MENTOR
Building Mental Health and Well-being Together

Joint Action
MENTAL HEALTH TOGETHER

Definition of the Integrated Care Pathway

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1.2. Statement of originality

The content of the deliverable is original and created solely by the contributors of the JA Mentor project.

1.3 Table of contents

1.4 Abbreviations and Acronyms

EU	European Union
JA	Joint Action
MENTOR	Mental Health Together
PLE	People with Lived Experience
WP	Work package

List of abbreviations – WP5.4 participants	
ASL of Turin	Azienda Sanitaria Locale Città di Torino (Italy)
BIOSISTEMAK	Asociación Instituto De Investigación En Sistemas De Salud-Biosistemak
FFIS	Fundacion para la Formacion e Investigacion Sanitarias de la Region de Murcia
FRCB-IDIBAPS/HCB	Fundació Recerca Clínic Barcelona-IDIBAPS/ Hospital Clínic de Barcelona
FUNDESALUD	Fundacion para la Formacion e Investigacion de los Profesionales de la Salud de Extremadura Fundesalud
GENCAT	Departament de Salut - Generalitat de Catalunya
ICO	Institut Català d'Oncologia
IDIVAL	Fundacion Instituto de Investigacion Marques de Valdecilla
ISS	Istituto Superiore di Sanità
Lombardy Region	Regione Lombardia
MOSA	Sotsiaalministeerium
NCMHFAD	Centrul National de Sanatate Mintala Si Lupta Antodrog
NHF	National Health Fund
PHC	State Institution Public Health Center of the Ministry of Health of Ukraine
PHCI	Primary Healthcare of the Capital Area
ProMIS	Azienda ULSS 4 Veneto Orientale

RDS	Southern Region of Denmark
SAS	Servicio Andaluz de Salud
SHSO-MHS	Organismos Kratikon Ypiresion Ygeias
SMS	Servicio Murciano de Salud
UNIMIBI	Università degli Studi di Milano-Bicocca

2. About the MENTOR project

MENTOR aims to promote mental health by sharing experiences across a wide spectrum, from political initiatives to clinical professional practices. It incorporates evidence-based best practices and adapts initiatives to achieve long-term sustainability, enhancing mental health and well-being at individual and population levels.

MENTOR objectives:

1. Ensure efficient dissemination of MENTOR activities/outcomes.
2. Promote the sustainability and implementation of MENTOR outcomes through the different mental health care systems across the Europe region.
3. Strengthen the capacity of mental health literacy by developing policy recommendations and intervention tools targeted to vulnerable groups and fighting stigma.
4. Contribute to increasing access to evidence-based practices and innovative mental health monitoring, promotion and prevention approaches to manage mental health conditions in communities.
5. Improve monitoring systems of mental health to heighten awareness for mental health problems and ensure earlier detection of individuals at risk, and address data-driven decisions.
6. Reduce social inequalities in population targeting people with mental health issues.
7. Foster methods to evaluate and implement MHIAP approaches at national and regional levels.
8. Identify evidence-based interventions for the promotion and prevention of mental health issues in the vulnerable and general populations.
9. Support recovery-oriented and inclusive practice in the care of people with mental health condition.
10. Implement personalized and comprehensive approaches to mental health.

2.1. Purpose of this document

This document serves as the Knowledge Exchange report of the deliverable 5.4.2 "Definition of the integrated care pathway" for the JA Mental Health Together – _MENTOR Task 5.4. Based on data gathered by D.5.4.1 and collected in the Knowledge Exchange Report (available at the following link: https://ja-mentor.eu/index.php/recources/), the essential elements of the integrated care pathway in mental health will be detailed involving:

1. members of the multidisciplinary equipe for the initial assessment;
2. testing tools and questionnaires to evaluate clinical and personal outcomes;
3. standardized format for the planning and monitoring of the integrated social-health interventions.

The present Knowledge exchange report includes the information collected among the Member States involved in the task.

The draft of the present document will be posted on the Joint Action (JA) website. Stakeholders (such as mental health clinical centres, people with lived experience, NGOs, municipalities, etc.) will be invited to provide feedback and suggestions. All feedback will be reviewed by the Panel for potential modifications, leading to the finalization of the document. The finalized document will be translated into all the different European languages of the Member States for broader accessibility and understanding.

2.2. Task 5.4

2.2.1. Task description

Integrated care pathway for promoting social inclusion and quality of life of people with Mental Health disorders

Personalization is a key element of healthcare policy, as underlined by the World Health Organization (WHO). It is built on the conception of a health care system centred on human principles and rights, such as equity, participation, self-determination, and non-discrimination. This means treating patients from a person-centred perspective, listening to their needs, and recognizing their abilities and freedom to choose for their own health. A person-centred approach enables different sectors to work together, using available resources and different competencies, to meet person's needs overall.

The task 5.4 helps participating partners in defining and implementing integrated care pathways for people with mental disorders within their countries and produce recommendations to promote health and social integration. Public policies, different

funding sources, health, educational and social services, various professional resources, etc. will collaborate in close integration and partnership. Objective of this synergic intervention is the recovery and full inclusion in the community of people with mental health disorders. Through the innovative methodology of the personal health budget, health and social services work together to provide integrated interventions in the following four areas: health, housing, job placement, affectivity/sociability/life and relationship skills. Each person is accompanied through a tailored individual project, designed according to his/her specific needs and preferences and using available public/private/personal resources. The individual's personal empowerment is ensured by his/her full involvement and consent at every stage of the negotiation and decision-making process.

The availability or absence of economic/material resources (i.e., house, income, pension, salary, annuity...) and informal assets (educational qualifications, family support, social network, personal skills....) resources is considered in defining the person's needs and personal health budget. The latter is defined as the set of resources available from the individual and his/her context and the list of resources/interventions that integrated services ensure or provide during the personalised project. The project is monitored, evaluated periodically, and updated accordingly.

During the task, data and information concerning public policy and mental health services' organization are collected from participating countries and analysed. People with lived experiences will be actively included in the multidisciplinary team evaluating data collected and defining the key components of the integrated health-social care pathway that will be implemented in some MS.

The personal health budget has been tested so far in different countries, including the United Kingdom, Belgium, Denmark, Italy, Finland, Austria, France, Sweden, Germany, Australia, and the United States, with different types of programs, varying from inclusion criteria related to commissioned services or the person's degree of choice. The main goal of most programs was to promote autonomy and independent living, whereas other programs focused more on improving the caregiver's system of care.

The task 5.4 is collaborating closely with task 5.3 to support the implementation of this integrated approach, through the active involvement of different sectors of the Public Health, Social and Educational System. Project partners transfer the experience, and the knowledge gained to other Member States, through these four main outcomes:

- Knowledge exchange report (D.5.4.1), published at: https://ja-mentor.eu/index.php/recources/
- Definition of the ICP (D.5.4.2) focusing on vulnerable people, the present report;
- Guidelines and the training material (D.5.4.3) focused on Mental health professionals;
- Policy recommendations (D.5.4.4) for National policymakers.

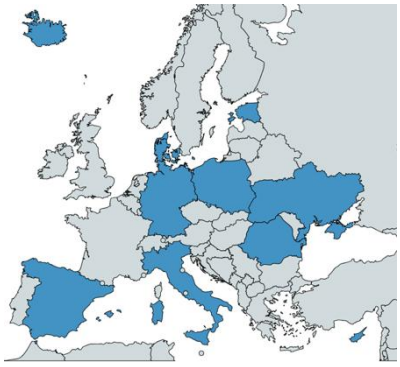
2.2.2. Task structure

JA MENTOR Task 5.4 consists of 4 subtasks: Survey dissemination and analysis (5.4.1), Definition of the integrated care pathway (5.4.2), Pilot implementation and monitoring of the integrated care pathway (5.4.3), and Definition and dissemination of community-based mental health policies (5.4.4).

The Task 5.4 has a task leader (National Institute of Health, Italy), who is responsible for reaching the task's deliverables and objectives. Twenty-one Member States join the Task 5.4.

2.2.3. Task set-up

The Task 5.4 has extensive geographical coverage across Europe (22 institutions across 10 countries) – Cyprus (SHSO-MHS), Denmark (RSD), Estonia (MOSA), Germany, Iceland (PHCI), Italy (ISS, ProMIS, ASL of Turin, UNIMIBI, Lombardy Region), Poland (NHF), Romania (NCMHFAD), Spain (Biosistemak, GENCAT, FRCB-IDIBAPS, ICO, IDIVAL, FFIS, SMS, SAS, FundeSalud, SES), and Ukraine (PHC).



All countries except Iceland, Germany, and Denmark are actively participating in the Work Package (WP) and therefore provide a more in-depth analysis of the current situation and related challenges.

Each participating institution and country/region contribute valuable and complementary expertise and experience to the Task. The partners possess the necessary skills, qualifications, and resources to carry out the Task effectively. They also hold the appropriate legal and technical mandates to implement the Task's activities at the national level.

2.3. Contacts

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D5.4.2. Knowledge exchange report

The present knowledge exchange report collects the work of a Panel consisting of members from ministries, public agencies, professionals in mental health and social work, municipalities, and Persons with Lived Experience of the Member States carried out during the first year of the Joint Action MENTAL HEALTH TOGETHER (MENTOR).

3. A European integrated care pathway with a person-centered approach for promoting social inclusion & quality of life of people with mental health disorders

3.1. Premise

Mental health is a primary objective of the European policies and fundings, 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 labour, housing, and socio-cultural markets, is a priority.

In Europe, integrated social and healthcare interventions are regulated by national and regional legislation and strategic frameworks, 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" organizational model, one of the most advanced and innovative proposals for integrating healthcare with community systems in mental health across Europe.

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.

Its main purpose is 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.

A national example developed in Italy (*Strategic Guidelines: Designing the Health Budget with a Person-Centered Approach – Proposal of Qualifying Elements*), providing administrative and operational guidance for the implementation of the Health Budget, has been translated and published on the JA MENTOR website and is available at the following link: https://ja-mentor.eu/wp-content/uploads/2025/06/Strategic-guidelines-for-health-budget-Italy-JA-MENTOR-Layout.pdf

3.2 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 29 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 29 international studies selected, involving approximately 11,541 users, family members, and professionals, eleven studies were conducted in the United Kingdom, 11 in the United States of America, 6 in Italy, and one in Australia 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, in Italy, 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, reflected 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, cantered 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.

The Joint Action MENTAL HEALTH TOGETHER (MENTOR) aims to promote mental health and well-being by sharing experiences across a broad spectrum—ranging from political initiatives to clinical and professional practices. It incorporates evidence-based best practices and adapts them for long-term sustainability, with the goal of improving mental health outcomes at both the individual and population levels.

As part of this initiative, a dedicated task focuses on the **Integrated Care Pathway for Promoting Social Inclusion and Quality of Life of People with Mental Health Disorders (MHDs)**. Within this framework, the **Knowledge Exchange Report** (available at the following link: https://ja-mentor.eu/index.php/recources/) was developed with the primary objective of assessing local population needs, available services, and relevant policies. This assessment was conducted by a multidisciplinary Panel comprising representatives from ministries, public agencies, mental health and social work professionals, municipalities, and individuals with lived experience.

The activities leading to the report began with a detailed evaluation of needs, services, and policies related to mental health in the participating countries and regions. The Panel, representing both public and private sectors, guided the comprehensive review of existing frameworks and services that support individuals with MHDs.

A key component of this process was the co-design of a survey, collaboratively developed by the partners. The survey aimed to gather critical information across three main areas:

1. The needs, suggestions, and challenges identified by local populations;
2. Characteristics of social and healthcare services dedicated to individuals with MHDs;
3. Existing national policies related to integrated social-health care pathways.

All active participants and observers designed and refined **the "Survey on Defining an Integrated Care Pathway for Promoting Social Inclusion and Quality of Life of People with Mental Health Disorders"** produced in English and translated/adapted into Italian, Spanish, Ukrainian, and Polish.

The survey included the following sections:

- Part 1 – Organization of health and social services / mental health and social care systems
- Part 2 – Types of interventions delivered
- Part 3 – Benefits and funding mechanisms
- Part 4 – Mental health and social sector information systems
- Part 5 – Personal Health Budget (PHB): national policies and local experiences
- Part 6 – Structuring of PHB
- Part 7 – Local experiences with PHB and integrated health-social care
- Part 8 – Strengths and challenges in the current system

In total, 401 participants accessed the survey, with 67% (n = 268) completing it fully or partially. Responses were collected from:

- 176 in Ukraine
- 39 in Italy
- 34 in Spain
- 12 in Poland
- 1 each from Estonia, Germany, Romania, and Latvia

The assessment of needs, services, and mental health policies in the participating countries and regions, along with the survey results presented in the Knowledge Exchange Report, served as the foundation for this document.

3.3. A European personal health budget application

The Personal Health Budget (PHB) is an innovative methodology in which health and social services work together to provide integrated interventions in the following areas:

- Affectivity/sociality/life and relational skills
- Educational - training - job placement
- Housing

Each person is accompanied through a tailored individual project, designed according to his/her specific needs and preferences and using available public/personal/private resources.

Personal empowerment should be supported through the person's involvement and informed consent at every stage, with appropriate support to ensure meaningful participation where decision-making is challenging.

3.4. Shift from standardized service packages to tailored support

People with mental health conditions co-design person-centred, recovery-oriented care plans and choose services aligned with their needs, preferences, and life goals, supported by coordinated action at micro, meso and macro levels, fostering autonomy and community inclusion.

Actions designed to address the person's evolving **needs, preferences, and aspirations**, taking into account their specific functional profile, environmental context, and personal goals.

The integration of clinical, educational, social, and relational interventions requires consistency across services and continuity over time.

Dynamic tool that guides personalized care trajectories, enhance participation, and promote **autonomy and quality of life** across the life course.

4. KEY COMPONENTS of the integrated care pathway

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.

4.1. Multiprofessional team

The Health Budget targets individuals managed by the network of territorial health services who have complex social and healthcare needs[1]. At the centre 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.

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. Health and social services work together, in line with national/regional regulations. Health services ensure clinical care and continuity of treatment, while social services ensure access to social rights, benefits and community-based supports. The multiprofessional team is the operational setting for joint assessment, co-planning and monitoring. The case manager coordinates the process.

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,

[1]Complex social and health needs refer to situations in which clinical severity and/or co-occurring conditions coexist with impaired functioning and relevant social vulnerabilities (e.g., housing instability, unemployment, economic hardship, social isolation). Complexity is therefore multidimensional and requires coordinated, multiprofessional and cross-sectoral interventions.

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.

The multiprofessional team should be composed as follows:

- **Health component**: at least one healthcare or social-health professional responsible for the individual's care, taking into account any specific comorbidities.
- **Social component**: a social worker from the Local Authority, along with other educational or social professionals involved in the individual's support.

In the 5.4 MENTOR survey, in response to the question "Is there a multiprofessional team in place to assess psychosocial functioning and develop the care plan?", most countries reported having such a team in place. Most of the professionals in the team include psychiatrists, psychologists, nurses, social workers, general practitioners, occupational therapists, rehabilitation therapists, and others.

The multiprofessional team should include, at least one professional from the health component and at least one from the social component.

Based on the report, suggested professionals for the health component include a psychiatrist, a psychologist, and a nurse, while for the social component, a social worker is recommended.

The person with mental health disorders should be ALWAYS a core member of the team and leads decisions based on their preferences; caregivers are involved only if and as the person chooses. Participation is ensured through shared decision-making, advance planning, supported self-management, and person-centred, recovery-oriented care

4.2. Multidimensional assessment and tools

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

After the diagnosis and the definition of the healthcare plan, each individual should be offered the development of a life project, tailored to all relevant areas. If the individual gives consent, the professional should initiate the definition of the healthcare plan and schedule a meeting with the person and the multiprofessional team, composed of at least one health professional and one social care professional.

The Integrated Care Pathway should be based on the individual's preferences. The process begins with an assessment of the clinical condition and functional profile. Next, the multiprofessional team should evaluate the individual's needs and preferences. Finally, the team should define the interventions in the areas identified (health, housing, training/education/employment, learning/socialization/affectivity) and prioritized by the person. In addition, the pathway should recognize that mental health crises can affect family and social networks; therefore, social interventions will be selected to support the person in managing family and social roles.

The case manager (facilitator) should be identified, and the individual's personal and community resources assessed, taking into account the clinical profile and the services available within the country. At this stage, the personal health budget can be established.

4.2.1. PHB definition by a CO-PROGRAMMING and CO-MANAGING APPROACH

The target age range is 18 years and older, with the option to include younger people during the transition phase when requested and clinically/psychosocially necessary.

Meeting of the multidisciplinary team includes the person with mental health disorders for the assessment of the:

- clinical conditions
- functioning profile
- quality of life.

The meeting is followed by a shared planning process, articulated in the following steps:

1. Understand the Individual needs and preferences.
2. The person requests interventions in specific areas such as health, housing, training/employment, education, socialization, and affectivity.
3. Set the interventions in the areas selected/suggested by each subject (co-creation)
4. Identify the personal and community resources available.
5. Identify the case manager (facilitator) in the area of greatest relevance.
6. Set the PHB and signing.

To support both the assessment and the shared planning process, a set of standardized tools was used. The tools were selected to be free of charge, available in multiple languages where possible, and already in use in the clinical practice of the Member States.

The scientific literature suggests using the following tools to evaluate clinical conditions, Mental health and psychosocial functioning (Gelkopf, Mazor, Roe, 2022):

- Health of the Nation Outcomes Scale (HoNOS; HoNOS secure, HoNOS- ABI, HoNOS-LD, HoNOS 65+);

The scientific literature suggests using the following tools to evaluate global functioning, disability and functional impairment (Gelkopf, Mazor, Roe, 2022):

- GAF (Global Assessment of Functioning)

The scientific literature suggests using the following tools to evaluate quality of life (Gelkopf, Mazor, Roe, 2022):

- WHOQoL-Bref (World Health Organization Quality of Life) available in several languages: https://www.who.int/tools/whoqol/whoqol-bref

4.3. Tailored and integrated intervention

Set the interventions in the areas selected/suggested for each subject, also taking into account individual needs and preferences:

- Health
- Housing
- Training/Education/Employment
- Learning/Socialization/Affectivity

Define the main objective of the interventions (short and long term), day/hour, professionals involved, resources available, indicators for monitoring.

The interventions listed below were identified primarily from the MENTOR 5.4 survey (Part 2: *Types of interventions delivered*), which mapped current practices across participating Member States/regions. Survey results were refined through panel discussions then organized into the four PHB domains. The interventions should be selected from the following list:

Health intervention	Housing intervention	Training/education/employment intervention	Learning/socialization/affectivity intervention
Outpatient therapy	Supported housing or assisted living arrangements	Occupational support services	Supported employment programs
Inpatient psychiatric care	Independent living skills training	Vocational training programs	Social skills training
Medication management/monitoring	Transitional housing programs	Job placement and employment	Support for caregivers
Psychological intervention	Long-term residential facilities	Skill development workshops	Housing assistance or supported living arrangements
Cultural and creative therapy	Emergency housing assistance	Supported education programs	Peer support groups
Psychological support	Housing first	Internships or apprenticeships with MH support	Community integration programs
Day-hospital	Other	Cooperatives and social enterprises	Personal autonomy programs
Community-based rehabilitation program		Associative leisure programs	Time-banking or volunteer programs

Community-based mental health promotion		Mentoring or job coaching programs	Community-based cultural program
Physical health monitoring		Youth transition programs	Other
Crisis int. service		Other	
Family int.			
Suicide prevention programs			
Targeted int. for specific groups			
Other			

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" is collaboratively developed with the individual, considering their preferences. The Individualized Therapeutic Rehabilitation Project outlines actions and objectives for each area and, as a recovery-oriented care pathway, it evolves alongside the life project.

4.4. Definition of the Personal Health Budget

Since there are different ways to deliver the findings, the multiprofessional team should outline these options and determine the most appropriate approach to ensure the person receives the maximum benefits and funding. The professionals should identify the resources available in the community and, if specific benefits are available, provide the person with the relevant information. Together with the person, access barriers should be analysed. Having a case manager can make it easier to apply for funding, but it may be challenging for individuals who first need to know how to apply for a case manager.

The multiprofessional team is composed of a **health professional from the Mental Health Services and a social worker from the municipality**.

The team should:

- **identify the available resources** (professional, personal, economic, etc.)
- **select the most appropriate** options with each individual and **facilitate access** to them

4.4.1. Challenges in developing PHB

As described in the Knowledge Exchange Report, the main challenges in developing Personal Health Budgets are closely linked to differences in **settings, funding sources and health-social systems**. In Italy and Spain, for instance, PHBs must operate across community mental health centres, social services and local municipalities, each with its own rules and priorities, which makes coordination between settings difficult. Ukraine, Poland, Romania and Latvia face similar fragmentation, but this is compounded by weaker community infrastructures, so PHBs have to bridge hospital services, underdeveloped social care and often informal family support. Funding streams also differ: in some areas of Italy and Spain resources come mainly from regional health budgets and municipalities, while in countries like Poland, Romania or Ukraine social benefits, disability pensions and occasional project funds must be combined, creating uncertainty and inequity in access. Germany and Estonia illustrate another layer of complexity, where PHBs (or analogous tools) must fit into systems largely based on health insurance and separate social insurance schemes, requiring agreements between insurers, social services and local authorities. Overall, across Ukraine, Italy, Spain, Poland, Estonia, Germany, Latvia and Romania, PHBs are challenged less by the idea itself than by the need to connect very different service settings, reconcile multiple and unstable funding sources, and navigate diverse health and social protection systems ranging from tax-funded public models to insurance-based ones.

JA MENTOR will promote cross-country benchmarking to identify transferable implementation solutions among countries/regions with similar health and social protection systems, producing practical options that can support other countries in scaling PHBs.

4.5. Identification of the case manager

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.

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.

a) Appointed within the sector where most interventions are concentrated (health or social care).
b) Clearly defines his/her role by informing the individual about available benefits and facilitating their access, making use of a Motivational Interviewing approach to foster engagement and active participation.

4.5.1. Recent literature on case manager: Key Functions and Roles

Case managers provide a range of supports, including relational, consistency, validation, social connection, daily living, and vocational assistance. These supports are tailored to the unique needs of mental health service users, emphasizing relationship-building, affirmation, and consistent engagement as core functions (Fitzgerald et al., 2024). Case managers also act as service coordinators, helping clients navigate complex systems to access housing, benefits, healthcare, and social support, often working in community settings (Kim et al., 2020).

4.5.2. Core functions of the Case Manager

Case managers for people with mental health needs are responsible for a range of supportive activities, including:

- Coordinating implementation of care plan across health, social, and community services to ensure patients receive appropriate and timely support.
- Building therapeutic relationships that foster trust, validation, and affirmation, which are crucial for patient engagement and recovery.
- Advocating for patients' needs, including access to housing, financial aid, and social services, and helping them navigate complex systems.
- Providing practical and emotional support such as assistance with daily living, vocational support, and social connection.
- Monitoring and assessing needs to identify changes in mental health status and connect patients to specialized care when necessary.
- Promoting autonomy and recovery by empowering patients to participate in care planning and supporting their independence.

4.6. Signature and monitoring

4.6.1. Definition of the indicators for monitoring the PHB or the European pilot study

These indicators are collected at the following time points: **T0 (baseline):** at admission/start of treatment and **T1 (follow-up):** at discharge or after a predefined follow-up period (e.g., 6 or 12 months after T0):

1. Number and total duration of Compulsory Medical Treatments / Involuntary Commitments
2. Number and total duration of hospital admissions
3. Clinical and functional outcomes
4. Assessment tools by age:
    - Adults (>18 years): HoNOS, GAF, WHOQoL BREF
    - Children and adolescents (<18 years): HoNOSCA
5. Treatment exposure period
6. Type of intervention and treatment intensity (hours/days)

5. FORMAT of the Integrated Care Pathway

SURNAME	FIRST NAME	DATE OF BIRTH

DATE OF FIRST VISIT _____ DATE OF LAST ASSESSMENT / FOLLOW-UP _____

ICD Diagnosis Codes _____

LEVEL OF SEVERITY

1 ☐ 2 ☐ 3 ☐

Date of completion: _____

FIRST NAME: _____ SURNAME: _____

START DATE: from approval _____ EXPIRY DATE: _____

LEVEL OF INTENSITY:

IDENTIFIED CO-MANAGING ACTORS:

REVIEWS: quarterly _____ six-months _____ other _____

PERSONAL DATA SHEET	
Place and date of birth	
Gender	
Nationality	

Address of residence (indicate if residence)	
Telephone number	
E-mail	
DEMOGRAPHIC DATA	
Recognition of civil invalidity and %	
Assessment of disability status	
Level of education	
Employment	
Other relevant data	
RESOURCES	
Pension/disability pension	
Attendance allowance	
Means of transport used	
Other sources of income (type/amount)	

MULTIDIMENSIONAL ASSESSMENT

FAMILY MEMBERS / REFERENCE PERSONS			
FIRST NAME	SURNAME	TYPE OF RELATIONSHIP	LIVING TOGETHER *yes/no*

HISTORY OF HEALTH / ILLNESS / DISTRESS	
Taking charge (date and Service)	
Family history	

Personal history	
Previous health interventions	
Previous social interventions	

PERSONAL CARE		
Aspects to be assessed	**Description of situation found**	**Priority needs**
Example	*Non-adherence, refusal of treatment, partial, or complete adherence, not applicable*	
Adherence to pharmacological treatment		
Adherence to therapeutic plan		

DIAGNOSIS	ICD-10	ICD-10 DESCRIPTION
Main diagnosis		
Secondary diagnosis		

FUNCTIONING PROFILE ASSESSMENT

ASSESSMENT		
Test *(e.g., HONOS, GAF, WHOQoL BREF)*	**Date of administration**	**Results** *(please provide the total and subscale scores for each test, if available)*

Brief description:_____

_____

_____

EVALUTATION OF PRIORITY NEEDS IN EACH AREA

	ASPECTS TO BE ASSESSED	DESCRIPTION OF SITUATION	PRIORITY NEEDS
Health			
Example	*drug therapy assumption*	*Instability in adherence to antipsychotic therapy*	*Monitoring medication intake and potential side effects*
1a			
2a			
3a			
Learning/socialization/affectivity			
Example	*Social interaction*	*Social isolation*	*Develop meaningful relationships*
1b			
2b			
3b			
Training /education/ employment			
Example	*Employment*	*Engaged in an internship with low perceived satisfaction*	*Meaningful and satisfying vocational opportunities*
1c			
2c			
3c			
Housing			

Example	*Independent living*	*Lives with unsupportive parents*	*Independent living*
1d			
2d			
3d			

SUMMARY, OBJECTIVES AND CO-MANAGED PLANNING

a. Health area

	Treatment schedule (days/hours)	Professional involved (e.g., psychiatrist, psychologist, nurse, social worker)	Available resources	Medium-term goals (up to 6 months)	Process indicators	Long-term goals (from 6 to 12 months)
1b						
2b						
3b						

b. Learning/communication/affectivity area

	Treatment schedule (days/hours)	Professional involved (e.g., psychiatrist, psychologist, nurse, social worker)	Available resources	Medium-term goals (up to 6 months)	Process indicators	Long-term goals (from 6 to 12 months)
1b						
2b						
3b						

c. Training/education/employment area

	Treatment schedule (days/hours)	Professional involved (e.g.,	Available resources	Medium-term goals	Process indicators	Long-term goals

	psychiatrist, psychologist, nurse, social worker)	(up to 6 months)		(from 6 to 12 months)
1b				
2b				
3b				

d. Housing area

	Treatment schedule (days/hours)	Professional involved (e.g., psychiatrist, psychologist, nurse, social worker)	Available resources	Medium-term goals (up to 6 months)	Process indicators	Long-term goals (from 6 to 12 months)
1b						
2b						
3b						

INTERVENTIONS

Planned actions	FROM..... TO.....	Human resources and level of intensity (monthly hours total)	Monthly cost of intervention

SIGNATURES

Role	Name and Surname (print)	Signature
Beneficiary / Project holder	_____	_____

Legal representative (if applicable)

Role	Name and Surname (print)	Signature
Parent	_____	_____
Guardian	_____	_____
Support administrator	_____	_____
Other (specify: _____)	_____	_____

Case manager (indicate professional role)

Professional role	Name and Surname (print)	Signature
Case Manager (role: _____)	_____	_____

Multidisciplinary team

Professional role	Name and Surname (print)	Signature
Psychiatrist	_____	_____
Psychologist	_____	_____
Social worker	_____	_____
Nurse	_____	_____

Professional role	Name and Surname (print)	Signature
Occupational therapist / Educator	_____	_____
Other (specify: _____)	_____	_____

Third-sector service provider

Role	Name and Surname (print)	Signature
Organisation name	_____	—
Legal representative	_____	_____

Date, _____

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7. Next step: Pilot implementation and monitoring of the integrated care pathway

Based on data gathered by D.5.4.1, the essential elements of the integrated care pathway in mental health (MH) will be detailed involving: 1. members of the multidisciplinary equip for the initial assessment; 2. testing tools and questionnaires to evaluate clinical and personal outcomes; 3. standardized format for the planning and monitoring of the integrated social-health interventions. The document defined will be posted on the Joint Action website to invite for feedback and suggestions from stakeholders such as MH clinical centres, people with lived experience (PLE), NGOs, municipalities, etc. All feedback will be reviewed by the Panel for potential modifications, leading to the finalization of the document. The finalized document will be translated into all the different European languages for broader accessibility and understanding.

7.1. Synergies

The collaborative development of the Definition of an Integrated Care Pathway (Subtask 5.4.2) has fostered valuable synergies among project partners and external stakeholders.

1. Cross-Country Exchange of Best Practices
   The biweekly meetings and continuous discussions have facilitated the exchange of national and regional policies, guidelines, and strategies related to integrated mental health care. This has strengthened mutual learning and informed the survey's content with diverse perspectives, ensuring its relevance across different healthcare systems.
2. Interdisciplinary Collaboration
   The involvement of Ministries, public agencies, mental health services, social welfare and labour sectors, individuals with lived experience, and third-sector organizations (NGOs, volunteer groups, and non-profits) has reinforced a multisectoral approach.
3. Strengthened Networks for Future Actions
   The survey dissemination process has reinforced connections between different institutions and stakeholders, laying the groundwork for future collaborations beyond the project's initial scope. These relationships are expected to facilitate future joint initiatives, policy developments, and research on integrated care pathways and social inclusion strategies.

4. Alignment with Policy and Research Frameworks

   The collected data contributes not only to the project deliverables but also to broader European and national policy discussions on mental health service improvement, social inclusion, and integrated care models. The knowledge gained through this initiative aligns with existing EU frameworks and serve as a reference for future research and policy recommendations.

These synergies, both planned and unforeseen, have enhanced the overall impact of the project, promoting a coordinated and sustainable approach to mental health care at local, regional, national, and European level.

MENTOR
Building Mental Health and Well-being Together

Definition of the Integrated Care Pathway

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