

The new plan for Mental Health in Italy: caveats, shortcomings, and recommendations for full implementation

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Submitted: 19/01/2026

Accepted: 01/08/2026

Abstract

The National Plan for Mental Health for the period 2025-2030 is a significant and ambitious document that addresses major mental health challenges in Italy. Is it too ambitious? Is it fully realizable? What are the biggest issues and obstacles to its full implementation? In this short paper, I will propose a series of potential problems and offer recommendations for addressing and mitigating them.

Keywords: Italian National Plan for Mental Health; common mental disorders; stratified care model; primary care psychologist.

New answers to new challenges...

In the last few decades, the area of mental health underwent huge transformations. Rather than the emergence of new disorders, the greatest population-level impact on mental health, with important implications for political decision-making has been the increased prevalence of common mental disorders (CMDs), such as major depression and anxiety disorders, as well as drug use disorders, particularly

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Rivista di Psicologia Clinica (ISSNe 1828-9363), n. 1/2026

DOI: 10.3280/rpc1-2026oa23594

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among younger populations. Other conditions of interest include the so-called “new” (behavioral) addictions, whose impact is difficult to evaluate, given that they are not currently classified as mental disorders in existing diagnostic taxonomies (with gambling disorder being the exception). It is difficult to establish the reasons for this growth. Rapid changes in habits related to the massive use of the internet and social media, and the global impact of the COVID-19 pandemic, have often been suggested as possible causes or determining factors worldwide. However, greater attention to mental health and successful campaigns against stigma might have helped to make psychological suffering more visible, leading to diagnosis and treatment. Even before the onset of the COVID-19 pandemic, England reacted to CMDs with a unique initiative called the Improving Access to Psychological Therapies (IAPT) programme, providing psychological and psychotherapeutic interventions to all citizens of England who required them within the National Health Service (NHS). IAPT (now called Talking Therapy for Anxiety and Depression) has been in operation for over 15 years. Several reviews, studies, and meta-analyses have evaluated its effects on mental health in England, reaching divergent conclusions. Thus, the aim of this paper is not to present another synthesis of the evidence. IAPT is relevant to this paper because the limitations of “treatment as usual” for CMDs are neither as recent as one might assume nor necessarily driven by increases in their incidence.

What are the most important mental health challenges for the next five years? What needs does the plan seek to address? A thorough reading of the document clearly highlights some of these challenges. Some general principles align with World Health Organization (WHO) statements such as “no health without mental health” and “health is not just the absence of disease”. These statements form the basis of the idea that you cannot impact on mental health without providing acceptable living conditions, including, for instance, housing and basic welfare. Other aspects are clearly described in specific chapters, including mental health during pregnancy and the postpartum period, mental health during adolescence, the transition from adolescence to adulthood, and mental health among inmates and individuals who have committed criminal offences but are ineligible for prison due to their mental status. Finally, the increasing problem of addiction and “new” addictions is extensively addressed. Although

other challenges are not explicitly stated, they have clearly influenced the document. For instance, the emphasis on early diagnosis, prevention, and treatment is, in my opinion, inspired by the following pieces of knowledge:

- a) CMD onset is common during late adolescence and early adulthood;
- b) The interval between symptom onset and the first contact with a mental health professional can be as long as a decade (P. S. Wang, Berglund, Olfson, & Kessler, 2004);
- c) The longer this interval, the poorer the prognosis.

What are the answers to these challenges? The present paper does not aim to summarize all the actions of the plan; however, the main idea is to create a multidisciplinary, integrated system involving the general practitioner (GP), the new professional known as the primary care psychologist, and several day-care, day-hospital, residential, and semi-residential structures, including the so-called *Centro di Salute Mentale* (Center for Mental Health, CSM). This is an integrated structure within the Italian NHS in which different professionals, such as psychiatrists, psychotherapists, rehabilitators, and social educators, work in équipe.

This integrated structure would provide an effective network for the prevention, early diagnosis, and stepped-care intervention for mental health issues. Moreover, the document effectively emphasises the importance of adhering to international guidelines for stepped-care interventions (National Institute for Health and Clinical Excellence, NICE 2009) and adopting evidence-based interventions.

...but with at least two old models

The plan clearly demonstrates a strong drive to innovate and to tackle mental disorders while promoting mental well-being. However, numerous possible shortcomings remain. Here, I will analyse those embedded in the adoption of the bio-psycho-social model (see for instance, and the Italian NHS model, which has been modified but not intimately changed in the plan.

Regarding the first, it is important to underline that the bio-psycho-social model is internationally recognized as one of the most effective

models for describing health at the intersection among physical and mental states and the social environment. The plan's goal is to pursue mental health using the One Health approach. This is in line with all the updated international guidelines. However, the plan itself lacks structural actions for the “social” part of the model. While a convincing policies on housing is detailed, especially for individuals with mental health problems, too little is detailed for the social aspect of preventing mental disorders and promoting psychological well-being. In an integrated, person-centered approach to health, it is reasonable to imagine that the entire welfare system, not just the NHS, should be involved. Of note, the physical aspect of the model is slightly undermined as well. Only a few hints are dedicated to mental health in patients with chronic physical diseases and informal caregivers. The latter are becoming a relevant issue in our country, considering the increasing ageing population).

As a Professor of Clinical Psychology and boarded psychotherapist, my main concerns are related to the second “old” model. To effectively address the challenges described above, one might imagine a deep revolution in the NHS's structure, however I do not see that in the plan. Once again might correctly argue that proposing a new NHS is not the objective of the plan and that several changes are nevertheless proposed. In my view, the lack of some structural changes, not only within the NHS but also in the education of mental health professionals and in research, risks jeopardizing the effective implementation of the plan.

A physician-centered model

As mentioned above, the plan is not intended to serve as a roadmap for modifying the Italian NHS. Thus, the model for promoting mental health is centered on medical doctors: the GP, as a physician, is responsible for initial diagnosis, initiating the therapeutic approach, and referring patients to other NHS structures, such as the *Case di Comunità* (Community Houses) – we will come back to these structures later – and the CSM. Typically, the CSM is held by psychiatrists who re-assess patients and define intervention strategies using a multi-professional approach. Therefore, in the CSM where more severe cases

arrive, psychiatrists decide which treatment is needed, including prescribing psychotherapy or other non-pharmacological interventions (e.g., occupational therapy, rehabilitation, etc.). Of note, in Italy, while psychiatrists are automatically considered psychotherapists upon receiving their specialization degree, most of them do not have sufficient knowledge to practice it. Psychiatrists also oversee hospital psychiatric wards for both inpatients and outpatients. To be enrolled in the NHS, both psychologists and physicians must have a specialization degree. However, with regard to mental disorders in the NHS, it seems that psychologists largely depend on psychiatrists. It is worth noting that the NHS includes psychological wards, for instance within hospitals, which typically provide care for health psychology or behavioural medicine issues. However, the biggest limitation of this model, in my opinion, is that many psychiatrists do not recognize talking therapies as effective treatments for CMDs and therefore do not prescribe them, despite the numerous proofs of evidence supporting their efficacy.

An ambiguous definition of severity...

Another issue embedded in the plan is that the severity of mental disorders is ill-defined. The plan generally suggests that GPs and primary care psychologists treat low-severity cases using a stepped-care approach, which is better described as stratified care (see below). However, it does not specify what should be considered a less or more severe case. Instead, it makes a general statement that severe cases require a multi-professional approach. Is depression always severe? National and international guidelines and literature would disagree with this statement. Is drug prescription a proxy for severity? Clearly not, since the plan suggests that GPs can prescribe treatment, which in this case could only be pharmacological. In line with several pieces of literature, I think an effective way to assess severity is related to functional impairment. By using functional impairment in daily life as a measure of severity, we can clearly distinguish individuals with low-severity Major Depressive Disorders from individuals with high-severity adjustment disorders, which are generally considered less severe than other CMDs.

...and an ambiguous definition of disorders...

Regarding mental health, the plan refers to various disorders, including psychological disorders (one hit in the document), psychiatric disorders (18 hits), psychic disorders (18 hits), and mental disorders (75 hits). It is unclear whether these terms are used as synonymous. Of interest, the only instance in which “psychological disorders” is mentioned pertains to the actions of the primary care psychologist, which include (among others) the “preventive, diagnostic, and early treatment of mild to moderate psychological disorders, especially in their initial phase”. Unfortunately, the specific characteristics of psychological disorders compared to mental disorders are not discussed and therefore remain unclear. International literature tends to use “psychological disorders” as a synonym for “mental disorders”. One of the most popular textbooks for clinical psychology courses, at least in Italy, edited by Kring and Johnson, is entitled “Abnormal Psychology: The Science and Treatment of Psychological Disorders”, and it describes mental disorders. Even in psychiatric journals, “psychological disorders” is used as an umbrella term for severe conditions such as post-traumatic stress disorder. Thus, in the absence of further explicit definition, should we consider that even a primary care psychologist should diagnose and treat some cases of mental disorders? Furthermore, this issue, is not only a matter of which cases (again, what should be an agreed criterion to assess severity?), but also of which treatment.

...contribute to an ambiguous definition of treatments

In Italy, psychotherapy can be administered by psychologists or physicians who are also psychotherapists, meaning they have completed a four-year course at a minimum after their master degree or medical school. Currently, there are three main ways to become a psychotherapist: complete a residency in psychiatry (for physicians only), which allows the administration of psychotherapy interventions without further courses; complete a residency in psychology (for psychologists only); or complete a four-year course at a private school of psychotherapy (open to both physicians and psychologists). While the law

states that a primary care psychologist must have a master's degree in psychology, another law defining the psychological profession (*Legge 56/89*) states that only psychotherapists can perform psychotherapy. What type of intervention can psychologists administer? To answer this question, we may need to answer other questions embedded in the essence of psychological clinical intervention, such as: "What does define psychotherapy?" and "Are all the talking therapies psychotherapy?"

Once again, the international literature does not leave room for doubt. The American Psychological Association's dictionary defines psychotherapy as

"[psychotherapy is] any psychological service provided by a trained professional that primarily uses forms of communication and interaction to assess, diagnose, and treat dysfunctional emotional reactions, ways of thinking, and behaviour patterns [...]. The psychotherapist is an individual who has been professionally trained and licensed [...] to treat mental, emotional, and behavioural disorders by psychological means. They may be a clinical psychologist, psychiatrist, counsellor, social worker, or psychiatric nurse. Also called therapy; talk therapy [...]"

This definition underlines that any type of psychological service is essentially psychotherapy when a trained professional uses it to assess, diagnose, and treat abnormal psychological patterns. However, I find it relevant that the definition does not mention how the training should be, to the extent that, in several countries, social workers and nurses can administer talk therapy. I think this is the turning point of the discussion. Modern clinical psychology has developed several new ways to work with mental disorders, such as guided self-help, internet/app-based interventions, and low-intensity interventions. This is a completely different perspective compared to when psychotherapeutic interventions were shaped by masters such as Freud, Beck, Ellis, and Rogers. These new interventions often do not require long-term learning or supervision, especially when applied in a stepped-care approach within a multidisciplinary *équipe*, where professionals with less knowledge and expertise can be supervised by more experienced mentors. However, this is exactly what the plan proposes within the complex welfare network of GPs, Community Houses and CSM. Guided

self-help, also through an app or the internet, is effective for mild CMDs, and a board-certified psychotherapist is not necessary. The recent Cobra study showed that behavioural activation administered by a junior mental health professional is as effective as Cognitive Behavioural Therapy (CBT) in treating mild depression, saving costs and allowing highly trained professionals to focus on more complex cases. By contrast, every four-year course recognised by the Italian Ministry of University and Research can train psychotherapists, even if the approach is not considered evidence-based by international guidelines.

Toward a better-defined role for psychologists and a better plan

To summarize, the plan provides an important effort to improve mental health in our country, bridging the expertise of many different and highly trained professionals within the framework of our NHS. Once again, it would be foolish to expect this plan to completely transform our NHS or rewrite the laws that discipline our health-care professionals. Nevertheless, for the plan to become effective, it is important to bravely expand on some aspects that are currently only sketched out and to fully implement the resulting changes in both legislation and clinical psychology.

First of all, degrees in psychology are now professional degrees. This means that upon graduation, one can join the board of psychologists, just as with any other health profession (including medicine). Licensed psychologists, after their graduation, are permitted to work with patients using their knowledge. For this reason, psychology degree programs should increasingly provide the basic skills necessary to deal with patients and clients. Within multidisciplinary équipes in a stratified/stepped-care fashion, psychologists, even without the title of psychotherapists, should treat CMDs of mild to moderate severity. They should be able to recognize patients who need more intensive or multifaceted treatment and be supported by supervision and équipe meetings. In multidisciplinary équipes, psychologists should be capable of administering simple, low-intensity interventions, such as behavioural activation interventions, and supervising guided self-help. This would save economic resources and allow for greater scalability and diffusion of psychological help throughout the population, leaving

the most severe and complicated cases to highly trained professionals.

These types of interventions should be manualized in *ad-hoc* treatment schemes (*Piano Diagnostico Terapeutico Assistenziale*, PDTA), which should prioritize evidence-based treatments. Primary health care psychologists should work back-to-back with GPs so that GPs do not always consider drug prescriptions as the first option.

GPs, primary health care psychologists, and Community Houses personnel should be able to recognize severe cases and refer them immediately to higher-intensity facilities, such as the CSM or a psychiatric ward. This distinguishes stepped-care, which provides everyone with a low-intensity intervention and moves them to a more intense intervention if it is not effective, from stratified care, which provides everyone with the appropriate intensity of intervention based on symptoms and symptom severity.

Acknowledgements

I would like to thank Letizia Zurlo for proof-reading this paper.

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