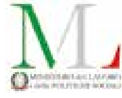

Guidance document on Integrated Mental Health for Adolescents in Italy

Output 3.2 of the project Addressing mental health and psychosocial support needs of children and youth in Italy

Part of the multicountry project "Child & Youth Wellbeing and Mental Health First"

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Acronyms

ADHD - Attention Deficit Hyperactivity Disorder

ASL - Local Health Authority (Azienda Sanitaria Locale)

CRC - United Nations Convention on the Rights of the Child

CSM - Mental Health Centre (Centro di Salute Mentale)

CUP - Central Booking Centre (Centro Unico di Prenotazione)

DBT - Dialectical Behavior Therapy

DSM - Mental Health Department (Dipartimento di Salute Mentale)

IASC - Inter-Agency Standing Committee

LEPS - Essential Levels of Social Services (Livelli Essenziali delle Prestazioni Sociali)

MBT - Mentalization-Based Treatment

MHPSS - Mental Health and Psychosocial Support

NPIA - Child and Adolescent Neuropsychiatry (Neuropsichiatria dell'Infanzia e dell'Adolescenza)

PANGI - National Action Plan for Child Guarantee (Piano di Azione Nazionale Garanzia Infanzia)

PANSM - National Mental Health Action Plan (Piano di Azione Nazionale Salute Mentale)

PCTO - Pathways for Transversal Competencies and Orientation (Percorsi per le Competenze Trasversali e per l'Orientamento)

PDTA - Diagnostic-Therapeutic-Care Pathway (Percorso Diagnostico Terapeutico Assistenziale)

PNES - National Plan for Social Interventions and Services (Piano Nazionale degli Interventi e dei Servizi Sociali)

PTOF - Three-Year Educational Offer Plan (Piano Triennale dell'Offerta Formativa)

PUA - Single Access Point (Punto Unico di Accesso)

SERD - Pathological Addiction Services (Servizio per le Dipendenze Patologiche)

SINPIA - Italian Society of Child and Adolescent Neuropsychiatry (Società Italiana di Neuropsichiatria dell'Infanzia e dell'Adolescenza)

SISM - Mental Health Information System (Sistema Informativo per la Salute Mentale)

TERP - Psychiatric Rehabilitation Technician

TSI - Technical Support Instrument

UNICEF - United Nations Children's Fund

UONPIA - Child and Adolescent Neuropsychiatry Unit (Unità Operativa di Neuropsichiatria dell'Infanzia e dell'Adolescenza)

UOS - Simple Operating Unit (Unità Operativa Semplice)

USR - Regional School Office (Ufficio Scolastico Regionale)

YAB - Youth Advisory Board

Preface

Mental health in the developmental age, and particularly among adolescents, today represents a pressing concern that requires a multidisciplinary approach. The Italian context, with its distinctive institutional framework — a national health system with a strong universalistic character, in a setting where school and social inclusion are a crucial regulatory and clinical element; the only country to have multiprofessional child and adolescent neuropsychiatry services that maintain an integrated developmental perspective across the neurological, psychiatric, and neuropsychological domains from 0 to 18 years, with innovative approaches that anticipated the current broad conceptualization of neurodevelopmental disorders — and at the same time its strong territorial variability, constitutes a privileged observatory for understanding both structural fragilities and the responses emerging at local, regional, and national levels.

The combined effects of the COVID-19 pandemic increased social and academic pressures, and persistent systemic barriers have contributed to a documented increase in anxiety, depression, self-harming behaviours, and widespread psychosocial distress among adolescents and young people. Understanding these dynamics requires looking at the Italian mental health and psychosocial support (MHPSS)[1] system as a whole, in order to identify cross-cutting areas for improvement, without neglecting the essential specificities of each component.

Historically, services developed along two parallel tracks — health and social — characterised by distinct governance, tools, and providers, despite the longstanding attention to school and social inclusion. In the last two decades, however, Italy has initiated a progressive orientation toward more integrated models, recognising that the promotion of neurodevelopment, mental health and psychosocial wellbeing requires an intersectoral approach that systematically involves Family Counselling Centres, Community Health Centres, Health Districts, Psychology Services, Child and Adolescent Neuropsychiatry Services (NPIA), Pathological Addiction Services, Psychiatry Services, Family Paediatricians and hospital paediatricians, General Practitioners, social services, the educational system, and the Third[2] and Fourth[3] Sectors.

[1] In this document, the expression "MHPSS services" (Mental Health and Psychosocial Support) refers to the set of services that comprise the Italian system for promoting mental health and psychosocial wellbeing for adolescents and their families and/or caregivers. Consistent with the IASC framework, these services operate at different intervention levels: educational and school institutions, Third and Fourth Sector, community and family networks, Social Services, and dedicated health services (Family Counseling Centers, Community Health Centers, Health Districts, Psychology Services, NPIA Services, Addiction Services, Psychiatric Services, Family Pediatricians, General Practitioners).

[2] In Italy the Third Sector comprises private non-profit entities operating for civic, solidarity-based and social utility purposes. It includes voluntary organizations, social promotion associations, philanthropic entities, social enterprises (including social cooperatives), associative networks, mutual aid societies, and other non-profit entities recognized by the Third Sector Code (Legislative Decree 117/2017). In the MHPSS context the Third Sector plays a fundamental role in delivering psychosocial support services, territorial proximity activities, peer education, cultural mediation, family support, and social inclusion interventions for children and adolescents.

[3] The Fourth Sector represents an emerging area that integrates elements of the profit and non-profit sectors, simultaneously pursuing economic sustainability and social impact objectives. It includes hybrid social enterprises, benefit corporations, community cooperatives, and other organizations operating with innovative social economy models. In the MHPSS context the Fourth Sector contributes innovative and sustainable solutions for MHPSS service delivery, combining management efficiency and social mission, often through public-private partnerships and social entrepreneurship models.

Despite this progress at the regulatory and programmatic level, significant obstacles remain to the full realization of an integrated model. The heterogeneity of regional regulations, the lack of consolidated coordination mechanisms between government levels, and the persistence of sectoral practices limit the continuity of care pathways and compromise equity in access to MHPSS services for adolescents.

The project "Addressing mental health and psychosocial support needs of children and youth in Italy" part of the multicountry TSI project "Child & Youth Wellbeing and Mental Health First", followed a progressive, evidence-based path that allowed for an in-depth understanding of MHPSS service integration dynamics.

The first phase involved a systematic review of international literature, useful for identifying effective collaboration models between health and social systems and defining a common theoretical framework through the Rainbow Model of Integrated Care. On this basis, a multi-regional analysis was developed, combining examination of regional mental health plans, interviews with key stakeholders, and discussions with district directors, highlighting the heterogeneity of organizational models, territorial disparities, and structural challenges that still limit full integration of services for adolescents.

In parallel, in-depth analysis of five representative case studies provided close insight into innovative practices and integrated approaches already operating on the ground, complemented by workshops and direct engagement with healthcare workers, social workers, educators, and families. Bringing together these three evidence sources — international, national, and local — revealed recurring patterns, enabling factors, and cross-cutting challenges, clarifying what is needed to strengthen MHPSS service integration.

The recommendations that follow translate insights from this structured process into practical guidance for national and regional policy-makers, public authorities and territorial service providers supporting adolescent mental health and psychosocial well-being.

Finally, it is important to emphasize that the recommendations contained in this document emerge directly from the consultation work described above. For this reason, they should be considered necessarily partial and non-exhaustive: they reflect the priority themes that emerged from this specific participatory process and are not intended to cover the entire spectrum of possible actions for MHPSS service integration.

Disclaimer

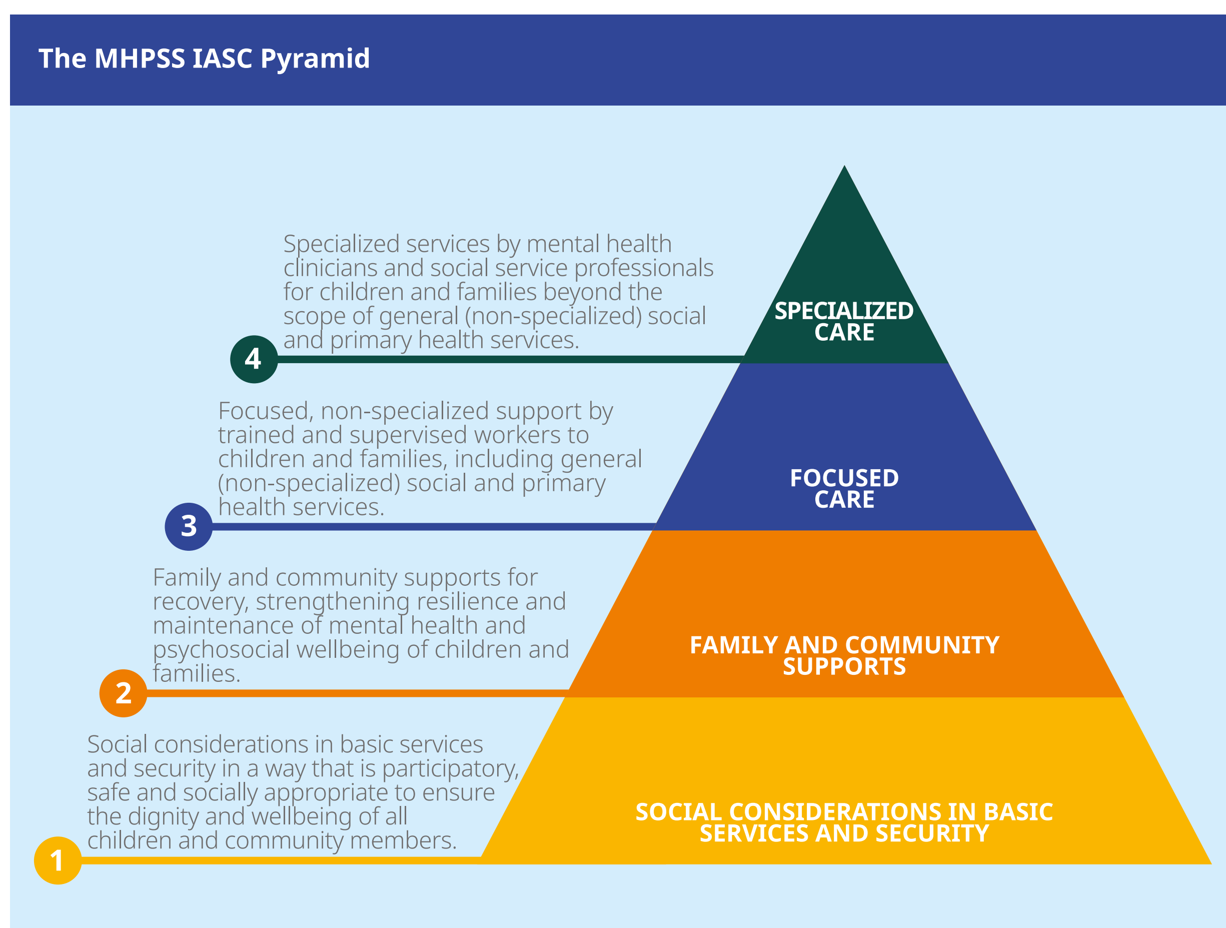
UNICEF's approach to mental health and psychosocial wellbeing (MHPSS) adopts a life course perspective, recognising that child and adolescent development involves interconnected pha-

ses — from the perinatal period to early childhood, from middle childhood to adolescence — each with specific needs and risk and protective factors (cf. Global Multisectoral Operational Framework for MHPSS of Children, Adolescents and Caregivers Across Settings, UNICEF 2022).

This document focuses on the 10–19 age group, in line with the mandate of the TSI project "Child & Youth Wellbeing and Mental Health First" and with the research and consultation phases carried out. This operational delimitation represents a conscious methodological limitation: the practices analysed, the territorial workshops, and the recommendations that follow specifically concern adolescence.

There is scientific evidence that mental health in adolescence depends to a large extent on what has been implemented in earlier stages of life. This perspective is confirmed by the validation workshops conducted across different Italian regions, which revealed how territorial services are already structuring prevention, promotion, and care pathways according to a logic of developmental continuity, recognising that interventions in adolescence are all the more effective the more they build upon early and coordinated actions throughout the entire developmental age span.

The MHPSS IASC Pyramid



In line with the IASC framework, the recommendations are articulated across the different levels of the intervention pyramid, from community wellbeing promotion to specialised services — including Child and Adolescent Neuropsychiatry Services (NPIA). For the same methodological reasons set out above, this document focuses on the cross-cutting and intersectoral dimensions of the MHPSS system and does not address specific clinical domains, such as neurodevelopment[4] and related disorders, for which reference is made to the relevant literature and sector guidelines (cf. SINPIA, 2019).

Building an Integrated System for Adolescent Mental Health and Psychosocial Wellbeing in Italy

Evidence gathered through case studies clearly shows that a system supporting adolescent wellbeing and mental health, whether public or public–private, must start from simple, non-stigmatizing, and culturally sensitive access, capable of early distress detection and offering safe spaces to seek help from which they can be rapidly redirected to higher intensity care levels when necessary. At the same time, there is a strong need to recognize young people not only as recipients but as active protagonists in designing and implementing interventions. Authentic participation, together with structured involvement of families and caregivers, represents a determining factor for strengthening trust, improving pathway adherence, and ensuring continuity of care throughout the development cycle.

Analyzed experiences also show that equity cannot be considered a spontaneous outcome: it requires intentional strategies capable of reaching the most vulnerable groups and integrating social deter-minants of wellbeing — from education to sports, from housing to legal support. In this framework, schools are confirmed as fundamental strategic nodes for early identification, prevention, and educational continuity. In parallel, digital innovation offers new opportunities for access and engagement, but requires ethical guarantees, security protocols, and governance capable of integrating it into formal systems.

The most promising practices are based on intersectoral collaborations, interoperable information platforms, and coordination mechanisms that overcome fragmentation between sectors,

[4] The term neurodevelopment describes the complex process through which the central nervous system and adaptive functions (sensory, motor, cognitive, communicative, emotional-relational, and social) mature from conception, in the first 1000 days and then until young adulthood, in a continuous interplay between genetic, epigenetic, neurobiological, and environmental risk and protective factors. When the neurodevelopmental process is altered, these are classified as neurodevelopmental disorders, an umbrella term encompassing neuropsychiatric disorders of childhood and adolescence, some evident from the early years of life such as autism spectrum disorders, language and learning disorders, attention deficit hyperactivity disorder, intellectual disability, conduct disorders, neurological conditions such as cerebral palsy and epilepsy, and others emerging later, in adolescence, with psychiatric disorders such as eating disorders, schizophrenia, and mood disorders. Safeguarding and supporting neurodevelopment is also crucial in determining good mental health.

services and institutional levels. However, significant territorial inequalities persist, requiring targeted investments in capacity building and rebalancing policies.

Finally, all experiences converge on a crucial point: without institutionalization processes, stable funding, and robust monitoring and evaluation systems, even the most innovative models risk remaining isolated initiatives. Long-term sustainability depends on institutions' capacity to integrate these interventions into their mandates, structures, and budgets. The following recommendations stem from this integrated reading and constitute a practical translation of the evidence gathered through literature review, regional analyses, case studies, and multi-stakeholder consultation. They aim to offer concrete guidance for strengthening, scaling, and making MHPSS services for adolescents in Italy sustainable, and are divided into 10 thematic areas. For the consultation process methodology, see Annex I.

The recommendations follow a gradual, MHPSS-aligned approach, recognizing that effective and sustainable interventions must be context-sensitive, proportionate to available resources, scalable through stepped care, and grounded in local needs. For each thematic area, proposed actions vary in intensity and complexity: some can be implemented quickly with limited resources, others require more structured organizational, relational, and financial conditions.

Regardless of complexity level, all recommendations assume a preliminary phase of local context analysis. Before activating any type of intervention, territories are called upon to verify a set of minimum cross-cutting requirements:

- **Map existing resources:** survey services, professional competencies, active experiences, existing collaborations, to avoid duplications and value what already works.
- **Identify specific needs of the target population:** through validated tools, direct consultations with adolescents, families, and operators, analysis of available data.
- **Identify barriers to access and organizational challenges:** understand what hinders integration and service effectiveness in the specific context.
- **Verify enabling conditions:** availability of data and information flows, existence of coordination tables, inter-institutional agreements, necessary regulatory validations, human and financial resources.

Needs assessment also allows identifying the most appropriate entry point for each territory: contexts with already mature systems can orient toward more complex actions; contexts in the building phase must first consolidate basic conditions before proceeding. The recommendations, therefore, do not constitute a rigid sequence to be implemented uniformly, but a repertoire of actions from which to select those most consistent with the local system's maturity level, priorities emerging from needs as-sessment, and available resources.

The Youth Advisory Board Perspective[5]

In parallel with the consultation process with operators and stakeholders of the Italian MHPSS system conducted across different regions, the YAB worked to develop its specific contribution to the programme's recommendations. For the methodological note on YAB involvement in the development of the recommendations, see **Annex II**; for the complete recommendations, see **Output 4.1**.

Supervision, Reflective Practice, and Practitioner Wellbeing: Cross-cutting Dimensions

Professional supervision and practitioner wellbeing constitute cross-cutting organizational prerequisites, indispensable for ensuring quality, continuity, and safety in MHPSS interventions, regardless of the thematic area addressed. Supervision and reflective practice represent key professional integration tools: structured dialogue spaces – protected team meetings, supervision with qualified external facilitators, interservice discussion of complex cases – allow practitioners to process challenging situations, develop common languages, and build shared care management approaches. In contexts marked by fragmentation and turnover, these mechanisms become essential for preserving and transmitting accumulated clinical and organizational knowledge.

In parallel, practitioner wellbeing concerns structural and organisational work conditions. Working with adolescents experiencing psychosocial distress or neuropsychiatric disorders, substance abuse or pathological addictions, and other complex conditions exposes practitioners to emotional stress, burnout risk, and vicarious trauma, requiring system-level prevention policies: periodic stress level monitoring, psychological support programs, sustainable workload management, and contractual stabilization to reduce precariousness and turnover. These interventions must be calibrated based on the complexity level of cases treated and the type of service. These are strategic choices requiring dedicated investments and clear commitment from health directorates, so that practitioner care becomes an integral part of overall service quality.

Ensuring Security and Privacy in Data Management

Protection of sensitive information is an ethical and regulatory prerequisite, but an excessively restrictive interpretation of privacy risks hindering sharing between services and effectiveness of integrated

[5] The YAB is the youth participation body of the European Child Guarantee initiative, established in December 2021 by UNICEF in collaboration with the Ministry of Labour and Social Policies and the Department for Family Policies of the Presidency of the Council of Ministers, with the support of the Istituto degli Innocenti. The YAB gathers the voices of children and adolescents and participates in the implementation, monitoring, and evaluation of the National Action Plan for the Child Guarantee (PANGI), aimed at combating child poverty and social exclusion. For further information on YAB activities, see: https://www.instagram.com/yabitalia/

care management. This tension emerges both in integrating digital tools into MHPSS services (telemedicine, online counseling, social channels) and in information sharing between health, social, and educational services.

Territorial Equity and Inter-Regional Learning

The consultation process highlighted significant disparities in the provision of MHPSS services across territories, both at the intra-regional level (differences between districts and zones within the same region, urban/rural divide, centres/peripheries) and between different regions. These inequalities manifest in the variability of service provision, the presence of underserved areas or significant service gaps, and the difficulty of ensuring consistent standards of care.

Stakeholders involved in implementing the recommendations contained in this document are therefore invited to:

- consider **territorial equity as a cross-cutting criterion** in planning and resource allocation, prioritising disadvantaged areas and periodically monitoring intra-regional inequalities with explicit targets for progressive reduction;
- define **minimum regional standards** guaranteed across all districts, regardless of geographical location, to ensure uniform essential levels of care.

At the national level, reducing disparities between regions requires the establishment of **stable spaces for technical exchange** to share good practices and analyse their transferability, the activation of **inter-regional training pathways** on priority topics, and the development of **shared monitoring systems** that are at the same time specific to the different types of needs and services, enabling comparison and mutual learning. While these actions fall outside the scope of individual regions, they represent enabling conditions for promoting common standards and reducing systemic disparities.

1

ACCESSIBLE, STIGMA-FREE ACCESS

Access to MHPSS services must be configured as a pathway free of structural, cultural, and psychological barriers, guaranteeing multiple entry points that respect adolescents' decision-making autonomy. This implies not only creating safe and non-judgmental spaces, but also integration with other low-threshold services already present in the territory (e.g., youth centers, information desks, social services, digital platforms). Such integration allows early detection of needs, offering support opportunities in familiar and accessible contexts, reducing the risk of exclusion.

The recommendations aim to ensure rapid and inclusive pathways, bringing first-contact services to young people's living environments and simplifying procedures and regulations that hinder access. Communication should take place through channels and languages familiar to adolescents. It is also a priority to reduce the stigma associated with mental health and psychosocial wellbeing, in all its forms. The system must facilitate transitions between services — both toward higher and lower intensity of care — and support early re-socialisation.

In summary, the objective is to build an accessible and flexible system, capable of early detection of distress, directing at-risk situations toward the most appropriate specialised services, preventing exclusion, and fostering young people's trust.

These recommendations fully align with priorities outlined in key national plans. The **National Mental Health Plan 2025–2030** calls for timely and inclusive pathways, integrated care management, and measures to combat stigma (Chapter 5), while promoting telemedicine and digital tools to reduce barriers. Complementarily (Chapter 1), the **Child Guarantee National Action Plan** emphasizes low-threshold, non-discriminatory, and easily accessible interventions (axis 2), strengthening family counseling centers (1.2 action 2), dedicated service desks, and outreach actions (1.2 action 10, 1.4 action 6). The **6th National Childhood and Adolescence Plan (2025–2027)** promotes psychological wellbeing through the connection between school psychology services (actions 6 and 7) and family counselling centers, territorial educational alliances (action 8), teacher training, prevention campaigns (action 13), and shared protocols. In this context, Theme 1 recommendations — proximity, simplification, effective communication, and stigma reduction — contribute to operationalizing national-level commitments, supporting construction of a truly facilitated, inclusive access system capable of early detection of adolescent distress and/or any disorders present.

YAB's perspective on Service Access

YAB highlighted how access to MHPSS services is hindered by multiple intersecting barriers: economic, bureaucratic, informational, relational, and stigma-related. These barriers are not only structural but often stem from lack of understanding by trusted adults and inadequate institutional communication.

Recommendation 1.1
Facilitated access and timely care management

Effective access to the different types of mental health services for adolescents requires removing structural, cultural, and psychological barriers through rapid, inclusive pathways that respect their autonomy, so as to foster early emergence of distress, timely diagnosis of any disorders, and reduce the risk of chronicity. Timely response times are particularly crucial for the most vulnerable minors, as prolonged delays significantly increase the likelihood of losing contact.

Achieving this objective requires establishing walk-in appointment slots for first-level services, setting guaranteed maximum waiting times for first contact (within 8–10 days), creating integrated access points with screening and rapid referral capacity toward the appropriate types of services, developing territorial triage systems for specialised services, and piloting digital channels.

Operational Action Point : Ensure rapid and appropriate access		
Suggested Actions	**Indicators**	**Implementing Actors**
Establish walk-in appointment slots without prior booking	No. of weekly walk-in slots activated	Health Districts, Family Counseling Centers
Define guaranteed maximum waiting times for first specialist visit (target: within 8–10 days of request)	% of first visits within 10 days; Average waiting time for first visit	Health Districts, Counseling Centers, Psychology Services
Create Single Access Points with triage function (reception, initial assessment, appropriate referral), including dedicated booking services for neurodevelopmental disorders	No. of integrated access points; % cases correctly referred at first contact; No. of contacts handled; No. of cases managed/year	Health Districts, Counseling Centers, Social Zones, Local Health Authorities, Regional Booking Center, NPIA Services, Addiction Services, Psychiatric Services
Activate 24-hour telephone services with rapid response protocols (48–72h) capable of promptly reorienting urgent situations such as psychological or psychiatric crises, situations of harm and protection	No. of calls handled/month; Average response time; No. of rapid interventions activated	Local Health Authorities, Counseling Centers, Psychology Services, NPIA Services, Addiction Services, Psychiatric Services, Social Services, Juvenile Court
Activate transparent and shared territorial triage criteria for access to specialist services	No. of specialist services with territorial triage No. of rapid interventions activated	NPIA Services, Addiction Services, Psychiatric Services

YAB Recommendation 1.1: Increase services ensuring free and accessible pathways

The supply of economically accessible psychological support services must be expanded, with particular attention to minors and those without independent income. Quantitative expansion of services should be accompanied by greater flexibility in opening hours, including time slots compatible with school schedules.

Recommendation 1.2
Proximity - Service Access Points in Young People's Living Environments

This recommendation aims to bring first-contact and low-threshold services into adolescents' everyday settings, moving beyond traditional environments and bringing the offer closer to their living spaces. This approach specifically concerns proximity services — listening desks, counselling outposts, educational workers — and not specialised services, to which young people are referred when necessary. It proposes establishing outreach points in schools, youth centres, sports facilities, rural areas, and informal settings, ensuring the presence of workers and desks in non-medicalised environments. Operationally, this includes extending the "Family Counselling Centre meets Schools" programme, creating informal listening spaces, conducting outreach in parks and neighbourhoods, and partnering with the Third Sector and local organisations. This approach improves accessibility, reduces barriers, and enables early detection of distress and disorders, consistent with the principle of going where young people are and facilitating the transition toward other higher-intensity services when necessary.

Operational Action Point: Intensify presence of service access points in young people's living environments		
Suggested Actions	**Indicators**	**Implementing Actors**
Operator presence in living spaces and gathering places	No. of informal listening spaces activated per social zone	Counseling Centers, Social Zones
Locate first-access services in less medicalized territorial settings (e.g., Health Houses, Community Health Centers)	Qualitative user feedback on accessibility	Local Health Authorities, Municipalities
Extend "Counseling Center meets schools" program to all secondary schools	% secondary schools involved	Family Counseling Centers, School Principals, Regional School Office
Ensure territorial proximity of operators (e.g., educators or TERP meeting youth at parks, schools, homes)	No. hours/week of activity in non-clinic settings per operator	Health Districts
Activate partnerships with volunteer organizations, juvenile detention, associations, and other non-school contexts	No. of youth reached/month through informal listening spaces; % appropriate referrals to structured services	Counseling Centers, Third Sector

Recommendation 1.3
Simplification Administrative and Regulatory Procedures

Even when services are present in young people's living environments, barriers such as parental consent, paperwork, and legal uncertainty for operators can prevent timely first contact. It is suggested to activate anonymous access points, reduce paperwork, develop regional guidelines on consent, and train operators to ensure legal security. These measures are essential to make the proximity principle effective and promote truly inclusive, low-threshold access.

Operational Action Point: Experiment with simplification solutions		
Suggested Actions	**Indicators**	**Implementing Actors**
Activate anonymous access points for first contact	No. of services with active anonymous access	Local Health Authorities, Counseling Centers
Pilot simplified consent modalities in school context (e.g., checkbox in electronic register at enrollment)	No. of participating schools; No. of consents collected; % increase in access	Schools, Order of Psychologists, Regional School Office
Develop regional guidelines on minor access and consent management for low-threshold services	Approved document; Dissemination to services	Regional Authorities, Order of Psychologists, Children's Ombudsman
Train low-threshold service operators on current regulatory framework and available legal protections for managing minor access	No. of trained operators; Training hours; Reduced risk perception	Local Health Authorities, Order of Psychologists
Train specialist service operators on consent management modalities for minors and treatments without consent	No. of trained operators; Training hours	Local Health Authorities, NPIA Services, Addiction Services, Psychiatric Services

Recommendation 1.4
Communication channels and Digital Access

This recommendation emphasises the importance of making the different types of mental health services visible and accessible to adolescents through the channels and language they use daily. Being present locally is not enough: services must be findable and communicate effectively. For communication and first contact, recommendations include activating dedicated digital channels (social media, chat), co-designing materials with young people, involving peer educators, and piloting support services via instant messaging and online consultations. These actions create communicative proximity, reduce perceived distance, and strengthen access, both low-threshold and specialised services.

Regarding service delivery, it is recommended to activate first-contact channels via instant messaging through platforms compliant with personal data protection regulations, managed by qualified practitioners; to implement psychological video-consultation services with dedicated slots for young people and flexible hours; and to structure progressive pathways from online first contact to in-person care. The goal is to use digital channels as a low-threshold entry point that facilitates engagement and reduces waiting times for first contact.

Operational Action Point: Activate digital access and first contact modalities		
Suggested Actions	**Indicators**	**Implementing Actors**
Activate first contact and listening services via instant messaging (through platforms compliant with personal data protection regulations) managed by qualified operators	No. of messaging listening services active; No. of contacts handled/month	Counseling Centers, Youth Spaces, Psychology Services
Activate contact and booking possibility via instant messaging for all MHPSS services, including specialist services	No. of services with active messaging booking; % MHPSS services with active digital contact channel	Counseling Centers, Youth Spaces, Psychology Services, NPIA Services, Addiction Services, Psychiatric Services
Activate video consultation services with dedicated youth slots (flexible hours, including evening)	No. of video consultation slots activated/week; No. of consultations provided/month	Counseling Centers, Youth Spaces, Psychology Services, NPIA Services, Addiction Services, Psychiatric Services

Implement online peer support services on the Youngle model (peer support with supervision by trained adults)	No. of active online peer support services; No. of peers involved; No. of contacts handled	Local Health Authorities, Third Sector, Youth Associations
Structured pathway of progressive accompaniment toward in-person care in the most appropriate service	% online contacts evolved to in-person; Average time for online>in-person transition	Counseling Centers, Youth Spaces, Third Sector, Youth Associations, Psychology Services, NPIA Services, Addiction Services, Psychiatric Services
Co-design communication materials on distress, neurodevelopmental disorders, psychiatric disorders, pathological addictions and various services with youth groups (naming, graphics, content)	No. of youth involved in co-design	Counseling Centers, Youth Councils, Youth Associations, Third Sector, Psychology Services, NPIA Services, Addiction Services, Psychiatric Services
Activate social media channels dedicated to wellbeing (e.g., Instagram), distress, neurodevelopmental disorders, psychiatric disorders, pathological addictions with links to territorial services and direct contacts, co-designed with youth	No. of channels activated; No. of followers/interactions; No. of contacts generated toward services	Counseling Centers, Universities (e.g., Design), Youth Associations, Third Sector, Psychology Services, NPIA Services, Addiction Services, Psychiatric Services
Involve peer educators as vehicles for knowledge about possible difficulties and related services	Reach/engagement on social media channels	Schools, Youth Associations

YAB Recommendation 1.2: Launch youth-targeted social media campaigns

Institutional communication about MHPSS services must be radically rethought to effectively reach the youth target. Campaigns must use channels actually frequented by young people (Instagram, TikTok), with appropriate content that takes into account the target's attention span. To ensure communication effectiveness, those who can communicate appropriately with this age group must necessarily be young people (e.g., content creators).

Recommendation 1.5
Stigma Reduction and De-medicalization

Even with accessible and well-communicated services, stigma can prevent access and promote inappropriate medicalisation or conversely delay access to indispensable care. In the case of first-access and low-threshold services, it is suggested to review service nomenclature, locate them in non-medicalised spaces, involve young people with lived experience in awareness activities, train practitioners to reduce implicit biases, and activate non-health response pathways for mild cases. These actions contribute to creating a welcoming context, reducing cultural barriers, and promoting a person-centred approach.

Operational Action Point: Implement strategies to reduce various forms of stigma and de-medicalization		
Suggested Actions	**Indicators**	**Implementing Actors**
Review nomenclature of low-threshold services and professional roles	No. of revised designations; User feedback on accessibility	Regional Authorities, Local Health Authorities, Municipalities
Locate first-access services in contexts perceived as not exclusively health-related and easily accessible (multifunctional spaces, shared locations with social services and community activities)	User feedback on accessibility	Regional Authorities, Local Health Authorities, Municipalities
Involve youth with lived experience (Expert Users) in awareness-raising and training	No. of testimonials involved; No. of interventions	Health Districts, User Associations, Schools, Specialist Services
Bring youth physically inside services to familiarize them with spaces through differentiated modalities (e.g., guided visits, informational meetings at facilities, work-based learning)	No. of familiarization encounters conducted/year	Counseling Centers, Youth Spaces, Schools, Specialist Services
Train health operators on reducing endogenous stigma and implicit biases	No. of trained operators; No. of training hours	Health Districts, Training organizations, Universities

Interventions to reduce stigma and increase capacity to accommodate different forms of difficulty in school settings (e.g., projects like "I support my friend"), including teacher training on recognizing distress signs and various student needs	No. of interventions conducted; No. of teachers trained; No. of students reached	Schools, Counseling Centers, Regional School Office, Local Health Authorities

YAB Recommendation 1.3: Build parents' and caregivers' capacity for active listening and early recognition of distress

Awareness programs for parents and caregivers on the importance of listening and recognizing distress are needed. The role of parents and caregivers is crucial for minors' access to services.

2

ACTIVE AND INFORMED YOUTH ENGAGEMENT

The meaningful involvement of adolescents in MHPSS service design and implementation represents an ethical and operational imperative. This approach transforms young people from passive beneficiaries to active co-creators, valuing their experiential expertise in defining culturally appropriate services responsive to target population needs. It involves promoting authentic participation in all phases, integrating peer education as a structural tool, and training professionals on participatory methodologies. In summary, the objective is to build a system that recognizes young people's role as competent interlocutors, promotes service co-creation, and ensures inclusive and transparent decision-making processes.

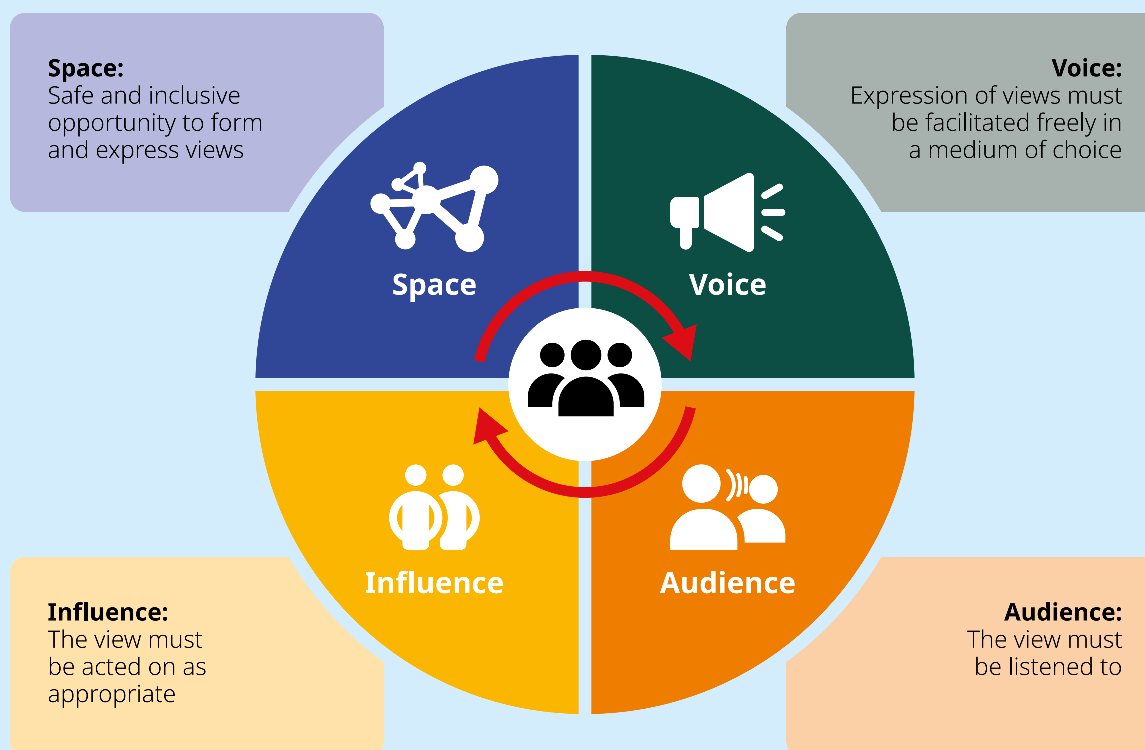
Theme 2 recommendations are fully aligned with orientations of main national plans promoting active participation of children, adolescents, and young people in defining policies and services concerning them. The **National Mental Health Plan 2025–2030** explicitly emphasizes the importance of user and community involvement through listening, consultation, and co-design tools (Chapter 6), while the **National Child Guarantee Plan** values minors' protagonism and their inclusion in decision-making processes (1.4 action 1), promoting peer education and creating dedicated participation spaces. Complementarily, the **6th National Childhood and Adolescence Plan (2025–2027)** encourages structured presence of children and adolescents in thematic tables, councils, and territorial listening initiatives (action 8). These are accompanied by additional policy tools reinforcing the centrality of young people's voice: the **National Prevention Plan 2020–2025**, supporting youth empowerment in public health programs; strategies of the Department for Youth Policies, providing participatory processes and consultation tables; and the **National Youth Plan 2025**, introducing co-creation mechanisms on social and health topics, including mental health. In this framework, Theme 2 recommendations contribute to operationalizing these commitments, promoting authentic, structured, and continuous youth involvement in MHPSS service design, evaluation, and governance.

UNICEF's Approach to Adolescent and Youth Participation

Participation is first and foemost a right. The United Nations Convention on the Rights of the Child (CRC), adopted in 1989 and ratified by Italy in 1991, recognizes the right to be heard and to participate (Art. 12) as one of four general principles for implementing all other rights. Children's participation constitutes one of UNICEF's strategy pillars and represents a key objective

for enabling adolescents to reach their full potential and contribute positively to their communities. UNICEF bases its participation promotion work on a dual track: active involvement in decision-making processes and, in parallel, support for developing young people's capacities and potential.

UNICEF's reference model for ensuring effective participation is the participation cycle (Lundy, 2007; UNICEF diagram, 2019), which identifies four necessary and interconnected conditions: a safe and inclusive Space to form and express opinions; Voice facilitation, meaning free expression through modalities chosen by young people themselves; an Audience that receives and listens to expressed viewpoints; and the possibility that these viewpoints have Influence, meaning concrete impact on reality.



Participation cycle, Lundy 2007, UNICEF diagram 2019

For participation to be meaningful, UNICEF identifies eight requirements: it must be transparent and informative, guaranteeing complete, accessible, age-appropriate information; voluntary, without any coercion to express opinions; respectful, recognizing young people's ideas and actions as fundamental contributions; relevant, offering opportunities to express views on issues affecting their lives; youth/adolescent-friendly, with environments and methods reflecting evolving capacities and interests; inclusive, involving adolescents of different ages, genders, back-

grounds, and conditions; safe and risk-aware, with assessment and mitigation of risks connected to expressing opinions; and accountable, with clear feedback on how participation effectively influenced decisions.

In Italy, UNICEF ECARO operationalized this approach through various initiatives. To cite some examples, The Future We Want (2020), conducted during lockdown, engaged adolescents through online meetings, surveys, and manifesto drafting, giving visibility to their visions for the post-Covid future through social campaigns and school materials. U-Report On The Move (since 2017) is a digital platform dedicated to migrant and refugee adolescents and youth integrating multilingual information, participation through polls and discussions, and socio-legal and psychological support; having always featured adolescents and youth as protagonists, in 2025 it established a steering committee of migrant and refugee young people who co-design and co-manage the platform while interfacing with institutions. The Youth Advisory Board for Child Guarantee implementation in Italy (since 2021) represents the most structured experience of "institutionalizing youth participation" and is described in this document's introductory section.

The YAB's involvement in the TSI projectobject (see Annex II and Output 4.1) and the recommendations presented here are situated within this framework.

Recommendation 2.1
Promoting Genuine Youth Participation in All Phases of MHPSS Service Design and Delivery

Young people must be authentically involved in the design and delivery of all types of MHPSS services. It is suggested to activate co-design processes for services and communication materials, create or strengthen participatory bodies with real decision-making power, integrate young people's proposals into decision-making processes with transparent feedback, and measure the impact of adopted strategies. It is essential to adapt participation modalities to vulnerable context needs, providing outreach mechanisms and structured collaborations with communities and associations. These actions ensure that services are not only for young people, but also with young people.

Operational Action Point: Activate real co-design processes for MHPSS services with young people		
Suggested Actions	**Indicators**	**Implementing Actors**
Involve youth in service design (e.g., Community Health Centers, Youth Spaces, Counseling Centers, Psychology Services, NPIA Services, Addiction Services, Psychiatric Services) and informational materials	No. of youth involved in co-design activities; No. of youth involved in co-creating informational materials	Counseling Centers, Social Zones, Youth Councils, Psychology Services, NPIA Services, Addiction Services, Psychiatric Services
Create or strengthen youth participatory bodies at local/ district level (councils, Youth Advisory Boards) with real decision-making power	No. of bodies activated or strengthened; No. of decisions made with binding youth vote	Municipalities, Social Zones
Integrate youth proposals into decision-making processes with monitoring and transparent feedback on outcomes	% youth proposals accepted and implemented; % proposals with justified feedback in case of non-acceptance	Social Zones, Health Districts, Research Bodies
Adapt participation modalities to specific needs of youth in vulnerable contexts, activating outreach mechanisms to reach those who don't come spontaneously and ensuring involvement of linguistic-cultural mediators where necessary	% youth in vulnerable contexts involved in participatory activities; No. of meetings with linguistic-cultural mediators present; No. of outreach actions activated for participatory process	Social Zones, Social Services, Third Sector, Counseling Centers, Psychology Services, NPIA Services, Addiction Services, Psychiatric Services
Formalize partnerships with communities and associations serving vulnerable groups to ensure participation continuity	No. of formalized partnership protocols; No. of associations/ communities stably involved	Social Zones, Local Health Authorities, Municipalities, Third Sector, Counseling Centers, Psychology Services, NPIA Services, Addiction Services, Psychiatric Services

Recommendation 2.2
Supporting Peer Education as a Structural Integration Tool

It is essential to promote peer education as a community culture and integrate it into regular programming (for example, local area plans, Local Health Authority activity plans, school three-year educational offer plans (PTOF), Family Counselling Service programming) to ensure its stability and diffusion. This approach strengthens youth participation and promotes horizontal integration among peers. Recommendations include training peer educators on neurodevelopment, mental health, and psychosocial wellbeing; activating interventions in schools and gathering places; ensuring ongoing supervision; and evaluating initiative effectiveness.

Operational Action Point: Activate and support structured peer education programs		
Suggested Actions	**Indicators**	**Implementing Actors**
Activate peer education interventions in schools and gathering contexts on various topics (psychosocial wellbeing, gender violence, bullying, affectivity, legality, neurodevelopmental and mental health disorders, pathological addictions)	No. of peer education interventions conducted	Schools, Counseling Centers, Associations, Specialist Services
Train peer educators on neurodevelopment, mental health, pathological addictions and psychosocial wellbeing topics	No. of peer educators trained/ year	Local Health Authorities, Schools, Youth Associations
Continuous supervision of peer educators by qualified operators	No. of supervision hours	Local Health Authorities, Counseling Centers
Evaluate effectiveness of peer education interventions	No. of youth reached by peer educators; Peer educator retention rate (target: >70% at 1 year)	Local Health Authorities, Social Zones, Schools, Universities
Promote peer education as culture and "way of being" of the community, not just as a technique	No. of events/initiatives spreading peer culture; No. of contexts (beyond school) where peer education is active	Social Zones, Associations

Guarantee multi-year continuity of peer education programs through inclusion in ordinary programming (not just fixed-term projects)	% peer education programs included in ordinary programming; No. of programs with guaranteed duration ≥3 years	Regional Authorities, Local Health Authorities, Social Zones

Recommendation 2.3
Ensuring MHPSS Professional Training on Participatory Methodologies

Recommendation 2.3 aims to ensure system sustainability through operator training on participatory methodologies and recognition of young people's social role as competent interlocutors. It is proposed to implement training pathways on participatory design techniques, active listening, and communication with young people, provide awareness initiatives for parents and teachers, and ensure continuous supervision and competency updating. These actions strengthen operators' capacity to involve young people authentically and structurally, promoting a truly participatory approach.

Operational Action Point	Implement training pathways on participatory methodologies and recognition of young people's social role	
Suggested Actions	**Indicators**	**Implementing Actors**
Training on participatory design techniques and active listening and communication with adolescents and youth	No. of trained operators; No. of training hours delivered	Local Health Authorities, Social Zones, Universities, Youth Associations
Raise awareness among reference adults (parents, teachers, coaches) on recognizing adolescents' and youth's competencies and their active participation also in institutional moments (e.g., in school context: parent meetings, class councils)	No. of adults reached; No. of awareness initiatives	Schools, Sports Associations, Family Counseling Centers
Ongoing supervision and skill development	No. of supervision/development sessions	Local Health Authorities, Universities

3

FAMILY INVOLVEMENT

Supporting families and caregivers is an essential component of integrated MHPSS. This includes interventions that strengthen parenting skills, facilitate understanding of adolescent challenges and possible neurodevelopmental, mental health, and addiction disorders, and create intergenerational dialogue spaces, recognizing the protective role of the family environment in adolescent psychosocial wellbeing and in supporting the management and care of possible disorders.

These recommendations aim to strengthen families' and caregivers' role as active partners in MHPSS pathways: reaching vulnerable families through outreach strategies; offering structured parenting support programs; involving caregivers in service co-design; supporting siblings and young carers; valuing schools as bridges with families; and managing family expectations to promote shared responsibility. The goal is to create a collaborative ecosystem integrating families, schools, and services, promoting inclusion, prevention, and continuity of care.

Theme 3 recommendations are situated within a national framework that increasingly recognizes families' central role in children's and adolescents' psychological wellbeing and in the care of possible neurodevelopmental, mental health, and addiction disorders. Various national plans and strategies emphasize supporting parenting, strengthening caregiver skills, and promoting structured collaboration between families, schools, social services, and the health system. In this context, these recommendations contribute to providing continuity and concreteness to these directions, valuing the active involvement of families in MHPSS pathways.

The **National Mental Health Plan 2025–2030** recognizes the role of families in care management and promotes parenting support interventions, psychoeducation pathways, and caregiver inclusion in dedicated developmental age care pathways (Chapter 2). The **National Child Guarantee Plan** provides actions to strengthen parenting competencies and support for vulnerable families, while the **6th National Plan for action and interventions for the protection of rights and development of subjects in developmental age (2025–2027)** promotes parenting competencies and collaboration between schools, social services, and families, with joint training initiatives, monitoring protocols, and family wellbeing interventions (Actions 1 to 7). These tools are complemented by additional policies that recognize the role of families in health pathways: the National Plan for the Family 2025–2027, which promotes service co-design through Family Centers (Action 5) and strengthens caregivers' role in service governance; the Guidelines for Positive Parenting, which encourage educational and support interventions actively involving parents, with focus on preventing child distress; and the National

Prevention Plan 2020–2025, which provides family empowerment actions and direct participation in prevention and health promotion programs.

Recommendation 3.1
Reaching Hard-to-Engage Families in Psychosocial Support and Care Pathways

Recommendation 3.1 aims to overcome linguistic, cultural, and logistical barriers preventing vulnerable families from accessing MHPSS services, through proactive outreach strategies. It is suggested to activate home and territorial interventions, linguistic and cultural mediation services, school-service protocols for monitoring absences as distress indicators, accessible informational materials in multiple languages, and protocols for integrated family care. These actions promote inclusion of the most vulnerable families and ensure equitable, timely access to care pathways.

Operational Action Point: Activate proactive outreach strategies toward vulnerable families		
Suggested Actions	**Indicators**	**Implementing Actors**
Home and territorial interventions for family engagement (home, school, gathering places)	No. hours/week of outreach activity; No. of families reached/year	Social Services, Counseling Centers, Third Sector, Psychology Services, NPIA Services, Addiction Services, Psychiatric Services
Activate structured linguistic and cultural mediation services for families with migratory background	No. of mediation hours delivered/year; No. of families with migratory background involved	Municipalities, Social Area Plans, Local Health Authorities, Psychology Services, NPIA Services, Addiction Services, Psychiatric Services
Monitor school absences as indicator of possible distress and early service activation	No. of reports from school to social services; Average response time	Schools, Social Services, Listening Spaces
Develop accessible informational materials on services in different languages and through channels suitable for families	No. of materials produced; No. of languages; No. of channels used	Counseling Centers, Social Zones, Psychology Services, NPIA Services, Addiction Services, Psychiatric Services

Define protocols for identifying and supporting families in so-called “grey zones”: households already known to services but without structured care, including households with parent in mental health service care	No. of defined protocols; No. of family units with integrated pathways	Social Services, Mental Health Centers, NPIA, Counseling Centers, Psychology Services, Addiction Services

Recommendation 3.2
Supporting Family-Based Intervention

Recommendation 3.2 promotes structured parenting support programs to support care pathways and prevent minor removal, with interventions differentiated by intensity level: from group psychoeducation to individual therapeutic support. Preadolescence and adolescence can be a critical moment for parent-child interactions, where communication can become difficult, particularly in the presence of problematic behaviors that affect various aspects of daily life, family relationships, emotional wellbeing, and more. Understanding children’s struggles and behaviors and how to support their growth can be difficult and counterintuitive, both when behaviors are substantially physiological and even more so when they express marked distress or mental health disorders.

Support interventions for parents of preadolescents and adolescents, both with psychiatric disorders and in situations of distress or prejudice, are very promising, particularly in group settings. It is proposed to activate multi-family groups and parent training pathways of varying specificity and intensity, experiment with the ‘co-therapist’ model for integrated interventions, implement programs like P.I.P.P.I., activate peer support among families, individual or group therapeutic interventions, and include parental involvement among accreditation requirements for facilities. The recommendation also includes support for siblings and young people assuming care roles in families, through self-help groups and dedicated listening spaces. These actions strengthen families’ capacity to face difficulties, reduce separation risk, and promote educational co-responsibility.

Operational Action Point: Activate structured parenting support programs		
Suggested Actions	**Indicators**	**Implementing Actors**
Activate multi-family groups and parent training pathways	No. of active groups; No. of participating parents/year	Family Centers, Counseling Centers
Structure differentiated parent training pathways by need level and intervention intensity: 1) Group psychoeducational for families with similar themes, led by specialist operator; 2) Targeted parent training, group or individual if necessary on specific disorders (ADHD, autism, depression, conduct disorders etc.) or other targeted interventions (Connect, DBT, MBT, ACT etc.); 3) Therapeutic for parents with emotional/ behavioral difficulties, reserved for professionals with psychotherapy competencies	No. of pathways by type; No. of parents by type; Differentiated outcomes	Competent Ministry, NPIA Services, Psychology Services, Addiction Services, Counseling Centers
Consolidate care models with different operators simultaneously dedicated to youth pathway and parental support, guaranteeing parallelism and intervention integration	No. of teams with co-therapist model; No. of families in care with dual operator	Counseling Centers, Social Services, NPIA Services, Addiction Services, Psychology Services
Activate peer support among families (family peer support model)	No. of trained supporting families; No. of supported families	Family Centers, Third Sector
Activate self-help groups and listening spaces for young caregivers and siblings	No. of active groups; No. of activated spaces; No. of participating youth	Social Services, Family Centers, Third Sector, Specialist Services
Train operators on managing family expectations and promoting co-responsibility	No. of trained operators; No. of training hours	Local Health Authorities, Universities, Training organization

Include parental interventions among mandatory requirements for accreditation of residential and semi-residential facilities for minors (socio-educational communities, therapeutic, socio-health, penal, addiction, semi-autonomy, group apartments etc.) ensuring parental support interventions are provided within activated care network, even when not directly delivered by facility itself	No. of facilities with parent training requirement; % compliant facilities	Regional Authorities, Local Health Authorities, Accreditation Bodies
Joint training for operators-teachers-parents on neurodevelopment, mental health and psychosocial wellbeing topics and family involvement	No. of training pathways; No. of participants	Regional School Office, Local Health Authorities, Counseling Centers, Social Zones
Explicit co-responsibility principle in care pathways: family is active partner with defined roles	% projects with explicit family roles; Signed co-responsibility document	All MHPSS services
Support teacher wellbeing to ensure quality of relationship with families	No. of support interventions; Teacher wellbeing indicators	Regional School Office, Local Health Authorities
Promote culture of family participation in educational and sports contexts	No. of initiatives; No. of reference adults involved	Schools, Sports Associations, Counseling Centers

YAB Recommendation 3.2: Promote education on affectivity and empathy

Creating awareness about affectivity is fundamental, learning to listen and understand others' problems without judging them. It is essential that family members, friends, and professionals recognize and validate adolescents' pain without minimizing it.

Recommendation 3.3
Active Involvement of families in co-design

Recommendation 3.3 promotes active involvement of families and caregivers as partners in care pathway design, overcoming the role of simple recipients. The goal is to create a collaborative approach that also includes significant non-health educational figures for the young person, such as coaches or scout educators, while ensuring respect for their autonomy and privacy. Operationally, it aims at co-design with families, creation of dedicated task forces, expansion of teams with educational figures, definition of protocols to balance privacy and autonomy, transparent feedback of results, and operator training on balanced involvement between family and adolescent.

Operational Action Point: Promote active involvement of families as partners in care		
Suggested Actions	**Suggested Actions**	**Implementing Actors**
Include family as member of multiprofessional team (not only recipient but co-designer)	% teams that include family members; No. of families involved/year	Social Services, Counseling Centers, Psychology Services, NPIA Services, Addiction Services, Psychiatric Services
Activate or consolidate Functional Units dedicated to disorders of greater clinical relevance, consistent with 2019 NPIA guidelines, with integrated pathways for users and families	No. of families reached; Specific outcomes	NPIA Services, Family Centers
Involve extra-health educational figures significant to the young person (coaches, scout educators, etc.) in individual care pathways, with function of supporting educational continuity and intervention generalization in life contexts	No. of extra-health figures involved	Social Services, Third Sector, Counseling Centers, Psychology Services, NPIA Services, Addiction Services
Define flexible protocols to balance youth privacy/autonomy and family involvement, including spaces where youth can express their preferences	No. of protocols defined and adopted	Local Health Authorities, Social Services, Counseling Centers, Psychology Services, NPIA Services, Addiction Services

Transparent feedback to family members on outcomes of shared planning	% projects with documented feedback	Social Services, Counseling Centers, Psychology Services, NPIA Services, Addiction Services
Create dedicated spaces/ moments where youth can express if and how they want family involved, with flexible protocols respecting preferences regarding privacy and setting, in light of different regulatory constraints present for individual services	No. of spaces/moments activated; % youth consulted before family involvement	Counseling Centers, Adolescent Services, Psychology Services, NPIA Services, Addiction Services
Train operators on balancing family centrality and respect for adolescent autonomy	No. of trained operators; No. of training hours on specific topic	Local Health Authorities, Universities, Training organizations

4

EQUITY AS A DESIGN PRINCIPLE

Equity in access and quality of MHPSS services requires differentiated strategies to reach vulnerable and marginalized populations. This implies cultural and linguistic service adaptation, proactive outreach in hard-to-reach communities, and elimination of systemic barriers perpetuating inequalities in access to care.

Theme 4 recommendations aim to ensure service access for vulnerable groups through active outreach and service adaptation actions, and to structure linguistic-cultural mediation as a stable service for adolescents and families with migratory background. In summary, the objective is to create flexible, culturally sensitive, and inclusive pathways, strengthening services' capacity to respond to diversity.

The **National Mental Health Plan 2025–2030** promotes equity in access, providing interventions to reduce territorial and social inequalities, and encouraging development of specific care interventions for the needs of migrant minors and their families (Chapter 2).

The **National Child Guarantee Plan** includes actions for protection of vulnerable minors and support for fragile families, promoting inclusion interventions and equitable access to services (1.2 axis 3).

The **6th National Plan for action and interventions for the protection of rights and development of subjects in developmental age (2025–2027)** supports interventions for social inclusion and inequality reduction, promoting equitable access to educational and health services and collaboration with local communities to reach the most marginalized groups (Actions 4, 11).

Furthermore, the National Program "Equity in Health" 2021–2027 and the National Plan for Social Interventions and Services 2024–2026 aim to reduce health and social inequalities through strengthening territorial networks, defining essential levels of services, and reinforcing prevention and inclusion services, creating conditions for more equitable access to services for vulnerable families and individuals.

Recommendation 4.1
Ensuring MHPSS Service Access for Vulnerable Groups Through Active Outreach and Service Adaptation

Recommendation 4.1 aims to ensure access to MHPSS services for vulnerable groups through active outreach interventions, service adaptation to their specific needs, knowledge, coordination and rapid reorientation among network services based on emerging needs. The objective is to reach those who

don't access spontaneously and remove barriers, creating flexible pathways and stable collaborations between services and with reference communities and associations. It includes training staff on different forms of vulnerability and activating community outposts and street outreach.

Operational Action Point: Activate outreach interventions and adapt services to vulnerable groups		
Suggested Actions	**Indicators**	**Implementing Actors**
Service presence in peripheral and high-vulnerability contexts (such as low-threshold services - soup kitchens, clinics, and day centers)	No. of presences activated in peripheral areas	Health Districts, Municipalities
Activate street education to reach those who don't access spontaneously	No. of outreach hours delivered/ week; No. of youth reached	Social Zones, Third Sector, Educators
Cross-sectoral training of operators on different forms of vulnerability, existing service network and timely reorientation of intercepted demand: neurodevelopmental disorders, substance abuse and pathological addictions, trauma and migration, educational poverty, gender identity, harmful traditional practices, children outside family	No. of training hours by type; No. of trained operators; % service coverage	Universities, Professional Orders, Counseling Centers, Psychology Services, NPIA Services, Addiction Services
Activate flexible access pathways adaptable to different group needs (schedules, decentralized locations, language support, free access, consent modalities)	No. of flexible modalities activated; No. of accesses by modality and group	Social Zones, Community Health Centers, Districts, Counseling Centers, Psychology Services, NPIA Services, Addiction Services, Psychiatric Services
Build stable networks between services and with communities and reference associations of different vulnerable groups	No. of active collaboration protocols; No. of communities/ associations involved	Third Sector, Associations, Community Health Centers, Districts, Counseling Centers, Psychology Services, NPIA Services, Addiction Services, Psychiatric Services

Recommendation 4.2
Establishing Linguistic-Cultural Mediation as a Service for Adolescents and Their Families with Migration Background

This recommendation aims to integrate ethnoclinical competencies and promote understanding of cultural representations of distress, ensuring more effective care that respects differences. It includes mapping available competencies, specific training for mediators and staff, activating supervision spaces, and including transcultural specialists in teams.

Operational Action Point: Structure mediation as a stable service		
Suggested Actions	**Indicators**	**Implementing Actors**
Structure cultural mediation as stable service	No. of guaranteed mediation hours/month; No. of ethnopsychological, ethnopsychiatric and psychosocial consultations in presence of linguistic-cultural mediators	Social Zones, Third Sector, Community Health Centers, Districts, Counseling Centers, Psychology Services, NPIA Services, Addiction Services, Psychiatric Services, Emergency Room
Train health operators on transcultural competencies and working with linguistic-cultural mediators	No. of trained operators; No. of training hours	Local Health Authorities, Regional School Office
Train linguistic-cultural mediators on specific topics such as: neurodevelopment, mental health, pathological addictions, psychosocial support, trauma informed care and mental health, etc.	No. of trained linguistic-cultural mediators; No. of training hours	Local Health Authorities, Third Sector
Activate specific discussion and supervision spaces for linguistic-cultural mediators	No. of supervision meetings/ year; No. of linguistic-cultural mediators	Local Health Authorities, Third Sector, External Supervisors with specific sector experience

Stable inclusion of figures with transcultural competencies in teams (anthropologists, sociologists, transcultural psychologists, NPIA with specific training, ethnopsychologists, ethnopsychiatrists etc.)	No. of teams with stable transcultural figures; Hours/week dedicated	Local Health Authorities, Universities, Third Sector

Operational Guidance from UNICEF's MHPSS Community of Practice[6]

To ensure equity in MHPSS service access:

Move beyond emergency linguistic-cultural mediation management, transforming it into a structural service with dedicated continuous investment.

Ensure contractual stability for linguistic-cultural mediators to reduce turnover and enable building stable teams and specialized training.

Include cultural mediators as permanent team members, not resources activated only when "communication problems" arise.

Integrate systematic training on cultural diversity and trauma into health professions' university curricula, moving beyond current dependence on individual practitioners' initiative.

[6] The consultation process also included the UNICEF MHPSS Community of Practice, an established network of professionals and organizations working in the MHPSS field with particular attention to unaccompanied minors and migrant and refugee youth. The UNICEF Community of Practice's contributions are reported in relevant themes as operational perspectives enriching the recommendations emerging from regional workshops.

5

CONTINUITY OF CARE IN THE TRANSITION TO ADULTHOOD

The transition from childhood and adolescent services to adult services represents a critical moment characterized by high dropout rates. An integrated approach requires developing programming models appropriate to different types of needs and local specificities, to ensure therapeutic continuity, gradual accompaniment, formalized protocols for handover between teams, and integrated functional teams or, in some particular situations and at low threshold, flexible services dedicated to the transition age group.

The National Mental Health Plan defines care continuity as a cardinal principle, providing transition protocols between NPIA and adult services, integration among different services and operators involved, and monitoring through national information systems. It supports flexibility in transition age, differentiation of transition support intensity levels, and involvement of bridge figures to ensure care throughout the life cycle (Chapter 2).

Recommendation 5.1
Ensuring Continuity of Care in the Transition to Adulthood

Recommendation 5.1 aims to ensure continuity of care in the transition to adulthood, preventing dispersion of care pathways at age 18. The objective is to activate individualized accompaniment mechanisms ensuring relational and project continuity, through transition protocols, differentiation of necessary support intensity levels, bridge figures, and flexible criteria for transition age. It also includes reducing admissions to adult wards and strengthening dedicated resources.

Operational Action Point: Activate accompaniment mechanisms in transition		
Suggested Actions	**Indicators**	**Implementing Actors**
Define transition protocols from child to adult services	No. of activated protocols; % accompanied transitions	NPIA Services, Mental Health Centers, Addiction Services
Activate transition protocol at least 6 months before reaching legal adulthood, with joint meetings between origin and destination teams	% transitions with protocol activated within 6 months; No. of joint meetings per case	NPIA Services, Mental Health Centers, Addiction Services
Define necessary support intensity level (very high, high, medium, low) and activate Professional Educators or Psychiatric Rehabilitation Technicians or other figures acting as bridge between child and adult services for situations with high or very high needs, with function of accompaniment in life contexts (home, school, territory)	No. of Professional Educators/ Psychiatric Rehabilitation Technicians dedicated to transition; No. of weekly hours of bridge activity	NPIA Services, Addiction Services, Psychiatric Services, Other Adult Services, Health Districts, Social Services, Third Sector
Adopt flexible criteria for transition age based on individual project: possibility to extend NPIA care up to 21 years for those still in school or for specific conditions (e.g., autism) or anticipate it for almost-adult youth with severe disorders, especially if without previous NPIA care	No. of cases with postponed transition; No. of cases with anticipated transition; Adopted flexibility criteria	Regional Authorities, NPIA Services, Addiction Services, Psychiatric Services
Reduce admissions of minors to adult wards through strengthening NPIA beds and alternatives to hospitalization (e.g., intensive outpatient interventions, day centers etc.)	% minors admitted to adult wards (target: progressive reduction from current 70%)	Regional Authorities, NPIA Services, Addiction Services, Psychiatric Services

Recommendation 5.2
Developing Flexibility in Responses for the Transition Age Group

Recommendation 5.2 aims to overcome fragmentation between childhood, adolescent, and young adult services, by increasing flexibility and integration among existing services, structuring multiprofessional functional teams bridging different services and dedicated to the transition age group, and developing flexible access models to low-threshold and first-contact services. The objective is to ensure continuity of care through transition protocols, stable integration of educational and social figures, and progression from experimental projects to structured services. It includes creating interfaces with primary care services and defining organizational models that promote integration among low-threshold services, Family Counseling Centers, psychology services, NPIA, Mental Health Centers, and Addiction Services (SerD).

Operational Action Point: Activate multiprofessional teams for transition		
Suggested Actions	**Indicators**	**Implementing Actors**
Progress effective programs from projects to structured services	- Structuring level reached (project/program/service/operational unit); No. of level transitions/year	Regional Authorities, Mental Health and Addiction Department, Health Directorate
Establish multiprofessional functional teams dedicated to transition age group, with structured periodic meetings	No. of activated functional transition teams; Meeting frequency (weekly/monthly)	Mental Health and Addiction Department, NPIA, Social Services

6

INTEGRATION BEYOND CLINICAL CARE

Effective psychosocial support goes beyond traditional clinical intervention, integrating social, recreational, and training activities as legitimate therapeutic components. This holistic approach recognizes the therapeutic value of social inclusion, peer activities, and practical support in promoting wellbeing and resilience. Recommendations aim to strengthen intersectoral and community approaches: building structured collaboration mechanisms between health, social services, and Third Sector with formalized protocols and co-design spaces; developing joint training and shared language to promote trust and operational integration; valuing non-health resources and community networks as strategic partners; facilitating early resocialization of young people with severe disorders.

The **National Mental Health Action Plan (PANSM)** explicitly calls for intersectoral integration and collaboration between health, social, and community services, providing coordination bodies and shared protocols for multidisciplinary care and promoting an integrated departmental organizational model where the Mental Health Department ensures care continuity, multidisciplinarity, and person-centered care. The PANSM also calls for promoting a social prescribing program, in line with World Health Organization guidance.

While the National Child Guarantee Plan (PANGI) and the 6th National Plan for Childhood and Adolescence create a supportive framework for inclusion and collaboration between educational, health, and social services, the National Equity in Health Program (PNES) and the National Plan for Social Interventions and Services 2024–2026 introduce more operational tools. The former supports formalizing collaboration protocols between Local Health Authorities, Municipalities, and Third Sector through agreements and co-design for socio-health outreach; the latter defines integrated governance, interoperability, and shared essential service levels (LEPS), laying the groundwork for formal agreements and structured partnerships.

The YAB's Perspective on Integration Beyond Clinical Care

According to YAB members, effective psychosocial support cannot be limited to traditional clinical intervention. Young people highlighted how the care pathway often remains 'self-contained', without integration with social, recreational, and reintegration activities essential for wellbeing recovery. The lack of continuity beyond the clinical session creates 'an endless loop' where the young person remains alone once they leave the consulting room.

Recommendation 6.1
Building Structured Mechanisms for Intersectoral Collaboration

This recommendation aims to build structured intersectoral collaboration mechanisms to overcome fragmentation and promote shared governance. The goal is to activate co-design spaces with operational mandate, involving health, social services, and Third Sector. It includes formalizing partnerships through protocols and agreements, ensuring continuity and decision-making effectiveness.

Operational Action Point: Activate structured, ongoing co-design bodies		
Suggested Actions	**Indicators**	**Implementing Actors**
Establish adolescence co-design roundtables with regular frequency and operational mandate	No. of activated roundtables; No. of meetings/year; No. of co-designed projects	Social Zones, Health Districts, Municipalities, Counseling Centers, Psychology Services, NPIA Services, Addiction Services, Psychiatric Services
Involve Third Sector in roundtables	% roundtables with Third Sector presence	Social Zones, Third Sector
Formalize collaborations through protocols and agreements defining roles, responsibilities and collaboration modalities in specific areas such as: proximity and outreach interventions, peer education and peer support activities, social inclusion and job placement, family support and linguistic-cultural mediation	No. of formalized protocols/ agreements	Local Health Authorities, Social Zones, Municipalities, Third Sector

YAB Recommendation 6.1: Create and promote youth centers as socialization spaces

Shared spaces where young people can meet, do group activities, and gather together must be built and supported. Youth centers should offer varied opportunities: social workshops, support groups, meetings with peers who have had similar experiences. A crucial point is the need to publicize and make these spaces visible.

Recommendation 6.2
Developing Intersectoral Training and Shared Language

This recommendation aims to identify training needs and current level of mutual understanding, then activate joint programs and experiential workshops strengthening communication and trust between practitioners. This strategy builds shared culture and improves intervention network effectiveness.

Operational Action Point: Implement joint intersectoral training		
Suggested Actions	**Indicators**	**Implementing Actors**
Joint training pathways where Third Sector, social services and health services dialogue	No. of training pathways; No. of trained operators by sector; No. of training hours	Regional Authorities, Local Health Authorities, Universities, Training organizations
Experiential training with expert facilitators on communication and trust-building between services	No. of experiential workshops; Qualitative participant evaluation	Local Health Authorities, Social Zones, Expert Facilitators

YAB Recommendation 6.2: Build a bridge between clinical pathway and social reintegration

Mental health services must systematically integrate the therapeutic pathway with concrete socialization and reintegration opportunities. A positive example cited: services that actively offer young people in care the chance to participate in workshops with other peers.

Recommendation 6.3
Valuing Community Resources and Networks as Strategic Partners

The goal is to activate structured partnerships with local entities—Third Sector, social services, educational and gathering spaces—recognizing social and cultural activities as integral to wellbeing. It includes formally including Third Sector in governance bodies and piloting social prescribing to integrate non-clinical interventions in mental health care.

The capacity for inclusion, sharing, and embracing difficulties across all life contexts represents an

important protective factor for promoting mental health and psychosocial wellbeing. For this reason, systematic interventions against stigma, bullying, minority stress, exclusion, and re-institutionalization are strategic, to develop contexts capable of handling the multiplication of diversities and fostering empathy, the ability to ask for and accept help, cooperation rather than competition, avoiding the expulsive mechanisms often present when facing young people with severe disorders, and in close coordination with schools and other educational and socialization contexts.

Operational Action Point: Activate structured partnerships with non-health resources		
Suggested Actions	**Indicators**	**Implementing Actors**
Formal inclusion of Third Sector representatives in governance bodies (e.g., Community Health Center boards)	No. of bodies with Third Sector representation	Local Health Authorities, Municipalities, Third Sector
Activate integrated socio-health teams with Third Sector educational figures	No. of activated teams; No. of cases managed in integrated way/year; % teams with Third Sector educators	Health Districts, Social Services, Third Sector
Implement multimodal approaches: direct interventions on adolescent (rehabilitative, therapeutic, educational, didactic) + interventions dedicated to families (parent training, psychoeducational work)	% cases with multimodal approach; No. of interventions by type	Social Services, Third Sector, Counseling Centers, Psychology Services, NPIA Services, Addiction Services, Psychiatric Services
Pilot social prescribing: prescription of social, cultural and sports activities as integral part of care pathway	No. of social prescriptions made; No. of organizations involved	Municipalities, Third Sector, Counseling Centers, Psychology Services, NPIA Services, Addiction Services, Psychiatric Services
Train educational, social, school, Third Sector operators, gathering spaces and more generally life context operators on welcoming youth with complex difficulties and managing specific aspects and/or possible critical situations ("I support my friend", de-escalation techniques, etc.)	No. of training pathways; No. of trained operators by sector; No. of training hours	Regional Authorities, Local Health Authorities, Universities, Training organizations

YAB Recommendation 6.3: Ensure support continues beyond the clinical session

Psychological support should not end with the session. Young people expressed the need for support that continues through concrete guidance and referrals to appropriate settings, including information about youth centers, support groups, and local activities.

Operational Guidance from the MHPSS Community of Practice

To strengthen intersectoral integration::
Recognize complementarity between public sector and Third Sector Establish coordination bodies with operational (not just consultative) mandate, involving health, social services, and Third Sector in co-constructing shared tools (e.g., observation forms, referral protocols, techniques for managing difficult situations).
Invest in building tools that create common language across professions, overcoming professional language fragmentation that hinders integration.
Formalize public-Third Sector partnerships through agreements and protocols defining roles, responsibilities, and collaboration modalities.

7

SCHOOLS AS STRATEGIC NODES

Schools are the primary setting for prevention, early identification, and first intervention in adolescent mental health. Systematic school-health service integration requires formalized protocols, school staff training, and dedicated psychosocial wellbeing spaces within educational environments.

Recommendations 7.1 and 7.2 align with a national framework increasingly recognizing schools as key sites for prevention, early identification, first intervention, and support for care pathways in neurodevelopmental disorders, adolescent mental health, and addictions. The **National Mental Health Strategy** emphasizes the importance of strengthening integration between school institutions and local services. The **National Child Guarantee Plan** promotes coordinated local networks between schools, social and health services, with particular attention to distress prevention and vulnerable minor support. The **6th National Plan for action and interventions for the protection of rights and development of subjects in developmental age (2025-2027)** also calls for structured collaboration between schools, educational community, and services, encouraging safe, inclusive school environments and shared student wellbeing protocols (Action 8). Finally, the **National Prevention Plan** further reinforces this direction, providing for integrated school-community prevention interventions and early reporting systems.

YAB's Perspective on Schools

Schools are the prime context for prevention and distress identification, but according to YAB members currently have numerous problems: poorly accessible psychological service desks lacking privacy, teachers untrained on psychosocial wellbeing, persistent stigma, and absence of mental health education in the curriculum. Young people identified schools as potential 'strategic nodes' in the MHPSS system, provided obstacles limiting their effectiveness are addressed.

Recommendation 7.1
Integrating School Support Spaces[7] into the MHPSS Network

This recommendation proposes integrating school support spaces into the MHPSS network, overcoming their fragmentation. This requires structuring integration through school psychologist participation in coordination bodies; defining collaboration protocols with services; and stabilizing funding. It also includes supporting school reintegration after crisis or prolonged absence through dedicated protocols. The goal is continuity between school and community for effective, coordinated psychosocial support.

Operational Action Point: Structure integration of school support spaces with services		
Suggested Actions	**Indicators**	**Implementing Actors**
Structural inclusion of school psychologists in territorial coordination roundtables	% support spaces represented in roundtables	Health Districts, Regional School Office, Schools
Recognition of coordination hours for school psychologists	Coordination hours provided	Schools, Social Zones
Define collaboration protocols between school support spaces and territorial services (counseling centers, NPIA, Addiction Services, Psychiatric Services, Social Services)	No. of active protocols	Local Health Authorities, Regional School Office, Social Zones
Protocols for welcoming youth with neurodevelopmental disorders, mental health disorders or pathological addictions and for post-crisis reintegration, with clear school-service roles	Defined protocol; Phases and responsibilities	Regional School Office, Social Zones, Counseling Centers, Psychology Services, NPIA Services, Addiction Services, Psychiatric Services

[7] The term 'school support spaces' is used here to distinguish these services from traditional school counselling. Rather than providing individual psychological counselling with subsequent referral to external services, these spaces are designed as low-threshold entry points that foster networking between school and territorial MHPSS services, offer initial listening and orientation, and promote early identification of distress within the educational context

Activate accompaniment figures (tutors, educators) for gradual reintegration	Identification of figures with support and tutoring function; No. of activated projects	Schools, Social Zones, Third Sector, Counseling Centers, Psychology Services, NPIA Services, Addiction Services, Psychiatric Services
Institutionalize Integrated Work Groups among school, health, social and employment sectors, with defined mandate and periodic renewal	No. of established Integrated Work Groups; No. of members by sector	Regional Authorities, Local Health Authorities, Regional School Office, Municipalities
Stabilize funding for school listening/intervention spaces	% initiatives with multi-year funding	Regional Authorities, Regional School Office, Municipalities

YAB Recommendation 7.1: Strengthen digital tools for school service access

Access to school psychological services needs to ensure confidentiality and overcome shame-related barriers. Participants proposed email addresses for booking, online forms, online service desks with qualified staff, and informational newsletters

Recommendation 7.2
Using Schools for Early Identification of Distress

The goal is rapid, targeted interventions that avoid stigmatizing labels and promote student wellbeing. This requires activating timely reporting systems through staff training, school-service collaboration protocols, dedicated liaison figures, and specialist units for complex cases.

Operational Action Point: Activate early identification and timely reporting systems		
Suggested Actions	**Indicators**	**Implementing Actors**
Train teachers on early recognition of distress signs and different types of neurodevelopmental disorders, mental health or pathological addictions	No. of trained teachers/year; No. of training hours; Institute coverage	Regional School Office, Local Health Authorities, Training organizations
Define school-service protocols for timely reporting of at-risk situations	No. of active protocols; Average time from report to care intake	Regional School Office, Local Health Authorities, Social Zones
Create liaison figures (reference teachers) trained on mental health in each institute	No. of trained references; Dedicated hours	Regional School Office, Schools
Activate units dedicated to school psychology for complex cases of dropout and withdrawal	No. of active units; No. of cases followed; % successful engagements	Local Health Authorities, Regional School Office
Student familiarization programs with services (e.g., "Counseling Center meets schools", guided service visits, work-based learning in services etc.)	No. of students reached; % institutes involved	Counseling Centers, Youth Spaces, Schools, Psychology Services, NPIA Services, Addiction Services, Psychiatric Services

YAB's Recommendations

Use school assemblies for awareness

Monthly assemblies are valuable opportunities to address psychosocial wellbeing. Invite a psychologist and organize interactive sessions with questions and discussion. An innovative element: using direct testimonies or anonymous audio recordings.

Promote peer education on wellbeing

Training students as peer educators creates a more accessible first level of listening and guidance, facilitating subsequent contact with professionals.

Train teachers on student psychosocial wellbeing

Training teachers to recognize psychological distress and respond appropriately is essential. Lack of training leads to inadequate responses or prejudice. Teachers should be trained not to replace specialists, but to identify distress and guide toward resources.

Clarify roles of professionals in schools

Students need clear information about which professionals are available and what they can do. There is still stigma and misinformation, particularly about some roles like social workers. It is important to reassure young people and clearly explain these roles.

8

INTEGRATED SERVICE DELIVERY PLATFORMS

Significant regional disparities in MHPSS access and quality require targeted system interventions for equalization. This includes knowledge transfer, capacity building for disadvantaged areas, and technical support mechanisms ensuring minimum uniform standards nationally.

In this perspective, the National Mental Health Action Plan also emphasizes the importance of information system interoperability for proper information sharing and for designing and implementing integrated pathways (Chapter 5).

Recommendation 8.1
Promoting Interoperability Across Health, Social, and Educational Systems

This recommendation aims to create a coordinated digital ecosystem simplifying information flows among professionals from health, social, and educational services involved in care management, ensuring more effective care.

Initially, existing platforms must be mapped and problems analyzed, evaluating integration level and technical barriers. Then platforms should be consolidated to enhance interoperability and reduce duplication, an integrated clinical record implemented across MHPSS services, and connection activated between social records and health systems using shared standards.

Operational Action Point: Achieve interoperability between health and social information systems		
Suggested Actions	**Indicators**	**Implementing Actors**
Rationalize existing platforms to reduce duplications	No. of platforms before/after rationalization; Time saved	Regional Authorities, Competent Ministries
Implement integrated clinical record among MHPSS services, maintaining necessary specificities while facilitating sharing	% services with integrated record; No. of data flows activated between services	Regional Authorities, Local Health Authorities, Information Systems, Competent Ministries
Activate interoperability of social record with health systems	% social zones with computerized record; No. of active connections with health system	Ministry of Labor and Social Policies, Ministry of Health, Regional Authorities, Social Zones

9

MONITORING AND EVALUATION

Standardized, multidimensional (encompassing all relevant domains for a comprehensive view), and multiperspective (encompassing different perspectives of professionals, services, and users involved) monitoring and evaluation systems are essential for documenting MHPSS intervention effectiveness, informing continuous improvement, and supporting model replication. This requires indicators capturing not only clinical outcomes but also strengths, psychosocial wellbeing dimensions, equity, and user satisfaction.

This recommendation aligns with a national framework recognizing the importance of monitoring and evaluation systems for improving service quality for children and adolescents. The National Mental Health Action Plan calls for strengthening information systems and monitoring intervention effectiveness to reduce regional inequalities and drive continuous improvement. The National Child Guarantee Plan uses indicator-based approaches to evaluate implementation of measures for minors, while the 6th National Action and Intervention Plan for the Protection of the Rights and Development of Children and Adolescents, developed on the basis of an analysis of the results of the previous plan and structured to be objectively measurable through dedicated indicators, highlights monitoring as a strategic component. In particular, it recognises its essential role in the early identification of social isolation and child maltreatment, ensuring more timely and effective interventions. In this context, defining a standardized monitoring system for adolescent MHPSS services is fully consistent with national guidance.

Recommendation 9.1
Service Monitoring and Evaluation Systems

This recommendation aims to ensure consistent data collection and effective evaluation processes useful for improving intervention quality and impact. Initially, existing practices and problems should be identified, mapping services with active systems and analyzing data types and collection frequency. Then a standardized monitoring system with shared indicators — drawing, where appropriate, on established frameworks such as the European Child Guarantee — should be defined, evaluation protocols developed, and staff trained on monitoring and evaluation methods.

Operational Action Point	Structure monitoring, evaluation, and impact assessment systems	
Suggested Actions	**Indicators**	**Implementing Actors**
Define standardized monitoring system for all adolescent MHPSS services	No. of platforms before/after rationalization; Time saved	Regional Authorities, Competent Ministries, National Observatory
Develop participatory outcome evaluation protocols	% services with participatory outcome evaluation protocols	Regional Authorities, Local Health Authorities, Information Systems
Train operators on monitoring and evaluation methodologies	No. of trained operators	Regional Authorities, Universities, Research Bodies, Local Health Authorities, Social Services
Activate partnerships with Universities/research centers for impact evaluations	No. of impact evaluations initiated; No. of activated partnerships	Regional Authorities, Universities, Research Bodies
Use evaluation results to guide decisions and advocacy	No. of decisions based on data from impact evaluation	Regional Authorities, Local Health Authorities

10

SUSTAINABILITY THROUGH INSTITUTIONALIZATION

Long-term sustainability of innovative MHPSS services requires moving beyond project logic through institutionalization. This means formal recognition in regulatory frameworks, structural funding, distributed leadership development, and integration into essential levels of care.

Recommendation 10.1

Defining Structured Pathways from Project to Permanent Service

This recommendation aims to define structured pathways for transforming effective projects into stable, institutionalized services. After evaluating projects with potential for wider diffusion, institutionalization processes should be activated through shared criteria and procedures, progressive transformation into consolidated services, inclusion in planning documents, and creation of dedicated operating units. The goal is ensuring continuity and sustainability, moving beyond fragmented, time-limited project logic.

Operational Action Point	Activate institutionalization processes for effective projects	
Suggested Actions	**Indicators**	**Implementing Actors**
Create permanent roundtable on neurodevelopment, mental health and psychosocial wellbeing of adolescents	Constitutive act of roundtable (resolution/decree); No. of meetings/year; No. of participants by sector	Ministries, Regional Authorities
Define criteria and procedures for transition from project to structured service	Defined criteria; Average duration	Regional Authorities, Ministries
Progressive transformation of effective projects into stable services	No. of projects transformed into services/year; % budget on services vs projects	Regional Authorities, Local Health Authorities, Social Zones

Include institutionalized services in planning documents (area plans, health plans)	No. of services included in planning; Level of formal recognition	Regional Authorities, Social Zones
Create simple operational units or dedicated organizational structures for consolidated services	No. of operational units created; Assigned resources; Dedicated staff	Local Health Authorities, Regional Authorities

Recommendation 10.2
Ensuring Stable and Predictable Funding

This recommendation aims to ensure stable, predictable funding for adolescent MHPSS services. Stable funding should be structured through multi-year programming, simplified administrative procedures, and three-year plans with annual review.

The three-year horizon reflects both standard Italian local programming cycles (local area plans, local health plans) and operational needs identified by practitioners during territorial consultations, who reported that annual budget uncertainty prevents effective planning and service systematization (see Output 2).

The recommendation also includes contractual stabilization of key professionals. The goal is ensuring operational continuity and reducing service vulnerability to temporary or uncertain funding.

Operational Action Point	**Structure stable funding and permanent staf-fing**	
Suggested Actions	**Indicators**	**Implementing Actors**
Transition to multi-year funding and programming	% multi-year funding; Average funding duration	Regional Authorities, Ministries
Simplify administrative steps to reduce time between fund allocation and effective availability	Average disbursement time; No. of simplified steps	Regional Authorities, Social Zones

Adopt three-year programming for adolescent MHPSS services with annual review	% services with three-year programming	Regional Authorities, Local Health Authorities
Stabilize contracts for key professional figures	% key roles with stable contract; Turnover rate	Regional Authorities, Local Health Authorities, Ministry of Labor and Social Policies, Ministry of Health, Relevant Professional Orders

Operational Guidance from the MHPSS Community of Practice

To ensure MHPSS service sustainability:

- Ensure funding stability and predictability.
- Combat staff turnover through contract stabilization and sustainable working conditions.
- Define minimum shared standards at regional/national level (maximum waiting times, team composition, training requirements) to guarantee a baseline regardless of location, while allowing space for local innovation beyond these requirements.
- Plan multi-year pathways for transitioning from pilot project to structural policy, including systematic data collection, impact evaluation, and sustained advocacy.

Conclusions

The recommendations presented in this document translate shared priorities into concrete actions aimed at strengthening coordination, reducing fragmentation, and ensuring equity across territorial contexts. Their implementation calls for more than short-term initiatives: it requires the institutional embedding of adolescent MHPSS within mandates, organizational structures, and planning frameworks, supported by stable governance arrangements and predictable investment over time. Building a system truly capable of responding to the needs of younger generations depends on sustained commitment to dialogue, workforce development, and intersectoral collaboration across the ten thematic areas. Only through long-term institutional commitment to the recommended pathways can integrated MHPSS models be consolidated, scaled sustainably, and contribute meaningfully to the future of communities.

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Annex (I) Regional Workshop Methodology

The recommendations in this document are the outcome of a participatory consultation process conducted within the TSI project “Child & Youth Wellbeing and Mental Health First”. The project’s preliminary phase, consolidated in Output 2.3, identified 15 priority themes for integration of MHPSS services for adolescents and their families and caregivers.

The 15 priority themes were then submitted for participatory validation through workshops conducted in four pilot regions: Emilia-Romagna, Umbria, Alto Adige/Südtirol, and Sardinia. During these pilot workshops, interdisciplinary groups of practitioners, administrators, and MHPSS stakeholders analyzed emerging themes, discussed their relevance to specific territorial contexts, and, through a democratic voting process, identified the themes considered most urgent and feasible for each intervention level (micro, meso, macro).

The democratic voting process conducted in each workshop identified priorities based on practitioners’ direct experience. Aggregated results from the four workshops led to priority theme refinement: five of the original 15 themes were not selected by stakeholders as priority intervention areas, as they were considered less urgent than others in the territorial context.

This document collects the recommendations emerging from this process. The themes addressed reflect priorities that proved most relevant and cross-cutting across different pilot contexts. Some original themes were merged by thematic affinity; others were integrated as cross-cutting principles across different intervention areas.

The 10 validated thematic areas, which constitute the structure of this document, are: (1) Facilitated, stigma-free access; (2) Active and informed youth engagement; (3) Family involvement; (4) Equity as a design principle; (5) Continuity of care in the transition to adulthood; (6) Integration beyond clinical care; (7) Schools as strategic nodes; (8) Integrated service delivery platforms; (9) Monitoring and evaluation; (10) Sustainability through institutionalization.

Annex (II) On YAB Contribution: YAB Workshop Methodology

The Youth Advisory Board recommendations presented in this document were developed during the seventh in-person YAB meeting (Bari, December 6-8, 2025), as part of the broader YAB engagement in the TSI program.

The YAB has participated as a permanent member of the project's Advisory Committee since January 2024. From the 10 priority themes emerging from the consultation process, the YAB chose to focus on three areas considered closest to their own experience and peers' urgent needs: (1) Facilitated, stigma-free access, (6) Integration beyond clinical care, (7) Schools as strategic nodes. For complete recommendation content, see Output 4.1.

Methodological approach: The 2-hour working session adopted an approach based on stimulus stories (case studies): three realistic stories of adolescents encountering obstacles in accessing or using MHPSS services. The three anonymous stories were read by three adolescents and shared via audio files. This approach anchored discussion in concrete situations, surfaced recommendations as solutions to real problems, and facilitated empathic identification with the described situations.

Session structure: Participants were divided into three working groups, each dedicated to one of the selected themes:

- Table 1 – Facilitated, stigma-free access
- Table 2 – The role of social support in care
- Table 3 – Schools as central nodes

Each group worked autonomously following a structured sequence: reading the stimulus story, identifying obstacles, formulating recommendations, selecting priorities, and preparing the plenary presentation.

Sources for this document: This document was developed by integrating post-its produced during group work (primary documentary base with obstacles and recommendations in their original formulation) and the plenary session transcript (argumentative context, rationale, and direct quotes). Organization of material into structured recommendations with Action points preserved original formulation and meaning attributed by participants as much as possible.