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Building Mental Health and Well-being Together

Joint Action
MENTAL HEALTH TOGETHER

Strategic Guidelines: Designing the Health Budget with a Person-Centered Approach – Proposal of Qualifying Elements – translation from Italian by the WP 5.4 team - Scattoni Maria Luisa, Martina Micai, Fulceri Francesca; Gila Letizia; Sabbioni Mara; Caruso Angela

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Agreement, pursuant to Article 8, paragraph 6, of Law No. 131 of June 5, 2003, between the Government, the Regions, and Local Authorities on the document titled "Strategic Guidelines: Designing the Health Budget with a Person-Centered Approach – Proposal of Qualifying Elements."

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STRATEGIC GUIDELINES: DESIGNING THE HEALTH BUDGET WITH PERSON-CENTERED APPROACH

PREMISE

Mental health is a primary objective of the National Health Service, with the main goal of a modern and effective healthcare system being to identify the most efficient methodologies and tools possible.

Proper management of severe mental disorders also results in a substantial reduction of the social and economic impact these disorders impose on the system.

Scientific evidence demonstrates the importance of ensuring adequate interventions within community settings for people with severe mental disorders. This approach prevents unnecessary hospitalizations and institutionalization, which are often non-resolutive, especially if prolonged over time. To effectively respond to the complexity of mental health care, it is essential to create structural conditions and innovative contexts that integrate healthcare policies and resources with those from social and community services.

In this perspective, the capacity of a community to provide responses that integrate healthcare needs with educational, employment, housing, and community engagement

needs is essential. Experimenting with integrated and personalized social inclusion paths for people with severe mental disorders, often marginalized in the labor, housing, and socio-cultural markets, is a priority.

Integrated social and healthcare interventions are regulated by the DPCM of January 12, 2017, in articles 24, 25, 26, 27, 28, 57, and 60, along with current legislation on Essential Levels of Social Services - LEPS (Law 328/2000; National Plan of Social Interventions and Services 2021-2023 - adopted by inter-ministerial decree on October 22, 2021; Plan for Poverty Alleviation Interventions and Social Services 2021/2023 - adopted by inter-ministerial decree on December 30, 2021; Law 234 of December 30, 2021, "State Budget for Fiscal Year 2022 and Multi-Year Budget for 2022-2024" art. 7, paragraphs 159-171) covering assistance for minors with neuropsychiatric disorders, people with mental disorders, disabilities, addictions, HIV/AIDS, and autism spectrum disorders. These are enforceable rights for citizens, aiming to recover and/or maintain and enhance individual autonomy, counter institutionalization and segregation, and avoid transferring care responsibilities to third parties, promoting personal and community engagement.

In recent years, growing interest has focused on territorial integration experiences conducted through the "Health Budget" (BdS) organizational model, one of the most advanced and innovative proposals for integrating healthcare with community systems in mental health across Italy.

The Health Budget combines economic, professional, human, and relational resources needed to foster supportive relational, family, and social contexts that enhance social inclusion. It is a generative tool supporting personalized Life Projects that guarantee the right to health through highly integrated and flexible social and healthcare interventions. The model also transforms the service network, guiding resource reallocation, countering new forms of institutionalization, and identifying social-economic and housing inclusion opportunities.

The Health Budget model is now expanding across Italian regions, albeit unevenly, with experiences differing in technical, professional, administrative aspects, financing methods, experimentation volume, and duration.

The Ministry of Health is tasked with actively collaborating with the Regions and Autonomous Provinces, along with their respective organizational structures, to enhance intervention models that have proven effective in specific territorial contexts, with the goal of making them transferable to a broader range of regional areas. On this topic, the Directorate General for Health Prevention of the Ministry of Health funded, in November 2019, within the expenses for programming and surveillance activities to protect human health, the project "Subject, Person, Citizen: Promoting Well-being and Social Inclusion of People with Mental Disorders through the Health Budget." The aim was to enhance the Health Budget model already implemented by several Regions. Among them, Emilia-Romagna has initiated a specific pilot project and a training pathway for all operators, with various roles, who will be involved in incorporating these practices into everyday operations.

The project proposal responded to the need to map various regional/provincial experiences and to propose national guidelines or recommendations to support the Regions and Autonomous Provinces in adopting the model.

All Regions and Autonomous Provinces participated in the project, with an in-depth comparison of their experiences, leading to a unified approach through a dedicated Consensus Conference. This process resulted in the development of national guidelines and recommendations to support the model's implementation across different Regions and Autonomous Provinces. This elaboration involved all stakeholders, including individuals, families and their associations, Social and Health Services, the Third Sector, volunteer organizations, and civil society representatives.

The Project and the Health Budget (HB) model were also the focus of one of the thematic sessions at the 2nd National Conference on Mental Health – For Community Mental Health – held on June 25 and 26, titled "Work, Housing, Support for Independent Living: Actors and Tools for Social Inclusion."

The aforementioned Conference provided an opportunity to reaffirm the commitment of the Ministry of Health to promote and revitalize territorial assistance for mental health, adopting the community as a reference framework, protecting human rights and the dignity of people suffering from mental health issues, encouraging inclusive and participatory care wherever possible, and improving the quality and safety of services for the benefit of patients, their families, and service providers.

The present strategic guidelines can be considered applicable, with specific adaptations and appropriate adjustments, to all projects aimed at individuals with complex social and healthcare needs, for whom empowering and developmental interventions are appropriate.

EXPERIENCES WITH THE HEALTH BUDGET METHODOLOGY

To introduce the topic, a review of international literature was conducted, and documentation from the Regions and Autonomous Provinces was collected to identify "Best Practices" in preparation for a national Consensus Conference.

The systematic review of international literature identified 31 publications related to the Health Budget in mental health contexts, from both qualitative and quantitative perspectives. It summarized recent evidence on interventions, outcomes, and cost-effectiveness of the Health Budget for individuals with mental health disorders. Of the 31 international studies selected, involving approximately 11,825 users, family members, and professionals, 6 studies were conducted in Italy between April 2013 and September 2021. The studies included in the systematic review reveal certain limitations that make it challenging to generalize the results. First, the distribution of countries among the studies is only representative of the Western world. Additionally, comparing Health Budgets across countries is complicated due to the significant differences in their respective healthcare systems. Second, many studies have small sample sizes, predominantly qualitative designs, do not use validated tools to measure outcomes, and the quality of the studies is not always satisfactory. Third, the samples in the included studies are not always representative of the studied population and often lack a comprehensive description of patient phenotypes. Finally, information on

the economic resources used in the Health Budget is frequently omitted. Taking these limitations into account, we can draw some general conclusions. Positive outcomes for individuals with mental health disorders using the Health Budget have been confirmed, particularly in terms of patient choice and control over their recovery pathway. The use of the Health Budget for these individuals has shown various benefits, including patient empowerment, increased stakeholder engagement, involvement of care providers and staff in defining the Health Budget, and timely and appropriate access to treatment. Additionally, several studies have indicated that users have expressed satisfaction with the implementation of the Health Budgets.

Moreover, the Health Budget has improved clinical outcomes for users, quality of life, engagement in paid work, and experiences in employment and independent living, with positive effects extending to the entire family and support network. Evidence has shown that the Health Budget has led to significant changes in resource utilization and personalized intervention approaches, resulting in cost savings for families and National Health Systems. However, concerns about the application of the Health Budget were raised in several studies. Families found the management and procedures of the Health Budget challenging and stressful, as well as its implementation with professionals, leading them to feel less involved in their loved one's care. In some studies, professionals viewed the management of the Health Budget as an additional burden in their work.

The wealth of experiences has highlighted diverse practices and conceptions of the Health Budget, reflecting the cultures and needs of local contexts and historically developed processes, particularly regarding mental health in relation to the closure of psychiatric hospitals. However, from the mapped experiences, the need to promote the Health Budget model has emerged to facilitate cross-cutting organizational changes in welfare services.

From a regulatory perspective, the need has also emerged to coordinate and integrate the provisions of the Public Procurement Code and the Third Sector Code with administrative practices capable of achieving the objectives of the Health Budget. Healthcare and social practices should be flexible and allow for the reconfiguration of

services to enhance personalization, enabling risk/benefit assessments and the innovative use of resources from services and the community, centered on the individual.

Therefore, it is essential to define administrative procedures that enable flexibility and innovation in the application of this model. The project strategy is thus aimed at making the Health Budget increasingly clear and established within service practices, promoting its use and appropriate application at the regional level.

Below are the qualifying elements, all of which must coexist to define the Health Budget, along with the operational elements, which include appropriate administrative pathways and tools. These two areas must proceed in tandem. To ensure unity in the process and full implementation of Health Budget pathways, it is necessary to create convergence points between the clinical-care and administrative components.

QUALIFYING ELEMENTS

1) The Health Budget targets individuals managed by the network of territorial health services who have complex social and healthcare needs. At the center of the Health Budget is the individual, viewed within their community context and considered in the full scope of their resources, social and healthcare needs, relationships, and goals, with respect to which they can exercise their right to self-determination. The Health Budget supports individualized projects aimed at promoting the individual's residence in their chosen home, involving various community stakeholders.

2) The Health Budget is publicly governed and coordinated to ensure true social-healthcare integration. The request to activate the Health Budget, which can also be initiated by the individual and/or their legal representative, must be made by a healthcare, social-healthcare, or social services professional responsible for the case. It aims to empower individuals, fully implementing their rights and upholding their civic responsibilities.

   The social component ensures the rights and duties of citizenship, while the healthcare component upholds the right to health, and both contribute to the

right to empowerment. Each service adheres to its own regulations to deliver interventions. The social-healthcare team, comprising at least one healthcare, social-healthcare, and social professional, must include input from the individual, any appointed legal guardian according to their mandate, and, upon the individual's request, relevant persons. The social-healthcare team, composed of at least one healthcare, social-healthcare, and social professional, must include input from the individual, any appointed guardian as per their mandate, and, at the individual's request, other significant persons. This setup ensures that the individual actively participates in assessing needs and resources and exercises their right to self-determination in shared care and the definition of their life project, where they can consciously invest their resources, including financial ones.

3) The empowering approach aims to build a trusting relationship to conduct a multi-professional and multidimensional assessment of needs and resources and to define the Health Budget. This assessment must be carried out through a relationship and dialogue with the individual, using validated and standardized tools, and should explore all of the following areas:
   - Clinical Area
   - Psychosocial Functioning Area
   - Personal and Community Needs and Resources Area
   - Quality of Life Area

4) The Health Budget integrates the individual's care pathway with their life project. Based on assessments conducted across all intervention areas (housing/living environment, education/work, socialization, and learning/ expression/communication), a customized "Individualized Therapeutic Rehabilitation Project (PTRI)" is collaboratively developed with the individual, considering their preferences. The PTRI outlines actions and objectives for each area and, as a recovery-oriented care pathway, it evolves alongside the life project. Each Health Budget project must be coordinated by a designated Case

Manager, who can be from either the healthcare or social sector, and who primarily oversees the coordination of the interventions defined by the team.

5) For the Health Budget to become operational, consent is required, which is expressed through an agreement signed by the individual, detailing the objectives and commitments of all parties involved. This agreement is an integral part of the Health Budget.

6) During the implementation phase, the Health Budget must be constantly monitored and reviewed by the social-healthcare team, at least annually, with the active participation of the individual. This monitoring and review process is coordinated by the Case Manager designated in the planning phase. Outcome indicators are also considered in the review.

To enable the application of the Health Budget and ensure the quality of the process while facilitating its adoption across all territorial areas, it is essential to define a broad and widespread strategic plan based on the qualifying and operational elements agreed upon by the Working Group. This plan should also include an appropriate collection of essential strategic information.

More specifically, it is necessary to share the strategic document containing the guidelines through a formal agreement in the Unified Conference, with a commitment from the Regions and Autonomous Provinces to adopt the content through their own measures and/or implementation plans. Additionally, a national periodic monitoring system should be established, with structured methods for implementation using indicators of process quality and outcomes in terms of quality of life.

OPERATIONAL ELEMENTS

The Health Budget places the individual at the center of the system, recognizing them as unique and irreplaceable, bearing individual values, beliefs, and choices. It also aims to rebuild and enhance family and community welfare systems.

a. **Co-Planning.**

To support the pathways identified through the Health Budget, Health Agencies and Local Authorities engage in co-planning, in accordance with Article 55 of Legislative Decree 117/2017. This process involves Third Sector entities and aims to identify the needs to be met, the necessary interventions, the methods for implementing them, and the resources available. It is recommended to formalize this co-planning through a program agreement, in alignment with the provisions for local planning (Law 328/2000), to define and share the financial resources needed for implementing social and healthcare programs and interventions with the Health Budget. In the co-design phase, in addition to Third Sector entities, all potentially interested parties in developing the Health Budget (e.g., associations, cooperatives, families, and private individuals) may be involved.

b. **Formulation of Lists of Qualified Entities for Implementing Health Budget Projects.**

In line with the individualized project and respecting the principle of subsidiarity as per Article 118 of the Constitution and Article 55 of Legislative Decree 117/2017 (Third Sector Code), health agencies and local authorities may establish specific lists of qualified entities. These entities will actively participate in defining activities, pathways, and social-healthcare interventions (e.g., social assistance, educational, occupational, and rehabilitative services) for individuals under the care of social and health services, with projects aimed at restoring autonomy and social reintegration according to the Health Budget model. Through innovative inclusion proposals, co-managers must be able to support empowerment and the individual's active role, enabling them to become the architect of their own life project.

Reaffirming the centrality of the individual and the active role of the patient and their family members/significant figures in defining a personalized care and social inclusion pathway that addresses their specific needs, the public notice aims to ensure:

- high-quality empowerment interventions and individualized pathways that enhance projects aimed at restoring autonomy and promoting social reintegration, utilizing the Health Budget methodology;

- uniformity in the service delivery system, providing territorial areas with a standardized tool to identify entities with whom to establish co-management contractual agreements;
- involvement of users and family members with lived experience (point f);
- adherence to the principles of transparency, equal treatment, impartiality, and proportionality in the formation of the list and in the selection of managing entities.

In general, public administrations retain the option to use the procedures provided by Legislative Decree no. 50/2016. Regions adopt guidelines, tools, and act templates, including the possibility of a framework agreement between each Region, Health Authorities/Districts, and Municipalities/Territorial Social Areas, for the homogeneous and integrated development and implementation of the Health Budget model across the regional territory, in alignment with health and social planning.

c. **Executive Planning**.

The Lists of qualified entities established through the procedures indicated in the previous point serve as the reference for selecting participants in individual projects, following these implementation phases:

- the individual is already under the care of health and social services, and an initial project outline is developed through a collaborative planning phase involving all parties in the project, including the individual;
- at the end of the planning phase, the Health Budget is signed, and the Case Manager is appointed;
- the Health Budget becomes operational upon signing the agreement/ contract;
- the Case Manager coordinates verification and monitoring actions carried out by the social-healthcare team.

d. **Multidisciplinary and Multidimensional Assessment: Tools Shared and Agreed Upon by the Social-Healthcare Team**

The multi-professional and multidimensional assessment is carried out by the social-healthcare team, which includes a healthcare component and a social component.

The healthcare component is represented by health and social-healthcare professionals responsible for the individual, also considering any comorbidities.

The social component is represented by the social worker from the Local Authority and other educational or social workers responsible for the individual.

Both components form the multidisciplinary team, contributing to the development of Personalized Therapeutic Rehabilitation Projects.

When team members do not have decision-making authority over funding sources, validation is required through the Multi-Professional Assessment Unit model.

The assessment includes the use of validated and standardized tools to investigate various areas: clinical, psychosocial functioning, quality of life, motivation for change, and satisfaction. The entire evaluation phase must involve the individual's participation and, upon their request, the signature of significant others.

The social-healthcare team with decision-making authority, or the Multi-Professional Assessment Unit, using the lists of qualified entities, is responsible for guiding and supporting the individual in identifying the service/pathway/intervention that can best meet their needs. This evaluation must consider the appropriateness of interventions, the quality of reception and offerings, the adequacy of structural/logistical features, and the use of financial resources in relation to different local organizational arrangements.

e. **PTRI Definition: Needs/Resources, Agreement, and Monitoring**

The PTRI must include:

- objectives across various areas of social determinants of health
- skills the individual needs to achieve the objectives
- human, environmental, and material (including financial) resources necessary to achieve the objectives, specifying existing resources and those to be

activated through identified funding sources, in line with relevant regulations, both for the care program and the life project

- a detailed intervention plan, indicating any priorities
- involved operators and other figures, detailing roles and responsibilities
- a verification schedule
- an estimated duration of the project
- project manager: case manager

The transition to the implementation phase of the PTRI requires the signing of an agreement that outlines the resources and commitments undertaken by each party involved. The agreement must be signed by:

- the individual
- a family member/caregiver if involved, with the consent of the assisted person
- a guardian/legal representative, if present
- the healthcare team responsible for care
- the team from the Local Authority's social service office
- a representative from a Third Sector entity or private enterprise involved in the project, chosen from the list of qualified entities

f. **Involvement of Users and Family Members with Lived Experience**

The involvement of associations of users and family members in the co-planning phase is recommended. In implementing the Health Budget, family members and significant figures for the individual can be involved, and the active participation of users with lived experience or facilitators should be encouraged, based on evidence consolidated in various regions/autonomous provinces through dedicated training programs.

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