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The Impact of the COVID-19 Pandemic on People with Lived Experience of Mental Illness Integrated into Community-Based Psychosocial Rehabilitation Structures in Portugal

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Abstract: Background: To analyze the prevalence and impact of SARS-CoV-2 infection in people with lived experience of mental illness integrated into community-based psychosocial rehabilitation structures in Portugal. Methods: One hundred and thirty-nine people with lived experience of mental illness integrated into community-based psychosocial rehabilitation structures in Portugal answered an online survey that included dimensions related to COVID-19 pandemic prevalence, routine/lifestyle, social support, access to health care, mental health and well-being during the pandemic and confinement, and life satisfaction and postpandemic future expectations. Results: The results point to a low prevalence of SARS-CoV-2 infections in this sample. High levels of resilience and mental well-being were identified in the individuals. We also found that participants were satisfied with the social support during this phase and their routine/lifestyle. Conclusions: The study showed that the COVID-19 pandemic seems not to have had a significant negative impact on people with experience of mental illness integrated into community-based psychosocial rehabilitation structures in Portugal. However, more research in this field should be done in the future.

Keywords: COVID-19 pandemic; mental illness; community-based psychosocial rehabilitation structures; resilience; mental well-being

1. Introduction

COVID-19 is an acute infectious disease primarily transmitted through the respiratory tract and caused by the SARS-CoV-2 virus [1,2]. The first Portuguese cases were reported on 2 March 2020, and numbers increased rapidly worldwide. As a consequence of this exponential increase, the World Health Organization declared COVID-19 a "pandemic" on 11 March 2020 [1]. To contain the pandemic, the Portuguese government declared a State of Emergency on 18 March 2020. In addition, it introduced a set of restrictions such as mandatory confinement, teleworking, distance learning, closing of non-essential services, the practice of respiratory etiquette, frequent hand disinfection, and others. Subsequently, the government added further measures, including social distancing of 2 m and the mandatory use of masks [3,4].

Due to the State of Emergency, some services provided by the community-based psychosocial rehabilitation structures were also interrupted. However, home support, which includes supervision and management of medication, support in activities of daily living, shopping, food preparation, and clothing care, was a service that continued to be provided by the institutions [5]. Healthcare services also felt the need to adapt by using more regularly Telemedicine, which the World Health Organization defines as the "delivery

of health care services, where distance is a critical factor, by all health care professionals using information and communication technologies for the exchange of valid information for diagnosis, treatment and prevention of disease and injuries, research and evaluation, and for the continuing education of health care providers, all in the interest of advancing the health of individuals and their communities." [6].

The COVID-19 pandemic is the most significant public health emergency faced by the international community in decades. It concerns physical health and the psychological suffering that the population may experience [7]. According to the National Epidemiological Study of Mental Health, quoted in the report "Sem Mais Tempo a Perder", Portugal is the second country in Europe with the highest prevalence—with 22.9%—of psychiatric disorders [8]. Among the psychiatric disorders, anxiety disorders are the most prevalent (16.5%), followed by mood disorders (7.9%) [8].

Since the beginning of the pandemic, several studies have shown increased psychiatric disorders [9–11]. This situation may be justified by quarantine or social isolation, resulting from SARS-CoV-2 viral infection and its rapid spread, triggering various psychopathological symptoms such as mood swings, anxiety, insomnia, fear, distress, excessive stress, and guilt [12]. In addition, some predictors of psychological distress during quarantine may be related to its duration, fear of infection, frustration and boredom, and inadequate supplies and information [13].

Although it is already known that the COVID-19 pandemic has been deteriorating general mental health, no studies assessing its impact on the mental health of people with lived experience of mental illness have yet been carried out in Portugal. According to the literature, this population is more predisposed to contract the SARS-CoV-2 virus. Therefore, it has a higher probability of morbidity and mortality associated with it [14], especially in people diagnosed with schizophrenia [14–16]. This situation can be justified by factors such as disadvantaged lifestyles, residential instability, reduced social networks, cognition deficits, presence of comorbidities and disparities in access to primary care, thus being more likely to have undiagnosed or untreated underlying medical conditions [14]. Furthermore, people with lived experience of mental illness also tended to worsen their psychiatric symptoms during the pandemic, consequently worsening their psychiatric condition [3]. Some factors identified as predictors of this are reduced support networks, the fear and stress caused by the pandemic, the lack of medication, and the difficulty in obtaining new prescriptions [3]. This situation can also lead to a lower quality of life and an increased risk of suicide in this population [14].

However, despite evidence referring to people with mental illness as a risk group for COVID-19, this population in Portugal was not a priority group in the vaccination plan at the time of the survey. Still, in April 2021, people with schizophrenia, severe bipolar disorder, and other severe schizophrenia spectrum disorders began to be part of the priority groups for vaccination [17]. Given the need to better understand this reality, this study aims to describe the prevalence and impact of the COVID-19 pandemic on people with lived experience of mental illness integrated into community-based psychosocial rehabilitation structures in Portugal, constituting a pioneering study in this area.

2. Materials and Methods

2.1. Sample

All people with lived experience of mental illness integrated into community-based psychosocial rehabilitation structures from entities associated with the National Federation of Rehabilitation Entities for Mental Illness (FNERDM) were invited to take part in this study. An email was sent to several community-based psychosocial rehabilitation structures at a national level by FNERDM, introducing the study with a link to the questionnaire posted online using Google Docs. We asked these institutions (with whom the authors regularly collaborate) to send to their patients the questionnaire inviting them to participate. We used a snowball sampling because FNERDM started with a small number of initial contacts who fitted the research criteria and then agreeable participants and institutions

were invited to recommend other contacts who met the research criteria and who potentially might also be voluntary participants, who then in turn recommended other potential participants, and so on [18]. Thus, the authors did not directly contact the patients.

As the inclusion criteria for the study, participants had to be over 18 years old. In addition, exclusion criteria for participation in the study included not being clinically compensated and having cognitive deficits that made it impossible to understand the questions in the questionnaire (in any case, in Portugal, the users of these structures are, usually, in phases of psychiatric stabilization and working towards social inclusion goals.). As a result, 139 individuals (from around 850) showed interest in collaborating and were eligible to answer the questionnaire according to the defined criteria.

2.2. Instruments

An online questionnaire was created using the Google Forms platform. The questionnaire was composed of the following sections: (1) sociodemographic data, (2) characterization of psychiatric condition, (3) data related to the COVID-19 pandemic, (4) routine/lifestyle, (5) social support, (6) access to health care, and (7) mental health and well-being during the pandemic and confinement due to the COVID-19 pandemic; (8) satisfaction with life and expectations for the postpandemic future. These dimensions are assessed using the Portuguese versions of the Social Support Satisfaction Scale, the Depression, Anxiety, and Stress Scale-21 Items (DASS-21), the Connor–Davidson Resilience Scale (CD-RISC), and the Warwick Edinburgh Mental Well-Being Scale.

The Social Support Satisfaction Scale aims to assess the level of satisfaction perceived by the individual regarding the social support received from various sources and social activities. It comprises 15 items assessed by a 5-point Likert-type scale (1 = strongly agree; 5 = strongly disagree). This scale has inverted items (4, 5, 9, 10, 11, 12, 13, 14, 15), where the "Strongly Agree" option is rated with 5 points and the "Strongly Disagree" option with 1 point. The score is obtained by adding up all the items, and it ranges from 15 to 75. Thus, the support can be classified as high (51–75), medium (26–50) or low (up to 25) [19]. The scale is validated for the Portuguese population and shows an internal consistency, with Cronbach's alpha values of 0.85 [19].

The Depression, Anxiety, and Stress Scale-21 Items (DASS-21) comprises three subscales with 7 items each and assesses anxiety (2, 4, 7, 9, 15, 19, 20), depression (3, 5, 10, 13, 16, 17, 21), and stress (1, 6, 8, 11, 12, 14, 18). The response is given on a 4-point Likert-type scale (0 = Never; 3 = Often). The scale provides three scores, one for each subscale—obtained through the sum of the 7 items—with the minimum score being "0" and the maximum "21". The total score is calculated by adding the scores of the 3 subscales. Higher scores correspond to more negative affective states [20]. This scale is validated for the Portuguese population with internal consistency values of 0.74 for anxiety, 0.85 for depression, and 0.85 for stress [20].

The Connor–Davidson Resilience Scale (CD-RISC) assesses an individual's coping skills in the face of traumatic events and changes. The Portuguese version is composed of 3 dimensions—self-efficacy, spirituality, and social support. It comprises 25 items evaluated with a 5-point Likert-type scale (0 = Not true; 4 = Always true). The score is calculated from the sum of all items and ranges from 0 to 100. The higher the score, the higher the individual's level of resilience [21,22]. This scale is validated for the Portuguese population and presents internal consistency, Cronbach's alpha values for several factors above 0.80 [22].

Finally, the Warwick Edinburgh Mental Well-Being Scale assesses mental well-being, including satisfactory interpersonal relationships, life satisfaction, and positive functioning. It consists of 14 items, rated on a 5-point Likert-type scale (1 = Never; 5 = Always). The minimum score is 14 points, and the maximum score is 70 points. The total score for this scale is calculated by summing the responses for each item, with higher scores representing high levels of mental well-being [23,24]. A study conducted with the Portuguese population showed a very good internal consistency with Cronbach's alpha value of 0.90 [25].

The sections (1) sociodemographic data, (2) characterization of psychiatric condition, (3) data related to the COVID-19 pandemic, (4) alterations in routine/lifestyle, (6) alterations in access to health care and (8) satisfaction with life and expectations for the postpandemic future were created by the researchers and reviewed by a panel of experts.

The sections (4) alterations in routine/lifestyle, (6) alterations in access to health care and (8) satisfaction with life and expectations for the future postpandemic are assessed using a Likert-type scale. Section (4) "alterations in routine/lifestyle" and section (6) "alterations in access to health care" use a 5 points Likert-type scale (1 = "Strongly Disagree"; 5 = "Strongly Agree"). In section (8), "satisfaction with life", uses a 5 points Likert-type scale (1 = "Not satisfied at all"; 5 = "Very Satisfied") and "expectations for the postpandemic future" uses a 4 points Likert-type scale (1 = "Nothing"; 4 = "A lot").

2.3. Procedures

The questionnaire used was active from 3 March to 21 May 2021. The questionnaire was self-administered and was filled out in the various institutions involved in the study. The questionnaire was completed in a single session; however, enough time was given to the participants to complete it at their own pace and take breaks according to their needs. Previously, a pilot study was conducted to ensure that individuals with mental health problems were capable of answering the questionnaire.

The privacy and confidentiality of the data collected were assured, the questionnaires were anonymous, and there was no contact with the participants involved in the study. In addition, the data were stored in an encrypted database to which only the researchers responsible had access and were processed in statistical aggregates. The study was approved by the Ethics Committee of the School of Health–Polytechnic of Porto (Proc. CE0028B).

Before proceeding to data analysis, the questionnaires were reviewed to validate their inclusion in the study. Initially, 163 questionnaires were collected, 24 of which were excluded because they were missing crucial responses to the results. Thus, we ended up with 139 valid questionnaires.

IBM Statistical Package for The Social Sciences (SPSS) 27 for Windows was used to process and analyze the collected data. Descriptive statistics, namely, relative and absolute frequencies, minimum and maximum values, mean, mode, and standard deviation, were used to analyze the variables under study.

3. Results

The results present the study participants' sociodemographic characterization, followed by the description of their psychiatric condition and COVID-19 prevalence. Finally, alterations in routine/lifestyle, (4) social support, (5) access to health care, (6) mental health and well-being during the pandemic and confinement (7) and life satisfaction and postpandemic future expectations (8) are presented.

3.1. Sociodemographic Characterization

Most of the participants in the study are male (66.2%), living in the district of Lisbon (64%), single (84.2%), with an average age around 47 years, with high school education (44.6%) or middle school education (23.7%), and retired (53.2%). Most participants live in their own house (43.2%) or community residences (35.3%). As for the characteristics of the house, the majority reside in an apartment without outdoor space (56.8%). As to the cohabitants, most of them live with relatives (43.2%) or with other people with mental illness (33.1%). By dividing the ages into five age groups, a central tendency can be seen in the classes (42–51) and (52–61), with 54 and 37 individuals, respectively.

3.2. Characterization of the Psychiatric Condition

Regarding the characterization of the psychiatric condition of the participants, it is possible to observe that most participants have a diagnosis of schizophrenia and other psychotic disorders—69.1%, followed by depressive disorder with 9.4%.

The participants were diagnosed on average 20.58 years ago, presenting a central tendency in the class of (10–20), with a total of 50 participants and have been followed within the institution they currently attend for an average of 9.35 years, presenting a central tendency in the class (1–10), with a total of 77 participants.

3.3. Data Regarding COVID-19

Regarding SARS-CoV-2 infection, only three participants (2.2%) were infected, see Table 1, of which two participants were infected in the third wave (since January 2021) and one participant in the second wave (between November 2020 and December 2020)—Table 2. None of the infected participants required hospitalization, having completed prophylactic isolation at home alone (*n* = 1) or at home with the support of friends/family/external professionals (*n* = 2)—Table 2, for an average of 17 days. Fourteen, 4% of the participants (see Table 1) were in isolation due to having contacted someone infected or travelling to a high-prevalence country. Regarding vaccination against COVID-19, through Table 1 it is possible to verify that, at the time of the survey, most participants were not vaccinated (63.3%); however, 71.9% of the participants considered that, given their psychiatric condition, they should be included in the priority groups for vaccination. Results also show that of those who had not been vaccinated, 86.4% would like to be vaccinated.

Table 1. Characterization of the sample regarding COVID-19.

		Frequency N (%)
SARS-CoV-2 infection	Yes	3 (2.2%)
	No	136 (97.8%)
Isolation due to contact with infected/at-risk country	Yes	20 (14.4%)
	No	119 (85.6%)
Has been vaccinated for COVID-19	Yes	51 (36.7%)
	No	88 (63.3%)
People with mental illness should be a priority group for vaccination	Yes	100 (71.9%)
	No	39 (28.1%)

Table 2. Data regarding the pandemic wave, isolation, hospitalization, and sequelae of infected participants.

		Frequency N (%)
Wave of the pandemic in which was infected	2nd wave—11/2020 to 12/2020	1 (33.3%)
	3rd wave—Since 01/2021	2 (66.7%)
Hospitalization	No	3 (100%)
	Yes	0 (0%)
Isolation	At home with support from friends/family/external professionals	2 (66.7%)
	At home alone	1 (33.3%)
Sequelae	Yes	1 (33.3%)
	No	2 (66.7%)

3.4. Alterations in Routine/Lifestyle

By examining the results regarding the satisfaction with the changes in routine and lifestyles during the pandemic and confinement due to COVID-19, it was possible to observe that most participants, when asked about the satisfaction with hobbies/leisure activities they performed, reported "agree" or "totally agree"—48.92% and 27.34%, respectively.

When asked about satisfaction with sleeping habits, the majority said they agreed with the statement (51.80%). Concerning satisfaction with the work situation, 45.32% of the participants replied that this statement did not apply to them; however, 18.71% agreed with this statement. As for the satisfaction with hygiene habits, most participants (53.96%) said they "agree" with the statement. Most participants (51.80%) agreed with the statement about satisfaction with eating habits. When it came to satisfaction with physical activity habits, 34.53% replied "agree" with this statement; however, 38.84% of the participants indicated "disagree" or "neither agree nor disagree" with this statement. Finally, about the satisfaction with sexual activity pattern, 30.94% replied that did not apply to them, while 19.42% of the participants replied "neither agree nor disagree" with the statement—Table 3.

Table 3. Alterations in routine/lifestyle.

	SD	D	AD	A	TA	NA
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Hobbies/leisure	3 (2.16%)	7 (5.04%)	21 (15.11%)	68 (48.92%)	38 (27.34%)	2 (1.44%)
Sleep habits	1 (0.72%)	13 (9.35%)	15 (10.79%)	72 (51.80%)	37 (26.62%)	1 (0.72%)
Work situation	7 (5.04%)	21 (15.11%)	12 (8.63%)	26 (18.71%)	10 (7.19%)	63 (45.32%)
Hygiene	-	2 (1.44%)	8 (5.76%)	75 (53.96%)	51 (36.69%)	3 (2.16%)
Eating habits	3 (2.16%)	7 (5.04%)	22 (15.83%)	72 (51.80%)	34 (24.46%)	1 (0.72%)
Physical activity	5 (3.60%)	27 (19.42%)	27 (19.42%)	48 (34.53%)	23 (16.55%)	9 (6.47%)
Sexual activity	19 (13.67%)	22 (15.83%)	27 (19.42%)	23 (16.55%)	5 (3.60%)	43 (30.94%)

SD—strongly disagree D—disagree AD—neither agree nor disagree A—agree TA—totally agree NA—does not apply.

3.5. Social Support during the Pandemic

The total scores obtained on the Social Support Satisfaction Scale [19] ranged in the sample between 29 and 58 points. Thus, most participants had a medium perception of social support (considering the scale's cut-off points) with a total of 118 individuals (84.89%), followed by high perception of social support with a total of 21 individuals (15.11%)—Table 4.

3.6. Mental Health and Well-Being during the Pandemic and Confinement Due to the COVID-19 Pandemic

By analyzing the scores obtained in the anxiety subscale, it was possible to verify that most participants present regular to mild anxiety levels (87.77%)—considering normal to mild level scores from 0 to 7. Likewise, in the depression subscale, it was possible to verify that most of the participants present normal to mild levels of depression (80.58%)—considering normal to mild level scores from 0 to 7. Finally, in the stress subscale, it was possible to verify that most participants present normal to mild stress levels (76.98%)—considering normal to mild level scores from 0 to 7.

The scale total scores analysis revealed that 81.29% of participants present normal or mild levels of anxiety, depression, and stress (normal to mild level scores from 0 to 21), followed by moderate to severe levels (17.27%) (moderate to severe level scores from 22 to 42). Only 1.44% of the participants present very severe levels (very severe level scores from 43 to 63)—Table 4.

Table 4. Scores of the assessment instruments.

	Social Support Satisfaction Scale	
		Frequency N (%)
Total Score	Low	0 (0%)
	Medium	118 (84.89%)
	High	21 (15.11%)
	Depression, Anxiety and Stress Scale–21 items (DASS-21)	
		Frequency N (%)
Total Score	0–21	113 (81.29%)
	22–42	24 (17.27%)
	43–63	2 (1.44%)
	Connor–Davidson Resilience Scale (CD-RISC)	
		Frequency N (%)
Total Score	<50	47 (33.81)
	≥50	92 (66.19%)
	Warwick Edinburgh Mental Well-Being Scale	
		Frequency N (%)
Total Score	<42	41 (29.5%)
	≥42	98 (70.5%)

The total scores obtained on the Connor–Davidson Resilience Scale (CD-RISC) [22] ranged in the sample between 3 and 97 points. After analyzing the total scores obtained in the scale, it was possible to ascertain that most of the participants present a medium to a high level of resilience—considering that a score above 50 means medium to high and below 50 means low to medium—with a total of 92 individuals (66.19%)—Table 4.

The total scores obtained on the Warwick Edinburgh Mental Well-Being Scale [25] ranged in the sample between 15 and 70 points. After examining the total scores obtained in the scale, it was possible to ascertain that most of the participants present a medium to high level of mental well-being—considering that a score above 42 means medium to high and below 42 means low to medium—with a total of 98 individuals (70.5%)—Table 4.

3.7. Satisfaction with Life and Expectations for the Postpandemic Future

Concerning satisfaction with life during the pandemic (see Table 5), there was a central tendency to identify themselves as "satisfied" with their life, 57 (41%), followed by the options "not very satisfied" or "neither satisfied nor dissatisfied" with a total of 28 (20.1%) each.

Table 5. Satisfaction with life during the pandemic.

		Frequency N (%)
Satisfaction with life	Not satisfied at all	8 (5.8%)
	Dissatisfied	28 (20.1%)
	Neither satisfied nor dissatisfied	28 (20.1%)
	Satisfied	57 (41%)
	Very satisfied	18 (12.9%)

Although many participants were satisfied with their lives during the pandemic, 71.2% indicated that they would like their lives to change "a lot" after the pandemic.

When asked qualitatively about the aspects of their lives they consider essential to change after the pandemic, the answers focused on the improvement of the labor/financial situation (e.g., "I want to get a job" "Increase of the salary"), the development or improvement of personal skills (e.g., "Increase resilience" "Increase autonomy" "Have more responsibility and initiative") and social relations (e.g., "Demonstration of physical affection" "Establish meaningful relationships" "Love relationships"). The participants also showed interest in increasing participation in leisure activities (e.g., "Traveling" "Socializing with family/friends" "Partying") and the desire to return to prepandemic life (e.g., "Back to routine" "Having freedom").

3.8. Pearson Correlations between Some Variables

The Pearson correlation analysis showed several significant correlations between the resilience score, mental well-being score, DASS-21 score, and satisfaction with life (see Table 6). The resilience score and the mental well-being score, the resilience score and satisfaction with life, and the mental well-being score and satisfaction with life show positive correlations, meaning that an increase/decrease in one variable leads to an increase/decrease in the other, respectively. The resilience score and the DASS-21 score, the mental well-being score and the DASS-21 score, and the DASS-21 score and satisfaction with life show negative correlations. An increase/decrease in one variable leads to a decrease/increase in the other, respectively. The Social Support Satisfaction Scale's score did not show significant correlations with any of the other scales applied in the study.

Table 6. Pearson Correlations Between Some Variables.

Variables	Mental Well-Being Score	DASS-21 Score	Social Support Satisfaction Score	Satisfaction with Life
Resilience Score	0.676 **	−0.285 **	−0.032	0.342 **
Mental Well-Being Score		−0.332 **	−0.018	0.399 **
DASS-21 Score			0.071	−0.351 **
Social Support Satisfaction Score				0.021

** $p < 0.01$.

4. Discussion

The data found in this study seem to contradict the trend seen in studies conducted with this population in other countries, focusing on a higher prevalence of SARS-CoV-2 infection and higher disease-related morbidity in these individuals [14]. In fact, contrary to expectations, the incidence of COVID-19 and disease-related morbidity in our sample was low, being only 2.2% and with no individual presenting severe complications. On the contrary, the country's media reported that the infection rate was much higher in large psychiatric institutions. This situation may be explained by the influence of other variables, namely the low representativeness of the sample at the national level—since most of the sample is concentrated in the Lisbon area—and by the sample having high educational levels. Furthermore, during the confinement and subsequent periods, there was constant dissemination of good practices shared and suggested by FNERDM. At the beginning of the study, specific groups were identified as a priority, namely elderly people, people with cardiorespiratory diseases and healthcare and armed forces professionals. Only later (end of April 2021), people with serious mental illness were included in this priority group and started to get vaccinated a few weeks later, hence the numbers related to their vaccination are so low in our sample.

As for the mental health during the pandemic of the participants who make up the sample of this study, it was found that most showed no symptoms or mild symptoms

related to anxiety, depression, and stress. In addition, they revealed medium to high levels of resilience and mental well-being.

It was also noted that resilience and well-being levels showed a positive correlation which increased the levels of resilience with an increase in the levels of well-being and vice versa. In addition, the levels of well-being and resilience showed a negative correlation with the scores obtained in the DASS-21, which means that a decrease in the levels of depression, anxiety, and stress increases the levels of well-being and resilience and vice versa. The levels of resilience and well-being showed a positive correlation with life satisfaction, meaning that with increased resilience and well-being, life satisfaction and vice versa. These findings are consistent with previous research, as perceived social support partially mediates the relationship between resilience and life satisfaction [26]. Moreover, the levels of depression, anxiety, and stress showed a negative correlation with life satisfaction, which results in an increase in life satisfaction with a decrease in the levels of depression, anxiety, and stress, and vice versa.

Participants were generally satisfied with their adopted routines and lifestyles and overall life during this phase. However, despite the satisfaction, they showed a high expectation of change in their lives in the postpandemic future. On the other hand, several people reported they wished their lives would go back to the way they were before the pandemic. This inconsistency in the answers can be explained by the fact that the participants showed a high capacity to adapt to the new situation.

The mediating effect of social support on the association between perceived stress and mental health has long been recognized. The relationship between COVID-19-related stressful experiences could be mediated by resilience, adaptive coping strategies, and social support. Social support plays a vital role in promoting health, alleviating stress in a crisis by moderating genetic and environmental vulnerability in stress adaptation and inhibiting behavioral and psychological responses to stress [19,27]. According to Southwick and colleagues [28], resilience and social support are complex constructs, and regarding social support, it could be defined as having or perceiving to have close others who can provide help or care, particularly during times of stress, including structural social support, functional social support, emotional social support, instrumental/material social support, and informational/cognitive social support. We know that social support from one's community can also help foster resilience in the individual. So, community members are strongly affected by the coping strategies of other community members, as well as by the community's capacity to prepare for and deal with adverse events and conditions. Furthermore, resilience is influenced by factors such as how participants view themselves and their interaction with the surrounding world, the social resources received, and the coping strategies used by individuals [29]. Thus, the participants' social support received during the pandemic may have been a contributory factor in promoting resilience in them. Moreover, since the literature identifies reduced support networks as predictors of worsening psychiatric symptoms [3] and considering that our sample perceives the social support received as average, perhaps this could justify the individuals under study showing high levels of mental well-being.

Due to the pandemic, on-site services provided by community-based psychosocial rehabilitation structures were interrupted. However, home support and distance support continued to be provided through individual or group activities at a distance, both through video calls and phone calls. This support may justify the satisfaction with the routine/lifestyle and their support network, the maintenance of their compensated psychiatric condition without worsening symptoms, and the favorable adaptation to the new reality presented by the beneficiaries of these services.

This study has some limitations, namely the low geographical diversity of the sample and a possible sample selection bias since people with lower levels of resilience and mental well-being suffered more from the mental illness. Consequently, they might have been unable or unwilling to participate in the study. The high satisfaction ratio does not necessarily mean that there was no significant impact since due to the lack of a comparison

group before and after the pandemic period, it is not possible to conclude what has been changed in the pandemic period. Another limitation present in the study may have been the period of data collection since the data was collected during the last wave of the pandemic and may not represent the reality experienced during the entire pandemic. Although there are limitations in this study, the value of the integration of people with mental illness in a community context seems to be also advantageous in terms of public health rather than large psychiatric institutions.

5. Conclusions

Despite the limitations, our study allowed us to conclude that the COVID-19 pandemic seems not to have had a significant negative impact on people with experience of mental illness integrated into community-based psychosocial rehabilitation structures in Portugal since the incidence of infection by SARS-CoV-2 was reduced, and in general, there was satisfaction with the routine/lifestyle during this phase and with the social support received. Moreover, there was no worsening of symptoms or psychiatric conditions in the sample, regarding mental health. Finally, it is also important to mention that the participants were resilient to the new situation and had high levels of mental well-being during the pandemic. Nevertheless, it is vital to continue monitoring the pandemic evolution and its impact on people with mental illness to understand how community-based psychosocial rehabilitation structures can continue to have a protective effect against COVID-19, protecting people from virus exposure and allowing them to support people's daily life activities.

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