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Lesson from COVID-19: the opportunity of telepsychiatry

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Summary

The need for remote mental health care services has increased in various countries with the evolving of the COVID-19 crisis. The suspension of the previous routine and of the non-urgent healthcare activities certainly contributed to the containment of the infection on one hand, while on the other hand it exposed the need for alternative methods to monitor patients, who were called to adapt to the rules of distancing and of staying at their home.

During the pandemic the difficulties of the mental health system, and in particular of the mental health care community, in meeting the multiple needs of individuals , while awaiting to get access to an adequate supply of personal protective equipment, allowed for the provision of some benefits via telephone communications with patients. While initially not explicitly requested, some clinicians started to virtually "see" patients from the comfort of their home using live videoconferencing. This eliminated the need to reach outpatient units and allowed them to operate regardless of their geographic location.

As the public health crisis unfolded, many applications of telepsychiatry developed in other areas of the Departments of Mental Health (DMHs) such as: psychological counseling and support services, rehabilitation individual and/or group sessions, consultation liaison services in COVID and non-Covid hospital areas, communications with family members and/or other stakeholders, clinical briefings and staff training.

As the reopening of healthcare activities progresses, many clinicians have come to appreciate the opportunity and the convenience of the telemedicine experience. So mental health care organizations have to implement video-conferencing technology, alongside the mental health standard of care. However, it's necessary to consider the main critical issues relating to remote services, which are the implication for security and the mainstreaming of the use of technology in psychiatric patients, who may have very little, if any, experience with telemedicine.

Key words: telepsychiatry, mental health-care delivery, COVID-19 pandemic

Background

In every historical period, a crisis is seen as an opportunity to look over old models and to advance new strategies. Some authors [1] define crisis as "an upset in equilibrium at the failure of one's traditional problem solving approach" in which usual patterns of behavior are no longer adequate to cope with the present situation [2]. In this perspective, a crisis is considered as an evolutionary stage in the process of growth and constant change [3].

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The coronavirus pandemic has demonstrated the limits of the health system in Italy and in the world, unveiling a deep crisis that has long-standing origins.

The latest report of the Ministry of Health dated 2018 [4] indicated that in the face of a 1.6% reduction in the number of patients in the public psychiatric operating units when compared to 2017, the staff units decreased by almost 2000.

And while in 2018 the number of hospitalizations decreases (107,662 against 109,622 the previous year) proportionally to the reduction in the number of beds in ordinary hospital stay (9.7 per 100,000 adult inhabitants in 2018 against 10.1 in 2017), conversely access to emergency rooms increases, indicating an increase of mental health needs among the population.

Italy was the first Western country to be severely affected by the COVID-19 pandemic. The epidemic has undoubtedly placed a huge strain on the National Health System, giving rise to grave concerns as to the ability of the system to effectively respond to the needs of the population and its patients.

To strengthen health surveillance measures and limit the spread of COVID-19 diffusive infectious disease, most health activities were also suspended, with the exception of those that could not be postponed. In some cases, patients and health care providers were infected in emergency rooms or other areas of the hospitals and of the outpatient units [5].

For those reasons in April 2020, the Institute of Health published a report with specific recommendations on the implementation of telemedicine services defining areas of intervention during the COVID-19 outbreak [6]. Those included , inter alia, patients with chronic diseases, rare diseases and people in fragile conditions, or that require long treatment periods such as patients with mental illness, otherwise managed in part or entirely by territorial services or by residential structures. This first report was followed by others, regarding the reorganization of the Departments of Mental Health (DMHs) for the management of the impact of the pandemic, and the use of telephone intervention, together with telemedicine, to offer health services and psychological support to people at home (see Tab. I).

In the reorganization of the DMHs, routine activities were suspended. Some Community Mental Health Centres (CMCHs) were closed or had limited hours of access.

The number of admissions to General Hospital Psychiatric Wards (GHPWs) significantly reduced, and was often limited to mandatory mental health treatments (Trattamento Sanitario Obbligatorio, or TSO).

At the same time, the psychiatric health system had to stop relying on the rehabilitative health services and its activities, which had to adapt to the rules of social distancing and of staying at home as necessary measures to curb the infection. The difficulty of the psychiatric health system, in particular of home and territorial assistance, to meet the multiple needs of the territory during the pandemic, have determined a rapid expansion of telepsychiatry. The popularization of internet services and smartphones, and the emergence of fifth generation (5G) mobile networks, have encouraged this step. Together, these factors have encouraged psychiatrists to sanction the tools of technology, or better of videoconferencing, as a possible therapeutic tool.

The report “Recommendations for Mental Health Departments regarding activities and measures of contrast and containment of the SARs-COV-19 virus”, published by the Italian Society of Psychiatry [7], states: “The capacity of these services as well as of CHMCs to maintain regular telephone/ video call contacts with clients should be granted, in particular as regards the accessibility of phone lines and the availability of apps for video-call”. To this ens, while many Organizations as well as Departments have used commonly used platforms,

Table I. Reports about COVID-19 from Italian ISS (Istituto Superiore Sanità), 2020.

Report	Title	Date	Authors
Rapporto ISS COVID-19 n. 12/2020	Indicazioni ad interim per servizi assistenziali di telemedicina durante l’emergenza sanitaria COVID-19	Versione 13 aprile 2020	Gabbrielli F, Bertinato L, De Filippis G, Bonomini M, Cipolla M
Rapporto ISS COVID-19 n. 23/2020	Indicazioni di un programma di intervento dei Dipartimenti di Salute Mentale per la gestione dell’impatto da epidemia COVID-19 sulla salute mentale	Versione 6 maggio 2020	Veltro F, Calamandrei G, Picardi A, Di Giannantonio M, Gigantesco A
Rapporto ISS COVID-19 n. 30/2020	Indicazioni sull’intervento telefonico di primo livello per l’informazione personalizzata e l’attivazione dell’empowerment della popolazione nell’emergenza COVID-19 - Gruppo di lavoro ISS Salute mentale ed emergenza COVID-19	Versione 24 maggio 2020	Cirulli F, De Mei B, Luzi AM
Rapporto ISS COVID-19 n. 31/2020	Indicazioni ad interim per il supporto psicologico telefonico di secondo livello in ambito sanitario nello scenario emergenziale COVID-19 - Gruppo di lavoro ISS Salute mentale ed emergenza COVID-19	Versione 26 maggio 2020	Rebecchi D, Lazzari D, Calamandrei G

others have employed dedicated platforms, safer than the traditionally used ones, to prevent the risk of violation of privacy and data security breach.
To keep contact even with non-urgent or indifferent patients, most of the services have converted into online therapies (psychiatric visits, individual psychotherapies, individual and group rehabilitation therapies).
In a second phase, teleconsulting stations were also activated in GHPWs, to allow communication between hospitalized patients and family members, between doctors and family members of the patient, between doctors and the territorial psychiatric network for the management of the post-acute phase; in residential psychiatric structures, to allow periodic re-evaluations of the Personalized Therapeutic - Rehabilitation Project between the community team and the sending team of the territory, and to maintain contact with family members in Departmental services dedicated to child and adolescent psychiatrist.

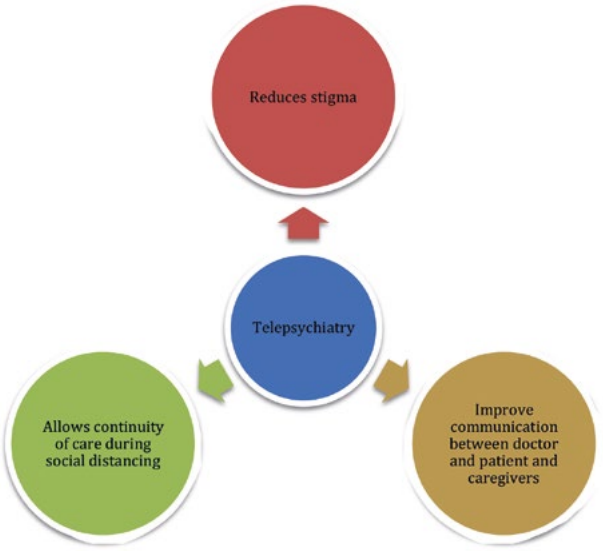

Figure 1.
Key points of e-Psychiatry.

e-Health and Telemedicine

In general the term of e-Health, for which the evolution of technological tools continually redefines the application fields, indicates the practice of personal care through the support of Information Technology (IT) tools, specialized personnel and innovative medical-patient and medical-medical communication techniques [8]. Telemedicine, a term which means "healing at a distance", represents an opportunity to overcome geographical barriers, and increase access to health care services [9].
The peculiar aspects of interventions in this area are (essentially characterized by):

- accessibility;
- ease of use;
- utility;
- high level of appeal;
- the ability to reach a large number of users.

The ability inherent in current tools to allow an adequate degree of anonymity in the face of a high level of interactivity and therefore personalization of care can represent a real turning point in the psychiatric field precisely for overcoming the barriers that have always conditioned the related interventions such as stigma.
Some authors define telemedicine the only way of assistance to people experiencing mental health crises in widespread catastrophes or natural disasters [10]. During lockdown and in general in the conditions in which social distancing is necessary, telemedicine is the only option capable of ensuring the safety of patients and operators (Fig. 1).
In different countries telemedicine is defined by the laws and regulatory provisions that describe the fields of application. In Italy for example the use of Information and Communication Technologies (ICTs) for the treatment of health information or the online sharing of data and/or health information (e-health) do not constitute a telemedicine service. Telemedicine does not include health information portals, social networks, forums, newsgroups, e-mail or other [11].
In the area of Telemedicine it is possible to distinguish specific areas:

- *Specialized telemedicine*. It includes the various ways in which specialist-provided remote medical services are provided within a specific medical discipline. It can occur between doctor and patient, or between doctors and other healthcare professionals;
- *Telehealth*. It mainly concerns the domain of primary care. Systems and services connect patients, especially the chronic ones, with doctors assisting in the diagnosis, monitoring, management, empowerment. It allows a doctor to remotely interpret the data necessary for telemonitoring and for taking care of the patient;
- *Teleservice*. Social assistance system for taking care of the elderly or frail persons at home, through the management of alarms, activation of emergency services, "support" calls from a service center.

These differences are useful to specify some aspects in the doctor-patient relationship. In telehealth, as well as in specialist telemedicine, the role of the doctor is active (taking charge of the patient) as well as the role of the patient (self-care). It differs from telemonitoring, which is exclusively intended as an exchange of health informations. Telehealth includes telemonitoring: the exchange of data (vital parameters) between the patient and a monitoring station takes place not only for analytical purposes, but also to provide and support therapy management programs and to improve information and patient training.
One central point is the management of health information between the provider, the structure of the NHS or NHS

operator (Clinical Center), and the user. This can happen directly or through a Service Center. The Service Center does not intervene at the level of clinical responsibility, as the latter responds to the Clinical Center on the effective performance of all its tasks, in particular on the integrity and security aspects of the health information transmitted during telemedicine activities.
Any system that processes sensitive data must comply with the regulatory provisions regarding the processing of personal data (Fig. 2).

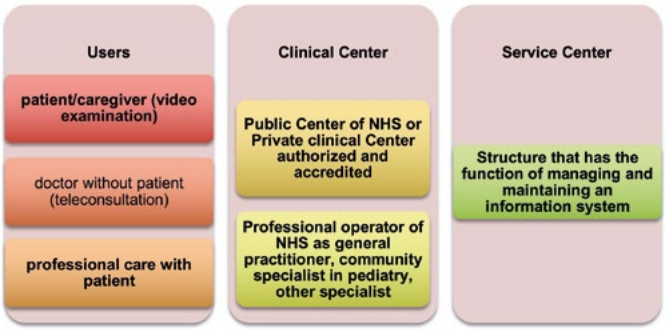

Figure 2
Users/clinical center/service center.

Telepsychiatry

Based on the ICTs tools used in the context of information/communication/management services regarding the promotion and protection of mental health, it is possible to distinguish different types of intervention:

- video-mode;
- telesupport;
- websites;
- mail;
- instant messaging and chat rooms;
- mobile-health-app.

As defined for telemedicine, the video and chat rooms, given their interactivity component in live mode, are generally considered a real treatment (e-Therapy), as they are able to provide online mental health services [12].
As for websites, emails or apps, which in general have a lower level of interactivity, they can fall within the scope of eTherapy only when the exchanged information concerns aspects of the private or intimate life of the users (Fig. 3).

Figure 3
Telepsychiatry.

Video mode

The speed of current internet connection systems, through the use of webcams, allow the therapist and the patient to communicate in real time with video, audio / text. Recently the Health Commission of National Health System of Italy has developed a document with the homogeneous rules for the delivery of remote outpatient services [13]. Video mode (Television) is available for outpatient services that either do not require the patient's physical examination (traditionally consisting of inspection, palpation, percussion and auscultation) or present the following conditions:

- the patient is included in a follow up path from a known pathology;
- the patient is placed in a diagnostic therapeutic care path (in Italian, Percorso Diagnostico - Terapeutico Assistenziale or PDTA), formalized in the health organization, or at a regional level;
- the patient needs monitoring, confirmation, adjustment, or change of the therapy in progress (e.g. renewal of the therapeutic plan or modification of the same);
- the patient needs anamnestic evaluation to get a prescription of diagnostic tests, or staging of known or suspected pathology;
- the patient requires an explanation by the doctor of the results of diagnostic or staging tests carried out, which can be followed by the prescription of any further information, or treatment;
- any other scenario where the doctor assesses the possibility of delivering the visit in "television" mode.

The activation of telemedicine service requires the patient's or tutor's prior adhesion, in order to confirm, inter alia, the availability of a telematic contact for documentary/information interaction with the specialist and access to a remote communication system according to the technical specifications and the current legislation on privacy and security (Fig. 4).
The provision of remote outpatient services shares the following system of rules:

- services: tariff system, classification, detection, reporting;
- informed patient adhesion;
- health responsibility during television activities;
- communication of the outcome of the outpatient service provided in television mode.

The minimum and sufficient elements to create a service equipped with the features allowing clinicians to deliver a TV service are as follows:

- basic features;
- connection network always available between doctors

Figure 4.
Mental Health and Technologies.

and patients;
- web portals, to which doctors access with their account to manage assigned patients;
- access to the web page from notebooks or tablets or smartphones for healthcare professionals;
- simple patient login, who must be able to access the service with their own account, with identity verification;
- compatibility with the General Data Protection Regulation (GDPR) for the processing of personal data.

The person connects to the internet with the available digital tools (computer, tablet, smartphone).
There are two ways of providing treatment [12]:
1. augmenting: further treatment compared to an already ongoing (psycho)therapeutic path;
2. stand alone: single treatment method.

Special consideration for psychiatry

If, on one hand, psychotherapeutic interventions or framing/treatment of mental disorders carried out by tele/videoconference, compared to the other systems, offer the possibility of creating a setting comparable to a traditional one (face to face) as much as possible, on the other hand some authors point out to limits inherent to the virtuality of the therapeutic relationship and the incomplete management of the setting in terms of communication times; those could also be affected by the user's removal or sudden disconnection [12].

Tele support

Given the extent of the COVID-19 epidemiological emergency, healthcare personnel working in a hospital environment or in the area may experience stress, anxiety, and manifest safety and health concerns during this period.

In almost all international and national scenarios, sadly affected by the epidemic, psychological interventions for the health emergency have been developed with telephone support from operators working in the health field. In a newly published study on mental health consequences among Chinese operators who dealt with the emergency, the results suggested that some categories, such as women, nurses, health workers operating in critical areas and those exposed on the front lines, are at high risk of developing unfavorable mental health outcomes and therefore needing support or psychological intervention [14].
Looking at the experience of those operators, there are many experiences, expressed or unexpressed, such as the fear of contagion, the concern for one's health or that of loved ones, the fear for those who share the workplace or for patients, the uncertainty about the outcome of the treatments, which can cause psychological discomfort and negatively affect mental health, causing emotional falls, feelings of anger and helplessness, tension. Even in the general population, restrictions on movement, the exposure at frighteningly critical news through the media and social media, loneliness and reduced social contact triggered or amplified phobias, a sense of bewilderment, confusion.
The experience of China taught us the usefulness of online mental health services have as interventions for psychological crises during the epidemic [15].
The obsession with contagion, the fright of physical contact, casual or necessary, the transmission of the virus in not very-known ways, the great mystery of asymptomatic, paucisymptomatic, symptomatic for others causes, have greatly amplified the sense of fear, which in some cases, has crossed the banks of reason: this is the case of the student from Messina who killed his partner for fear of having contracted the infection. Of note is the fact that the COVID-19 outbreak has particularly affected the most fragile and most at risk people; a study by a group of Italian researchers [16] has shown that those who suffer from a psychiatric disorder, even of minor severity, have a higher level of stress related to COVID infection, and a higher probability of developing symptoms anxious and depressive of a certain severity. In the midst of the COVID-19 exceptional emergency, there were some professional categories subjected to particularly stressful work rates (such as police operators, personnel operating in basic services), or who had to quickly deploy new resources for the requests of the context (for example teachers, struggling with the need to ensure continuity of training in different ways; agents who engage in smart working; interventions and social agencies); or again, like freelancers, who had to deal with the "vacuum" at work and economic concerns. Without forgetting the needs of the family, the first connector of social ties and community memberships, which found itself responding to insurance claims from children and adolescents, dealing with an exceptional event, but also to address questions for working future.

In the early phase of the lockdown, almost all the Italian Mental Health Departments and the health and university companies activated a free psychological/psychiatric support service, dedicated to health workers and general population, to break down the barrier of fear in the request for help and offer guidance and information on the possible need for specialized help.
The consultation was offered 24 hours a day or in specific time slots, usually through dedicated telephone lines answered by a qualified operator, who guaranteed one or more telephone interviews with the aim of promoting individual resilience and optimal use of personal resources, implementing stress management measures with the aim to maintain the mental well-being of the community. If necessary, the operator or the applicant requested on-site consultation. Some health agencies also offered support to family members of COVID-19 victims. As the weeks went by, the psychological and psychiatric phone counseling has been shifted in many organizations to a video platform.

Mail

In general, communication via email is considered one of the easiest communication tools in the doctor-patient relationship (smartphone) as it allows a valid and accurate exchange of information even in the absence of simultaneous availability of the clinician and patient. Initially designed as a tool for registration, confirmation, change of appointment, reminder system, request for information or change regarding a medical prescription, general information relating to the service to which you want to access (e.g. timetables, contacts), this tool is part of Telemedicine and therefore included in e-Therapy when the content of the communication concerns personal information [12].
Often this communication system integrates more complex systems, such as specialist websites on specific ailments, by individual professionals or by scientific societies. The possibility of attaching electronic documents, both in the form of texts and images, allows this tool to create a real archiving system that can be used in the creation of a clinical diary, with the possibility of bi-directional information exchange (clinician-patient).
These characteristics, based on the type of information exchanged, can at the same time create specific profiles of responsibility for the clinician, in particular when the contained data concerns aspects that can compromise/discriminate the patient, such as sensitive clinical data, including on HIV positivity, use of substances, information regarding third parties (identity, personal information), judicial documents or legal issues, required to start a treatment. About this, it is extremely important in the use of this communication tool to provide clear, exhaustive and adequate information to the patient, regarding the use and the related limits, disable automatic response and download functions, avoid archiving on cloud systems (for risks connected to data security). It could be useful the periodic control of the communications exchanged (number, content) as they could indicate an improper use by the patient linked to his own disorder. With regard to professional liability related to communications for which the content reflects urgent/emergency conditions including suicide, some authors recommend specifying their terms and conditions of use with the final user from the onset. This approach aims to manage critical issues, so that the procedures that the user should put in place in critical conditions, such as direct contacts with emergency/emergency services, are clearly established well in advance.

Websites

Websites are an easy tool for a clinician who can provide information on his activity especially for new – onset patients [12]. In general, they can be categorized in two groups, based on the level of interactivity:
- basic (static) websites, that describe the activity of the services;
- interactive websites that allow a two-way exchange of information.

In general, current websites contain both of the characteristics listed, creating real services with a high level of interactivity.
The main specific critical issues connected to this communication tool essentially concern security relating to the risk of access by third parties and in the storage of data. In this regard, the application of a series of measures is recommended to reduce the risks associated with these critical issues including the use of passwords to be renewed periodically or protection systems constantly updated.

Instant messaging and chat rooms

The use of instant messages can be considered like emails, with similar advantages and limitations.
Chat rooms can allow, in case of live connections, forms of group therapy which, through the use of webcams, can be equated to telepsychiatric interventions by video mode [12].

Mobile-health

Data from market analysis shows that an extremely high percentage of young adult subjects, about 90% in industrialized countries, owns a smartphone. These data have led to increasingly implement applications (apps) for these devices in recent years also in the context of health promotion and protection. In the document drawn up by the National Bioethics Committee of the Presidency of the Council of Ministers [17], "mobile-health" is defined as the set of mobile or wireless communication technologies (mobile phones and smartphones, tablets, digital devices, with or without wearable sensors), applied in specific areas to health [12]. In general apps can be considered a

Table II. Issues of telemedicine.

	Indication	Critical issue
Video mode	• Patient with known pathology • Alone in stable phase • In presence of caregiver during relapse	• Risk of virtuality of the relationship • Incomplete management of the setting
Telesupport	• General population • Colleagues	• Anonymous
Mail	• Communication in the absence of simultaneous availability • Integrate visit (face to face or video mode) • Monitoring the course of illness	• Comunication of sensitive clinical data, risk of security • Comunication of emergency conditions including suicide
Websites	• Provide information of service activities • Exchange information doctor-patient bidirectional	• Risk of access by third parties • Storage data
Chat rooms	• Similar to mail but in case of live connection and in presence of webcams it is like to video mode	• Similar to mail or video mode
Apps	• Telemonitoring	• Useless if not integrated

valid tool for telemonitoring (Tab. II).

Specific populations: child, adolescent, geriatric

With some populations (i.e., children and adolescents, older people), telepsychiatry may be better than inperson services, for different reasons.

For children, it is a convenient, accessible model of care, because they are more willing to open up when they are in a familiar environment, surrounded by their toys or in reach of pets who may offer comfort. With remote connection, clinicians also get clues and information from a home environment they will never see in an office setting. It may be preferable to in-person care in some specific populations (e.g., autism spectrum).

For adolescent and younger adults, the easier scheduling of the remote interaction can help to overcome one of the greatest barriers in engaging younger populations in mental health treatment, which is stigma. Adolescent and young people who come to the CMCHs often have problems of engagement and adherence to treatment. They therefore require a therapeutic course "built", tailored to the individual's attention, needs skills and competencies, as well as challenges and level of attention, in a non-stereotypical way [18]. A pleasant context is preferable, possibly not physically connected to other care facilities, and neither characterized nor stigmatizing, supported by a team with a style of work that is as informal as possible, friendly and sensitive to youth interests and language. Information technology holds great potential to address gaps in care, also because this is a mode of communication familiar for the youth. Telehealth and digital services should be useful for patients with physical limitations, or comorbid conditions, and those with significant geographical obstacles. It is advised to improve access to culturally appropriate care providers for asylum seekers, refugees and migrants. They could prefer telepsychiatry in their mother tongue, rather than interpreter-assisted care [19].

However, there may be logistical problems and drawbacks associated with the use of remote therapies, especially in people who might be in greater need. A technical support provided by nurses or rehabilitation technicians (care personnel) should be available during the early stages of switching to video-conferencing, particularly for older people or people with low technological literacy.

In addition to technological proficiency, therapists and others offering support need to develop a way of supporting and maintaining the important therapeutic partnership that enables recovery. People who find remote communication more challenging than face-to-face interactions might disengage from treatment, and their loneliness could increase without in-person contact. It is necessary to carry out an analysis of the satisfaction level and perceived advantages reported by users and family members, trying to appreciate if they were able to achieve their goal and express everything they wanted through the ICTs. Telehealth and digital services should not replace face-to-face treatment for patients in need particularly those requiring intensive mental health treatment and support, when in-person contact is evaluated by clinicians as safer. There are serious limits in the application of this tool in patients suffering from serious psychotic disorders in which, during the phases of decompensation, the examination can result strongly compromised. At the same time, this modality could be particularly effective in disorders with serious forms of social anxiety that often limit patients starting from their access to the care phase. Therefore an adequate assessment is recommended before undertaking this form of treatment by envisaging the possibility to switch to a traditional form of intervention [12] already in the formulation phase of the therapeutic contract.

Conclusions

After the acceleration impressed by the epidemiological emergency from SARS-CoV-2, psychiatry is the branch

that is most suitable for entering telemedicine, since no special equipment is needed to perform psychiatric and psychological services, nor it requires the detection of the patient's physical parameters in most cases. Under social distancing, many mental health care organizations have been unable to offer in-person care for anything but the most urgent or serious conditions, while patients can be reluctant to risk visiting a facility even if available. The initial difficulty was for some organizations to equip a platform and make it operational in few days, allowing for several operating units to work simultaneously, also through training webinars (the teleconsultation had a strong implementation, in healthcare companies, for other services, from pre-birth courses to the cancer network, phoniatric rehabilitation). In many operating units, it was necessary to update obsolete operating systems, which quickly had to adapt to the new provisions, also taking into account the problems in obtaining electronic media supplies during the pandemic. Currently the advantage of telepsychiatry certainly bypasses the problem of geographical distances (with limitations on movement, access to health facilities if physical health problems coexist) and phone contact to check psychic conditions, which is often limited in duration.

After the first wave of the pandemic, the current opinion is that telepsychiatry is here to stay. On-line sessions, even in the re-opening phase of healthcare activities, appear to be more appreciated than on-site ones, both by patients and operators, because they allow to carry out the interview without masks, without physical distancing in medical and psychological rooms, without the necessary triage before accessing inpatients and outpatients units.

In an atmosphere in which users and health professionals certainly feel more relaxed and calm, it is still possible to grasp the facial expressions and guarantee empathic contact; if necessary, a face to face interview can be scheduled. In Italy some psychiatric services have equipped themselves with a room in which the patient, if he does not have a personal connection, can access a video consult with an operator who is set in another room (to avoid personal protective equipment, allow physical distancing etc.) The use of a corporate platform, which also allows video recording (of the consent given by the patient, or if necessary of the whole session), avoids the operators' personal connections.

Connection difficulties persist for patients, for economic and cultural reasons. We believe that even in the future, the implementation of telematic services should be strongly encouraged and supported, and differentiated in their offer, alongside the traditional method.

To this end the following is highly recommended :

1. telepsychiatry shall be regulated by specific guidelines, allowing the safe and regulatory delivery of the use of online platforms providing assistance, with regard to legal, clinical, cultural and practical aspects in use of technology. This could also apply to telemedicine;
2. remedy the poor digitization of the patient population (minors, adults), supplying smartphones, tablets (as it already happens for schools);
3. raise awareness on the subject, also through a regional project with the support of Scientific Societies (of the sector, or general), with telephone companies providing free or unlimited connections to patients to promote e-health;
4. implement health training to guarantee online evidence-based services, including rehabilitation, in different settings (inpatient and outpatients services, prisons, residential and semi-residential structures, or in emergency in support of non-medical teams, such as law enforcement agencies).

Telepsychiatry has emerged as a solution for the lack of access to mental health care because it enables patients to see providers remotely over secure videoconferencing technology. Many health care organizations could offer this service to supply to the shortages of psychologists and psychiatrists, which risk to leave our most vulnerable population without care. Such solution will address the issue of the growth of the average age of healthcare workers while reducing the risk for people with preexisting mental health disorders, who might have a higher risk of SARS-CoV-2 infection than those without mental health disorders [20].

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