Ann Ist Super Sanità 2025 | Vol. 61, No. 4: 250-258
DOI: 10.4415/ANN_25_04_03

Organization and functioning of the Italian Departments of Mental Health in the pandemic and post-pandemic period

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Abstract

Introduction. The pandemic significantly affected mental health, leading to a reorganization of services. This study examines changes in Italy's Departments of Mental Health (DMHs), comparing surveys from 2021 (during COVID-19) and 2023 (post-pandemic).

Methods. The two surveys involved 19 Italian DMHs and covered variables related to mental health care (number of centres, available staff, services provided and intervention methods).

Results. Between 2021 and 2023, services show structural stability with a solid territorial network. Organizational changes point to greater flexibility and customization, with a stronger semi-residential hospital offer. Human resources give mixed signals: psychologists and health care social workers are increasing, while social workers and psychiatric rehabilitation technicians are decreasing. Clinically, hospitalizations in General Hospital Psychiatric Units (GHPUs), Emergency Department (ED) visits, and self-harm cases are rising, while psychiatric and psychological visits decline. Remote nursing and psychosocial interventions are increasing. The growth in first psychological consultations and users taken into care suggests a gradual return to in-person access and partial pre-pandemic normality.

Conclusions. The data substantiate the need for continuous attention and adequate support to address post-pandemic mental distress, highlighting the importance of reorganizing services to effectively respond to the new needs of the population.

Key words

- Departments of Mental Health
- health care
- structure and process indicators
- epidemiology

INTRODUCTION

The consequences of the pandemic have affected people's mental health and psychosocial well-being in several ways. These include bereavement, social isolation, fear of infection or infecting others, uncertainty about the economic consequences and loss of livelihood, and anxiety about future developments. The measures implemented to combat the spread of infection have resulted in a marked decline in various protective factors, including social support, engagement in professional and academic studies, opportunities for physical activity, daily routines, and access to healthcare services. The interplay of these factors has resulted in an increase in mental health concerns within the general population, while concurrently exacerbating those already present in individuals diagnosed with a mental disorder [1].

The World Health Organization [2] has indicated that in over ninety percent of cases, services directed at the management of mental disability on a global scale were disrupted during the early months of the pandemic. In response to the crisis, several services attempted to manage the situation by offering remote provisions, including psychological support and virtual psychiatric consults via telephone and video calls. However, it is important to acknowledge the possibility of a deterioration in care conditions, which may be attributable to the organisational stresses experienced by services and

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the deterioration of mental health in the population. Although mental health services in Italy have appeared to be resilient in maintaining their operations, there is a conspicuous absence of definitive data concerning the scope of their functionality and the accessibility of these services, either in-person or remotely, to individuals in the period after the first waves of the pandemic.

At the end of 2020, the Centre for Behavioural Sciences and Mental Health of the Italian National Institute of Health (Istituto Superiore di Sanità, ISS, Rome), with the support of the Ministry of Health, promoted the project "Consolidation of national sentinel Departments of Mental Health (DMHs) network for monitoring the consequences of the SARS-CoV-2 pandemic on mental health" [3]. Mental health care in Italy is provided by about 139 DMHs that include territorial services for outpatient day care (Community Mental Health Centres, CMHCs); semi-residential facilities (day centres, DCs); non-hospital residential facilities (RFs); General Hospital Psychiatric Units (GHPUs), specialized units of the Department of Mental Health in which diagnostic, therapeutic and care activities carried out in hospital settings. Semi-residential and RFs also involve private contracted facilities and private contracted hospital departments.

The project directly involved the DMHs to conduct a timely and detailed monitoring of the organisational structure of care for people with mental disorders during the pandemic. The survey was then repeated in 2023, with the objective of describing changes over time using some activity indicators.

OBJECTIVE

The objective of the study was to describe the organisation and functioning of mental health services, with respect to a selection of indicators derived from data published by the Mental Health Information System (SISM) of the Ministry of Health, comparing data from the pandemic period (January-June 2021) with data from the post-pandemic period (January-June 2023).

METHODS

The survey involved a monthly assessment of service operations conducted from January to June 2021 and the same period in 2023. The adherence of DMHs was voluntary. Thirty-seven DMHs in 2021 and twenty-three in 2023 agreed to participate in the monitoring. The comparison was made by selecting the nineteen DMHs that had submitted complete data in both 2021 and 2023. The DMHs that participated are listed at the end of the article.

For data collection, an *ad hoc* form was prepared and shared with the DMHs. The information covered: allocation and types of staff present; hospital, residential and semi residential activities; number of users treated in-person and remotely; direct provision of assistances to the person provided by professionals present in the various services; and consultations in emergency rooms. The data collection form was made available on an online platform, built specifically for this survey. The collected data were periodically checked centrally for outliers or inconsistent values. At the end of the survey, the data were further subjected to quality verification by the survey managers at each DMHs and the ISS.

It should be emphasized that this monitoring program does not constitute nor is it intended as a measure of the efficiency or adequacy of a DMH but is only meant to gather information to evaluate the reorganization of DMHs following the pandemic experience.

The rate per 10,000 residents in the catchment area was calculated for each DMH. The "resident population as of December 31, 2020, by Local Health Units (LHUs), age and gender" published on the Ministry of Health website [4] for 2021 and that as of December 31, 2021, for 2023 data were used as the reference population. Given the high variability in the data, the median rate per 10,000 and 100,00 residents was used to summarise the information and to compare the estimates from 2021 and 2023. We also used the percentage difference between the median rate in 2023 and 2021. Changes below ±10% were not considered significant.

RESULTS

Analysis of data on the facilities and beds provided by DMHs (*Figure 1*) shows a median rate of CMHCs of 1.28 per 100,000 residents in 2021 and 1.30 in 2023. The median rate of the GHPUs offering 24-hour psychiatric consult was 0.61 per 100,000 population in 2021 and 0.57 in 2023 with a bed availability in the same services of 6.42 per 100,000 population in 2021 to 6.28 in 2023.

The median rate of GHPUs with available beds in day hospital (DH) was 0.54 per 100,000 population in

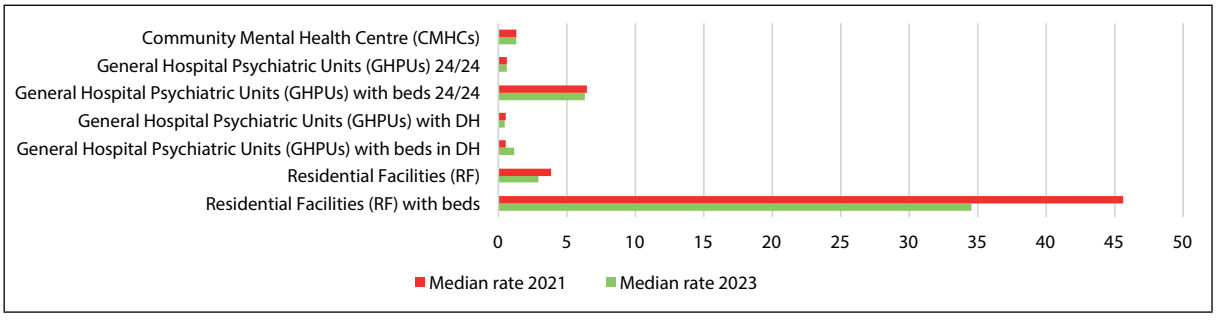

Figure 1
Facilities and beds provided by Departments of Mental Health (DMHs).

2021 to 0.48 in 2023 and the availability of DH beds in GHPUs had a median rate of 0.49 per 100,000 population in 2021 to 1.17 in 2023.

As for RFs the median rate was 3.85 per 100,000 population in 2021 to 2.92 in 2023 and that of available beds at 4.56 per 10,000 population in 2021 to 3.45 in 2023.

The median rate of psychiatrists (*Figure 2*) decreased from a value of 10.15 per 100,000 inhabitants in 2021 to 9.75 in 2023. Psychologists, on the other hand, reported a median rate of 2.98 per 100,000 inhabitants in 2021 to 3.29 in 2023. Nursing staff had a median value of 21.85 per 100,000 inhabitants in 2021 to 21.39 in 2023.

Psychiatric rehabilitation technicians and social workers reported median values of 2.13 per 100,000 inhabitants in 2021 to 1.91 in 2023 and 2.65 per 10,000 inhabitants in 2021 to 2.47 in 2023, respectively.

Health care social workers (HSW) show a median value of 3.32 per 100,000 inhabitants in 2021 and 4.39 in 2023. For administrative and support staff, values of 1.54 per 100,000 inhabitants were observed in 2021 and 1.86 in 2023.

Regarding hospital activity (*Figure 3*), the median rate of admissions occurring in GHPUs increased from 1.0 per 10,000 population in 2021 to 1.20 in 2023, and patients present in GHPUs from 1.40 per 10,000 population in 2021 to 1.55 in 2023.

Compulsory psychiatric treatments (CPT) decreased from a median rate of 0.20 per 10,000 population in 2021 to 0.15 in 2023; compulsory psychiatric evaluation (CPE) vary from 0.02 per 10,000 population in 2021 to 0.03 in 2023.

Patients discharged from RFs, reported a median rate of 0.10 per 10,000 population in 2021 to 0.09 in 2023.

In 2021, the median rate of patients who received at least one health or social provisions either in-person or remotely (provided through remote modalities, e.g., telemedicine, online consultations, etc.) was 67.20 per 10,000 population. In 2023, this value increased to 73.40. The median rate of patients who received health or social provisions exclusively remotely was 0.48 per 10,000 population in 2021 and dropped to 0.03 in 2023 (*Figure 4*).

The median rate of face-to-face provisions provided by DMHs (considering that a patient may receive more than one health and social provisions and considering the total number of psychiatric consults, psychological visits, nursing provisions and psychosocial interventions, excluding first visits) was 193.30 per 10,000 population in 2021 and 203.29 in 2023. Health and social provisions provided remotely decreased from a median of 16.70 per 10,000 population in 2021 to 8.72 in 2023 (*Figure 5*).

Total median rate of remote psychiatric and psychological consult provisions decreased from 5.09 in 2021 to 1.86 in 2023 and from 2.29 in 2021 to 0.76 in 2023, respectively, while remote nursing and psychosocial interventions increased from 2.46 in 2021 to 3.95 in 2023 and from 1.37 in 2021 to 2.57 in 2023, respectively (*Figure 6*). Total median rate in-person psychiatric and psychological consult provisions decreased from 54.18

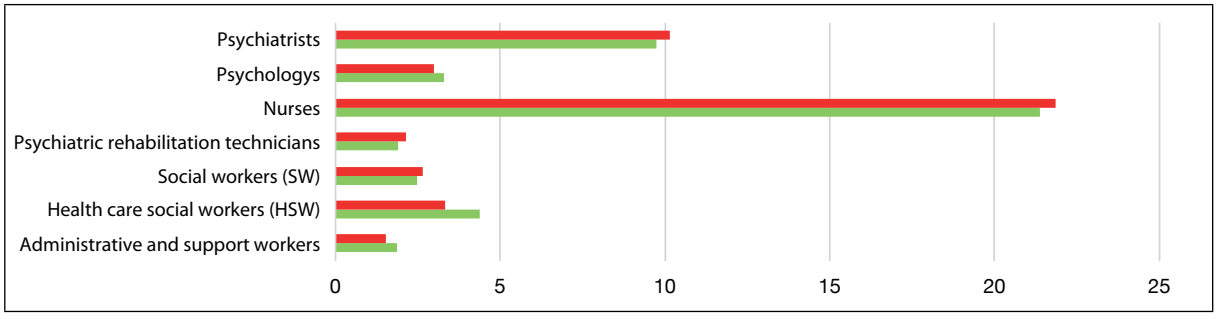

Figure 2
Departments of Mental Health (DMHs) staff.

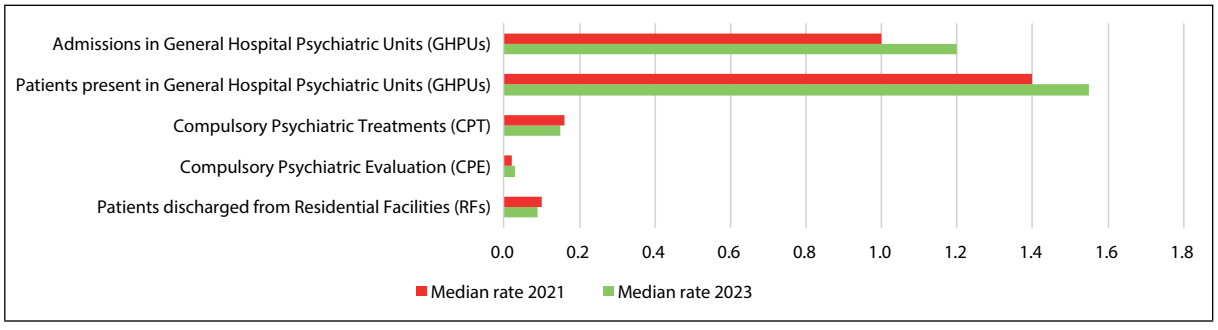

Figure 3
Residential Facilities (RFs) and hospital activities.

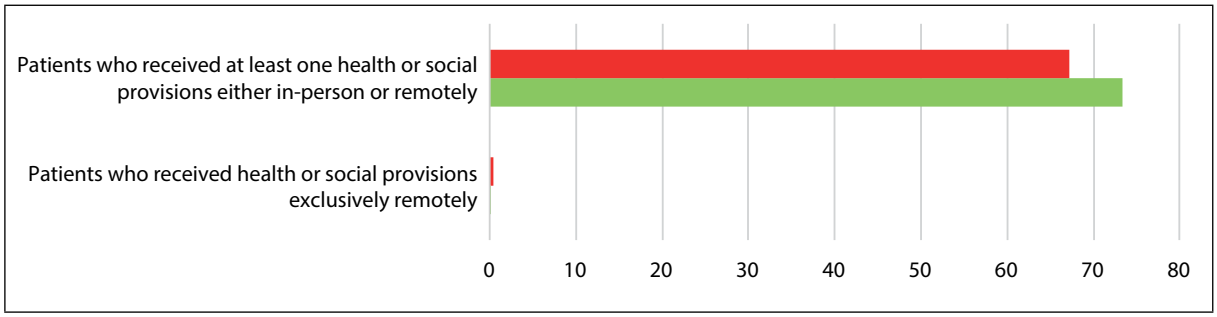

Figure 4
Patients under treatment.

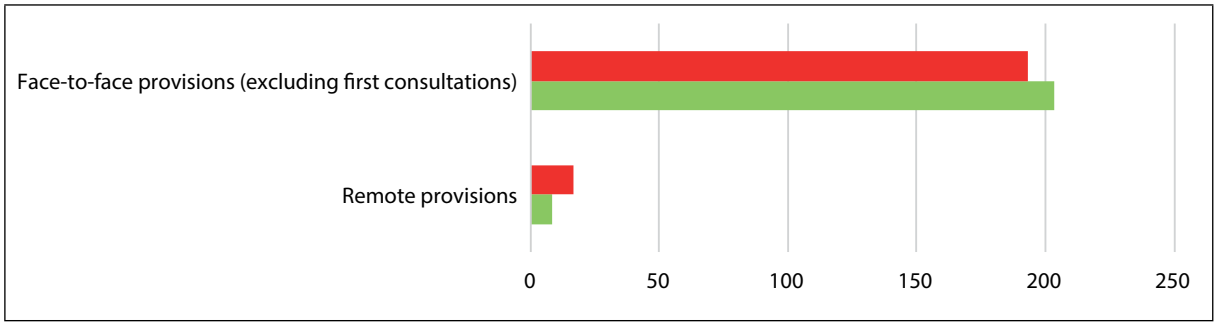

Figure 5
Provisions provided face-to-face or remotely.

in 2021 to 49.90 in 2023 and from 15.35 in 2021 to 8.33 in 2023, respectively. The first psychiatric and psychological consults took place exclusively in presence mode, with no change in the median rates for the two periods (3.90 per 10,000 in 2021 and 4.00 in 2023 for psychiatric consults; 0.60 per 10,000 in 2021 and 0.80 in 2023 for psychological consults). In 2023, the median of psychotherapy sessions was 8.22 per 10,000 population for face-to-face and 0.02 for remote. Data in 2021 was missing. In-person nursing provisions increased from 70.60 per 10,000 to 100.88 in 2023, while remote nursing provisions increased from 2.46 to 3.95 in 2023. In-person psychosocial interventions went from 33.02 per 10,000 to 31.39 in 2023, while

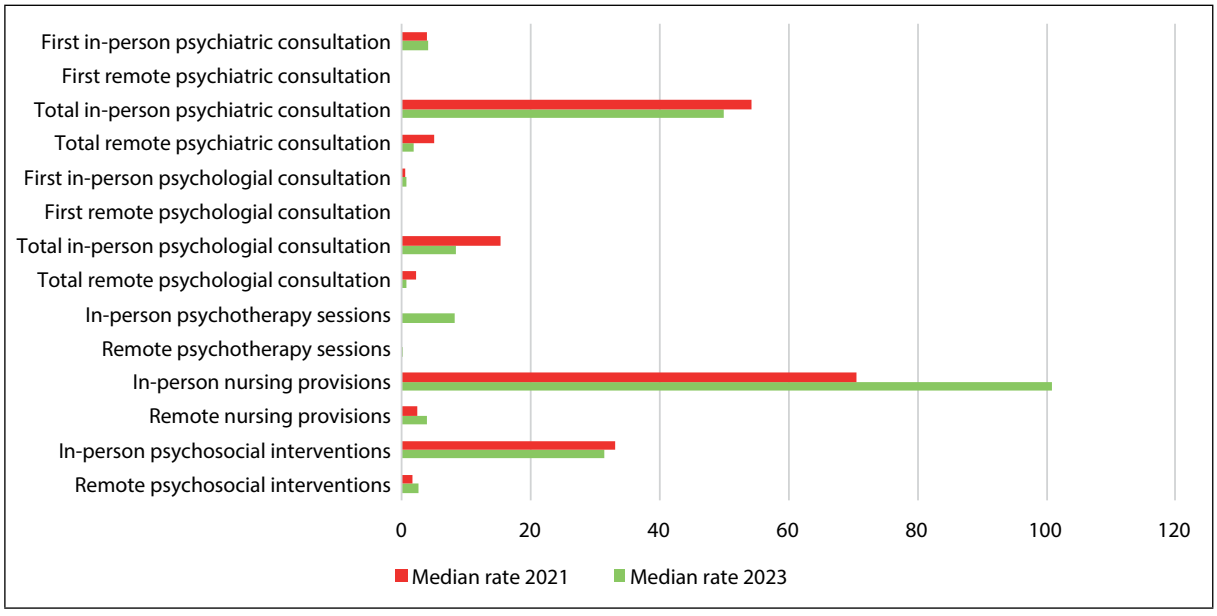

Figure 6
Type of provisions provided face-to-face or remotely.

remote psychosocial interventions went from 1.73 to 2.57 in 2023.

Regarding psychiatric and psychological consultations carried out by DMHs staff at the general hospital Emergency Department (ED) (*Figure* 7), the median rate of consultations was 2.90 per 10,000 population in 2021 and 3.44 in 2023. Self-injurious gestures ascertained at the ED were 0.20 per 10,000 in 2021 and 0.26 in 2023.

A summary of the comparison of key indicators from 2021 and 2023 is shown in *Table 1*.

DISCUSSION

Organization

The stability of the number of CMHCs in the two periods considered seems to confirm the solidity of the territorial network, the cornerstone of the national mental health system in Italy. However, the numerical data alone do not allow a complete evaluation: it will be necessary to delve deeper into the issue of human resources and capacity for care. The number of GHPUs with 24/7 care and the relative availability of beds remain equally stable in the two periods.

Although the number of GHPUs offering DH has slightly decreased (about -11%), the average number of available DH beds has more than doubled with an increase of 138.8% in 2023. This indicates a rise in semi-residential hospital activities, concentrated in a smaller number of facilities, but with greater care capacity. This model can promote greater flexibility in the therapeutic offer and respond more adequately to clinical needs without resorting to prolonged hospitalization.

Human resources

Regarding full-time permanent staff at the DMHs, in 2023, compared to 2021, a fairly stable median value of psychiatrists is observed, a 10.4% increase in psychologists, a slight decrease in social workers (-6.8%) and psychiatric rehabilitation technicians (-10.4%), indicating that some DMHs may have redirected resources towards professional profiles considered more strategic (such as psychologists), penalising other roles. Furthermore, the pandemic might have changed the organization of health service to the detriment of these professional figures. The observed increase of 32.3% in 2023 compared to 2021 in the median value of HSW probably highlights a greater demand of assistance and support to patients following the pandemic, for instrumental activities of daily living, and perhaps a greater sensitivity towards social support for people with mental disorders. The constant presence of nurses highlights their fundamental role in psychiatric health care. In-person and remote nursing provisions (mostly telephone calls aimed at assessing the progress and modulation of ongoing therapy) increased by 42.9% and 60.6% respectively in 2023, which could reflect an enhancement of the role of nursing care, especially in the territorial management of patients, in the administration of therapies and in supporting continuity of care.

Hospital activities

Data on hospital activities show a 20% increase in admissions to GHPUs in 2023 compared to 2021, indicating greater pressure on diagnosis and acute treatment departments, with a potential increase in demand for acute hospital psychiatric care. An increase, albeit smaller (10.7%) from 2021 to 2023, also affected the median rate of patients present in GHPU, suggesting a strengthening of the role of acute hospital services.

In the same period, CPT decreased by 6%, which is consistent with the trend at a national level and can be interpreted as a positive effect of early intervention and timely care by territorial services, reducing the need to resort to coercive measures.

The 50% increased use of CPE (although small in absolute value) could reflect greater attention by services in the early detection of mental distress, activating assessment interventions even in the absence of direct patient consent.

The increase in the median (18.8%) of psychiatric and psychological consultations carried out by psychiatrists and psychologists of the DMH at the ED and of self-harm gestures ascertained at the ED increased by 29.3% in the two-year period could indicate a greater use of the ED for psychological or psychiatric problems and probably an increase in acute situations, crises or states of suffering not previously intercepted in the territory. Furthermore, there is evidence of growing pressure on emergency services, which also find themselves managing aspects related to mental health. Particularly alarming are the data on the growth of self-harm ges-

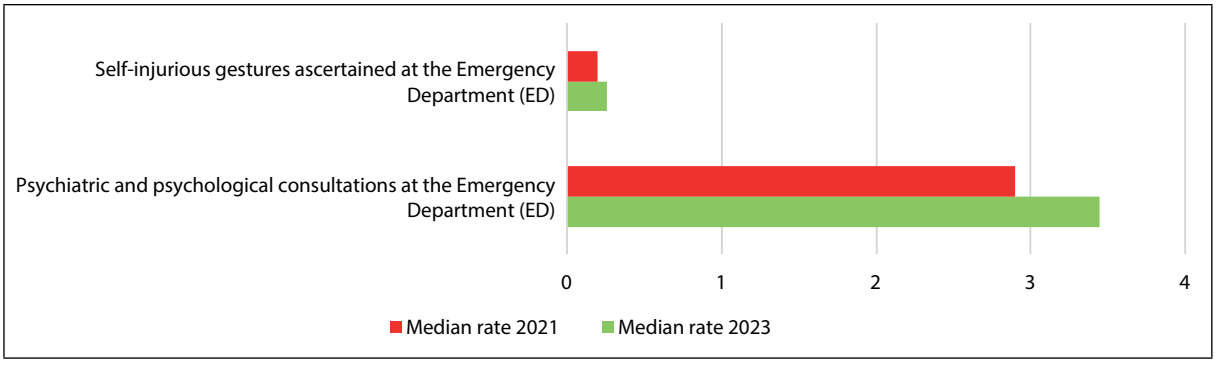

Figure 7
Consultations and ascertained carried out at the Emergency Department (ED).

Table 1
Summary of key indicators

	Median rate 2021	Median rate 2023	Difference 2023-2021*
Facilities and beds provided by Departments of Mental Health (DMHs)			
Residential Facilities (RF) with beds	45.58	34.5	↓
Residential Facilities (RF)	3.85	2.92	↓
General Hospital Psychiatric Units (GHPUs) with beds in DH	0.49	1.17	↑
General Hospital Psychiatric Units (GHPUs) with DH	0.54	0.48	↓
General Hospital Psychiatric Units (GHPUs) with beds 24/24	6.42	6.28	=
General Hospital Psychiatric Units (GHPUs) 24/24	0.61	0.57	=
Community Mental Health Centre (CMHCs)	1.28	1.3	=
DMHs staff			
Administrative and support workers	1.5	1.9	↑
Health care social workers (HSW)	3.3	4.4	↑
Social workers (SW)	2.7	2.5	↓
Psychiatric rehabilitation technicians	2.1	1.9	↓
Nurses	21.9	21.4	=
Psychologys	3.0	3.3	↑
Psychiatrists	10.2	9.8	=
Residential facilities and hospital activities			
Patients discharged from Residential Facilities	0.10	0.09	↓
Compulsory Psychiatric Evaluation (CPE)	0.02	0.03	↑
Compulsory Psychiatric Treatments (CPT)	0.16	0.15	↓
Patients present in GHPUs	1.40	1.55	↑
Admissions in GHPUs	1.00	1.20	↑
Patients under treatment			
Patients who received health or social provisions exclusively remotely	0.48	0.03	↓
Patients who received at least one health/social provisions either in-person or remotely	67.20	73.40	↑
Provisions provided face-to-face or remotely			
Remote provisions	16.72	8.72	↓
Face-to-face provisions (excluding first consultations)	193.3	203.49	↑
Type of provisions provided face-to-face or remotely			
Remote psychosocial interventions	1.73	2.57	↑
In-person psychosocial interventions	33.02	31.39	↓
Remote nursing provisions	2.46	3.95	↑
In-person nursing provisions	70.60	100.88	↑
Remote psychotherapy sessions		0.02	
In-person psychotherapy sessions		8.22	
Total remote psychologial consultation	2.29	0.76	↓
Total in-person psychologial consultation	15.35	8.33	↓
First remote psychologial consultation			
First in-person psychologial consultation	0.60	0.80	↑
Total remote psychiatric consultation	5.09	1.86	↓
Total in-person psychiatric consultation	54.18	49.90	↓
First remote psychiatric consultation			
First in-person psychiatric consultation	3.90	4.00	=
Consultations and ascertained carried out at the Emergency Department (ED)			
Psychiatric and psychological consultations at ED	2.90	3.44	↑
Self-injurious gestures ascertained at the ED	0.20	0.26	↑

*Values with differences below 10% were considered equal (=); DMHs: Departments of Mental Health; DH: day hospital; RFs: residential facilities.

tures ascertained at the ED which could reflect a possible difficulty in intercepting such phenomena early.

Provisions provided in-person and remotely

Users with at least one health or social provision in-person or remotely increased by approximately 6 points, equal to a percentage increase in 2023 of 9.2% and could reflect a general slight increase in access to healthcare services probably due to greater availability of services or, not to be excluded, greater demand for services to recover visits/postponements accumulated in previous years. This increase is consistent with the treated prevalence of any mental disorders by psychiatric services trend at a national level. There is a general reduction in total psychiatric and psychological consult provisions with reduction percentage values of 7.9% and 45.7% respectively for in-person visits and 63.5% and 66.8% for remote visits. These data suggest that, in the post-pandemic period, not only has the use of mental health technologies decreased, but there has been a general decline in the provision of psychological and psychiatric consults, with a potentially critical impact on the quality of care.

Between 2021 and 2023, the data show a significant return to face-to-face interventions, with some differences depending on the type of intervention. The comparison between the median of users with at least one remote-only health and social provisions in 2021 and 2023 shows a very significant decrease (by approximately 94%). These data suggest that in 2021 a substantial share of users received provisions exclusively remotely, likely due to the COVID-19 pandemic that had made massive use of telemedicine and other remote provisions necessary. In 2023, however, this modality seems to have drastically decreased and was used in an extremely marginal way. This could reflect a return to the prevalence of in-person provisions with the end of health restrictions, a preference for direct contact or even organizational and technological limitations that did not allow the full integration of remote modalities in the long term.

This is also confirmed by the slight increase in the number of in-person health and social provisions per user (about 5%) which could reflect greater confidence in in-person visits as the pandemic has eased, leading patients to prefer traditional methods for treatment, and decreasing remote provisions.

Unlike psychiatric and psychological consults, psychosocial interventions (informative and psychoeducational interventions aimed at the person and/or the supporting family) show substantial stability in-person and a strong increase remotely (48.6%), signalling a different trajectory in the evolution of services. These interventions are particularly well suited to being delivered remotely, thanks to their more "dialogical" and less clinical nature and have instead found a new opportunity for growth in the digital world probably because they are more easily adaptable and less dependent on direct physical contact.

First in-person psychiatric consults remained stable while first in-person psychological visits increased (33.3% in 2023).

No first remote psychiatric or psychological consultations are being carried out. The increase in first in-person psychological visits and the stability of psychiatric visits indicate a constant attention to the reception and diagnosis phase, which remains strongly anchored to the in-person modality. The absence of first remote consults confirms a clear distinction between access channels: remote is used only for subsequent interventions and not for the start of the clinical path, probably for reasons of clinical accuracy and the need for direct observation.

LIMITATIONS OF THE STUDY

While the study provides an in-depth and detailed overview of changes in mental health services and healthcare resources in a sample of DMHs in Italy, there are several limitations that should be considered.

Firstly, the sample of DMHs involved cannot be considered representative of all Italian DMHs even though almost all Italian Regions were represented. Furthermore, those who agreed to participate may have had better internal organisation, enabling them to participate in research projects alongside their usual activities.

As the study is observational, the data presented can provide useful insights, but they do not allow us to fully understand the underlying causes of certain changes or the clinical and social contexts that could have influenced the observed trends.

Finally, the presented data do not take into consideration the geographical distribution of resources and psychiatric care. The situation in more remote regions or disadvantaged socioeconomic contexts may differ significantly from that in urban areas or richer regions. It is unclear whether this trend is distributed equally across the country.

CONCLUSION

The analysis of the data from the two-year period 2021-2023 offers a complex and evolving picture of mental health in our healthcare system. On the one hand, the structural stability of the territorial network is confirmed. However, important qualitative critical issues and operational processes emerge that require attention and in-depth analysis, regarding human resources, continuity of care and the effective accessibility of services.

The strengthening of the semi-residential offer through the increase in beds in DH, despite the reduction in facilities, highlights an organizational change oriented towards flexibility and personalization of care. At the same time, the contraction of non-hospital psychiatric RFs suggests a trend towards deinstitutionalization and a greater emphasis on territorial care models, although these data are only partially confirmed at national level.

On the staffing front, diversified dynamics are observed: while psychiatrists and nurses remain substantially stable, the number of psychologists and HSWs is increasing – probably in response to greater post-pandemic demand of support in daily activities – while the number of psychiatric rehabilitation technicians and social workers is decreasing, highlighting possible critical issues in the multidisciplinary management of the patient.

The data on clinical activity show contrasting signals: hospitalizations in GHPUs and psychiatric and psychological consultations at the Emergency Department are increasing, together with a worrying increase in self-harm. This draws attention to the increase in mental distress not intercepted promptly and to the growing pressure on emergency services, which are faced with increasingly complex and urgent situations.

At the same time, there has been a significant contraction in psychiatric and psychological consultations, both in-person and remotely, which raises questions about the continuity and adequacy of care. On the contrary, there has been a significant increase in nursing provisions and remote psychosocial interventions, signalling a partial reorganization of the therapeutic offer, which, if well structured, could contribute to a more proactive and integrated management of needs.

Finally, the increase in first psychological consults and users admitted into care, together with the decline in exclusively remote provisions, highlights a return to the centrality of physical presence in the therapeutic relationship and a gradual normalization of access to services after the health emergency.

Overall, the data indicate a system in transformation, which seeks a new balance between in-person and remote care, between hospitalization and territory, between emergency response and continuous care. The challenges that have emerged require a strategic vision and coordinated interventions, capable of strengthening the network of services, enhancing multidisciplinary work and promoting increasingly accessible, personalized and person-centred care.

While providing a detailed picture of the evolution of mental health services between 2021 and 2023, it is necessary to highlight some limitations. The analysis is based on aggregate data from a small and selected number of DMHs, neglecting possible regional and local inequalities that could influence access and quality of services and hide critical or virtuous situations at the local level. Furthermore, the absence of clinical outcome indicators limits the evaluation of the real effectiveness of the interventions. Finally, the lack of consideration of the point of view of users and caregivers reduces the understanding of the impact of changes on care pathways.

Considering what has emerged, it appears essential to promote a more integrated and multidimensional analysis of mental health services, capable of combining quantitative and qualitative data, territorial vision and centrality of the person, to guide strategic choices that are truly effective and sustainable over time.

Funding sources

This study was supported by funds of the National Center for Disease Prevention and Control (Centro Nazionale per la Prevenzione e il Controllo delle Malattie), CCM Programme 2021(CUP: I85F21003210001), Ministry of Health, Italy.

Acknowledgments

The Authors thank Franco Veltro for contributing to the realization of the study with valuable advice and Giuseppe Salamina for the continued support of the study.

Authors' contributions

AP, GM conceived and designed the study; LC, FM and AG wrote the manuscript. LC and FM analysed the data; EM, AP, CG, AG, LC and MF revised and edited the manuscript; MF and LC managed database. DDR, IC and NF supported the study in all stages. All Authors revised the manuscript for important intellectual content and agreed with this article's contents.

Conflict of interest statement

The Authors declare no competing interests.

Received on 11 June 2025.
Accepted on 11 September 2025.

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