



Booklet

Mental Health Collection of Practices

A collection of inspiring mental health practices from regional and local health authorities across Europe, turning shared priorities into concrete action.

EXECUTIVE SUMMARY

This EUREGHA collection brings together **22 mental health practices submitted by EUREGHA members**, showcasing how regional and local actors across Europe are translating mental health priorities into concrete action. The collection includes regional frameworks, established programmes, community-based initiatives, integrated care pathways, digital solutions, European and cross-border projects, as well as emerging and pilot approaches.

Across the practices, several common directions emerge. Children and young people are a particularly prominent target group, while many initiatives increasingly address mental health beyond traditional healthcare settings, connecting support with education, employment, housing, social participation and community life. The collection also highlights approaches focused on the mental wellbeing of the healthcare workforce, the integration of mental and physical health, and a broader shift towards community-based, integrated and person-centred care.

The experiences also reveal common implementation challenges, including coordination across sectors and services, workforce capacity, organisational readiness, sustainable resources, equitable access, and monitoring and evaluation. At the same time, strong political and institutional commitment, clear governance, multidisciplinary partnerships, co-production, community networks and investment in workforce capacity repeatedly emerge as important enabling factors. A central lesson across the collection is the importance of combining common frameworks and objectives with sufficient flexibility to adapt approaches to different regional and local contexts.

The practices are organised into five thematic areas: Population and settings-based prevention; Youth access, transitions and inclusion; Integrated community care and recovery; Targeted support and workforce capacity; and Cross-border healthcare implementation. Together, they provide a practical resource for exchange and mutual learning and demonstrate the diversity of approaches being developed across the EUREGHA membership.

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INTRODUCTION

Mental health is an essential component of health and wellbeing and an increasingly important priority for health and care systems across Europe. Addressing mental health challenges requires coordinated action across different levels of governance, as well as approaches that bring together prevention, early intervention, care and community support. In this context, regional and local health authorities play a crucial role in translating policy priorities into concrete actions, adapting services to the needs of their populations and developing innovative approaches to mental health promotion and care. As key spaces for implementation, regions and local communities offer valuable opportunities to develop, test and scale up solutions that can inform mental health policies and practices across Europe.

Building on EUREGHA's ongoing work on mental health and following its 2025 Annual Conference, *Together for Mental Health: Regions Building Europe's Healthier Future*, this booklet aims to collect and present a series of practices and initiatives from EUREGHA members, showcasing the breadth and diversity of regional and local action on mental health across Europe. The collection highlights the important role of regional and local health authorities in addressing mental health challenges and seeks to facilitate knowledge exchange, mutual learning and the transfer of experiences between territories, contributing to the development of more effective and responsive mental health policies and services at local, regional, national and European levels.

To this end, the booklet brings together practices covering different areas of mental health promotion, prevention and care, including overarching regional and local strategies, frameworks and policies, as well as specific initiatives addressing areas such as youth mental health, suicide prevention, community-based services, workplace and health workforce mental health, prevention and early intervention, and digital mental health. The collection encompasses initiatives at different stages of development and implementation, from emerging and recently launched approaches to established programmes and concluded projects, including practices developed through European collaboration.

Methodology

The collection was developed through a dedicated call for contributions addressed to EUREGHA's full and associate members, who were invited to submit one or more practices using a common template. The information collected through this process was used to develop the 22 practice profiles presented in the booklet, ensuring a common structure while reflecting the diversity of regional contexts, approaches and experiences represented in the collection. As contributions were provided directly by participating organisations, the level of detail available varies across practices, depending on the nature and stage of development of each initiative and on the information provided by contributors.

The template was also aligned, as closely as possible, with the parallel Collection of Practices developed by the Joint Action MENTOR, facilitating potential submissions to both initiatives while maintaining their independent scope and processes.

For each practice, the booklet provides key information on the initiative, including its objectives, main components, implementation approach, cooperation partners and relevant experiences and lessons learned, where available. Through these contributions, readers can gain insights into different regional approaches to mental health and identify experiences that may inform the development or adaptation of similar initiatives in other territories.

To facilitate navigation through the collection, the practices presented in this booklet are grouped according to their main area of intervention. While several initiatives address multiple dimensions of mental health, each practice has been placed under the thematic cluster that best reflects its principal focus. The practices are therefore organised around five main clusters:

- **Population and settings-based prevention**
- **Youth access, transitions and inclusion**
- **Integrated community care and recovery**

- **Targeted support and workforce capacity**
- **Cross-border healthcare cooperation**

This thematic organisation is intended to guide readers through the collection and highlight common areas of action across different regional and local contexts, rather than to provide a strict classification of the practices.

To facilitate further exchange and cooperation, each practice also includes relevant contact information and additional references, where available, allowing interested stakeholders to explore the initiatives in greater detail and connect directly with the organisations involved.

This booklet is conceived as a **living collection**, which EUREGHA intends to continue developing as new regional and local experiences emerge. **EUREGHA members interested in contributing additional practices to future versions of the collection are invited to contact the EUREGHA Secretariat.** In this way, the collection can continue to reflect evolving approaches to mental health across the EUREGHA membership and provide a growing resource for exchange and mutual learning.

Analysis: key trends across the collected practices

Looking across the collected practices, several common trends emerge, reflecting both shared priorities and the diversity of approaches adopted by regional and local actors. A particularly visible focus is on **children and young people**, addressed through initiatives ranging from prevention and mental health promotion to access to services, education, employment and crisis support. The Asti Youth Mental Health Hub, Trento C.O.P.E., Central Denmark's youth IPS initiative and the Welsh alternatives to admission all place young people at the centre of their interventions, while the Groningen regional programme and JOGG Healthy Primary School demonstrate how mental wellbeing can also be addressed through preventive and settings-based approaches. Other initiatives, such as JOGG Healthy Neighbourhoods (The Netherlands) and INTEVIDI (Liguria), include young people as an explicit priority within programmes targeting broader populations. Taken together, the practices illustrate how youth mental health can be approached across different stages and environments, from schools and neighbourhoods to employment pathways, community services and more specialised forms of support.

Another important trend is the attention given to **mental health beyond traditional mental healthcare services**. Several practices address the wider social and everyday conditions that influence wellbeing, connecting mental health with housing, employment, education, social relationships and participation in community life. The Health Budget approaches in Emilia-Romagna and Veneto are particularly illustrative, combining personalised care with support related to housing, work, affective relationships and social life. Central Denmark's IPS initiative connects mental health support with education and competitive employment, while C.O.P.E. (Autonomous Province of Trento) and the Asti Youth Mental Health Hub create pathways linking young people with opportunities and resources available within their communities. JOGG Healthy Neighbourhoods takes a different approach by acting on the physical and social environment itself. Together, these experiences point towards a broader understanding of mental health that extends beyond healthcare provision and requires cooperation across health, social, educational, employment and community sectors.

The collection also brings forward some **distinctive areas of regional action**. The Asti healthcare workforce initiative places the mental health and wellbeing of healthcare professionals at the centre of the intervention, combining the monitoring of work-related stress with mindfulness and aggression-prevention training, group debriefing following critical incidents and access to individual psychological support. This provides a concrete example of how regional mental health action can also address the wellbeing of those delivering health services. Another distinctive example comes from Central Denmark, where mental wellbeing is integrated into a cardiac rehabilitation pathway. Adults entering municipal cardiac rehabilitation receive a structured psychosocial consultation, with additional support available where persistent distress is identified and with attention also given to the involvement of relatives. Developed together with patients, relatives and professionals across participating municipalities, the initiative illustrates how mental health can be incorporated into physical-health pathways rather than treated as a separate area of care.

Community-based and integrated approaches are also recurrent throughout the collection. Personalised care plans, rehabilitation, peer support, social prescribing and connections with community resources appear in different forms across the practices. The Health Budget initiatives, the Emilia-Romagna peer network, the Asti Community to Care initiative and the Welsh social prescribing framework all illustrate approaches that seek to connect clinical care with people's everyday lives and communities. Although their models differ, they share an emphasis on participation, recovery and coordination between different forms of support. This reflects the important position of regional and

local authorities in bringing together healthcare, social services and community actors around needs that cannot always be addressed through a single service or sector.

Finally, the collection highlights the potential of **cooperation across territories and borders**. Some practices have been developed through European collaboration or involve the transfer and implementation of approaches across different health systems, while INTEVIDI provides a particularly clear example of cross-border service development between Italy and France. JA PRISM similarly demonstrates how approaches can be implemented and adapted across different national contexts. These experiences underline the value of European and cross-border cooperation not only for exchanging knowledge, but also for testing how practices can be adapted to different institutional and territorial settings.

These trends should be considered in light of the diversity of the collection itself. The practices are at different stages of development: some describe established programmes and multi-site activities, while others concern pilots, frameworks, recently launched initiatives or interventions still under development. The information available also varies according to the contributions provided by participating organisations, and the practices do not follow a common evaluation framework or report the same types of outcomes. The analysis therefore does not seek to compare or rank their effectiveness. Rather, it identifies recurring priorities, distinctive approaches and areas of innovation emerging from the experiences shared by EUREGHA members, providing a basis for further exchange and mutual learning across regional and local health systems.

Cluster analysis

Thematic group	n	Assigned practices
1) Population and settings-based prevention	4	Flanders policy framework; Groningen regional programme; JOGG Healthy Neighbourhoods; JOGG Healthy Primary School
2) Youth access, transitions and inclusion	4	Asti Youth Mental Health Hub; Trento C.O.P.E.; Central Denmark youth IPS; Wales alternatives to admission
3) Integrated community care and recovery	8	Asti From Community to Care; Central Denmark cardiac rehabilitation; EGTC GO Community Houses; EGTC GO Mental Health Strategies; Emilia-Romagna Health Budget; Emilia-Romagna peer network; Wales social prescribing framework; Veneto Health Budget
4) Targeted support and workforce capacity	3	Asti healthcare workforce; Trento ALBA; Basque BIZI
5) Cross-border healthcare cooperation	3	Basque JA PRISM; EGTC GO Strategies Promoted by Slovenia in the Italian Border Area; Liguria INTEVIDI

Challenges, enablers and learning points

Across the collection, regions report different challenges depending on the populations targeted, the maturity of the initiatives and the organisation of their health and social care systems. Nevertheless, **several common** implementation **issues** emerge.

Coordination across services and sectors is one of the most recurrent challenges, particularly where mental health interventions require cooperation between healthcare, social services, education, employment, community organisations or different levels of government. Establishing clear responsibilities, referral pathways and information-sharing arrangements can be difficult when organisations operate according to different procedures and professional cultures. This is visible, for example, in the integrated pathways developed in Asti, the multi-stakeholder approach of C.O.P.E. in Trento and the different local models operating within the Welsh Alternatives to Admission Programme.

Workforce capacity and organisational readiness represent another recurring issue. Practices report difficulties related to staff availability, recruitment, protected professional time, new competencies and resistance to changing established ways of working. In Asti, building trust among healthcare workers and overcoming organisational resistance were important challenges in developing the occupational mental health initiative, while INTEVIDI highlights the training gap and initial scepticism among professionals towards integrating digital technologies into psychological care.

Other challenges are more specific to the context or target population: reaching young people who are socially isolated or distrust institutions, ensuring equitable access in rural and remote areas, navigating regulatory and data-protection requirements in digital and cross-border initiatives, and overcoming stigma that can discourage people from seeking support. The practices also reveal a common challenge around **evaluation and sustainability**: several initiatives are still pilots or developing models, while differences in data collection, outcome measures and available resources can make it difficult to demonstrate impact and plan longer-term implementation.

Despite these differences, the collection points to a relatively consistent set of **enabling conditions**.

Strong political and institutional commitment can provide the mandate, resources and continuity needed to move from experimentation towards more stable implementation; C.O.P.E., for example, highlights the importance of regional political endorsement and dedicated funding in moving from an EU-funded pilot towards an institutionalised service. Clear governance structures, shared protocols and defined coordinating roles similarly help

translate collaboration into workable pathways. **Co-production and early stakeholder involvement** emerge particularly strongly across very different practices: young people, patients, carers, professionals, third-sector organisations and people with lived experience are involved not simply as beneficiaries but in designing or adapting interventions. The Welsh practices, JA PRISM and several community-based initiatives all underline how this can strengthen ownership, relevance and implementation readiness. Existing community networks and multidisciplinary expertise are another important asset, particularly for approaches that connect clinical support with education, employment, housing or other community resources. Training and capacity building are especially important where implementation requires new professional roles, methods or technologies.

Finally, the experiences suggest that **local flexibility works best when combined with a clear common framework**: regions need sufficient room to adapt interventions to their populations, resources and institutional settings, while retaining shared objectives, core components and mechanisms for monitoring progress. This balance is particularly visible in JA PRISM, which combines a common implementation approach with adaptation across very different health systems, and in Wales, where variation between local crisis models has highlighted the value of common principles and outcome measures.

Taken together, the **learning points** suggest that successful regional mental health action depends less on identifying a single model that can be reproduced everywhere than on creating the conditions in which approaches can be adapted and sustained.

Early assessment of local needs, meaningful involvement of the people and organisations concerned, clear coordination between sectors, investment in workforce capacity and attention to evaluation from the beginning repeatedly emerge as important lessons.

The collection also shows that implementation is often an iterative process: practices evolve through piloting, feedback, evaluation and adaptation rather than moving directly from design to a fixed model.

Community assets and existing local networks can provide an important foundation for this process, while European and cross-border cooperation can offer additional opportunities to exchange knowledge and adapt experience developed elsewhere. At the same time, the practices underline that transferability does not necessarily mean replication: differences in governance, workforce, geography, service organisation and population needs mean that approaches generally need to be adapted to their regional context while preserving the elements that make them effective.

Population and settings-based prevention



Working together to promote mental health: an integrated policy framework for more mental health promotion in Flanders



Key info:

Organisation name:	Department of Care
Region:	Flanders
Country:	Belgium
Practice cooperation partners – International collaboration (e.g., Please indicate any organisations involved in the implementation of the practice, particularly if developed through European collaboration (e.g. Joint Actions, Horizon Europe, Interreg, EU4Health, Erasmus+, etc.). If not applicable, write "N/A".):	This policy plan is the result of a collaboration between: ▪ A consortium ○ The Department of Care was responsible for policy direction and coordination of the process. ○ LUCAS KU Leuven provided the scientific foundation and coordinated consultation with experts and academics. ○ I-CHER Ghent University developed the health-economic framework. ○ Over de Muur facilitated collaboration. ○ Möbius provided process guidance and coordinated stakeholder engagement. ○ The Flemish Institute for Healthy Living contributed expertise in the field of mental health promotion. ▪ A stakeholder group The stakeholder group consisted of 63 organisations, whose role was to provide broad input and feedback and to identify opportunities for collaboration: Agency for Integration and Civic Integration, Agency for Agriculture and Fisheries, Agency Growin Up, General Union of Nurses of Belgium, De Ambrassade, Bataljong, çavaria, Centres for General Welfare Work (CAW), CGG Adentro, Co-Prev, Department of Culture, Youth and Media, Department of Education and Training, Department of Work and Social Economy, Department of Care (Mental Health and Psychosocial Rehabilitation Team, Policy Coordination Division, Home Care Team), De Gezondheidsmakers, the Interdepartmental Working Group The First 1,000 Days, Family Platform, Gavoorgeluk

Fund, GO! Education, Houses of the Child, IDEWE, Intermunicipal Prevention Services (IGP), Internet Collaboration Cell (ISC), Eetexpert Knowledge Centre, KU Leuven, Autism League Flanders, Network of Independent Healthcare Providers (NZZ), Educational Association of Cities and Municipalities (OVSG), National Institute for Health and Disability Insurance (NIHDI), Red Cross Flanders, Support Centre for People and Society (SAM), Support Centre for Inclusive Higher Education (SIHO), Similes, Solentra, the Flemish central cities, Flemish Education Council (VLOR), Support Centre for Work, The Human Link, UCLL, Ghent University, VDAB, Flemish Brabant Confidential Centre for Child Abuse, Flemish Institute for Primary Care (VIVEL), Flemish Agency for Persons with Disabilities (VAPH), Flemish Pharmacists Network (VAN), Flemish Institute for Healthy Living, Flemish Intermunicipalistic Prevention College, Flemish Network “Choose Colour Against Bullying”, Flemish Patient Platform, Flemish Council for Older People, Flemish Association of Clinical Psychologists (VVKP), Flemish Scientific Association for Youth Health Care (VWVJ), University of Antwerp, Psyche vzw, Te Gek!?, ZoJong!, Zorggezind and Zorgnet-Icuro. In addition, actions were submitted by organisations outside the stakeholder group.

- An expert panel

The expert panel consisted of 17 academics affiliated with KU Leuven, Ghent University and the Vrije Universiteit Brussel (VUB). They provided content expertise and feedback for the different life stages and thematic areas addressed in the policy plan.

- An indicators’ working group

- Sciensano (Prevention Barometer, Health Interview Survey)
- Ghent University (HBSC Study and JOP Monitor)
- The Flemish Institute for Healthy Living (Prevention Survey)
- Statistics Flanders
- Kind en Gezin (Child and Family)
- VIKZ (Flemish Institute for the Quality of Care)

The group provided input for the development of a monitoring and evaluation framework to assess the impact of the policy plan over time.

Keywords:

Mental health promotion, resilience, integrated care, collaboration/participation, life-course approach.

Implementation status:

Ongoing implementation of a mental health policy/programme/initiative, Integrated care / cross-sectoral mental health initiative. Integrated policy

framework for more mental health promotion in Flanders adopted by the Flemish Government in 2025. Implementation and specific actions will follow in the next years.

Focus areas:

- Mental Health Promotion and Prevention – proactively strengthening mental well-being and preventing mental health problems.
- Resilience and Mental Health Skills – resilience, emotional regulation, stress management and coping skills.
- Life-Course Approach – addressing the first 1,000 days, children and young people, adults and older adults.
- Social Connectedness and Inclusion – connectedness, participation, meaningful relationships and combating loneliness.
- Support for Vulnerable Groups – providing additional support in line with the principle of proportionate universalism.
- Mental Health in Everyday Settings – integrating mental health promotion into education, the workplace, local communities, wellbeing, healthcare and leisure settings.
- Cross-Sectoral Collaboration – promoting shared responsibility and cooperation across policy domains and organisations.
- Evidence, Implementation and Impact Monitoring – using effective and cost-effective interventions, scaling up successful initiatives, and monitoring progress through indicators and evaluation.

Summary:

The practice addresses the growing burden of mental health issues in Flanders, including psychological distress, social exclusion, pressure on healthcare services and substantial societal and economic costs. Existing mental health promotion initiatives were fragmented, sometimes overlapping and insufficiently coordinated, while important gaps remained for vulnerable groups and older adults.

The practice targets the entire Flemish population throughout the life course—from the first 1,000 days to older age—with additional support for people in vulnerable situations, in line with the principle of proportionate universalism. Relevant intermediaries and settings include families, schools, workplaces, healthcare, wellbeing and welfare services, local authorities, community organisations and the media.

Its main objective is to establish an integrated, evidence-based and cross-sectoral framework that promotes positive mental health, strengthens resilience and protective factors, reduces risk factors and prevents mental health problems. It also aims to improve coordination, ensure efficient use of resources and make policy outcomes measurable.

Activities included a participatory policy-development process involving 63 stakeholder organisations, 17 academic

experts and an indicator working group. Scientific literature and international good practices were reviewed; effective and cost-effective interventions were identified; existing initiatives were mapped and assessed; strategic and operational objectives were developed for different life stages; and proposals for monitoring, health-economic evaluation, collaboration and portfolio management were formulated.

Key results include a broadly supported mission, vision and life-course strategy; an initial inventory of 114 actions; the identification of 69 actions with potential for scaling up; 26 concrete scale-up proposals; and 17 proposals for new actions addressing identified gaps. The practice also produced an indicator framework for monitoring outcomes and impact, together with recommendations for cyclical portfolio management, cross-sectoral governance and sustained collaboration.

Overall, it provides Flanders with a coherent foundation for more effective, equitable and measurable mental health promotion.

Description and strategic context:

The practice addresses the growing burden of mental health issues in Flanders. One in three Flemish citizens experiences psychological distress, while 15% live with a mental disorder. Mental health problems affect quality of life, social participation, education and employment, and are estimated to cost Belgium more than €20 billion annually. Existing promotion initiatives are valuable but fragmented, with overlaps, gaps and insufficient reach, particularly among vulnerable groups and older adults.

Mental health promotion is therefore a regional priority because it strengthens resilience, reduces inequalities, supports sustainable healthcare and helps society respond to challenges such as digitalisation, population ageing, climate change and social inequality.

The practice implements the Flemish Government Agreement 2024–2029 and the Policy Note on Welfare, Public Health, Family Affairs and Poverty Reduction. It builds on the Flemish Health Objective “The Fleming Lives Healthier” and complements the Flemish Suicide Prevention Action Plan, Youth and Children’s Rights Policy Plan, Loneliness Strategy and Elderly Policy Plan. Its integrated, life-course and cross-sectoral approach is also aligned with international and European public-health principles, including Health in All Policies, proportionate universalism, evidence-based prevention and the promotion of mental health in everyday settings.

The framework fits in the EU work on “a comprehensive approach to mental health” and WHO policies on mental health.

Objectives:

Overall objective: To build a society in which everyone in Flanders can be born, grow up, live and age with the highest attainable level of mental well-being and as few mental health problems as possible. The practice aims to strengthen protective factors, reduce preventable risks and embed mental health promotion in everyday settings throughout the life course. The intended benefit is improved quality of life, resilience, social participation and health equity, together with lower demand for intensive care.

Specific objectives

- Strengthen mental health competencies. Increase people’s knowledge, positive attitudes and practical skills related to mental health, including emotional regulation, stress management, adaptive coping, healthy boundary-setting and timely support-seeking.
- Promote social connectedness and inclusion. Strengthen supportive formal and informal networks, meaningful relationships, participation and a sense of belonging across generations, while reducing loneliness, stigma, bullying and exclusion.
- Create mentally healthy environments. Integrate mental health promotion into families, childcare, education, workplaces, healthcare wellbeing and welfare services, leisure settings, residential care, local communities, public spaces and digital media.
- Apply a life-course approach. Tailor objectives and interventions to the first 1,000 days, children and young people, adults and older adults, addressing the specific challenges and transitions associated with each life stage.
- Reduce mental health inequalities. Combine population-wide measures with more intensive support for people in vulnerable situations, in line with proportionate universalism.
- Scale up effective action. Assess the quality and reach of existing initiatives, expand interventions with demonstrated potential, and develop new actions where gaps remain. The initial portfolio identified 114 actions, including 69 potential scale-up candidates, 26 scale-up proposals and 17 proposals addressing unmet needs.
- Improve coordination and accountability. Strengthen cross-sectoral collaboration, reduce duplication and monitor progress through input,

process, output, outcome and impact indicators. Intended measurable benefits include improved mental well-being, resilience, life satisfaction and help-seeking, alongside reduced psychological distress, loneliness and mental-health-related work disability.

Target group(s):

Direct beneficiaries are all people living in Flanders, across the life course: expectant and new parents and their children during the first 1,000 days; children and young people; (young) adults; and older adults. The practice follows proportionate universalism: universal mental health promotion is available to everyone, while the intensity and focus of support vary according to need.

Priority subgroups include people living in poverty or socioeconomic disadvantage; those experiencing bereavement, trauma, divorce or other major life events; people with chronic illness or disabilities; informal carers; people with a migration background; single or young parents; LGBTQ+ people; children and young people in youth care; early school leavers and NEETs; unemployed adults; workers in high-risk occupations; and socially isolated older adults. Inclusion is based primarily on life stage, exposure to increased risk factors, vulnerable living circumstances or reduced access to protective resources and support.

Indirect beneficiaries include families, caregivers, peers, local communities and society as a whole. Intermediary beneficiaries comprise professionals and organisations in childcare, education, workplaces, healthcare, wellbeing and welfare, residential care, youth and leisure services, local government, community organisations and the media. They benefit from clearer objectives, evidence-based guidance, stronger collaboration and improved capacity to promote mental health.

Equity dimension:

The practice addresses health inequalities through proportionate universalism: mental health promotion is intended for the whole population, while additional or more intensive support is provided according to level of need. A life-course approach adapts objectives and interventions to the first 1,000 days, childhood and adolescence, adulthood and older age, recognising age-specific transitions and risks.

Priority is given to people facing socioeconomic disadvantage or poverty, unemployment, insecure living conditions, major life events, chronic illness or physical or mental disability. The framework also identifies families with a migration background, single and young parents,

informal carers, LGBTQ+ people, children in youth care, early school leavers and NEETs, socially isolated older adults, and workers in high-risk occupations.

Health inequalities are addressed through accessible interventions in everyday settings—including childcare, education, workplaces, healthcare, wellbeing and welfare services, residential care, leisure settings, digital environments and local communities. Actions aim to reduce barriers to participation and support, strengthen inclusive and non-stigmatising environments, and improve access to social networks, mental health skills and timely assistance. Local, neighbourhood-oriented approaches and inclusive public spaces allow interventions to be tailored to differing community contexts, including areas with limited access to services.

Methodology and processes:

In 2025, the Department of Care completed the implementation period of the Flemish health goal 'Flemish People Live Healthier in 2025'. This marked the transition to [a new health goal](#) for the ten-year period 2026–2035: 'Healthy Generation'. The new health goal was approved by the Flemish Government on 26 June 2026.

The health goal is structured around four integrated health promotion and prevention programmes:

- Healthy eating and physical activity
- Substance use and addiction, including tobacco, vaping, alcohol, drugs, gambling, psychoactive medication and screen use
- Mental well-being
- Sexual health

The mental well-being promotion and prevention programme builds on the policy plan 'Working Together to Promote Mental Health: An Integrated Policy Framework for Strengthening Mental Health Promotion in Flanders'. At the end of 2025, a call for proposals was launched to select a partner organisation and conclude a management agreement for the implementation of this prevention programme. The programme's scope, objectives and delivery framework are grounded in the policy plan.

Involvement of other organisations/actors:

The design of the Flemish Mental Health Promotion Policy Plan followed a participatory, multi-stakeholder approach. Stakeholder involvement was a core principle of the practice. The Flemish Department of Care initiated and supervised the process, provided policy direction and institutional anchoring, and ensured coherence and quality. A multidisciplinary consortium combined scientific, health-economic, implementation and facilitation expertise.

Citizen and service-user perspectives were incorporated primarily through organisations representing patients, families, caregivers and vulnerable groups. The process explicitly placed citizens' needs above organisational interests. End-user and intermediary involvement were also included as a quality criterion when assessing existing interventions.

Over 60 organisations—including service users, patients, caregivers, civil society groups, and representatives from sectors such as health, wellbeing, education, welfare, youth, and employment—were actively engaged through three major stakeholder meetings in 2024. These sessions featured interactive roundtables, group exercises, and digital feedback tools (e.g., Slido), enabling participants to shape priorities, identify key determinants, and propose interventions across all life stages.

Stakeholders contributed to:

- Design & Co-creation: Input on mission, vision, and strategic objectives was gathered and iteratively refined based on feedback from diverse groups, including vulnerable populations. Civil society and sectoral actors identified gaps, suggested priorities, and co-developed action fiches for new or scalable interventions.
- Implementation: Key actors (e.g., caregivers, educators, local authorities, youth workers) were mapped per setting and life phase, clarifying roles and fostering cross-sectoral collaboration. Coaching sessions and a 'marketplace' for pitching new actions further supported joint implementation.
- Monitoring & Evaluation: An indicator working group, including experts and stakeholders, co-developed a set of indicators for ongoing monitoring. Feedback on these indicators was collected and integrated. Qualitative and quantitative data, as well as stakeholder and citizen input, inform ongoing evaluation and adjustment.

This inclusive process ensured the policy is evidence-based, widely supported, and responsive to the real needs of the Flemish population, with mechanisms for continuous improvement through stakeholder engagement.

Funding source(s) and sustainability:

The initiative is primarily supported through Flemish Government funding within preventive health policy. The Flemish Department of Care commissioned and coordinated the policy-development process, supported by a consortium of academic, health-economic, implementation and health-promotion partners. Existing mental health promotion

programmes are financed through several Flemish policy domains and implementation channels, including the management agreement with partner organisations for mental well-being of the Flemish Government. The framework does not specify a single consolidated budget or confirmed long-term funding envelope for all proposed actions.

Financial sustainability is expected to rely on strategic prioritisation within a broadly stable overall budget, complemented where necessary by additional investment in response to societal needs and political commitments. Portfolio management will support efficient resource allocation by identifying effective existing initiatives, preventing duplication, scaling up high-quality actions and directing funding towards unmet needs. Future decisions should consider effectiveness, reach, equity and cost-effectiveness, using the proposed CHEERS II-based health-economic framework¹.

Organisational sustainability will be supported through clear responsibilities, trained intermediaries, strong cross-sectoral collaboration and the integration of mental health promotion into existing structures and everyday settings. A proposed Flemish-level gatekeeper function would safeguard coherence, review the portfolio cyclically and align new initiatives with strategic objectives.

Political sustainability is reinforced by the framework's alignment with the Flemish Government Agreement 2024–2029, the relevant policy note and the new health goal “Healthy Generation”. Long-term sustainability will nevertheless require continued political commitment, appropriate regulation, recurrent funding, scientific support, robust monitoring and periodic adjustment based on evidence and evolving population needs.

Innovation, Impact and Outcomes:

The practice is innovative because it moves beyond isolated prevention projects towards a single, integrated Flemish policy framework for positive mental health promotion. It combines several complementary features: a life-course approach covering the first 1,000 days through older age; proportionate universalism, linking population-wide action with intensified support for vulnerable groups; and a settings-based approach embedding mental health in education, workplaces, families, communities, care, leisure and digital environments.

A further innovation is the systematic integration of scientific evidence, stakeholder expertise, implementation conditions and health economics. The framework draws on the Two-Continua Model (Keyes) and the prevention typology of Arango et al., a 70-page literature review of effective interventions, and a CHEERS II-based framework for evaluating cost-effectiveness and transferability to Flanders. It also introduces chain analysis to guide collaboration, leverage analysis at intermediary, organisational and policy levels, and cyclical portfolio management to reassess, scale, adapt or discontinue actions over time.

The development process itself produced important outputs. It involved 63 stakeholder organisations, 17 academic experts and a dedicated indicators working group. Three stakeholder sessions were held in 2024. An inventory identified 114 unique actions. Quality and reach assessments indicated that 69 actions had potential for scaling up; stakeholders submitted 26 concrete scale-up proposals and 17 proposals for new actions, particularly addressing gaps for vulnerable groups and older adults. Reach was assessed partly against implementation across Flanders and whether actions reached at least 15% of the intended target population.

The evidence review found strong support for cognitive behavioural, mindfulness, mind-body, parenting and social-emotional skills interventions. Digital interventions were considered accessible and potentially cost-effective, although generally less effective than guided face-to-face approaches. Mental health literacy and stigma-reduction initiatives improved knowledge and attitudes but showed limited effects on mental health outcomes or help-seeking intentions. Evidence was strongest for children and young people, especially in education, and more limited for the first 1,000 days and older adults.

Population-level impacts cannot yet be attributed to the framework because it establishes the basis for future implementation and evaluation rather than reporting a completed outcome evaluation. Proposed monitoring covers input, process, output, outcome and impact indicators. Measures include life satisfaction, positive mental health, resilience, psychological distress, loneliness, help-seeking, service use, quality of life and mental-health-related work disability. Existing data systems—including the Health Interview Survey, HBSC and JOP Monitor—are intended to support longitudinal assessment. The policy plan

¹ Werbrouck A, De Bekker-Grob E, Al M, Putman K, Willems R. (2024) Consolidated Health Economic Evaluation Reporting Standards 2022 (CHEERS II) statement: a validated Dutch translation. Expert Rev

acknowledges that much portfolio information was self-reported and not independently validated; stronger monitoring and multiple data sources are therefore recommended.

Evaluation:

No formal outcome evaluation has yet been completed, as the policy framework establishes the basis for future implementation and long-term monitoring. The planned evaluation uses a logic-model approach covering input, process, output, outcome and impact indicators. Input indicators will assess resources such as funding, staff and materials; process indicators will examine implementation quality, efficiency, compliance and participation; and output indicators will monitor programmes delivered and people reached. These indicators will be further specified during implementation.

Population-level evaluation will use repeated measurements from existing monitoring systems, including the Belgian Health Interview Survey, Health Behaviour in School-aged Children study, JOP Monitor, Prevention Barometer, Prevention Survey and municipal monitoring instruments. Results should be analysed over time and, where possible, by life stage and vulnerable subgroup to assess equity.

Barriers, enables, and learning points:

CHALLENGES:

- Cross-sectoral Coordination: Achieving effective collaboration among diverse sectors (health, wellbeing, education, welfare, youth, employment) proved complex due to differing priorities, terminologies, and working cultures.
- Stakeholder Engagement: Ensuring meaningful participation from all relevant stakeholders, especially vulnerable groups and those with lived experience, required sustained outreach and tailored engagement strategies.
- Data and Evidence Gaps: Limited availability of up-to-date, relevant data on mental health determinants and outcomes hindered evidence-based decision-making and monitoring.
- Resource Constraints: Both financial and human resources were stretched, impacting the capacity to implement and scale up interventions.
- Balancing Ambition and Feasibility: The broad scope of the policy ambitions sometimes conflicted with practical limitations,

necessitating prioritization and phased implementation.

- Sustaining Momentum: Maintaining stakeholder motivation and commitment throughout a lengthy, iterative process was challenging, especially given competing agendas and external pressures (e.g., policy changes, societal events).

These challenges were addressed through transparent communication, iterative feedback loops, and adaptive planning, but they remain important considerations for ongoing implementation.

ENABLERS:

- Strong Cross-Sectoral Collaboration: The plan was built on robust partnerships across health, wellbeing, education, welfare, youth, employment, and civil society sectors. Regular stakeholder meetings, interactive workshops, and a marketplace for pitching new actions fostered joint ownership and innovation.
- Evidence-Based Approach: Actions were selected and prioritized based on scientific evidence of effectiveness and cost-effectiveness, ensuring interventions were impactful and scalable.
- Participatory Co-Creation: Service users, caregivers, and vulnerable groups were actively involved in co-designing actions, ensuring relevance and inclusivity.
- Clear Vision and Strategic Framework: A shared mission, vision, and strategic objectives provided direction and coherence, making it easier to align diverse actors and resources.
- Portfolio Management: Systematic mapping and evaluation of existing actions identified strong practices for scaling and highlighted gaps for new initiatives.
- Capacity Building and Support: Coaching sessions, accessible templates, and facilitation supported organizations in developing and scaling actions.
- Continuous Monitoring and Feedback: An indicator working group and regular feedback loops enabled ongoing evaluation and adaptation, supporting sustainable impact.

These enablers create a solid foundation for broad, sustainable improvements in mental health promotion across Flanders.

LEARNING POINTS:

- Inclusive Co-Creation: Broad, early, and continuous involvement of stakeholders—including service users, caregivers, civil society, and multiple sectors—ensured relevance, buy-in, and sustainability. Participatory methods (workshops, feedback loops) were essential.
- Cross-Sectoral Collaboration: Success depended on strong partnerships across health, wellbeing, education, welfare, youth, and employment sectors. Joint ownership and clear role mapping facilitated implementation.
- Evidence-Based and Contextualized Actions: Prioritizing interventions with proven effectiveness and cost-effectiveness, while adapting to local needs and contexts, increased impact and transferability.
- Scalability and Integration: Leveraging existing structures and integrating new actions into established systems (e.g., schools, local authorities) supported scaling and sustainability.
- Transparent Communication: Open, regular communication—built trust and maintained momentum among diverse actors.

Legal and/or ethical issues:

The practice sits within Flemish preventive-health governance, which prioritises evidence-based action, health equity, proportional universalism, citizen participation and cross-sectoral implementation. Governance should therefore define accountable controllers, partner roles, referral responsibilities, quality assurance and transparent decision-making, while preserving professional independence and confidentiality. The integrated policy framework itself is population-oriented and preventive rather than a diagnostic or treatment programme. [Flemish preventive-health policy](#) and the [integrated mental-health-promotion framework](#) explicitly emphasise participation, monitoring and attention to vulnerable groups. Implementation by participating organisations must comply with applicable professional standards, safeguarding duties and regulations, including the EU General Data Protection Regulation (GDPR) and Belgian data-protection legislation.

The policy framework itself does not involve diagnosis, treatment or the collection of individual clinical data. However, specific interventions and monitoring activities may process personal or health-related information. In such cases, organisations must establish a lawful basis, apply purpose limitation and data minimisation, ensure secure storage and controlled access, and provide transparent information on data use. Where required, informed consent

or another valid legal basis must be obtained, especially when working with children or other vulnerable groups. Evaluation results should preferably be aggregated or anonymised.

Ethically, the practice prioritises equity, inclusion, autonomy, non-stigmatising communication and proportionate universalism. Governance is led by the Flemish Department of Care and supported by cross-sectoral partners, scientific experts and a proposed gatekeeper function. Clear responsibilities, transparent decision-making, confidentiality and appropriate representation of citizens and vulnerable groups are necessary to maintain trust and accountability.

Transferability to other regions:

Transferable with contextual adaptation.

The practice has moderate transferability maturity. It provides a well-developed policy framework, objectives, implementation conditions, evidence review and monitoring approach, but population-level implementation and outcome evaluation are still at an early stage. Its transferability is therefore strongest as a structured policy-development and portfolio-management model rather than as a fully validated intervention package.

The approach could be replicated by another region or organisation through the following steps: define the scope of mental health promotion; conduct a local needs and policy analysis; establish cross-sectoral governance; involve citizens, practitioners, civil society and academic experts; develop life-course objectives; map existing actions; assess their evidence, quality, equity and reach; identify gaps and scale-up candidates; and create an indicator-based monitoring framework. Individual interventions should not be transferred automatically: their cultural relevance, target-group needs, delivery settings, workforce capacity, costs and compatibility with local systems must first be assessed.

Key prerequisites include sustained political commitment, a coordinating authority, cross-sectoral partnerships, recurrent funding, access to scientific and health-economic expertise, trained intermediaries, stakeholder participation, reliable population data and clear arrangements for governance and accountability. Adaptation should preserve core principles—positive mental health, proportionate universalism, life-course and settings-based approaches, co-creation and evidence-informed decision-making—while allowing operational objectives and delivery models to reflect local conditions.

Dissemination and further information:

Dissemination is centred on the “[Samen bouwen aan geestelijke gezondheid](#)” webpage of the Flemish Department of Care. It presents the framework’s rationale, mission, methodology and main outputs, and provides downloadable versions of the integrated policy plan and process report. A separate scientific report offers more extensive academic substantiation. The webpage notes that the scientific report will be published separately.

The wider [Mental Well-being webpage](#) connects the framework to Flemish prevention policy, relevant statistics, monitoring through the Prevention Barometer and Public Health Monitor, and the available advisory, training and coaching network. More information on the [new health goal](#) “Healthy Generation” can also be found online.

Media:

The [Flemish Department of Care policy webpage](#), which provides the integrated policy plan, process report and scientific report as downloadable PDFs. These are the principal authorised reference materials explaining the framework, participatory process, evidence base, objectives, portfolio-management method and monitoring approach. The page can be shared as the main institutional source.

The broader [Mental Well-being webpage](#) provides policy context, mental-health figures, links to monitoring instruments and information on Flemish prevention partners and initiatives.

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Population and settings-based prevention

umcg: Northern Netherlands Mental Health Program



Key info:

Organisation name:	University Medical Center Groningen
Region:	Province of Groningen and three northern municipalities of the Province of Drenthe
Country:	The Netherlands
Practice cooperation partners – International collaboration (e.g., Please indicate any organisations involved in the implementation of the practice, particularly if developed through European collaboration (e.g. Joint Actions, Horizon Europe, Interreg, EU4Health, Erasmus+, etc.). If not applicable, write "N/A".):	Mentaal Gezond Groningen is delivered through a broad regional partnership including University Medical Center Groningen (UMCG), municipalities, public health services (GGD), youth health services, mental healthcare providers, educational institutions, social /welfare care organisations, youth participation organisations, and knowledge institutes.

Keywords:

Youth mental health, prevention, cross-sector collaboration, community of practice, early intervention, mental health promotion.

Implementation status:

Ongoing implementation of a mental health policy/programme/initiative, Pilot or promising practice currently being tested, Prevention or mental health promotion initiative, Integrated care / cross-sectoral mental health initiative, Practice addressing vulnerable or underserved groups.

Focus areas:

Mental health promotion, prevention, early intervention, youth mental health, workplace mental health, suicide prevention, digital mental health, access to services, psychosocial support for vulnerable groups, training of professionals, anti-stigma initiatives.

Summary:

Mentaal Gezond Groningen is a regional mental health prevention programme established in 2022 in response to persistently poorer mental health outcomes among residents of Groningen compared with national averages. The initiative was initiated to address both emerging mental health problems and the broader social determinants that influence mental wellbeing.

The programme brings together organisations from mental healthcare, education, public health services, municipalities, social services, welfare, youth participation organisations and knowledge institutes within a Community of Practice. The Prevention Community of Practice enables collaboration, learning and implementation across sectors. Within the programme, a dedicated coordinating backbone organisation, facilitates communication, collective learning, and alignment between participating organisations and individual prevention interventions.

The overarching ambition is to reduce the prevalence of mental disorders in the region by 10% by 2032. To achieve this, the programme combines universal, selective and indicated prevention strategies. Activities focus on strengthening resilience, improving mental health literacy, facilitating early identification of problems, supporting vulnerable groups and addressing social determinants that contribute to mental health inequalities.

Rather than implementing a single intervention, Mentaal Gezond Groningen coordinates multiple complementary actions aimed at improving mental wellbeing and reducing the future burden of mental disorders. Current programme components include interventions targeting specific target groups.

Currently, the majority of interventions target students: the STORM approach for adolescents in high school, School als Wijk (translation: school as a community) for vocational education students, Move aHead! for (applied) university students. In addition, a number of interventions focus on people with increased risk for developing mental disorders: children of parents with mental illness, young people transitioning to working life, people with psychosocial complaints, mild intellectual disabilities or mild mental health complaints. Youth participation is embedded throughout the programme.

A distinctive element of the programme is its commitment to long-term monitoring, evaluation and adaptive learning. Alongside intervention-specific evaluations, the programme is developing a monitoring infrastructure enabling continuous improvement while generating evidence on how regional prevention can contribute to better mental health outcomes over time within the system.

Description and strategic context:

Although increasing mental health problems are a major global health concern, this is particularly the case in certain regions in the Netherlands. The Northern Netherlands faces a number of challenges that increase the risk of poor mental health, including socioeconomic inequalities, financial insecurity, loneliness and the long-term consequences of gas extraction and subsequent earthquake-related stress. Mental health problems among adolescents and young adults are particularly prominent.

Mentaal Gezond Groningen was established to respond to these challenges through a coordinated prevention strategy. The programme reflects a shift from standalone preventive interventions towards a public health model that prioritises prevention and early intervention via a comprehensive package of preventive interventions. It aligns with regional ambitions under Nij Begun

(compensation fund for gas extraction and related earthquake damage) and with UMCG's strategic focus on prevention, population health and societal impact.

The programme recognises that mental health is shaped by a complex interaction of individual, family, community and societal factors (Bronfenbrenner, 1994). It therefore combines evidence-based interventions with cross-sector collaboration, aiming to strengthen mental health and improving long-term population outcomes.

Objectives:

Overall objective: To improve population mental health and reduce the prevalence of mental disorders in Groningen region by 10% by 2032.

Specific objectives

- Strengthen mental wellbeing and resilience among children, adolescents and young adults.
- Identify emerging mental health difficulties at an earlier stage.
- Strengthen protective social networks around high-risk groups.
- Improve collaboration between healthcare, education, public health and social care & welfare sectors.
- Reduce fragmentation of preventive efforts across the region.
- Generate evidence on effective population-level prevention strategies.

Target group(s):

The primary focus is on children, adolescents and young adults living in Northern-Netherlands.

Specific target groups include:

- Secondary school students.
- Vocational education students.
- Students in higher education: (applied) universities.
- Children of parents with mental illness (COPMI).
- People experiencing psychosocial vulnerabilities.
- Families and social networks supporting vulnerable young people.

Indirect beneficiaries include parents, caregivers, educators, communities and regional organisations involved in prevention, health promotion and wellbeing.

Equity dimension:

Groningen experiences higher levels of socioeconomic disadvantage than many other Dutch regions, including

poverty, energy insecurity and financial stress. The region also has high rates of unemployment, families struggling with debts, child abuse and children growing up in poverty. These factors contribute to an elevated mental health risk profile.

The programme addresses inequities through a combination of universal interventions and targeted approaches for groups at increased risk. Particular attention is given to young people facing adverse social circumstances, children of parents with mental illness and students experiencing educational or psychosocial challenges. Universal activities aim to reduce the overall risk profile of the population.

By combining prevention activities with support embedded in educational and community settings, the programme aims to improve accessibility and reduce barriers to support once detected.

Methodology and processes:

Mentaal Gezond Groningen applies a population-based prevention model that combines universal, selective and indicated prevention approaches within a single regional framework. The programme operates through a Prevention Community of Practice that serves as the coordinating infrastructure connecting stakeholders, interventions, implementation support, monitoring and that facilitates knowledge exchange. The implementation process consists of the following:

1. Assessment of regional needs and risk factors:

Identification of population needs using public health data, scientific evidence, and stakeholder input.

2. Selection and implementation of interventions:

Deployment of evidence-based and practice-informed interventions targeting different age groups and risk profiles.

3. Cross-sector coordination via backbone infrastructure:

Regular meetings of programme partners. Knowledge sharing between implementation teams, researchers, policy makers and practitioners

4. Monitoring, evaluation and adaptation:

Collection of implementations, reach and outcome data. Continuous learning through feedback loops and stakeholder reflection. Adaptation of interventions and implementation strategies based on findings.

Involvement of other organisations/actors:

The programme was developed and is implemented through extensive collaboration between organisations operating in (mental) healthcare, education, public health, municipalities, social services and organisations with lived

experience experts. The model is based on the principle that sustainable improvements in mental health require coordinated action across domains. Key stakeholder groups include:

- Municipalities across Groningen and the three northern municipalities of Drenthe.
- University Medical Center Groningen.
- Mental healthcare providers.
- Public health services (GGD).
- Youth health services.
- Secondary, vocational and higher education institutions.
- Social care and community (welfare) organisations.
- Youth participation organisations.
- Researchers and knowledge institutes.

Young people are actively involved in programme development and adaptations. Through cooperation with Inbegrepen (cooperation for and by people with lived experience) and Jimmy's (advocates for youth participation), young people contribute to programme design, evaluation activities and future programme development. This strengthens relevance, accessibility and responsiveness to local needs.

Funding source(s) and sustainability:

Mentaal Gezond Groningen was initially established through funding from the National Programma Groningen (NPG). This investment enabled the creation of a regional prevention infrastructure and supported the implementation of several preventive interventions.

Since 2025, programme activities have been further embedded within the Sociale Agenda of Nij Begun (gas extraction compensation fund), which provides a long-term (30-years) framework for strengthening wellbeing and social development in the region. Additional co-financing and organisational contributions support the continuation of several programme components.

Sustainability is supported through:

- Embedding interventions within existing educational, healthcare and community structures.
- Building local implementation capacity.
- Shared ownership among partner organisations.
- Generation of evidence to inform policy and investment decisions.
- Long-term regional commitment to prevention and wellbeing

Innovation, Impact and Outcomes:

Mentaal Gezond Groningen can be considered innovative as it enabled a shift from isolated interventions towards a

regional prevention programme. Rather than focusing on a single project or intervention, the programme creates an infrastructure that connects stakeholders, interventions, research and policy around a shared population-health goal.

Key innovations include:

- Integration of (evidence based) universal, selective and indicated prevention strategies.
- Coordination through a Prevention Community of Practice.
- Cross-sector collaboration across health, education, public health and social domains.
- Strong youth participation and co-creation.
- Long-term monitoring and adaptive learning.

The intended impact is a measurable reduction in the prevalence of mental disorders and improvements in wellbeing, educational and labour participation. At the system level, the initiative aims to strengthen collaboration, align regional prevention efforts and generate transferable knowledge for other regions.

Evaluation:

Evaluation is a central component of Mentaal Gezond Groningen. The programme combines implementation evaluation, outcome evaluation and system-level learning within a comprehensive monitoring framework.

The evaluation strategy consists of four complementary components:

1. Realist Evaluation: Examines how interventions work, for whom they are effective and which contextual factors influence outcomes. Particular attention is paid to fidelity, reach, adaptation and mechanisms of change.

2. Complex Systems Evaluation: Recognises that mental health outcomes emerge from interactions between individuals, organisations and social environments. Methods include transition-oriented monitoring, stakeholder reflection and systems mapping.

3. Outcome Effectiveness Evaluation: Population-level monitoring draws upon regional and national datasets, public health surveys and intervention-specific evaluations.

4. Broader Societal and Economic Evaluation: Assesses wider benefits beyond health outcomes, including educational, societal and economic impacts.

Barriers, enables, and learning points:

CHALLENGES:

- Coordinating stakeholders across multiple sectors with different priorities and governance structures.

- Addressing the multifactorial determinants of mental health while having limited influence over major structural drivers such as income inequality, housing, education, and social security.
- Overcoming the “wrong-pocket problem”, where the organisations investing in prevention are not necessarily those that realize the resulting benefits and cost savings.
- Securing sustained commitment and funding during a long implementation period.
- Measuring population-level effects of prevention initiatives, which may take many years to become visible.
- Integrating data from different organisations and monitoring systems.
- Maintaining programme coherence while allowing interventions to adapt to local needs
- Maintaining a workable balance between network leadership on the one hand, enabling flexibility, engagement, adaptability of the program and coming to action, and governance on the other hand, needed for assigning formal responsibilities.
- Changing from implementing interventions among and collaborating with a ‘coalition of the willing’ (early adoptors) to large-scale scaling up, targeting the entire region including organisations that may have other priorities or perspectives.

ENABLERS:

- A shared regional ambition to improve mental health.
- Strong collaboration between healthcare, education, public health and social sectors.
- Dedicated backbone infrastructure and set-up of the Prevention Community of Practice.
- Support from regional funding programmes.
- Commitment to continuous learning and evidence-informed decision-making.
- Meaningful youth participation in programme development and implementation.

LEARNING POINTS:

- Long-term mental health (disorder) prevention requires sustained cross-sector partnerships rather than isolated projects.
- Building a prevention Community of Practice is as important as implementing the individual interventions.
- Monitoring should capture both intervention outcomes and wider system change.

- Flexibility and adaptation are necessary when addressing complex population health challenges.
- Engaging young people as active partners improves relevance and acceptability of prevention initiatives.
- Population mental health improvement requires attention to social determinants alongside individual risk factors.

Legal and/or ethical issues:

- Shared decision making requires mutual trust. It is challenging to reflect shared responsibility (and accountability) in a governance structure.
- Much is still unknown about what interventions are effective in preventing mental health problems. This requires a funding model that provides scope for experimentation, while also ensuring that public resources are used in a lawful and cost-effective manner.
- Additional attention for prevention (e.g. early recognition) sometimes leads to an increase in help-seeking behaviour, which can lead to an increase in waiting time for help due to shortage in staff.
- Monitoring and evaluation can be difficult due to data protection issues, e.g. collecting data on users of preventive interventions is not always appropriate, which makes it challenging finding out who makes use of the services (especially when they concern universal prevention) and what their effects are.
- Cross-sector interventions, e.g. in COPMI families in which (youth) mental healthcare organisations collaborate with social community teams, are not always allowed to share data, hampering smooth collaboration and early risk identification.

Transferability to other regions:

Estimated transferability maturity: non yet assessed.

The programme's structure is highly transferable because it combines evidence-based interventions with a governance model that can be adapted to local contexts.

Essential prerequisites include long-term commitment from regional stakeholders, cross-sector partnerships, a coordinating backbone organisation and access to monitoring data.

Individual interventions may vary across regions, but the underlying model of collective action, prevention infrastructure and continuous learning can be replicated elsewhere. The Community of Practice approach is particularly relevant for regions seeking to align fragmented prevention activities under a shared mental health strategy.

Dissemination and further information:

Knowledge dissemination is embedded throughout the programme. Findings are shared through regional stakeholder network events, scientific publications and reports, workshops and national and international conferences.

Further information:

[Website](#) - [LinkedIn page](#) - [Reports](#)

Media:

[Website](#) - [Communication Materials](#)

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Population and settings-based prevention



Healthy Neighbourhoods



Key info:

Organisation name:	JOGG
Region:	The Netherlands
Country:	The Netherlands
Practice cooperation partners – International collaboration (e.g., Please indicate any organisations involved in the implementation of the practice, particularly if developed through European collaboration (e.g. Joint Actions, Horizon Europe, Interreg, EU4Health, Erasmus+, etc.). If not applicable, write "N/A".):	Jantje Beton, IVN Natuureducatie

Keywords:

Social cohesion, community empowerment, mental wellbeing, social inclusion, healthy living environments.

Implementation status:

Ongoing implementation of a mental health policy/programme/initiative, Prevention or mental health promotion initiative.

Focus areas:

Mental Health Promotion, Prevention, Psychosocial Support, Social Inclusion, Youth Mental Health, Health Promotion through Healthy Environments, Community Participation and Empowerment, Reducing Loneliness and Strengthening Social Cohesion.

Summary:

Healthy Neighbourhoods is a community-led approach that addresses growing challenges related to mental wellbeing, loneliness, physical inactivity, declining outdoor play and reduced neighbourhood liveability in socio-economically

disadvantaged communities. The programme creates green, inclusive and community-owned public spaces where people can meet, play, move and connect with nature, while simultaneously strengthening social cohesion, health and community resilience.

The primary target groups are children, young people and residents living in neighbourhoods with limited opportunities for outdoor play, social interaction and access to quality green spaces. Municipalities are the key implementation partners, working together with local organisations, such as schools, welfare providers, sports coaches, volunteers and residents.

Healthy Neighbourhoods combines three core themes (play and physical activity, nature and social connection) through a six-step participatory methodology. Children and residents actively contribute to identifying local needs, designing solutions, shaping activities and helping to sustain the neighbourhood after implementation. The approach also promotes collaboration between social and physical policy domains within municipalities.

To date, 43 Healthy Neighbourhoods have been completed, 13 are under development and more are under way across the Netherlands. Independent process evaluations by Vrije Universiteit Amsterdam (2021), DSP-groep (2024) and Ecorys (2025) found that the approach increases resident engagement, strengthens relationships between residents and municipalities, stimulates outdoor play and physical activity, enhances social cohesion and creates greater neighbourhood ownership. The Ecorys Social Cost-Benefit Analysis estimated that every euro invested generates at least €1.50 in societal value when the approach is implemented in neighbourhoods with needs related to green space, social interaction and play.

Healthy Neighbourhoods demonstrates how participatory neighbourhood development can contribute to mental wellbeing, healthier living environments and stronger communities, while supporting municipalities in delivering integrated solutions to complex social, environmental and health challenges.

Description and strategic context:

Healthy Neighbourhoods addresses growing (mental) health and wellbeing challenges in socio-economically disadvantaged neighbourhoods in the Netherlands. In the Netherlands 50% of young people are dissatisfied with their mental health² and 29% experience loneliness³. At the same time, opportunities for outdoor play, physical activity and social interaction are decreasing, especially in lower socioeconomic neighbourhoods. These neighbourhoods usually have fewer green spaces, suffer from neglected maintenance, or have unsafe traffic conditions. For example, more than half of the neighbourhoods in the 32 largest Dutch municipalities are paved over⁴ and this has increased significantly over the past five years. It is especially alarming as nature has a proven positive effect on

(mental) health: it can reduce stress and negative emotions⁵ for both adults and children⁶. Children exhibit less bullying behaviour when they play in nature, which contributes to a more positive social climate⁷. Furthermore, playing in nature encourages children to engage in more active and creative behaviour. This contributes to better motor, cognitive, and emotional development⁸.

Developed with support from the Dutch Ministry of Health, Welfare and Sport (VWS), Healthy Neighbourhoods helps municipalities translate policy ambitions into practical neighbourhood action. Via the Healthy Neighbourhoods approach, we create green, inclusive and participatory public spaces where residents can meet, play, move and connect, in co-creation with children and residents.

Healthy Neighbourhoods supports local, regional and national ambitions on prevention, health equity, healthy living environments, social cohesion and climate adaptation.

Objectives:

Healthy Neighbourhoods addresses growing (mental) health and wellbeing challenges in socio-economically disadvantaged neighbourhoods in the Netherlands. In the Netherlands 50% of young people are dissatisfied with their mental health⁹ and 29% experience loneliness¹⁰. At the same time, opportunities for outdoor play, physical activity and social interaction are decreasing, especially in lower socioeconomic neighbourhoods. These neighbourhoods usually have fewer green spaces, suffer from neglected maintenance, or have unsafe traffic conditions. For example, more than half of the neighbourhoods in the 32 largest Dutch municipalities are paved over¹¹ and this has increased significantly over the past five years. It is especially alarming as nature has a proven positive effect on (mental) health: it can reduce stress and negative

² GGD GHOR, 2024

³ Gezonde Generatie, 2025

⁴ Natuur & Milieu & Sweco Nederland (2024). Tekort aan groen in Nederlandse steden – december 2024. <https://natuurenmilieu.nl/publicatie/tekort-aan-groen-in-nederlandse-steden/>

⁵ Zhang Y, Mavoa S, Zhao J, Raphael D, Smith M. The Association between Green Space and Adolescents' Mental Well-Being: A Systematic Review. *Int J Environ Res Public Health*. 2020 Sep 11;17(18):6640. doi: 10.3390/ijerph17186640. PMID: 32932996; PMCID: PMC7557737.

⁶ McCormick, R. (2017) Does Access to Green Space Impact the Mental Well-being of Children: A Systematic Review, *Journal of Pediatric Nursing*, Volume 37, Pages 3-7, ISSN 0882-5963, <https://doi.org/10.1016/j.pedn.2017.08.027>.

⁷ Vries S. de, Langers, F., Goossen, C.M., Rijn, S.E.M. van, Vlasblom, E., Sterkenburg, R.P., & Pierik, F.H. (2017) Interventiestudie Gezonde Schoolpleinen; Het effect op leerlingen van het herinrichten van schoolplein tot gezond schoolplein. Wageningen, Wageningen Environmental Research, Rapport 2830.

⁸ Maas, J., & Postma, J.A. (2022) Natuur en gezonde leefstijl. De wetenschappelijke onderbouwing van de relatie tussen natuur en gezondheid (Herziene versie). Vereniging Arts en Leefstijl

⁹ GGD GHOR, 2024

¹⁰ Gezonde Generatie, 2025

¹¹ Natuur & Milieu & Sweco Nederland (2024). Tekort aan groen in Nederlandse steden – december 2024. <https://natuurenmilieu.nl/publicatie/tekort-aan-groen-in-nederlandse-steden/>

emotions¹² for both adults and children¹³. Children exhibit less bullying behaviour when they play in nature, which contributes to a more positive social climate¹⁴. Furthermore, playing in nature encourages children to engage in more active and creative behaviour. This contributes to better motor, cognitive, and emotional development¹⁵.

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Healthy Neighbourhoods supports local, regional and national ambitions on prevention, health equity, healthy living environments, social cohesion and climate adaptation.

Target group(s):

The primary beneficiaries of Healthy Neighbourhoods are residents of socio-economically disadvantaged neighbourhoods, with a particular focus on children and young people who have limited access to safe, attractive spaces for outdoor play, physical activity, social interaction and contact with nature. The programme prioritises neighbourhoods where liveability, social cohesion, green space and opportunities for play and recreation are under pressure.

Children and residents are actively involved in designing, developing and maintaining the neighbourhood space, making them both beneficiaries and co-creators of the intervention.

Indirect beneficiaries include municipalities, schools, community organisations, sports and welfare providers, and local environmental groups. These stakeholders benefit from stronger social cohesion, improved community engagement and healthier, more attractive neighbourhoods (Ecorys, 2026). The approach also strengthens collaboration between the social and physical domains within

municipalities and between local services and residents (Ecorys, 2026).

Equity dimension:

Healthy Neighbourhoods is specifically designed to reduce health inequalities by prioritising neighbourhoods facing socioeconomic disadvantage, limited social cohesion, insufficient green space and a lack of quality opportunities for play, physical activity and social interaction. The programme focuses on communities where residents are more likely to experience poorer health outcomes, loneliness and reduced wellbeing.

Equity is embedded in the participatory approach. Children, residents and local organisations are actively involved in identifying needs and co-designing solutions, ensuring that interventions reflect the priorities of the people who use them. Participation activities take place within the neighbourhood itself, making them accessible and familiar to residents. To reach diverse groups, multiple communication channels are used, and materials are adapted when needed, including providing information in different languages.

The approach benefits people of different ages, cultural backgrounds and abilities by creating inclusive spaces that support play, meeting, movement and contact with nature for all generations. Bringing residents together during the design process also encourages mutual understanding and helps balance different needs and perspectives.

By involving schools, welfare organisations, health professionals and other local partners, Healthy Neighbourhoods strengthens relationships between services and residents, supporting community engagement and earlier identification of social and health-related needs.

Methodology and processes:

Healthy Neighbourhoods is a participatory, place-based approach that combines green space, play, physical activity and social connection. The methodology is designed to ensure that neighbourhood improvements are co-created with residents and children and embedded within local

¹² Zhang Y, Mavoa S, Zhao J, Raphael D, Smith M. The Association between Green Space and Adolescents' Mental Well-Being: A Systematic Review. *Int J Environ Res Public Health*. 2020 Sep 11;17(18):6640. doi: 10.3390/ijerph17186640. PMID: 32932996; PMCID: PMC7557737.

¹³ McCormick, R. (2017) Does Access to Green Space Impact the Mental Well-being of Children: A Systematic Review, *Journal of Pediatric Nursing*, Volume 37, Pages 3-7, ISSN 0882-5963, <https://doi.org/10.1016/j.pedn.2017.08.027>.

¹⁴ Vries S. de, Langers, F., Goossen, C.M., Rijn, S.E.M. van, Vlasblom, E., Sterkenburg, R.P., & Pierik, F.H. (2017) *Interventiestudie Gezonde Schoolpleinen; Het effect op leerlingen van het herinrichten van schoolplein tot gezond schoolplein*. Wageningen, Wageningen Environmental Research, Rapport 2830.

¹⁵ Maas, J., & Postma, J.A. (2022) *Natuur en gezonde leefstijl. De wetenschappelijke onderbouwing van de relatie tussen natuur en gezondheid (Herziene versie)*. Vereniging Arts en Leefstijl

municipal structures. The full process typically takes around 18 months and should ideally not exceed two years, as neighbourhood needs and priorities may change over longer periods.

Throughout the entire process, community events and neighbourhood gatherings are organised. These activities help gather ideas and feedback from residents and children while creating opportunities for social interaction and community building.

Historically, municipalities joined the programme through a national funding scheme supported by the Dutch Ministry of Health, Welfare and Sport (VWS), which provided co-funding for physical improvements and process guidance. Today, municipalities can implement the approach independently using a documented six-step methodology, guidance materials, and training programmes, or choose tailored support. Where needed, additional funding opportunities are explored jointly with municipalities to support implementation.

The approach starts with a preparation phase, during which the municipality selects a neighbourhood based on neighbourhood data, resident needs and existing community structures. Funding is secured and a multidisciplinary project team is established, including representatives from the municipality's social and physical domains, local professionals, community organisations and, sometimes, the Healthy Neighbourhoods programme.

Step 1: Discover the neighbourhood

A stakeholder meeting brings together local professionals, key community figures and municipal staff to define roles, opportunities and communication structures. Furthermore, a kick-off informs all residents about the project. Neighbourhood walks are organised with residents and children separately to identify strengths, challenges and opportunities for improvement. These activities help determine the exact location and priorities for the intervention.

Step 2: Dream and design

Residents and children participate in separate co-creation sessions to develop their vision for the location chosen in step 1. An urban designer translates their ideas into a preliminary design that balances community wishes with practical and technical requirements.

Step 3: Present and refine

The preliminary design is presented to residents and children. Feedback is collected and incorporated into a final design, ensuring transparency and shared ownership of the outcome.

Step 4: Mobilise the community

While the municipality prepares procurement, permits and construction activities, the project team works with residents and local partners to develop an activity calendar for the new-designed neighbourhood space. Community events continue during this phase to maintain engagement and strengthen local networks.

Step 5: Build

The drawings come to life. Residents and children remain actively involved through planting days, community events and symbolic construction milestones, reinforcing ownership of the new space.

Step 6: Celebrate

The Healthy Neighbourhood is officially opened with a community celebration, activities and healthy food. The activity programme is launched.

Healthy Neighbourhoods are intended to remain active community spaces. Municipalities retain overall responsibility for maintenance, programming and management, often in partnership with local organisations and residents. Continuous programming and community involvement are considered essential for sustaining health, wellbeing and social cohesion outcomes over time.

Involvement of other organisations/actors:

Co-creation is at the heart of the Healthy Neighbourhoods approach. Children and residents are involved throughout the entire process, from identifying local needs and priorities to designing, refining and activating neighbourhood spaces.

Municipalities are the key implementation partner. They provide leadership, secure resources, connect policy domains and are ultimately responsible for the long-term maintenance and governance of the neighbourhood space. In municipalities that participate through the former subsidy programme or receive support from the Healthy Neighbourhoods programme, implementation is guided by dedicated process facilitators from the cooperation partners Jantje Beton and IVN Natuureducatie. These facilitators support municipalities, connect stakeholders, facilitate participation activities and help apply the methodology effectively. Independent evaluations identified this role as an important driver of progress and collaboration.

A wide range of local stakeholders is involved throughout implementation, either as part of the core project team or through a broader stakeholder network. Key partners typically include community workers, social welfare organisations, youth workers, neighbourhood sports coaches, schools, libraries, community centres, playground associations, nature organisations and housing associations. In addition, key community figures, such as

active residents, informal community leaders and trusted volunteers, play an important role in connecting with residents and sustaining activities after completion.

Together, these partners help reach and engage residents who might otherwise not participate, provide valuable insights into local needs and community dynamics, and contribute to the long-term success of Healthy Neighbourhoods through activities, stewardship and ongoing community engagement.

Funding source(s) and sustainability:

Healthy Neighbourhoods was initially supported through a national funding scheme via the Dutch Ministry of Health, Welfare and Sport (VWS), which co-funded municipal investment in neighbourhood improvements and implementation support. To date, 43 Healthy Neighbourhoods have been completed and 13 are currently under development. Most were realised through this national funding scheme, while additional projects have been financed through external foundations, partnership funding secured by the Healthy Neighbourhoods programme. Today, municipalities are responsible for financing neighbourhood improvements through the Healthy Neighbourhoods approach themselves.

In many cases, funding can be drawn from existing municipal budgets for public space maintenance, urban regeneration, health promotion, climate adaptation, biodiversity, play provision or social cohesion. Because Healthy Neighbourhoods contributes to multiple policy objectives simultaneously, municipalities can align resources from different departments around a shared neighbourhood ambition. This allows the approach to be integrated into regular municipal planning and investment processes.

However, adopting the Healthy Neighbourhoods approach is not always straightforward. The methodology requires cross-sector collaboration, long-term resident participation and integrated working across social and physical municipal departments, which often differs from established municipal procedures and organisational structures. For this reason, external guidance and additional funding can be important catalysts for implementation. Municipalities can access a documented six-step methodology, guidance materials and training programmes, or commission tailored support from the Healthy Neighbourhoods programme through a learning-by-doing approach. The programme also helps municipalities identify and apply for external funding opportunities when needed. Several municipalities have already independently initiated and financed Healthy Neighbourhood projects, while discussions are ongoing with

additional municipalities interested in adopting the approach.

The long-term ambition is for municipalities to use the Healthy Neighbourhoods methodology as a standard approach for neighbourhood regeneration and new urban developments, making healthy, green and socially connected neighbourhoods the norm rather than the exception.

Innovation, Impact and Outcomes:

Healthy Neighbourhoods is innovative because it combines three domains that are often addressed separately (green space, play and physical activity, and social connection) within one integrated, community-led approach. Rather than designing neighbourhood improvements *for* residents, the programme enables children and residents to *co-create* public spaces together with municipalities and local organisations. This participatory process ensures that interventions reflect local needs while simultaneously strengthening ownership, empowerment and community cohesion.

Another innovative aspect is the integration of social and physical policy domains within municipalities. Healthy Neighbourhoods brings together departments responsible for public space, (mental) health, social welfare, sports and community development, creating solutions that address multiple challenges simultaneously, including mental wellbeing, loneliness, physical inactivity, biodiversity and climate adaptation. In this way, the programme operationalises the principle of “(mental) Health in All Policies” by embedding health and wellbeing objectives across multiple sectors and policy domains. In doing so, the programme takes a prevention-oriented approach to mental health by addressing upstream determinants of wellbeing within the living environment, rather than focusing solely on treatment and care.

Over the past eight years, Healthy Neighbourhoods has been developed and evaluated in close collaboration with municipalities, residents, children, community organisations and researchers. To date, 43 Healthy Neighbourhoods have been completed and 13 additional projects are under development.

Research consistently shows positive outcomes. The DSP evaluation (2024) concluded that the strongest impact lies in increased social cohesion: neighbourhoods become busier, residents interact more often, and new social connections emerge. Another important outcome is that children play outside more frequently and spend more time being physically active. Residents also report a stronger sense of ownership and engagement with their

neighbourhood. The scientific process evaluation by the Vrije Universiteit van Amsterdam (2021) found that the approach successfully engages residents and children who were often previously not involved in neighbourhood development. It improved relationships between residents and municipalities, increased participation, revitalised underused public spaces and stimulated outdoor play and movement.

The programme also contributes to healthier and more climate-resilient neighbourhoods through additional green space and biodiversity. According to the Ecorys Social Cost-Benefit Analysis (2025), Healthy Neighbourhoods generates at least €1.50 in societal value for every €1 invested when implemented in neighbourhoods with needs related to green space, social interaction and play. The analysis identified benefits related to health, liveability, physical activity and neighbourhood quality, while noting that several important outcomes, such as improved mental health, social cohesion and climate resilience, could not be fully monetised and therefore are not fully reflected in this ratio.

Together, these findings demonstrate that Healthy Neighbourhoods is an evidence-informed, scalable approach that improves social connectedness, promotes mental wellbeing and creates healthier, greener and more resilient communities.

Evaluations also highlight important implementation challenges, including the time required for meaningful community participation, the need for long-term municipal commitment and the importance of sustainable programming after completion. While some broad wellbeing indicators could not be quantified statistically in the research of the Vrije Universiteit van Amsterdam, multiple qualitative evaluations consistently demonstrate positive effects on community engagement, social cohesion, outdoor play and neighbourhood ownership.

Together, these findings demonstrate that Healthy Neighbourhoods is a scalable approach that improves social connectedness, promotes mental wellbeing and creates healthier, greener and more resilient communities. By increasing social cohesion, reducing loneliness, creating opportunities for physical activity and play, and improving access to green public spaces, Healthy Neighbourhoods strengthens several well-established protective factors for mental health. Rather than addressing mental health problems after they emerge, the programme seeks to create environmental and social conditions that support wellbeing and reduce risk factors for future mental health difficulties at a population level.

Evaluation:

Healthy Neighbourhoods has been evaluated through multiple independent studies focusing on both implementation processes and observed outcomes. To date, no long-term longitudinal studies have been conducted and no formal impact evaluation with pre- and post-measurements has been carried out. It is important to note that it is difficult to evaluate the impact within a neighborhood. A lot of different factors can have an influence and evaluation methods are often not well aligned with practice. Current evidence is therefore primarily based on process evaluations, stakeholder experiences and a societal cost-benefit analysis.

The Vrije Universiteit Amsterdam (2018–2021) conducted a mixed-methods evaluation combining quantitative and qualitative research. While no statistically significant effects were found on broad indicators such as wellbeing and neighbourhood satisfaction, the researchers concluded that the participatory methodology successfully increased resident engagement, strengthened collaboration between residents and municipalities, improved the use of public space and facilitated meaningful involvement of children in neighbourhood development.

In 2024, DSP-groep evaluated eight Healthy Neighbourhoods developed in 2022. The study included desk research, focus groups with process facilitators, neighbourhood visits, interviews with residents, children, professionals and municipal staff, and a focus group with municipalities. Findings showed increased social interaction, stronger community connections, more outdoor play and greater neighbourhood ownership.

In 2025, Ecorys conducted a Social Cost-Benefit Analysis. The study combined desk research, interviews with municipal project leaders, focus groups with residents and interviews with children. The assessment analysed effects related to green space, social connection, participation, play and physical activity, health and neighbourhood liveability. The analysis estimated that, under appropriate conditions, every euro invested generates at least €1.50 in societal value.

Future monitoring priorities include generating more insight into long-term use of Healthy Neighbourhoods, as well as a formal impact evaluation with pre- and post-measurements in collaboration with a research facility or university.

Barriers, enables, and learning points:

CHALLENGES: Implementation of Healthy Neighbourhoods comes with several challenges, many of which stem from its participatory and integrated nature.

A first challenge is balancing meaningful resident participation with municipal procedures and constraints. The approach encourages open dialogue with residents and children, while municipalities must operate within technical, financial and legal frameworks. Participation also requires more time and flexibility than municipalities are often accustomed to, making expectation management essential.

A second challenge is achieving effective collaboration across municipal departments. Healthy Neighbourhoods depends on cooperation between social, health, public space, sports, sustainability and maintenance teams. If key departments are not involved early, feasibility, budgets or commitments made to residents may be affected.

Coordinating Healthy Neighbourhoods with other neighbourhood projects can create synergies, but may also complicate planning and extend timelines, risking a loss of community engagement.

ENABLERS: A key enabler of Healthy Neighbourhoods is its integrated approach. By combining play and physical activity, nature and social connection, the programme addresses multiple policy goals simultaneously, including (mental) health, wellbeing, biodiversity, climate adaptation and social cohesion. This enables municipalities to align budgets, projects and ambitions across domains and supports the principle of (mental) Health in and For All Policies.

A second success factor is the strong partnership between municipalities, local professionals and residents. Municipalities provide leadership and resources, local organisations contribute neighbourhood knowledge and networks, and residents bring lived experience and local priorities. In many projects, dedicated process facilitators from Jantje Beton and IVN Natuureducatie support this collaboration. As external experts, they connect stakeholders, open doors across organisations and policy domains, challenge established ways of working and maintain momentum. Independent evaluations identified this role as an important driver of progress and collaboration.

Resident and child participation is another key enabler. By actively involving end users in the design and development process, Healthy Neighbourhoods strengthens ownership, social cohesion and long-term use of the space.

The combination of physical improvements, community activities and collaborative governance helps transform public spaces into vibrant community assets.

Finally, sustainability is built in from the start through community ownership, local partnerships and integration

into municipal maintenance and management systems, increasing the likelihood of lasting impact.

LEARNING POINTS: One of the most important lessons is that successful implementation starts long before community participation begins. Municipal departments, local professionals and community partners need a shared understanding of the approach, roles and responsibilities. Early alignment helps prevent misunderstandings, delays and unrealistic expectations.

A second lesson is that Healthy Neighbourhoods is not a one-size-fits-all solution. In neighbourhoods facing severe issues such as organised crime, violence or substance abuse, other interventions may be needed before a participatory neighbourhood approach can be successful.

Third, sustainable management and maintenance must be considered from the start. Governance, maintenance, programming and long-term ownership should be agreed upon during the design phase rather than after implementation.

Fourth, evaluations also show that meaningful participation takes time. Building trust, maintaining engagement and managing expectations are often more important than achieving quick results.

Finally, physical redesign alone is not enough. Community activities before, during and after implementation are essential to activate the space and sustain long-term benefits.

Legal and/or ethical issues: N/A

Transferability to other regions:

Transferable with contextual adaptation.

Healthy Neighbourhoods has demonstrated its applicability across a wide variety of urban and suburban neighbourhoods in the Netherlands. The approach is designed as a structured six-step methodology, that allows flexibility to respond to local needs, priorities, demographics and policy challenges. Evaluations consistently show that this balance between a common framework and local tailoring is essential for success.

The methodology can be adapted and replicated by municipalities to strengthen mental wellbeing, social cohesion, outdoor play, physical activity and access to green space. Transferability is facilitated because the approach focuses on processes and partnerships rather than on a predefined physical design. The core principles (resident and child participation, integrated working and community ownership) can be applied in many different settings.

Several prerequisites have been identified. Successful implementation requires commitment from local government, collaboration between social and physical policy domains, involvement of local organisations and sufficient capacity to engage residents throughout the process. Long-term planning for maintenance, programming and governance is also needed from the early stages of implementation.

Transferability is supported by practical implementation tools, including a documented six-step methodology, guidance materials, training programmes and implementation support from the Healthy Neighbourhoods programme in the Netherlands. Eight years of experience, 43 completed Healthy Neighbourhoods and multiple independent evaluations have generated substantial practical knowledge that can support adoption in new regions.

The approach is currently being further embedded within municipalities with the long-term ambition of making Healthy Neighbourhoods a standard way of working for neighbourhood regeneration and new urban developments. This accumulated experience provides a solid foundation for replication in other regions while allowing the necessary adaptation to local contexts.

While further research on long-term outcomes would strengthen the evidence base, existing implementation experience and independent evaluations indicate that the methodology can be successfully adapted and replicated in other regions, provided it is tailored to local contexts and governance structures.

Dissemination and further information:

At present, no peer-reviewed scientific publications on Healthy Neighbourhoods are publicly available. The evidence base currently consists of independent evaluations and reports conducted by Vrije Universiteit Amsterdam, DSP-groep and Ecorys, as well as implementation experience gathered over eight years of practice.

- [Infographic Social Return on Investment by Ecorys](#) (in Dutch)
- [Infosheet impact Healthy Neighbourhoods by DSP-groep](#) (in Dutch)

Full reports and summaries can be made available upon request, as well as the process evaluation infographic by VU Amsterdam (in Dutch).

Media:

- The official Healthy Neighbourhoods website (<https://www.gezondebuurten.nl>) includes more information about the approach and background information and will be expanded with implementation examples and inspiration from our ambassador municipalities (in Dutch).
- [Our Health Neighbourhoods video](#) showcases what Healthy Neighbourhoods look and feel like (in Dutch).
- Photographs and communication materials are available upon request and subject to applicable publication permissions.

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Population and settings-based prevention



The Healthy Primary School of the Future



Key info:

Organisation name:	JOGG, Stichting Gezonde Basisschool van de Toekomst
Region:	The Netherlands
Country:	The Netherlands
Practice cooperation partners – International collaboration (e.g., Please indicate any organisations involved in the implementation of the practice, particularly if developed through European collaboration (e.g. Joint Actions, Horizon Europe, Interreg, EU4Health, Erasmus+, etc.). If not applicable, write "N/A".):	JOGG, Stichting Gezonde Basisschool van de Toekomst

Keywords:

Youth mental health, school health, nutrition, physical activity, bullying prevention

Implementation status:

Ongoing implementation of a mental health policy/programme/initiative, Prevention or mental health promotion initiative.

Focus areas:

Prevention, early intervention, school-based (mental) health promotion, whole school approach.

Summary:

The Healthy Primary School of the Future (HPSF) is an evidence-based whole-school approach that integrates health promotion into the core of primary education to improve children's physical, mental, and social wellbeing while supporting educational outcomes. Developed in the Parkstad Limburg region in the Netherlands, a region characterised by a low social economic status (SES) and substantially higher obesity rates than the national average, HPSF addresses persistent socioeconomic health inequalities by creating school environments where healthy choices become the easy and normal choices for every child.

HPSF combines healthy school lunches, daily structured physical activity, curriculum-based health education, supportive school policies, and strong collaboration

between schools, municipalities, public health services, researchers, and parents. Rather than implementing isolated health interventions, HPSF transforms schools into health-promoting organisations through continuous co-creation, organisational learning, and contextual adaptation.

A comprehensive longitudinal mixed-methods evaluation has demonstrated improvements in children's dietary behaviours, physical activity, body mass index, social climate, and selected educational outcomes, while implementation research has identified the organisational conditions required for sustainable change. The programme has also shown positive effects beyond the school setting by supporting healthier behaviours within families and has demonstrated favourable long-term societal value through health economic analyses.

Building on the strong scientific evidence generated in Parkstad, HPSF is currently being scaled up across the Netherlands through a national implementation programme coordinated by JOGG (Healthy Youth, Healthy Future) in collaboration with Stichting Gezonde Basisschool van de Toekomst, Maastricht University, Gezonde School, the Dutch Nutrition Centre (Voedingscentrum), and Kenniscentrum Sport & Bewegen. Rather than promoting a one-size-fits-all intervention, this national partnership supports municipalities and primary schools in adopting the HPSF principles through tailored implementation pathways, practical tools, online guidance, implementation coaching, and shared learning. The ambition is to enable many more

schools to integrate healthy nutrition, daily physical activity, and wellbeing into the school day, while adapting the approach to local contexts and strengthening equal opportunities for healthy child development nationwide.

Description and strategic context:

The Healthy Primary School of the Future (HPSF) was developed in response to the disproportionately high prevalence of childhood overweight, unhealthy lifestyles, and socioeconomic health inequalities in the Parkstad Limburg region of the Netherlands. Traditional school health programs had achieved only modest and often short-lived effects because they primarily focused on health education without changing the broader school environment. HPSF was therefore designed as a systems-based approach that embeds health promotion into the everyday organisation of primary schools, making healthy behaviour part of normal school life rather than an additional activity.

The program is strategically aligned with the World Health Organisation's Health Promoting Schools framework, the socio-ecological model of health, and contemporary implementation science.

Implementation began in 2015 through a partnership between Maastricht University, regional municipalities, schools, public health organisations, and community partners.

Over the past decade, HPSF has evolved from an innovative regional research project into a recognised implementation framework for sustainable school health promotion. Today, implementation is supported nationally through collaboration with JOGG (Healthy Youth, Healthy Future), Stichting Gezonde Basisschool van de Toekomst, Maastricht University, Gezonde School, the Dutch Nutrition Centre (Voedingscentrum), Kenniscentrum Sport & Bewegen, municipalities, and schools, facilitating wider dissemination and adaptation across the Netherlands.

Objectives:

The overall objective of the Healthy Primary School of the Future (HPSF) is to improve children's physical, mental, and social health by embedding health promotion into the daily routines, culture, and organisation of primary schools. Rather than implementing isolated health interventions, HPSF aims to transform schools into health-promoting environments where healthy choices become the easy and natural choices for every child.

Specific objectives include:

- improving children's dietary behaviours by increasing daily consumption of fruit, vegetables, and water while reducing the intake of sugar-sweetened beverages and unhealthy snacks
- increasing daily moderate-to-vigorous physical activity through structured and enjoyable activities integrated into the school day

- improving children's physical health outcomes, including maintaining a healthy body weight and reducing inequalities in overweight and obesity
- strengthening children's mental wellbeing by promoting self-esteem, social connectedness, emotional wellbeing, executive functioning, and a positive school climate
- enhancing children's health-related quality of life and overall well-being
- reducing socioeconomic inequalities in health by providing universal access to healthy food and physical activity regardless of family background
- supporting schools in developing sustainable organisational capacity for health promotion through long-term collaboration between education, public health, and community partners.

Unlike traditional school health programs that mainly focus on classroom education, HPSF aims to create structural changes in the educational environment. Health promotion is integrated into school policy, pedagogical practice, organisational routines, staff responsibilities, and parental involvement. The long-term ambition is to establish a sustainable whole-school system in which healthy nutrition, physical activity, wellbeing, and learning mutually reinforce each other.

Target group(s):

The primary target group consists of children attending Dutch primary schools (approximately 4–12 years of age), with particular attention to schools located in socioeconomically disadvantaged neighbourhoods where children experience increased risks of unhealthy lifestyles, overweight, obesity, and poorer mental wellbeing.

Indirect beneficiaries include:

- parents and caregivers
- teachers and school leaders
- pedagogical staff
- school support staff
- local municipalities
- public health organisations
- youth health care professionals
- sports and community organisations.

The initial implementation focused on primary schools in the Parkstad Limburg region, one of the most socioeconomically deprived regions of the Netherlands. HPSF was deliberately implemented as a universal intervention rather than targeting only children at increased risk. This universal approach reduces stigma while ensuring that all children benefit from healthier school environments regardless of socioeconomic status, ethnicity, and/or family circumstances.

Schools voluntarily participate following extensive consultation with staff, parents, and local stakeholders.

Equity dimension:

Reducing health inequalities is a core principle of the Healthy Primary School of the Future (HPSF). HPSF was initially developed in Parkstad Limburg, a Dutch region characterised by relatively low socioeconomic status, poorer population health, and higher prevalence of childhood overweight, and obesity compared with the Dutch average. HPSF adopts a proportionate universalism approach by offering healthy lunches, structured physical activity, and health-promoting environments to every child, while particularly benefiting those who have fewer health-promoting opportunities at home. Universal provision prevents stigmatisation and ensures equitable access to nutritious food, physical activity, and supportive social environments.

HPSF recognises that children's health behaviours are shaped by multiple interacting social, environmental, and economic determinants. Consequently, interventions extend beyond health education to modify the school environment, organisational practices, and parental engagement.

Methodology and processes:

The Healthy Primary School of the Future (HPSF) is based on a whole-school systems approach grounded in socio-ecological theory and Health Promoting Schools principles. Rather than introducing a predefined intervention package, HPSF combines evidence-based health promotion with continuous adaptation to local school contexts through a contextual action-oriented research approach.

Implementation started in 2015 in four intervention schools in Parkstad Limburg, the Netherlands. Two schools implemented the full HPSF programme, including a free healthy daily lunch combined with structured physical activity and cultural activities during an extended lunch break. Two additional schools implemented the physical activity component without introducing school lunches. Four comparable schools served as controls for scientific evaluation.

Implementation follows several iterative phases:

Preparation

Schools assess organisational readiness, establish local leadership, engage teachers, parents, and external partners, and identify opportunities and barriers within their specific context.

Co-creation

Researchers, school professionals, municipalities, public health organisations, and parents jointly design implementation strategies. Local ownership is considered essential for sustainable change.

Implementation

Healthy lunches are provided according to national dietary guidelines. In addition, children participate in at least 60 minutes of physical activity. Health is integrated throughout the curriculum, while school policies, food environments, and parental involvement are aligned with healthy lifestyle objectives. Implementation is supported by multidisciplinary collaboration involving education

professionals, pedagogical staff, health promotion experts, youth health care services, municipalities, sports organisations, and policy makers.

Continuous adaptation

Implementation and efficacy in the eight initially participating schools in Parkstad was monitored in a large-scale mixed-method research project. Scientific evaluation used a longitudinal quasi-experimental design combining quantitative outcome measurements with qualitative implementation research. Outcomes included anthropometric measures, dietary behaviour, physical activity, sedentary behaviour, health-related quality of life, psychosocial wellbeing, academic outcomes, implementation fidelity, and organisational change. Continuous feedback between researchers and schools facilitated organisational learning and long-term sustainability.

Involvement of other organisations/actors:

The Healthy Primary School of the Future (HPSF) was developed through intensive cross-sectoral collaboration between education, public health, academia, municipalities, and community organisations. From its inception, the programme has been based on co-creation, recognising that sustainable school health promotion requires shared ownership among all stakeholders.

Primary schools serve as the central implementation setting, with school boards, principals, and teachers taking responsibility for embedding health-promoting practices into daily school routines. Parents are actively involved during the design phase through consultations, information meetings, and formal voting procedures before implementation. Their continued involvement supports healthy behaviours beyond the school environment and strengthens acceptance of organisational changes such as extended school days and healthy school lunches.

Scientific leadership and independent evaluation of the initial research project in Parkstad have been provided by Maastricht University through a multidisciplinary research team with expertise in health promotion, implementation science, behavioural sciences, nutrition, epidemiology, education, and health economics. Researchers worked closely with schools using a contextual action-oriented research approach, enabling continuous adaptation while maintaining scientific rigour.

Regional public health services, municipalities, and youth health care professionals contribute expertise in prevention, health promotion, and policy alignment. Pedagogical professionals can supervise the daily lunch and structured physical activity sessions, ensuring both educational quality and child wellbeing. Sports organisations, cultural partners, and local service providers can support the delivery of physical activity and enrichment activities during the school day.

Over time, implementation has expanded through collaboration with Stichting Gezonde Basisschool van de Toekomst (Foundation Healthy Primary School of the

Future), JOGG (Healthy Youth, Healthy Future), municipalities, educational support organisations, and national health promotion partners. These collaborations have facilitated dissemination, implementation support, and scaling to additional schools and regions.

The program demonstrates how long-term partnerships across traditionally separate sectors can create integrated health promotion systems that are both scientifically robust and practically sustainable.

Funding source(s) and sustainability:

The initial development, implementation, and scientific evaluation of the Healthy Primary School of the Future (HPSF) were supported through a combination of regional governmental funding, research grants, municipal investments, and contributions from public and societal partners. Funding reflected the program's cross-sectoral nature, combining resources from public health, education, research, and regional development.

Implementation required investments in healthy school lunches, additional pedagogical staff, extended school hours, and program coordination. Scientific evaluation was funded separately to ensure independent assessment of implementation processes, effectiveness, and cost-effectiveness.

A defining characteristic of HPSF is its emphasis on organisational sustainability rather than dependence on temporary project funding. Schools progressively integrate health promotion into their regular organisational structures, educational vision, and daily routines. Instead of adding stand-alone health projects, HPSF restructures existing school processes.

Recent implementation research has shown that long-term sustainability depends on adaptive capacity rather than strict adherence to fixed intervention components. Schools continuously modify implementation strategies while preserving the program's core health-promoting principles. Leadership, stakeholder ownership, organisational learning, and stable partnerships have proven more important for sustainability than maintaining identical intervention activities over time.

To support wider implementation, a national implementation team stationed at JOGG provides implementation guidance, practical tools, and quality assurance for participating schools. National collaboration with JOGG and regional authorities further strengthens long-term institutional support.

Economic evaluations suggest that although implementation requires additional short-term investments, potential long-term societal returns include improved child health, reduced healthcare utilisation, enhanced educational outcomes, and lower future costs associated with being overweight and chronic disease. These findings strengthen the case for structural rather than project-based financing.

Innovation, Impact and Outcomes:

The Healthy Primary School of the Future (HPSF) represents an innovative whole-school systems approach that integrates health promotion into the organisational core of primary education. Unlike conventional school health programmes that primarily provide classroom-based health education, HPSF simultaneously changes the physical, social, educational, and organisational environments in which children learn and develop.

Its innovation lies in combining several evidence-based strategies into one coherent system. Daily healthy lunches, structured physical activity, extended lunch breaks, curriculum integration, organisational change, parental involvement, and continuous organisational learning are implemented as mutually reinforcing components rather than isolated interventions.

Equally innovative is the contextual action-oriented research approach that was applied in the initial research project. Instead of testing a fixed intervention under controlled conditions, researchers and practitioners continuously co-created and adapted implementation to local school contexts while maintaining fidelity to core programme principles. This systems perspective acknowledged schools as complex adaptive organisations and has generated valuable implementation knowledge beyond traditional effectiveness research.

Scientific evaluations over multiple years have demonstrated a range of positive outcomes. Children attending full HPSF schools showed significantly healthier dietary behaviours, including increased consumption of fruit, vegetables, and water and reduced intake of sugar-sweetened beverages during the school day. Improvements extended beyond school hours, suggesting transfer of healthy habits into home environments. Longitudinal analyses demonstrated favourable effects on body mass index (BMI), particularly among children attending schools implementing both healthy lunches and structured physical activity. These effects became more pronounced over several years, highlighting the importance of sustained implementation rather than expecting immediate results. Beyond physical health, HPSF contributes to children's psychosocial wellbeing through improved social interaction, inclusive lunch experiences, increased participation, enhanced school climate, and opportunities for positive peer relationships. The program supports socio-emotional development by creating predictable daily routines, strengthening feelings of belonging, and promoting positive interactions between children and adults. Additionally, children and teachers from full HPSF schools experienced a decrease in bullying and conflicts, and children's results on yearly mathematics tests improved after implementation of HPSF.

Implementation research further demonstrated that successful outcomes depend on organisational change rather than intervention fidelity alone. Schools that developed strong leadership, collaborative cultures, and adaptive learning capacities achieved more sustainable implementation over time.

Economic evaluations indicate that HPSF has the potential to generate favourable long-term societal returns through reductions in overweight and chronic disease risk, improvements in health-related quality of life, and possible future gains in educational attainment and labour market participation.

Perhaps HPSF's most important impact is demonstrating that health promotion can become an integral component of high-quality education rather than an additional responsibility placed upon schools. The knowledge generated through nearly a decade of implementation and evaluation has informed regional and national discussions on sustainable school health promotion and continues to support wider dissemination of HPSF throughout the Netherlands.

More information on the results of the initial research project can be found in the various scientific articles on HPSF that have been published and are included in the references section of this document.

Evaluation:

The Healthy Primary School of the Future (HPSF) has been evaluated through a comprehensive longitudinal mixed-methods research program led by Maastricht University. The evaluation combined effectiveness research, implementation science, health economics, and organisational studies to understand not only whether the intervention works, but also how and under which conditions sustainable implementation can be achieved.

The primary effectiveness evaluation used a longitudinal quasi-experimental design involving four intervention schools and four comparable control schools. Data were collected repeatedly over multiple years to assess both short- and long-term effects. Outcome measures included children's dietary behaviour, physical activity, sedentary behaviour, body mass index (BMI), waist circumference, health-related quality of life, psychosocial wellbeing, and selected educational indicators.

Process evaluation was conducted alongside the effectiveness study using interviews, focus groups, observations, implementation logs, and continuous stakeholder feedback. This allowed researchers to monitor implementation fidelity, organisational adaptation, stakeholder engagement, contextual influences, and mechanisms explaining differences between schools.

Additional studies examined cost-effectiveness, organisational learning, adaptive implementation processes, and long-term sustainability. Rather than viewing implementation fidelity as strict adherence to predefined activities, HPSF evaluation increasingly adopted a systems perspective in which successful implementation is assessed by sustained achievement of core health-promoting functions despite local adaptation.

The extensive evaluation programme has generated one of Europe's strongest evidence bases for whole-school health promotion. Findings consistently demonstrate that integrated school health promotion can improve children's

dietary behaviours, increase physical activity, contribute to healthier weight development, and support broader school wellbeing while remaining feasible within routine educational practice. The evaluation also highlights that organisational readiness, leadership, stakeholder ownership, and continuous adaptation are critical determinants of long-term success. More information on the research results can be found in the various scientific articles on HPSF that have been published and are included in the references section of this document.

Barriers, enables, and learning points:

CHALLENGES:

Implementation of HPSF demonstrates that transforming schools into health-promoting organisations requires substantial organisational change rather than merely introducing additional health activities. One of the main challenges is balancing implementation fidelity with adaptation to local school contexts. Schools differ considerably in organisational culture, available resources, leadership capacity, and readiness for change, making identical implementation neither feasible nor desirable.

Introducing healthy school lunches in the Netherlands, where children usually bring their own lunch from home, requires major logistical changes involving food procurement, storage, hygiene procedures, supervision, and scheduling. Reorganising lunch breaks also affects teachers' working routines, contractual arrangements, and classroom planning.

Maintaining long-term stakeholder engagement proves another challenge. Changes affect teachers, parents, children, school boards, and external partners, each with different expectations and priorities. Concerns regarding children's food preferences and organisational changes require continuous communication with parents.

Long-term financing remains an important challenge. Sustainable implementation requires structural rather than temporary funding for program coordination, healthy meals, and physical activity sessions.

ENABLERS:

Several factors consistently facilitate successful implementation of HPSF across participating schools.

- Strong and visible leadership by school principals creates organisational commitment and helps integrate health promotion into the school's educational vision rather than treating it as a temporary project.
- Co-creation with teachers, parents, and municipalities generates shared ownership and increases acceptance of organisational changes. Rather than imposing standardised interventions, implementation strategies are jointly developed and continuously refined.
- Close collaboration between education and public health professionals ensures that health promotion

complements rather than competes with educational objectives.

- The contextual action-oriented research approach adopted in the initial research project proved particularly valuable. Continuous monitoring, reflection, and adaptation enabled schools to respond to emerging challenges without abandoning the HPSF's core principles. Researchers acted as knowledge partners rather than external evaluators only.
- Universal participation strengthens social inclusion and prevents stigmatisation. Because every child participates in healthy lunches and physical activity, health promotion becomes part of normal school life.
- Finally, long-term partnerships between schools, municipalities, Maastricht University, JOGG, Stichting Gezonde Basisschool van de Toekomst, and regional public health organisations creates stable governance structures that support sustained implementation.

LEARNING POINTS: HPSF demonstrates several important lessons for future school health initiatives.

First, sustainable school health promotion requires systems transformation rather than isolated interventions. Changes in school organisation, leadership, culture, and stakeholder relationships are as important as changes in children's behaviour.

Second, implementation should balance evidence-based core principles with local adaptation. Maintaining the program's underlying functions is more important than replicating identical intervention components across schools.

Third, health promotion and education should be viewed as mutually reinforcing objectives. Schools reported that healthier children were generally better able to participate in learning, while positive school climates supported both educational and health outcomes.

Fourth, long-term implementation requires patience. Many organisational changes occurred gradually, while measurable health improvements often became visible only after several years of continuous implementation.

Finally, successful scaling depends on investing in implementation capacity, leadership development, and cross-sector collaboration rather than simply disseminating intervention manuals. Building sustainable local ownership is essential for maintaining program quality over time.

Legal and/or ethical issues: N/A

Transferability to other regions:

Transferable with contextual adaptation.

The Healthy Primary School of the Future (HPSF) has demonstrated considerable potential for transfer to other schools and regions, provided implementation is adapted to local educational systems, governance structures, and

available resources. Research consistently indicates that successful transfer depends less on replicating specific intervention components than on preserving the program's underlying principles of whole-school health promotion, cross-sector collaboration, and continuous organisational learning.

The HPSF model has already informed implementation beyond the original Parkstad Limburg region in the Netherlands, through collaboration with JOGG, Stichting Gezonde Basisschool van de Toekomst, and municipalities across the Netherlands. The program's conceptual framework aligns closely with the World Health Organisation's Health Promoting Schools framework, increasing its relevance for international implementation.

Prerequisites for successful transfer include committed school leadership, long-term political and organisational support, multidisciplinary partnerships between education and health sectors, adequate implementation capacity, and sustainable financing. Active involvement of teachers, parents, and local stakeholders from the earliest planning stages is essential to build ownership and ensure contextual fit.

Rather than transferring a fixed intervention package, HPSF should be regarded as an implementation framework that enables schools to develop locally appropriate solutions while maintaining evidence-based health promotion principles. Supporting tools include implementation guidance, organisational development methods, monitoring instruments, scientific publications, and practical experiences from participating schools.

The extensive scientific evaluation provides a strong evidence base for adaptation in different educational and cultural contexts. Future implementation in other European regions should continue combining rigorous evaluation with local co-creation to ensure both effectiveness and sustainability.

Dissemination and further information:

The Healthy Primary School of the Future (HPSF) has been widely disseminated through peer-reviewed scientific publications, doctoral theses, international conferences, professional workshops, and collaboration with national and regional health promotion networks.

Research findings have been published in international journals covering public health, implementation science, nutrition, school health promotion, and health economics and HPSF has been presented at various (inter)national conferences. Practical implementation knowledge is disseminated through JOGG and Stichting Gezonde Basisschool van de Toekomst, which support schools, municipalities, and policymakers interested in adopting HPSF. Materials, implementation guidance, and practical examples are shared through professional learning networks, dedicated workshops, and the HPSF website.

HPSF continues to contribute to national discussions on sustainable school health promotion and serves as an internationally recognised example of integrating health

promotion into mainstream education through a whole-school systems approach.

Media:

[The official Healthy Primary School of the Future website](#) includes implementation examples, videos, and background information (in Dutch).

Photographs and communication materials are available upon request and subject to applicable publication permissions.

LINKS AND CONTACTS:

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Youth access, transitions and inclusion



Youth Mental Health Hub: An Integrated Early Intervention and Social Prescribing Model for Young People



Key info:

Organisation name:	ASL AT – Local Health Authority of Asti
Region:	Piedmont
Country:	Italy
Practice cooperation partners – International collaboration (e.g., Please indicate any organisations involved in the implementation of the practice, particularly if developed through European collaboration (e.g. Joint Actions, Horizon Europe, Interreg, EU4Health, Erasmus+, etc.). If not applicable, write "N/A".):	Local cooperation partners are being identified and formal agreements are under development. The intended network includes Child and Adolescent Neuropsychiatry (NPI), Adult Mental Health Services, Addiction Services (SERD), primary care, municipalities, social services, schools, vocational and employment services, youth organisations and Third Sector providers. International collaboration: N/A at the current stage.

Keywords:

Youth mental health; integrated care; early intervention; social prescribing; transition to adulthood.

Implementation status:

Practice planned for future implementation, Community-based mental health initiative, Prevention or mental health promotion initiative, Integrated care / cross-sectoral mental health initiative, Practice addressing vulnerable or underserved groups.

Focus areas:

Youth mental health; prevention and early intervention; community-based mental health services; integrated care across NPI, Adult Mental Health and Addiction Services; continuity of care during transition to adulthood; social prescribing; access to services; social inclusion; family support; support for vulnerable and underserved young people.

Summary:

The “Youth Mental Health Hub” is a new community-based integrated care model being developed by the Local Health Authority of Asti for young people aged 16–25 experiencing emerging mental health problems, psychological distress, substance-related risks or complex psychosocial needs. It addresses a critical service gap at the transition between adolescent and adult care, when fragmented pathways, different eligibility rules and multiple referrals can delay support and increase disengagement.

The practice will establish a shared pathway involving Child and Adolescent Neuropsychiatry (NPI), Adult Mental Health Services and Addiction Services (SERD), supported by primary care and community partners. Young people will access a timely multidisciplinary assessment followed by a single, person-centred care plan. Interventions may include psychological and psychiatric care, addiction support,

nursing and educational interventions, family work and coordinated transition between services.

Social prescribing is a core clinical and organisational component. Alongside healthcare interventions, the team will assess social determinants and connect each young person, through supported referral and follow-up, with community opportunities in education, employment, sport, culture, peer support, volunteering and social participation. The purpose is not merely to signpost services but to accompany the young person, verify engagement and incorporate social outcomes into the care plan.

Expected benefits include earlier access, improved continuity and engagement, reduced avoidable emergency department use and hospital admission, better educational and employment participation, stronger social networks and improved wellbeing. A structured evaluation framework will monitor access, timeliness, clinical outcomes, service use, patient-reported outcomes and social-prescribing participation. The model is currently in the design and partnership-building phase.

Description and strategic context:

Mental disorders commonly emerge during adolescence and young adulthood, while service organisation often separates child and adult care during this high-risk developmental period. Young people with overlapping mental health, substance-use and social needs may consequently experience repeated assessments, unclear responsibilities, interrupted care and delayed intervention, contributing to clinical deterioration, disengagement from education or employment, social isolation and avoidable use of emergency services.

The Youth Mental Health Hub establishes a coherent local pathway for people aged 16–25, based on shared responsibility across Child and Adolescent Neuropsychiatry (NPI), Adult Mental Health Services and Addiction Services (SERD). It reflects the person-centred, community-based and recovery-oriented principles promoted by the WHO Comprehensive Mental Health Action Plan and European priorities on prevention, integrated care, health equity and social inclusion. At national level, it aligns with Italy's "National Mental Health Action Plan 2025–2030 (PANSM)", which prioritises early diagnosis, multidisciplinary community teams, integrated health and social care, and continuity during the transition to adult services.

The approach is also consistent with the OECD report *"The Economic Case for Preventing Mental Ill Health"* (2026), which emphasises appropriate governance, workforce organisation, sustainable implementation and cross-sectoral action. Social prescribing translates these principles into practice by integrating community opportunities into individual care plans to promote recovery, autonomy and inclusion.

Objectives:

Overall objective: to establish an accessible, integrated and community-based pathway that identifies and supports

mental health and substance-related needs early among people aged 16–25, while strengthening social inclusion and continuity between adolescent and adult services.

Specific objectives are to:

- create one shared assessment and individualised care plan across NPI, Adult Mental Health and SERD
- reduce delays, duplicated assessments and loss to follow-up during transitions
- provide proportionate, time-limited psychological, psychiatric, addiction, nursing, educational and family interventions
- embed social prescribing in routine care, with supported access to education, employment, sport, culture, volunteering, peer support and other community resources
- monitor engagement with prescribed community activities and their contribution to personal goals
- improve functioning, wellbeing, social connectedness and participation in education or employment
- reduce avoidable emergency department attendance and psychiatric hospitalisation
- develop a documented and transferable implementation model, including governance, pathway, referral criteria and evaluation indicators.

Numerical annual targets will be finalised after baseline mapping and confirmation of staffing and partner capacity.

Target group(s):

Direct beneficiaries are young people aged 16–25 who live in the ASL AT area and present emerging or established mental health difficulties, psychological distress, substance-related risks, functional decline or complex psychosocial needs. Access may follow self-referral, family contact with the young person's agreement, or referral from NPI, Adult Mental Health, SERD, primary care, emergency services, schools, social services or community organisations.

Priority subgroups include young people at transition between child and adult services; those with co-occurring mental health and substance-use needs; young people not in education, employment or training; socially isolated young people; and those facing socioeconomic, family, migration or geographical barriers. Indirect beneficiaries include families and caregivers, professionals, schools and community partners. Final inclusion and exclusion criteria will be agreed through the multidisciplinary governance process, with urgent and specialist pathways maintained where clinically required.

Equity dimension:

The "Youth Mental Health Hub" is designed to reduce inequalities created by fragmented services, complex

referral procedures, stigma, transport difficulties and the cost or limited availability of non-clinical opportunities. A single-entry pathway and active coordination will help young people who might otherwise disengage. Flexible contact methods and community-based appointments will be considered, alongside accessible communication and reasonable adjustments for disability or communication needs.

Assessment will include socioeconomic, educational, occupational, family, housing, cultural and geographical factors. Social prescribing will offer tailored, low-cost or free opportunities and supported participation rather than passive signposting. Partnerships will seek coverage across urban and rural areas of the Asti territory. Monitoring data will be disaggregated, where legally and ethically appropriate, by age, gender, area of residence and relevant vulnerability factors to identify inequities in access, retention and outcomes. Co-design with young people and community actors will help ensure that available activities are acceptable and relevant.

Methodology and processes:

Implementation is planned in six linked stages.

1. Governance and mapping. ASL AT will establish a steering group involving NPI, Adult Mental Health and SERD, map existing pathways and community assets, define responsibilities, referral criteria, escalation routes, consent procedures and a shared minimum dataset.

2. Access and triage. Young people may enter through self-referral or professional/community referral. A designated professional will provide an initial response, followed by multidisciplinary triage assessing symptoms, risk, substance use, functioning, family context, education/employment and social determinants. Urgent presentations will follow established emergency procedures.

3. Shared formulation and care planning. A small multidisciplinary team will agree one individualised plan with the young person. Depending on need, it may include psychiatric assessment, psychological treatment, harm-reduction or addiction intervention, nursing and educational support, family work, physical-health coordination and facilitated transition between NPI and adult services.

4. Social prescribing. Social needs and personal goals will be assessed systematically. A trained link function, delivered by an identified professional or partner, will co-produce a social prescription and provide supported connection to community resources such as sport, arts and culture, learning, volunteering, peer groups, youth activities, employment support and opportunities that reduce isolation. The team will confirm uptake, address practical barriers and review outcomes within the same care plan.

5. Review and transition. The multidisciplinary team will review plans regularly, adapting intensity and coordinating transfer or discharge. Pathways will be time-limited where

appropriate, with relapse-prevention planning and follow-up.

6. Evaluation and improvement. Baseline and follow-up indicators will cover access, timeliness, engagement, clinical and functional outcomes, service use, social participation and experience of care. Detailed staffing, launch date and activity targets remain subject to formal approval.

Involvement of other organisations/actors:

The practice is being designed as a cross-sectoral initiative. Within ASL AT, NPI, Adult Mental Health and SERD will share pathway design, case formulation, operational protocols and clinical governance. Primary care, emergency services and other health services will support identification, referral and continuity.

Municipalities, social services, schools, vocational training providers, employment services, sport and cultural organisations, youth services, peer-support groups and Third Sector organisations will be invited to map community assets and co-design the social-prescribing pathway. Their role will include receiving supported referrals, reducing access barriers, feeding back on participation and contributing to evaluation.

Young people and, where appropriate, families and caregivers will be involved in co-designing access routes, communication materials, outcome measures and the range of acceptable community opportunities. Participation will be voluntary and based on informed consent. Formal partners and governance arrangements are currently being identified; therefore, no organisation is presented as a confirmed partner until agreements are completed.

Funding source(s) and sustainability:

The practice is primarily based on an internal reorganisation of existing services rather than on a substantial increase in structural resources. Sustainability will be pursued by improving coordination between Child and Adolescent Neuropsychiatry (NPI), Adult Mental Health Services and Addiction Services (SERD), clarifying shared priorities and responsibilities, reducing duplicated assessments and fragmented referrals, and making more efficient use of existing professional expertise and service capacity.

This organisational redesign is complemented by funding from Fondazione Compagnia di San Paolo, which supports additional professional resources, particularly psychologists and professional educators. These resources will strengthen the multidisciplinary pathway during its development and early implementation. Its integration into routine ASL AT governance, workforce organisation and service planning is intended to ensure longer-term continuity beyond the funding period.

This approach is consistent with the OECD report “The Economic Case for Preventing Mental Ill Health” (2026), which emphasises that effective interventions must be supported by appropriate governance, workforce and sustainable financing arrangements to achieve impact at

scale. The report also highlights the importance of cross-sectoral action addressing the social and economic determinants of mental health.

Social prescribing therefore represents a further key element of both the model and its sustainability. Rather than creating parallel services, the practice will identify and mobilise existing community assets as therapeutic resources, including educational, cultural, sporting, volunteering, employment-support and social-participation opportunities. Supported referral, active accompaniment and follow-up will integrate these resources into individualised care plans. This approach is expected to broaden the available range of interventions, strengthen recovery, autonomy and social inclusion, and improve outcomes while making efficient and coordinated use of resources already present in the community.

Innovation, Impact and Outcomes:

The “Youth Mental Health Hub” combines four innovations: a continuous 16-25 pathway across the usual child-adult boundary; shared responsibility between NPI, Adult Mental Health and SERD; a single individualised plan for clinical, addiction and social needs; and social prescribing embedded within routine mental healthcare.

Social prescribing is treated as an active intervention rather than a directory or referral list. The young person will identify meaningful goals with the team, receive supported connection to an appropriate community resource, and have participation and outcomes reviewed alongside clinical progress. This creates a bridge between symptom-focused care and the conditions that sustain recovery: education, employment, relationships, identity, autonomy and belonging.

As the initiative is not yet implemented, no outcome claims are made. Expected impacts include earlier and more equitable access; fewer repeated assessments; improved continuity at age-related transitions; better retention in care; earlier recognition of co-occurring substance-use needs; reduced social isolation; improved participation in education, training or employment; and fewer avoidable emergency presentations and admissions.

Planned output indicators include numbers referred, assessed and enrolled; referral sources; response and waiting times; proportion receiving a shared care plan; proportion offered and taking up social prescribing; types of community activity; retention and completion; family involvement; and transitions completed without loss to follow-up. Planned outcome indicators include change in symptom burden, functioning, wellbeing, quality of life and goal attainment; education/employment participation; social connectedness; patient-reported experience; emergency attendance; hospital admission; and equity of access.

The pilot will also examine feasibility, acceptability, professional collaboration and the capacity of community partners. Findings will guide refinement before any wider roll-out.

Evaluation:

A prospective mixed-method evaluation will be embedded from the start. Baseline data will be collected at entry and repeated at agreed review points and discharge, with follow-up where feasible. Final validated instruments will be selected during protocol development and may include brief measures of symptoms, functioning, wellbeing, quality of life, recovery or goal attainment appropriate to age and clinical presentation.

Process indicators will measure referral volume and source, response and waiting times, eligibility, engagement, drop-out, duration and intensity of support, shared care planning, transitions between services and social-prescribing offer, uptake and completion. Outcome indicators will include education/employment status, social participation, emergency department attendance, psychiatric admission and patient- and family-reported experience. Equity analyses will examine variation by age, gender, residence and vulnerability factors where data quality and privacy permit.

Barriers, enables, and learning points:

As the practice is currently in the planning phase, the following barriers, enabling factors and learning points are prospective. They reflect the risks identified during service design, the conditions considered necessary for successful implementation and the principles guiding the development of the model. They should not be interpreted as findings from a completed implementation or evaluation.

CHALLENGES:

- Aligning eligibility, cultures and operational procedures across three services
- Securing protected multidisciplinary time and a clearly accountable coordinating function
- Sharing information lawfully and proportionately across services and external partners
- Avoiding discontinuity at age 18 and loss to follow-up
- Developing sufficient, accessible community opportunities across urban and rural areas
- Ensuring social prescribing is supported and monitored rather than reduced to signposting
- Establishing baseline data and feasible outcome measures before launch

ENABLERS:

- Formal inter-service governance
- A shared protocol, single entry route and named coordinators
- Existing multidisciplinary competencies within ASL AT
- Early co-design with young people, families and community partners
- A maintained community-asset map and agreed feedback routes

- Training in youth-friendly practice, transition, substance use, safeguarding and social prescribing
- Small-scale piloting

LEARNING POINTS:

Key principles identified during the design phase:

- Design the pathway around the young person's goals rather than service boundaries
- Make transition a managed process with shared responsibility, not a referral event
- Treat substance-use and mental-health needs concurrently
- Give social prescribing the same planning, follow-up and outcome discipline as clinical interventions
- Involve community partners before launch and address practical barriers to participation
- Keep the minimum dataset concise and collect baseline information from the first participant.

Legal and/or ethical issues:

The practice will operate within applicable Italian and EU law, including the GDPR and national rules on health data, professional confidentiality and informed consent. Health information will not be disclosed to community organisations unless authorised. Social-prescribing partners will normally receive only the information required to support participation.

Specific procedures will address consent and decision-making for participants aged 16-18, parental or caregiver involvement, safeguarding, suicide and self-harm risk, substance-related risk, emergencies, withdrawal of consent and young people's preferences regarding family involvement. Participation in social prescribing and evaluation will be voluntary and refusal will not affect access

to healthcare. Ethical oversight for service evaluation or research components will be sought as required.

Transferability to other regions:

Transferability requires further validation.

The model is designed for transfer but requires further validation because it has not yet been implemented or evaluated. Its core components are potentially adaptable: a 16-25 pathway; shared governance across child/adolescent mental health, adult mental health and addiction services; one multidisciplinary assessment and care plan; supported transition; embedded social prescribing; and a common evaluation framework.

Dissemination and further information:

As the practice is under development, dissemination activities and dedicated publications are not yet available. Planned actions include accessible information for young people and families, referral guidance for professionals, stakeholder workshops, presentations within ASL AT and to regional networks, and publication of implementation and evaluation findings when available.

Media:

No authorised media materials are currently available. Future materials may include a pathway diagram, youth-friendly information sheet, community-asset map and implementation infographic, subject to ASL AT approval, accessibility review, consent and publication rights.

LINKS AND CONTACTS:

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Youth access, transitions and inclusion



PROVINCIA AUTONOMA DI TRENTO

C.O.P.E. "Capabilities, Opportunities, Places and Engagement"



Key info:

Organisation name:	Autonomous Province of Trento
Region:	Autonomous Province of Trento (Trentino)
Country:	Italy
Practice cooperation partners – International collaboration (e.g., Please indicate any organisations involved in the implementation of the practice, particularly if developed through European collaboration (e.g. Joint Actions, Horizon Europe, Interreg, EU4Health, Erasmus+, etc.). If not applicable, write "N/A".):	EaSI program (Employment and Social Innovation)

Keywords:

Social inclusion; Youth engagement (NEET); Mental health; Community network; Social prescribing.

Implementation status:

The Autonomous Province of Trento has fully implemented the programme on mental health.

Focus areas:

Access to services, psychosocial support, social inclusion, support for vulnerable groups, training of professionals.

Summary:

Problem Identification: Young people who are NEET (Not in Employment, Education, or Training) often face social exclusion, limited access to health and social services, and increased risk of mental health issues. Traditional support systems frequently fail to address their complex and interconnected needs, leaving a gap in preventive and holistic care.

Target Groups: The practice specifically targets young people aged 16–29 in NEET situations across Europe, with a focus on those experiencing social isolation, mental health challenges, or barriers to education, employment, and community engagement.

Objectives:

- Enhance social inclusion and wellbeing of NEET youth
- Improve access to health, social, and community services through tailored interventions
- Foster skills development, social engagement, and personal resilience
- Promote sustainable community networks that support young people's holistic needs.

Methodology: C.O.P.E. employs a social prescribing approach, connecting young people with community-based services and resources through personalized guidance. The methodology is based on:

- Needs assessment to identify individual challenges and aspirations
- Co-designed action plans with each participant, linking them to educational, social, cultural, and health-related activities
- Multidisciplinary support networks, including social workers, educators, and health professionals
- Realist evaluation to measure outcomes and refine intervention strategies.

Results: Preliminary findings from pilot sites indicate:

- Improved mental health and wellbeing among participants
- Increased engagement with educational, vocational, and community opportunities

- Strengthened local service networks and collaboration between sectors
- Evidence that personalized, community-based approaches can reduce social exclusion and support long-term resilience in NEET youth.

Description and strategic context:

Mental Health Problem Addressed: the C.O.P.E. practice targets mental health challenges among young people aged 16–29 who are NEET (Not in Employment, Education, or Training).

These individuals are at higher risk of anxiety, depression, low self-esteem, social withdrawal, and stress due to social exclusion, unemployment, and limited access to support services. The problem is widespread across Europe, affecting an estimated 14% of youth in this age group, with long-term consequences including chronic mental health disorders, educational and employment gaps, and reduced social participation. Addressing these issues is a public health priority because early intervention can prevent long-term psychological, social, and economic costs, while fostering wellbeing and social cohesion.

Strategy Adopted: C.O.P.E. implements a social prescribing and community-based strategy at the European level, linking young people to tailored educational, social, cultural, and health-related activities. The approach combines mental health promotion, prevention, and social integration, emphasizing personalized support, empowerment, and equity. By creating multidisciplinary networks and co-designed action plans, the practice improves access to services, strengthens resilience, and enhances social inclusion, targeting both individual wellbeing and systemic barriers that perpetuate mental health inequalities.

Objectives:

The C.O.P.E. practice is grounded in the social prescribing model and the ecosystem theory of service delivery. Social prescribing is a person-centred approach that connects individuals to non-clinical community resources to improve health and wellbeing (Bertotti et al., 2018; Kimberlee, 2016). The model emphasizes empowerment, co-production, and holistic care, addressing social determinants of mental health such as isolation, unemployment, and lack of educational opportunities.

The practice also draws on realist evaluation theory, which focuses on understanding “what works, for whom, and under what circumstances” (Pawson & Tilley, 1997). This framework guides both the design and assessment of interventions, ensuring they are tailored to local contexts and individual needs.

Evidence supporting the approach includes studies demonstrating that social prescribing improves mental health outcomes, reduces loneliness, and increases engagement with education, employment, and community resources (Bertotti et al., 2025; Cooper et al., 2022). Research on NEET populations shows that integrated, community-based interventions are more effective than

standard services in promoting social inclusion and preventing long-term psychological distress (Farina et al., 2025).

The innovative aspect of C.O.P.E. lies in its ecosystem-based co-creation of support networks. By combining mental health promotion, social integration, and tailored community referrals, the practice moves beyond individual interventions to build resilient local systems. Preliminary evaluations indicate improvements in wellbeing, social participation, and service coordination, highlighting the value of linking multidisciplinary resources with personalized guidance.

Target group(s):

Participants of the Practice: The **primary target** group of the C.O.P.E. practice is young people aged 16–29 who are NEET (Not in Employment, Education, or Training). These are considered the direct beneficiaries, as they receive tailored support through social prescribing, personalized action plans, and access to community, educational, and health resources.

Subgroups of direct beneficiaries include youth experiencing mental health challenges, social isolation, low educational attainment, unemployment, migrants and refugees, and young people with disabilities. Inclusion criteria focus on age (16–29), NEET status, and willingness to engage with the program. Exclusion criteria typically include individuals already engaged in full-time education or employment, or those whose needs require intensive clinical mental health intervention beyond the program's scope.

Indirect beneficiaries include families, caregivers, local service providers, and community organizations. These groups benefit from improved youth wellbeing, strengthened community networks, and more effective coordination of services.

By targeting vulnerable youth and integrating equity considerations (gender, socioeconomic status, geographic location, and cultural background), C.O.P.E. ensures that both direct and indirect beneficiaries experience measurable improvements in mental health, social inclusion, skill development, and community cohesion across local, regional, and European contexts.

Equity dimension:

The C.O.P.E. practice integrates equity at every stage, ensuring that interventions are inclusive, accessible, and tailored to the diverse needs of vulnerable youth. The primary target group—young people aged 16–29 who are NEET—often face compounded disadvantages linked to socioeconomic status, education gaps, unemployment, and social marginalization. Implementation strategies explicitly consider age, gender, and socioeconomic background, ensuring that both young men and women, including those from low-income families or underrepresented communities, can participate. Special attention is given to rural and urban contexts, adapting referral pathways and

community activities to local resource availability. The practice also addresses the needs of vulnerable subgroups, such as migrants, refugees, youth with disabilities, and those experiencing mental health challenges, by providing personalized guidance and culturally sensitive support. Equity is operationalized through co-designed action plans, participatory decision-making, and partnerships with local organizations to reduce barriers to access. By embedding social inclusion, fairness, and diversity into its design and delivery, C.O.P.E. ensures that all participants, regardless of background or circumstances, can benefit from improved mental health, social integration, and empowerment, contributing to a more equitable public health approach at the European level.

Methodology and processes:

The C.O.P.E. practice actively involves participants, stakeholders, and civil society throughout all stages of the intervention, ensuring co-creation, relevance, and responsiveness to local needs. During the development phase, young people in NEET situations contribute through focus groups, interviews, and surveys to identify their priorities, challenges, and aspirations. This input informs the design of social prescribing pathways, personalized action plans, and the selection of community-based services.

Involvement of other organisations/actors:

Relevant stakeholders—including local authorities, schools, health and social service providers, NGOs, and youth organizations—collaborate to map existing resources and define operational procedures. Civil society organizations provide insight into local needs, cultural sensitivities, and equity considerations, ensuring interventions are inclusive and context specific.

In the implementation phase, participants are actively engaged in co-designing their individualized action plans, selecting activities, and choosing community resources.

Stakeholders coordinate service delivery and provide mentorship, guidance, and monitoring of participants' engagement. Civil society partners facilitate access to educational, cultural, and social opportunities, enhancing program reach and relevance.

During monitoring and evaluation, participants provide feedback through structured questionnaires, interviews, and reflective sessions, enabling real-time adjustments.

Stakeholders contribute data on service utilization and outcomes, while civil society organizations support community-level impact assessment. The structure, organization, and content of C.O.P.E. are thus co-established with participants, stakeholders, and civil society. This collaborative approach ensures interventions are tailored to individual and community needs, fostering ownership, empowerment, and sustainability. By embedding participatory mechanisms, C.O.P.E. strengthens trust, engagement, and effectiveness, ensuring both individual outcomes (mental health, skills development,

social integration) and systemic improvements (networked services, equity, and inclusivity) are achieved across the local, regional, and European levels.

Funding source(s) and sustainability:

C.O.P.E. was a project funded by the European Commission under EaSI (European Programme for Employment and Social Innovation), dedicated to the health and social inclusion of NEETs, young people excluded from training, study and employment, running from January 2022 to June 2024, with the involvement of 7 partners from 4 different European countries.

C.O.P.E.+ is the evolution and capitalization of the results achieved during the original European C.O.P.E. project (which concluded in June 2024), officially institutionalized by the Autonomous Province of Trento through Resolution No. 1745 on November 17, 2025. With a planned duration of **3 years** (running until November 2028) and provincial funding of **900,000 Euros** (€300,000 per year), the project aims to transition from an experimental pilot into a structured, sustainable, and replicable service. Moving beyond the original focus restricted solely to NEETs, the new target expands to people experiencing fragility, focusing on improving their mental well-being and social inclusion. The initiative scales up the "Social Prescribing" model across the provincial territory, utilizing trained *Link Workers* who connect vulnerable individuals to community resources through a structured 6-phase operational process overseen by a dedicated Steering Committee (*Cabina di Regia*) and an Operational Core (*Nucleo Operativo*).

Innovation, Impact and Outcomes:

The C.O.P.E. practice reached approximately 1000 young people NEET in Europe, representing diverse backgrounds, including youth from low-income families, migrants, refugees, and young people with disabilities. Recruitment strategies combining community outreach, digital campaigns, and peer referrals were effective in engaging hard-to-reach subgroups.

Observations indicate that the implementation of activities largely followed the planned schedule and structure, with participants attending educational, vocational, cultural, and mental health support sessions as outlined in their personalized action plans. Flexibility in scheduling and adaptation to individual needs ensured high participation and engagement.

Feedback from participants and implementers shows high levels of satisfaction and appreciation. Youth reported increased confidence, social engagement, and access to relevant community resources. Implementers highlighted the benefits of multidisciplinary collaboration and co-designed action plans, while also noting challenges such as coordinating multiple partners and adapting activities for diverse needs.

Overall, anecdotal evidence suggests that the practice is well-received, feasible, and effective in maintaining participant engagement, with strong potential for scaling up

and sustaining impact across different local and regional contexts.

Evaluation:

Available Evidence:

The C.O.P.E. practice is a community-based, social prescribing intervention targeting young people aged 16–29 who are NEET (Not in Employment, Education, or Training). While largescale randomized controlled trials (RCTs) specifically on C.O.P.E. are still in progress, preliminary studies and evaluations provide evidence of its beneficial effects.

- Peer-Reviewed and Project Documentation:
- Bertotti, M., et al. (2025). Social prescribing for young people in NEET situations: A realist evaluation of the C.O.P.E. project in Italy and Portugal. *SSM – Mental Health*, 7, 100440.
- Methodology: Mixed-methods pre-post design evaluating mental health, wellbeing, social inclusion, and engagement in education/employment.
- Results: Significant improvements were observed in mental health scores (GHQ-12), wellbeing (WHO-5), and social participation after 6–12 months. Participants reported higher confidence, motivation to re-engage in education or training, and reduced social isolation.
- Subgroup Effects: Migrants, refugees, and youth with disabilities benefited similarly, demonstrating equity in impact.
- Adverse Effects: No major adverse effects reported; minor challenges included initial stress adapting to new activities.
- Farina, I., et al. (2025). A service ecosystems perspective to explore social prescribing value co-creation for vulnerable young people in NEET situation. *BMC Health Services Research*. Methodology: Realist synthesis and stakeholder evaluation of service delivery and outcomes.
- Results: Co-creation of action plans and community engagement led to increased access to education, vocational training, and social networks. Implementers reported improved coordination across local services, enhancing the holistic impact on participants.

Observational Evidence (for ongoing pilot sites):

Participants demonstrate improved self-confidence, motivation, and engagement in community activities.

- Strong satisfaction from implementers and participants regarding co-designed interventions.
- Recruitment strategies successfully reach vulnerable subgroups, including youth from low-income backgrounds, migrants, and rural areas.
- Challenges include coordinating multidisciplinary teams and adapting interventions to diverse needs, but these have not compromised overall effectiveness.

Cost-Effectiveness: Formal economic evaluation is ongoing. Preliminary observations suggest that social prescribing and community-based interventions can reduce long-term costs associated with mental health deterioration, unemployment, and social exclusion by preventing chronic issues and facilitating re-engagement in education or employment.

Conclusion: The evidence available, including pre-post quantitative assessments and qualitative evaluations, indicates that the C.O.P.E. practice effectively improves mental health, wellbeing, social inclusion, and skill development among NEET youth. While full RCT data are forthcoming, preliminary results demonstrate measurable benefits across direct and indirect beneficiaries and confirm the feasibility, replicability, and scalability of the practice.

Barriers, enables, and learning points:

CHALLENGES:

The C.O.P.E. practice faces several implementation obstacles that may limit its effectiveness if not addressed. Observed barriers include:

- Recruitment and engagement challenges: Some NEET youth are hard to reach due to social isolation, mistrust of institutions, or limited digital access.
- Multidisciplinary coordination: Managing multiple stakeholders (social services, health providers, educators, NGOs) can lead to delays or inconsistent delivery.
- Adaptation to diverse needs: Participants' varying literacy levels, disabilities, or cultural backgrounds require tailored materials and approaches, which can increase resource demands.
- Logistical constraints: Transportation, scheduling, or facility availability may hinder participation.
- Potential harmful effects are minimal but could include temporary stress or anxiety when participants face new social or educational challenges.
- Identification and Mitigation: Obstacles have been identified through staff observations, participant feedback, and ongoing monitoring. Strategies to address them include flexible scheduling, culturally and linguistically adapted materials, peer support networks, and close mentorship by social prescribers. Referral pathways to specialized services ensure that participants with higher mental health needs receive appropriate care.

Through proactive monitoring and adaptive strategies, C.O.P.E. mitigates potential harms while maximizing benefits in mental health, social inclusion, and empowerment for vulnerable NEET youth.

ENABLERS:

The successful implementation and subsequent scaling of the C.O.P.E. practice into the institutionalized C.O.P.E.+ framework was facilitated by several key enabling factors:

- **Political Commitment and Institutionalization:** a decisive factor for scaling up was the formal endorsement by the Autonomous Province of Trento through Resolution No. 1745 (November 2025). Securing a dedicated 3-year provincial budget of €900,000 (€300,000/year) transitioned the project from a time-limited EU-funded experimental pilot (EaSI) into a stable, structured regional service.
- **Robust Governance and Operational Structure:** the establishment of a clear governance model—featuring a dedicated Steering Committee (Cabina di Regia) for strategic direction and an Operational Core (Nucleo Operativo) for daily management—ensured systemic coordination, clear accountability, and smooth cross-sectoral communication.
- **The Role of Trained Link Workers:** the deployment of Link Workers acted as the operational backbone of the social prescribing model. Their specific competencies in social work, youth counselling, and motivational interviewing allowed for high-quality, personalized needs assessments and co-designed action plans.
- **Ecosystem-Based Multi-Stakeholder Network:** the practice thrived due to pre-existing and newly consolidated trusted networks among diverse local actors, including public health authorities (ASUIT), social services, educational institutions, NGOs, and civil society organizations. This cross-sectoral ecosystem optimized resource mapping and streamlined non-clinical referral pathways.
- **Solid Theoretical and Evaluation Framework:** grounding the methodology in established social prescribing models, ecosystem theory, and Realist Evaluation ("what works, for whom, and under what circumstances") provided scientific legitimacy. The availability of peer-reviewed evidence (e.g., Bertotti et al., 2025) and measurable positive outcomes on mental well-being (GHQ-12, WHO-5) crucial for convincing policymakers to fund and expand the initiative.
- **Participant Co-Creation and Flexibility:** actively involving NEET youth and vulnerable individuals in the co-design of their own trajectories fostered high levels of ownership, trust, and empowerment, significantly reducing drop-out rates. The inherent flexibility of the 6-phase operational process allowed the practice to easily adapt to the diverse needs of subgroups (migrants, youth with disabilities, rural populations).
- **Capitalization on European Collaboration:** the initial phase, supported by the European Commission's EaSI program involving 7 partners across 4 countries, provided the necessary space

for cross-border learning, benchmarking, and the development of a comprehensive implementation manual that proved vital for local replication and scaling.

LEARNING POINTS:

The C.O.P.E. practice is designed to be replicable and adaptable across local, national, and European contexts. Core components—social prescribing, co-designed action plans, and ecosystem-based service delivery—are documented in a comprehensive manual, including step-by-step activity descriptions, assessment tools, monitoring templates, and guidance for tailoring interventions to diverse populations.

- Adaptation: Local implementers can adjust recruitment strategies, activity types, and scheduling to fit regional resources, participant demographics, and cultural contexts.
- Equity considerations (e.g., language, disability, migrant status, urban/rural settings) are integrated to ensure accessibility.

Legal, ethical, governance, or data protection issues: N/A

Transferability to other regions:

Easily transferable with minimal adaptation.

Transfer and Scaling: The practice has already been piloted in multiple European countries, demonstrating feasibility in different healthcare, social service, and educational systems. Transfer is supported through:

Training modules for staff and stakeholders.

- Detailed protocols for participant assessment, co-design, and monitoring.
- Guidelines for establishing multidisciplinary partnerships and community engagement.
- Documentation and structured evaluation processes enable future implementers to replicate the practice, measure outcomes, and adapt it sustainably while maintaining fidelity to core objectives. This approach supports scaling and cross-border implementation in diverse European settings.

Dissemination and further information:

The C.O.P.E. practice adopts a multichannel communication strategy to disseminate results to stakeholders, participants, policymakers, and the broader public. Key components include:

- Project Website and Online Platforms: Results, publications, reports, and toolkits are shared on the official C.O.P.E. website (copeproject.eu) and social media channels to reach youth, practitioners, and civil society.
- Scientific Publications and Conferences: Findings are published in peer-reviewed journals and presented at national and European conferences on youth, mental health, and social inclusion.

- Policy Briefs and Reports: Summarized outcomes and recommendations are provided to local authorities, EU policymakers, and funding bodies to inform policy and practice.
- Community Engagement: Local workshops, webinars, and meetings with participants, families, and community organizations ensure results are communicated in accessible formats, fostering awareness, ownership, and replication.
- Media Outreach: Press releases and newsletters highlight key achievements and lessons learned to increase visibility and public engagement.

The strategy emphasizes transparency, accessibility, and equity, ensuring results are available to all stakeholders and

supporting the scaling-up, replication, and sustainability of the practice across European contexts.

<https://copeproject.eu/what-is-cope/>

Media:

<https://drive.google.com/drive/u/1/folders/1VmLTR1iFy4fL5u3Q20DIN72e8rckamhi>

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Youth access, transitions and inclusion



Two Individual Placement and Support (IPS) interventions for young people with mental health problems in Denmark (IPS for Young and the Youth Lift)



Key info:

Organisation name:	DEFACTUM
Region:	Central Denmark Region
Country:	Denmark

Keywords:

Youth mental health, Vocational rehabilitation, Integrated care, social inclusion, Early intervention.

Implementation status:

Ongoing implementation of a mental health policy/programme/initiative, Community-based mental health initiative, Integrated care / cross-sectoral mental health initiative, Practice addressing vulnerable or underserved groups.

Focus areas:

Youth mental health, Early intervention, Community-based mental health services, Integrated care, Access to services, Psychosocial support, social inclusion, Support for vulnerable groups, Workplace mental health, Employment and educational participation.

Summary:

Two Individual Placement and Support (IPS) interventions for young people with mental health problems in Denmark (IPS for Young and the Youth Lift) are national initiatives designed to improve educational and labour market participation among young people experiencing mental health problems.

The interventions address the growing number of young people who are not in education, employment or training (NEET), a group with a high prevalence of mental health problems and an increased risk of long-term social exclusion, unemployment, welfare dependency, and poor health outcomes.

Both initiatives are based on the evidence-based Individual Placement and Support (IPS) model, which integrates

vocational support with mental health and social services. The programmes emphasise rapid engagement in competitive employment or education, person-centred support, and close collaboration between employment specialists, municipalities, and mental health services.

IPS for Young was launched in 2024 and is implemented in 27 municipalities. It targets young people under 30 years with mental health problems who are receiving educational support, unemployment benefits, or participating in rehabilitation programmes. **IPS Youth Lift** was launched in 2025 and is being implemented nationally until 2028. It targets young people aged 15–29 years with mental health problems and weak attachment to employment or education.

The overall objective is to support young people in achieving and sustaining participation in education or employment while strengthening social inclusion and long-term well-being. The interventions are implemented through cross-sectoral collaboration between labour market services, mental health services, and social services, making them an example of integrated and community-based mental health support.

As implementation is ongoing, final outcomes are not yet available. However, the initiatives build on a strong international evidence base for IPS and represent one of the largest national investments in vocational and educational support for young people with mental health problems in Denmark.

Description and strategic context:

Mental health problems among young people have become an increasing public health and social policy concern in Denmark. Young people experiencing mental health

problems are disproportionately represented among those who are not in education, employment or training (NEET) and face elevated risks of long-term exclusion from both the labour market and society.

To address these challenges, the Danish Government has made substantial investments in Individual Placement and Support (IPS) for young people through the initiatives IPS for Young and IPS Youth Lift. The interventions reflect a strategic shift towards earlier, community-based and recovery-oriented support that combines mental health, educational, and employment services.

The initiatives align with national priorities aimed at improving labour market participation, reducing social exclusion, and strengthening support for vulnerable young people. They are also consistent with broader European priorities related to mental health promotion, social inclusion, early intervention, integrated care, and participation in education and employment for people with mental health problems.

By integrating employment and educational support with mental health and social services, the initiatives seek to address both the health and social determinants of mental well-being.

Objectives:

Overall objective

To improve educational participation, employment outcomes, and social inclusion among young people with mental health problems through implementation of the Individual Placement and Support (IPS) model at scale across Denmark.

Specific objectives

- To support young people with mental health problems in obtaining and maintaining competitive employment, education, or training opportunities.
- To reduce the proportion of young people who are not in education, employment or training (NEET).
- To provide personalised and recovery-oriented vocational support based on individual preferences, resources, and goals.
- To strengthen collaboration between municipalities, employment services, mental health services, and social support providers through an integrated care approach.
- To improve access to evidence-based vocational rehabilitation for young people experiencing mental health problems or psychological distress.
- To promote long-term labour market attachment, educational attainment, and social participation.
- To support municipalities in implementing IPS with high fidelity while allowing adaptation to local contexts and needs.
- To generate knowledge on implementation, effectiveness, and sustainability that can inform

future policy development and scaling of integrated mental health and employment services.

The intended beneficiaries are young people aged 15–29 years with mental health problems who experience difficulties accessing or maintaining participation in education and employment. By addressing both vocational and mental health-related barriers simultaneously, the interventions aim to improve well-being, increase opportunities for independent living, and reduce long-term social and economic inequalities.

Target group(s):

The **direct beneficiaries** of the practice are young people with mental health problems who experience difficulties participating in education, employment, or training.

IPS for Young targets young people aged under 30 years who are not in education, employment, or training (NEET) and who receive educational support, unemployment benefits, or participate in rehabilitation programmes. Participants include both young people receiving treatment in regional mental health services and young people experiencing psychological distress who receive support through municipal social psychiatry or other support services.

IPS Youth Lift targets young people aged 15–29 years with mental health problems and weak attachment to education or employment. The target group includes social benefit recipients, young people without a job or education, and young people working part-time up to 18 hours per week. Participants may be receiving support from mental health or social psychiatry services but can also be young people with mental health-related challenges who are not currently engaged with these services.

Indirect beneficiaries include families, employers, educational institutions, municipalities, mental health services, and local communities, which may benefit from improved social inclusion, reduced welfare dependency, and stronger labour-market participation among vulnerable young people.

Equity dimension:

The interventions are specifically designed to address inequalities experienced by young people with mental health problems, a group that faces substantial barriers to educational attainment, employment, and social participation.

IPS Young and IPS Youth Lift apply a **person-centred approach**, where support is tailored to the individual's preferences, abilities, goals, and support needs rather than being determined by diagnosis, work readiness, or expected employability. Eligibility is based on willingness to participate rather than on predefined thresholds of functioning.

The programmes support a diverse population, including young people with severe mental disorders, young people experiencing psychological distress, young people receiving social benefits, and young people with limited attachment to the labour market or educational system. By integrating

employment, educational, health, and social services, the interventions seek to reduce structural barriers that disproportionately affect vulnerable groups.

The nationwide implementation of IPS Youth Lift also aims to improve equitable access to evidence-based support across municipalities and geographical areas. At the same time, local adaptation allows municipalities to address specific contextual needs while maintaining fidelity to the core IPS principles.

Methodology and processes:

IPS Young and IPS Youth Lift are implemented using the Individual Placement and Support (IPS) model, an evidence-based approach originally developed for adults with severe mental disorders and subsequently adapted to support both employment and educational participation among young people.

The IPS model is based on the principle that people with mental health problems can successfully participate in competitive employment or education when provided with appropriate, individualised support. The interventions follow the IPS "place-then-support" approach, where participation in employment or education is pursued as early as possible, followed by ongoing support tailored to the individual's needs.

Implementation is organised through collaboration between municipalities, employment services, mental health services, social psychiatry services, educational institutions, and employers. Each participating municipality identifies eligible young people and provides access to IPS support.

Young people are supported by specially trained IPS consultants, who work closely with participants to identify educational or employment goals, develop opportunities based on individual preferences, facilitate contact with employers or educational institutions, coordinate relevant services, and provide ongoing support before and after placement.

National implementation is supported by IPS ambassadors, who provide training, supervision, quality assurance, and guidance to municipalities. Their role is to strengthen fidelity to the IPS model while supporting implementation in diverse local contexts.

Both initiatives are based on eight core IPS principles, including competitive employment or education as the primary goal, integration of vocational and mental health services, rapid engagement, personalised support, and time-unlimited follow-up.

IPS Young is implemented from 2024 to 2027 in 27 municipalities, while IPS Youth Lift is being rolled out nationally from 2025 to 2028. Although the initiatives differ in eligibility criteria and scale, both apply the same core methodology and share the objective of promoting long-term participation in employment and education among young people with mental health problems.

Involvement of other organisations/actors:

The design and implementation of IPS Young and IPS Youth Lift involve collaboration across multiple sectors and levels of governance. The initiatives were developed by the Danish Government and the Danish Agency for Labour Market and Recruitment (STAR) in response to growing concerns about mental health problems and labour-market exclusion among young people.

Implementation is carried out by municipalities in collaboration with regional mental health services, social psychiatry services, educational institutions, employers, and employment services. Municipalities are responsible for identifying eligible participants and organising local IPS services, while regional mental health services and social psychiatry services contribute clinical expertise and coordinated support. Educational institutions and employers play a central role in creating opportunities for participation in education and employment.

National implementation is supported by IPS ambassadors, who provide training, supervision, quality assurance, and implementation support to participating municipalities. IPS consultants work directly with young people and act as a key link between participants, services, employers, and educational institutions.

Young people receiving IPS support are actively involved in defining their own goals and pathways through a person-centred approach. Their preferences regarding employment, education, and support needs guide intervention planning and service delivery. The IPS model is based on shared decision-making and individual choice, ensuring that service users play a central role throughout the intervention process.

The initiatives also involve ongoing dialogue between municipalities, national authorities, and practitioners to support learning, implementation, and continuous improvement.

Funding source(s) and sustainability:

IPS Young and IPS Youth Lift are publicly funded national initiatives supported by the Danish Government through dedicated funding administered by the Danish Agency for Labour Market and Recruitment (STAR).

IPS Young was launched in 2024 as a time-limited national initiative implemented in 27 municipalities, while IPS Youth Lift was established as a larger national investment aimed at extending access to IPS-based support for young people across Denmark. Municipalities receive funding to recruit and train IPS consultants and to establish the necessary organisational structures to deliver the intervention according to IPS principles.

The initiatives are designed to strengthen collaboration between employment services, mental health services, social psychiatry services, and educational institutions. This integration increases the likelihood that successful components can be embedded within existing municipal and regional service structures beyond the initial funding period.

Long-term sustainability will depend on demonstrated effectiveness, implementation fidelity, local organisational capacity, and political priorities. To support future decision-making, comprehensive evaluations are being conducted to assess implementation, effectiveness, and cost-effectiveness. Evidence from these evaluations will inform decisions regarding continuation, adaptation, and potential permanent integration of IPS approaches within Danish employment and mental health services.

The use of established municipal and regional service infrastructures, combined with national implementation support, strengthens the potential for sustainable scale-up and long-term system integration.

Innovation, Impact and Outcomes:

The most innovative aspect of IPS Young and IPS Youth Lift is the large-scale implementation of an evidence-based supported employment model for young people with mental health problems within routine public services. While Individual Placement and Support (IPS) has traditionally been targeted towards adults with severe mental disorders, the Danish initiatives adapt and scale the approach for a broader population of young people experiencing mental health challenges and difficulties participating in employment or education.

A second innovative feature is the integration of services across sectors that traditionally operate separately. The initiatives bring together employment services, educational institutions, mental health services, social psychiatry services, and community-based support around the goals and preferences of the individual young person. This integrated approach addresses the complex and interconnected barriers that often contribute to long-term exclusion from education and employment.

The initiatives also represent one of the largest national investments in IPS implementation for young people in Europe. IPS Youth Lift in particular aims to make IPS-based support available across all Danish municipalities, allowing evidence-based vocational rehabilitation to reach a much broader population than previous programmes.

The intended outcomes include:

- Increased participation in competitive employment.
- Increased participation in education and training.
- Reduced time spent outside employment and education (NEET).
- Improved social inclusion and community participation.
- Stronger collaboration between employment, education, health, and social care services.
- Reduced long-term welfare dependency.
- Improved long-term labour-market attachment and educational attainment.

At the time of submission, implementation is ongoing and comprehensive outcome data are not yet available. However, the initiatives build on a strong international evidence base. Multiple randomised controlled trials and

systematic reviews have demonstrated that IPS is more effective than traditional vocational rehabilitation approaches in helping people with mental health problems obtain competitive employment. More recent evidence suggests that IPS can also improve employment outcomes among young people and support transitions into education.

To strengthen the evidence base for large-scale implementation, Denmark has launched a nationwide evaluation programme examining reach, implementation, effectiveness, and cost-effectiveness. The evaluations will generate knowledge about how IPS performs under real-world conditions and across different municipal contexts, providing valuable evidence for future policy and practice both within Denmark and internationally.

Beyond individual outcomes, the initiatives have the potential to contribute to broader societal goals, including improved mental well-being, reduced social inequalities, increased workforce participation, and more integrated support systems for vulnerable young people.

Evaluation:

A comprehensive evaluation programme has been established alongside the implementation of IPS Young and IPS Youth Lift. The evaluation is designed to generate evidence on implementation, effectiveness, and cost-effectiveness under real-world conditions and to support future decisions regarding continuation and scale-up.

The evaluation combines national administrative register data, municipal implementation data, and survey data from IPS ambassadors and IPS consultants. Four complementary studies are being undertaken.

First, an implementation study examines reach, adoption, fidelity, and variation in local implementation practices across municipalities. Second, an effectiveness study evaluates IPS Young. Third, a separate effectiveness study evaluates IPS Youth Lift. Both effectiveness studies assess participants' attachment to employment and education using indicators such as NEET status (not in education, employment or training) and cumulative time spent in NEET status during follow-up. Finally, a societal economic evaluation assesses costs and benefits related to healthcare use, welfare benefits, education, and labour market participation.

The evaluation uses natural experimental methods, taking advantage of differences in implementation timing, eligibility criteria, and municipal participation. This approach enables assessment of outcomes in routine practice settings where randomised controlled trials are not feasible.

As implementation is ongoing, final results are not yet available. Findings will be used to inform municipalities, national authorities, and other stakeholders about how IPS can be implemented effectively and sustainably for young people with mental health problems.

Barriers, enablers, and learning points:

CHALLENGES:

Young people with mental health problems often face multiple and interconnected barriers related to health, education, employment, housing, and social participation, requiring coordinated support across sectors.

- IPS Young and IPS Youth Lift are implemented within a decentralised municipal system, resulting in variation in organisational structures, local priorities, available resources, and implementation capacity.
- Establishing effective collaboration between employment services, mental health services, social psychiatry services, and educational institutions can be time-consuming and resource intensive.
- Recruitment and retention of qualified IPS consultants and ensuring ongoing training and supervision may be challenging, particularly in smaller municipalities.
- Maintaining high fidelity to the IPS model while allowing adaptation to local settings requires continuous monitoring and support.
- As implementation is ongoing, municipalities are at different stages of maturity and experience with IPS.

ENABLERS:

- Strong national political commitment and dedicated government funding have provided a supportive framework for implementation.
- IPS is supported by a substantial international evidence base, increasing confidence among decision-makers and practitioners.
- The use of clearly defined IPS principles provides a common framework across municipalities while still allowing local adaptation.
- IPS ambassadors provide training, supervision, implementation support, and quality assurance, facilitating consistency and knowledge sharing.
- Close collaboration between municipalities, regional mental health services, social psychiatry services, employers, and educational institutions supports integrated service delivery.
- The person-centred nature of IPS helps ensure that support is aligned with the goals and preferences of young people, enhancing engagement and motivation.
- Existing Danish administrative data systems make it possible to monitor implementation and evaluate outcomes at population level.

LEARNING POINTS:

- Successful labour-market and educational inclusion for young people with mental health problems requires coordinated action across health, social, educational, and employment sectors.

- Evidence-based models developed for adults can be successfully adapted for younger populations when implementation is supported by appropriate training, supervision, and local partnerships.
- National implementation strategies benefit from combining standardised core principles with flexibility for local adaptation.
- Early engagement in education or employment may serve as an important component of recovery and social inclusion for young people with mental health problems.
- Building sustainable partnerships between municipalities, mental health services, employers, and educational institutions is essential for long-term success.
- Embedding evaluation from the outset provides valuable information for continuous improvement, accountability, and future scale-up.
- Large-scale implementation offers important opportunities to understand how evidence-based mental health interventions perform in routine practice and across diverse local contexts.

Legal and/or ethical issues:

IPS Young and IPS Youth Lift are implemented within existing Danish health, social, and employment service systems and are therefore subject to the legal and governance frameworks that regulate these sectors. Participation in the interventions is voluntary and based on the individual's willingness to engage in employment or education support.

Service delivery involves collaboration across municipalities, employment services, mental health services, and social psychiatry services. Information sharing and coordination are conducted in accordance with applicable Danish legislation and data protection requirements.

Implementation follows established IPS principles and national guidance provided by the Danish Agency for Labour Market and Recruitment (STAR) and IPS ambassadors. Municipalities are responsible for ensuring appropriate governance, quality assurance, and adherence to relevant legal obligations.

The evaluation of the initiatives is conducted separately from service delivery and uses secure administrative register data in accordance with Danish data protection legislation, ethical requirements, and institutional governance procedures. Results are reported only in aggregated form to protect confidentiality and privacy.

Transferability to other regions:

Estimated transferability maturity: Transferable with contextual adaptation.

IPS is an internationally recognised and evidence-based model that has been successfully implemented in a wide range of countries and service settings. The Danish initiatives demonstrate how IPS can be adapted and scaled

for young people with mental health problems within a publicly funded welfare system while maintaining the core IPS principles.

The approach is likely to be transferable to other regions seeking to strengthen labour-market participation, educational engagement, and social inclusion among young people with mental health challenges. However, implementation should be adapted to local governance structures, labour-market conditions, mental health systems, benefit systems, and available support services.

Several factors support transferability:

- The intervention is based on a well-established IPS methodology with internationally available manuals and implementation resources.
- The model emphasises person-centred support rather than diagnosis-specific treatment approaches.
- The intervention can be integrated into existing employment, education, and mental health services.
- National training, supervision, and fidelity support mechanisms can be replicated in other regions.

Key prerequisites include political commitment, cross-sectoral collaboration, trained IPS professionals, sustainable funding, and mechanisms for monitoring implementation fidelity and outcomes. Regions intending to adopt a similar model would benefit from implementation guidance, training programmes, IPS manuals, fidelity tools, and opportunities for knowledge exchange with experienced implementation sites.

The ongoing Danish evaluations will generate additional evidence regarding implementation, effectiveness, and cost-effectiveness that may further support adaptation and scaling in other European regions.

Dissemination and further information:

IPS Young and IPS Youth Lift are supported by national dissemination activities led by the Danish Agency for Labour Market and Recruitment (STAR), participating municipalities, and IPS implementation networks. Information about the initiatives is shared through official government websites, guidance documents, webinars, workshops, and professional networks.

A comprehensive research programme is currently evaluating implementation, effectiveness, and cost-effectiveness of both initiatives. Findings will be disseminated through scientific publications, conference presentations, policy briefs, stakeholder reports, and professional seminars targeting municipalities, employment services, mental health services, and decision-makers.

The initiatives are also expected to contribute to knowledge exchange within European networks concerned with mental health, employment, social inclusion, and integrated care.

Further information is available through:

- The Danish Agency for Labour Market and Recruitment (STAR)
- IPS Young (IPS for unge)
- IPS Youth Lift (Ungeløftet)
- National IPS implementation networks and training activities

Ongoing evaluation reports and scientific publications as they become available.

Media:

LINKS AND CONTACTS:

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Youth access, transitions and inclusion



Alternatives to Admission Programme for Children and Young People



Key info:

Organisation name:	Welsh Government
Region:	Pan-Wales
Country:	Wales
Practice cooperation partners – International collaboration (e.g., Please indicate any organisations involved in the implementation of the practice, particularly if developed through European collaboration (e.g. Joint Actions, Horizon Europe, Interreg, EU4Health, Erasmus+, etc.). If not applicable, write "N/A".):	NHS Wales, Third Sector Partners – Adferiad, Plattform

Keywords:

Youth mental health, community-based, early intervention.

Implementation status:

Pilot or promising practice currently being tested, community-based mental health initiative, prevention or mental health promotion initiative

Focus areas:

This is a pilot project that focuses on early intervention and community-based mental health support to children and young people as an alternative to admission to emergency departments and hospital-based settings.

Summary:

A variety of service models have been developed by health boards as pilots, extending mental health provision for young people in crisis. These are offering either Sanctuary-based services, or intensive community treatment services, or both. The pilots have been commissioned in each of the seven health boards across Wales and were initially planned to run for two years with an evaluation. This has now been extended for a further year until 2027, and health boards will work together and with NHS Joint Commissioning Committee, NHS Performance and Improvement, Welsh Government and Royal College of Psychiatrists on how the

services can be integrated into the Open Access Model being developed.

Description and strategic context:

The aim of the pilot project is for more children and young people to receive mental health support in their own community and to provide a broader range of alternatives to admission to hospital. This is outlined in our Mental Health Strategy 2025-2035 [Mental health and wellbeing strategy 2025 to 2035 | GOV.WALES](#) and our fourth vision statement: there are seamless mental health services – person-centred, needs led and guided to the right support first time, without delay. This outlines work that supports the delivery of mental health services in the context of 'A Healthier Wales' [A healthier Wales: long term plan for health and social care | GOV.WALES](#), creating a clear plan for services to work together to meet growing mental health needs, deliver therapeutic care, with a focus on early intervention, more support in the community and alternatives to hospital admission.

Objectives:

Overall objectives: The NHS Wales Alternative to Admission Programme for Children and Young People has been commissioned to:

- Provide alternative safe spaces to undertake health and social care assessments for children and young people
- Mitigate the need to undertake assessments in busy emergency departments/ adult section 136 suites/ adults assessment wards
- Support children and young people to reduce, manage and cope with immediate distress, anxiety and stress
- Build the evidence base to understand the optimum service to meet the needs of children and young people in crisis
- Provide access to compassionate and experienced staff who will listen and provide information and assistance
- Connect children and young people to appropriate community support

Target group(s):

Direct beneficiaries: The focus of the pilot projects has been for children and young people. Eligibility to the pilots has been varied as they test different models, however in general this has been for those aged between 12-18 years.

Equity dimension:

The programme seeks to reduce inequalities in access to crisis mental health support for children and young people by providing community-based alternatives to emergency departments and inpatient settings. Traditional crisis pathways can be particularly challenging for young people, those from rural communities, neurodivergent children and young people, and those experiencing socioeconomic disadvantage. The pilots offer a range of locally tailored responses, including crisis sanctuaries, intensive home treatment and outreach approaches, enabling support to be delivered closer to home and within familiar environments. Services have also sought to improve accessibility through co-produced, youth-friendly environments and by working alongside families, carers, education services and community organisations. Ongoing development aims to further reduce exclusion criteria and improve access for young people with complex presentations, including those with co-occurring conditions and those transitioning between child and adult services.

Methodology and processes:

The Alternatives to Admission Programme was commissioned by NHS Wales Joint Commissioning Committee and implemented across all seven health boards in Wales. Each health board was provided with flexibility to develop local models that respond to population need while meeting the overarching objective of reducing unnecessary attendance at emergency departments and admissions to hospital.

Models developed include community sanctuaries, crisis hubs, assertive outreach services and intensive home treatment teams. Referrals are generally received through

CAMHS crisis pathways, emergency departments, 111 Press 2, single points of access, community mental health services and other health and care professionals. Following assessment and risk triage, children and young people are offered timely interventions in the most appropriate setting. Core components of the programme include psychosocial assessment, safety planning, emotional regulation support, brief therapeutic interventions, family engagement, signposting and onward referral to specialist or community services where required. Services utilise multidisciplinary teams including mental health nurses, psychiatrists, psychologists, therapists, assistant practitioners and third-sector partners. Many services provide flexible support over several days or weeks, with some offering extended opening hours and overnight provision where required.

A key feature of implementation has been co-production. Young people and families have been involved in service design, including the development of therapeutic environments, furnishing choices and service models. Services are also increasingly aligning with wider developments in crisis care, including NHS 111 Press 2 and the wider Open Access Model being developed across Wales. Evaluation data is collected locally and nationally to inform future service design and commissioning decisions

Involvement of other organisations/actors:

In three health boards (Cardiff & Vale, Swansea Bay, and Hywel Dda University Health Boards) third sector partners have been commissioned to provide services. These partners are Platform, Adferiad and Mind Cymru. Almost every board involved young people and carers in the design phase, from selecting furniture to choosing colour schemes.

A key feature of implementation has been co-production. Young people and families have been involved in service design, including the development of therapeutic environments, furnishing choices and service models. Services are also increasingly aligning with wider developments in crisis care, including NHS 111 Press 2 and the wider Open Access Model being developed across Wales. Evaluation data is collected locally and nationally to inform future service design and commissioning decisions.

Funding source(s) and sustainability:

The programme has been funded through Welsh Government investment and commissioned through the NHS Wales Joint Commissioning Committee. Funding was initially provided as a two-year pilot programme across all health boards, enabling the development and testing of a range of service models designed to provide alternatives to hospital admission.

The programme has subsequently been extended for a further year until 2027, reflecting continued commitment to evaluating effectiveness and identifying sustainable approaches. Future sustainability is expected to be supported through integration of successful elements into

wider regional mental health pathways and the emerging Open Access Model for Mental Health in Wales.

Long-term sustainability will depend on continued partnership working between Welsh Government, NHS Wales, health boards, third-sector organisations and local services, alongside development of a stronger national evidence base demonstrating impact on admissions, emergency department attendance and service user outcomes.

Innovation, Impact and Outcomes:

The programme represents an innovative approach to supporting children and young people experiencing mental health crisis through community-based, youth-friendly alternatives to hospital settings. Rather than relying solely on emergency departments and inpatient care, health boards have developed a diverse range of models including intensive home treatment, crisis sanctuaries, crisis hubs, outreach services and therapeutic community environments.

A significant innovation is the co-production of service environments with young people and carers. Services have intentionally moved away from traditional clinical settings and created welcoming spaces designed to reduce distress and stigma. Examples include themed rooms, creative spaces, living walls, bespoke artwork and environments specifically designed to support de-escalation and recovery.

The programme has demonstrated positive outcomes for children and young people, families and services. Case studies show reductions in repeated crisis presentations, avoidance of hospital admissions, improved emotional regulation, strengthened family relationships and improved engagement with education and community supports. Young people and families consistently report feeling listened to, supported and more comfortable receiving care in community settings than hospital environments.

The review also identified improved alignment with early intervention and crisis access pathways, particularly NHS 111 Press 2, highlighting opportunities for further integration across Wales' mental health system.

Evaluation:

The programme is subject to ongoing evaluation. The Royal College of Psychiatrists Wales was commissioned to undertake a national review covering activity from May 2024 to September 2025. The review examined service profiles, implementation approaches, referral pathways, case studies and emerging outcomes across Wales.

Evaluation has combined quantitative and qualitative approaches, including service activity data, service-user feedback, outcomes measures and case-study evidence. Measures used across some services include reductions in emergency department attendance, hospital admissions, use of crisis services and improvements in functioning such as Children's Global Assessment Scale (CGAS) scores.

The review identified a need for greater consistency in outcome measurement and data collection across Wales. It recommends the adoption of enhanced local and national evaluation approaches, including Interrupted Time Series Analysis, to better understand the impact of alternatives to admission on emergency department presentations, admissions and wider service utilisation. Further evaluation will continue throughout the extended pilot period and inform future commissioning decisions.

Barriers, enables, and learning points:

CHALLENGES:

- Significant variation emerged between local service models, referral pathways, exclusion criteria and outcome measures.
- Some services experienced challenges relating to medical cover and clinical support arrangements.
- Inconsistent data collection limited opportunities for direct comparison across Wales.
- Existing exclusion criteria may unintentionally restrict access for some high-need groups, including young people with complex presentations and co-occurring conditions.
- Workforce recruitment and sustainability remain ongoing considerations for service development.

ENABLERS:

- Strong national commissioning support and Welsh Government investment.
- Co-production with children, young people and carers throughout service design.
- Effective partnerships between NHS organisations and third-sector providers.
- Development of welcoming, non-clinical environments that improve engagement.
- Alignment with wider developments including NHS 111 Press 2 and Open Access Mental Health services.
- Highly motivated multidisciplinary teams committed to innovation and service transformation.

LEARNING POINTS:

- Community-based crisis alternatives can safely support many young people who might otherwise attend emergency departments or require admission.
- Co-produced and trauma-informed environments improve engagement and experience.
- Flexible local models are valuable but require a common national framework and outcome measures.
- Close collaboration with families, education, social care and community organisations is essential.

- Ongoing evaluation and shared learning across Wales are critical to support scaling and sustainability.

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Legal and/or ethical issues:

The programme operates within existing NHS Wales governance, safeguarding, information governance and clinical governance frameworks. All referrals and interventions are delivered in accordance with relevant legislation, including safeguarding responsibilities, confidentiality requirements, Mental Health Act provisions where applicable, and UK General Data Protection Regulation (UK GDPR) requirements.

Risk assessment and clinical oversight are central components of service delivery. Young people who require emergency medical treatment, inpatient care or formal Mental Health Act assessment are escalated through appropriate pathways. Consent, information sharing and safeguarding arrangements are managed in line with local health board policies and national guidance.

Transferability to other regions:

Transferable with contextual adaptation.

The programme has strong potential for adaptation in other regions seeking to reduce reliance on emergency departments and inpatient mental health care for children and young people. The pilot demonstrates how a range of models; including crisis sanctuaries, crisis hubs, outreach services and intensive home treatment, can be developed to suit local needs while operating within common commissioning principles.

Successful implementation requires strong partnership arrangements between health services, local authorities, education partners and the voluntary sector. Co-production with young people and families should be considered a fundamental element of implementation. Regions should also ensure appropriate governance, clinical oversight, workforce capacity and links to broader crisis pathways.

Work carried out so far has shown the importance of developing clear commissioning principles, robust evaluation arrangements and integrated pathways that connect community services, emergency care and specialist mental health provision. These lessons provide a strong foundation for transfer and scale.

Dissemination and further information:

[Mental health and wellbeing strategy 2025 to 2035 | GOV.WALES](#)

Media:

[The Hangout mental health support and activity hub for young people opens in Cardiff - Cardiff and Vale University Health Board](#)

LINKS AND CONTACTS:

Gruffydd Waldron
Mental Health

Integrated Community Care and Recovery



From Community to Care: An Integrated Multi-Level Model for Early Mental Health Intervention and Suicide Prevention



Key info:

Organisation name:	A.S.L. AT
Region:	Piemonte
Country:	Italy
Practice cooperation partners – International collaboration (e.g., Please indicate any organisations involved in the implementation of the practice, particularly if developed through European collaboration (e.g. Joint Actions, Horizon Europe, Interreg, EU4Health, Erasmus+, etc.). If not applicable, write "N/A".):	N.D.

Keywords:

Suicide prevention, early intervention, community mental health, integrated care, mental health promotion.

Implementation status:

Practice planned for future implementation, Community-based mental health initiative, Prevention or mental health promotion initiative, Integrated care / cross-sectoral mental health initiative.

Focus areas:

Mental health promotion, Suicide prevention; Early intervention; Community-based mental health services; Integrated care; Access to services; Support for vulnerable groups; Training of professionals; Social inclusion

Summary:

The proposed project establishes an innovative, integrated, and scalable model for mental health promotion and suicide prevention, structured as a continuum of care across three complementary levels of intervention. The model is designed to strengthen the entire pathway from community-based prevention to specialist mental healthcare, ensuring early identification of psychological distress, rapid clinical assessment, timely intervention,

and continuity of care for individuals experiencing mental health difficulties or at increased risk of suicide.

By combining community engagement, rapid access to specialist psychological services, and targeted interventions in high-vulnerability settings, the project addresses existing gaps in mental healthcare while promoting person-centred, accessible, and evidence-informed services

Description and strategic context:

Mental health disorders and suicidal behaviours represent a growing public health challenge in Italy and across Europe. Delays in recognising psychological distress, limited coordination between community and specialist services, and barriers to timely access to care contribute to worsening outcomes, increased use of emergency services, and avoidable hospitalisations.

In the Piemonte Region, strengthening community-based mental healthcare and suicide prevention has become a strategic priority, particularly for vulnerable populations and individuals experiencing social isolation, socioeconomic disadvantage, or complex psychosocial needs. The project responds to these challenges by creating an integrated pathway that combines prevention, early detection, rapid assessment, and continuity of care.

The initiative is aligned with the principles of the WHO Comprehensive Mental Health Action Plan, the European Commission Comprehensive Approach to Mental Health, and the Italian National Action Framework for Mental Health. It supports the transition towards person-centred, community-based services and promotes stronger integration between healthcare, social care, educational settings, local authorities, and civil society.

Objectives:

Overall objective: To improve mental health outcomes and reduce suicidal behaviour through an integrated, community-based model that ensures early identification, rapid intervention, and continuity of care across different service settings.

Specific objectives:

- Increase mental health literacy and reduce stigma within the community.
- Strengthen the capacity of community stakeholders to recognise early signs of psychological distress and suicide risk.
- Improve early detection of vulnerable individuals through structured community engagement.
- Reduce waiting times for specialist psychological assessment and intervention.
- Enhance access to evidence-based mental healthcare for people at risk of suicide.
- Improve continuity of care across community, primary care, emergency, and specialist mental health services.
- Strengthen multidisciplinary collaboration and integrated care planning.
- Improve mental health support in high-vulnerability settings, including correctional facilities.
- Reduce avoidable psychiatric crises, emergency presentations, and hospital admissions.
- Develop a scalable and transferable model for wider regional and European implementation

Target group(s):

Direct beneficiaries

- Adults experiencing psychological distress.
- Individuals presenting early signs of mental health problems.
- People at risk of suicide or self-harm.
- Individuals referred by primary care, emergency departments, community services, or trained community sentinels.
- People living in socially vulnerable circumstances.
- Individuals in correctional facilities and other high-risk environments.

Indirect beneficiaries

- Families and caregivers.
- Healthcare professionals.

- Community organisations and volunteers.
- Educational institutions.
- Local authorities and social services.
- The wider community through improved mental health awareness and prevention.

Equity dimension:

The practice specifically addresses inequalities in access to mental healthcare by promoting early identification and rapid referral for individuals who may face barriers to seeking support. Special attention is given to socially disadvantaged groups, people experiencing social isolation, and populations exposed to increased psychosocial vulnerability.

The model reduces access barriers by combining community outreach, facilitated referral pathways, and rapid specialist assessment. The inclusion of correctional settings further addresses the needs of populations often excluded from traditional healthcare pathways. The approach promotes equitable access regardless of socioeconomic status, gender, age, educational level, or social background.

Methodology and processes:

Level 1 – Community Prevention and Early Detection

The first level focuses on the early identification of psychological distress within the general population through the Sentinels Project, a community-based prevention programme involving citizens, healthcare professionals, educators, volunteers, local organisations, and other key community stakeholders.

The programme includes:

- community awareness campaigns aimed at improving mental health literacy and reducing stigma
- training of community “sentinels” to recognise early signs of psychological distress and suicidal risk;
- early identification of vulnerable individuals
- activation of social prescribing pathways to strengthen social inclusion, community participation, protective factors, and overall wellbeing.

Whenever significant psychological vulnerability or suicide risk is identified, the model activates fast-track referral pathways to Community Mental Health Centres (CMHCs or C.S.M. in Italian), ensuring rapid access to the Rapid Psychological Assessment Service (Level 2) and facilitating timely specialist intervention.

Level 2 – Rapid Psychological Assessment

The second level consists of a dedicated Rapid Psychological Assessment Service operating within Community Mental Health Centres.

This service provides rapid access to specialist psychological assessment through daily protected clinical sessions specifically reserved for urgent psychological presentations.

Priority access is granted to referrals originating from:

- the facilitated referral pathways established in Level 1
- emergency department and primary care referrals
- nursing triage services
- other healthcare professionals involved in community mental healthcare.

Following a comprehensive specialist assessment, each individual is directed towards the most appropriate evidence-based intervention according to clinical severity, psychosocial needs, and suicide risk.

The service aims to reduce waiting times, improve access to psychological care, prevent clinical deterioration, and optimise resource allocation within community mental health services.

Level 3 – High Vulnerability Settings

The third level focuses on suicide prevention and mental health promotion within settings characterised by increased psychosocial vulnerability, particularly correctional facilities.

The model provides:

- structured suicide risk assessment
- continuous clinical monitoring
- scheduled psychological reassessments
- multidisciplinary case management
- integrated care planning
- continuity of care before, during, and after detention whenever applicable.

This level aims to improve early recognition of suicide risk, reduce suicidal behaviour, strengthen collaboration among professionals, and ensure equitable access to mental healthcare for highly vulnerable populations.

Involvement of other organisations/actors:

The project is based on a collaborative, multi-sectoral approach involving healthcare providers, local authorities, social services, educational institutions, community organisations, voluntary associations, and representatives of civil society.

Community stakeholders participate in awareness campaigns, sentinel training programmes, and referral networks supporting early identification of psychological distress. Primary care professionals, emergency departments, community mental health centres, psychologists, psychiatrists, nurses, and social workers contribute to the implementation of integrated care pathways.

Service users and caregivers provide valuable feedback to support continuous service improvement and ensure that

interventions remain person-centred and responsive to local needs.

Funding source(s) and sustainability:

The initiative is primarily supported through regional healthcare resources allocated to community mental health services and prevention programmes. Existing infrastructure and professional resources within Community Mental Health Centres are utilised to maximise sustainability and cost-effectiveness.

Long-term sustainability is strengthened through integration into routine healthcare pathways, workforce capacity building, and collaboration with community partners. The model promotes efficient use of healthcare resources by reducing crisis presentations, improving early intervention, and preventing clinical deterioration.

Future sustainability may be supported through participation in national and European funding opportunities focused on mental health promotion, suicide prevention, integrated care, and health system innovation. For the funding and sustainability component of the project, we also intend to involve the association “*Un Libro per Daniela*” as a partner.

“Un Libro per Daniela” is an emerging association, founded in 2023, dedicated to shedding light on the shadow of depression. Its mission is to strive for a world built on understanding rather than judgment, on acceptance rather than alienation. As an association, it raises awareness of depression and mental health conditions as widely as possible, and it shares experiences in order to create a safe space—a place where people can find support or help.

Innovation, Impact and Outcomes:

The strength of the project lies in the integration of all three intervention levels into a single coordinated care pathway. Individuals can move seamlessly from community-based prevention to rapid specialist assessment and, when required, to specialised interventions in high-risk environments without fragmentation of care.

The model therefore promotes:

- earlier identification of psychological distress
- rapid access to specialist mental healthcare
- continuity of care across different healthcare settings
- integration between health, social care, and community services
- multidisciplinary collaboration
- personalised interventions proportional to clinical risk
- strengthened suicide prevention strategies across the entire healthcare pathway

- enhance coordination between healthcare, social, and community sectors
- improve patient outcomes and quality of life
- reduce avoidable psychiatric crises and hospital admissions
- optimise the use of healthcare resources
- provide a scalable and transferable model that can be implemented across different healthcare systems.

By integrating prevention, rapid intervention, and specialist care into a unified framework, the project contributes to the development of more resilient, equitable, and person-centred mental health systems throughout Europe.

Evaluation:

The practice will be evaluated through a mixed-methods framework combining quantitative indicators with qualitative assessment to monitor implementation, effectiveness, and long-term sustainability. Evaluation activities will be embedded within routine service delivery and will support continuous quality improvement.

Process indicators will assess implementation fidelity across the three intervention levels and include: number of community awareness initiatives delivered; number of community "sentinels" trained; number and source of referrals; waiting time from referral to Rapid Psychological Assessment; proportion of urgent cases assessed within the target timeframe; and number of multidisciplinary care plans developed.

Outcome indicators will measure the effectiveness of the integrated care pathway, including: number of individuals receiving timely psychological assessment; access to appropriate follow-up care; continuity of care across community, primary care, emergency, and specialist services; adherence to scheduled appointments; and changes in psychological wellbeing using validated clinical assessment tools where routinely adopted. Trends in emergency department presentations, psychiatric admissions, and repeat mental health crises will also be monitored where available.

For interventions implemented in high-vulnerability settings, additional indicators will include suicide risk assessments completed, scheduled psychological reassessments, multidisciplinary case reviews, and continuity of care following discharge or release.

Qualitative evaluation will involve healthcare professionals, community stakeholders, service users, and caregivers through structured feedback, interviews, or focus groups to assess acceptability, perceived accessibility, quality of care,

organisational collaboration, and barriers to implementation.

Evaluation findings will be reviewed regularly by the multidisciplinary governance team to identify opportunities for service improvement and optimise resource allocation. Whenever feasible, outcomes will be compared with historical service data to assess improvements in access, timeliness of care, continuity, and suicide prevention. The evaluation framework is designed to facilitate future scalability and transferability to other regional and European healthcare settings.

Barriers, enables, and learning points:

As the practice is currently in the planning phase, the barriers, enabling factors, and learning points presented here should be regarded as hypotheses. They reflect the risks identified during the service design process, the conditions considered necessary for successful implementation, and the principles guiding the development of the model. They should not be interpreted as findings from a complete implementation or evaluation.

CHALLENGES:

The implementation of an integrated, multi-level mental health pathway requires strong coordination across healthcare, social care, community organisations, and institutional partners. One of the main challenges is ensuring timely communication and shared clinical pathways among services with different organisational cultures and operational procedures.

A further challenge is promoting early help-seeking behaviours in a context where mental health stigma may discourage individuals from accessing care. Achieving broad community engagement and maintaining the motivation of trained community "sentinels" also requires continuous investment in awareness, supervision, and networking activities.

Operational challenges include balancing the demand for rapid psychological assessment with available workforce capacity, ensuring equitable access across urban and rural areas, and maintaining continuity of care during transitions between community services, emergency care, and specialist mental health settings.

Within correctional facilities, additional complexities arise from organisational constraints, security procedures, and the need for close collaboration between healthcare professionals and prison authorities to ensure effective suicide prevention and continuity of care.

ENABLERS:

Several factors support the successful implementation of the practice. The project builds upon the existing Community Mental Health Centre network and benefits from the long-standing experience of multidisciplinary mental health teams operating within the regional healthcare system.

Strong institutional commitment from ASL AT, together with collaboration between primary care, emergency departments, social services, correctional healthcare, municipalities, voluntary organisations, and community stakeholders, facilitates the development of integrated care pathways and coordinated interventions.

The adoption of standardised referral procedures, rapid access to specialist psychological assessment, and multidisciplinary case management promotes timely decision-making and continuity of care. Community awareness campaigns and the training of local "sentinels" strengthen early detection of psychological distress and reinforce protective social networks.

Finally, the involvement of the association *Un Libro per Daniela* contributes to the sustainability of the initiative by supporting community engagement and the mobilisation of additional resources to complement public healthcare investment.

LEARNING POINTS:

The experience demonstrates that effective suicide prevention requires a coordinated continuum of care rather than isolated interventions. Integrating community prevention, rapid specialist assessment, and targeted support for high-risk populations enables earlier identification of psychological distress and more timely access to appropriate care.

Multidisciplinary collaboration and shared referral pathways are essential to reducing fragmentation between services and improving patient outcomes. Investing in mental health literacy and training community members to recognise early warning signs significantly strengthens prevention efforts and facilitates earlier engagement with healthcare services. Embedding rapid psychological assessment within routine community mental health services improves accessibility while optimising the use of specialist resources. Continuous monitoring of implementation indicators and stakeholder feedback allows services to adapt to emerging needs and improve quality over time.

Because the model is based primarily on organisational integration rather than costly technological solutions, it is highly adaptable and can be replicated in other regions with appropriate contextual adaptation, strong leadership, and

sustained collaboration between healthcare providers, local authorities, and civil society organisations.

Legal and/or ethical issues:

The practice is implemented in accordance with the Italian legal framework governing healthcare services and the European Union General Data Protection Regulation (GDPR – Regulation (EU) 2016/679). Personal and health-related data are processed exclusively for healthcare purposes through secure institutional information systems, with access restricted to authorised professionals involved in the patient's care. Clinical activities follow established ethical principles, including respect for autonomy, confidentiality, non-discrimination, and person-centred care. Where required by national legislation and organisational procedures, informed consent is obtained for clinical assessment, treatment, and data processing. Given the focus on suicide prevention and vulnerable populations, the project adopts shared clinical protocols for risk assessment, multidisciplinary decision-making, safeguarding, and continuity of care, ensuring that interventions are proportionate to clinical need and delivered in the least restrictive manner.

The governance model is based on multidisciplinary collaboration across healthcare, social care, community organisations, and institutional partners, with clearly defined roles and responsibilities. Regular governance meetings support quality assurance, monitor implementation, promote continuous improvement, and ensure compliance with legal, ethical, and organisational standards throughout the care pathway.

Transferability to other regions:

Transferable with contextual adaptation.

The proposed model has a high potential for transferability because it is based primarily on organisational innovation, integrated care pathways, and multidisciplinary collaboration rather than on highly specialised infrastructure or proprietary technologies. Its three-level structure—community prevention and early detection, rapid psychological assessment, and targeted interventions for high-vulnerability settings—can be adapted to different healthcare systems while preserving its core principles.

Successful implementation requires the availability of community-based mental health services, multidisciplinary teams, defined referral pathways, and collaboration between healthcare providers, social services, local authorities, educational institutions, voluntary organisations, and community stakeholders.

While the specific organisation of services may vary across regions, the model can be tailored to local governance arrangements, available resources, and population needs. Transferability is further supported by the use of standardised referral procedures, shared clinical protocols, community training programmes, and a structured evaluation framework based on measurable process and outcome indicators. These components facilitate implementation, monitoring, and continuous quality improvement in different contexts.

The practice is particularly suitable for regions seeking to strengthen suicide prevention strategies, improve early access to mental healthcare, reduce fragmentation between services, and promote integrated, person-centred care. Its scalability allows gradual implementation, starting with selected pilot areas before wider regional expansion.

To facilitate replication, implementation guidance, training materials for community "sentinels", governance arrangements, and evaluation tools can be documented and shared with other organisations. Participation in national and European professional networks would further support knowledge exchange, peer learning, and adaptation of the model across different healthcare settings.

Dissemination and further information:

Dissemination activities will aim to promote knowledge sharing, stakeholder engagement, and the wider adoption of integrated approaches to mental health promotion and suicide prevention. Project results, implementation experiences, and lessons learned will be communicated through regional and national professional networks, scientific meetings, workshops, and conferences focusing on mental health, public health, and integrated care.

Where appropriate, implementation tools, referral pathways, training materials, and evaluation findings will be shared with other healthcare organisations to facilitate replication and adaptation in different settings. The project will seek opportunities to contribute to national and European networks and initiatives dedicated to mental health promotion, suicide prevention, and community-based care.

Scientific publications and presentations may be developed as evaluation data become available, supporting the dissemination of evidence and the continuous exchange of good practices at regional, national, and European levels.

LINKS AND CONTACTS:

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Media: N/A

Integrated Community Care and Recovery



Person-centred cardiac rehabilitation: Enhancing mental well-being for patients with cardiac disease and their relatives



Key info:

Organisation name:	DEFACTUM
Region:	Central Denmark Region
Country:	Denmark
Practice cooperation partners – International collaboration (e.g., Please indicate any organisations involved in the implementation of the practice, particularly if developed through European collaboration (e.g. Joint Actions, Horizon Europe, Interreg, EU4Health, Erasmus+, etc.). If not applicable, write "N/A".):	Lead organisation: DEFACTUM, Central Denmark Region, Denmark. Practice partners: Aarhus Municipality, Skanderborg Municipality, and Ringkøbing-Skjern Municipality (development and feasibility sites), with six additional Danish municipalities participating in the implementation and evaluation phase. International collaboration: The practice benefits from collaboration with Dr Jemma Hawkins (Cardiff University, United Kingdom), Reader in the School of Social Sciences and Assistant Director of DECIPHer (Centre for Development, Evaluation, Complexity and Implementation in Public Health Improvement). Dr Hawkins contributes expertise in co-production, stakeholder engagement, and the development and evaluation of complex public health interventions throughout the co-production, feasibility, and implementation phases. The programme is further supported by an international advisory board comprising experts in cardiac rehabilitation, mental health, co-production, implementation science, and health services research. European collaboration: The practice is not funded through a European programme (e.g. Horizon Europe, Interreg, EU4Health, Erasmus+, or a Joint Action).

Keywords:

Mental well-being, Cardiac rehabilitation, Psychosocial intervention, Co-creation, practice oriented.

Implementation status:

Pilot or promising practice currently being tested, Community-based mental health initiative.

Focus areas:

Psychosocial support, training of professionals, Community-based mental health support, co-creation.

Summary:

Cardiovascular disease affects not only physical health but also mental well-being. Around one-third of patients experience clinically relevant psychological distress

following a cardiac event, while many relatives report persistent worry, uncertainty, and emotional burden. Despite psychosocial care being recognised as a core component of cardiac rehabilitation (CR), its delivery remains inconsistent and unsystematic across Danish municipalities, resulting in unequal access to mental health support.

This practice aims to strengthen mental well-being among patients with cardiovascular disease and their relatives by systematically integrating a structured psychosocial intervention into routine community-based cardiac rehabilitation. Rather than introducing a separate psychological service, the initiative embeds psychosocial support within existing CR pathways, enabling healthcare professionals to address emotional well-being as a routine part of rehabilitation.

The practice targets adults referred to municipal cardiac rehabilitation following cardiovascular disease, as well as their relatives. It has been co-produced with patients, relatives, clinicians, and managers from three Danish municipalities to ensure feasibility, acceptability, and alignment with routine practice.

The intervention is informed by metacognitive principles and consists of three integrated components: (1) a structured psychosocial consultation offered to all patients at the beginning of rehabilitation to identify concerns and support needs; (2) integration of brief psychosocial and metacognitive strategies into existing rehabilitation activities, including patient education and follow-up consultations; and (3) targeted individual sessions for patients experiencing persistent psychological distress. Healthcare professionals receive dedicated training, supervision, and implementation support to facilitate sustainable delivery within existing services.

The practice is currently progressing from development to implementation and evaluation. Development has been completed through an iterative co-production process, while feasibility testing, implementation, and effectiveness evaluation are underway using a mixed-methods approach across multiple municipalities. The evaluation will assess mental well-being, anxiety, depression, health-related quality of life, implementation outcomes, and cost-effectiveness.

The long-term ambition is to establish a scalable, person-centred model for integrating mental well-being into routine cardiac rehabilitation, reducing inequalities in access to psychosocial support and strengthening holistic rehabilitation for patients with cardiovascular disease and their relatives.

Description and strategic context:

Mental health problems are common following cardiovascular disease and extend beyond diagnosable anxiety and depression. Many patients experience persistent worry, uncertainty, fear of recurrence, and difficulties adjusting to everyday life after a cardiac event. Relatives are also frequently affected by emotional distress

and increased caregiving responsibilities. Although psychosocial care is recognised as a core component of cardiac rehabilitation (CR), its delivery remains inconsistent across Danish municipalities, resulting in unequal access to support and variation in clinical practice.

Strengthening mental well-being in CR has therefore become an important priority. This practice responds to the need for a feasible, person-centred, and systematic approach that enables existing healthcare professionals to identify and address psychosocial needs as an integral part of routine rehabilitation rather than as an additional specialist service.

The practice aligns with the **2025 ESC Clinical Consensus Statement on Mental Health and Cardiovascular Disease**, which calls for broader and more integrated approaches to psychological well-being throughout the cardiovascular care pathway. It also supports the WHO European Mental Health Framework and the EU Comprehensive Approach to Mental Health by promoting early intervention, integrated care, and equitable access to person-centred services. Within Denmark, the practice complements national recommendations for cardiac rehabilitation by strengthening the psychosocial component of existing municipal rehabilitation programmes and reducing unwarranted variation in care.

Objectives:

Overall objective

To improve mental well-being and everyday functioning among patients with cardiovascular disease and their relatives by systematically integrating person-centred psychosocial support into routine community-based cardiac rehabilitation.

Specific objectives

The practice aims to:

- Strengthen the psychosocial component of cardiac rehabilitation by embedding structured, evidence-informed support within existing rehabilitation pathways.
- Identify psychosocial needs early through a structured consultation offered to all patients entering cardiac rehabilitation.
- Reduce psychological distress, including persistent worry, anxiety, depressive symptoms, and illness-related uncertainty, by providing support tailored to patients' individual needs.
- Improve patients' health-related quality of life, confidence in self-management, and ability to resume everyday activities following a cardiac event.
- Support relatives by acknowledging their emotional needs and strengthening their involvement in the rehabilitation process where appropriate.
- Increase the competence and confidence of healthcare professionals to recognise and address

psychosocial needs through targeted training, practical tools, and ongoing supervision.

- Promote more equitable access to psychosocial support by reducing variation in service delivery across municipal cardiac rehabilitation programmes.
- Establish a sustainable model that can be implemented within existing resources and scaled to other rehabilitation settings.

The intended benefits are improved mental well-being and quality of life for patients and their relatives, more consistent delivery of psychosocial care across rehabilitation services, and greater integration of mental and physical health within routine cardiac rehabilitation. By embedding psychosocial support into existing clinical pathways, the practice seeks to ensure that emotional well-being becomes a routine and accessible component of high-quality cardiac rehabilitation rather than an optional or ad hoc service.

Target group(s):

The **primary target group** comprises adults (≥ 18 years) referred to community-based cardiac rehabilitation following a diagnosis of cardiovascular disease, including ischaemic heart disease, heart failure, or heart valve disease. The practice is integrated into routine rehabilitation and is therefore offered to all eligible patients participating in municipal cardiac rehabilitation, regardless of socioeconomic status, gender, or psychological symptom level. Patients experiencing persistent or elevated psychological distress receive additional individual psychosocial support as part of the stepped intervention.

Relatives are an important secondary target group. Although they do not receive a separate intervention, the practice acknowledges their emotional needs and encourages their involvement in the rehabilitation process where appropriate. This reflects the recognition that cardiovascular disease affects both patients and those close to them.

Indirect beneficiaries include healthcare professionals delivering cardiac rehabilitation, who receive training and practical tools to strengthen their competence in recognising and addressing psychosocial needs. Municipal rehabilitation services also benefit through a more systematic and equitable approach to psychosocial care, while the broader healthcare system may benefit from improved continuity of care, greater consistency in service delivery, and a scalable model that can be implemented across cardiac rehabilitation programmes.

Equity dimension:

The practice is designed to reduce inequalities in access to psychosocial support within cardiac rehabilitation. Although psychosocial care is recognised as a core component of cardiac rehabilitation, its availability and content vary considerably across Danish municipalities, resulting in unequal access to support for patients with

cardiovascular disease. By embedding a structured psychosocial approach into routine rehabilitation, the practice seeks to provide more consistent and equitable access to mental health support regardless of where patients receive care.

The intervention follows a person-centred, stepped-care approach. All patients are offered a structured psychosocial consultation, while the intensity of support is tailored to individual needs rather than determined solely by psychological screening scores or diagnostic criteria. This approach increases the likelihood of identifying patients with psychosocial needs that might otherwise remain unrecognised and supports timely intervention.

The practice has been co-produced with patients, relatives, clinicians, and managers from municipalities representing both urban and rural settings, ensuring that it is feasible and relevant across diverse local contexts. By integrating psychosocial support into existing community-based cardiac rehabilitation and delivering it through the existing workforce, the practice aims to reduce unwarranted variation in service delivery and promote more equitable, person-centred rehabilitation for people living with cardiovascular disease and their relatives.

Methodology and processes:

The practice is implemented within routine community-based cardiac rehabilitation (CR) and follows a person-centred, stepped-care approach. Rather than introducing a separate psychological service, it strengthens the psychosocial component of existing rehabilitation by equipping healthcare professionals with practical tools to recognise and address patients' mental well-being throughout the rehabilitation pathway.

The intervention was developed through an iterative co-production process involving patients, relatives, clinicians, managers, and researchers from three Danish municipalities (Aarhus, Skanderborg, and Ringkøbing-Skjern). Through a series of workshops, stakeholders identified unmet psychosocial needs, prioritised areas for improvement, and co-designed an intervention that is both evidence-informed and feasible within routine municipal cardiac rehabilitation. The intervention draws on metacognitive principles and was developed in accordance with the UK Medical Research Council framework for complex interventions.

Implementation begins with competence development for healthcare professionals delivering cardiac rehabilitation. Staff participate in a structured training programme comprising a two-day course, a follow-up training day, ongoing supervision, and a concise intervention manual. The training focuses on recognising common psychological reactions following cardiovascular disease, conducting structured psychosocial consultations, and integrating metacognitive principles into routine rehabilitation activities.

The intervention consists of three integrated components delivered according to patients' individual needs:

- **Structured psychosocial consultation:** All patients receive an individual consultation at the beginning of cardiac rehabilitation using a structured dialogue tool to identify concerns, emotional reactions, coping strategies, and psychosocial support needs.
- **Integration into routine cardiac rehabilitation:** Core psychosocial and metacognitive principles are incorporated into existing rehabilitation activities, including patient education, lifestyle counselling, and follow-up consultations. This enables mental well-being to be addressed systematically throughout the rehabilitation programme rather than as a stand-alone service.
- **Targeted individual support:** Patients experiencing persistent psychological distress are offered three to five additional individual sessions focusing on managing worry, rumination, heightened threat monitoring, and other maintaining processes using adapted metacognitive techniques.

The practice has initially been implemented in the three development municipalities where the intervention was co-produced. It is currently undergoing feasibility testing to assess its acceptability, feasibility, and integration into routine cardiac rehabilitation while informing minor refinements to both the intervention and the implementation strategy.

Following this phase, the practice will be implemented in six additional municipal cardiac rehabilitation centres across Denmark. This broader implementation will evaluate the intervention under routine clinical conditions in municipalities representing diverse organisational and geographical contexts. Alongside implementation, a mixed-methods evaluation will assess patient outcomes, implementation fidelity, acceptability, and cost-effectiveness. The findings will support continuous refinement of the practice and inform a strategy for wider implementation and long-term integration of structured psychosocial support within community-based cardiac rehabilitation nationally.

Involvement of other organisations/actors:

The practice was developed through an iterative co-production process that actively involved patients, relatives, healthcare professionals, managers, and researchers from the outset. Rather than consulting stakeholders at the end of the development process, they participated as equal partners in identifying needs, generating solutions, and refining the intervention to ensure relevance, feasibility, and sustainability within routine cardiac rehabilitation.

The co-production process was undertaken in collaboration with three municipal cardiac rehabilitation services in Aarhus, Skanderborg, and Ringkøbing-Skjern. Five structured co-production workshops brought together patients with cardiovascular disease, relatives, nurses, physiotherapists, occupational therapists, managers, and researchers. Participants shared experiences of current

rehabilitation pathways, identified unmet psychosocial needs, discussed barriers and facilitators to implementation, and jointly developed solutions that could be integrated into existing clinical workflows.

Patients and relatives contributed lived experiences of everyday life after cardiovascular disease, highlighting emotional challenges, uncertainty, and unmet support needs. Their perspectives directly informed the development of the structured psychosocial consultation, dialogue-support tools, communication approaches, and the overall design of the psychosocial add-in intervention. Healthcare professionals and managers ensured that the intervention was compatible with existing organisational structures, competencies, and available resources, thereby increasing the likelihood of successful implementation. The intervention was continuously refined through iterative feedback between workshops.

Stakeholder involvement continues beyond the development phase. The intervention is currently undergoing feasibility testing in the three development municipalities, where patients, relatives, clinicians, and managers contribute to refining both the intervention and the implementation strategy through interviews, workshops, and structured feedback. As the practice is implemented in six additional municipalities, these stakeholders will continue to contribute to monitoring, evaluation, and further refinement. This sustained partnership ensures that the practice remains responsive to users' needs while supporting long-term implementation and future scale-up across municipal cardiac rehabilitation services.

Funding source(s) and sustainability:

The development and implementation of the practice have been supported through complementary funding from three sources. The **Independent Research Fund Denmark** has funded the development of the psychosocial intervention and the core research programme, including two postdoctoral positions. The **Central Denmark Region's Public Health Fund** has supported the feasibility phase, including testing and refinement of the intervention in collaboration with the three development municipalities. The **Danish Heart Foundation** supports the broader implementation, evaluation, and future scaling of the intervention across additional municipal cardiac rehabilitation centres.

From the outset, the practice has been designed with long-term sustainability as a central objective. Rather than establishing a new stand-alone service, the intervention is embedded within existing community-based cardiac rehabilitation and delivered by the current multidisciplinary workforce. This approach minimises the need for additional resources while strengthening an existing core component of rehabilitation.

Sustainability is further supported through competence development, practical implementation tools, and an implementation strategy co-produced with clinicians,

managers, patients, and relatives. By integrating the intervention into routine clinical workflows, the practice is intended to become part of standard rehabilitation rather than a time-limited project.

Organisational sustainability is strengthened through close partnerships with participating municipalities, while the ongoing implementation in additional municipalities will generate knowledge to support wider adoption. If the intervention proves feasible, acceptable, and effective, it has strong potential for regional and national implementation within existing municipal cardiac rehabilitation services and may serve as a model for integrating psychosocial support into rehabilitation programmes for other chronic conditions.

Innovation, Impact and Outcomes:

The practice introduces an innovative approach to strengthening mental well-being in cardiac rehabilitation by systematically embedding psychosocial support into routine community-based care rather than offering it as a separate psychological service. While psychosocial care is recommended in international guidelines, its delivery is often fragmented, inconsistent, or dependent on local resources. This practice addresses that gap by integrating structured psychosocial support into existing rehabilitation pathways using a person-centred, stepped-care model that can be delivered by the existing multidisciplinary workforce.

A second innovative feature is the intervention's theoretical foundation. Rather than focusing exclusively on symptoms of anxiety and depression, the intervention draws on metacognitive principles to address common psychological processes following cardiovascular disease, including persistent worry, rumination, heightened threat monitoring, and illness-related uncertainty. This broader focus reflects emerging evidence that psychological distress after cardiovascular disease extends beyond diagnosable mental disorders and requires more holistic support.

The practice is also innovative in its development process. Instead of adapting an existing intervention, it was co-produced through an iterative partnership involving patients, relatives, clinicians, managers, and researchers. Five structured co-production workshops ensured that lived experiences, organisational realities, and scientific evidence were integrated throughout the development process. This resulted in an intervention that is both evidence-informed and designed for implementation within routine municipal cardiac rehabilitation.

As the practice is currently undergoing feasibility testing, final effectiveness data are not yet available. However, several important milestones have already been achieved. The psychosocial intervention has been successfully developed, implementation materials and healthcare professional training have been completed, and the intervention has been integrated into routine cardiac rehabilitation in the three development municipalities. Early implementation is assessing acceptability, feasibility, and

delivery within existing services, with findings informing minor refinements before broader implementation.

The next phase will implement the practice in six additional municipalities, where its impact will be evaluated using a mixed-methods approach. Outcomes include mental well-being, anxiety, depression, health-related quality of life, implementation fidelity, acceptability, and cost-effectiveness. Process evaluations will further explore how the intervention works, for whom, and under which circumstances.

If demonstrated to be feasible, acceptable, and effective, the practice has considerable potential to strengthen the psychosocial component of cardiac rehabilitation, reduce unwarranted variation in service delivery, improve equitable access to mental health support, and provide a scalable model for wider implementation across Denmark and other healthcare systems.

Evaluation:

The practice is evaluated using a mixed-methods approach to determine whether it improves patients' mental well-being, reduces psychological distress, and can be implemented sustainably within routine community-based cardiac rehabilitation.

The evaluation follows the UK Medical Research Council framework for developing and evaluating complex interventions and is conducted in successive phases. The current phase focuses on feasibility testing in the three development municipalities, assessing whether the intervention is acceptable, feasible, and can be integrated into existing rehabilitation services. Findings from this phase are used to refine both the intervention and the implementation strategy before wider implementation.

The subsequent phase will implement and evaluate the practice in six additional municipal cardiac rehabilitation centres using a stepped-wedge cluster randomised design. This phase will examine both clinical and implementation outcomes under routine practice conditions.

The evaluation includes quantitative and qualitative methods. Patient-reported outcome measures assess changes in mental well-being and health-related quality of life, including symptoms of anxiety (GAD-7), depressive symptoms (PHQ-9), and health-related quality of life (EQ-5D-5L), measured at baseline and after 3, 6, and 12 months. Secondary outcomes include perceived stress, sleep, and social support.

Implementation is evaluated through indicators such as acceptability, reach, fidelity, appropriateness, adoption, and sustainability. Qualitative interviews, observations, workshops, and structured feedback from patients, relatives, clinicians, and managers are used to understand how the practice is delivered, identify barriers and facilitators, and explain variations in implementation across different municipal contexts. A societal economic evaluation will assess cost-effectiveness and cost-utility using Quality-Adjusted Life Years (QALYs).

As the practice is currently undergoing feasibility testing, no formal effectiveness results are yet available. However, the evaluation has been designed to generate robust evidence on both outcomes and implementation, providing knowledge on what works, for whom, and under which circumstances to support future regional and national scale-up.

Barriers, enables, and learning points:

CHALLENGES:

- Coordinating diverse stakeholders: Bringing together patients, relatives, clinicians, managers, and researchers for co-production workshops required substantial planning and coordination to accommodate different schedules and responsibilities.
- Variation across municipalities: Differences in the organisation of cardiac rehabilitation, local workflows, and digital systems for collecting patient-reported outcome measures (PROMs) required the intervention to be adapted to local contexts while maintaining fidelity to its core components.
- Balancing standardisation and flexibility: Developing an intervention that was sufficiently standardised to ensure consistent delivery, yet flexible enough to fit different municipal settings, was a key implementation challenge.
- Protected time for competence development: Allocating time for staff training, supervision, and implementation activities within already busy clinical services required careful planning and organisational commitment.
- Integrating a new practice into routine care: Embedding structured psychosocial support within existing rehabilitation pathways, without increasing the workload or disrupting routine care, required close collaboration with frontline healthcare professionals and managers.

ENABLERS:

- Strong partnerships between research and practice: Established collaboration between DEFACTUM and the participating municipalities created a strong foundation for joint development, open dialogue, and shared ownership throughout the project.
- Leadership commitment: Managers in all participating municipalities actively prioritised the initiative by allocating time for staff training, co-production activities, and implementation despite competing demands in routine clinical practice.
- Co-production throughout the development process: Patients, relatives, clinicians, managers, and researchers worked together from the outset to identify needs, develop solutions, and refine the

intervention. This collaborative approach increased both the relevance of the intervention and local ownership.

- Engaged patients and relatives: Patients and relatives contributed actively throughout the development process by sharing lived experiences, validating proposed intervention components, challenging assumptions, and helping to refine dialogue tools, communication approaches, and intervention content. Their continuous feedback ensured that the intervention remained meaningful, acceptable, and centred on real-world needs.
- Building on existing clinical practice: Rather than creating a parallel service, the intervention was designed to strengthen and systematise the psychosocial component of existing cardiac rehabilitation. This facilitated integration into routine care and increased the potential for long-term sustainability.
- Healthcare professionals as co-developers: Clinicians were involved not only as future users but also as co-designers of the intervention. Their practical knowledge ensured that the intervention was compatible with existing workflows and organisational realities.
- Specialist expertise and scientific support: Development was strengthened by collaboration with a psychologist certified in metacognitive therapy, an international expert in co-production, and an international advisory board. This combination ensured that the intervention was both evidence-informed and practically applicable while supporting future implementation and scale-up.

LEARNING POINTS:

- Invest in co-production from the outset. Effective co-production is not cost-neutral. It requires dedicated funding, protected time for participants, and organisational commitment to support iterative collaboration between patients, relatives, clinicians, managers, and researchers. This investment was essential for developing an intervention that was both evidence-informed and feasible for routine practice.
- Co-production should begin before the intervention is designed, not after. Involving patients, relatives, clinicians, and managers from the outset ensured that the intervention addressed real-world psychosocial needs, reflected routine clinical practice, and fostered ownership among those responsible for delivering and receiving the intervention.
- Standardise the core intervention, not the delivery. Maintaining a clear set of core intervention components while allowing adaptation to local

organisational structures, workflows, and digital systems enabled implementation across municipalities without compromising intervention fidelity.

- Embed mental well-being into existing rehabilitation rather than creating a parallel service. Integrating psychosocial support into routine consultations and rehabilitation activities increased feasibility, reduced implementation burden, and strengthened the potential for long-term organisational sustainability.
- Leadership engagement is essential. Successful implementation depended on managers actively prioritising staff training, co-production activities, and implementation despite competing demands in everyday clinical practice.
- Healthcare professionals should be partners in implementation, not only recipients of training. Involving clinicians as co-developers increased ownership, strengthened confidence in delivering the intervention, and improved its fit with routine clinical practice.
- Patients and relatives provide unique expertise. Their lived experiences challenged professional assumptions, refined intervention content, and ensured that the practice addressed the psychosocial challenges that matter most in everyday life with cardiovascular disease.
- Implementation should be viewed as an iterative process. Feasibility testing before wider implementation created opportunities to identify barriers, refine intervention components, and strengthen the implementation strategy before scaling the practice to additional municipalities.

Legal and/or ethical issues:

The practice has been developed and implemented through a formal partnership between DEFACTUM and participating municipalities, with clearly defined governance structures, roles, responsibilities, and quality assurance procedures supporting implementation within routine cardiac rehabilitation.

The accompanying research programme complies with applicable Danish legislation and the General Data Protection Regulation (GDPR). The relevant components of the programme were submitted to the Regional Committee on Health Research Ethics for assessment. Following review, the Committee concluded that these activities did not constitute notifiable health research under Danish legislation and therefore did not require formal ethical approval. The research programme is registered in the Central Denmark Region's internal register of research projects.

All research participants provide informed consent before participating in interviews or completing questionnaires. Personal data are processed and stored securely in accordance with institutional data protection procedures,

and access to identifiable data is restricted to authorised members of the research team, ensuring participants' privacy, confidentiality, and autonomy throughout the project.

Transferability to other regions:

Estimated transferability maturity: Transferable with contextual adaptation.

The practice has been designed with transferability as a central objective. Rather than being tailored to a single organisation, it has been developed through co-production across three municipalities representing different organisational structures and service contexts. The intervention is currently undergoing feasibility testing before implementation in six additional municipalities, providing further evidence on its adaptability across diverse community-based cardiac rehabilitation settings.

The core components of the intervention are intended to remain consistent, including the structured psychosocial consultation, integration of psychosocial support into routine cardiac rehabilitation, and targeted individual support for patients with persistent psychological distress. However, the delivery model is designed to be adapted to local organisational structures, staffing models, clinical workflows, and digital infrastructure. This balance between fidelity and local adaptation is considered essential for successful implementation.

Several factors are expected to facilitate transfer to other regions. The intervention is embedded within existing cardiac rehabilitation services and delivered by the existing multidisciplinary workforce rather than requiring a new specialist service. Supporting materials include a structured intervention manual, dialogue-support tools, a healthcare professional training programme, supervision, and a practice-oriented implementation strategy developed through co-production.

Although formal evidence on large-scale transferability is not yet available, the ongoing implementation across additional municipalities will provide valuable knowledge on how the intervention performs under different organisational conditions. Findings from the implementation and process evaluations will identify contextual factors influencing successful adoption and inform recommendations for wider regional and national implementation.

The practice may also have broader applicability beyond cardiac rehabilitation. The implementation principles, including person-centred care, co-production, integration into existing services, and a stepped psychosocial approach, could potentially be adapted to rehabilitation programmes for other chronic conditions. However, further evaluation is required before transfer to other clinical settings can be recommended.

Dissemination and further information:

The practice is being disseminated through scientific, professional, and stakeholder-oriented channels

throughout its development, implementation, and evaluation.

The first scientific publication, describing the co-production and development of the psychosocial intervention, is currently in preparation. A second publication reporting the feasibility evaluation is planned following completion of the ongoing feasibility study. Additional peer-reviewed publications will report the intervention's effectiveness, implementation outcomes, cost-effectiveness, and process evaluation as the programme progresses.

Findings from the development phase have been accepted for presentation as a poster at the 18th European Public Health Conference (EPH Conference) 2026, providing an opportunity to share early experiences with researchers, clinicians, and policymakers from across Europe.

Knowledge dissemination also includes presentations at national and international scientific conferences, engagement with participating municipalities and healthcare professionals, and communication through professional and stakeholder networks. Practical implementation materials, including the intervention manual, dialogue-support tools, training materials, and implementation strategy, will support future adoption by other municipalities and regions as the programme develops.

Following completion of the programme, findings will be disseminated through peer-reviewed publications, implementation guidance, and collaboration with national and international partners to support wider uptake of the practice. Ongoing evaluation reports and scientific publications as they become available.

Media:

LINKS AND CONTACTS:

Jakob Feldtfos Christensen – Research Advisor – DEFACTUM, Research in Public Health, Central Denmark Region – JAKOCI@rm.dk

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Integrated Community Care and Recovery



The case of Community Houses in the Autonomous Region Friuli Venezia-Giulia



Key info:

Organisation name:	EGTC GO
Region:	Autonomous Region Friuli Venezia-Giulia
Country:	Italy
Practice cooperation partners – International collaboration (e.g., Please indicate any organisations involved in the implementation of the practice, particularly if developed through European collaboration (e.g. Joint Actions, Horizon Europe, Interreg, EU4Health, Erasmus+, etc.). If not applicable, write "N/A".):	European EU-PROMENS program for youth community mental health

Keywords:

Implementation status:

Focus areas:

Summary:

In Friuli Venezia Giulia, the implementation of Community Houses (Case della Comunità) and their integration with mental health services follow the guidelines of the Italian Ministerial Decree 77/2022 to establish a localized social and healthcare model.

Integration of Mental Health Services: Friuli Venezia Giulia's historic Mental Health Centers (Centri di Salute Mentale - CSM)—a long-standing regional point of excellence—are functionally linking with the new Community Houses and Territorial Operational Centers (Centrali Operative Territoriali - COT) to prevent care fragmentation and ensure comprehensive clinical and social management.

Description and strategic context:

In Friuli Venezia Giulia, the implementation of Community Houses (Case della Comunità) and their integration with mental health services follow the guidelines of the Italian Ministerial Decree 77/2022 to establish a localized social and healthcare model.

Objectives:

Integration of Mental Health Services: Friuli Venezia Giulia's historic Mental Health Centers (Centri di Salute Mentale - CSM)—a long-standing regional point of excellence—are functionally linking with the new Community Houses and Territorial Operational Centers (Centrali Operative Territoriali - COT) to prevent care fragmentation and ensure comprehensive clinical and social management.

Target group(s):

Equity dimension:

Methodology and processes:

- **Achievement of Targets:** The FVG Region has validated the opening and progress of the planned network (over 30 structures scheduled across hubs and spokes within the ASUFC, ASFO, and ASUGI healthcare authorities).
- **Involvement of General Practitioners:** The regional supplementary agreement is currently active, providing for the voluntary participation of family doctors within the Community Houses, alongside a push in August/September 2026 to enhance structured medical presence.
- **Integration of Mental Health Services:** Friuli Venezia Giulia's historic Mental Health Centers (*Centri di Salute Mentale - CSM*)—a long-standing regional point of excellence—are functionally linking with the new Community Houses and Territorial Operational Centers (*Centrali Operative Territoriali - COT*) to prevent care fragmentation and ensure comprehensive clinical and social management.
- **Training and Projects:** Specific initiatives include the European EU-PROMENS program for youth community mental health, aimed at creating networks between social workers, psychologists, and local healthcare facilities.
- **Onboarding by October 2026:** An agreement has been reached between the FVG Region (Health Department) and primary care physician unions, overcoming previous standstills.
- **Need-Based Module:** Family doctors will operate within Community Houses on a flexible, scheduled basis calculated according to each local area's specific needs. This ensures continuity of care without draining existing local practices.
- **Facility Completion:** The FVG Region has met all NRRP deadlines for the construction and technological outfitting of local facilities.
- **Active ASUGI Key Hubs:** Active sites include Gorizia, Cormons, Monfalcone, Grado, Muggia, and Trieste (*Ospedale Maggiore and Via Sai*), representing a total investment exceeding **€84 million** (combining NRRP and regional funds).

Involvement of other organisations/actors:

- **Involvement of General Practitioners:** The regional supplementary agreement is currently active, providing for the voluntary participation of family doctors within the Community Houses, alongside a push in August/September 2026 to enhance structured medical presence.
- **Training and Projects:** Specific initiatives include the European EU-PROMENS program for youth community mental health, aimed at creating networks between social workers, psychologists, and local healthcare facilities.
- **Onboarding by October 2026:** An agreement has been reached between the FVG Region (Health

Department) and primary care physician unions, overcoming previous standstills.

- **Information Campaigns:** Following summer public presentations across Trieste, Gorizia, Monfalcone, and Cormons, awareness initiatives are underway to inform citizens about accessing services via the single European hotline **116117**.

Funding source(s) and sustainability:

Active ASUGI Key Hubs: Active sites include Gorizia, Cormons, Monfalcone, Grado, Muggia, and Trieste (*Ospedale Maggiore and Via Sai*), representing a total investment exceeding **€84 million** (combining NRRP and regional funds).

Innovation, Impact and Outcomes:

Emergency Room Diversion: In the first operational months of 2026, approximately **95% of cases handled** at Hub Community Houses (e.g., *Ospedale Maggiore* in Trieste) were resolved locally, preventing unnecessary visits to emergency departments.

Service Volume: Over **11,000 total local interventions** were provided across the Giuliana and Isontina areas (spanning Primary Care clinics, family nursing services, and Single Points of Access).

Evaluation:

Barriers, enables, and learning points:

CHALLENGES:

Transparency and Monitoring: Local representatives and political stakeholders continue to emphasize the need to complete internal staffing (nursing and support personnel) before reaching full operational capacity in autumn.

ENABLERS:

Onboarding by October 2026: An agreement has been reached between the FVG Region (Health Department) and primary care physician unions, overcoming previous standstills.

LEARNING POINTS:

Legal and/or ethical issues:

In Friuli Venezia Giulia, the implementation of Community Houses (*Case della Comunità*) and their integration with mental health services follow the guidelines of the Italian Ministerial Decree 77/2022 to establish a localized social and healthcare model.

Transferability to other regions:

Dissemination and further information:

More info here:

[https://asugi.sanita.fvg.it/it/news/2026_07_09_cda_prese
ntazione.html](https://asugi.sanita.fvg.it/it/news/2026_07_09_cda_prese
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Media:

LINKS AND CONTACTS:

Integrated Community Care and Recovery



Most Innovative Mental Health Strategies Promoted by the FVG Region



Key info:

Organisation name:	EGTC GO
Region:	Autonomous Region Friuli Venezia-Giulia
Country:	Italy
Practice cooperation partners – International collaboration (e.g., Please indicate any organisations involved in the implementation of the practice, particularly if developed through European collaboration (e.g. Joint Actions, Horizon Europe, Interreg, EU4Health, Erasmus+, etc.). If not applicable, write "N/A".):	

Keywords:

Inclusive housing, Peer support, Participatory care, economic and social integration.

Implementation status:

Prevention or mental health promotion initiative, Promising mental health strategies.

Focus areas:

Community-based primary care integration (for the establishment of localized Hub and Spoke Community Houses providing integrated primary care, family nursing, and single points of access under Ministerial Decree 77/2022).

Mental health and social service coordination (for the functional linkage between historic regional Mental Health Centers (CSM) and new territorial operational structures to ensure comprehensive clinical management and prevent care fragmentation).

Multidisciplinary primary care networks (for the structured, flexible onboarding and participation of general practitioners within community facilities to guarantee continuous medical support tailored to local needs).

Acute care diversion and emergency decongestion (for localized patient triage and management designed to resolve cases close to home and significantly reduce unnecessary visits to hospital emergency departments).

Youth mental health and specialized training (for targeted initiatives such as the European EU-PROMENS program, fostering collaborative networks between social workers, psychologists, and local healthcare facilities).

Summary:

Friuli Venezia Giulia is advancing the consolidation of a socio-health model that evolves the principles of Franco Basaglia into modern administrative and therapeutic strategies. Regional planning (structured through the Healthcare System management guidelines and the Mental Health Plan) invests approximately 20 million euros annually into the Health Budget (BdS) tool, involving over 1,300 individuals.

The most innovative strategies and pillars of this methodology are structured across three main levels.

1. Reconversion of Residential Care into Social Habitats

The true innovation of the FVG model lies not in "assisting" individuals within traditional sheltered facilities, but in gradually overcoming standard concepts of residential and semi-residential care.

2. Co-production and ESPs (Experts in Peer Support)

Friuli Venezia Giulia has formalized and integrated the role of ESPs into clinical pathways.

3. Co-management with the Third Sector via a Single Procurement Specification

Unlike other contexts where the social private sector acts as a mere service provider, FVG operates on a model of equal co-design and co-management.

Description and strategic context:

Friuli Venezia Giulia is advancing the consolidation of a socio-health model that evolves the principles of Franco Basaglia into modern administrative and therapeutic strategies. Regional planning (structured through the Healthcare System management guidelines and the Mental Health Plan) invests approximately **20 million euros annually** into the Health Budget (BdS) tool, involving over 1,300 individuals.

Extension of the Model: The success of this strategy led the Region, through Regional Law 22/2019, to formally extend the Health Budget methodology beyond mental health, progressively applying it to all areas of socio-health vulnerability, including substance abuse and child/adolescent neuropsychiatry.

Objectives:

- From facility to project: Economic resources no longer fund a bed rate in a closed clinic or community home; instead, they follow the individual.
- Inclusive housing: Health Budget funds are used to support micro-living areas, supported apartments, or co-housing within the regular urban fabric, transforming the concept of care into "living in the community."

Target group(s):

Primary Target Group: Residents of the Friuli Venezia Giulia region (spanning the ASUFC, ASFO, and ASUGI healthcare authorities) requiring localized primary care, preventive health services, and community-based social assistance through the newly established network of Hub and Spoke Community Houses (*Case della Comunità*).

Secondary Target Group / Specific Subgroups: Vulnerable individuals, chronically ill patients, and persons experiencing mild-to-moderate psychological distress who benefit from the functional linkage between historic Mental Health Centers (*Centri di Salute Mentale* - CSM) and the new territorial structures. Youth populations engaged via dedicated programs such as the European EU-PROMENS initiative.

Indirect Beneficiaries: General practitioners, family nurses, social workers, and multidisciplinary healthcare professionals operating within the integrated local networks, as well as local communities benefiting from single points of access and streamlined emergency avoidance.

Equity dimension:

Addressing Territorial Inequalities: The Community Houses model bridges geographical and structural gaps across the FVG region by deploying over 30 structured hub and spoke

facilities (supported by an investment exceeding €84 million) to guarantee uniform access to primary care and social services.

Integrated Access for Vulnerable Groups: By structurally linking historic Mental Health Centers (CSM) and Territorial Operational Centers (COT) with primary care clinics, the practice ensures that vulnerable and marginalized citizens receive comprehensive, non-fragmented clinical and social support close to home.

Overcoming Administrative and Physical Barriers: The integration of primary care, family nursing, and single points of access (coordinated via the single European hotline 116117) actively eliminates barriers to care. Furthermore, the active onboarding of General Practitioners ensures that primary medical support is equitably distributed according to the specific needs of each local community.

Methodology and processes:

From facility to project: Economic resources no longer fund a bed rate in a closed clinic or community home; instead, they follow the individual.

Inclusive housing: Health Budget funds are used to support micro-living areas, supported apartments, or co-housing within the regular urban fabric, transforming the concept of care into "living in the community."

Experiential knowledge: ESPs are current or former users of mental health services who, following a regional training-intervention program, are regularly employed within Mental Health Departments.

Participatory care: They work alongside healthcare professionals in building the IHRP (*Individualized Therapeutic Rehabilitative Project*). This ensures that the plan is not imposed from above, but co-produced with the patient and their family, valuing those who have personally experienced psychological distress.

Economic and social integration: Through regional framework agreements, over 30 social cooperatives and Third Sector organizations do not just offer "hours of assistance." Instead, they co-invest human resources and relational networks to create genuine employment opportunities (work grants, placements in Type-B social cooperatives) and recovery pathways (reclaiming autonomy and citizenship).

Involvement of other organisations/actors:

Participatory care: They work alongside healthcare professionals in building the IHRP (*Individualized Therapeutic Rehabilitative Project*). This ensures that the plan is not imposed from above, but co-produced with the patient and their family, valuing those who have personally experienced psychological distress.

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cooperatives) and recovery pathways (reclaiming autonomy and citizenship).

Funding source(s) and sustainability:

Regional planning (structured through the Healthcare System management guidelines and the Mental Health Plan) invests approximately 20 million euros annually into the Health Budget (BdS) tool, involving over 1,300 individuals.

- **Funding Sources:** The implementation and technological outfitting of the Community Houses network in Friuli Venezia Giulia are heavily financed through the National Recovery and Resilience Plan (NRRP / PNRR) alongside dedicated regional public health allocations, representing a total investment exceeding €4 million.
- **Organisational and Political Sustainability:** Long-term organizational sustainability is anchored within the regional health governance framework following Italian Ministerial Decree 77/2022. Institutional stability is ensured by formally integrating primary care physicians (via regional supplementary agreements) and aligning historic mental health services (CSM) and Operational Centers (COT) into a permanent, codified regional workflow.

Financial and Practical Sustainability: Continuous operational sustainability is maintained by embedding these decentralized services directly into the regular budgets of the regional health authorities (ASUFC, ASFO, ASUGI). The active participation of general practitioners on a flexible, need-based module ensures ongoing local engagement without overstraining existing resources

Innovation, Impact and Outcomes:

The true innovation of the FVG model lies not in "assisting" individuals within traditional sheltered facilities, but in **gradually overcoming standard concepts of residential and semi-residential care**.

Friuli Venezia Giulia has formalized and integrated the role of **ESPs** into clinical pathways.

Unlike other contexts where the social private sector acts as a mere service provider, FVG operates on a model of **equal co-design and co-management**.

Extension of the Model: The success of this strategy led the Region, through Regional Law 22/2019, to formally extend the Health Budget methodology **beyond mental health**, progressively applying it to all areas of socio-health vulnerability, including substance abuse and child/adolescent neuropsychiatry.

Innovative Aspects of the Practice: The primary innovation of the FVG Community Houses model is the successful transition from a hospital-centric paradigm to a localized, multidisciplinary community network that fully integrates

primary care, social services, and historic regional models of mental health excellence (CSM). By enforcing ministerial decree standards (DM 77/2022) through a network of Hubs and Spokes, the model redefines proximity care. A key operational innovation is the seamless coordination via Territorial Operational Centers (COT) and the single European hotline 116117, which acts as a single gateway for citizens. Furthermore, the model innovates through structural collaboration with General Practitioners operating on flexible, need-based schedules within the facilities, and targeted youth-focused European frameworks like EU-PROMENS that connect social workers, psychologists, and local healthcare structures.

Main Impacts and Outcomes: Though in its scaling and consolidation phase as of late 2026, the initiative has already delivered remarkable quantitative and qualitative results across the region:

- **Emergency Room Decongestion:** In the initial operational months of 2026, Hub Community Houses (such as Ospedale Maggiore in Trieste) achieved a local resolution rate of approximately 95% for incoming cases, drastically preventing unnecessary visits to hospital emergency departments.
- **High Service Volume:** The network has delivered over 11,000 total local interventions across the Giuliana and Isontina areas, spanning primary care clinics, family nursing, and single access points.
- **Prevention of Care Fragmentation:** The functional linkage between CSMs, COTs, and Community Houses has successfully bridged the gap between mental health and general medical care, ensuring comprehensive management for vulnerable groups.
- **Infrastructure and Staffing Targets:** All regional NRRP milestones for facility construction and technological outfitting have been successfully met across more than 30 planned structures in ASUFC, ASFO, and ASUGI.

Future Evaluation and Scalability: The rapid diversion of emergency cases and high intervention volumes demonstrate the immediate efficacy of the model. Future developments will focus on completing internal staffing (nursing and support personnel) and expanding structured GP presence, providing a highly scalable blueprint for regional primary and mental healthcare integration across Europe.

Evaluation:

Evaluation Approach and Framework: The Community Houses initiative utilizes a rigorous mixed methods monitoring framework to track operational progress, clinical

efficacy, and institutional integration across the Friuli Venezia Giulia health authorities (ASUFC, ASFO, ASUGI). The evaluation focuses on measuring how effectively decentralized hub-and-spoke facilities reduce care fragmentation and alleviate pressure on acute care settings.

Methodologies and Indicators:

The evaluation relies on standardized regional data systems and performance indicators:

- **Quantitative Indicators:** Monitoring service volume and local intervention counts (such as the 11,000+ interventions recorded across Isontina and Giuliana areas); tracking emergency room diversion rates (measuring the percentage of cases resolved locally, such as the ~95% success rate at major hubs); tracking infrastructure target completion under NRRP deadlines; and quantifying General Practitioner onboarding rates and working hours.
- **Qualitative Methods:** Stakeholder reviews, administrative monitoring by regional health departments, and feedback sessions involving local representatives, political stakeholders, and multidisciplinary healthcare teams (social workers, psychologists, family nurses) to assess internal staffing levels, workflow cohesion, and patient satisfaction.

Expected Outcomes and Future Scaling: Ongoing data collection ensures full transparency and accountability as facilities reach full operational capacity. The evaluation framework provides vital evidence on the viability of blending primary care with historic regional mental health policy evaluations.

Barriers, enables, and learning points:

CHALLENGES:

Initial GP Standstills: Initial resistance and scheduling standstills regarding the integration of General Practitioners into community facilities required extensive negotiations between the FVG Health Department and primary care physician unions.

Staffing and Resource Constraints: Reaching full operational capacity has required careful management to secure adequate internal staffing levels (specifically nursing and support personnel) across all newly constructed hub and spoke structures.

Bureaucratic Coordination: Aligning historic regional mental health centers (CSM) and territorial operational centers (COT) with newly built physical infrastructure demanded meticulous administrative synchronization across different healthcare authorities (ASUFC, ASFO, ASUGI).

ENABLERS:

Robust Regulatory and Financial Framework: Strong backing from national guidelines (Ministerial Decree 77/2022) and substantial financial investments combining NRRP funds and regional allocations (exceeding €84 million) provided a clear roadmap and secure resources.

Flexibility in Operational Agreements: The establishment of a tailored, need-based module for family doctors enabled voluntary participation without destabilizing existing local medical practices.

Strong Institutional Commitment: Active oversight by regional health authorities, combined with public transparency initiatives and structured citizen awareness campaigns (promoting the 116117 hotline), ensured strong community buy-in.

LEARNING POINTS:

Immediate Impact on Acute Care: An unexpectedly high positive effect was the rapid diversion rate—approximately 95% of cases at major hub facilities were resolved locally in early 2026, proving that proximity-based infrastructure can immediately relieve pressure on hospital emergency departments.

The Value of Flexible Compromise: The experience demonstrated that rigid top-down staffing models must be paired with flexible operational agreements (such as customized GP scheduling) to successfully bridge independent primary care with public health networks.

Public Engagement as a Catalyst: Broad summer public information campaigns across Trieste, Gorizia, Monfalcone, and Cormons highlighted that transparent community communication is essential to drive public trust and utilization of single access points.

Legal and/or ethical issues:

Governance Framework: The implementation of Community Houses operates strictly under the governance guidelines of Italian Ministerial Decree 77/2022, coordinated regionally through ASUFC, ASFO, and ASUGI healthcare authorities.

Legal and Regulatory Compliance: Integrating General Practitioners into public structures required formal regional supplementary agreements and adherence to national labor and professional liability frameworks for primary care physicians.

Data Protection and Consent: The functional linking of historic Mental Health Centers (CSM) and Territorial Operational Centers (COT) necessitates strict compliance with the **EU General Data Protection Regulation (GDPR)**.

Secure, interoperable digital health records ensure safe clinical data sharing between primary care providers and specialized mental health teams while safeguarding patient privacy.

Ethical Considerations: The model upholds fundamental healthcare ethics, ensuring equitable geographic access, voluntary community-based care, and the protection of vulnerable and chronically ill patients through person-centred local services.

Transferability to other regions:

Transferability requires further validation.

Transferability Maturity: The Friuli Venezia Giulia Community Houses model possesses a high level of transferability and maturity, demonstrating how regional health systems can successfully operationalize national decree standards (like DM 77/2022) to merge primary care, social services, and specialized mental health networks.

Adaptation and Replication Potential: The framework is highly replicable in other European regions seeking to overcome hospital-centric care models. Its core components—hub-and-spoke facility distribution, flexible general practitioner integration, and the functional bridge between territorial operational centers (COT) and mental health services (CSM)—can be adapted to diverse national legislative contexts.

Prerequisites for Success: Key prerequisites for successful replication include:

- Solid national or regional regulatory frameworks providing clear structural standards for community-based healthcare.
- Dedicated capital investment streams (such as EU recovery funds or regional public allocations) for infrastructure and technological outfitting.
- Formal agreements with primary care physician unions to establish flexible, need-based staffing models.

Tools and Documentation Supporting Transfer: To facilitate transfer to other regions, valuable documentation includes regional decree implementation guidelines, standardized protocols for linking mental health centers with primary care hubs, interoperable digital health data-sharing frameworks, and public communication toolkits for single access points (like the 116117 hotline infrastructure).

Dissemination and further information:

Communication and Outreach Activities: Dissemination of the FVG Community Houses model is driven by public presentations, institutional workshops, and regional information campaigns. Noteworthy activities include public meetings held across Trieste, Gorizia, Monfalcone, and Cormons to engage citizens on local health access.

Media and Public Engagement: The initiative is actively promoted through regional institutional web portals, press releases, and specialized health updates, ensuring continuous public awareness regarding the rollout of the over 30 planned hub and spoke facilities.

Reports and Online Resources: Comprehensive updates, official decrees, and operational guidelines are publicly documented on official regional healthcare portals. Further details, news updates, and institutional reports are accessible directly via the **ASUGI official website** (asugi.sanita.fvg.it) and regional health department channels, providing complete references for external organizations and stakeholders.

Media:

LINKS AND CONTACTS:

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Integrated Community Care and Recovery



Personal Health Budget: A Methodology for Designing Individualized Therapeutic, Rehabilitation Social Inclusion Programmes



Key info:

Organisation name:	Emilia-Romagna Region
Region:	Emilia-Romagna
Country:	Italy
Practice cooperation partners – International collaboration (e.g., Please indicate any organisations involved in the implementation of the practice, particularly if developed through European collaboration (e.g. Joint Actions, Horizon Europe, Interreg, EU4Health, Erasmus+, etc.). If not applicable, write "N/A".):	At a regional level: Local Health Authorities (AUSL), Municipal Social Services and Third Sector organisations. Primarily developed at regional level. The practice is aligned with Italian national guidelines on Budget di Salute and has contributed to the national experimentation coordinated by the Ministry of Health and the Istituto Superiore di Sanità. It is also coherent with WHO principles on community mental health, recovery and social inclusion

Keywords:

Community mental health, recovery-oriented care, social inclusion, personalised care, integrated health and social services.

Implementation status:

Fully implemented mental health policy/programme/initiative, community-based mental health initiative, integrated care / cross-sectoral mental health initiative, practice addressing vulnerable or underserved groups.

Focus areas:

Community-based mental health services, Recovery and rehabilitation, Integrated care, Social inclusion, Access to services, Person-centred care, Support for vulnerable groups, Anti-institutionalisation approaches.

Summary:

The Health Budget (Budget di Salute) is a community-based and recovery-oriented intervention developed in Emilia-Romagna to support people with severe mental health conditions and complex social needs. It combines

healthcare, social care, housing, employment, educational and community resources within a single personalised therapeutic and rehabilitation project.

The practice was introduced to address the limitations of traditional service-centred approaches and to prevent long-term institutionalisation. Instead of focusing only on clinical treatment, the model places the individual, their aspirations, capabilities and social environment at the centre of care. Each project is co-designed with the person and involves a multidisciplinary assessment conducted jointly by mental health services and social services.

The initiative promotes independent living, access to education and employment opportunities, participation in community life and the strengthening of social relationships. Resources may come from health services, municipalities, welfare programmes, third-sector organisations, families and community actors, creating an integrated package of support tailored to individual needs.

Since its adoption through regional guidelines, the model has progressively expanded across Emilia-Romagna and has become an important tool for recovery, social inclusion and continuity of care. It supports transitions from residential settings to community living, improves coordination

between sectors and encourages active participation of service users in decisions affecting their lives. The practice is increasingly recognised as an effective mechanism for combining health and social investments while promoting dignity, autonomy and quality of life for people experiencing serious mental health difficulties.

Description and strategic context:

Mental health services across Europe face the challenge of supporting people with severe mental illness who experience social exclusion, unemployment, housing instability and repeated institutionalisation. Emilia-Romagna identified the need for a more integrated and person-centred approach capable of addressing both clinical and social determinants of mental health. The Budget di Salute was formally supported through regional guidelines adopted in 2015 and has been progressively strengthened through regional working groups and implementation programmes. The model is consistent with the Italian mental health reform tradition, the recovery-oriented approach promoted by WHO and the growing European emphasis on community-based care and social inclusion.

The initiative also supports the principles of integrated care promoted through national reforms and the Italian Territorial Care Reform (DM 77/2022), which highlights the importance of personalised care pathways and community-based services.

At the national level, the Health Budget (Budget di Salute) approach was consolidated through an interregional process launched in 2019, which led to the development of national programme guidelines. In 2022, the Italian Ministry of Health initiated a national experimentation programme coordinated by the Emilia-Romagna Region and the National Institute of Health (ISS), aimed at supporting implementation, documenting experiences and assessing outcomes across participating regions.

Objectives:

Overall objective: To improve mental health recovery, autonomy, social participation and quality of life of people with severe mental health conditions through personalised, community-based and integrated support plans.

Specific objectives

- Reduce institutionalisation and dependence on residential care.
- Promote independent living and community inclusion.
- Support access to education, vocational training and employment.
- Strengthen social networks and meaningful relationships.
- Improve coordination between health services, social services and community organisations.
- Enable service users to participate actively in defining their own life projects.

- Address social determinants of mental health through integrated interventions.
- Improve efficiency and appropriateness in the use of health and social care resources.
- Promote recovery-oriented and rights-based mental healthcare.

The practice aims to move from a service-driven model towards a person-driven model where individual aspirations and capabilities guide care planning and resource allocation.

Target group(s):

The primary beneficiaries are adults with severe mental health disorders receiving treatment within Community Mental Health Services and presenting complex health and social needs.

Specific target groups include who:

- are at risk of institutionalisation
- experience housing difficulties
- face social isolation
- have limited family support
- experience unemployment or barriers to education
- require integrated health and social interventions.

Indirect beneficiaries include families, carers, community organisations, health professionals and social services involved in supporting recovery pathways.

Equity dimension:

The Budget di Salute specifically addresses inequalities experienced by individuals with severe mental illness, a population at high risk of poverty, discrimination, social exclusion and reduced access to opportunities.

The model recognises that recovery depends not only on treatment but also on access to housing, employment, education, social participation and community resources. By tailoring support to individual circumstances and vulnerabilities, it promotes equitable access to opportunities and seeks to reduce structural disadvantages affecting people with mental health conditions.

Particular attention is given to individuals with complex needs, limited social networks and high levels of dependency on services.

Methodology and processes:

The Health Budget (Budget di Salute) is implemented through a personalised and multidisciplinary approach. A multidisciplinary assessment team, involving mental health services, social services and other relevant actors, jointly defines a personalised therapeutic and rehabilitation plan. The plan integrates healthcare, social support, housing, employment, education and community resources according to the person's goals, strengths and needs.

Based on the objectives identified, each sector contributes the resources under its responsibility, which may include healthcare interventions, social care, housing support, employment measures, educational opportunities or community-based initiatives. The Health Budget therefore

acts as a coordination mechanism that aligns and integrates multiple funding streams and resources around a single person-centred recovery project. Regular monitoring by the multidisciplinary team ensures coherence, avoids fragmentation and allows resources to be adjusted according to the individual's evolving needs. Progress is regularly monitored, and the project is adapted over time to support recovery, autonomy and social inclusion, with the ultimate aim of reducing institutionalisation and promoting independent living within the community.

Involvement of other organisations/actors:

The model is inherently collaborative.

Participants include:

- Local Health Authorities (AUSL);
- Community Mental Health Centres;
- Municipal Social Services;
- Housing and employment services;
- Third Sector organisations and social cooperatives;
- Families and caregivers;
- Service users;
- Regional Mental Health Consultation bodies.

Service users are directly involved in designing, agreeing and monitoring their individual projects. Families and community stakeholders may contribute to implementation whenever appropriate.

Funding source(s) and sustainability:

The term *Budget di Salute* (Health Budget) does not refer simply to a dedicated financial allocation. Rather, it describes a model for integrating and coordinating different sources of resources around a personalised recovery project. Thus, Funding is flexible and combines multiple sources including

- Regional Health Service;
- Municipalities – Social service budgets;
- Contributions from third-sector organisations;
- Individual and family resources where appropriate.

The “budget” is a combination of health, social, housing, educational, employment and community resources that can be mobilised to support an individual's life goals and recovery pathway. These resources may come from regional health services, municipal social services, welfare programmes, third-sector organisations, families, community networks and, where appropriate, the individual themselves. The key innovation of the model is the integration and flexible use of these multiple funding and support streams within a single personalised care and life project, rather than financing separate services in isolation.

The coordination of the Health Budget is achieved through a shared governance process rather than through a single pooled fund.

Innovation, Impact and Outcomes:

The main innovation lies in shifting from funding services to funding personalised recovery pathways.

Key innovative features include:

- integration of health and social resources;
- personalised allocation of support;
- co-production with service users;
- focus on recovery instead of symptom management only;
- strong community-based orientation.
- Observed impacts include:
- greater individual autonomy;
- improved social inclusion;
- enhanced collaboration between sectors;
- reduced dependence on residential services;
- stronger alignment between available resources and individual needs.
- The model has remained operational and has progressively expanded across the region over almost a decade, demonstrating organisational feasibility and policy sustainability. It has also informed national discussions on community mental health and personalised care pathways.

Evaluation:

The mechanisms to monitor the application of the Health Budget (*Budget di Salute*) implementation in Emilia-Romagna were established in the *Delibera di Giunta Regionale* No. 1554/2015.

Since 2016, the regional “Social Inclusion and Health Budget” Working Group, coordinated by the Local Health Authority of Parma (AUSL Parma), has been responsible for promoting, monitoring and further developing the model across the different local territories of Emilia-Romagna. Over the years, the Working Group has produced technical guidance documents and operational recommendations, while collecting experiences, lessons learned and implementation challenges from local services throughout the region.

Barriers, enables, and learning points:

CHALLENGES:

Implementing the *Budget di Salute* requires a significant organisational and cultural shift. One of the main challenges has been moving from a service-centred approach, where interventions are linked to predefined services and facilities, to a person-centred model built around individual life projects. This transition requires continuous coordination between health services, social services, municipalities and third-sector organisations, as well as the adaptation of administrative and procurement procedures to support personalised and flexible interventions. Differences in local implementation practices, governance arrangements and resource availability across territories have also represented challenges that the regional working groups have sought to address through shared guidance and exchange of experiences.

(See [II Budget di Salute in Emilia-Romagna: Work in Progress](#))

ENABLERS:

Several factors have enabled the successful development of the model in Emilia-Romagna. These include sustained regional commitment since the adoption of the 2015 Guidelines, the establishment of the Regional Working Group on Social Inclusion and Health Budgets, and the active involvement of Mental Health Departments, municipalities, service users, families and third-sector organisations. The existence of a strong tradition of community mental health care and intersectoral collaboration has provided a favourable environment for implementing personalised recovery pathways. The regional governance structure has also facilitated continuous learning, dissemination of good practices and progressive refinement of operational procedures. (See [II Budget di Salute in Emilia-Romagna: Work in Progress](#))

LEARNING POINTS:

A key lesson emerging from the Emilia-Romagna experience is that recovery is strongly influenced by social determinants such as housing, employment, education, relationships and community participation. The Budget di Salute demonstrates that these dimensions cannot be treated as separate from healthcare but need to be integrated within a single personalised project. Another important lesson is that the concept of “budget” should not be understood merely as a financial allocation but as a mechanism for coordinating different resources and stakeholders around shared objectives defined together with the person. Finally, the experience shows that sustainable community-based mental health care requires long-term partnerships between institutions, communities and service users, supported by flexible governance arrangements and a continuous process of monitoring and improvement. (See [II Budget di Salute in Emilia-Romagna: Work in Progress](#))

Legal and/or ethical issues: The practice operates within Italian and regional health and social care legislation. Individual projects are based on informed participation, multidisciplinary assessment and shared decision-making. Personal data are managed according to applicable Italian and European data-protection regulations (GDPR). Governance is ensured through collaboration between health authorities, municipalities and authorised service providers.

Transferability to other regions:

Transferable with contextual adaptation.

The experience of Emilia-Romagna suggests that the Budget di Salute is highly relevant for other European regions seeking to strengthen community-based mental health care, integrated care and recovery-oriented approaches. Its core principles, namely personalised care planning, co-production with service users, integration of health and

social support, and a focus on social determinants of health, are consistent with current European policy priorities on mental health, social inclusion and deinstitutionalisation.

A key strength of the model is that it does not require the creation of a new funding programme. Rather, it provides a governance and coordination framework through which existing health, social, housing, employment and community resources can be aligned around a shared individual recovery plan. This makes the approach potentially adaptable to different welfare systems and institutional settings across Europe.

Importantly, transferability has already been tested within Italy. Since the publication of national programme guidelines and the launch of the national experimentation coordinated by the Emilia-Romagna Region and the National Institute of Health (ISS), several regions have adapted the model to their own organisational and regulatory contexts. This experience has demonstrated that the approach can be implemented in diverse territorial settings while maintaining its core principles of personalisation, recovery and integrated care.

The Italian experience also highlights several enabling factors for successful transfer. These include strong political commitment, a shared governance framework involving health and social services, active participation of municipalities and third-sector organisations, and the existence of multidisciplinary teams capable of co-designing personalised projects with service users and families. Continuous exchange of experiences through regional and national networks has also been essential for consolidating practice and addressing implementation challenges.

At the same time, implementing the model in other European countries may present challenges. These include fragmented funding responsibilities between sectors, different legal and administrative frameworks, limited experience with co-production approaches, and insufficient coordination between health and social care systems. The Emilia-Romagna experience shows that the main challenge is often not financial but organisational, requiring a cultural shift from service-centred provision towards person-centred recovery pathways. Developing common assessment procedures, flexible administrative mechanisms and cross-sector governance arrangements may therefore be necessary prerequisites for successful adaptation.

Overall, the Budget di Salute should be viewed not as a specific funding instrument, but as a transferable methodology for integrating resources and responsibilities around the life goals of people with complex mental health needs. Its implementation in different Italian regions demonstrates both the feasibility of adaptation and the importance of tailoring governance arrangements to local institutional and welfare contexts.

Dissemination and further information:

- **Regione Emilia-Romagna, “[Il Budget di salute](#)” (2025)**
Approfondimento istituzionale che descrive il Budget di Salute come strumento per costruire progetti terapeutico-riabilitativi personalizzati centrati su abitare, lavoro, relazioni e inclusione sociale.
- **AUSL Parma, “[Budget di Salute in Emilia-Romagna: work in progress](#)”**
Ricostruisce il percorso regionale, la DGR 1554/2015 e l'applicazione del Budget di Salute nei Dipartimenti di Salute Mentale e Dipendenze Patologiche.
- **Regione Emilia-Romagna, [Piano Attuativo Salute Mentale 2024](#)** Il Budget di Salute viene indicato come modello di riferimento per i progetti individualizzati e per il “Fondo per l'autonomia possibile - Salute mentale”.
- <https://salute.regione.emilia-romagna.it/salute-mentale/>
- **[Panorama della Sanità](#) (18 giugno 2024)**
Articolo dedicato al Piano Salute Mentale da 40

milioni di euro, che evidenzia il Budget di Salute come approccio innovativo per l'inclusione sociale e la personalizzazione degli interventi

- **[Documentazione regionale e formativa sul Budget di Salute](#)**
Presentazione “Il Budget di Salute in Emilia-Romagna”, che descrive sperimentazioni regionali, recovery, integrazione sociosanitaria e collegamento tra sistema di cura e comunità
- **[“Il Budget di Salute: percorso di implementazione regionale”](#)**
Documento che ripercorre l'evoluzione del modello in Emilia-Romagna, le sperimentazioni nelle AUSL e il Tavolo regionale “Inclusione sociale e Budget di Salute”

Media:

LINKS AND CONTACTS:

Regione Emilia-Romagna, Direzione Generale Cura della Persona, Salute e Welfare
[Settore Assistenza territoriale](#) - [Settore Ricerca](#) e [Innovazione nei Sistemi Sanitari e Sociali](#)

Integrated Community Care and Recovery



Regional Network of Peer Support Experts and Social Facilitators of Emilia- Romagna



Key info:

Organisation name:	Emilia-Romagna Region
Region:	Emilia-Romagna
Country:	Italy
Practice cooperation partners – International collaboration (e.g., Please indicate any organisations involved in the implementation of the practice, particularly if developed through European collaboration (e.g. Joint Actions, Horizon Europe, Interreg, EU4Health, Erasmus+, etc.). If not applicable, write "N/A".):	At a regional level: Local Health Authorities (AUSL), Municipal Social Services and Third Sector organisations. Presented at JA Mentor international conference in Bologna (May 2026) , even though RER is not directly involved in the JA. Collaboration w/ University of Padua

Keywords:

Peer support; social inclusion; empowerment; community-based mental health services, integrated care; training of professionals, anti-stigma initiatives.

Implementation status:

Ongoing implementation of a mental health policy/programme/initiative.

Focus areas:

Peer support; social inclusion; empowerment; community-based mental health services, integrated care; training of professionals, anti-stigma initiatives.

Summary:

The **Regional Network of Peer Support Experts and Social Facilitators of Emilia-Romagna (RETE ESP/FS)** was established in 2016 to promote recovery, social inclusion, empowerment and active citizenship for people experiencing mental health and psychosocial challenges. The Network brings together Peer Support Experts (ESPs), social facilitators, mental health professionals, family members, volunteers and community organisations,

fostering collaboration between services and people with lived experience.

A **Peer Support Expert (ESP)** is a person who has experienced mental health difficulties, undertaken a personal recovery journey, developed self-awareness and resilience, and completed specific training to support others. Drawing on their lived experience, ESPs provide empathetic and non-judgemental support to people facing similar challenges, complementing professional interventions with experiential knowledge and offering hope, encouragement and practical guidance.

Within the project, ESPs play a central role. They support individuals in recovery, facilitate communication between service users and professionals, promote autonomy and social inclusion, and contribute to the design and improvement of services. Their involvement helps reduce stigma, strengthens trust in recovery processes, and makes mental health services more person-centred, accessible and responsive to users' needs. The Network also ensures that the perspectives of service users are represented in regional and local policy and planning forums.

A distinctive feature of the project is its commitment **to the professional recognition and qualification of the ESP role.**

Since its creation, the Network has advocated for the formal acknowledgement of ESPs within the regional welfare and healthcare system, identifying professionalisation as a key step towards sustainable employment opportunities. With support from the Emilia-Romagna Region, dedicated training programmes have been developed, including vocational courses leading to the regional qualification of **“Orientatore” (Counsellor/Guide)**, currently the professional framework used to recognise and employ ESPs. The Network has also organised workshops, conferences and continuing training initiatives, while promoting pathways towards a specific professional recognition of the ESP role within mental health and addiction services.

Description and strategic context:

The practice addresses the social and personal consequences of **mental health difficulties and psychosocial distress**, including social exclusion, stigma, reduced participation in community life, and the need for more recovery-oriented and person-centred support. People who have experienced mental illness often benefit from support provided by others with similar lived experience, as peer relationships can foster hope, empowerment, self-determination, recovery and engagement with care pathways. The initiative also seeks to make mental health services more responsive by incorporating experiential knowledge alongside professional expertise.

Emilia-Romagna has progressively recognised the value of **peer support** within its mental health system. Since the first ESP experiences started in 2009, the Region has supported the development of structured networks, training opportunities and dedicated funding mechanisms. The creation of the Regional Network in 2016 reflects the regional commitment to strengthening recovery-oriented approaches, fostering social inclusion, reducing stigma and increasing the participation of service users in service design and governance. The growing institutional support, including dedicated regional funding and the extension of the ESP model to addiction services, demonstrates that this is considered a strategic priority for improving mental health and community wellbeing.

The practice is strongly embedded in regional mental health policies, as outlined in the **Emilia-Romagna Mental Health Implementation Plan (DGR 313/2009)**, which established the Regional Mental Health Consultation as a key participation mechanism and supported the growth of the ESP movement. The initiative has subsequently been reinforced through several regional funding programmes and policy measures promoting innovation, participation, recovery, community-based care and mental health service improvement.

Objectives:

Overall objective: Promote recovery, empowerment, social inclusion and active citizenship of people with lived

experience of mental health and psychosocial difficulties through peer support and participatory approaches.

Specific objectives

- Develop and strengthen peer support as a complement to professional mental health care.
- Support individual recovery journeys through mutual aid, hope and empowerment.
- Improve mental health services by incorporating perspective and experiential knowledge of service users.
- Promote person-centred, participatory and recovery-oriented models of care.
- Reduce stigma and discrimination associated with mental health conditions
- Foster social inclusion, citizenship and community participation of people experiencing psychosocial distress.
- Represent the voice of service users in regional and local policy and planning forums.
- Provide training, qualification and professional development opportunities for Peer Support Experts and advocate for formal recognition of their role
- Strengthen collaboration among users, professionals, families, associations and public institutions.

Target group(s):

The practice benefits a broad range of stakeholders involved in mental health recovery and social inclusion across Emilia-Romagna.

Direct beneficiaries are primarily **Peer Support Experts (ESPs) and Social Facilitators**, namely people with lived experience of mental health or psychosocial difficulties who have undertaken a recovery journey and completed specific training. Through participation in the Network, they gain opportunities for further training, peer exchange, professional development, empowerment, and access to pathways toward employment and formal role recognition. A second group of direct beneficiaries comprises **people currently experiencing mental health challenges or psychosocial distress** who receive peer support from ESPs. They benefit from motivational support, guidance through recovery pathways, increased self-determination, social inclusion opportunities, and improved access to services through relationships based on shared lived experience.

Indirect beneficiaries include:

- **Mental health services and professionals** (psychiatrists, psychologists, nurses, educators and social workers), who benefit from the integration of experiential knowledge into care and service planning.
- **Family members and carers**, who are involved in Network activities and benefit from more recovery-oriented and inclusive support systems.

- **Voluntary organisations, community associations and local authorities**, which participate in collaborative actions promoting recovery, inclusion and community wellbeing.
- **The wider community**, through reduced stigma, increased awareness of mental health issues and stronger models of active citizenship and social participation.

The main inclusion criterion for ESPs is having **personal lived experience of mental health difficulties and recovery**, combined with participation in dedicated training pathways that prepare them to provide peer support and act as facilitators within services and community settings.

Equity dimension:

The practice primarily addresses inequalities experienced by people with **mental health and psychosocial difficulties**, a group that often faces stigma, social exclusion, barriers to employment, limited participation in community life, and unequal access to support networks. By valuing lived experience as a resource, the Network promotes a more inclusive and recovery-oriented approach that empowers individuals who are traditionally viewed only as recipients of care.

A key feature of the practice is its focus on **peer support**, which helps reach people who may feel disconnected from or mistrustful of traditional services. Through relationships based on shared experience, ESPs provide emotional support, foster hope, strengthen self-determination and facilitate engagement with care and rehabilitation pathways. This approach is particularly relevant for individuals experiencing social vulnerability, marginalisation, long-term mental health conditions, or difficulties in social and occupational inclusion.

The Network also promotes **active citizenship and participation**, ensuring that people with lived experience can contribute to service planning, evaluation and decision-making processes. In doing so, it helps reduce power imbalances between professionals and service users and gives voice to groups that are often underrepresented in mental health governance.

Although the documents do not describe specific actions targeting age groups, gender, migrants, rural populations or ethnic minorities, they clearly emphasize inclusion of **fragile and vulnerable individuals**, social participation, anti-stigma actions, and equal opportunities for people with mental health difficulties to access training, employment and community life.

Methodology and processes:

The practice has been implemented progressively in Emilia-Romagna since the first experiences involving **Peer Support Experts (ESPs)** emerged within community mental health services in 2009. These local initiatives were gradually consolidated through regional policy support, leading to the establishment of the **Regional Network of Peer Support Experts and Social Facilitators (RETE ESP/FS)** in 2016 as a

structured platform for coordination, training, advocacy and exchange of practices.

The implementation process begins with the identification and engagement of people with lived experience of mental health difficulties who have undergone a recovery journey and are willing to use their experiential knowledge to support others. Prospective ESPs participate in dedicated training programmes that strengthen competencies in peer support, communication, facilitation, empowerment and recovery-oriented approaches. Regional funding has supported vocational training pathways, including courses leading to the regional qualification of **Orientatore**, currently used as the professional framework for ESPs.

Once trained, ESPs are integrated into a network involving mental health professionals, service users, family members, volunteers, associations and public institutions. The Network meets regularly, including monthly meetings held in different local areas, to facilitate coordination, mutual learning and exchange of experiences. Workshops, residential seminars, conferences and training events are organised to strengthen competencies, disseminate good practices and consolidate common values and methodologies.

The main implementation methodology is **peer support**, whereby ESPs use their lived experience to offer emotional support, motivational encouragement, guidance through recovery pathways and mediation between service users and professionals. Their activities complement clinical and social care interventions and are based on principles of mutual understanding, active listening, solidarity, self-determination, empowerment and recovery. ESPs operate in collaboration with mental health services, accredited organisations, community associations and, more recently, addiction services (SerDP).

At system level, the Network carries out awareness-raising activities, promotes participatory service development, represents users' perspectives in regional and local working groups, and advocates for the recognition of the ESP role. Key implementation tools include regional mapping of ESP initiatives, networking activities, training curricula, workshops, conferences and collaborative governance mechanisms involving service users and professionals.

More recently, the model has been expanded to addiction services through a dedicated regional programme (2023-2025), including mixed training courses involving both professionals and peer experts, the creation of regional working groups, and research activities conducted with the University of Padua to support the integration and sustainability of the ESP role within services.

Involvement of other organisations/actors:

The practice is characterised by a high degree of stakeholder participation and co-production. It was developed from the recognition that people with lived experience of mental health difficulties possess valuable knowledge that can contribute to recovery pathways, service improvement and community wellbeing. The

creation of the Regional Network in 2016 formalised a collaborative approach involving service users, Peer Support Experts (ESPs), mental health professionals, family members, volunteers, associations and regional institutions.

Service users and Peer Support Experts are at the core of the practice. Individuals with lived experience actively contribute not only as beneficiaries but also as providers of support, trainers, advocates and representatives of the user perspective. Through the Network, they participate in defining priorities, sharing experiences, developing training activities and promoting recovery-oriented approaches. The Network also represents users' perspectives in regional, departmental and social policy forums, ensuring their involvement in decision-making processes.

Mental health professionals, including psychiatrists, psychologists, nurses, educators and social workers, are directly involved in the implementation of activities, training initiatives and collaborative service delivery models. ESPs work alongside professionals within mental health services, contributing experiential knowledge that complements clinical expertise.

Family members, carers, volunteers and civil society organisations are active participants in the Network and contribute to awareness-raising, community engagement and social inclusion initiatives. The Network itself brings together associations and community organisations from across Emilia-Romagna, fostering collaboration around recovery and anti-stigma objectives.

At the institutional level, the **Region of Emilia-Romagna**, Mental Health Departments, local services and, more recently, addiction services (SerDP) have supported the development of the practice through funding, planning, training and governance mechanisms. Stakeholder involvement has also extended to academia, including a collaboration with the University of Padua to evaluate organisational conditions affecting the integration of ESPs and to generate evidence supporting further development of the mode.

Funding source(s) and sustainability:

The practice is supported primarily through **regional public funding** provided by the Emilia-Romagna Region within its mental health, addiction and community wellbeing policies. Since the establishment of the Regional Network in 2016, the Region has financed a range of activities, including peer-support workshops, residential training events, conferences, publications, networking activities and vocational training pathways for Peer Support Experts (ESPs). Dedicated regional funding programmes have continued over time through successive regional resolutions supporting innovation in mental health and addiction services.

Organisational sustainability is ensured through the Network's structure, which brings together ESPs, mental health professionals, family members, volunteers, associations, Mental Health Departments and other local

stakeholders. Regular meetings, shared governance mechanisms, training initiatives and collaboration with public services allow the practice to remain active and embedded within the regional mental health system. The Network also operates as a platform for knowledge exchange, advocacy and continuous capacity building for ESPs.

Political sustainability is supported by the progressive institutional recognition of peer support within regional mental health planning. The practice is linked to regional policy frameworks promoting participation, recovery and community-based mental health care, including the Regional Mental Health Consultation and subsequent regional programmes dedicated to mental health and addictions. Continued policy support is reflected in dedicated funding allocations and the expansion of the ESP model to addiction services.

Financial sustainability is further strengthened through efforts to formalise and professionalise the ESP role. The development of accredited training pathways, including the regional qualification of **Orientatore**, and ongoing advocacy for specific professional recognition aim to create stable employment opportunities for ESPs within public and accredited services. Recent investments in training, regional coordination structures and research partnerships, including collaboration with **the University of Padua**, support the long-term integration of peer support into routine mental health and addiction services.

Innovation, Impact and Outcomes:

The practice is innovative because it systematically integrates **lived experience** into mental health services, recognising Peer Support Experts (ESPs) not merely as service users but as active contributors to recovery, service delivery, training and policy development. Rather than relying exclusively on professional expertise, the model combines clinical knowledge with experiential knowledge, promoting a recovery-oriented, person-centred and co-produced approach to mental health care. The establishment of a regional network connecting ESPs, professionals, families, voluntary organisations and institutions is itself an innovative feature, creating a structured framework for peer support, mutual learning and participation across the entire region.

Another innovative aspect is the Network's commitment to the **professionalisation of peer support**. Beyond informal mutual aid, the practice has developed training pathways, promoted vocational qualifications, supported employment opportunities and advocated for formal recognition of the ESP role within the regional health and social care system. The extension of the model to addiction services and the development of mixed training programmes involving both professionals and peer experts further demonstrate its capacity for innovation and adaptation.

The main reported outcomes are both organisational and social. The practice has contributed to:

- the creation of a **regional network of Peer Support Experts and Social Facilitators** operating across Emilia-Romagna;
- greater participation of people with lived experience in mental health services, training activities and policy discussions;
- increased visibility and legitimacy of the ESP role within mental health and addiction services;
- the development of regional training programmes and vocational pathways, including courses leading to the regional qualification of *Orientatore*;
- stronger collaboration among service users, professionals, families, associations and public institutions;
- promotion of recovery, empowerment, active citizenship, social inclusion and stigma reduction.

Evidence of impact is primarily qualitative. The documents report sustained regional support since the first ESP experiences in 2009, the formal establishment of the Regional Network in 2016, dedicated regional funding for workshops, training and networking activities, the implementation of vocational training programmes, and the expansion of the model to addiction services from 2023 onward. They also document the participation of ESPs in regional consultation mechanisms and service-development processes.

The available documentation does **not provide quantitative outcome indicators** such as numbers of beneficiaries reached, employment rates, service utilisation outcomes, clinical improvements, cost-effectiveness measures or satisfaction scores. Similarly, no formal evaluation results or user-feedback data are reported. However, the Region has invested in further evidence generation through a research collaboration with the University of Padua examining organisational factors influencing the integration and effectiveness of ESPs within services. This demonstrates a commitment to strengthening the evidence base and supporting future evaluation of outcomes.

Evaluation:

So far, no formal impact evaluation with predefined outcome indicators or quantitative performance measures

To date, monitoring has primarily occurred through the Network's ongoing coordination activities, regular meetings, regional mapping of ESP experiences, training programmes, workshops and conferences, which have enabled the collection of information on the development and diffusion of Peer Support Experts (ESPs) across Emilia-Romagna. Evidence of progress includes the establishment of the Regional Network in 2016, the expansion of ESP activities within mental health services, the development of vocational training pathways, and the inclusion of ESPs in regional consultation and governance mechanisms.

A more structured evaluation approach is currently being developed in collaboration with the University of Padua, through a research on the implementation of ESPs within addiction services (SerDP). The results of this research are

expected to provide evidence to guide future implementation and support the long-term integration of ESPs within regional services.

In addition, regional plans for 2026 include the creation of mixed working groups involving both professionals and ESPs, further training activities, and the analysis and use of research findings to refine the model.

Barriers, enables, and learning points:

CHALLENGES:

- Limited recognition of experiential knowledge within traditional mental health services at the early stages of implementation. The Network was created partly to promote awareness and legitimacy of the ESP role.
- Lack of a formally recognised professional profile for Peer Support Experts, which has made stable employment opportunities more difficult to achieve.
- Persistent stigma and social exclusion affecting people with mental health difficulties, reducing opportunities for participation, employment and active citizenship.
- Challenges related to integrating ESPs within service organisations, including clarification of roles, boundaries, confidentiality issues, and relationships between peer experts and professionals. These aspects are currently being examined through regional research activities.
- Uneven development of peer-support experiences across territories, which initially required mapping, networking and coordination efforts.

ENABLERS:

- Strong and sustained support from the Emilia-Romagna Region through policies, dedicated funding and strategic planning.
- Creation of the Regional Network as a structured platform for collaboration among ESPs, professionals, families, voluntary organisations and institutions.
- Shared values centred on recovery, empowerment, mutual support, self-determination and active participation.
- Availability of dedicated training pathways, workshops and vocational qualification opportunities that increase the skills and credibility of ESPs.
- Active involvement of mental health services and regional consultation bodies, providing institutional legitimacy and opportunities for participation in governance and policy development.
- Collaboration with universities and European initiatives, supporting innovation, knowledge exchange and evidence generation.

LEARNING POINTS:

- People with lived experience can make a meaningful contribution to recovery-oriented services when adequately trained and supported.
- Integrating experiential and professional knowledge can improve service responsiveness, accessibility and person-centredness.
- Peer support creates benefits not only for service users but also for ESPs themselves, strengthening their own recovery, self-esteem and social participation.
- The initiative has evolved beyond mutual support activities to include vocational training, advocacy, service innovation and participation in policy-making processes.
- An important emerging effect has been the expansion of the model from mental health services to addiction services, demonstrating its adaptability and wider applicability.
- The experience highlighted the importance of investing in organisational culture and role clarification to ensure successful integration of peer workers within multidisciplinary teams.

Legal and/or ethical issues:

The practice is implemented within the governance framework of the Emilia-Romagna mental health system and is supported by regional policies promoting participation, recovery, and the involvement of people with lived experience in service development and delivery. The Regional Network brings together service users, Peer Support Experts (ESPs), professionals, family members, associations, and public institutions, ensuring a collaborative and participatory governance model.

A key governance challenge concerns the **lack of a formally recognised professional profile for Peer Support Experts**. Although ESPs are increasingly involved in mental health and addiction services, there is currently no specific professional category formally regulating their role. To address this gap, the Region has promoted training pathways and the use of the regional qualification of **Orientatore** as an interim framework for employment and professional recognition, while continuing to advocate for a dedicated professional status for ESPs.

From an ethical perspective, the practice is based on principles of mutual respect, empowerment, self-determination, active listening, and the responsible use of lived experience in supporting others. The integration of ESPs within multidisciplinary teams requires careful attention to role boundaries, professional responsibilities, and the balance between experiential and professional expertise.

The documents do not describe specific data protection procedures or consent protocols. However, they identify issues related to **privacy, confidentiality, role boundaries, and management of sensitive information** as important areas requiring attention when integrating ESPs into

services. These aspects are currently being explored through a research collaboration with the University of Padua, aimed at supporting the effective and ethical implementation of the ESP role within mental health and addiction services.

Transferability to other regions:

Easily transferable with minimal adaptation.

The Emilia-Romagna Peer Support Expert (ESP) model demonstrates a **high level of transferability maturity**, having evolved from local pilot experiences launched in 2009 into a structured regional network established in 2016 and supported by dedicated policies, funding mechanisms, training programmes and governance structures. Its core principles, namely recovery, empowerment, peer support, co-production and active participation of people with lived experience, are applicable across different health and social care systems and can be adapted to diverse organisational contexts.

The practice is particularly relevant for regions seeking to strengthen community-based and recovery-oriented mental health services. Successful replication would require several enabling conditions:

- Political and institutional commitment to recovery-oriented care and service-user participation.
- Collaboration among mental health services, people with lived experience, families, civil society organisations and local authorities.
- Dedicated training and supervision pathways for Peer Support Experts.
- Sustainable funding mechanisms to support coordination, training and implementation.
- Clear governance arrangements and role definitions to facilitate the integration of ESPs within multidisciplinary teams.

Several tools and resources developed in Emilia-Romagna could facilitate transfer, including the Regional Network structure, the **Mi-Manifesto**, regional mapping exercises, training curricula, workshop methodologies, collaborative governance mechanisms, and practical experience in integrating ESPs into both mental health and addiction services.

Transferability is further supported by the existence of comparable peer-support models in several European countries, including the United Kingdom, Ireland, Germany and the Nordic countries, where people with lived experience are involved in mental health services as Peer Support Workers, Experts by Experience or Persons with Lived Experience. Although these experiences are not described in the annexed documents, they share similar principles of recovery, empowerment, mutual support and co-production.

The Emilia-Romagna experience is also connected to broader European learning and exchange processes. The documentation refers to international collaboration activities linked to **Joint Action MENTOR (Mental Health Together)**, including a conference organised by the

Istituzione Gian Franco Minguzzi and the **Metropolitan City of Bologna**, involving European experts and organisations working on the implementation of lived-experience roles in mental health services. However, neither the Emilia-Romagna Region nor the Regional ESP Network are identified in the documents as formal partners of the Joint Action.

A key lesson for transfer is the importance of establishing an appropriate professional framework. Emilia-Romagna's experience shows that training standards, employment pathways and formal recognition of the ESP role are essential for long-term sustainability and successful scaling, while the current absence of a dedicated professional profile remains one of the main challenges to be addressed.

Dissemination and further information:

A key dissemination tool is [Parliamone Insieme](#), the communication platform established by the Regional Mental Health Consultation of Emilia-Romagna and users' and family associations. The website serves as a regional information hub, publishing news, interviews, testimonies, good practices, policy updates and materials related to mental health, recovery and peer support. The editorial team itself includes Peer Support Experts, ensuring direct involvement of people with lived experience in communication activities.

The Regional ESP Network disseminates knowledge through:

- regular workshops, conferences and public events focused on recovery, empowerment and peer support;
- publication of mapping reports documenting the development of ESP initiatives across Emilia-Romagna;
- awareness-raising activities promoting recognition of the ESP role and combating mental health stigma;
- training activities and seminars for service users, professionals, families and community organisations.

Available materials include the **Mi-Manifesto of the Regional ESP Network**, regional mapping reports on the presence and activities of ESPs, articles documenting the Network's evolution, and publications hosted through the **Parliamone Insieme** platform. The website also provides dedicated sections describing the ESP role, training pathways, professional recognition efforts and ongoing regional initiatives.

The Regional Network of Peer Support Experts has also gained visibility through international knowledge-exchange initiatives. In particular, the experience was presented within activities connected to **the Joint Action MENTOR** (Mental Health Together), a European collaborative initiative focused on strengthening mental health systems and the involvement of people with lived experience. According to

the regional documentation, the Istituzione Gian Franco Minguzzi and the Metropolitan City of Bologna organised an international conference (**7-8 May 2026**) dedicated to the implementation of Experts by Experience in mental health services. The event brought together researchers, practitioners and peer-support leaders from several European countries, including Ireland, the United Kingdom and Germany, and provided an opportunity to showcase and discuss the Emilia-Romagna experience alongside other European models of peer support. Conference sessions addressed topics such as the transformation of mental health services through lived experience, the integration of Peer Support Experts into multidisciplinary teams, implementation challenges, and research conducted by people with lived experience. The event contributed to the dissemination of the Emilia-Romagna model, promoted mutual learning with other European initiatives, and strengthened the Network's links with international communities of practice working on recovery-oriented mental health services.

Media:

[Joint Action MENTOR official website: Bologna Conference](#)

See also:

- [Istituzione G.F. Minguzzi: Transforming Mental Health Through Lived Experience](#) (international conference page)
- [ProMIS \(Programma Mattone Internazionale Salute\):](#)
- [Salute mentale. Uscire dal disagio si può: quando il paziente si prende cura di altri pazienti](#) (Regione Emilia-Romagna, 1 July 2022).
The article reports on the graduation of 15 **Orientatori Esperti in Supporto tra Pari (ESP)**, describes the ESP role, recalls that the training course was formally recognised by the Region, and states that a project would be launched to support the **Regional ESP Network**. It also reports regional funding for the training programme.
- [Parliamone Insieme is the regional mental health communication platform hosting ESP materials, news and resources](#)
- [La Rete regionale ESP \(official Network page\)](#)
- [Chi è l'ESP? \(description of the ESP role and professional recognition pathway\)](#)
- [Sono 184 gli ESP mappati in Emilia-Romagna \(regional mapping and development of the movement\)](#)
-

LINKS AND CONTACTS:

Regione Emilia-Romagna, Direzione Generale Cura della Persona, Salute e Welfare

[Settore Assistenza territoriale](#) - [Settore Ricerca e Innovazione nei Sistemi Sanitari e Sociali](#)

Rete regionale ESP: reteregionaleesp@gmail.com

Integrated Community Care and Recovery



REGIONE DEL VENETO

“HEALTH BUDGET” as a tool for social and health integration in mental health



Key info:

Organisation name:	VENETO REGION – HEALTH AND SOCIAL AREA – HEALTH PLANNING DIRECTORATE
Region:	VENETO
Country:	Italy
Practice cooperation partners – International collaboration (e.g., Please indicate any organisations involved in the implementation of the practice, particularly if developed through European collaboration (e.g. Joint Actions, Horizon Europe, Interreg, EU4Health, Erasmus+, etc.). If not applicable, write "N/A".):	

Keywords:

Health budget-social and health integration.

Implementation status:

Fully implemented mental health policy/program/initiative

Focus areas:

- Social and health integration
- Recovery
- Participatory healthcare

Summary:

“HEALTH BUDGET” is a social and health policy tool that goes beyond the logic of services in favor of the construction of personalized projects that are built with the PATIENT himself with the actors of the community. They concern projects on the axis of affectivity, work, living, socialization, creating a tailor-made care path.

Description and strategic context:

The “health budget” overcomes the fragmentation of responses to complex social and health needs and returns to the patient the role of protagonist in the construction of his or her health path.

Objectives:

The overall goal is to increase patients' personal recovery. The goal of Sistema is to promote, through the empowerment of patients, health pathways. An indirect expected objective is the decrease of psychiatric institutionalization, as well as a benefit for the community, which becomes inclusive, in terms of outcome.

Target group(s):

Direct beneficiaries: eligible patients being treated in mental health departments, with complex social and health needs.

Indirect beneficiaries are caregivers, and the territory understood as a community.

Equity dimension:

Equity is guaranteed by the construction of the health intervention by a team made up of the patient together with his caregivers and those who manage the resources of the community.

Methodology and processes:

The first step is represented by the identification of patients who can take advantage of the intervention of the health budget, starting from the needs they express but also

considering their personal resources, in terms of motivation, commitment, adherence to treatments and material goods, as well as whether or not there is a family and support network. Therefore, the patient together with the professionals of the mental health centers, family members or caregivers, representatives of local authorities, and possibly associations operating in the area build a project that includes interventions on the theme of housing, work, affectivity and socialization, which is integrated with the social and health services that the subject already uses. The project consists of various steps and monitoring actions, which assess the response to the patient's needs but also how much this type of planning impacts on the communities.

Personal satisfaction, improvement in quality of life, and specific indicators concerning personal recovery, i.e. elements of rehabilitation, in terms of restitution or reacquisition of skills and competencies, are positively evaluated with the elements of improvement. The progressive autonomy of the beneficiaries from the care network of the health system also represents a goal with respect to the coping with problems such as psychiatric ones, which can also be cronichs.

Involvement of other organisations/actors:

In addition to the patient and his family members (or reference persons), the district socio-sanitary services, the health authority, the municipality of residence of the patient, in the figure of the social worker, and the voluntary associations or Third Sector Organizations (TSOs) that collaborate in the design first and then in the implementation of the project in the territory are compulsorily involved in the design of health budgets.

Funding source(s) and sustainability:

For the years 2025-2026-2027, the Veneto Region has financed these projects with 2 million euros. The funding will serve as a stimulus for the start of projects in all territories and will guarantee the social and health authorities that the administrative organization is formed to make this tool operational.

Innovation, Impact and Outcomes:

- Personalization of care
- Patient Empowerment
- Anti-stigma practice
- Creating inclusive communities
- Deinstitutionalization of the psychiatric patient
- Indicators exploded by the end of 2026

Evaluation:

Preliminary observations: Greater adherence to the pathway compared to treatments as usual, satisfaction of caregivers who feel they are actors in the construction of the pathways. In addition, this type of planning allows multidisciplinary teams working within mental health departments to operate synergistically, each with their own skills, limiting the medical-centric approach to care, present in the past. Another evaluation will be carried out regarding hospitalization and institutionalization of psychiatric patients, which should decrease.

Barriers, enables, and learning points:

CHALLENGES:

- Skills to be acquired regarding the new administrative procedure that accompanies the health budget, which is the co-design
- Overcoming the medical-centric model of treatments

ENABLERS:

- Presence of examples of co-design in the social sphere
- Wealth of actors operating in the territories in terms of social inclusion
- Rehabilitation of people with fragility

LEARNING POINTS:

- Ongoing experimentation

Legal and/or ethical issues: None.

Transferability to other regions:

Easily relocatable with minimal adaptation.

This model of intervention can be easily transferred to other regions, its strength lies in the centralization of the responses of the social and health system on the expertise of the patient, who is "expert by experience" and who actively contributes to designing his treatment path.

Dissemination and further information:

Media:

LINKS AND CONTACTS:

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Integrated Community Care and Recovery



Llywodraeth Cymru
Welsh Government

National Framework for Social Prescribing



Key info:

Organisation name:	Welsh Government
Region:	Pan-Wales
Country:	Wales
Practice cooperation partners – International collaboration (e.g., Please indicate any organisations involved in the implementation of the practice, particularly if developed through European collaboration (e.g. Joint Actions, Horizon Europe, Interreg, EU4Health, Erasmus+, etc.). If not applicable, write "N/A".):	Wales School for Social Prescribing Research Health Education and Improvement Wales Wales Council for Voluntary Action Public Health Wales

Keywords:

Social prescribing, wellbeing, prevention, community assets, person-centred.

Implementation status:

Ongoing implementation of a mental health policy/programme/initiative, community-based mental health initiative, prevention or mental health promotion initiative, integrated care/cross-sectoral mental health initiative, practice addressing vulnerable or underserved groups.

Focus areas:

- Prevention
- Early intervention
- Person-centred approach
- Community based
- Social inclusion
- Community assets
- Co-production
- Reducing inequalities
- Core knowledge, skills and behaviours for those carrying out Social Prescribing roles in Wales.

Summary:

A task and finish group were established to understand how social prescribing could aid Wales in its recovery from Covid-19. In partnership with primary care, health boards, third sector and other relevant bodies, the group guided development of a National Framework for Social Prescribing (NfSP) which delivers a vision of social prescribing in Wales that is of a consistent high-quality standard across the country. The framework provides a shared national approach while retaining flexibility for local delivery.

Social Prescribing is for people who may benefit from non-clinical support to improve their health and wellbeing, particularly those experiencing issues such as loneliness, social isolation, poor mental wellbeing, long-term health conditions, or wider social challenges. The NfSP supports social prescribing practitioners, commissioners, referrers, community assets and partner organisations to deliver quality social prescribing across Wales.

The NfSP was published in December 2023. The main objectives are:

- Develop a shared understanding of social prescribing across Wales and develop a common language and a model centred around the 'no wrong door' approach where referrals can come from any sector, not just healthcare.
- Support and strengthen the social prescribing workforce through skills and knowledge

development using the Competence Framework for Social Prescribing Practitioners in Wales.

- o Improve the quality and consistency of social prescribing provision.
- o Strengthen quality assurance, outcomes measures and data consistency across Wales via the publication of the Core Standards and Values for Social prescribing in Wales.
- o Address inequalities and ensure safe, effective relationships across the social prescribing pathway.

The Welsh model of social prescribing is a person-centred approach that connects people to community assets and sources of support based on “what matters” to them. It is supported by guidance, workforce development resources, competency frameworks, standards for community assets, data and evaluation tools, and collaborative governance arrangements to support implementation across Wales.

The NffSP aims to improve access to high-quality social prescribing, strengthen partnerships between health, social care and community organisations, improve consistency and credibility of provision, and support better evidence of impact. It seeks to empower individuals to improve their health and wellbeing through community-based support, reduce loneliness and isolation, promote prevention and wellbeing, and help address health inequalities while supporting a sustainable, community-focused approach to health and care.

Description and strategic context:

The National Framework for Social Prescribing (NffSP) addresses mental health and wellbeing challenges linked to loneliness, social isolation, poor emotional wellbeing, long-term health conditions and the wider social determinants of health. It recognises that many factors affecting mental health lie outside traditional healthcare services and that people may benefit from support available within their communities, such as arts, culture, sport, volunteering, nature-based activities and peer support.

Social prescribing can help people access early support, improve wellbeing, strengthen community connections and reduce pressure on statutory health and care services through a preventative, person-centred approach. The framework also seeks to address inequities in access to social prescribing and improve consistency and quality across Wales.

From a legislative and strategic context, the principles of social prescribing, such as an early preventative approach to enhancing people’s health and wellbeing, addressing health inequalities and strengthening community cohesion, are consistent with the [Social Services and Well-being Act \(Wales\) 2014](#); the [Well-being of Future Generations Act \(Wales\) 2015](#); and our long-term plan for health and social care ‘[A Healthier Wales](#)’.

The NffSP supports partnership working across health, social care and the third sector, and reflects wider European and WHO approaches that emphasise prevention,

community-based support, social connectedness and action on the social determinants of health.

Objectives:

Overall objectives: Social prescribing is an umbrella term that describes a person-centred approach to connecting people to local community assets. It can help empower individuals to recognise their own needs, strengths, and personal assets and to connect with their own communities for support with their personal health and wellbeing. Social prescribing may provide a continuum of support, play a preventative role, or form part of a ‘step down’ model of support.

The National Framework for Social Prescribing (NffSP) does not intend to dictate how social prescribing is delivered in different communities. Rather it seeks to support its growth by setting out effective, high-quality standards across the ‘whole system’.

The **core objectives** of the NffSP are to:

- o develop a shared understanding of the language used and the approach taken to deliver social prescribing in Wales
- o support the social prescribing workforce and drive-up knowledge and skills
- o ensure quality of provision by community assets
- o monitor and evaluate the development of social prescribing as it continues to grow across Wales
- o improve outcomes for individuals, organisations, commissioners, and referrers.

Target group(s):

Direct beneficiaries: Often, people will have the confidence and ability to recognise opportunities and act themselves to support their own health and wellbeing. Or they may be prompted and supported to do so by family members and friends.

However, it is recognised that a spectrum of support is required to enable effective behaviour to change so that people can engage in activities and access the interventions/ services they need. The level of support a person need will vary over a person’s lifetime and be dependent on the circumstances people find themselves in. This is why the NffSP adopts a life course approach; it is applicable for children through to older adults.

We know that people who are lonely or socially isolated are at greater risk of being inactive, heart disease, stroke and high blood pressure and premature death. They are also more likely to experience depression, low self-esteem, sleep problems and an increased response to stress. Evidence suggests social prescribing can have multiple benefits in these situations.

In addition, social prescribing can present an established route for individuals who may not engage with mainstream services or otherwise face stigma to re-enter the community, for example, those who have experienced homelessness or substance misuse

Equity dimension:

The National Framework for Social Prescribing (NFFSP) seeks to reduce health inequalities by improving access to community-based support for people whose health and wellbeing are affected by wider social, economic and environmental factors.

The framework promotes a person-centred approach, starting with a “what matters” conversation to develop a person-centred action plan. This recognises people have different needs depending on their age, disability, gender, culture, language, socioeconomic circumstances and other characteristics. The NFFSP seeks to improve equity of access and consistency of provision across Wales, while enabling support to be tailored to individual circumstances and local communities.

The [Core Standards and Values for Social Prescribing in Wales](#) set out clear expectations for the delivery of social prescribing, and the enabling components that support effective delivery. These include making information accessible, removing practical barriers such as transport or childcare, and value lived experience as expertise. Social Prescribing services must also actively address inequalities. All partners have a responsibility to ensure that support is inclusive, accessible, and targeted towards those most often excluded. This includes tackling barriers like cost, digital access, language, and stigma, and using data to understand unmet need and direct resources where they will make the greatest difference.

Methodology and processes:

The [National framework for social prescribing](#) sets out the Social Prescribing Pathway in Wales

1. Referral

There can be self-referral or referrals from healthcare professions and community and voluntary organisations. In some cases, statutory services could make targeted referrals.

2. Social Prescribing

This includes the “what matters” conversation, action planning, signposting or onward referral, monitoring and reporting of activity outcomes.

3. Community Assets

Examples of onward referral include creative referrals, exercise on referral, green/blue referrals, education referrals and welfare support referrals.



Involvement of other organisations/actors:

The National Framework for Social Prescribing has been developed working in close collaboration with primary care,

health boards, NHS Wales, third sector, other relevant public bodies, Welsh citizens, and key stakeholders who have a role in delivery or interest in social prescribing.

Officials engaged with almost 1,000 stakeholders to develop a Welsh model of Social Prescribing that was issued for consultation. The consultation, which ran 28 July to 20 October 2022, received over 190 responses, which together with feedback received via online stakeholder events held during the consultation period, directly shaped the National Framework. In addition, there were a series of positive and constructive meetings between officials across government to understand and develop potential areas of collaboration. A Task and Finish Group with a range of stakeholders was established and met regularly from March 2021 to March 2022.

Detailed engagement included with the following:

- NHS Wales
- primary care representatives
- Valley Regional Park
- Older People's Commissioner for Wales
- UK/devolved government officials
- Royal Colleges
- Welsh Government sponsored bodies, including the arts, sport and culture
- health board policy leads
- National Lottery Community Fund
- Tier 0 / third sector partners
- Local government
- Social prescribing representative bodies

Engagement also included hearing from children and their representatives, people with protected characteristics and Welsh speakers

Funding source(s) and sustainability:

Main sources of funding include the £144.6m Health and Social Care Regional Integration Fund, which directly supports the development and delivery of integrated care, which includes direct investment in social prescribing.

Other funding sources for social prescribing include from health and social care services, Regional Partnership Boards, local authorities, and the third sector.

Sustainable funding remains a challenge in Wales as the system has developed organically over many years, with funding predominantly coming from short-term grants, pilot funding, and local commissioning arrangements, rather than any particular long-term funding model.

Innovation, Impact and Outcomes:

The National Framework for Social Prescribing, published in December 2023, established a shared definition and vision for social prescribing in Wales and clearly sets out the social prescribing pathway. The National Framework sets out a distinct Welsh model which shifts from a healthcare centred model, to a ‘no wrong door’ approach that recognises that health and wellbeing are shaped by wider social, economic, cultural, and environmental factors. The most recent

guidance, our '[Core Standards and Values for Social Prescribing in Wales](#)', outlines a clear set of standards and value for social prescribing, including performance measures recommended as most appropriate, and the key components that enable effective delivery.

Awareness and understanding of social prescribing have improved, with unpublished data showing a 26% increase in known users between 2021 and 2024. Furthermore, the evidence for the impact of social prescribing continues to grow. Through its early preventative approach, social prescribing can help reduce pressure on frontline services. Evidence suggests it may lower GP visits by 15% – 28%, with one review reporting an average 28% reduction in demand for GP services following referral, and another noting 25% drop-in appointments. Given that estimates show around 20% of patients consult with their GP for what is primarily a social condition, the potential for social prescribing to reduce impact on frontline services is evident.

Welsh Government is committed to an independent evaluation of the National Framework, commencing 2026–27, providing an opportunity to assess and better understand what is working well, understand variation in implementation across Wales, and identify barriers to adoption and scale up.

Evaluation:

An evaluation of the National Framework for Social Prescribing is planned to commence the latter part of 2026/27 and will provide an opportunity to assess and better understand what is working well, understand variation in implementation across Wales, and identify barriers to adoption and scale-up.

Further elements to be considered as part of the evaluation include:

- How social prescribing is meeting the needs of different population groups, including people living with chronic conditions, and children and young people.
- Workforce development needs.
- Gaps in community asset provision
- Opportunities to strengthen data collection and evidence generation.
- How social prescribing contributes to wider policy priorities, including prevention, tackling health inequalities, community cohesion, access to nature and physical activity.

Barriers, enables, and learning points:

CHALLENGES:

- Limited staff and financial resources shaped the development and implementation approach, making co-production essential. While resource constraints presented challenges, the co-production approach ultimately strengthened stakeholder buy-in, understanding, and support, particularly across the third sector.

- A key challenge was varying understanding of social prescribing and the medical connotations of the term 'prescribing'. To address this, and with ministerial support, we stuck with the existing terminology but developed a bilingual (Welsh and English) [glossary of terms](#) to promote consistent language and improve understanding among both public and professional.

ENABLERS:

- Strong and visible political / ministerial support, including inclusion in the Programme for Government and ongoing public endorsement.
- Co-production with partners across the social prescribing sector fostered stakeholder buy-in, shared learning, and the sharing of best practice, helping to maintain momentum throughout development.
- Regional Partnership Board social prescribing champions strengthened engagement, raised awareness of the National Framework, and provided valuable local intelligence.
- The National Framework's clear definition of social prescribing, underpinned by Core Standards and Values, established a shared understanding of best practice and improved quality assurance, outcomes measurement, and data consistency across Wales.

LEARNING POINTS:

- Key lessons learned include the importance of strong political leadership to drive progress and maintain momentum.
- Meaningful co-production with the third sector ensured components complemented existing services, added value, and remain flexible to local needs rather than impose a one size fits all approach.
- Recognising and supporting community assets is also critical, as in Wales, they are central to delivering effective social prescribing and improving health and wellbeing through locally tailored, non-clinical support.
- In Wales, social prescribing is best understood as a function rather than a role, as it can be delivered by a wide range of professionals and organisations, including health, social, and voluntary sector staff.
- Framing social prescribing as a person-centred approach to connecting people to community support has been both challenging and highly beneficial. Once understood, the distinction has improved the understanding of what social prescribing means in Wales, and how it is delivered in practice.

Legal and/or ethical issues:

The [Core Standards and Values for Social Prescribing in Wales](#) outlines a set of standards and values for social prescribing in Wales. The purpose is to establish social prescribing as a recognised, credible approach within health and care systems, while maintaining flexibility to accommodate local needs and encourage innovation.

The 6 core standards include safeguarding and managing risk:

- All members of the social prescribing pathway should understand when safeguarding thresholds are met, how to respond appropriately, and how to escalate concerns in a timely and proportionate way.
- Statutory partners must ensure social prescribing is commissioned and delivered in line with the Social Services and Well-being (Wales) Act 2014, ensuring the safety and wellbeing of children and adults at risk.
- Any concerns that someone may be at risk must be reported to the local authority in line with Wales Safeguarding Procedures. Services working with children and young people must follow national guidance and ensure staff are trained and supported to work safely with all age groups.

The Core Values underpin positive behaviours and interactions, acting as guiding values and beliefs that shape behaviour, decisions, and culture of an individual, organisation, or community. across the social prescribing pathway.

Transferability to other regions:

Transferable with contextual adaptation.

The National Framework for Social Prescribing could be transferred to other regions as it focuses on establishing a shared understanding, common principles, quality standards, and outcomes, rather than prescribing a single delivery model. Key to the success and stakeholder buy-in is that the National Framework sets out best practice and guidance, however, it allows local places / community assets

to decide how social prescribing is delivered in practice, making it scalable and adaptable across different settings. The National Framework could be replicated in aspects such as:

- Establishing a clear, agreed definition of social prescribing, and develop a glossary of terms that provides a common language for practitioners, stakeholders and public alike.
- Adopting core standards and values to support quality, consistency, and evaluation.
- Embedding co-production with communities, service users, the voluntary sector and other delivery partners.
- Supporting local flexibility so that local community assets deliver need reflecting their communities.
- Developing governance and champions to drive implementation, engagement and continuous improvement.
- Strengthen data collection and outcomes measurement to demonstrate impact of social prescribing, support sustainability, and secure funding.

Dissemination and further information:

The National Framework for Social Prescribing (NFFSP) was formally launched at a virtual national event on 7 December 2023, attended by 433 stakeholders.

An in-person [National Showcase](#) event was held on 10 March 2026, spotlighting the NFFSP and showcasing a range of social prescribing activity taking place across Wales and the benefits each brings to their respective local communities.

Media:

[46896 NFSP Wales Model Explainer / Videos & Movies on Vimeo](#)

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Targeted support and workforce capacity



Ensure occupational health and safety, protect health and mental well-being and prevent experience of stress, burnout and violence among public healthcare workers



Key info:

Organisation name:	ASL AT - Local Health Authority of Asti
Region:	Piedmont
Country:	Italy
Practice cooperation partners – International collaboration (e.g., Please indicate any organisations involved in the implementation of the practice, particularly if developed through European collaboration (e.g. Joint Actions, Horizon Europe, Interreg, EU4Health, Erasmus+, etc.). If not applicable, write "N/A".):	Local cooperation partners are being identified and formal agreements are under development. International collaboration: N/A at the current stage.

Keywords:

Innovative, integrated, and scalable model for mental health promotion, work stress prevention and management in the health care setting.

Implementation status:

Fully implemented mental health policy/programme/initiative, Prevention or mental health promotion initiative, Practice addressing vulnerable or underserved groups.

Focus areas:

Work stress prevention and management plan set 4 different levels of intervention: survey across all the organization, stress management training courses for large healthcare workers groups at low risk, defusing and debriefing interventions for small healthcare teams at medium/high risk of stress after critical incident, rapid clinical assessment, timely and individual intervention for healthcare workers experiencing acute stress or mental health difficulties. Actions take shape through three cross-cutting strategies: advocacy, which concerns promoting health as a political and social priority; enablement,

understood as the process of enhancing the abilities of people and communities to control the determinants of health; Mediation, that is, the ability to connect the interests, values, and priorities of the different players who influence health. From this perspective, the ASL AT Project named "Community Action" is a practical application of salutogenesis, meaning a participatory process that helps develop a sense of community coherence, that is, the conditions people create to live better, supporting health, solidarity, and inclusion, among citizens but also among health workers as prosumers (Norman, 1999).

Summary:

The model is designed to strengthen the entire pathway from community-based prevention to specialist mental healthcare by combining healthcare workers engagement in training courses (aggression prevention training and mindfulness training to manage stress), defusing e debriefing group sessions, rapid access to specialist psychological services for individual referral. Organizations that are part of the social and health care networks are special organizations in many ways: because of the complexity of their task (preventing and treating illness,

promoting health and social well-being), because of the variety of factors that contribute to achieving their goals (ethical, social, technological, interpersonal, economic factors), because of the consequences generated by expectations (which sometimes turn into demands) of full restoration that has spread through much of society (more conflicts with health and social care staff, defensive medicine), and because of the high potential stress caused by the work structure (frequent shifts, high interdependence) and its inherent nature (systematic exposure to suffering, loss, and trauma). Care and support work is valuable and often rewarding, but it also involves, to varying degrees, costs for the workers, such as fatigue, anxiety and distress, sacrifice, discomfort, giving things up risk. These are 'costs' – physical, emotional, social – not values, even though they are often presented as such, and if they exceed a certain threshold of tolerance, they become penalties, losses, expropriations, exploitation, and sometimes violence. However, they could become 'prices' and even 'values' if they are appropriate and sustainable and properly recognized and rewarded. A healthcare system that assesses the risks, helps workers to manage them, and strives to reduce or at least contain them by proposing adequate prevention and protection measures, including organizational ones, can enhance care and support work, making it productive effort rather than an undue masochistic and sacrificial mission. The project addresses existing gaps in mental healthcare promotion in the health public system.

Description and strategic context:

Healthcare institutions and social services cannot just provide staff with psychological support desks, and even less so encourage them to 'take care of themselves' or self-protect, because that would avoid their ethical, political, and regulatory responsibility to take care of the health of those who provide care and assistance to citizens, by promoting healthy, sustainable, and safe work environments, and by removing the most significant work-related issues linked to underfunding of the NHS and the resulting staff shortages. Likewise, they cannot just treat and compensate them once they fall into burnout, because that would mean monetizing the damage and continuing to maintain the unhealthy work environment. Similarly, one cannot be satisfied with adopting violence protection measures based solely on the presence of a few security agents or offering self-defence courses. In ASL AT, health is understood as a dynamic process that is expressed, among other things, through health promotion, that is, the 'process that allows people to increase control over their health and improve it,' focusing on their autonomy and active participation in health-related decisions, as well as valuing personal, community and organization resources. Among the key areas of action is strengthening community action, which aims to promote accountability and direct involvement of people (e.g.: health workers), valuing local resources, solidarity, and social participation.

Objectives:

Overall objective:

- Provide the assessment of Work-Related Stress through all the health care workers belonging to all services in ASL AT (hospital units and community-based unit)
- Set realistic goals by optimizing staff performance, improving wellbeing in the whole organization, in order to reduce stress
- Recognize and reward good work (not just financially), encouraging and valuing those who perform better through an effective, targeted reward system (such as company welfare proposals and benefits).
- Acknowledge the demanding nature of social and healthcare professions and reduce their physical, emotional, and risk burdens by improving strategic workforce planning.
- Review the organizational cultures of Services by funding policies for the prevention, assessment, and management of stress, as well as the development of organizational well-being.
- 6. Adopt effective policies to prevent and protect staff from physical and psychological violence they may face while performing their duties, without just relying on simple measures of repression and control.
- Take care of healthcare and social care workers by funding stable practices of support, protection, and maintenance of their caregiving role, as well as any interventions to repair damage and address distress.
- Also assess gender-related risks by adjusting work activities and workloads, taking gender differences into account, and generally promoting all necessary actions to protect against any form of discrimination, moral or sexual harassment perpetrated by colleagues, supervisors, or service users.

Target group(s):

Target is the whole health and care workforce ASL AT, according to the Chart of Bucharest (WHO, 2023).

Equity dimension:

According to the Chart of Bucharest (WHO, 2023) main aim to addresses health inequalities or considers different needs related to age, gender, socioeconomic status, disability, migration background, rurality or other vulnerable populations is creating decent, safe, adequately staffed work environments and terms of employment that motivate and support health and care for all workers, ensure their occupational health and safety, and protect their health and mental well-being – users and services will benefit when workers are better supported; taking into account gender- and age-based differences in workers' risks and needs, such

as burnout, violence, workplace safety, and child and family care support; and ensuring health and care workers' capabilities are used to the full extent in delivering health and care services.

Methodology and processes:

1. Stress Assessment and survey

The assessment of Work-Related Stress (hereinafter WRS) is a legal requirement (Legislative Decree 81/2008), but in 2025, at ASL AT, it was also seen as an opportunity for organizational development: a systematic survey of WRS had never been carried out before. After numerous comparisons of methodologies and tools, the company's WRS group decided to adopt the INAIL methodology, adapted to the company reality and reviewed by the CUG, RLS, and the company's DPO. The final result was an online questionnaire (fillable via computer or smartphone via QR Code) that considered both the workers' subjective point of view and collected, from company sources, the objective data potentially related to the phenomenon (absences, turnover, accidents, assaults, etc.).

2. Training on specific topics to prevent and to manage stress: de-escalation and mindfulness techniques

3. Group defusing and debriefing sessions at medium/high risk of stress after critical incident

Aim of psychological training is to help health care workers to handle critical moments and personal emotions, and more generally on communication with users and their families, colleagues, and the organization; to build the space and time needed to reflect on work experiences, address doubts or indecision, listen to your own emotions and experiences and make it possible to share experiences among various professionals, such as supervision or peer support sessions. Healthcare care staff can share their daily experiences in a group, making sense of them and understanding them better – and defusing sessions, where sharing the emotional experience of being victims, directly or indirectly, of a trauma is aimed at briefly processing the meaning of the event in a group setting, in order to moderate the impact of that potentially traumatic event.

4. Individual intervention for healthcare workers experiencing acute stress or mental health difficulties

The project aim is to set up a “protected” pathway (free for the initial consultation sessions, subject to a fee for any subsequent short psychotherapy sessions) for employees, characterized by anonymity, brevity (maximum five sessions), and, while not initially constituting full psychotherapy, the ability to provide a first response to a moment of crisis experienced by the worker. The psychological consultation and potential short therapy sessions are aimed at issues most reported by employees during visits with the company doctor, such as:

- Performance problems (concentration, attention, mistakes, etc.)
- Conflicting interpersonal relationships, managing anger and aggression
- Struggles with role/position changes

- Work-related stress management
- Symptoms of anxiety or depression
- Stress management
- Losses and griefs
- Crises related to specific life cycle challenges

Involvement of other organisations/actors: N/A

Funding source(s) and sustainability:

The practice is primarily based on an internal reorganisation of existing services rather than on a substantial increase in structural resources.

Innovation, Impact and Outcomes:

a. Stress Assessment and survey: over the course of 2025, the mapping of all company divisions was completed with a 63.29% response rate, corresponding to about two-thirds of the ASL AT population. The analysis of stress-related data was carried out anonymously and in aggregate, divided roughly according to the company's complex structures (SC) and simple departmental structures (SSD). About one-third of the company's structures showed a good organizational health status and no significant issues; however, the remaining two-thirds showed the presence of some stress factors. Moreover, since a survey should never be just about capturing a situation but also—above all—about planning and implementing improvement actions, after the evaluation the results were shared with all Directors and company Coordinators of the “non-critical” divisions via email, and specific Focus Groups were organized with the divisions identified as “critical”, in order to discuss and consider strategies to reduce and/or prevent the condition of work-related discomfort.

b.1 Mindfulness training: more than 100 health care workers has been enrolled in three courses inspired to MBSR courses (Kabat Zinn, 2006), lasting 2 months, 8 session and daily homework (meditation).

b.2 Aggression prevention courses: more than 180 health care workers have been enrolled in 6 courses to learn de-escalation techniques to prevent and manage aggressions

c. Defusing and Debriefing: rapid access to defusing (within 48h) and debriefing group sessions (within 72h) in case of potential traumatic experiences on the job: 8 sessions in 2025 (Oncology, Palliative care, Internal medicine, Obstetrics, Paediatric and Emergency Room Units).

d. Access to specialist psychological services for individual referral in case of severe stress: more than 75 health care workers enrolled

e. Sharing a Company ASL AT Manifesto for promoting organizational health ASL AT

- Promote workplaces that are increasingly welcoming and suitable, including not only care areas but also waiting areas, implementing all necessary measures to prevent violence and protect staff from physical and verbal assaults, from escape routes to the presence of security guards or law enforcement.

- Identify and reduce stressful aspects of work, giving priority to organizational areas found to be "critical." These aspects can include fatigue, fast-paced work, extended working hours and limited breaks, overload of tasks and responsibilities, uncertainty about roles or tasks, lack of control, poor or unclear communication, and demands exceeding available skills and resources.
- Set realistic goals by optimizing staff performance, providing the Services and the professionals who work there with the necessary resources (human, material, technological, space, and time), improving recruitment, and creating the conditions for keeping healthcare and care workers in service, also to eliminate waiting lists and maintain service quality. Recognize and reward good work (not just financially), encouraging and valuing those who perform better through the trial of an effective reward system rather than a 'blanket' approach (company welfare proposals, benefits, promotions).
- Plan a work organization (schedules, shifts, roles, and tasks) that allows a healthy work-life balance without having to sacrifice family and social relationships, taking into account the age, gender, and physical and psychological vulnerabilities of the staff.
- Support stable practices for backing, protecting, and maintaining the caregiving role, and start assessments of traumatic risk (direct, indirect, and from 'vicarious trauma') for exposed staff, immediately activating the necessary support measures, event processing, and emotional stabilization.
- Evaluate, in collaboration with the Single Guarantee Committee and the Trustee Advisor, the gender-related risk by adjusting work activities and workloads, taking gender differences into account, and generally promoting all necessary actions to protect staff from any form of moral and/or sexual harassment by colleagues, superiors, or service users.
- Support the newly established Committee for the Prevention of Organizational Psychosocial Risks and Well-being (PROB) in its functions of periodic monitoring of critical areas for SLC purposes.
- Promote a culture of workplace well-being through the promotion of the Codes of Conduct.
- Provide ongoing training for managers and coordinators to promote leadership that supports the well-being of employees and work teams.
- For managers overseeing people and teams (Directors, Coordinators, Supervisors, Organizational Roles), aim to actively contribute to fostering a positive work environment with colleagues and team members.

Evaluation:

The practice has been evaluated through satisfaction and learning questionnaires. Main objective outcomes (injuries, absences due to illness, turnover etc...) will be measured in the next survey in order to size changes.

Barriers, enables, and learning points:

CHALLENGES:

Main challenge has been to gain trust among health care workers in order to start the survey. A second challenge has been to win organizational resistance in order to start specific training courses, which have never been realized in recent times in ASL AT.

ENABLERS:

- CEO ASL AT strong and clear commitment
- Formal inter-service governance
- Shared protocols
- Existing multidisciplinary competencies in training and topics (de-escalations techniques, mindfulness) and clinical competences within ASL AT.
- Early co-design with RSPP, Health workers and Trade Unions
- A maintained community-asset map and agreed feedback routes

LEARNING POINTS:

Benefit other regions wishing to implement a similar initiative are, after proper stress survey, setting general corrective and improvement measures as primary, secondary, and tertiary prevention measures: Promoting more comfortable and ergonomic workplaces, Training programs for managing clinical risk, conflicts, aggression, stress, and improving interpersonal communication, Discussion groups for cases and debriefing/defusing interventions aimed at healthcare staff periodically exposed to potentially traumatic experiences; Strengthening the clinical support and listening service for employees, Establishment of the company committee for managing organizational psychosocial risks and well-being, Adoption of a company manifesto to promote organizational health; Keep the minimum dataset concise and collect baseline information from the first participant.

Legal and/or ethical issues:

The practice will operate within applicable Italian and EU law, including the GDPR and national rules on health data, professional confidentiality and informed consent. Health information will not be disclosed to community organisations unless authorised. Social-prescribing partners will normally receive only the information required to support participation.

Transferability to other regions:

Transferable with contextual adaptation/Transferability requires further validation.

Core components of the intervention are potentially adaptable.

Dissemination and further information:

Dissemination activities, dedicated publications and stress evaluation results and improvement measures for each ASL Unit are currently available on the ASL AT Intranet. The proposals for specific corrective measures for each ASL AT organizational unit found to be critical are instead reported in the company's Risk Assessment Documents (DVR) for the purposes of Law 81 and will be available in the dedicated Intranet section. Planned actions include accessible information for health workers, result presentations within ASL AT and to regional networks, and publication of implementation and evaluation findings when available.

Additionally, in order to better tackle the growing difficulties that staff encounter in work in general and in care and assistance in particular, ASL AT is committed to carrying out the mapping of the psychosocial work environment (SLC) every two years and to promoting suitable policies over the 2026-2028 period aimed at wellbeing and protection from work-related distress, in line with the principles set out by the Piedmont Region (see 2025 Handbook "Helping those who care: instructions for use").

Media:

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Targeted support and workforce capacity



ALBA – A Digital Self-Help Plus (SH+) Virtual Coach for Psychological Wellbeing in Pregnancy



Key info:

Organisation name:	Fondazione Bruno Kessler (FBK), in collaboration with Azienda Sanitaria Universitaria Integrata Trentina (ASUIT) and Provincia Autonoma di Trento (PAT), within the TrentinoSalute4.0 program.
Region:	Provincia Autonoma di Trento / Trentino
Country:	Italy
Practice cooperation partners – International collaboration (e.g., Please indicate any organisations involved in the implementation of the practice, particularly if developed through European collaboration (e.g. Joint Actions, Horizon Europe, Interreg, EU4Health, Erasmus+, etc.). If not applicable, write "N/A".):	Fondazione Bruno Kessler (FBK); Azienda Sanitaria Universitaria Integrata Trentina (ASUIT); Provincia Autonoma di Trento (PAT); Istituto Pavoniano Artigianelli of Trento; WHO Collaborating Centre for Mental Health Research at the University of Verona.

Keywords:

Perinatal mental health, pregnancy, digital intervention, Self-Help Plus, ACT, chatbot.

Implementation status:

Ongoing implementation of a mental health policy/programme/initiative, Pilot or promising practice currently being tested, Prevention or mental health promotion initiative, Practice addressing vulnerable or underserved groups, Practice addressing vulnerable or underserved groups.

Focus areas:

Digital mental health; prevention and early intervention; psychosocial support; access to services; support for vulnerable groups; community-based maternal mental health; integrated care; training and collaboration with health professionals; promotion of psychological wellbeing in pregnancy.

Summary:

ALBA is a virtual coach developed to deliver Self-Help Plus (SH+), an evidence-based intervention from the World Health Organisation based on the principles of Acceptance and Commitment Therapy (ACT), in a digital format. The programme is aimed at pregnant women living in the Autonomous Province of Trento and was created to address a growing need for psychological support during a stage of life characterised by vulnerability, stress, anxiety and barriers to accessing specialist services.

The project forms part of the 'Percorso Nascita' ecosystem and the TrentinoSalute4.0 programme, with the aim of offering psychoeducational support that is accessible, flexible and complementary to clinical care. The programme offers a 6-week course comprising one weekly session of approximately 40 minutes, which can be split into two shorter sessions if required. The content includes text, audio, video, images, exercises to be completed independently and a personal diary within the app.

The project is currently in the proof-of-concept study phase and primarily assesses acceptability, feasibility, user experience and user engagement, as well as exploring pre- and post-intervention changes in psychological well-being,

psychological flexibility, self-efficacy, emotional regulation and coping. The project involves an initial screening, self-report questionnaires at various time points, and qualitative interviews two months after childbirth.

ALBA is an example of the digital adaptation of a low intensity WHO intervention in a real-world setting. The value of this approach lies in its ability to extend support beyond the clinical consultation, reduce geographical and stigma-related barriers, and provide a tool that can be integrated into regional maternal and child health services.

Description and strategic context:

This initiative addresses the need for psychological support during pregnancy, a period associated with physical, mental and social changes, as well as frequent symptoms of anxiety, stress and depression. Despite growing evidence of the benefits of psychological interventions during pregnancy, geographical, organisational and cultural barriers persist, alongside a shortage of professionals and the stigma attached to seeking help.

ALBA forms part of the community welfare framework promoted by the Autonomous Province of Trento and the 'Percorso Nascita' programme, which ensures continuity of care from pregnancy through to the postpartum period. The initiative is consistent with WHO strategies on mental health and with the promotion of digital technologies as inclusive, scalable and accessible tools for promoting psychological wellbeing.

Objectives:

The main aim is to help people learn and put into practice skills that are useful for managing stress in difficult situations. The programme is based on Acceptance and Commitment Therapy, an evidence-based approach that uses experiential strategies of acceptance and mindfulness, alongside strategies for acting and behaviour change, with the aim of increasing psychological flexibility.

Target group(s):

The direct beneficiaries are pregnant women living in Trentino, specifically those between the 14th and 26th weeks of pregnancy, aged 18 or over.

Inclusion also involves specific psychological screening criteria: moderate levels of distress/stress and psychological well-being, measured using the K10, GHQ and the 'Mental Health' scale of the SF-36. Women with severe psychopathological vulnerability, suicidal tendencies, recent addictions, depression or other psychiatric diagnoses, women already undergoing psychological or psychotherapeutic treatment, and women undergoing assisted reproductive technology (ART) are excluded.

Indirect beneficiaries include local maternal and child health services, midwives and the regional perinatal care system, which can make use of an additional tool for psychoeducational support.

Equity dimension:

The programme addresses certain inequalities in access to psychological support, particularly those linked to geographical distance, limited availability of professionals, time constraints and the social stigma associated with seeking help during pregnancy. The digital format allows for flexible access anywhere and at any time, reducing logistical and organisational barriers.

The programme is designed for women during a specific period of vulnerability – namely, pregnancy – and forms part of an existing regional care pathway. However, the programme requires certain prerequisites: an understanding of the Italian language, the ability to use a smartphone and access to the internet. This means that, whilst improving accessibility for many women, the programme may remain less accessible for certain sub-populations facing linguistic, digital or socio-economic barriers.

Methodology and processes:

The programme is being implemented as a proof-of-concept study within the ORBIT model, phase 2a. The intervention is delivered by ALBA, a virtual coach integrated into the TreC Ricerca app and is based on the digital adaptation of SH+, a low intensity WHO protocol founded on the principles of ACT. The content was developed by psychologists from the Digital Health Research Unit at FBK and the Pavoniano Artigianelli Institute, based on the WHO's SH+ manual, reviewed by a Senior Psychologist at ASUIT and supervised by professionals from the WHO Centre for Mental Health Research at the University of Verona. The material is educational and not intended for the management of emergencies.

The programme lasts 6 weeks, with one weekly session of approximately 40 minutes, which can be split into two 20-minute sub-sessions if required. Each session includes text, images, audio and video, as well as exercises to be completed independently and the completion of a diary within the app. The content follows the five chapters of SH+: grounding, detaching, acting in line with values, being kind, and making space.

The process involves:

- Identification of potential participants by midwives and doctors from ASUIT services.
- Collection of socio-demographic data.
- Initial screening to verify psychological inclusion criteria, carried out by a psychologist, with follow-up feedback where necessary.
- Formal enrolment, informed consent and authorisation for data processing.
- Delivery of the intervention via ALBA.
- Administration of questionnaires at baseline, during the programme and at the end of the study.
- A qualitative interview two months after childbirth, subject to consent.
- The evaluation includes both quantitative and qualitative indicators. Psychological questionnaires and usability/engagement tools will be used.

Involvement of other organisations/actors:

The project involves a range of institutional, clinical and research stakeholders. FBK is coordinating the scientific and technological design of the virtual coach and the study protocol. ASUIT is involved through its maternal and child health services, midwives and clinical support for content review. The Autonomous Province of Trento is supporting the initiative as part of TrentinoSalute4.0. The Pavoniano Artigianelli Institute has contributed to the development of the psychoeducational content. The WHO Centre for Mental Health Research at the University of Verona has provided methodological and scientific supervision for the adaptation of SH+.

Midwives and, where applicable, doctors involved in ASUIT services play a key role in the information, recruitment, consent-gathering and initial collection of socio-demographic data stages. Participating women are involved not only as end-users, but also as a source of feedback through UX/UE questionnaires and postpartum qualitative interviews.

Funding source(s) and sustainability:

The initiative is supported by the TrentinoSalute4.0 digital health programme, promoted by the Department of Health and Social Policies of the Autonomous Province of Trento, in collaboration with ASUIT and under the technical and scientific management of FBK.

As regards sustainability, the initiative is integrated into an existing local ecosystem, namely the 'Percorso Nascita' (Birth Pathway) and the TreC platform, elements which facilitate its organisational integration. Long-term sustainability is currently under assessment, with favourable prospects linked to the digital infrastructure and the institutional partners already involved.

Innovation, Impact and Outcomes:

The main innovative feature of this initiative is the digital adaptation of Self-Help Plus (SH+), a WHO-validated intervention, for a population for whom it had not previously been used in this format, namely pregnant women. The intervention is delivered via a rule-based virtual coach, integrated into an existing local healthcare platform, and combines evidence-based psychoeducational content with flexible, asynchronous delivery methods.

The innovation also covers:

- integration with the TreC regional digital health system
- linkage with the 'Percorso Nascita' programme
- the use of structured multimedia content
- the combination of screening, longitudinal questionnaires and qualitative follow-up
- positioning as a tool that complements, rather than replaces, clinical services

As regards impact and outcomes, at present we are primarily reporting expected results and progress, rather than definitive outcomes, as we are still in the proof-of-concept phase. Specifically, the following are expected:

- high levels of satisfaction and engagement with the use of ALBA
- pre-post improvements in psychological well-being, quality of life, psychological flexibility, self-efficacy, emotional regulation and functional coping
- a reduction in certain barriers to access and stigma associated with seeking psychological support during pregnancy.

According to the evidence currently available, the procedure was formalised in a published protocol:

- Rizzi et al. (2025), *A Chatbot-Based Version of a World Health Organization-Validated Intervention (Self-Help Plus) for Stress Management in Pregnant Women: Protocol for a Usability Study*, JMIR Research Protocols

And an initial study involving target users and subject matter experts suggests that we are heading in the right direction:

- Fietta et al. (2024), *A Chatbot-Based Version of the World Health Organization-Validated Self-Help Plus Intervention for Stress Management: Co-Design and Usability Testing*, JMIR Human Factors

Evaluation:

The programme is currently being evaluated using a proof-of-concept design with a mixed quantitative and qualitative approach.

The quantitative evaluation includes: psychological questionnaires administered at baseline and at the end of the intervention to measure stress, psychological well-being, psychological flexibility, self-efficacy, emotional regulation and coping strategies; and questionnaires on usability, user experience and user engagement administered during and at the end of the programme.

The qualitative evaluation involves semi-structured interviews two months after childbirth, to explore the participants' experiences and their experience of using the app and the virtual coach.

An estimated sample size of 50 women has also been defined, taking into account statistical power and potential dropouts. As of the date of this report, the evaluation is still ongoing.

Barriers, enables, and learning points:

CHALLENGES:

- Persistent barriers to accessing psychological support during pregnancy, linked to distance, limited availability of professionals and stigma.
- The need for accurate screening to distinguish cases suitable for low-intensity intervention from situations requiring specialist care.
- Reliance on digital and linguistic prerequisites, such as owning a smartphone, having internet access and understanding Italian.
- The need for organisational integration with local services and obstetric staff.

ENABLERS:

- o Integration of the programme into an existing regional ecosystem, namely the 'Percorso Nascita'.
- o Institutional support from PAT, ASUIT and FBK via TrentinoSalute4.0.
- o Use of an established digital platform such as TreC Ricerca.
- o Strong theoretical foundation: a WHO-validated intervention based on ACT.
- o Multidisciplinary scientific and clinical supervision.

LEARNING POINTS:

- o Digital technology can expand psychological support during pregnancy without replacing clinical care.
- o Low-intensity interventions are most promising when integrated into a real-world care pathway rather than being offered as stand-alone tools.
- o The combination of asynchronous support, multimedia content and continuity over time can reduce certain barriers to access.
- o The role of midwives and local services is crucial for recruitment, initial engagement and practical integration.

Legal and/or ethical issues:

The study requires approval from the Regional Ethics Committee of the Autonomous Province of Trento. Participation is voluntary and requires written informed consent, as well as consent for the processing of personal data and, where applicable, for the recording of the qualitative interview.

Data is processed for research purposes, with pseudo-anonymisation measures applied prior to analysis. Personal information is not disclosed, except in anonymous or aggregated form. The TreC Ricerca app uses two-factor authentication (OTP) and the questionnaires are managed using tools that comply with current legislation on the protection of personal data.

The platform and the virtual coach are not classified as medical devices; they do not make diagnoses, do not generate alerts and are not intended for the management of emergencies.

Transferability to other regions:

Estimated transferability maturity: Easily transferable with minimal adaptation.

This practice is potentially transferable to other regions or organisations, particularly in contexts that have a structured maternal and child healthcare pathway and a digital infrastructure compatible with the delivery of asynchronous content and the secure collection of data. The intervention has the advantage of being based on a well-established WHO protocol and on adaptable, modular content.

However, transferability requires certain conditions: availability of a secure digital platform

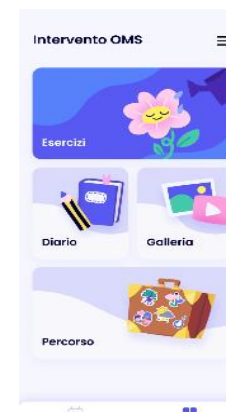
- o the ability to integrate with local services and relevant professionals
- o content adapted to the local linguistic and organisational context
- o appropriate ethical and privacy procedures
- o the presence of a screening system to identify cases unsuitable for a low-intensity intervention

The documentation relevant to transferability includes the published study protocol, the structure of the SH+ modules, the questionnaires used, and the model for integration with midwifery services and regional digital health services.

Dissemination and further information:

The practice has been disseminated through scientific literature and study protocols. In particular, the protocol published in JMIR Research Protocols regarding the chatbot-based adaptation of SH+ for pregnant women is available. The project is also part of the research and validation of digital interventions for mental wellbeing developed by FBK in collaboration with clinical and institutional partners in the Trentino region.

Media:



LINKS AND CONTACTS:

Silvia Rizzi - Fondazione Bruno Kessler (FBK) - Email: srizzi@fbk.eu - Role: researcher / project scientific lead

Targeted support and workforce capacity



BIZI Program: An interactive, online, self-paced, and open-access course designed to improve suicide prevention in community settings



Key info:

Organisation name:	Basque Healthcare Provider – Osakidetza
Region:	Basque Country
Country:	Spain
Practice cooperation partners – International collaboration (e.g., Please indicate any organisations involved in the implementation of the practice, particularly if developed through European collaboration (e.g. Joint Actions, Horizon Europe, Interreg, EU4Health, Erasmus+, etc.). If not applicable, write "N/A".):	

Keywords:

Suicide prevention, gatekeepers, prevention, online training, community.

Implementation status:

Fully implemented mental health policy / programme/ initiative.

Focus areas:

Mental health, suicide prevention, support for vulnerable groups, community, training of gatekeepers.

Summary:

Suicide causes more than 45,000 deaths each year in the EU. Although suicide can be prevented, only a minor percentage of citizens access specialised help in the weeks prior to suicide, partly due to the lack of knowledge and stigma surrounding the phenomenon. The use of new formats (e.g., open access and online) is changing this situation, allowing a broader dissemination of knowledge. However, these solutions are still scarce; no known studies support their effectiveness. For this reason, a gatekeeper training programme was designed to contribute to suicide

prevention at the community level. This programme consists of an online, interactive, self-managed, short, and free-access course that has been shown to improve critical competencies for suicide prevention in community professionals (social workers, educators, pharmacists, etc.). This might be among the first programmes of this type in which such efficacy has been demonstrated.

Description and strategic context:

Suicide is a complex phenomenon and is recognized as a public health problem in many countries. Early identification of this risk and addressing it through psychosocial approaches or specific therapies can prevent it. However, the literature shows that only a small percentage of people who die by suicide contacted specialized mental health services in the months leading up to their death, a fact linked to the stigma and lack of awareness surrounding the issue, which hinders access to such help.

Training gatekeepers (GTK) is one of the most widespread suicide prevention initiatives at the community level and aims to improve the ability of certain community members and the general public (gatekeepers) to identify people at risk, provide initial support, and facilitate their referral to

specialized support services. Although there is no conclusive evidence of its direct effectiveness in reducing suicide rates, its usefulness in prevention is recognized because it facilitates the dissemination of key knowledge and skills to enable preventive action in community settings, which are often unaccustomed to addressing this risk and where misinformation and taboos surrounding suicide are common.

In recent years, some academic and government institutions have developed GTK programs in online, self-paced, and license-free formats that have made training accessible to a significant number of people and promoted the dissemination of this knowledge in certain communities. Such is the case with the Dutch program *VraagMaar* (Zelfmoord Preventie 113) or the Alliance for Zero Suicides (ZSA) in England, which has reportedly been accessed by more than two million people. These formats have great potential for disseminating key ideas among the public but, nevertheless, present the drawback of making it more difficult to ensure adherence to the content (participants must self-manage) or even to evaluate the intervention itself, raising questions about their actual impact on those who access the content. Furthermore, their availability remains limited in Spanish-speaking countries.

Objectives:

Overall goal was to develop, evaluate and deploy an online, brief, self-completed and freely accessible GTK training resource to disseminate competencies for suicide prevention in community settings.

Specific goals were:

- To develop the resource based on scientific evidence and the accumulated experience with previous courses in the Basque Country.
- To evaluate its impact on the three key GTK competences of Attitude, Self-efficacy and Knowledge, on adherence to the programme and satisfaction.
- To deploy the resource to reach as many “gatekeepers” as possible. To evaluate and adapt it on an ongoing basis.

Target group(s):

Direct target population: Non-health professionals and volunteers working in the community with populations vulnerable to suicide (e.g. social workers, educators, police, pharmacists, etc). These professionals would be identified and reached through public health coordinators in health districts. Estimated size is >10.000

Indirect target population: The population with suicidal ideation in the Basque Country. Estimated size is 23.000 inhab. or 1,1% in Basque Country (according to health surveys).

Equity dimension: N/A

Methodology and processes: N/A

Program Development

The work was carried out in two phases. In the first phase, a panel of five professionals—including experts in suicide prevention with experience in GTK training, public health, and health communication—developed the program based on a comprehensive review of the scientific evidence and a set of GTK programs available online. The technical development was handled by a company specializing in online courses.

The program was tested with participants, all of whom were community professionals outside the health sector, with the aim of analyzing the clarity and perceived usefulness of the content, its ease of use, and identifying areas for improvement. This preliminary analysis identified improvements that were implemented to produce the final version of the program.

Features of the BIZI Program

This is an interactive, online, theoretical and practical, self-paced course offered free of charge by the Basque Health Service’s School of Health for Citizens in the Basque Country; enrolment is simple and requires only an email address.

The program includes audio recordings, videos, exercises, text, and images, and provides basic knowledge and skills to help prevent suicide in community settings. The average time to complete the course is 90 minutes; participants have unlimited access to the platform for two weeks until they complete the course. It focuses on the characteristics of the phenomenon in Spain and is available in Spanish and Basque.

It features a theoretical section with three modules (“Basic Concepts of Suicide,” which examines the magnitude of the phenomenon and the myths surrounding it; “When to Suspect a Risk,” which covers risk factors, warning signs, and the stages of the suicidal process; and “How to Respond to a Suspicion,” which proposes four specific actions to help, including limiting access to lethal means or facilitating access to specialized help) and a practical section with four case studies in which participants interactively work through different situations and must select the most appropriate intervention. Summary sheets and other downloadable materials are available. Participants who complete the course receive a certificate of completion.

There is an “SOS Button,” visible always, that redirects participants to the Basque Government’s Department of Health suicide prevention website, which provides information on hotlines and other support resources. An online informational video describes its main features.

Involvement of other organisations/actors:

Intersectoral cooperation and the involvement of diverse stakeholders have been fundamental to the success of the BIZI Programme. Given the complexity and multifactorial nature of suicide, the initiative has adopted a collaborative, multidimensional approach involving agencies across health, social, and community sectors. Below are a list of key

stakeholders and their roles during the different phases of the initiative lifecycle.

Key Stakeholders and Roles by Phase (1-program creation, 2-evaluation, 3-deployment)

1. Basque Public Health Service (Osakidetza) (Phases 1, 2, 3):

- Played a central role in programme development, evaluation, and territorial implementation.
- Coordination and leadership, ensuring the integration of the programme into public health strategies.

2. University of the Basque Country (Phases 1, 2):

- Contributed to the scientific design and development of the programme.
- Led the evaluation phase, ensuring evidence-based outcomes to guide future implementations.

3. Basque Government Departments (Phase 3):

- Departments of Health, Social Services, and Education facilitated programme dissemination in their respective sectors, supporting implementation at a policy level.

4. Provincial Councils of Gipuzkoa, Bizkaia, and Araba (Phases 2, 3):

- Provided logistical and financial support for implementation.
- Enabled collaboration with local organisations and services within their territories.

5. Municipalities (Phase 2, 3):

- Examples include the Municipality of Azpeitia, which involved local police, social services, and home support services.
- Helped adapt and implement the programme locally, ensuring accessibility to community professionals.

6. Professional Societies (Phases 2, 3):

- Examples include the Professional College of Psychology and the Professional College of Pharmacy.
- Advocated for the programme within their networks and facilitated engagement with their members.

7. Non-Professional Associations (Phases 2, 3):

- Examples include Kolore Guztiak, Sirimiri, and Agipad, which supported dissemination and facilitated access to vulnerable groups.

8. Non-Governmental Organizations (Phases 2, 3):

- Organisations such as Red Cross and Caritas engaged in outreach and supported programme implementation among underserved populations.

9. Entities for Social and Labor Insertion (Phases 2, 3):

The Gureak business group is an example of stakeholders working to integrate mental health training into their employment and support services.

Funding source(s) and sustainability:

The BIZI Program was developed as a research project. Its positive results, combined with the fact that its focus was fully aligned with the strategies of the Basque Country's Department of Health and Osakidetza, led to the program becoming an institutional initiative. In fact, the BIZI Program is now part of Osakidetza's Health School and it is open to the whole population. From the outset, the program was designed in such a way that corporatization has been straightforward.

Innovation, Impact and Outcomes:

Since its launch, the BIZI program has yielded significant results in terms of both its output and its social, institutional, and economic impact. It is a free, self-paced, bilingual (Basque and Spanish) online course designed for non-healthcare professionals and the general public, which enhances key skills for suicide prevention in community settings.

As mentioned earlier, the evaluation of results has shown a significant improvement in participants' gatekeeper competencies for suicide prevention, as well as high adherence to and satisfaction with the training. To the best of our knowledge, BIZI is one of the first programs of this design to evaluate its effectiveness, and it is also the first to be implemented in Spain.

Social Impact

BIZI has helped improve the ability of community workers to identify and assist people at risk of suicide. To date, more than 6,757 people have completed the training (5,220 Osakidetza professionals and 1,537 members of the public). According to follow-up data, 23% of participants reported having identified or helped a person at risk after completing the course, and 7% have done so on more than one occasion. Seventy-eight percent of those who took action indicated that the course helped them quite a bit, and 25% said it helped them a great deal in that effort.

These figures reflect a direct impact on reducing stigma and ignorance—key barriers to seeking and offering help in situations of suicide risk. Furthermore, the program received an average satisfaction rating of 8.5 out of 10, and 100% of participants would recommend the training.

Institutional and Regulatory Impact

BIZI was developed as part of the Basque Country's Suicide Prevention Strategy and is currently part of Osakidetza's institutional resources and the Osasun Eskola+ platform, ensuring its sustainability in the short, medium, and long term.

The course platform itself includes an "SOS" button that redirects users directly to the Basque Suicide Prevention Service's website, which provides information on what to do and offers support resources.

Its integration and alignment with these official systems solidifies the program's position as a strategic tool for community mental health training and as an example of applied research that has successfully become part of public policy.

Economic Impact

The program has been developed primarily using the public health system's own resources—specifically, the budgets allocated to Osasun Eskola—which demonstrates its efficiency and sustainability.

- Technology development: 12,000 €
- Monthly platform maintenance: 600 €
- Promotional materials: 3,242 €
- Human resources: 0.5 (full-time) in the first year and 0.2 (full-time) during the platform maintenance phase

Thanks to its online, concise, and self-directed format, BIZI allows for easy scalability without the need for constant technical supervision. This reduces operating costs and facilitates its rollout across different regions. In addition, the program has been selected for replication in several European countries as part of a joint initiative co-funded by the European Commission, which reinforces its value as an efficient and transferable innovation.

Environmental Impact

Although environmental impact is not the program's primary focus, its digital format eliminates travel, paper consumption, and the use of physical resources, thereby indirectly contributing to a reduced ecological footprint compared to traditional in-person training.

Evaluation:

The program's results have been published in the Pan American Journal of Public Health (DOI: <https://doi.org/10.26633/RPSP.2024.20>), which reinforces their scientific validity and facilitates their transfer through academic dissemination.

Objective

To evaluate the BIZI program, a Spanish-language gatekeeper training program with a novel online self-learning format that is brief and open-access. It was developed as part of the suicide prevention strategy in Euskadi (Spain) to improve community-based suicide prevention.

Methods

A group of experts from different fields created the program and tested its usability in a preliminary phase. A single-group design was used for the evaluation, with repeated measurements (before, immediately after, and after three months). Online questionnaires were used to evaluate the program's impact on core competencies for gatekeepers, as well as adherence to content and user satisfaction. Community agents (educators and social workers, among others) who responded to an invitation sent by regional public health coordinators were included in the study.

Results

In total, 728 people accessed the training, and 86% completed it; 569 people completed the assessment (81.2%

women, mean age 41.4 years). The core gatekeeper competencies of attitude, self-efficacy, and knowledge improved significantly, and improvement was sustained ≥ 3 months in a subsample ($P = 0.0001$).

Conclusions

The results are promising and suggest that BIZI is useful in improving the capacity and willingness of community agents to identify people at risk and refer them to specialized resources. Its novel format gives it important advantages over other more common gatekeeper training programs, facilitating its dissemination in low-resource environments. It is the first program of its kind whose effectiveness has been demonstrated and the first available in Spanish.

Furthermore, BIZI was recently awarded in the "Best Learning Technologies Project – Public & Non-Profit Sector" category at the 2025 Learning Technology Awards. This nomination reinforces its international impact and visibility, highlighting the project's value in the field of educational and technological innovation, as these awards offer a unique opportunity to open new avenues and strengthen its profile within the learning technology community.

Barriers, enables, and learning points:

CHALLENGES:

Among the lessons learned, the importance of having support strategies and local contextualization to prevent dropout in self-managed formats stands out. Although the design facilitates scalability, it has been observed that adherence improves when there is a local or institutional connection that reinforces the user's commitment.

As for the challenges overcome, one of the main ones was adapting the content of in-person training to an online format without losing depth or rigor. The in-person format limited the training's reach; thanks to this adaptation, the number of people reached increased from 600 in the in-person format to more than 6,000 using this platform.

ENABLERS:

One of the main factors behind the success of the BIZI program has been its **innovative and accessible format**. Its online, interactive, self-directed, concise, and open-access design has made it possible to overcome common barriers found in more traditional programs, such as cost, rigid schedules, or the need for constant technical supervision. These features have fostered high participation and satisfaction, even among groups less familiar with digital tools.

The course combines **theoretical content with an interactive practical module**, which facilitates the acquisition of key skills in a safe environment. Its flexible structure allows each user to progress at their own pace, adapting to their needs and availability. Specifically, the estimated completion time is 90–120 minutes, which can be completed over a three-week period starting from the time of registration. Furthermore, the use of clear and accessible

language has been key to reaching a diverse audience, including volunteers and non-healthcare professionals.

Another facilitating factor has been the **low maintenance cost**, which ensures its sustainability within the public health system. The largest investment is concentrated in the development phase, while the recurring costs are manageable for Osakidetza. The automation of reminders and follow-up reduces the technical workload, further reinforcing its operational viability.

The **multisectoral and multidisciplinary nature** of the co-creation process has also been a key factor. The involvement of professionals in public health, health communication, and suicide prevention has made it possible to design a tool tailored to the region's actual needs.

LEARNING POINTS:

The BIZI program has high potential for replication and scalability, due both to its technical design and its institutional and scientific validation. Its online, brief, self-managed, and open-access format allows for easy implementation in other regions, sectors, and communities, without the need for extensive infrastructure or significant human resources. The automation of processes such as sending reminders reduces the technical burden, which facilitates its operational sustainability.

As basic recommendations for replicating this model, the following are suggested:

- Ensure the involvement of local stakeholders in the adaptation process.
- Maintain a flexible and modular approach to facilitate contextualization.
- Ensure sustainability through institutional integration and process automation.
- Design follow-up strategies that reinforce adherence without requiring intensive supervision.

Finally, BIZI is one of the practices being transferred to different European region in JA PRISM. The stepped implementation framework designed in this Joint Action is of high value for other regions that might be interested in adopting BIZI practice.

Legal and/or ethical issues:

There are not relevant legal, ethical, governance, or data protection issues.

Transferability to other regions:

Estimated transferability maturity: Easily transferable with minimal adaptation.

The BIZI program has high potential for replication and scalability, due both to its technical design and its institutional and scientific validation. Its online, brief, self-directed, and open-access format allows for easy implementation in other regions, sectors, and communities, without the need for extensive infrastructure or significant human resources.

The transfer process could take place in several phases:

- Situation analysis: identification of key stakeholders, available resources, and local priorities.
- Contextual adaptation: translation, adjustment of content based on specific epidemiological characteristics, and visual adaptation of the platform.
- Development of action plans: definition of objectives, activities, indicators, responsible parties, and a timeline.
- Incorporation of micro-interventions: addressing cross-cutting issues such as alcohol use among people with suicidal ideation.
- Rollout and monitoring: phased implementation and evaluation of results and sustainability.

Dissemination and further information:

- <https://osasuneskola.osakidetza.eus/es/compound-course/curso-de-prevencion-del-suicidio>
- https://mapa.innobasque.eus/casos-practicos/osakidetza_programa-bizi-un-curso-interactivo-online-autocompletado-y-abierto-para-mejorar-la-prevencion-del-suicidio-desde-entornos-comunitarios
- <https://webgate.ec.europa.eu/dyna/bp-portal/best-practice/449>
- <https://japrim.eu/technical-work-packages/bizi/>

Media: N/A

LINKS AND CONTACTS:

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Cross-border healthcare cooperation



Prevention oriented Rights-based approach to Support Mental health in vulnerable population groups (JA PRISM)



Key info:

Organisation name:	Basque Healthcare Provider – Osakidetza
Region:	Basque Country
Country:	Spain
Practice cooperation partners – International collaboration (e.g., Please indicate any organisations involved in the implementation of the practice, particularly if developed through European collaboration (e.g. Joint Actions, Horizon Europe, Interreg, EU4Health, Erasmus+, etc.). If not applicable, write "N/A".):	• ASOCIACIÓN INSTITUTO DE INVESTIGACIÓN EN SISTEMAS DE SALUD-BIOSISTEMAK • Agencia de Salut Publica de Barcelona • NSTITUT DE RECERCA DE L'HOSPITAL DE LA SANTA CREU I SANT PAU FUNDACION • CONSEJERIA DE SANIDAD DE LA COMUNIDAD DE MADRID • FUNDACION PARA LA INVESTIGACION E INNOVACION BIOSANITARIA DE ATENCION PRIMARIA • FUNDACIO DE RECERCA CLINIC BARCELONA-INSTITUT D INVESTIGACIONS BIOMEDIQUES AUGUST PI I SUNYER • HOSPITAL CLINIC DE BARCELONA • FUNDACION INSTITUTO DE INVESTIGACION MARQUES DE VALDECILLA • FUNDACION PUBLICA MIGUEL SERVET • SERVICIO ANDALUZ DE SALUD • 7.1 AE FISEVI FUNDACION PARA LA GESTION DE LA • INVESTIGACION EN SALUD DE SEVILLA

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- ESZAK-BUDAI SZENT JANOS CENTRUMKORHAZ

- ISTITUTO SUPERIORE DI SANITA
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- UNIVERSIDADE NOVA DE LISBOA
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- FEDERAL MINISTRY OF HEALTH
- JAVNA ZDRAVSTVENA USTANOVA DOM ZDRAVLJA U BANJOJ LUCI
- JZU INSTITUT ZA JAVNO ZDRAVSTVO REPUBLIKE SRPSKE
- SERVICIO MADRILENO DE SALUD

Keywords:

Mental health, Vulnerable groups, Prevention, Human rights, Emotional well-being, Suicide prevention, Loneliness in the elderly Multisectoral collaboration, Quality of life.

Implementation status:

Ongoing implementation of a mental health policy / programme / initiative

Focus areas:

Mental health, Vulnerable groups, Prevention, Human rights, Emotional well-being, Suicide prevention, Loneliness in the elderly Multisectoral collaboration, Quality of life.

Summary:

The Joint Action Prevention oriented Rights-based approach to Support Mental health in vulnerable population groups (JA PRISM) aims to reduce the burden of mental ill health with a specific focus on vulnerable groups through promoting good mental health, effectively preventing mental health problems and improving access to mental health treatment and services across the EU Member States and Associated countries, by supporting the transfer and roll-out of best and promising practices to new contexts. JA PRISM will facilitate the implementation of three practices with a clear human rights approach, targeting vulnerable groups such as children and adolescents, older people, migrants, substance users, and people with mental health conditions. According to the preferences and priorities of the Member States, practices to be transferred are focused on suicide prevention (BIZI programme), addressing loneliness in elderly (Circle of Friends) and fostering emotional wellbeing in children and young people (Act, Belong, Commit). The activities of JA PRISM are distributed into 7 work packages (WPs): four transversal WPs (coordination and management, communication and dissemination, evaluation and sustainability) and three technical WPs, each of them devoted to the transfer of each selected practice. In overall, JA PRISM represents 61 implementation sites (13 sites will gain insight on methodological approaches and practices but deployment is not expected, 34 sites will roll-out small-scale pilots and 14 sites will deploy large-scale implementations) across 18 Member States and 2 Associated Countries. JA PRISM pretends to increase awareness and knowledge on human rights-oriented approaches, enhance empowerment and quality of life of vulnerable and socio-economically disadvantaged groups, remodel the public health services

and policy making towards a prevention oriented comprehensive mental health approach.

Description and strategic context:

Mental health issues affect many people worldwide. Prior to the COVID-19 pandemic, it was estimated that at least more than 970 million citizens were affected by mental illness (84 million across the Union, 1 in 6). The prevalence of mental disorders varies with sex and age. In both males and females, anxiety disorders and depressive disorders are the two most common mental disorders. Among adults, depressive disorders are the most prevalent of all mental disorders. Between 2000 and 2019, an estimated 25% more people were living with mental disorders. In addition to the direct costs of treatment, mental health conditions come with a variety of indirect costs associated with reduced economic productivity, higher rates of unemployment and other economic impacts.

Mental health is determined by a complex interplay of individual, family, community and structural factors that vary over time and space and that are experienced differently from person to person. Mental health conditions result from the interaction between an individual's vulnerability and the stress caused by life events and chronic stressors. Although most people are remarkably resilient, people who are more exposed to unfavourable circumstances are at higher risk of experiencing mental health conditions.

Objectives:

The general goals of JA PRISM is to reduce the burden of mental ill health with a specific focus on vulnerable groups through promoting good mental health, effectively preventing mental health problems and improving access to mental health treatment and services across the EU Member States and Associated countries by supporting the transfer and roll-out of best and promising practices to new contexts.

The **Specific Objectives** at Joint Action level are:

- To promote good mental health and prevention of mental health problems
- To improve access to evidence-based and innovative, promising and personalised approaches and interventions in the management of mental health problems, including improving community-based care and approaches
- To improve the quality of life through appropriate and patient centred follow-up care with a focus on

fundamental rights and addressing stigma and discrimination

- o To support Member States to adopt a comprehensive approach to mental health for vulnerable groups
- o To contribute to the long-term sustainability of adapted practices and results at country levels
- o To facilitate the transfer to new contexts of practices supporting mental health in vulnerable groups
- o To boost synergies and collaboration with JA MENTOR and other initiatives
- o To effectively disseminate and communicate, at national and international level, JA objectives, activities and results
- o To ensure high-quality assessment of JA PRISM performance and impact.

Target group(s):

The aim of JA-PRISM is to reduce the burden of mental ill health with a specific focus on vulnerable groups through promoting good mental health, effectively preventing mental health problems and improving access to mental health treatment and services across the EU. The Joint Action will support the transfer and roll-out of promising and best practices and approaches in the Member States, such as collected under the EU Best Practice Portal.

BIZI programme (Spain) – Direct target population: Non-health professionals and volunteers working in the community with populations vulnerable to suicide (e.g. social workers, educators, police, pharmacists, etc).

Circle of Friends (Finland) – Target: The Circle of Friends was developed originally for lonely, older adults living at home. Over the last two decades, it has been carefully and widely disseminated in Finland. The initiative is ongoing. Many older target groups have adopted it. Furthermore, it is feasible among home-dwelling older adults, residents in long-term care facilities (nursing homes and assisted living facilities), people with cognitive decline, and older adults who use sign language.

Act, Belong, Commit (ABC) (Australia) – Target: social marketing campaigns address a range of sectors and audiences including health services, local governments, schools, workplaces, community organisations and local clubs.

Equity dimension:

JA PRISM is focused on vulnerable populations, the three practices are addressing this target (people in suicide risk, elderly, adolescents). Additionally, all implementation teams are completing the WHO Quality Rights Training, which covers: taking care of one's own mental health;

supporting friends, family and colleagues with their mental health; tackling stigma, discrimination, abuse and coercion in mental health services; and taking action in support of transformation of mental health services towards a person-centred, rights-based recovery approach.

<https://www.who.int/teams/mental-health-and-substance-use/policy-law-rights/QualityRights>

One of the JA PRISM tasks specifically deals with the active incorporation of People with Lived Experience (PLE) from the beginning of the practice design, a real co-creation approach. Guidelines have been developed to orient implementation sites in the process of involving PLER.

Methodology and processes:

The JA-PRISM approach is based on the scaling-out methodology devised to guide and support countries in designing and implementing practices according to their real needs, possibilities and resources. The methodology is grounded on the interconnection of independent theoretical models that address crucial aspects when it comes to the implementation of complex interventions in disparate contexts. The methodology, which has been used in other Joint Actions such as JADECARE and JACARDI, not only specifies the critical issues to be considered during the implementation process (transfer and adoption mechanisms) but also emphasizes the relevance of analysing the readiness of the organizations, implementation facilitators and support delivered, and evaluation of the effectiveness of the practices. Thus, the scaling-out methodology includes three interrelated elements: the Transfer and adoption process, the Capacity building model, and the Evaluation Framework.

The **transfer and adoption process** includes four steps:

1. Situation analysis: By applying a structured and strategic planning tool Local Implementation Teams will explore, describe and assess the existing strengths, weaknesses, opportunities and threats that might influence the selected practice(s) deployment. This approach will guide the definition of the practice to be implemented.

2. Adaptation to new context: The practices will be adapted to achieve better fit with the new context. Local Implementation Teams will explore the core features of the selected practice(s), identify potential mismatches between these features and the context, undertake modifications (intervention content, language, or delivery mechanisms), and develop the local practice. During this step, PLE and/or civil society representatives will be involved at local level to help adapting the practices to their real needs and expectations. These key stakeholders will be engaged from

the beginning as active members of the implementation teams.

3. Action planning: The definition of the required activities to implement the practice(s) will be performed. Responsible actors for each activity will be nominated, resources allocated, timing scheduled, and settings agreed.

4. Deployment: The adapted practice(s) will be rolled-out in the new contexts based on Quality Improvement models that propose developing actions, designing multiple tests, collecting, and analysing data and making appropriate updates to the change actions.

Capacity building activities will be carried out for the successful transfer of practices. These activities will not only focus on training the sites in the implementation strategy but also provide deeper insights into the original practices being transferred. The activities are:

- Mentorship and expert consultation. At the beginning of JA-PRISM study visits will be planned where the best practice owners, with support of other key representatives, present the details of their practices including potential barriers that can hinder transferability to other contexts.
- Knowledge sharing activities. During the implementation, thematic workshops will be held to assess the progress of the implementation as well as to collaboratively reflect on solutions to overcome existing challenges. Representatives of BIZI, Circle of Friends and ABC practices will be available for consultation when needed.
- Didactic activities and methodological assistance. A thorough, practical and easy-to-use guide of the implementation methodology will be developed and presented in hands-on workshops by ISS.

Involvement of other organisations/actors:

The implementation sites (61) will make use of different strategies to involve key organizations and actors. This information will be detailed in their action plan which will guide the roll-out phase (to be defined by August 2026). The strategy will depend on the context and the scope of each implementation.

Funding source(s) and sustainability:

Sustainability actions will take place mainly at two levels:

1) Pilot level

Our approach is to integrate sustainability aspects into best practice transfer from the very beginning of the project. Key elements for sustainability at the pilot level include stakeholder engagement, policy uptake and funding generation. A sustainability toolkit summarising policy, stakeholder and sustainable implementation aspects as well

as a guide to the inclusion of persons with lived experience, will be prepared. This toolkit will be revised based on lessons learned during the project to ensure relevance and adaptability.

Long-term sustainability cannot be achieved without capacity building. The capacity building activities will focus on vulnerable groups and people with lived experience in the vulnerability. The training also prepares the representatives of vulnerable groups to integrate what they have learned into their environment and to pass on the knowledge in their community. By the end of the project, each implementation site will identify the main action points for sustainability and in some cases, expansion.

2) Project level

The major tools for sustaining the joint achievements at the project level will be the unified sustainability plan and community of practice. The unified sustainability plan will outline joint actions to be undertaken by the consortium, explore means of securing additional resources, and provide policy-level recommendations.

A Community of Practice will be established and maintained, consisting of key representatives from project partners, international stakeholders and people with lived experience. This community will foster ongoing learning, exchange, joint problem solving, and peer support. It will also serve as a “club of champions” with a focus on change management and leadership development. Special attention will be paid to ensuring the continuity of this community after the project ends. This platform will be instrumental in catalysing ongoing collaboration and scaling up joint activities.

Innovation, Impact and Outcomes:

The ambition of JA PRISM is to reduce the burden of mental ill health with a specific focus on vulnerable groups through promoting good mental health, effectively preventing mental health problems and improving access to mental health treatment and services across the EU Member States and Associated countries by supporting the transfer and roll-out of best and promising practices to new contexts.

Short-term outcomes

- Support the implementation of 3 best and promising practices in mental health across 18 Member States and beyond. The project will lead to a small-scale deployment in 34 implementation sites and large-scale deployment in 14 implementation sites, allowing a direct impact on the European population of 20,000 inhabitants.
- Augment the knowledge on the specific needs of Member States in the field of suicide prevention, loneliness in elderly and emotional wellbeing in

children and adolescents. The implementation of the 3 practices in different regions around the EU, thanks to the development of an adaptable implementation strategy will allow generating unique information that will be thoroughly evaluated.

- Enhance the knowledge of Consortium members in practice implementation methodologies and sustainability strategies thanks to the work developed in WP3 where Capacity building will also be a crucial task.
- Strengthen local, national, and international key stakeholder networks in the area of mental health. Around 59 entities from 20 different countries will be involved in the project guaranteeing the transfer of knowledge also to the corresponding 20 health authorities involved in the project.

Medium-term outcomes

- Increase awareness and knowledge on human rights-oriented approaches. During the project at least 59 entities will perform the WHO quality rights training and more than 30% of implementation sites will incorporate micro-interventions addressing stigma and discrimination.
- Contribute to the implementation of flagship actions and boost synergies with other international initiatives to support a comprehensive approach to mental health. JA PRISM will implement 4 flagship actions of the communication of a comprehensive approach to mental health and will generate a transversal synergy group with the key JA MENTOR.
- Enhance empowerment through improved health literacy and self-management, of vulnerable and socio-economically disadvantaged groups to take better care of their own mental health and to seek help and support. JA PRISM will provide a training programme for people with lived experience.
- Support policy making on mental health prevention of vulnerable and socioeconomically disadvantaged groups. JA PRISM will generate a report on policy making guidance and tools on mental health promotion that will be a key tool to guarantee that at least 45 national plans are outlined to address specific mental health challenges. The participation of 20 national health authorities will be a key element for the necessary change in mental health policies.

Long-term outcomes

- Improve quality of life of vulnerable and socio-economically disadvantaged groups due to stepped up actions, such as guidelines and awareness-raising activities, on breaking through stigma and discrimination. JA PRISM will work to support the long-term sustainability of adapted practices and results at country level to guarantee the real impact.
- Reduce the burden of mental health disorders and years lived with disability. JA PRISM will increase health authorities' capacity to deliver a comprehensive approach to mental health for vulnerable groups.
- Remodel the public health services towards a prevention oriented and comprehensive mental health approach to mental health in vulnerable population.
- Address social determinants of mental health by designing and deploying impactful policies and approaches in Europe.
- Reinforce social networks and services (health, education, social and cultural promotion) and equal access to them for vulnerable subjects at risk of mental disturbs.

Evaluation:

The evaluation framework consists of different pillars:

1) Effectiveness of the JA-PRISM transfer and adoption process. The dimensions investigated will be appropriateness; feasibility; fidelity; penetration; and sustainability. In addition, the usability of the transfer and adoption process will be assessed.

2) Power of the capacity building model. Expected outcomes can be classified into the following categories: knowledge attainment; perceived ability to implement evidence, and satisfaction.

3) Impact of implemented practices:

On one hand, there is a battery of general dimensions that will be investigated at implementation site level, such as: scope and reach of the practice adoption, involvement and commitment of local stakeholders.

On the other hand, the dimensions to be explored at each specific practice level are:

- BIZI programme:
 - Number of entities invited to participate in BIZI programme
 - Percentage of professionals registered who start the training
 - Number of gatekeepers trained per year
 - Changes in key gatekeepers' competencies
 - Attitude towards suicidal behavior

- Self-efficacy regarding suicidal behavior
 - Knowledge about the suicide phenomenon
- Adherence to the BIZI programme
- Satisfaction with the BIZI programme
- Gatekeepers' perception of having helped someone with suicidal thoughts
- Circle of Friends:
 - Number of participations to the group meetings
 - Perception of loneliness and alleviation of loneliness
 - Perception of subjective health
 - Satisfaction and expectations of participants with the group
 - Continuity of the group continue meetings after the facilitated group has ended
- ACT. Belong. Commit:
 - Number of partners engaged in ABC partnership
 - Satisfaction and perceived impact by ABC partners (questionnaire)
 - Assessment of partner capacity (building)
 - Partners assessment of programme impact
 - Perception among citizens with campaign (when relevant) (survey)
 - Recollection of ABC campaign message
 - Actions taken in response to ABC messages
 - Perception of ABC programme participants
 - Awareness of mental health strategies (ABC)
 - Actions taken in response to ABC local activities.

Barriers, enables, and learning points:

CHALLENGES:

The main challenges to be faced in JA PRISM are related to the best practice transfer:

- Adapting practices to different national and local contexts. The project recognizes that implementation sites differ in their healthcare systems, resources, organizational maturity, and population needs.
- Maintaining fidelity while allowing local adaptation. Practices must be tailored to local settings without

changing the core components responsible for their effectiveness.

- Identifying and overcoming implementation barriers. Potential barriers are expected to vary across implementation sites.
- Building implementation capacity. Many implementation teams may lack experience in transferring evidence-based practices.
- Stakeholder engagement and coordination. Successful implementation requires identifying and engaging key stakeholders, establishing local implementation teams, and coordinating actors across health, social, and community sectors.
- Ensuring sustainability. The project highlights the challenge of maintaining practices beyond the funding period.
- Monitoring implementation consistently across countries.

ENABLERS:

The factors expected to facilitate successful implementation and scaling of best practices to different contexts include:

- Use of a structured implementation science (scaling-out) methodology.
- Early assessment of local readiness and context.
- Adaptation to local settings while maintaining fidelity to core practice components.
- Comprehensive capacity building, mentoring, and expert support.
- Active stakeholder engagement and multisectoral collaboration.
- Continuous knowledge sharing between implementation sites.
- Standardized monitoring and evaluation to identify successful implementation factors.
- Early integration of sustainability planning.
- Participation of people with lived experience in co-design and implementation.
- Flexible add-on interventions to address context-specific mental health needs.

LEARNING POINTS:

As JA PRISM is still in the early stages of implementation, these learning points are based on the preparation and action planning process rather than on implementation outcomes.

- **Thorough preparation is essential.** Conducting a comprehensive situation analysis before

implementation has proven crucial for understanding local needs, identifying barriers and facilitators, and designing realistic Action Plans.

- **One size does not fit all.** The diversity of the 61 implementation sites across 17 European countries highlights the importance of adapting implementation strategies to local contexts while preserving the core components of the best practices.
- **Early stakeholder engagement strengthens implementation readiness.** Involving policymakers, service providers, community organisations, and people with lived experience from the outset increases ownership and supports the development of feasible and sustainable Action Plans.
- **Knowledge exchange accelerates learning.** Study visits, workshops, and regular interactions between practice owners and implementation sites have enabled partners to share experiences, identify common challenges, and benefit from solutions developed in other regions.
- **Capacity building is a key enabler.** Training and continuous methodological support have helped local implementation teams develop the skills and confidence needed to prepare for implementation.
- **The project's diversity is a major asset for transferability.** Working simultaneously across highly heterogeneous health systems and organisational settings provides a unique opportunity to generate practical evidence on how evidence-based practices can be successfully adapted and transferred across Europe.

Legal and/or ethical issues:

No relevant legal, ethical, governance, data protection or consent issues are envisioned.

Transferability to other regions:

Estimated transferability maturity: Transferable with contextual adaptation.

Transferability is one of the core strengths of JA PRISM. The project brings together **61 implementation sites across 17 European countries**, encompassing a wide range of health systems, governance models, organisational capacities, cultural contexts, and population needs. This diversity provides a unique opportunity to assess whether the selected best practices can be successfully implemented beyond their original settings.

Unlike projects conducted in relatively homogeneous environments, JA PRISM deliberately tests implementation across highly heterogeneous regions. If the practices prove effective and feasible in such diverse contexts, this will provide strong evidence of their robustness, adaptability, and potential for wider adoption across Europe. The project therefore serves not only to implement the practices but also to generate practical knowledge on how evidence-based interventions can be transferred to different health and social care systems.

Transferability is supported by a structured implementation science methodology that combines a common implementation framework with context-specific adaptation. Each implementation site conducts a situation analysis to identify local needs, barriers, facilitators, and available resources, ensuring that the core components of the practices are preserved while allowing flexibility to fit local realities. Continuous knowledge exchange, capacity building, and a common monitoring and evaluation framework further strengthen the transfer process and will help identify the key factors that enable successful implementation and future scale-up in other European regions.

Dissemination and further information:

Website: <https://japrism.eu>

Linkedin: PRISM Mental Health Joint Action

Media:

Leaflet: <https://japrism.eu/community-of-practice-repository/>

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Cross-border healthcare cooperation



The Most Innovative Mental Health Strategies Promoted by Slovenia in the Italian Border Area



Key info:

Organisation name:	EGTC GO
Region:	Goriška
Country:	Italy, Slovenia
Practice cooperation partners – International collaboration (e.g., Please indicate any organisations involved in the implementation of the practice, particularly if developed through European collaboration (e.g. Joint Actions, Horizon Europe, Interreg, EU4Health, Erasmus+, etc.). If not applicable, write "N/A".):	EGTC GO (European Grouping of Territorial Cooperation of Gorizia, Nova Gorica, and Šempeter-Vrtojba); Friuli Venezia Giulia; Šent (The Slovenian Association for Mental Health).

Keywords:

Cross-border cooperation; Deinstitutionalisation; Community-based mental health; Integrated care; Social inclusion.

- Anti-stigma initiatives and cultural planning (for the use of culture as a public health tool and bilingual awareness campaigns)

Implementation status:

Ongoing implementation of a mental health policy/programme/initiative, Community-based mental health initiative, Practice addressing vulnerable or underserved groups.

Focus areas:

- Community-based mental health services (for the strengthening of proximity-based mental health centers, open-door approaches, and the transition towards territorial care)
- Integrated care / cross-sectoral collaboration (for the creation of a cross-border network of socio-health services shared between Italy and Slovenia)
- Social inclusion and support for vulnerable groups (for labor market integration pathways through social cooperatives and involvement in art/craft workshops)

Summary:

In the border area with Italy, Slovenia's most innovative mental health strategies are closely linked to **cross-border collaboration with Friuli Venezia Giulia**, particularly through the EGTC GO (European Grouping of Territorial Cooperation of Gorizia, Nova Gorica, and Šempeter-Vrtojba). The most innovative strategies and projects promoted by Slovenia in this border region include:

1. The Creation of Joint Cross-Border Services (Salute-Zdravstvo Project)

Slovenia has overcome the concept of national borders in mental healthcare by participating in the creation of the first **cross-border network of socio-health services**.

2. Adoption and Adaptation of the "FVG Model" (Deinstitutionalization)

The Slovenian strategy in the *Goriška* region is undergoing a profound transition toward community-based care, heavily influenced by its proximity to Trieste and Gorizia.

3. Destigmatization and Mental Health through Culture

One of the most innovative and recent strategies involves using **cultural planning as a public health tool**.

4. Integration of Social Support Systems and Self-Help Groups (Šent)

Slovenia promotes the work of robust non-governmental organizations along the border, most notably **Šent** (The Slovenian Association for Mental Health).

Description and strategic context:

Historically, Slovenia maintained a more institutional approach compared to the Italian Basaglian model. However, in recent years, the border area has transformed into a true **European laboratory for social and psychiatric innovation**, a process accelerated by the joint initiatives of Nova Gorica and Gorizia as the European Capital of Culture.

Community Mental Health Centers (CDZ): In line with the Slovenian Resolution on the National Mental Health Program, the border area has seen the strengthening of Centri za duševno zdravje for both adults and children/adolescents. These centers apply a proximity-based, open-door approach inspired by Italian Mental Health Centers.

Objectives:

- **Moving Beyond Large Institutions:** Slovenia is implementing reforms to reduce long-term hospitalizations in psychiatric hospitals (such as the one in Idrija, which historically serves the area), investing instead in the creation of community group homes and supported housing within the local area.
- **Bilingual Anti-Stigma Campaigns:** Joint awareness campaigns aim to dismantle taboos surrounding mental health, merging Slovenia's strong tradition of self-help with the active citizenship experience of the Italian Third Sector.
- **Cross-Border Social Enterprise:** Šent actively collaborates with social cooperatives in Friuli Venezia Giulia to develop employment programs for individuals with mental health disorders. This strategy aims to build an inclusive labor market that allows Slovenian service users to experience recovery pathways through work, modeled after Italian Type-B social cooperatives.

Target group(s):

- **Primary Target Group:** Adults and children/adolescents experiencing mental health vulnerabilities, psychological distress, or social

isolation in the cross-border area of Gorizia, Nova Gorica, and Šempeter-Vrtojba, who benefit from the strengthened network of Community Mental Health Centers (Centri za duševno zdravje – CDZ) operating with a proximity-based, open-door approach.

- **Secondary Target Group / Specific Subgroups:** Individuals with severe mental health disorders participating in cross-border social enterprise and employment programs developed through collaboration with social cooperatives in Friuli Venezia Giulia and the Slovenian Association for Mental Health (Šent).
- **Indirect Beneficiaries:** Mental health professionals, clinicians, and multidisciplinary mobile outreach teams (comprising both Slovenian and Italian healthcare workers) who collaborate across borders, as well as local communities engaged through bilingual anti-stigma campaigns and cultural planning initiatives.

Equity dimension:

- **Addressing Cross-Border Inequalities:** The practice directly tackles health and administrative inequalities by bridging the healthcare systems of Slovenia and Italy in the Goriška border region. It ensures that citizens are not disadvantaged by national borders when accessing mental health support.
- **Vulnerable Groups and Inclusion:** The initiative focuses on vulnerable populations—including individuals with severe mental health disorders and youth facing social isolation—by offering inclusive pathways such as cross-border social enterprises, employment programs modeled after Italian social cooperatives, and shared day-center activities.
- **Overcoming Linguistic and Cultural Barriers:** Through multidisciplinary mobile outreach teams composed of both Slovenian and Italian clinicians, the initiative actively bypasses linguistic and administrative obstacles, guaranteeing equitable, proximity-based access to care for all residents in the border area.

Methodology and processes:

Mobile Outreach Teams: Slovenian mental health professionals (from the network of Mental Health Centers – Centri za duševno zdravje) and Italian clinicians work together in multidisciplinary teams to address youth

distress and social isolation directly within the border territory, bypassing linguistic and administrative barriers.

Shared Access to Facilities: Slovenian and Italian citizens in the Gorizia/Nova Gorica area can access day centers and socialization activities interchangeably, pooling the resources of both healthcare systems.

Moving Beyond Large Institutions: Slovenia is implementing reforms to reduce long-term hospitalizations in psychiatric hospitals (such as the one in Idrija, which historically serves the area), investing instead in the creation of community group homes and supported housing within the local area.

Community Mental Health Centers (CDZ): In line with the Slovenian Resolution on the National Mental Health Program, the border area has seen the strengthening of Centri za duševno zdravje for both adults and children/adolescents. These centers apply a proximity-based, open-door approach inspired by Italian Mental Health Centers.

Shared Urban Spaces: The Nova Gorica/Gorizia railway station area and other border spaces have been transformed into hubs of inclusion. Individuals with psychological vulnerabilities from both countries are actively involved in artistic projects, craft workshops, and job placement initiatives tied to cross-border events.

Bilingual Anti-Stigma Campaigns: Joint awareness campaigns aim to dismantle taboos surrounding mental health, merging Slovenia's strong tradition of self-help with the active citizenship experience of the Italian Third Sector.

Cross-Border Social Enterprise: Šent actively collaborates with social cooperatives in Friuli Venezia Giulia to develop employment programs for individuals with mental health disorders. This strategy aims to build an inclusive labor market that allows Slovenian service users to experience recovery pathways through work, modeled after Italian Type-B social cooperatives.

Involvement of other organisations/actors:

Mobile Outreach Teams: Slovenian mental health professionals (from the network of Mental Health Centers – Centri za duševno zdravje) and Italian clinicians work together in multidisciplinary teams to address youth distress and social isolation directly within the border territory, bypassing linguistic and administrative barriers.

Cross-Border Social Enterprise: Šent actively collaborates with social cooperatives in Friuli Venezia Giulia to develop employment programs for individuals with mental health disorders.

Funding source(s) and sustainability:

- **Funding Sources:** The cross-border mental health strategies and joint services (such as the Salute-Zdravstvo project) have been developed and supported so far through European Territorial Cooperation funding, specifically leveraging Interreg programmes (such as Interreg Italy-Slovenia) designed to foster integration, cooperation, and joint public health initiatives across the border area. Additional institutional support is provided through regional and national public health allocations from both sides of the border (Friuli Venezia Giulia and Slovenia).
- **Organisational and Political Sustainability:** Long-term organizational sustainability is rooted in the institutional framework of the EGTC GO (European Grouping of Territorial Cooperation of Gorizia, Nova Gorica, and Šempeter-Vrtojba), which provides a stable legal and political structure for cross-border governance. By institutionalizing cooperation between local health authorities, municipalities, and non-governmental organizations like Šent, the practice transitions from a project-based approach into a permanent, structured model of cross-border healthcare delivery.
- **Financial and Practical Sustainability:** Financial continuity is maintained by integrating cross-border services and mobile outreach teams into the regular operational budgets of the participating regional health frameworks and community mental health centers (CDZ). Furthermore, collaboration with social cooperatives ensures sustainable pathways for work-integration and social enterprise, anchoring the initiative within local economic and social structures for long-term impact.

Innovation, Impact and Outcomes:

The Added Value: The most innovative aspect of the Slovenian strategy in this region is not merely the internal modernization of its services, but the political and clinical decision to **co-design mental health care with another State**, setting a unique European precedent for managing psychiatric vulnerability in border zones.

Innovative Aspects of the Practice: The primary innovation of this cross-border strategy lies in the political, administrative, and clinical decision to co-design and integrate mental health care across national borders, setting a unique European benchmark for managing psychiatric vulnerability in border zones. Rather than maintaining isolated national systems, the initiative

successfully bridges the Slovenian proximity-based model and the Italian deinstitutionalization framework (inspired by the Basaglian reform) within the Goriška border area. A key structural innovation is the creation of joint cross-border services—such as the Salute-Zdravstvo project—and multidisciplinary mobile outreach teams composed of both Slovenian and Italian mental health professionals who jointly address youth distress and social isolation directly in the territory, bypassing linguistic and administrative barriers. Furthermore, the practice innovates through cultural planning, using art, workshops, and community events as public health tools for destigmatization, alongside pioneering cross-border social enterprises developed in collaboration with non-governmental organizations like Šent and Italian social cooperatives.

Main Impacts and Outcomes: Although formal quantitative longitudinal studies are ongoing, the practice has already achieved significant milestones and qualitative impacts across the cross-border community:

- **Enhanced Access and Proximity:** Slovenian and Italian citizens in the Gorizia and Nova Gorica area now enjoy shared access to day centers and socialization activities, effectively pooling the resources of both healthcare systems and expanding coverage for underserved populations.
- **Transition to Community-Based Care:** The practice has accelerated Slovenia's strategic reform to reduce long-term hospitalizations in large psychiatric institutions (such as the hospital in Idrija), redirecting investments toward community group homes and supported housing within the local area.
- **Inclusive Labour Markets and Recovery:** Through active partnerships with Friuli Venezia Giulia social cooperatives, Slovenian service users gain access to structured work-integration programs, fostering real-world recovery pathways and active citizenship.
- **Destigmatization and Social Cohesion:** Joint bilingual awareness campaigns and shared urban spaces—such as the revitalized Nova Gorica/Gorizia railway station area—have transformed a historical border into an active European laboratory of social inclusion, engaging vulnerable individuals in artistic projects and craft workshops.

Future Evaluation and Scalability: The outcomes achieved so far demonstrate that cross-border psychiatric and social collaboration is not only feasible but highly effective in reducing territorial inequalities. Future phases will deepen the mixed-methods evaluation to measure long-term improvements in social inclusion, service utilization, and

quality of life, providing a scalable model that can be replicated in other European border regions.

Evaluation:

The cross-border mental health practice is evaluated using a comprehensive mixed-methods framework combining quantitative service utilization metrics and qualitative assessments. Given the unique cross-border and inter-institutional nature of the initiative (spanning Slovenia and Italy in the Goriška region), the evaluation focuses on assessing how effectively integrated services, mobile outreach teams, and deinstitutionalization strategies improve accessibility, social inclusion, and continuity of care for vulnerable populations.

Methodologies and Indicators: The evaluation methodology incorporates both service-level and community-level indicators:

- **Quantitative Indicators:** Tracking service uptake and cross-border utilization rates, such as the number of Slovenian and Italian citizens accessing shared day centers, community mental health centers (CDZ), and joint socialization activities; reduction in long-term hospitalizations in regional psychiatric facilities (such as the hospital in Idrija); and participation rates in cross-border employment programs and social cooperatives.
- **Qualitative Methods:** Conducting semi-structured interviews, focus groups, and structured feedback sessions with service users, relatives, multidisciplinary mobile healthcare professionals, and administrative stakeholders from the EGTC GO and local health authorities. These evaluations explore barriers, cross-administrative hurdles, linguistic enablers, and the overall impact of joint cultural planning and anti-stigma campaigns.

Expected Outcomes and Future Scaling: While formal longitudinal effectiveness and cost-utility studies are being structured for future phases, ongoing monitoring provides vital insights into the feasibility of joint cross-border governance in public health. The findings are designed to measure improvements in social recovery and service equity, serving as a robust evidence base for policy refinement and future replication across other European border regions.

Barriers, enablers, and learning points:

CHALLENGES:

- **Administrative and Legal Discrepancies:** Differences in public procurement, employment

regulations, and social security frameworks between Italy and Slovenia created initial friction when trying to establish joint cross-border hiring and integrated social enterprise models.

- **Linguistic and Communication Hurdles:** Despite the historical and geographical proximity of Gorizia and Nova Gorica, linguistic barriers between Italian and Slovenian healthcare providers, administrative staff, and patients occasionally complicated immediate clinical communication and coordination.
- **Siloed Institutional Mindsets:** Navigating distinct bureaucratic cultures and institutional procedures between regional health authorities required extensive diplomatic effort to align differing operational timelines and reporting standards.

ENABLERS:

- **The EGTC GO Governance Framework:** The institutional backing and legal umbrella provided by the European Grouping of Territorial Cooperation (EGTC GO) served as a vital anchor, offering a stable governance structure to negotiate cross-border hurdles.
- **Shared Strategic Vision and Previous Cooperation:** Building upon existing frameworks and successful pilot initiatives—such as the Salute-Zdravstvo project—ensured established trust, mutual understanding, and strong political commitment from regional stakeholders on both sides of the border.
- **Multidisciplinary and Proximity-Based Approaches:** The active involvement of mobile outreach teams, combined with the engagement of non-governmental organizations like Šent and Italian social cooperatives, facilitated a seamless bridge between clinical care and community life.

LEARNING POINTS:

- **Culture as a Public Health Catalyst:** An unexpected positive effect was the profound impact of joint cultural planning and bilingual artistic workshops; using shared spaces (such as the transnational railway station square) as public venues for anti-stigma campaigns significantly accelerated community acceptance and reduced social anxiety around mental health.
- **Flexibility in Operational Protocols:** Experience demonstrated that formal agreements must be supported by informal, regular working groups of

frontline clinicians and administrators to solve day-to-day operational bottlenecks swiftly.

- **Scalability and Institutional Learning:** The practice proved that cross-border deinstitutionalization is most effective when it pairs high-level institutional cooperation with grassroots economic inclusion (e.g., social cooperatives), offering a blueprint that can be replicated in other European border regions.

Legal, ethical, governance, or data protection issues:

Governance Framework: The initiative operates under the legal umbrella of the **EGTC GO** (Gorizia, Nova Gorica, and Šempeter-Vrtojba), which provides a stable institutional and public governance structure for cross-border cooperation, though navigating differing Italian and Slovenian administrative laws requires continuous alignment.

Legal and Regulatory Compliance: Cross-border healthcare delivery must carefully reconcile distinct national health regulations, professional licensing rules, and employment frameworks between Italy and Slovenia, particularly for multidisciplinary mobile outreach teams operating across jurisdictions.

Data Protection and Consent: Handling sensitive mental health data across borders strictly adheres to the European Union's **General Data Protection Regulation (GDPR)**. Robust consent protocols and secure, interoperable communication channels must be maintained to ensure patient privacy while enabling safe clinical information sharing between Italian and Slovenian health providers.

Ethical Considerations: The practice upholds core bioethical standards, prioritizing patient autonomy, voluntary community-based care, and the reduction of stigma, ensuring vulnerable individuals are fully empowered and protected throughout their social and employment inclusion pathways.

Transferability to other regions:

Transferable with contextual adaptation.

Transferability Maturity: The cross-border mental health model demonstrates a **high level of maturity and scalability**, having successfully proven that distinct regional welfare systems (such as the Italian deinstitutionalization model and the Slovenian proximity-based CDZ approach) can be effectively integrated within a unified European framework.

Adaptation and Replication Potential: The practice can be successfully replicated in other European border regions facing administrative, linguistic, or cultural divides. The core components—such as joint mobile outreach teams, cross-border social enterprises, and anti-stigma cultural

planning—are highly adaptable to different legislative contexts provided there is a strong political will to bridge neighboring health systems.

Prerequisites for Success: Key prerequisites for successful transfer include:

- A stable legal and governance vehicle (analogous to the EGTC GO framework) to facilitate cross-border institutional dialogue.
- Initial financial commitment via European Territorial Cooperation funds (such as Interreg programmes) or shared regional public health allocations.
- Active collaboration with civil society organizations, non-governmental actors (like Šent), and social cooperatives to ground services in the local community.

Tools and Documentation Supporting Transfer: To facilitate replication in other regions, essential documentation includes standardized cross-border memoranda of understanding (MoUs), interoperable data-sharing protocols compliant with GDPR, multilingual clinical operating guidelines for mobile teams, and modular toolkits for co-designing public awareness and cultural anti-stigma campaigns.

Dissemination and further information:

Communication and Outreach Activities: Dissemination of the cross-border mental health practice is driven by public conferences, multi-stakeholder workshops, and joint awareness campaigns. A notable milestone includes public events hosted by the **EGTC GO**, such as conferences on the fair distribution of mental health resources and the final dissemination events of the **Salute-Zdravstvo** and **Sanitas** projects.

Media and Public Engagement: The initiative has been widely promoted through regional media, institutional video features (such as national broadcast reports on cross-border psychiatric and social inclusion efforts), and transnational cultural events tied to joint regional milestones like Nova Gorica-Gorizia European Capital of Culture.

Reports and Online Resources: Comprehensive information, project deliverables, and partnership guidelines are documented on official institutional web portals. Further details and updates are publicly accessible through the **EGTC GO official website** (euro-go.eu) and the dedicated cross-border cooperation channels, providing complete documentation and toolkits for interested stakeholders and external organizations.

Media:

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Cross-border healthcare cooperation



INTEVIDI – Technological and Digital Innovation in the Rehabilitation of Social Interactions Across the Life Cycle



Key info:

Organisation name:	ATS Liguria – Social and Health Care Area 1
Region:	Liguria – Province of Imperia (IM)
Country:	Italy
Practice cooperation partners – International collaboration (e.g., Please indicate any organisations involved in the implementation of the practice, particularly if developed through European collaboration (e.g. Joint Actions, Horizon Europe, Interreg, EU4Health, Erasmus+, etc.). If not applicable, write "N/A".):	ATS Liguria – Social and Health Care Area 1 University of Genoa University of Nice Côte d'Azur University Hospital of Nice

Key words:

Adolescent psychology, social interaction, rehabilitation, psychotherapy, digital mental health, digital mental health research.

Implementation status:

Fully implemented mental health policy/programme/initiative, Pilot or promising practice currently being tested, Prevention or mental health promotion initiative, Integrated care/cross-sectoral mental health initiative.

Summary:

The European INTEVIDI project tackles the growing prevalence of psychological distress and social isolation in the ALCOTRA cross-border area (Italy–France). These issues affect various age groups: from the rise in autism spectrum disorders, apathy and early school leaving amongst young people, to cognitive decline and Alzheimer's disease amongst the elderly. These conditions are often exacerbated by difficulties in accessing social and healthcare services in

the rural and mountainous areas typical of the region's geography.

The INTEVIDI project aims to support people in the cross-border area throughout all stages of life: children, adolescents, young adults and older people with psychopathological or relational disorders, people with disabilities and their careers. It also aims to promote the digitalisation and integration of digital technologies into social and healthcare services, particularly in the field of psychology. The aim is to promote fairer and more effective access to care, thereby reducing regional inequalities.

To provide care for adolescents and young adults in the province of Imperia, the Me-Lab has been established within the framework of the National Health Service, specifically within the Liguria Health Protection Agency – Social and Healthcare Area 1. This centre is designed as a non-medicalised space where, on the one hand, programmes promoting health and awareness of digital technology use (Media Education) are offered to lower secondary school classes; and on the other hand, psychotherapy and psychological support programmes are provided for young people aged 13–25, including through

the use of digital tools such as virtual reality, video game therapy and telemedicine.

Preliminary results from the project show an improvement in patient adherence to treatment, enhanced remote care provision in isolated areas, and the creation of an operational model that can be replicated outside the project area.

Description and strategic context:

The cross-border area is experiencing a dramatic rise in psychological and emotional distress. Adolescence and early adulthood are increasingly characterised by social isolation, apathy, conflict and dropping out of school. Traditional treatment methods based exclusively on face-to-face sessions struggle to identify these young people at an early stage, a gap exacerbated by the scarcity of services in rural and inland areas.

Timely intervention with adolescents is crucial to preventing psychopathological disorders from becoming chronic. Integrating digital tools for young people (Virtual Reality, Video Game Therapy, telemedicine) into social and healthcare services helps to break down stigma, boost motivation and ensure effective, immediate and universally accessible therapeutic engagement.

Media education programmes are essential because they foster critical and emotional literacy in young people, guiding them towards the mindful use of devices and helping them to manage their online image appropriately. By teaching young people to balance their virtual lives with the centrality of physical and sensory experiences in the real world, these initiatives provide them with the tools needed to experience the digital space as an integrated resource – neither demonised nor treated as a substitute for physical presence and interpersonal relationships.

The project aligns with:

- EU policies: *The EU Youth Strategy 2019–2027* (promoting the wellbeing and inclusion of young people) and the *Next Generation EU* programme for the digitalisation of psychosocial care.
- *National/Regional Strategies*: The PNRR (*Mission 6 – Digital healthcare and prevention for minors*) and local social and healthcare guidelines for combating educational poverty and youth distress.

Objectives:

Overall objectives: To promote digitalisation in the healthcare sector and innovative approaches to managing disorders linked to social interactions throughout the life course. In Italy, the primary focus is on the psychological and emotional distress experienced by adolescents and young adults in the ALCOTRA cross-border area. The project aims to break down barriers to accessing care and reduce regional inequalities by integrating digital technologies into everyday clinical practice. It also combines clinical care with prevention and health promotion programmes in order to foster, on the one hand, greater awareness of the digital world and, on the other, an understanding of a healthcare context in which, alongside clinical psychotherapy, initiatives are offered to people without overt psychological distress, addressing current and significant issues related to the digital world. This enables young people to engage with a health-focused setting in a non-clinical context, fostering a greater sense of familiarity and trust, breaking down the stigma surrounding mental health, and increasing the likelihood that, should they experience any form of psychological distress in the future, they will find it easier to turn to a service they are already familiar with.

Specific objectives:

- **Needs assessment and early engagement:** Distribution of 300 questionnaires and interviews across the entire cross-border area to identify relational vulnerabilities and select the target population for digital care pathways.
- **Training and digitalisation of healthcare professionals:** Design and deliver cross-border training programmes for at least 50 clinicians and social and healthcare professionals (psychologists, neuropsychiatrists, doctors) to ensure the effective adoption of technological tools in therapeutic practice.
- **Co-design and development of bespoke technological solutions:** Develop six advanced digital products and software programmes, with a particular focus on the care of adolescents: immersive Virtual Reality (VR) modules and serious games for youth distress and apathy.
- **Clinical trials in the community:** Testing the new methodologies on a sample of at least 200 patients (including a significant proportion of adolescents receiving care in Italy), ensuring the delivery of at least five technological paradigms.
- **Definition of a replicable and sustainable model:** To consolidate at least two highly effective

technological solutions for long-term integration into public healthcare services.

Expected benefits for adolescents and service users: Young people benefit from therapeutic approaches that are more in line with their cultural codes (e.g. VR and video games), which increase motivation and reduce resistance to treatment. For those living in rural or isolated areas, the use of telemedicine ensures continuity of care that would otherwise be difficult to achieve, reducing social isolation, preventing early school leaving and improving overall relational well-being. Prevention programmes also promote the responsible use of devices, with a view to preventing issues related to the digital world.

Target group(s):

Direct beneficiaries:

- Adolescents and young adults: classes of lower secondary school pupils taking part in Media Education workshops; individuals exhibiting signs of psychological, emotional and relational distress, apathy, social withdrawal, risk of deviant behaviour or dropping out of school (with particular focus on the Italian area/ATSL Area 1).
- Older adults (seniors): People aged over 65 suffering from cognitive decline, neurodegenerative conditions (e.g. Alzheimer's), apathy and social isolation (with particular focus on the French area/CHU de Nice).

Inclusion and eligibility criteria: Residence in the ALCOTRA cross-border area; presence of a diagnosis or indicators of relational/cognitive frailty; voluntary participation in the programme.

Equity dimension:

- **Equity of access and tackling rural isolation:** The project tackles geographical inequalities by offering telemedicine and remote monitoring solutions for people living in rural and mountainous areas within the ALCOTRA zone, reducing the need to travel to large urban centres to receive psychosocial care.
- **Focus on age and the life cycle:** INTEVIDI adapts technological approaches to specific developmental stages: in Italy, it uses virtual reality and video games to engage, motivate and treat young people throughout their care pathway; in France, it employs simplified interfaces for monitoring cognitive decline in older people.
- **Socio-economic inclusion and disability:** The introduction of digitalisation helps to remove physical and economic barriers to accessing care for people with physical or mental disabilities and for

disadvantaged households or those with limited logistical support.

- **Gender and vulnerability:** The initiative builds on the results of previous ALCOTRA projects (e.g. PROSOL Femmes and PROSOL Giovani) to ensure inclusive treatment pathways free from discrimination, including gender-based discrimination, by providing personalised care that is accessible to marginalised communities.

Methodology and processes:

Implementation and main stages: The INTEVIDI project will be carried out over a period of **37 months** (from October 2023 to October 2026) using a transdisciplinary and cross-border methodology structured around four main operational Work Packages (WP):

Phase 1: Mapping and Needs Analysis (WP3 – October 2023 / March 2024) Quantitative and qualitative analysis of the local area through literature reviews and the administration of 300 questionnaires/interviews to service users and their families to map clinical profiles and select the target population.

Phase 2: Co-design, Living Labs and Technological Development (WP3 – April 2024 / July 2025)

- Involvement of clinicians: organisation of 4 Living Labs with doctors, psychologists and healthcare professionals to assess the acceptability and usability of the technologies.
- Software Development: the partner universities (UniGe and UCA) will co-design and develop six digital products and software applications.
- Professional training: Delivery of joint IT-FR training courses (online and/or face-to-face) aimed at least 50 clinicians.

Phase 3: Clinical Trials (WP4 – April 2024/February 2026)

- Pilot phase and patient recruitment: Direct administration of five technological paradigms to at least 200 eligible patients (primarily adolescents and young people in Italy at ATSL Area 1; older adults in France at CHU de Nice). The sessions include Virtual Reality sessions, Video Game Therapy, telemedicine consultations, neurobiofeedback and serious games.

Phase 4: Impact Assessment, Replicability and Dissemination (WP4 – February 2026 / October 2026) Continuous monitoring and evaluation using 200 final questionnaires to measure perceived well-being and clinical impact. Drafting of an evaluation report and consolidation of a replicable operational model.

Professionals and expertise involved:

A cross-border multidisciplinary team comprising:

- Clinicians and healthcare professionals: Child neuropsychiatrists, psychologists, neurologists, geriatricians and educators from ATSL Area 1 and CHU de Nice.
- Technologists and researchers: Computer scientists, bioengineers and specialists in virtual reality and biosensors from the University of Genoa (DIBRIS – Perception & Interaction Lab) and the Université Côte d’Azur (CoBTek team).
- Management and Communication: Administrative staff and Public Relations Offices (URP) for project governance and dissemination events.

Tools and protocols used: VR headsets, interactive *serious games*, commercial video games, neurobiofeedback, corporate web platforms for telemedicine, impact questionnaires, media education workshops.

Involvement of other organisations/actors:

- **Co-design with users and carers** Patients (including adolescents, young people and older adults) and their careers are directly involved in the co-design phases through the needs analysis stage. Their participation is essential to guide the adaptation of technologies to real clinical and everyday needs, assessing the usability and acceptability of *video games*, *telemedicine* and Virtual Reality in psychological care pathways.
- **Active involvement of healthcare staff** Clinicians from local services (psychologists, neuropsychiatrists, doctors) actively participates in *Living Lab* sessions prior to the start of trials. This process enables us to gather their *feedback* and develop cross-border training programmes aimed at breaking down barriers to the use of digital tools in clinical practice.
- **Involvement of local authorities and universities** Local authorities not part of the partnership but belonging to the third sector (ANGSA, Centro di Solidarietà l’Ancora – Cooperativa Sociale Onlus, Associazione Effetto Farfalla, Casa di Accoglienza “Miracolo della Vita”) and universities for research purposes (Università Cattolica del Sacro Cuore in Milan, UniMercatorum) are also involved in carrying out the project activities.
- **Multidisciplinary and cross-border partnership** The project is based on integrated collaboration between:
 - Public Health Authorities: ATSL Area 1 (Lead Partner, focusing on adolescents

and young adults) and CHU de Nice (specialising in older people and cognitive decline). Research Institutes and Universities: University of Genoa (DIBRIS – Perception & Interaction Lab, specialising in Virtual Reality) and Université Côte d’Azur (CoBTek team, experts in biosensors and mental health)

- **Stakeholders, public decision-makers and civil society** From the kick-off meeting onwards, the project involves local public decision-makers, citizens’ associations, schools and local organisations. This ongoing dialogue continues through the organisation of two cross-border public events (kick-off and closing) and the distribution of information material in clinics and schools.
- **Evaluation and monitoring** The quality and effectiveness of the activities are monitored both by patients via 200 final impact questionnaires and by a joint internal audit team comprising representatives from all partners to ensure compliance with the strategic objectives.

Funding source(s) and sustainability:

The total eligible budget for the INTEVIDI project is €1,890,000.00. The funding is structured as follows:

- European Regional Development Fund (ERDF): covers 80% of the total cost, amounting to €1,512,000.00, provided through the Interreg VI-A France-Italy (ALCOTRA) Programme 2021–2027.
- National co-funding (20 per cent, amounting to €378,000.00)
 - For the Italian partners (ATSL Area 1 and the University of Genoa), the 20 per cent share is funded by the Italian government through the Revolving Fund of the Agency for Territorial Cohesion (CPN).
 - For the French partners (CHU de Nice and Université Côte d’Azur), the 20% co-funding is provided from their own resources.

Organisational, political and economic sustainability

- Organisational and clinical sustainability: long-term integration is ensured by the consolidation of healthcare professionals’ skills following the training courses. ATSL Area 1 and CHU de Nice will permanently incorporate telemedicine systems, VR programmes and video game therapy pathways validated by the project into their social and healthcare protocols.

- Political and institutional sustainability: the project is fully aligned with national and European strategies for the digitalisation of healthcare (*Next Generation EU*, PNRR Mission 6, *EU Youth Strategy*). The involvement of local public decisionmakers and the creation of shared guidelines facilitate the adoption of these solutions by the National Health Service.
- Financial sustainability and replicability: as no commercial revenue is anticipated during or after the project's implementation, operational continuity will be supported by the public healthcare facilities involved. Furthermore, the development of a best-practice model and the publication of a specialist scientific article will enable the replicability and transfer of methodologies to other local contexts or future cooperation projects.

Innovation, Impact and Outcomes:

The INTEVIDI project marks a genuine paradigm shift within the National Health Service, introducing a space where prevention and treatment coexist: the Me-Lab. Within this framework, digital tools play an active role in psychological prevention and treatment pathways – which tend to be rooted in more traditional models – in a non-medicalised setting. This unique context helps to overcome the hesitation that often keeps young people away from traditional services, offering an informal and welcoming space where adolescents and young adults feel at ease asking for help. Youth engagement is enhanced by the opportunity to utilise, at a clinical level, technological approaches previously excluded from local outpatient practice (immersive virtual reality, neurobiofeedback, video game therapy, telemedicine). The clinical use of these tools provides a therapeutic bridge that speaks the same language as young people, drastically reducing the stigma associated with mental health and stimulating intrinsic motivation. Furthermore, media education programmes promote not only the prevention of inappropriate device use – through greater awareness of the digital world and one's relationship with one's own body – but also an understanding of a healthcare setting where, alongside clinical psychotherapy, initiatives are offered to people without overt psychological distress, addressing current and significant issues in their daily lives. This enables young people to engage with a health-focused setting in a non-clinical context, fostering a greater sense of familiarity and trust and increasing the likelihood that,

should they experience any form of psychological distress in the future, they will find it easier to turn to a service they are already familiar with.

The impact on the local area is profound: isolated adolescents, those experiencing apathy or at risk of dropping out of school and engaging in deviant behavior, benefit from early intervention, strengthening of their interpersonal and emotional skills, and guaranteed continuity of care provided remotely for those living in the most isolated rural and mountainous areas.

In quantitative terms, the project indicators confirm the administration of 300 needs assessment questionnaires, the organisation of 4 living Labs involving clinicals, the cross/border training of 50 healthcare professionals, and the creation of 6 advanced digital software programmes. The project has led to the implementation of five cross-border pilot initiatives (VR, video game therapy, neurobiofeedback, telemedicine, and serious games) and the permanent adoption within the National Health Service of at least two technological solutions validated in the Me-Lab. Finally, the qualitative impact is documented by 200 questionnaires assessing adolescents' perceived well-being and by the publication of a specialist scientific article, designed to establish the Me-Lab model as a replicable benchmark for health services at national and European level.

Evaluation:

The evaluation of the INTEVIDI project is based on an integrated, continuous, and multi-methodological approach, designed to examine both the technical feasibility of the solutions adopted and their actual clinical and psychosocial effectiveness. The model pays particular attention to assessing the emotional and relational impact generated by the introduction of digital technologies among adolescents and young adults receiving care within the welcoming, non-medicalised environment of the Me-Lab. It also aims to understand the effectiveness of media education programmes linked to health promotion and the responsible use of digital devices. To ensure the rigour of the processes, a cross-border internal audit committee, comprising representatives from all project partners, constantly monitors the physical, procedural and scientific progress of each phase.

The measurement of results is based on a combination of quantitative and qualitative indicators collected throughout the entire experimental process. Clinical effectiveness and the well-being perceived by patients – in particular by the adolescents supported by the ATSL Area 1 – are assessed through at least 200 interviews and final impact

questionnaires, designed to verify the effectiveness of the method.

In parallel, the projects formalise the evaluation of cross-border pilot initiatives through detailed reports on the use of various technologies (immersive VR, neuro biofeedback, video game therapy, serious games and telemedicine), whilst also measuring the level of permanent adoption within the National Health Service of at least two digital solutions from among those most successfully applied in the Me-Lab.

All data emerging from the initial and final questionnaires, together with the qualitative feedback provided, are summarized in an Impact Assessment Report which highlights the strengths and weaknesses of the methodologies tested.

Barriers, enables, and learning points:

CHALLENGES:

- Traditionalism in psychological services: whilst medicine for physical conditions has extensively integrated digital technologies, the public sector dealing with psychological distress has remained tied to traditional models of intervention.
- Resistance and the training gap among healthcare professionals: the lack of specific training and healthcare staff's limited familiarity with new technological tools constitute a major barrier to the adoption of digital technology in everyday clinical practice.
- Differences in healthcare and socio-cultural systems: the marked regulatory, institutional and socio-cultural differences between the Italian and French healthcare systems (e.g. reimbursement arrangements for services and the role of the family network) hinder the spontaneous adoption of standardized solutions.
- Complex regulatory framework regarding privacy: the introduction of telehealth tools requires compliance with strict legal requirements relating to the GDPR, the security of sensitive health data and patient protection.
- Inequalities and isolation in inland areas: the absence of certain social and healthcare services in rural and mountainous areas of the cross-border region exacerbates social isolation and makes it difficult for vulnerable people, young people and the elderly, to access care on an equal footing.

ENABLERS:

- Multidisciplinary cross-border partnership: integrated collaboration between clinical facilities operating in the field (ATSL Area 1 Liguria and CHU de Nice) and highly specialized technological research centres (University of Genoa and Université Côte d'Azur) creates strong synergy between clinical and digital expertise.
- Complementarity of target groups and expertise: the strategic division of clinical roles — with ATSL Area 1 focusing primarily on adolescents and young adults, and the CHU de Nice specialising in the older population — ensures coverage across the entire life cycle.
- Capitalising on previous experience and tools: the adaptation of technologies and expertise developed in previous ALCOTRA and H2020 projects (such as the PITEM PROSOL and PITEM CLIP E-Santé projects) has accelerated the development of digital products.
- Co-design and the Living Lab approach: the adoption of a co-design process that directly involves clinicians, patients and carers from the earliest stages ensures high usability and acceptability of the technologies (virtual reality, video games, telemedicine, neurobiofeedback).
- Accredited training for healthcare professionals: the provision of joint cross-border training programmes helps healthcare professionals overcome technological scepticism.

LEARNING POINTS:

- Integration of prevention and clinical care: promoting structured and ongoing prevention activities within a healthcare setting facilitates the early identification of young people who have participated in prevention programmes and have subsequently begun to experience psychological distress, thereby enabling their early intervention.
- Continuous training of healthcare professionals ensures sustainability: the continuity of a digital project depends not only on the provision of hardware or software, but on the motivation and ongoing training of healthcare staff.
- Standardisation across different systems: the co-development of cross-border operational protocols demonstrates that it is possible to harmonise patient management and assessment even in the

face of differing regulatory and healthcare contexts.

- Improved equity of care and environmental sustainability: the use of telemedicine and remote monitoring makes it possible to reach patients in the most remote areas, ensuring equitable access and reducing the environmental impact associated with travel to urban centres.
- Continuous feedback loop between clinical practice and development: constant monitoring of the impact on patients enables software developers to refine products based on the actual clinical needs identified in the field.
- Replicability of the model: the systematic documentation of the trial and the publication of specialist scientific articles enable the methodologies developed to be transferred to other European regions facing similar demographic and territorial challenges.

Legal and/or ethical issues:

Data Protection and Privacy (GDPR): Action 4.1 is entirely dedicated to privacy protection procedures in telehealth. In Italy, the Data Protection Officer (DPO) is involved following a study carried out with external experts to verify the compliance of the technologies and web applications used with the GDPR.

Ethical Authorisations and Patients' Rights: In France, the trial requires formal approval by the Comité de Protection des Personnes (CPP). In both countries, clinical activities are conducted in accordance with current regulations safeguarding patients' rights and their freedom of choice.

Governance and Monitoring: Cross-border governance is organised through half-yearly Steering Committees (COPIL). The assessment of the project's quality is entrusted to a joint team comprising representatives from the partners' internal audit departments.

Legal Framework and State Aid: All partners (ATSL Area 1, CHU de Nice, UNIGE, UCA) participate as local public authorities, hospitals or research bodies and carry out non-commercial activities; for this reason, they are not subject to State aid rules (de minimis).

Transferability to other regions:

Transferable with contextual adaptation.

Transferability Maturity: the project demonstrates a high degree of transferability, as it builds on methodologies and experiences already validated in previous European contexts (such as the PITEM PROSOL and CLIP E-Santé projects). The initiative was designed from the outset to

establish an operational model that can be replicated both within and outside the ALCOTRA area.

Replication & Scaling Up: the intervention model can be easily adapted to other European regions facing similar demographic and geographical challenges (an increase in mental health issues among adolescents and young adults, an ageing population, isolation in rural and mountainous areas, and a shortage of specialist services). The technologies and methodologies envisaged can be adapted for different age groups (children, adolescents, adults and older people) and for different psychological conditions.

Prerequisites for transferability:

- Multidisciplinary collaboration: structured synergy between local healthcare facilities and technological/university research centres.
- Acceptability and training: early involvement of clinicians through Living Labs and the provision of specialist training courses.
- Regulatory compliance: prior assessment of GDPR aspects, privacy protection and ethical authorisations for the use of telemedicine.

Supporting tools and documentation:

Tools and software developed: modules and scenarios for immersive virtual reality, serious games to engage young people and older adults, and web-based telemedicine platforms.

Operational documentation: Needs analysis report, guidance document on privacy in healthcare, Living Lab protocols and impact assessment reports.

Scientific model: drafting of a final specialist scientific article summarising the results and setting out the prevention and treatment model that can be replicated in other contexts.

Dissemination and further information:

Communication strategy and channels: the bilingual (Italian/French) communication plan includes the creation of a dedicated web section/page, campaigns on the organisation's social media channels, informative clips and the distribution of press releases to daily newspapers and specialist magazines.

- [Web pages](#)
- [Project page](#)
- [News pages](#)
- [Several Daily news](#)
- [Campaigns](#)
- [Me.Lab activities](#), [meetings](#) and [practice \(Videogame therapy\)](#)
- [Digital Therapy](#)
- [ASL Imperia](#)

- [Media Education](#)
- [Against Cyberbullying](#)
- [OPEN Project](#)

Public information materials: production of physical and digital information [materials](#) (leaflets, brochures and posters with a coordinated design) distributed widely across clinics, diagnostic centres, doctors' surgeries and schools in the cross-border area.

Public events and engagement: organisation of two major cross-border [events](#) — a public launch event and a press conference/closing event — aimed at engaging stakeholders, public decision-makers,

associations and the local population.

Media:

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