

Reframing mental health governance in Italy: Psychological competencies and third sector integration in the PANSM



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Abstract

The Italian National Action Plan for Mental Health 2025-2030 promotes a broader view of mental health, with greater attention to prevention, continuity of care and community-based services. However, there is still a gap between this vision and the way the Plan is expected to be implemented. The proposed system remains strongly centered on specialist and psychiatric services, while psychological support, early intervention and prevention in everyday settings receive less attention. This contribution focuses on the role that third sector Organizations can play in addressing this gap. Voluntary associations, social cooperatives and user-led organizations are often closely connected to local communities and can reach people who may struggle to access formal services. Their work can support early recognition of distress, reduce stigma and help maintain continuity between care and daily life. Yet the Plan still tends to describe the third sector mainly as a provider of services rather than as an active partner in planning and decision-making. To make

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its community-oriented vision more concrete, stable forms of collaboration with these organizations are needed, together with stronger psychological expertise and greater investment in prevention.

Keywords: National Action Plan for Mental Health; third sector; community mental health; prevention; psychological care; service integration.

Introduction

The National Action Plan for Mental Health 2025-2030 marks a turning point in the Italian mental health landscape, signaling renewed political and cultural commitment to move beyond hospital-centered psychiatric models. The Plan adopts a multidimensional understanding of mental health shaped by individual vulnerability as well as social relationships, living conditions, and life transitions. Mental health is framed as both a human right and a collective responsibility, closely linked to social inclusion, equity, and community well-being.

This perspective aligns with international frameworks promoted by the World Health Organization, emphasizing community-based care, proximity, prevention, and the integration of mental health into primary health systems. The Plan recognizes that specialist- and hospital-centered responses are insufficient amid rising demand, social fragmentation, and limited institutional capacity.

The Plan acknowledges that mental health cannot be supported through treatment alone, but requires investment in prevention, empowerment, and social cohesion. Policy is therefore called to shift from crisis management toward environments that foster resilience and participation.

Despite the conceptual strength of this vision, concerns remain about its practical implementation. Critics highlight a persistent psychiatric bias, whereby the language of “mental health” continues to mask a system centered on medicalized responses. Prevention, early psychological support, and school-based interventions remain underdeveloped, while workforce planning reflects a specialist-oriented model. This tension risks limiting the Plan’s transformative potential, particularly in strengthening psychosocial infrastructures.

In this gap between institutional vision and lived reality, the third

sector becomes pivotal. Voluntary organizations, social cooperatives, and user-led associations have long shaped community-based responses to distress by creating spaces of belonging, support, and recovery that extend beyond service provision. Operating at the intersection of care and citizenship, they translate rights into practice through territorial rootedness and trust-based relationships, reframing mental health as relational rather than purely technical. A genuinely community-oriented reform requires network-based governance in which clinical expertise and community knowledge work in synergy, treating the third sector as a structural pillar rather than a supplementary resource. The challenge is not merely to expand services, but to rebuild governance around shared responsibility, co-production, and social trust.

The PANSM's vision and its implicit model of mental health

The PANSM adopts an ecological and bio-psycho-social perspective, recognizing that social inequalities across the life course shape mental health, thereby signaling a shift away from strictly symptom-based and diagnostic models.

Organizationally, one of the Plan's strengths lies in its reaffirmation of the integrated departmental model, intended to ensure continuity between prevention, care, rehabilitation, and social inclusion. The emphasis on strengthening territorial services, multidisciplinary teamwork, and reducing coercive practices reflects an effort to modernize governance and clinical cultures.

A central innovation is the concept of continuity of care, addressing long-standing challenges in transitions between services as individuals' clinical and developmental needs evolve. A crucial example is the shift from child and adolescent neuropsychiatry to adult mental health services, where inadequate coordination may create gaps, increase dropouts, and worsen outcomes. In this context, continuity of care represents a key element in ensuring not only the continuation but also the effectiveness of treatment, through the coordinated work of multidisciplinary teams. Within this framework, the third sector plays a crucial role through associations and social cooperatives, acting as a bridge between citizens and the public healthcare system.

However, some tensions remain between principles and implementation. While the Plan adopts a rights-based and preventive language, organizational priorities remain predominantly anchored to specialist services. The limited development of primary psychological care and school-based interventions risks constraining early prevention and underutilizing psychological expertise. Where mental health governance remains institutionally centered on specialist services, community actors may be involved consultatively rather than structurally. As a result, despite its declared commitment to multidisciplinary, governance may continue to privilege medical perspectives, while psychological, educational, and social contributions remain unevenly integrated and civil society engagement is more episodic than systematic.

Within this framework, the third sector appears positioned mainly as an implementing partner rather than a co-producer of mental health cultures and services. The absence of formalized co-planning and shared accountability mechanisms may limit community actors' capacity to contribute fully to a reform that aspires to place community care at its center.

The strategic role of third sector organizations in mental health

Third sector organizations occupy a distinctive position within Italy's mental health ecosystem, particularly in relation to the community-based and territorial orientation promoted by the PANSM. Operating at the interface between formal services and everyday life, they translate institutional objectives into relational, context-sensitive practices. Their contribution extends beyond service delivery, linking health systems with families, schools, municipalities, and vulnerable groups.

Embedded in local contexts, third sector organizations play a key role in the early interception of distress, recognizing vulnerability before it reaches clinical thresholds. Through preventive and inclusion-oriented initiatives, they operationalize a territorial model of care consistent with the Plan's vision.

A further strategic contribution lies in stigma reduction and mental health promotion. Through public campaigns, narrative initiatives, and mental health literacy activities, civil society organizations help

reshape representations of psychological distress and encourage help-seeking, supporting the PANSM's goal of expanding access to care by reducing social and symbolic barriers.

The third sector is also central to peer support and empowerment. By valuing lived experience as a form of knowledge, participatory and advocacy-based models reposition service users as active agents in recovery processes and, potentially, in policy dialogue – an approach consistent with the PANSM's rights-based framework, though not yet fully operationalized.

Crucially, these organizations are not alternatives to public services but enabling actors within an integrated system. They support continuity across phases of care often fragmented by institutional boundaries, including transitions between treatment and social reintegration, or between crisis intervention and everyday functioning.

Alignment and gaps between PANSM and third sector potential: participation in governance

The PANSM formally recognizes participation and dialogue with civil society as core principles of mental health governance. Stakeholder engagement is framed as both an ethical and methodological requirement, and the language of partnership recurs throughout the document. However, this recognition remains largely programmatic. While consultation is encouraged, the Plan does not yet outline a stable governance framework through which third sector organizations are formally and systematically involved in decision-making, planning, and evaluation.

Participation thus appears more as a guiding orientation than as an institutionalized mechanism. In the absence of defined instruments for co-governance, third sector actors risk remaining peripheral, engaged primarily through episodic consultation rather than sustained involvement.

The limited formalization of co-design mechanisms may also constrain innovation, leaving it dependent on local initiative rather than embedded in system-wide governance. Permanent consultative bodies capable of ensuring continuity, accountability, and strategic alignment at regional or national level are not clearly envisaged. While informal

collaboration plays an important role across many territories, it cannot, on its own, substitute for governance structures designed to sustain long-term transformation.

Community accountability similarly remains underdeveloped. The PANSM provides limited guidance on how service users, families, and advocacy groups might be meaningfully involved in the evaluation of service quality and policy coherence. As a result, the participatory potential of mental health governance may remain only partially realized, and the third sector's role in promoting transparency, rights protection, and social responsiveness is largely implicit.

Overall, the Plan articulates an inclusive vision but does not yet establish the institutional conditions necessary to realize it. For participation to become transformative rather than symbolic, it would need to evolve toward more formalized arrangements of co-governance and shared responsibility; otherwise, inclusion risks remaining rhetorical rather than structurally embedded.

Prevention and early intervention

A central challenge for the PANSM lies in translating its commitment to prevention into fully operational frameworks. This gap becomes particularly visible when compared with the extensive practices already developed by third sector organizations across Italy. In many territories, non-profit associations and social cooperatives have long been active in areas the Plan identifies as crucial, including school-based prevention, youth outreach, caregiver support, and community-based anti-stigma initiatives.

Yet the PANSM does not articulate an operational framework capable of integrating these resources into a coherent national prevention strategy. Prevention is addressed largely in aspirational terms, without clearly defined tools or governance mechanisms. As a result, the system continues to prioritize secondary and tertiary levels of care, while psychological prevention and early psychosocial support remain marginal.

What remains underdeveloped is a strategy to structurally connect existing community-based prevention networks with public mental health governance. The Plan does not formally position the third sector as a core actor in prevention, nor does it establish shared protocols for

early identification or stable channels for collaboration with public services. Consequently, an already active prevention infrastructure risks remaining outside strategic planning.

This gap reflects a broader conceptual challenge: mental health is still managed predominantly within a clinical framework rather than fully recognized as a developmental and social process unfolding across schools, families, workplaces, and public spaces. Without embedding prevention within community-based governance, the PANSM may underutilize one of Italy's strongest resources for early intervention and mental health promotion.

Socio-health integration

One of the most promising aspects of the PANSM is its commitment to socio-health integration. The Plan acknowledges that mental health cannot be confined to the clinical sphere alone and requires coordination between health services, social systems, and community resources. This orientation reflects the international shift promoted by the World Health Organization toward primary health care, centered on accessibility, continuity, and proximity of care. By identifying territorial services as the backbone of the system and encouraging links between primary care, specialist services, and community interventions, the PANSM aligns with contemporary standards.

However, while the strategic vision is coherent, its operational translation remains limited. Integration is still primarily conceived as coordination within public institutions rather than as a shared ecosystem where community actors are recognized as structural partners. International experience shows that socio-health integration becomes effective only when civil society organizations are involved as co-producers of care.

In this context, the third sector is indispensable. Acting on key social determinants of mental health often lies beyond clinical services. Third sector organizations are often the first to intercept distress linked to social vulnerability, operating in neighborhoods, schools, shelters, prisons, and reception centers, providing relational continuity, mediation, and context-sensitive support in settings where institutional care is often intermittent or difficult to access.

Moreover, they typically address mental health across its emotional, relational, and material dimensions, combining psychological support with social inclusion and empowerment. In everyday practice, they give concrete form to the holistic vision articulated by the PANSM, treating mental health as embedded in living environments rather than confined within service settings. Despite this convergence at the level of principles, the Plan does not clearly define how third-sector actors should be integrated into formal care pathways. Collaboration remains largely discretionary and dependent on local initiatives. What is missing is a system of shared pathways rather than parallel interventions, supported by joint planning, shared case management, integrated training, and coordinated evaluation.

Without such structural integration, socio-health collaboration risks remaining rhetorical. Recognizing the third sector as a core component of the system requires a shift from cooperation to co-responsibility and shared governance. Clinical excellence alone cannot ensure recovery without social inclusion, empowerment, and community participation.

A concrete instrument capable of operationalizing integration is the Italian *Budget di Salute* (Health Budget), which combines health, social, housing, and employment resources into individualized recovery pathways. More than a funding tool, it represents a governance mechanism based on co-design and shared responsibility between public services and third sector organizations. If systematically embedded within the PANSM, it could move socio-health integration from principle to structured co-production. However, uneven regional implementation and the lack of standardized national guidance currently limit its transformative potential.

From a broader European perspective, similar reforms have advanced where community actors are structurally embedded within governance frameworks. In countries such as the United Kingdom and several Scandinavian systems, civil society organizations are formally integrated into primary care networks and municipal socio-health planning, contributing to prevention, recovery, and continuity of care. Compared to these models, the PANSM articulates a coherent community-oriented vision but has yet to consolidate equally structured mechanisms of co-governance. Strengthening psychological competencies and third sector integration would therefore align Italy more closely with evolving European standards in community mental health.

What the third sector brings that is still needed

One of the third sector's most distinctive contributions is its ability to build community-based infrastructures that public services struggle to replicate. Embedded in everyday life, these organizations often reach individuals before they enter clinical pathways, ensuring relational continuity grounded in daily experience rather than diagnostic thresholds.

Another irreplaceable contribution concerns cultural mediation and trust-building. In contexts marked by stigma and distrust, especially among young people, migrants, and marginalized groups, third sector actors provide the first relational bridge to care through their presence in schools, neighborhood spaces, and community settings, enabling early engagement without the symbolic weight of institutional entry points.

Equally crucial is the third sector's capacity to ensure continuity beyond the clinical "episode of care". Organizations remain engaged throughout recovery processes, family crises, and phases of social re-integration. In doing so, they provide what no protocol can guarantee: durable relationships. This function is particularly relevant in cases of severe mental distress, where fragmentation remains a persistent systemic vulnerability.

Finally, third sector organizations play a key role in advocacy and rights protection. They act as watchdogs and agents of accountability in a field historically shaped by asymmetries of power. While the PANSM affirms a commitment to overcoming coercive practices, its effectiveness will depend in practice on the presence of civic actors capable of monitoring implementation and sustaining a rights-based culture beyond formal declarations.

In short, the third sector inhabits the social and relational dimensions of care that institutional systems struggle to govern fully. Without formally embedding this infrastructure into policy design and implementation, the PANSM risks remaining institutionally robust but socially fragile. Mental health reform, ultimately, is not only about services: it is about citizenship.

Recommendations for strengthening PANSM through third sector engagement

For the PANSM to realize its transformative potential, the role of third sector organizations needs to evolve from symbolic acknowledgment to structural inclusion. Although participation and integration are endorsed, they remain largely aspirational in the absence of concrete mechanisms capable of embedding them into governance and service delivery. In this context, the third sector is uniquely positioned to operationalize these principles through its territorial presence, trust-based relationships with vulnerable populations, and experience in cross-sector collaboration.

One of the most relevant areas for further development concerns governance. While the Plan refers to consultation and listening processes, it does not yet establish stable institutional arrangements through which third sector organizations can participate meaningfully in planning, implementation, and evaluation. Without such structures, participation risks remaining primarily formal rather than substantive, reinforcing a dynamic in which communities are consulted but only partially empowered. Integrating third-sector representatives into governance frameworks at national, regional, and local levels would strengthen the participatory architecture envisaged by the Plan.

Existing co-planning models in Italian social policy offer a valuable reference for the mental health field. Participatory design processes could enable service planning and evaluation to reflect lived experience alongside administrative and clinical priorities. Likewise, the establishment of permanent advisory bodies, including user organizations, family associations, and third sector representatives, would help institutionalize dialogue and continuity of accountability, reducing reliance on episodic or symbolic forms of participation.

The PANSM's alignment with international frameworks that position primary care as the backbone of mental health systems represents an important opportunity. However, integration remains largely framed within public health structures. To be fully effective, this model should extend more explicitly into the community, with primary care functioning not only as an access point but also as a hub within a broader ecosystem of social and civic resources.

In this perspective, formalized partnerships between third sector

Organizations and primary care teams could enhance outreach to populations often excluded from formal services – such as migrants, people experiencing homelessness, socially isolated older adults, and at-risk young people – while strengthening continuity of care through social inclusion and family engagement.

Joint training programs represent another strategic area. Interprofessional learning involving clinicians, community workers, and volunteers can foster a shared language grounded in recovery, human rights, and person-centered care. Trauma-informed practice, peer involvement, and mental health literacy offer fertile ground for cross-sector integration.

Recognition must be matched by sustainable funding structures, as reliance on short-term project financing undermines continuity and long-term planning. Targeted investment is needed in areas of growing strategic relevance, such as digital mental health literacy, online support platforms, and community-based tele-mental health services. Although many third sector Organizations are already innovating in these domains, their impact remains uneven without coordinated support and capacity-building in volunteer management and leadership.

Finally, no mental health reform can succeed without addressing stigma. Structural change must be accompanied by cultural transformation, and the third sector plays a decisive role through its presence in schools, communities, and workplaces, where mental health becomes visible and discussable. Communication strategies gain legitimacy when delivered by actors embedded within social networks rather than solely through institutional channels.

Civil society also acts as a guardian of rights, reinforcing accountability and ethical oversight. The PANSM articulates a forward-looking vision by placing community care at the center of reform. What is now required is the institutional capacity to allow the third sector not merely to accompany this transition, but to shape it actively. Without such a shift, reform risks remain rhetorically ambitious while progressing more slowly in practice.

For the PANSM to become a genuine reform rather than a programmatic document, the system must strengthen the psychological dimension and structurally integrate the third sector into governance. Otherwise, the rhetoric of “mental health” risks remaining anchored to a

predominantly psychiatric framework, leaving prevention, proximity, and continuity underdeveloped.

Three core priorities can therefore be identified:

1. Establish stable co-governance mechanisms with third sector organizations, service users, and families, moving from episodic consultation to co-planning.
2. Reinforce clinical and community psychology at the center of prevention, early identification, and service transitions.
3. Invest in structural prevention by integrating territorial networks already active in schools, communities, and vulnerable settings.

Only by consolidating shared governance, the centrality of psychology, and community-based prevention can the PANSM translate into meaningful change, anchoring mental health within communities and everyday life.