

June 2026

From Asylums to Recovery

The Italian Model of Community Mental Health in a European Perspective

This June edition of the EUCOMS Network Newsletter marks an important moment for our network. We are proud to officially announce our upcoming one-day international seminar, taking place on 15 September 2026 in Brescia, Italy, in collaboration with the IRCCS Saint John of God Clinical Research Centre.

The seminar - titled From Asylums to Recovery: The Italian Model of Community Mental Health in a European Perspective - brings together leading European experts to explore nearly fifty years of Italian psychiatric reform, recovery-oriented practice, and the future of community mental health across Europe.

Alongside this announcement, we share a scientific article by Alessandra Martinelli, psychiatrist, researcher at IRCCS Brescia and EUCOMS Board Member, which provides an in-depth exploration of the themes at the heart of this seminar.

We hope this edition inspires reflection, exchange, and connection.

In this edition

KEY THEMES

- Italian psychiatric reform & deinstitutionalisation
- Recovery-oriented care across Europe
- Lived experience & peer support
- Community mental health in the Netherlands, England & Italy

EVENTS

- Seminar in Brescia, 15.09.2026
- Full seminar programme
- Upcoming EUCOMS events & webinars
- Register - join us in Brescia

From Asylums to Recovery: The Italian Model of Community Mental Health in a European Perspective



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Over the last decades, Europe has pursued a complex historical process aimed at promoting integration among countries while respecting national autonomy and cultural diversity. This effort has also profoundly influenced the field of mental health, where European institutions and international organizations have attempted to establish common principles, policies, and objectives capable of addressing both old and emerging challenges (Ruggeri & Martinelli, 2022).

The World Health Organization (WHO) European Region currently includes 53 Member States, 27 of which belong to the European Union (EU). The development of common mental health priorities in Europe has been strongly shaped by the progressive construction of the EU itself. The Maastricht Treaty in 1992 formally established the EU with 12 original Member States: Belgium, France, Germany, Luxembourg, the Netherlands, Denmark, Ireland, Italy, the United Kingdom, Greece, Spain, and Portugal. Subsequent enlargements occurred in 1995, with the accession of Sweden, Finland, and Austria; in 2004, with Cyprus, Estonia, Latvia, Lithuania, Malta, Poland, the Czech Republic, Slovakia, Slovenia, and Hungary; and finally with Bulgaria and Romania in 2007 and Croatia in 2013. On February 1st, 2020, the United Kingdom officially left the EU, resulting in the current composition of 27 Member States.

Despite these efforts toward integration, Europe remains characterized by remarkable heterogeneity in terms of health care organization, political systems, socioeconomic conditions, welfare models, cultural traditions, and environmental contexts. These differences have significantly influenced the organization and quality of mental health care across countries.

A major turning point for mental health policy in Europe was represented by the WHO European Ministerial Conference on Mental Health held in Helsinki in 2005. The resulting Mental Health Declaration for Europe established a shared framework for future action, identifying several key priorities: increasing awareness of the importance of mental well-being; combating stigma, discrimination, and inequalities; empowering service users, families, and caregivers in shared decision-making processes; developing integrated and efficient mental health systems focused on promotion, prevention, treatment, rehabilitation, and recovery; strengthening the competencies of mental health professionals; and fostering co-design and co-production approaches involving users and carers in service planning and delivery (WHO - European Ministerial Conference on Mental Health, 2005a).

These priorities emerged in response to the growing burden of mental health disorders in Europe. Mental disorders currently represent the leading cause of non-fatal disease burden, accounting for 22.4% of years lived with disability, and the third-largest contributor to the overall disease burden, accounting for roughly one in six (approx. 15.6% to 17%) of all worldwide disability-adjusted life years (Liu et al., 2025). Consequently, the WHO European Region progressively developed strategies aimed at promoting mental health, preventing mental disorders, improving access to integrated and evidence-based services, protecting human rights, and encouraging the exchange of knowledge and best practices among countries.

However, achieving these common goals remains challenging because of the substantial inequalities that persist both within and between European countries. The WHO European Region encompasses nearly 900 million people living under highly diverse social, cultural, political, and economic conditions. Recognizing these disparities, the WHO has promoted several initiatives to support less-resourced countries in addressing common challenges and strengthening their mental health systems (WHO - Regional Office for Europe, 2022).

One of the main targets identified by international organizations has been the development and implementation of national mental health policies and legislation aligned with international human rights standards. National mental health plans are essential for coordinating stakeholders and agencies, defining funding priorities, protecting individuals with mental disorders from discrimination and rights violations, and ensuring accountability through monitoring systems (Knapp et al., 2007).

Currently, approximately 94% of countries in the WHO European Region have adopted a specific mental health policy or plan. Around 78% have enacted stand-alone mental health legislation, whereas 22% have integrated mental health regulations within broader health or disability laws. Moreover, nearly 70% of countries have updated their mental health policies within the previous five years. In almost half of the countries, implementation and evaluation are overseen by dedicated authorities or independent bodies that regularly report to stakeholders (WHO, 2021).

Nevertheless, the existence of policies and legislation does not necessarily guarantee their effective implementation. Important gaps persist between formal commitments and practical applications, particularly in countries with fewer resources, where mental health reforms may remain largely symbolic rather than structural (Winkler et al., 2017).

Within this broader context, deinstitutionalisation has represented one of the most important and challenging transformations in modern psychiatry. Since the 1960s and 1970s, major thinkers in social psychiatry, including Basaglia (1968), Cooper (1979), Foucault (1961), Goffman (1961), and Szasz (1984), criticized the asylum system and advocated for a radical rethinking of psychiatric care based on human rights, social inclusion, and community support.

Despite international efforts, the deinstitutionalisation process has developed unevenly across Europe. In several low-resource countries, insufficient political support and inadequate investments have resulted in the persistence of institutional forms of care for people with severe mental disorder (Muijen, 2012), (Killaspy, 2016).

At the same time, many individuals with common but disabling mental disorders still lack access to adequate treatments and support services (Muijen, 2012).

To better evaluate and monitor the process of deinstitutionalisation, several international initiatives and studies have been developed. European multicentre projects such as the Epsilon Study (Becker et al., 2000), the Odin Study (McCracken et al., 2006), the EuroSC project (Bebbington, P.E. Angermeyer, Azorin and et al., 2005), the EDEN Study (Kallert et al., 2007), and the Quatro Study (Gray et al., 2006) explored the organization, use, and outcomes of mental health services across Europe. Reviews and conceptual analyses further contributed to clarifying the meaning and components of deinstitutionalisation (Chow and Priebe, 2013).

In addition, instruments such as the Mental Health Services Deinstitutionalisation Measure (MENDit) were developed to assess the level of deinstitutionalisation in different countries (Taylor Salisbury et al., 2016), while the WHO QualityRights Toolkit promoted the evaluation and implementation of human rights-oriented community care (WHO European Region, 2018).

European institutions have consistently identified several priorities for advancing deinstitutionalisation and strengthening Community Mental Health Services (CMHSs), including reducing reliance on psychiatric hospital beds, improving professional training, enhancing integration between mental health and primary care, reducing involuntary admissions, ensuring continuity of care, and avoiding territorial inequalities in service provision (Ruggeri & Martinelli, 2022).

Among European countries, Italy represents one of the most emblematic and internationally recognized examples of psychiatric deinstitutionalisation. Over the last five decades, the Italian mental health care system has undergone profound reforms, culminating in the closure of psychiatric hospitals and the establishment of a fully community-based model of care. The Italian reform marked a historic shift from an asylum-based and hospital-centered approach toward a territorial and community-oriented system grounded in social inclusion and continuity of care (Erlicher & Tansella, 2012).

The organization of Italian mental health care is based on the Departments of Mental Health (DMH), which coordinate all psychiatric services within geographically defined catchment areas. Currently, Italy includes 123 DMHs (Ministero della Salute, 2024). These departments are responsible for planning, managing, and integrating all levels of care to ensure comprehensive, accessible, and equitable mental health services.

The DMH system includes CMHSs, which provide outpatient assessment, treatment, and home interventions; day centers and day hospitals delivering structured therapeutic and rehabilitative activities; residential facilities offering medium- and long-term supported accommodation; and General Hospital Psychiatric Wards (GHPWs) dedicated to acute inpatient treatment within general hospitals. Additional services include psychiatric consultations for other hospital wards and 24-hour emergency psychiatric interventions. Overall, the Italian model aims to reduce fragmentation of care and guarantee continuity across outpatient, inpatient, residential, and emergency settings while promoting treatment within the community whenever possible (Ministero della Salute, 1999).

The Italian experience anticipated many of the principles later promoted internationally. Since the early 2000s, several international documents—including the Declaration on Mental Health for Europe (WHO – European Ministerial Conference on Mental Health, 2005b), the European Commission’s Green Paper (European Commission, 2005), and the United Nations Convention on the Rights of Persons with Disabilities (United Nations, 2006) – have increasingly emphasized the protection of human rights, social participation, and community inclusion for individuals with psychosocial disabilities (Caldas de Almeida & Killaspy, 2011). Similarly, the NICE guidelines strongly recommend community-based and recovery-oriented approaches involving all relevant stakeholders (NICE, 2020).

Within this evolving framework, the concept of personal recovery has progressively become central to modern mental health care. Anthony (Anthony, 1993) defined recovery as a deeply personal and transformative process involving changes in attitudes, values, feelings, goals, skills, and social roles, allowing individuals to live meaningful and satisfying lives despite the limitations associated with mental disorder. Recovery therefore extends beyond symptom reduction and includes participation in meaningful social roles at home, school, work, and within the broader community (Frank et al., 2016; Martinelli & Ruggeri, 2020b; WHO, 2010).

Over the last decades, recovery-oriented approaches have shifted the focus of mental health services toward hope, self-determination, empowerment, social inclusion, and quality of life (Deegan, 1996; Leamy et al., 2011; Rapp & Goscha, 2006). Evidence suggests that recovery-oriented practices are associated with better clinical and functional outcomes as well as

improved subjective well-being (Beale & Lambric, 1995; Martinelli & Ruggeri, 2020a). However, the implementation of these approaches remains heterogeneous (Martinelli, 2024; Martinelli & Ruggeri, 2020a).

The adoption of evidence-based recovery-oriented practices within CMHSs (Frank et al., 2016; SLAM/SWLSTG, 2010) has been associated with improved self-management, autonomy, self-efficacy, and social outcomes (Maone & D’Avanzo, 2015; McCabe et al., 2018; Slade et al., 2014). Moreover, these practices appear capable of improving treatment outcomes while reducing health care costs (Bee et al., 2015; Department of Health, 2009; Needham et al., 2009; Slade et al., 2014). Consequently, contemporary CMHSs are increasingly expected to provide continuous (Wolfson et al., 2009), personalized, and recovery-oriented care that integrates evidence-based medicine with users’ experiences (Bee et al., 2015; NICE, 2016a, 2016b; van Os et al., 2019), preferences, and shared decision-making processes (Barnes & Pant, 2005; Carozza, 2006; Liberman, 2007).

In this regard, Italy possesses important strengths derived from its long-standing tradition of community psychiatry (Giusti et al., 2021).

Over the past decade, several initiatives have promoted key components of the recovery paradigm, including the dissemination of recovery narratives, peer support initiatives, co-production practices, and interventions targeting important life domains such as employment and social participation (Basso et al., 2016; Crowther et al., 2019; Martinelli & Ruggeri, 2020a; Slade et al., 2012).

Furthermore, specific training programs for professionals and culturally adapted recovery assessment tools (Barbato et al., 2014; Chiaf et al., 2016; Lucchi, 2017) have been developed and implemented in several Italian settings (Boggian et al., 2020; Corrigan et al., 2004; Gigantesco et al., 2006; Morosini et al., 2004; Placentino et al., 2018). Despite these advances, significant challenges remain. The implementation of recovery-oriented care in Italian CMHSs is still incomplete and often inconsistent with international recommendations. Many professionals continue to rely on paternalistic models of care (Basso et al., 2016; Martinelli et al., 2022), while individualized and shared treatment planning remains insufficiently developed. (Giusti et al., 2019, 2021; Martinelli et al., 2023).

In addition, substantial regional disparities persist in the availability and quality of services, reflecting broader inequalities within the Italian health care system (Basso et al., 2016; Giusti et al., 2019; Vera San Juan et al., 2021; Yeo et al., 2021). The Italian experience demonstrates that deinstitutionalisation alone is insufficient if not accompanied by sustained investments, evidence-based interventions, professional training, and the effective implementation of recovery-oriented practices.

The evolution of mental health care in Europe reflects a gradual but profound transition from institutional and custodial approaches toward community-based, recovery-oriented systems grounded in human rights and social inclusion. However, today, European mental health systems face common challenges, including inequalities in access to care, persistent stigma, workforce shortages, and the need to integrate users' perspectives into service planning and delivery.

In this context, the recovery paradigm offers an important opportunity to further transform mental health services by promoting empowerment, autonomy, and meaningful social inclusion. Within this framework, Italy has played a pioneering role through its radical deinstitutionalisation reform and represents one of the clearest examples of how psychiatric care can be reorganized around the principles of continuity of care, territorial responsibility, and social participation. However, recover-oriented practice remains insufficiently developed.

Future efforts should therefore focus not only on maintaining community-based systems, but also on improving their quality, accessibility, and recovery orientation through collaborative, person-centered, and evidence-informed approaches capable of responding to the evolving needs of individuals and communities across Europe.



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Join us on 15 September in Brescia, Italy

We warmly invite you to our upcoming EUCOMS on-location seminar in Brescia, Italy, hosted in collaboration with the IRCCS Saint John of God Clinical Research Centre.

This one-day seminar takes place on 15 September – the day before the EPA Congress (16–19 September, Brescia) – making it an ideal opportunity to combine both events in one trip.

The seminar will explore the Italian model of community mental health care, its roots in the reform movement, and its relevance for European mental health systems today. Through presentations, discussions, and a site visit to local services, participants will have a rare chance to learn directly from practitioners and researchers who have shaped this model over decades.

Spots are limited. Registration is available at the link below

[Click here to register for the seminar](#)



From Asylums to Recovery
The Italian Model of Community Mental Health
in a European Perspective

A EUCOMS Network One-Day Seminar

Brescia, Italy
15 September 2026

EUCOMS
The European Community Based Mental Health Services Providers Network
www.eucoms.net

IRCCS "Centro San Giovanni di Dio Fatebenefratelli"

A EUCOMS Network seminar in collaboration with Saint John of God Clinical Research Centre – IRCCS Istituto Centro San Giovanni di Dio Fatebenefratelli

For registration: eucoms.net/eucoms-network-meetings

08:00 – 08:20	<i>Participants' Registration</i>
08:20 – 08:40	Institutional Greetings & Seminar Introduction Alessandra Martinelli — EUCOMS · IRCCS Saint John of God Clinical Research Centre, Brescia
Morning Session — Part 1	
Chair	<i>Alessandra Martinelli — EUCOMS · IRCCS Saint John of God Clinical Research Centre, Brescia</i>
08:40 – 09:00	Lived Experience Perspectives & Presentation of EUCOMS Network Eva Torosani — Peer Expert, Brescia Department of Mental Health – Spedali Civili, Brescia Italy René Keet — EUCOMS · GGZ Noord-Holland-Noord, The Netherlands
09:00 – 09:30	State of the Art of Community-Based Mental Health Services in Europe Giovanni de Girolamo — IRCCS Saint John of God Clinical Research Centre, Brescia, Italy
09:30 – 09:50	The Italian Mental Health System: Focus on the Brescia Department of Mental Health Antonio Vita — Brescia Department of Mental Health – Spedali Civili & University of Brescia
09:50 – 10:10	Individual Health Budgets in Community Mental Health: The Brescia Experience Rodolfo Mazzoncini — Iseo Department of Mental Health, Brescia
10:10 – 10:20	Discussion & Q&A
10:20 – 10:40	<i>Coffee Break</i>
Morning Session — Part 2	
Chair	<i>Alessandra Martinelli — EUCOMS · IRCCS Saint John of God Clinical Research Centre, Brescia</i>
10:40 – 11:00	The IRCCS Saint John of God Clinical Research Centre: Clinical and Research Activities Giovanni Battista Tura, Roberta Rossi — IRCCS Saint John of God Clinical Research Centre, Brescia
11:00 – 11:20	The Dutch Mental Health System Lisette van der Meer — University of Groningen, The Netherlands
11:20 – 11:30	The European Assertive Outreach Foundation (EAOF) Niels Mulder — EUCOMS · Erasmus MC / Parnassia Psychiatric Institute, Rotterdam, The Netherlands
11:30 – 12:00	The English Mental Health System Helen Killaspy — University College London, United Kingdom
12:00 – 12:30	General Discussion & Q&A
12:30 – 14:30	<i>Lunch, Poster Session & Networking</i>
Afternoon Session — Part 1	
15:00 – 17:00	Site Visits to Community Mental Health Services in Brescia IRCCS Saint John of God Clinical Research Centre · Community services of the Brescia Department of Mental Health · Mental health social cooperatives, Brescia area <ul style="list-style-type: none"> • Participants will be divided into smaller groups and will attend one selected site visit.
Afternoon Session — Part 2	
17:30 – 19:00	Roundtable Discussion Following the Site Visits
19:00 – 19:30	Closing Remarks & Seminar Conclusion

[**Click here to register for the seminar**](#)

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San Giovanni di Dio Fatebenefratelli

Upcoming on-location EUCOMS meetings

From Asylums to Recovery | Brescia, Italy

15 September 2026

Area Focused Mental Health | Utrecht/Leiden, Netherlands

3-4 June 2027



Upcoming EUCOMS webinars

Promoting recovery using a network-based approach

17 June 2026

Peer Expertise from 3 continents. Canada, Japan, Europe

30 September 2026

Effectiveness of community mental health interventions

25 November 2026

DO YOU WANT TO BECOME A PARTNER?

That is possible! Becoming a partner or collaborator is open for individuals and organisations that provide or support services for people affected by mental illness. For more information and to register please click the link below.

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info@eucoms.net

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