri all'urto iniziale del COVID-19. Dall'estate 2020, anche grazie alla collaborazione di associazioni di utenti e familiari e del terzo settore, nella gran parte dei DSM italiani è iniziata la ripresa verso livelli di attività pre-covid sia cliniche che psicosociali (Fioritti et al., 2021).

Questa ricerca ha inteso esplorare, a un anno dall'inizio del COVID 19, il punto di vista degli operatori di un DSM italiano sulle trasformazioni positive indotte dalla pandemia nelle pratiche e nell'organizzazione del servizio e nelle relazioni tra equipe, utenti e famiglie. La ricerca è stata condotta nel DSM di Trieste e Gorizia, una rete di servizi sanitari che dal 1970 è stata pioniera nell'implementazione della community based mental health care in Italia e nel mondo (Mezzina 2018, WHO, 2021). Lo studio è stato realizzato mediante un questionario ad hoc sviluppato con una

metodologia partecipata e successivamente validato. Lo studio ha esplorato il punto di vista degli operatori del DSM e del privato sociale che lavora in sinergia con il DSM in merito ai seguenti aspetti:

- a) Riconoscimento e valorizzazione delle capacità degli utenti
- b) Senso di appartenenza all'equipe
- c) Flessibilità del SSM
- d) Mantenimento e incremento di buone pratiche
- e) Percezione della pandemia come di un'esperienza che ha avuto anche aspetti positivi sul proprio lavoro.

Rispetto agli aspetti a-e sopraindicati abbiamo verificato se la percezione di cambiamenti fosse maggiore negli operatori del territorio vs. quelli dei servizi ospedalieri e residenziali.

## **Metodologia**

### **Study design**

La ricerca è stata condotta nel Dipartimento di Salute Mentale di Trieste e Gorizia, Azienda Sanitaria Universitaria Giuliano Isontina (ASUGI) ed ha coinvolto operatori del DSM e del privato sociale che hanno compilato un questionario online sviluppato con una metodologia partecipata.

Lo studio è stato coordinato dal Dipartimento di Psicologia dell'Università della Campania "Luigi Vanvitelli" e sviluppato in sinergia con il DSM di Trieste e Gorizia. Il protocollo dello studio è stato approvato dal Comitato Etico del Dipartimento di Psicologia dell'Università della Campania "Luigi Vanvitelli" di Caserta (aut. N. 1 del 2/2/2021) e recepito dall'Ufficio Studi Clinici ed Epidemiologici, SC Ricerca e Innovazione, dell'ASUGI. Lo studio è stato condotto in accordo con la convenzione di Helsinki.

### **Il DSM di Trieste e Gorizia.**

Il DSM dell'Azienda Sanitaria Universitaria Giuliano Isontina (ASUGI) è una rete di servizi per la salute mentale a forte impostazione comunitaria che serve un bacino di utenza di 371000 abitanti e copre il territorio di Trieste e quello confinante di Gorizia. Il DSM è un no restrain system of care che opera "secondo il principio della "porta aperta" e della massima accessibilità dei servizi (non-selection of the demands) ". Il DSM si articola in 6 Centri di Salute Mentale (CSM), nel Servizio Psichiatrico di Diagnosi e Cura (SPDC), e nel Servizio di Abilitazione, Residenze e Rems (SARR). I CSM sono aperti h24, 7 giorni a settimana e coprono la maggior parte dei bisogni di cura, incluso la gestione delle acuzie, la prevenzione dei disturbi mentali, i trattamenti farmacologici e la

riabilitazione. La residenzialità è garantita da “supported housing facilities” gestite dal terzo settore in collaborazione con il DSM. Inoltre, il DSM lavora in stretta sinergia con un alto numero di cooperative sociali che promuovono programmi nell’area della recovery, dell’inclusione sociale e del lavoro. Le persone sono sostenute nell’accesso a opportunità sociali (casa, istruzione, formazione al lavoro, gestione della salute, attività del tempo libero) e accompagnate in percorsi abilitativi individuali in larga misura basati sull’uso di budget di salute. Il DSM di Trieste e Gorizia è Centro collaboratore OMS per la deistituzionalizzazione e la community mental health care dal 1978, ed è considerato uno dei servizi più innovati di cura della salute mentale al mondo (WHO, 2001), indicato come esempio di “well-established mental health service network” nella WHO Guidance on community mental health services (2021).

### **Fasi dello studio**

Lo studio ha previsto: a) una fase preliminare di sviluppo di un Questionnaire on mental health services Transformations during the COVID-19 pandemic – Staff version (QT-S), condotta nel periodo settembre 2020-dicembre 2021; b) una fase di raccolta online dei dati rivolta agli operatori del DSM ASUGI e del privato sociale che operava in sinergia con il DSM, realizzata nel periodo 15 febbraio 2021-31 marzo 2021.

#### **a) Preliminary phase – development of the Questionnaire on mental health services Transformations during the COVID-19 Pandemic – Staff version (QT-S)**

Lo sviluppo del QT-S è stato realizzato con una metodologia partecipata da un gruppo di lavoro che comprendeva ricercatori, clinici e responsabili dei principali comparti professionali coinvolti nella ricerca. Inizialmente, i componenti del gruppo di lavoro hanno visionato 6 video-interventi di operatori del DSM e del privato sociale presentati in un webinar sugli effetti del COVID-19 sul DSM di Trieste e Gorizia a settembre 2020 (link ....). Utilizzando una scheda ad hoc, ogni partecipante ha estrapolato dai 6 video-interventi i temi prevalenti, riformulando le affermazioni in forma di domande a risposta multipla. Il lavoro individuale sui video interventi è stato successivamente discusso dal gruppo di lavoro e ha portato ad una prima lista di 244 domande, poi ridotte a 232 per eliminazione dei doppioni. Le 232 domande sono state valutate individualmente dai componenti del gruppo di lavoro per chiarezza e utilità su una scala a 10 punti, da 1 “per niente” a 10 “completamente” e di inclusione/esclusione nel questionario “sì/no”. Le domande con un punteggio di chiarezza/appropriatezza < 7 e/o che sono state considerate da

includere da non più di 4 partecipanti su 7 sono state eliminate (N=160). Il testo delle restanti 72 domande è stato nuovamente revisionato dal gruppo di lavoro e sono state eliminate ulteriori 25 domande considerate ridondanti. I restanti 47 items sono stati nuovamente valutati per chiarezza e utilità sulla scala 1-10 e di inclusione/esclusione dai componenti del gruppo di lavoro, escludendo ulteriori 17 domande. Le 30 domande restanti sono state raggruppate sulla base dei contenuti come segue: a) valorizzazione delle capacità delle persone che frequentano i servizi (5 items); b) senso di appartenenza all'equipe e del proprio lavoro (8); c) flessibilità e capacità di reinventarsi del servizio (4 items); d) capacità di mantenere e di introdurre buone pratiche (12 items); riconoscimento dell'esperienza della pandemia come avente, complessivamente, anche aspetti positivi (1 item). La scala di risposta delle 30 domande è stata fissata a 6 livelli da 1 "non è proprio vero" a 6 "è proprio vero". Alle 30 domande sulle trasformazioni positive sono state aggiunti: una spiegazione iniziale su contenuti della ricerca, modalità di partecipazione, uso dei dati e consenso; due domande aggiuntive in aperto, sugli effetti più positivi e più negativi della pandemia sul DSM da parte del rispondente; una sezione sulle principali caratteristiche socio-demografiche e il background professionale dei partecipanti. Questa versione del questionario è stata utilizzata per la raccolta dei dati mediante modulo google.

#### **b) Main phase - raccolta dei dati online rivolta agli operatori del DSM ASUGI e del privato sociale**

Nel periodo 15 febbraio - 31 marzo 2021 tutti gli operatori del DSM e del privato sociale che operava in sinergia con il DSM e che erano in servizio a marzo 2020 (primo lockdown) sono stati invitati a compilare online il QT-S (DSM: , privato sociale: x operatori di cooperative). All'inizio della fase di raccolta dei dati e due volte durante il suo svolgimento, la Direzione del DSM ha inviato a ciascun potenziale partecipante una mail di invito a prendere parte allo studio con il link per collegarsi al modulo Google da un qualsiasi device elettronico. La ricerca inoltre è stata presentata nella riunione mensile di equipe dal Direttore del DSM a marzo 2020. La partecipazione infine è stata sollecitata via passaparola e con WhatsApp inviati dai componenti del gruppo di lavoro agli operatori dei comparti professionali di competenza e ai referenti del privato sociale.

#### **Analisi statistica**

Descriptive statistics were computed on QT-S single items and main socio-demographic and professional characteristics. Confirmatory Factorial Analysis (CFA) was performed on the global sample to verify the construct validity of the QT-S. Maximum likelihood estimation of the

covariances was applied. Cronbach's  $\alpha$  values were computed to explore the content validity of the confirmed factors. Multivariate Analysis of Variance (MANOVA) was performed to compare the mean scores of the five QT-S factors (dependent variables) with respect to main work settings (community mental health centres vs. cooperatives vs. day-centres, residential facilities and psychiatric ward - independent variable). Statistical significance level was set at  $p < .05$ . CFAs were performed using the LISREL 8 Program (Jöreskog and Sörbom 1996). Other tests were performed using the SPSS package, version 21 (IBM 2012).

## **Risultati**

Hanno partecipato allo studio 184 operatori, di cui 127 (69%) dipendenti del DSM e 57 (31%) operatori di privato sociale (campione atteso del DSM: 248, participation rate: 51.2%; privato sociale, campione atteso (approssimato): participation rate:). La maggior parte dei partecipanti erano donne, con un livello di istruzione medio alto e che lavoravano nel comprensorio di Trieste (75.5%; Tabella 1). La categoria professionale più ampia era quella degli infermieri. La maggior parte dei partecipanti lavorava in ambito clinico-assistenziale e socio-riabilitativo, nei CSM e nel privato sociale (Tabella 1).

Per quanto riguarda le domande relative alle pratiche, il 91.8% (punteggi 5/6) dei partecipanti riteneva "vero/proprio vero" che durante la pandemia gli operatori avessero informato gli utenti su cosa fare per ridurre il rischio individuale di contagio, l'82.6% che lo staff avesse maggiormente curato la pulizia degli ambienti, e l'82.1% che gli operatori avessero aumentato i contatti telefonici con gli utenti (Tabella 2). Per il 78.6% era "vero/proprio vero" che durante la pandemia gli operatori avessero imparato ad usare le tecnologie digitali per lavorare con istituzioni pubbliche e del privato sociale. Per il 69.3% durante la pandemia erano stati rivisti i programmi degli utenti in base ai loro nuovi bisogni. Per quanto riguarda la capacità di reinventarsi/flessibilità del servizio, il 79.6% dei partecipanti riteneva vero/proprio vero che l'equipe avesse reinventato il modo di lavorare in linea con i DPCM e il 78.6% riteneva che il gruppo di lavoro fosse stato in grado di mediare tra le esigenze degli utenti e le procedure necessarie per lavorare in sicurezza. Riguardo alle domande sul senso di appartenenza all'equipe, il 79.4% ha affermato che l'equipe ha riscoperto l'importanza di gesti semplici e abitudini piacevoli, e il 65% di essersi fatto forza con i colleghi per affrontare la paura. In merito agli items relativi al rapporto operatori-utenti, il 54.4% dei partecipanti ha ammesso di aver scoperto in molti utenti risorse personali che non credeva avessero e il 35.5% ha affermato che durante la pandemia le persone con disturbo mentale grave avevano dimostrato

buone capacità di adattamento. Complessivamente, il 59.6% dei partecipanti considerava “vera/proprio vera” l’affermazione “ho trovato qualcosa di positivo in questa esperienza”.

CFA performed on the 30 items included in the QT-S, confirmed a five-factor structure. The final model fit the data well,  $\chi^2(396) = 900.24$ ,  $p < .0001$ ; non-normed fit index [NNFI] = 0.90; comparative fit index [CFI] = 0.91; root mean square error of approximation [RMSEA] = 0.087, 90% C.I. (0.080; 0.095); standardized root mean square residual [SRMR] = 0.086. All factor loadings were significant at the  $p < .001$  level. Cronbach’s  $\alpha$  values ranged from .68 to .83. The details of the psychometric analyses are presented in Table 3.

La MANOVA ha evidenziato significative differenze tra gli operatori dei diversi servizi rispetto alla percezione di mantenimento e introduzione di buone pratiche, alla flessibilità riconosciuta al servizio e alla valorizzazione degli utenti (MANOVA Wilks’s  $\lambda=0.7$ ,  $F_{(10, 330)}=5.9$ ,  $p<.0001$ ). I post hoc di Bonferroni evidenziano una maggiore percezione di cambiamento nelle pratiche tra gli operatori dei CSM rispetto a quelli del contesto ospedaliero e residenziale e una maggiore percezione di flessibilità tra gli operatori del privato sociale rispetto a quelli del contesto ospedaliero e residenziale. L’analisi ha inoltre evidenziato una tendenza a un maggior riconoscimento delle capacità degli utenti tra gli operatori del CSM rispetto a quelli delle cooperative ( $p=0.56$ ). Non si evidenziano significative differenze tra i servizi negli altri fattori (Tabella 4).

## **Discussione**

### **Commento critico dei dati**

I risultati di questo studio mettono in luce come nel primo anno di pandemia gli operatori della salute mentale abbiano modificato pratiche e modalità organizzative del servizio e nello stesso tempo abbiano rivalutato l’importanza del lavoro di equipe e riconosciuto agli utenti capacità e competenze. Lo studio inoltre ha messo in luce come la percezione di cambiamento sia maggiore tra gli operatori dei servizi di comunità rispetto a quelli di servizi clinici e residenziali.

La maggioranza degli partecipanti ha affermato con convinzione di aver scoperto anche qualche aspetto positivo nell’esperienza della pandemia. Questa affermazione probabilmente riflette le alte percentuali di risposta “vero/proprio vero” alla maggior parte delle domande del questionario che possono essere considerate un indicatore indiretto della tenuta del servizio. I cambiamenti in positivo segnalati dai partecipanti riguardano sia i programmi, rivisti alla luce dei nuovi bisogni, che la maggiore attenzione per la salute fisica delle persone, così come il maggior ricorso alla domiciliarità anche per la gestione delle crisi. Va segnalata inoltre l’aver garantito anche

durante il ricovero il diritto alle persone di restare in contatto con amici e familiari. Il 78.6% dei partecipanti riferisce di aver usato il digitale per comunicare con istituzioni pubbliche e privato sociale. Questo aspetto è in linea con quanto rilevato in altri studi (Johnson et al., 2020; Rains et al., 2021; D'Avanzo et al., 2020). L'uso del digitale ha consentito non solo di alleggerire il carico legato agli spostamenti, facilitando la partecipazione alle riunioni, ma ha anche portato allo sviluppo di forme di supporto innovative. In particolare, è stata progettata una piattaforma di comunicazione, informazione, help care, intrattenimento e formazione per integrare i percorsi di presa in carico. La piattaforma, chiamata "Palinsesto per l'inclusione" ha potenziato le attività domiciliari e di contatto in remoto, contrastando la solitudine e facilitando l'acquisizione di abilità (alfabetizzazione digitale) e di nuovi strumenti educativi. Studi di efficacia saranno necessari per valutare l'impatto dei diversi usi del digitale nei SSM post covid e la loro applicabilità ad ampio raggio.

Il 57% dei partecipanti ha affermato che il servizio è diventato più flessibile per rimanere a fianco delle persone. Questa percentuale è maggiore di quella riportata da D'Avanzo et al (2020) nelle prime fasi della pandemia in cui il 32% dei partecipanti riferiva una maggiore elasticità nella routine lavorativa. Lo studio, inoltre, ha evidenziato come la pandemia abbia portato gli operatori a recuperare il valore del lavoro in equipe e dei piccoli gesti quotidiani. Il 65% dei partecipanti ha affermato di essersi fatto forza tra colleghi per affrontare la paura, un dato in linea con quanto rilevato da Johnson (2020) sull'importanza di questa forma di sostegno nella prima fase della pandemia. Il 54.% degli operatori ha affermato di aver scoperto negli utenti risorse personali che non credeva avessero e il 35.5% dei partecipanti ha riconosciuto anche alle persone con disturbi mentali gravi buone capacità di adattamento. Questi dati sono in linea con quanto riportato in altri studi nei quali il miglioramento delle condizioni degli utenti viene messo in relazione con la minore pressione sociale durante la pandemia (Rains et al., 2021; Gillard et al., 2021). E' probabile che la pandemia, riducendo la possibilità di relazioni degli utenti nei SSM, abbia portato alcuni di loro a recuperare spazi e risorse esterne e che questo, a sua volta, abbia rinforzato le capacità di far fronte alla pandemia delle persone. La valorizzazione degli utenti, qualunque siano le motivazioni, è un aspetto particolarmente importante perché può incidere positivamente sullo stigma associato ai disturbi mentali al quale neppure gli operatori sanitari sono immuni (Schulze, 2007; Magliano et al., 2017). Studi ad hoc saranno necessari per stimare nel tempo l'impatto della pandemia sulle relazioni operatori-utenti e sui percorsi di empowerment e guarigione delle persone con disturbi mentali.

Lo studio ha evidenziato significative differenze nelle trasformazioni positive in relazione ai luoghi di cura. In particolare, rispetto ai servizi residenziali e semi-residenziali e ospedalieri, sul



territorio è risultata maggiore la percezione degli operatori di cambiamenti positivi nelle pratiche e nella capacità del servizio di rispondere in maniera flessibile ai nuovi bisogni degli utenti. Queste differenze sono in linea con quelle riportate da Johnson et al. (2021) e da D'Avanzo (2020) ed evidenziano come la pandemia sia stata più gestibile a livello di servizi di comunità, anche grazie a una più consolidata collaborazione del terzo settore e delle associazioni di utenti e familiari (Fioritti et al., 2021). La minore percezione di cambiamento positivo negli operatori di servizi ospedalieri e residenziali potrebbe anche dipendere dalle condizioni cliniche degli utenti e dalle caratteristiche delle strutture, a lungo soggette a regole più rigide per contenere i contagi (De Girolamo et al., 2020).

Nel complesso, questi dati evidenziano come in un servizio di salute mentale fortemente orientato in senso comunitario la pandemia sia stata anche una opportunità per cambiare le pratiche e ripensare il senso delle relazioni tra le persone. Ci auguriamo che questi dati possano contribuire a una riflessione sull'impatto del COVID sui SSM e a disegnare servizi di salute mentale post covid community-oriented e vicini alle esigenze delle persone.

### **Aspetti metodologici**

Questo è il primo studio condotto in Italia che ha sistematicamente esplorato il punto di vista degli operatori della salute mentale sulle trasformazioni positive avvenute nei SSM durante la pandemia. La raccolta dei dati a un anno dall'inizio del fenomeno permette allo studio di documentare le condizioni maturate negli operatori una volta che meccanismi di coping *problem-oriented* hanno preso il posto delle strategie *emotion-focused* messe in atto per fronteggiare le fasi iniziali di questo evento così drammatico (Lazarus & Folkman, 1984). L'inclusione nel gruppo di lavoro di operatori referenti dei principali comparti professionali e servizi coinvolti e l'adozione di una metodologia partecipata ha portato allo sviluppo di uno strumento bene accetto dai partecipanti (la percentuale di missing nelle risposte è molto bassa) e capace di descrivere i diversi punti di vista. L'uso di un questionario a risposta multipla, di rapida compilazione e dalle buone proprietà psicometriche potrà facilitare la replicazione della ricerca in contesti sanitari con organizzazioni diverse e il confronto dei dati. Lo studio presenta diversi limiti che suggeriscono cautela nell'interpretazione dei risultati. La ricerca è stata condotta in uno dei DSM che, a livello mondiale, rappresenta una delle più complete esperienze di deistituzionalizzazione e di salute mentale nella comunità (WHO, 2001; 2021). Il "modello Trieste" esteso in larga parte all'intera regione FVG (Castelpietra et al., 2020) è solo in parte confrontabile con i modelli organizzativi dei

DSM in altre regioni italiane. Le differenze interregionali nell'organizzazione dei SSM – pur nella cornice unitaria dell'applicazione della legge 180 elaborata a partire dall'esperienza di Franco Basaglia a Gorizia e a Trieste (Mezzina, 2018) - potrebbero riflettersi in modalità di risposta al COVID diverse da quelle descritte in questa ricerca. Pertanto, i risultati di questo studio non possono considerarsi del tutto rappresentativi della situazione dei SSM italiani. Va inoltre considerato che circa il 50% dello staff del DSM non ha preso parte allo studio. Non si può escludere che a non partecipare siano stati proprio gli operatori che hanno affrontato durante la pandemia situazioni professionali più difficili. Pertanto, i risultati potrebbero sovrastimare gli aspetti positivi delle trasformazioni indotte dal COVID. La ricerca, inoltre, indaga la *percezione* degli operatori sulle trasformazioni positive ma non fornisce dati su quanto quelle percezioni riflettano i cambiamenti effettivamente avvenuti nel servizio. Non si può escludere inoltre che le risposte siano state influenzate dalla desiderabilità sociale. Infine, lo studio esamina le trasformazioni dalla prospettiva degli operatori, senza considerare il punto di vista degli utenti e delle loro famiglie. Alcuni dei limiti sopraelencati verranno presi in considerazione in ulteriori studi in via di pianificazione.

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Table 1. Participants' socio-demographic and professional characteristics (N=184).

Gender, N (%)	
female	113 (61.4)
male	68 (39.6)
other	3 (1.6)
Age, mean $\pm$ sd	46.3 $\pm$ 10.5
Educational level, N (%)	
Secondary school degree	7 (3.8)
High school degree	51 (27.7)
Bachelor degree	66 (35.9)
Master degree	60 (32.6)
Years of work in the mental health field, mean $\pm$ sd	13.8 $\pm$ 9.5
Professional role	
Psychiatrist	17 (9.2)
Psychologist	11 (6.0)
Nurse	57(31.0)
Health care assistant	9 (4.9)
Educator	37 (20.1)
Social cooperation worker	30 (16.3)
Rehabilitator	7 (3.8)
Social worker	3 (1.6)
Administrative staff	6 (3.3)
Community animator	1 (0.5)
Trainee	1 (0.5)
Volunteer	1 (0.5)
Other, not specified	4 (2.2)
Main place of work	
Community Mental Health Center (CMHC)	89 (48.4)
Coop	57 (31.0)
General Hospital Psychiatric Unit (GHPU)	14 (7.6)
Day-center, supported housing, residential facilities	12 (6.5)
Missing	12 (6.5)
Main working area	
Clinical and nursing	82 (45.6)
Social and rehabilitative	75 (41.7)
Technical and management	20 (11.1)
Cleaning and other	3 (1.7)

Table 2. MH staff views on positive changes during the pandemic (N=184).

QT-S items	Not really true										Really true	
	1		2		3		4		5		6	
	N	%	N	%	N	%	N	%	N	%	N	%
<b>Acknowledgement of user capabilities</b>												
* , people with severe mental disorder demonstrated good adaptive skills	3	1.6	25	13.7	41	22.4	49	26.8	57	31.1	8	4.4
* , I discovered in many users personal resources that I did not believe they had	7	3.8	9	4.9	21	11.5	46	25.3	64	35.2	35	19.2
* , users organized themselves into peer support groups	34	19.5	43	24.7	45	25.9	29	16.7	14	8.0	9	5.2
* , users showed that they are able to self-organize and find new solutions	12	6.7	23	12.8	33	18.4	57	31.8	41	22.9	13	7.3
* , I realized that there are users who know how to use digital technologies better than I do	29	16.4	27	15.3	24	13.6	36	20.3	30	16.9	31	17.5
<b>Awareness and value of teamwork</b>												
* , we realized how important simple gestures like drinking coffee together, shaking hands and hugging each other were	6	3.3	6	3.3	10	5.4	16	8.7	43	23.4	103	56.0
* , there was more sharing of responsibilities within the team	10	5.5	16	8.7	26	14.2	46	25.1	54	29.5	31	16.9
* , more centrality was given to the meeting and dialogue with the other person	6	3.3	14	7.8	35	19.4	57	31.7	43	23.9	25	13.9
* , I had more time to think about my work	15	8.2	22	12.1	31	17.0	37	20.3	46	25.3	31	17.0
* , we colleagues strengthened each other to face the fear	7	3.8	14	7.7	20	10.9	23	12.6	67	36.6	52	28.4
* , the sense of being part of a team strengthened	16	8.8	19	10.5	26	14.4	55	30.4	42	23.2	23	12.7
* , service meetings were also an opportunity for group reflection on work practices	8	4.4	14	7.7	24	13.2	42	23.1	61	33.5	33	18.1
* , the guidelines of the Local Health Authority on how to work in safety have made us feel more reassured	26	14.3	28	15.4	40	22.0	43	23.6	33	18.1	12	6.6
<b>Flexibility and ability to reinvent the service</b>												
* , we become more flexible to remain close to users	7	3.8	12	6.6	20	11.0	39	21.4	53	29.1	51	28.0
* we reinvented our way of working in line with government decrees	2	1.1	5	2.8	10	5.5	20	11.0	62	34.3	82	45.3
* , we were able to make organizational/operational changes very quickly	6	3.3	5	2.7	16	8.8	34	18.7	59	32.4	62	34.1
* , we mediated between user demands and the procedures needed to work safely	1	0.5	0	0	6	3.3	32	17.6	71	39.0	72	39.6
<b>Maintenance and introduction of best practices</b>												
* we increased phone contact with users	4	2.2	4	2.2	9	5.0	15	8.4	55	30.7	92	51.4
* , we took more care of the cleanliness of the working places	2	1.1	6	3.3	12	6.5	12	6.5	58	31.5	94	51.1
* , we placed more importance on family members and close relationships of users	4	2.2	11	6.1	27	15.0	43	23.9	60	33.3	35	19.4
* , we learned to use digital communication technologies to work with other public institutions and the third sector	1	0.5	2	1.1	11	6.0	25	13.7	56	30.8	87	47.8
* , we paid more attention to the physical health of users	5	2.8	4	2.2	16	8.8	50	27.6	66	36.5	40	22.1
* , we redefined the use of service spaces in a more rational way	5	2.8	10	5.6	15	8.4	36	20.1	51	28.5	62	34.6
* , we revised the users' programs according to their new needs	2	1.1	3	1.7	19	10.6	31	17.3	71	39.7	53	29.6
* , I learned to use the pc and digital technologies better (e.g., video calling and conferencing platforms)	10	5.5	12	6.6	15	8.2	41	22.5	44	24.2	60	33.0
* , the CMHC remained the key point of referral for people with a fragile/absent family network	9	5.2	11	6.4	13	7.5	27	15.6	47	27.2	66	38.2
* , during hospitalization we guaranteed the contact of users with their families	2	1.2	11	6.7	15	9.1	29	17.7	57	34.8	50	30.5
* , we also managed as much as possible at home for people in crisis	4	2.3	5	2.9	17	9.9	32	18.6	57	33.1	57	33.1
* , we informed users about the pandemic and how to reduce individual risk of infection	0	0	1	0.5	5	2.7	9	4.9	62	34.1	105	57.7
<b>Acknowledgement of positive aspects in the pandemic experience</b>												
* , I found some positives in this experience	8	4.4	12	6.6	17	9.3	37	20.2	54	29.5	55	30.1

\*during the pandemic.

Table 3. Confirmatory Factorial Analysis (CFA) on the 30 items of the QT-S (N=184).

Items	Factor loadings				
	1	2	3	4	5
* , people with severe mental disorder demonstrated good adaptive skills	.42				
* , I discovered in many users personal resources that I did not believe they had	.72				
* , users organized themselves into peer support groups	.60				
* , users showed that they are able to self-organize and find new solutions	.71				
* , I realized that there are users who know how to use digital technologies better than I do	.33				
* , we realized how important simple gestures like drinking coffee together, shaking hands and hugging each other were		.43			
* , there was more sharing of responsibilities within the team		.74			
* , more centrality was given to the meeting and dialogue with the other person		.68			
* , I had more time to think about my work		.42			
* , we colleagues strengthened each other to face the fear		.64			
* , the sense of being part of a team strengthened		.83			
* , service meetings were also an opportunity for group reflection on work practices		.70			
* , the guidelines of the Local Health Authority on how to work in safety have made us feel more reassured		.60			
* , we become more flexible to remain close to users			.70		
* we reinvented our way of working in line with government decrees			.54		
* , we were able to make organizational/operational changes very quickly			.63		
* , we mediated between user demands and the procedures needed to work safely			.57		
* we increased phone contact with users				.31	
* , we took more care of the cleanliness of the working places				.48	
* , we placed more importance on family members and close relationships of users				.54	
* , we learned to use digital communication technologies to work with other public institutions and the private social sector				.45	
* , we paid more attention to the physical health of users				.69	
* , we redefined the use of service spaces in a more rational way				.61	
* , we revised the users' programs according to their new needs				.72	
* , I learned to use the pc and digital technologies better (e.g., video calling and conferencing platforms)				.50	
* , the CMHC remained the key point of referral for people with a fragile/absent family network				.35	
* , during hospitalization we guaranteed the contact of users with their families				.32	
* , we also managed as much as possible at home for people in crisis				.34	
* , we informed users about the pandemic and how to reduce individual risk of infection				.41	
* , I found some positives in this experience					1
Cronbach's $\alpha$	.68	.83	.71	.79	-

\*During the pandemic; Factor 1: Acknowledgement of user capabilities; factor 2: Awareness and value of teamwork; factors 3: Flexibility and ability to reinvent the service; factor 4: Maintenance and introduction of best practices; factor 5: Acknowledgement of positive aspects in the pandemic experience. The correlations among the five factors were all significant for  $p < .001$  (standardized solution).



Table 4. MH staff views on positive changes during the pandemic: differences related to participants' workplaces.

QT-S factors	Participants' workplaces			MANOVA
	DH, residential facilities and (N=26)	CMHC (N=89)	Coops (N=57)	F (2, 172)
	mean ± sd	mean ± sd	mean ± sd	
Acknowledgement of user capabilities	3.5±0.9	3.8±0.9	3.5±0.9	3.57, p<.05
Awareness and value of teamwork	3.9±0.7	4.2±0.9	4.3±1.1	2.08, NS
Flexibility and ability to reinvent the service	4.5±0.8 <sup>b</sup>	4.8±0.9 <sup>a,b</sup>	5.1±0.8 <sup>a</sup>	5.90, p<.01
Maintenance and introduction of best practices	4.5±0.5 <sup>b</sup>	5.0±0.6 <sup>a</sup>	4.8±0.6 <sup>a,b</sup>	6.34, p<.01
Acknowledgement of positive aspects in the pandemic experience	4.3±1.5	4.5±1.3	4.6±1.5	0.65, NS

\*12 missing data excluded from MANOVA; Bonferroni post-hoc comparisons: a>b; NS=non-significant p value.



# Views of Mental Health Professionals on Positive Changes in Service Practices and Staff-User Relationships After One Year of Covid-19 Pandemic in Italy

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**Abstract** This study explored views of mental health services (MHS) professionals regarding positive changes in service practices and organizations, and staff-user relationships after one year of COVID-19 in Italy. Professionals from a community-oriented MHS completed online the Questionnaire on MHS Transformations during the COVID-19 pandemic, a 30-item tool developed by a participatory approach and validated. Of the 184 participants, 91.8% felt it was “true/definitely true” that during the pandemic they had informed users on procedures to reduce contagion risks, and 82.1% stated that they had increased telephone contact with users. Sixty-nine percent of professionals reported that staff revised treatment plans according to new needs of care and 78.6% stated that they had been able to mediate between user needs and safe working procedures.

Moreover, 79.4% of respondents stated that they had rediscovered the importance of gestures and habits, and 65% that they had gained strength among colleagues to face fear. Fifty-four percent of participants admitted that they had discovered unexpected personal resources in users. Overall, 59.6% of participants stated that they found some positives in the COVID-19 experience. Perceived positive changes was greater among professionals from community facilities vs. those from hospital and residential facilities. In community-oriented MHS, the pandemic offered an opportunity to change practices and rethink the meaning of relationships between people. This data may be useful in generating a more balanced understanding of COVID-19’s impact on MHS and for MHS planning in the pandemic era.

**Keywords** COVID-19 · Mental health staff · Mental health services · Service users · Staff views

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## Introduction

Since the early phase of COVID-19 pandemic, research has shown an increase of mental health problems in the general population [23, 30] and negative effects on mental health services (MHS) [12, 30], particularly in the reduction of hospital and community activities, and the closure of residential

facilities [2, 5, 26]. In persons with mental disorders, clinical worsening, increased social isolation [9], and difficulties in accessing care were reported [26]. Among the staff, stress and burnout were indicated [22], mainly related to abrupt work changes, fear of contagion, and difficulty in ensuring acceptable levels of care to persons with severe mental disorders [15].

While negative effects of COVID-19 pandemic on MHS have been largely described, its potential beneficial effects have been relatively unexplored. The preponderance of difficulty-focused studies [4, 9, 15, 26] may have led to an underestimation of the role those adaptive mechanisms may have exerted on MHS staff, positively influencing relationships and practices. Available data revealed that sometimes the COVID-19 pandemic has led to increased staff collaboration, reduced bureaucracy, and greater flexibility in healthcare [1, 11, 15]. Remote work was useful to facilitate staff participation in meetings and to provide psychological support and clinical assessments to users [4, 15, 26]. Staff perception of the pandemic as leading something useful was also reported [4]. In users with severe mental disorders, the widespread reduction in social relationships has been found to be associated with reduced marginalization and increased empathy toward them [9]. The focus on the pandemic seemed to distract some users from their mental condition, apparently leading to symptom relief [26] and a greater community involvement [9]. Available studies were often conducted using qualitative methodologies, which are difficult to adopt in routine settings, or through poorly validated tools. Moreover, most studies were conducted at the beginning of the pandemic, when coping mechanisms were centered on initial emotional reactions, but these were later replaced by problem solving strategies [17]. It is likely that the persistence of COVID-19 pandemic has led mental health professionals to develop new organizational and intervention approaches, and to give new values to their work and the relationships with users and their families. Knowledge of this data may be useful in generating a more balanced understanding of COVID-19 pandemic's impact on MHS and for mental health policy planning in the pandemic era [10].

During the first year of the COVID-19 pandemic, Italy was one of the most affected European countries, with 2,800,000 infected people and 95,000 fatalities at one year [14, 21]. During the first lockdown (from

March 9 to May 18, 2020), MHS activities dropped by 30% overall, while voluntary and compulsory hospital admissions dropped by 50% and 70%, respectively [2, 24]. In MHS closely aligned to a community-oriented approach, outpatients services continued to operate normally during the emergency, while hospital services decreased their activities [3]. As of summer 2020, most clinical and rehabilitation activities gradually resumed at the pre-COVID-19 levels, including collaboration of the third sector and user and family associations [7].

This study explored views of MHS professionals regarding the beneficial changes occurred in service practices and organizations, and in staff-user relationships during the first year of the COVID-19 pandemic in Italy. The research was conducted in the Trieste MHS, one of the MHS network with the longest experience of community care in Italy and internationally [20, 28]. The study was carried out using an ad hoc questionnaire developed by a participatory approach and then validated. In particular, the study examined views of the MHS staff regarding the following issues:

- (a) Acknowledgement of user capabilities
- (b) Awareness and value of teamwork
- (c) Flexibility and ability to reinvent the service
- (d) Maintenance and introduction of best practices
- (e) Acknowledgement of positive aspects in the pandemic experience.

With respect to the issues listed above, the study tested whether the perception of beneficial changes was greater in staff from community services vs. those from hospital and residential services.

## Materials and Methods

### Study Design and Participants

The research was conducted in the Trieste MHS from September to December 2020 (preliminary phase of instrument development) and from February to March 2021 (main phase of data collection). The Trieste MHS is managed by the Department of Mental Health of the Giuliano Isontina University Health Authority (Azienda Sanitaria Universitaria Giuliano Isontina – ASUGI) and covers Trieste and the nearby territory of Gorizia (catchment area: 370,000 inhabitants).

The eligible sample consisted of professionals from the Mental Health Department and the third sector working in synergy with the Department. Staff hired after March 2020 (first COVID-19 lockdown in Italy) were excluded from the study. The expected sample was 248 Mental Health Department staff and 174 third sector staff, respectively. Potential participants were invited to complete online an anonymous questionnaire on their views regarding the positive changes occurred in the MHS during the pandemic. The questionnaire was specifically developed for the purposes of the study by using a participatory approach (see assessment instrument section).

The study was coordinated by the Department of Psychology of the University of Campania “Luigi Vanvitelli”, Caserta, Italy and conducted in collaboration with the Department of Mental Health of the Giuliano Isontina University Health Authority (ASUGI), Trieste, Italy. Study protocol was approved by the Ethics Committee of the Department of Psychology of the University of Campania “Luigi Vanvitelli”, Caserta, Italy (authorization n. 1 of 2/2/2021) and acknowledged by the Office of Clinical and Epidemiological Studies, SC Research and Innovation, ASUGI, Trieste, Italy. The study was conducted in accordance with the Helsinki Declaration.

### Setting

The Trieste MHS network adheres to a no-restraint system of care and operates according to “open door” and maximum accessibility principles (non-selection of demands) [19]. It includes community mental health centers, a general hospital psychiatric unit, and residential facilities. The community mental health centers are open 24 h a day, 7 days a week and cover most care needs, including crisis management, mental disorder prevention, and pharmacological and rehabilitative interventions. The general hospital psychiatry unit is a six-bed ward located in the General Hospital of Trieste and serving the entire catchment area of the Trieste MHS. This inpatients unit is dedicated to voluntary and compulsory admissions of persons with acute psychiatric symptoms. It is mainly used for night emergencies and the duration of admissions is short (a few days): people are transferred as soon as possible from the psychiatric unit of the general hospital to the reference mental health center, where there are additional beds for the community

management of acute psychiatric conditions. Residential care is provided by supported housing facilities managed by the third sector in collaboration with the Mental Health Department. The Mental Health Department collaborates with many social cooperatives promoting recovery, social inclusion, and employment programs. Individuals are supported in accessing social opportunities and in pursuing individualized rehabilitative plans, developed using a health budget approach [8, 27]. The Trieste MHS network is listed by the WHO as one of the most innovative and well-established community mental health systems [28, 29].

### Data Collection

The online data collection was conducted from February 15 through March 31, 2021. At the beginning of the data collection and twice during it, potential participants received an email from the employer inviting them to participate in an online study requesting their views regarding the transformations that occurred in the service during the first year of the COVID-19 pandemic. Those who accepted completed the Questionnaire on MHS Transformations during the COVID-19 pandemic—Staff version (QT-S). The research was also presented at the monthly team meeting by the Mental Health Department Director in March 2020. Participation was also solicited by word of mouth and WhatsApp by Mental Health Department coordinators and referents from cooperatives.

Participants completed the QT-S online using their personal devices (staff received a link to Google forms via invitation e-mails and WhatsApp messages). The possibility to stop the completion of QT-S and delete the answers already given was guaranteed by the online mode (simply close the Internet page without saving).

### Assessment Instrument

The QT-S is a self-reported assessment instrument exploring staff views on potential positive changes occurred in MHS during the pandemic. The QT-S development took place from September to December 2020 by a workgroup including researchers, clinicians, and coordinators of the main health sectors involved in the study. Initially, workgroup members individually examined six video interventions by staff presented at

a webinar on the effects of COVID-19 pandemic on the MHS network of Trieste and Gorizia, held in September 2020 [6]. Using an ad hoc form, each participant extrapolated the prevailing themes from the video-interventions and rephrased the speakers' statements as multiple-choice items. This process led to a preliminary list of 232 items that were individually scored by the participants for clarity/appropriateness on a 10-point scale,—ranging from 1 “not at all” to 10 “completely”—and for inclusion/exclusion in the questionnaire. Items with a clarity/appropriateness score  $< 7$  and/or suitable for inclusion by no more than 4/7 participants were eliminated ( $N = 160$ ). The remaining 72 items were revised by the work-group, and 25 redundant items were removed. The 47 items were re-evaluated for clarity/usefulness and inclusion/exclusion, and additional 17 items were excluded. The final 30 items were grouped on the following content basis: a) Acknowledgement of user capabilities (5 items); b) Awareness and value of teamwork (8 items); c) Flexibility and ability to reinvent the service (4 items); d) Maintenance and introduction of best practices (12 items); e) Acknowledgement of positive aspects in the pandemic experience (1 item). The rating scale included 6 levels, ranging from 1 “not really true” to 6 “really true.” In addition to the 30 items there was: an initial section of study aims and informed consent to participate and publish data; two additional open-ended items on respondent views of the most positive and most negative effects of COVID-19 pandemic on MHS; and, a section on the respondent's main sociodemographic and professional characteristics.

### Statistical Analysis

Descriptive statistics were computed based on QT-S 30-items and the main socio-demographic and professional characteristics. Confirmatory Factorial Analysis was performed on the global sample to verify QT-S construct validity. Maximum likelihood estimation of the covariances was applied. Cronbach's  $\alpha$  values were computed to explore content validity of the confirmed factors. Multivariate Analysis of Variance and Bonferroni's post-hoc were used to compare the mean scores of the five QT-S factors (dependent variables) with respect to main work settings (community mental health centres vs. social cooperatives vs residential facilities vs. general hospital psychiatric

unit—dependent variable). Statistical significance level was set at  $p < 0.05$ . Confirmatory Factorial Analysis was performed using the LISREL 8 Program [16]. Other tests were performed using the SPSS package, version 21 [13].

### Results

A total of 184 professionals completed the online questionnaire (participation rate: 43.6%). Participants had a mean age of  $46.3 \pm 10.5$  (SD) years and most of them were females (61.4%), and highly educated (68.5%). Participants' professional roles were as follows: psychiatrist 9.2%; psychologist 6.0%; nurse 31.0%; health care assistant 4.9%; educator/rehabilitator 23.8%; social cooperatives worker 16.3%; social worker 1.6%; administrative staff 3.3%; other/not specified: 3.7%. Participants worked in the mental health field for  $13.8 \pm 9.5$  years on average. Of the 184 participating professionals, 48.4% worked in community mental health centers, 31.0% in social cooperatives, 7.6% in the general hospital psychiatric unit, and 6.5% worked in residential facilities (missing data 6.5%).

Ninety-two percent of participants felt it was “true/definitely true” (scores 5 and 6) that during the pandemic they had informed users on procedures to reduce individual risk of contagion, and 82.6% stated that they had taken greater care in the cleanliness of the environments (Table 1). Eighty-two percent stated that they had increased telephone contact with users, and 69.3% reported that staff revised individual treatment plans according to users' new needs of care. Moreover, 58.6% of respondents stated that they had paid greater attention to users' physical health, and 66.2% indicated that they had managed people in crisis as much as possible at home. Seventy-nine percent of staff learned to use digital technologies to work with public and private social institutions. Seventy-nine percent stated that the staff had been able to mediate between user needs and safe working procedures and 57.1% indicated that they had become more flexible regarding working alongside people during the pandemic. Moreover, 79.4% of respondents stated that the team had rediscovered the importance of gestures and habits, and 65.0% that they had gained strength among colleagues to face fear. Fifty-four percent of participants admitted that they had

**Table 1** Views of MHS staff on positive changes during the first year of the COVID-19 pandemic (N = 184)

QT-S items	Not really true Really true											
	1		2		3		4		5		6	
	N	%	N	%	N	%	N	%	N	%	N	%
<b>Acknowledgement of user capabilities</b>												
*, people with severe mental disorder demonstrated good adaptive skills	3	1.6	25	13.7	41	22.4	49	26.8	57	31.1	8	4.4
*, I discovered personal resources in users that I did not believe they had	7	3.8	9	4.9	21	11.5	46	25.3	64	35.2	35	19.2
*, users organized themselves into peer support groups	34	19.5	43	24.7	45	25.9	29	16.7	14	8.0	9	5.2
*, users showed that they were able to self-organize and find new solutions	12	6.7	23	12.8	33	18.4	57	31.8	41	22.9	13	7.3
*, I realized that there were users who know how to use digital technologies better than I did	29	16.4	27	15.3	24	13.6	36	20.3	30	16.9	31	17.5
<b>Awareness and value of teamwork</b>												
*, we realized the importance of simple gestures like drinking coffee together, shaking hands, hugging each other	6	3.3	6	3.3	10	5.4	16	8.7	43	23.4	103	56.0
*, there was more sharing of responsibilities within the team	10	5.5	16	8.7	26	14.2	46	25.1	54	29.5	31	16.9
*, more centrality was given to the meetings and to dialogue with the other person	6	3.3	14	7.8	35	19.4	57	31.7	43	23.9	25	13.9
*, I had more time to think about my work	15	8.2	22	12.1	31	17.0	37	20.3	46	25.3	31	17.0
*, we colleagues strengthened each other to face the fear	7	3.8	14	7.7	20	10.9	23	12.6	67	36.6	52	28.4
*, the sense of being part of a team strengthened	16	8.8	19	10.5	26	14.4	55	30.4	42	23.2	23	12.7
*, service meetings were an opportunity for group reflection on work practices	8	4.4	14	7.7	24	13.2	42	23.1	61	33.5	33	18.1
*, the guidelines of the Local Health Authority on how to work safely made us feel more reassured	26	14.3	28	15.4	40	22.0	43	23.6	33	18.1	12	6.6
<b>Flexibility and ability to reinvent the service</b>												
*, we became more flexible toward remaining close to users	7	3.8	12	6.6	20	11.0	39	21.4	53	29.1	51	28.0
*, we reinvented our way of working in line with government mandates	2	1.1	5	2.8	10	5.5	20	11.0	62	34.3	82	45.3
*, we were able to make organizational/operational changes very quickly	6	3.3	5	2.7	16	8.8	34	18.7	59	32.4	62	34.1
*, we mediated between user demands and the procedures needed to work safely	1	0.5	0	0	6	3.3	32	17.6	71	39.0	72	39.6
<b>Maintenance and introduction of best practices</b>												
*, we increased phone contact with users	4	2.2	4	2.2	9	5.0	15	8.4	55	30.7	92	51.4
*, we took more better care maintaining cleanliness in the work environment	2	1.1	6	3.3	12	6.5	12	6.5	58	31.5	94	51.1
*, we placed more importance on family members and the close relationships of users	4	2.2	11	6.1	27	15.0	43	23.9	60	33.3	35	19.4
*, we learned to use digital communication technologies to work with other public institutions and the third sector	1	0.5	2	1.1	11	6.0	25	13.7	56	30.8	87	47.8
*, we paid more attention to the physical health of users	5	2.8	4	2.2	16	8.8	50	27.6	66	36.5	40	22.1
*, we redefined the use of service spaces in a more rational way	5	2.8	10	5.6	15	8.4	36	20.1	51	28.5	62	34.6
*, we revised the users' programs according to their new needs	2	1.1	3	1.7	19	10.6	31	17.3	71	39.7	53	29.6

**Table 1** continued

QT-S items	Not really true Really true											
	1		2		3		4		5		6	
	N	%	N	%	N	%	N	%	N	%	N	%
*, learned to use the PC and digital technologies better (e.g., video calling and conferencing platforms)	10	5.5	12	6.6	15	8.2	41	22.5	44	24.2	60	33.0
*, the CMHC remained the key point of referral for people with a fragile/absent family network	9	5.2	11	6.4	13	7.5	27	15.6	47	27.2	66	38.2
*, during hospitalization we guaranteed the contact of users with their families	2	1.2	11	6.7	15	9.1	29	17.7	57	34.8	50	30.5
*, we managed people in crisis as much as possible at home	4	2.3	5	2.9	17	9.9	32	18.6	57	33.1	57	33.1
*, we informed users about the pandemic and how to reduce individual risk of infection	0	0	1	0.5	5	2.7	9	4.9	62	34.1	105	57.7
<b>Acknowledgement of positive aspects in the pandemic experience</b>												
*, I found some positives in this experience	8	4.4	12	6.6	17	9.3	37	20.2	54	29.5	55	30.1

\*During the pandemic

discovered personal resources in many users that they had not expected, and 35.5% acknowledged that persons with severe mental disorders had shown good adaptive skills in the pandemic. Overall, 59.6% of participants stated that they found some positives in the COVID-19 pandemic experience.

Confirmatory Factorial Analysis performed on the 30 QT-S items, confirmed the five-factor structure. The final model fit the data well,  $\chi^2(396) = 900.24$ ,  $p < 0.001$ ; non-normed fit index [NNFI] = 0.90; comparative fit index [CFI] = 0.91; root mean square error of approximation [RMSEA] = 0.087, 90% C.I. (0.080; 0.095); standardized root mean square residual [SRMR] = 0.086. All factor loadings were significant at the  $p < 0.001$  level. Cronbach’s  $\alpha$  values ranged from 0.68 to 0.83 (see Table 2 for details of the psychometric analyses).

Multivariate Analysis of Variance showed significant differences between the facilities with respect to staff perception of maintenance/introduction of practices, service flexibility, and acknowledgement of users’ capacities (Wilks’s  $\lambda = 0.72$ ,  $F(10, 330) = 5.9$ ,  $p < 0.0001$ ). Bonferroni’s post hoc highlighted a greater perception of changes in practices among community mental health centers staff vs. general hospital psychiatric unit and residential facilities staff; and, a greater perception of service flexibility among social cooperatives staff vs. general hospital psychiatric unit and residential facilities staff. The analysis

also showed a tendency for greater acknowledgement of users’ capabilities among community mental health centers staff vs. social cooperatives staff ( $p = 0.56$ ). No other significant difference between facilities was detected (Table 3).

## Discussion

### Interpretation of the Results

The results of this study indicated that after one year of the pandemic, most MHS staff felt they had been able to change practices and reinvent the work organization, reevaluating teamwork and recognizing capabilities to users. The study also revealed that perceptions of positive changes were greater among professionals working in the community than among those working in hospital/residential facilities.

Most participants stated that they had found some positives in the pandemic experience. This belief may reflect the high percentage of “true/completely true” responses to most items, which, in turn, could be an indirect indicator of the service resiliency. It is likely that the one-year assessment gave enough time for people to use their inherent capacities to bounce back. It should be noted that positive changes involve several aspects of MHS functioning, such as revision of therapeutic plans in light of new needs for care,

**Table 2** Confirmatory Factorial Analysis (CFA) on the 30 items of the QT-S (N = 184)

Items	Factor loadings				
	1	2	3	4	5
*, people with severe mental disorder demonstrated good adaptive skills	.42				
*, I discovered personal resources in users that I did not believe they had	.72				
*, users organized themselves into peer support groups	.60				
*, users showed that they were able to self-organize and find new solutions	.71				
*, I realized that there were users who know how to use digital technologies better than I did	.33				
*, we realized the importance of simple gestures like drinking coffee together, shaking hands, and hugging each other		.43			
*, there was more sharing of responsibilities within the team		.74			
*, more centrality was given to the meetings and to dialogue with the other person		.68			
*, I had more time to think about my work		.42			
*, we colleagues strengthened each other to face the fear		.64			
*, the sense of being part of a team strengthened		.83			
*, service meetings were an opportunity for group reflection on work practices		.70			
*, the guidelines of the Local Health Authority on how to work safely made us feel more reassured		.60			
*, we became more flexible toward remaining close to users			.70		
*, we reinvented our way of working in line with government mandates			.54		
*, we were able to make organizational/operational changes very quickly			.63		
*, we mediated between user demands and the procedures needed to work safely			.57		
*, we increased phone contact with users				.31	
*, we took more better care maintaining cleanliness in the work environment				.48	
*, we placed more importance on family members and the close relationships of users				.54	
*, we learned to use digital communication technologies to work with other public institutions and the third sector				.45	
*, we paid more attention to the physical health of users				.69	
*, we redefined the use of service spaces in a more rational way				.61	
*, we revised the users' programs according to their new needs				.72	
*, I learned to use the PC and digital technologies better (e.g., video calling and conferencing platforms)				.50	
*, the mental health center remained the key point of referral for people with a fragile/absent family network				.35	
*, during hospitalization we guaranteed the contact of users with their families				.32	
*, we managed people in crisis as much as possible at home				.34	
*, we informed users about the pandemic and how to reduce individual risk of infection				.41	
*, I found some positives in this experience					1
Cronbach's $\alpha$	.68	.83	.71	.79	-

\*During the pandemic; Factor 1: Acknowledgement of user capabilities; factor 2: Awareness and value of teamwork; factors 3: Flexibility and ability to reinvent the service; factor 4: Maintenance and introduction of best practices; factor 5: Acknowledgement of positive aspects in the pandemic experience. The correlations among the five factors were all significant for  $p < .001$  (standardized solution)

greater attention to users' physical health, and increased home-based crisis management. In line with other studies [4, 15, 26], most participants reported an increased use of digital technology. The use of video-communication platforms not only reduced travel-

related workloads but also led to devising innovative treatment packages. In particular, since the early pandemic phase, a platform for help care, entertainment and training was developed to integrate into the healthcare programs. The "Platform for Inclusion"



**Table 3** Views of mental health services staff on positive changes during the pandemic: differences between work settings

QT-S factors	Participants' workplaces			MANOVA F (2, 172)
	Residential facilities and general hospital psychiatric unit (N = 26)	Community mental health centers (N = 89)	Social cooperatives (N = 57)	
	mean ± sd	mean ± sd	mean ± sd	
Acknowledgement of user capabilities	3.5 ± 0.9	3.8 ± 0.9	3.5 ± 0.9	3.57, < .03
Awareness and value of teamwork	3.8 ± 0.7	4.2 ± 0.9	4.3 ± 1.0	2.08, NS
Flexibility and ability to reinvent the service	4.5 ± 0.8 <sup>b</sup>	4.8 ± 0.9 <sup>a, b</sup>	5.1 ± 0.8 <sup>a</sup>	5.90, < .003
Maintenance and introduction of best practices	4.5 ± 0.5 <sup>b</sup>	5.0 ± 0.6 <sup>a</sup>	4.7 ± 0.6 <sup>a, b</sup>	6.39, < .002
Acknowledgement of positive aspects in the pandemic experience	4.3 ± 1.4	4.5 ± 1.3	4.6 ± 1.5	0.65, NS

\*12 missing data excluded from Multivariate Analysis of Variance (MANOVA); Bonferroni post-hoc comparisons: a > b; NS = non-significant p value

enhanced home activities, facilitated the acquisition of skills and new educational tools by the users, and reduced loneliness [6]. Effectiveness studies are needed to assess the long-term impact and feasibility of digital resources on MHS in the COVID-19 pandemic era [10].

Fifty-seven percent of the participants indicated that they had become more flexible regarding working alongside people during the pandemic, a percentage higher than that reported by D'Avanzo et al. [4] in the early COVID-19 pandemic, where 32% of MHS staff pointed out greater work flexibility. In line with previous research data [15], most professionals revalued the teamwork and relied upon colleagues' support to cope with contagion fear. Interestingly, 54.4% of participants were convinced that they discovered personal resources in users that they did not expect to find, and 35.5% acknowledged good coping skills to people with severe mental disorders. As hypothesized by some authors [9, 26], it might be that the reduced social pressure facilitated the adaptation of users with severe mental disorders to the pandemic. Another explanation could be that the pandemic reduced users' social opportunities within the MHS. This may have led some to revalue external social relationships that, in turn, reinforced coping skills. Regardless of the motivation, the staff acknowledgement of users' capacities is encouraging, since this can positively influence stigma in MHS [18, 25] and facilitate users' empowerment. Ad hoc studies are needed to estimate

the long-term impact of the pandemic on the staff-user relationships and the recovery processes.

The study found significant differences in positive changes between facilities. Specifically, compared to residential and hospital facilities staff, professionals in community services had greater perceptions of positive changes in the practices and valued the services as more capable of adapting to users' new needs. These differences, in line with previous findings [4, 15], highlight the greater manageability of the pandemic in community MHS, which is partially related to long-term collaboration with the third sector and the user and family associations [7]. The lower perception of positive changes by the general hospital psychiatric unit and residential facilities staff could also be related to users' clinical conditions and facilities' characteristics requiring stricter rules to limit contagions [5].

Overall, the encouraging results of this study can be interpreted within the framework of Lazarus and Folkman's [17] transactional model, which postulates that the adaptation to an event is a process based on primary and secondary cognitive appraisal. Regarding the impact of COVID-19 pandemic on MHS, primary appraisal referred to what the pandemic was, as documented by the early-phase studies. Secondary appraisal concerned the emotional and problem-oriented strategies to cope with the pandemic in the long-term. Internal factors, such as individual attitudes and commitment to work, and external factors, such as MHS approach and team cohesion, may have

influenced the adaptation process. This, in turn, may have led professionals to recognize several positive changes in their work during the pandemic, despite the difficulties they encountered [2, 22].

### Strength and Limitations of the Study

This is the first study conducted in Italy that systematically explored staff views on the positive transformations occurring in MHS during the first year of the pandemic. The multidisciplinary working group and the participatory approach facilitated the development of an instrument, which was well accepted by participants (low percentage of missing responses) and encompassed different perspectives. The fact that the QT-S is rapid to fill in and has good psychometric properties will facilitate the study replication in other settings as well as data comparison. Moreover, the fact that the QT-S items can be grouped into five higher-order dimensions makes it easier to interpret the results.

The survey was conducted in a single MHS network whose organizational model, largely adopted throughout the Friuli Venezia Giulia region [3], is strongly community-oriented. Therefore, the results of this study may not be fully generalizable to services with different patterns of care. Moreover, a total of 43.6% of eligible participants completed the questionnaire. It cannot be excluded that non-participants had a more negative perception of the impact of COVID-19 pandemic on the service. Therefore, the results may overestimate the positive changes in the MHS. In addition, the research investigated staff *perceptions* of positive changes and it did not explore whether such perceptions reflected real changes in the service. Nor can it be ruled out that responses were influenced by social desirability, despite the anonymity in [data collection](#). Finally, the study examines changes from the view of staff, not considering the perspectives of users and their families. Some of these limitations will be addressed in further studies, which are currently in the planning stages.

### Conclusions

This survey sought to examine the pandemic with a new approach, i.e., looking at the positive changes rather than the negative impact it produced. The study

provided a snapshot of a community-oriented MHS network that looked back and gave an all-around positive rating of its performance in the first year of the COVID-19. The results of this study highlight that, in a community-oriented MHS, the pandemic also represented—and continues to represent—an opportunity to change practices and the relationships among professionals and between professionals and users. We hoped that these data will contribute to the understanding of the impact of COVID-19 on MHS and to the design of community-oriented and person-centered services in the pandemic era [10, 28].

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**Availability of Data and Material** The data that support the findings of this study are available from the corresponding author upon reasonable request, which must include a protocol and statistical analysis plan and not be in conflict with our publication plan.

### Declarations

**Conflicts of interest** None.

**Ethics Approval** The study protocol was approved by the Ethics Committee of the Department of Psychology of the University of Campania “Luigi Vanvitelli” (authorization n. 1 of 2/2/2021), Caserta, Italy and acknowledged by the Office of Clinical and Epidemiological Studies, SC Research and Innovation, Giuliano Isontina University Health Authority (Azienda Sanitaria Universitaria Giuliano Isontina - ASUGI), Trieste, Italy. The study was carried out in accordance with the principles of the Declaration of Helsinki.

**Consent to Participate and for Publication** Informed consent for participation and data publication was requested from each participant in the initial section of the online questionnaire.

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