From residential facilities to supported housing: the Individual Health Budgeting method as a form of co-production.

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Summary

In Trieste the de-institutionalisation process has singled out and used an array of different residential facilities, which evolved in time in terms of their functions as integrated within the DSM (Mental Health Department) and in close connection with 24-hour CSM (Mental Health Centres). Over the last decade, the progressive decrease of residential beds was based on the health budget method in connection with a bespoke therapeutic rehabilitation process. The whole process was focused on disarticulating and transforming existing facilities and organisations to move them closer to the needs of the involved people, thus fostering a re-appropriation of living areas in a process of deep project personalisation. Supported housing has always been a central element to rehabilitation, enabling and recovery processes, acting and establishing itself as a crucial design tool shared with users and private non-profit organisations, in view of engaging community resources – including services – and the social capital of people. Empirical data regarding this process indicate a reconversion of resources from facilities to living settings of people and the relevant contexts, as well as a number of consequences on the overall system which may be described in qualitative terms and go beyond the issue of supported housing. As such, they support individual care project for people whose needs are complex.

Introduction and background

If we consider people receiving mental health care as passive, rather than active and autonomous subjects who think, choose and are self-responsible, we undermine the efficacy of the intervention. As A. Sen maintained (2001), any qualification as disabled, poor, or sick – and the expected disadvantages or feelings of being labelled – supports the negative effect "on self-esteem and on the view that others have of you" and neutralizes the benefits an intervention could lead to. The capability approach stresses the importance of developing functions as the main instrument to afford available social opportunities and resources: “what a person is capable to do and be?” (Nussbaum, 2011).

Trieste is an internationally known experience that started from the first closure of a psychiatric hospital in Europe (in 1980) as a process of change of thinking, practice and services. It includes 24 hrs CMH Centres with few beds each, only a 6 bed unit in general hospital for a town of 240.000, a high number of social cooperatives and many innovative programmes in the area of recovery and social inclusion. Recognised as a WHO Collaborating Centre, this is considered a sustainable model for service development in Europe and worldwide with a clear demonstration of effectiveness (Mezzina, 2014). The experience in Trieste stands as a comprehensive definition of rehabilitation as a program of restitution and (re) construction of full rights (political, civil, social) and citizenship for people suffering from mental illness, and the material enforcement of these rights. This implies an articulated approach that aims at: a) a legal recognition of civil and social rights and the material means to exercise them through diversified strategies which b) acquire resources (houses, jobs, goods, services, relationships) primarily through a deinstitutionalisation reconverting total institutions to community services and c) improve access to resources, mainly by developing user capabilities (primary users first, and then family members) (De Leonardis, Mauri and Rotelli, 1986; Rotelli, 1993; Rotelli et al., 1994; Mezzina, 2010, 2014). This in turn requires training (living and

vocational skills, education), information (psycho-educational, social awareness and information about rights and resources – when, how and where); as well as the creation of social support networks that facilitate the delivery of resources, and which are managed by comprehensive community services totally alternative to mental institutions.
In order to achieve these goals, it is essential to empower primary consumers, provide support for family members, re-skill and re-orient professionals, provide health education and bring about a cultural change in attitudes, especially in those directly involved in providing services. All these actions must minimize the limitations and social barriers which contribute to producing disability and stigma, and which reinforce ill behaviour (such as long-term institutionalisation, forensic hospitals). Therefore, a good programme for the reintegration of people with mental disabilities requires a competent support not only for the re-acquisition of lost skills, but above all the provision of places and situations where they can spend these skills: that is a system of opportunities, in the areas of home, work, and social relations (Davidson et al., 2010).

Housing
In community psychiatry, the residence matter is key in autonomy and recovery processes (Borg et al., 2005) for people with mental disorders. The lack or impossibility to live in a place of one's own are causes that worsen any form of difficulties and exclusion, if not the main cause of distress where they lead to undesired or detrimental cohabitation, or prevent the same person from experiencing more emancipating situations. In any case, people who access residential facilities are mainly those with the least bargaining power, at a higher risk of stigma and social invalidation, hindered in their exercise of essential citizenship rights, sometimes because of difficult family situations, severe social isolation and poor self-care skills. This category of people is precisely the most exposed to the risk of being offered de-personalising management methods and involved in institutionalisation conditions.
In the second half of the Nineties in Italy there was a radical increase in the number of beds in residential psychiatric institutions. After the reform and the ban of Mental Institutions, a broad and quite controversial type of residential care has risen (as highlighted in 2000 by the ProgRes survey – De Girolamo et al., 2002; Picardi et al. 2006, 2014) and there is still a lack of a clearer definition of the overall design approach to the residential method as a social inclusion tool. The way resources are often massively invested – often being the main expenditure item of DSM – are also quite obscure, not to mention a lack of adequate qualification of care (Taylor et al., 2009; Killaspy et al., 2011) and assessment of intervention outcomes.
In this framework, it is important to distinguish between residential care and the housing issue, which sometimes see people suffering from severe disorders and social exclusion without a home; moreover, the housing facilities mostly focused on care are even different. Most of the times residential facilities are a mix of all this and mainly stand as an answer to the question "where do I put them", rather that to the needs, times and priorities of the users.
Therefore it is important to distinguish between:
-a residential therapeutic and rehabilitative type of community, in which the style of work is clearly focused and temporality is important;
-the need for a place to live, and live, with due support, for people with severe mental disorders.
These two objectives, not easily conjugated, may lead to different types of residential solutions and very different characteristics of the mode of operation of such structures, despite the fact that the literature face usually reference to them as a unitary concept. There is a gap between the optimistic expectation that the path should be considered a residential therapeutic segment of the overall project, with a beginning and an end, and the observation of the problematic nature of this segment.
Residential care should be, within mental health services – one of the tools fostering and supporting the de-institutionalisation process as it promotes a transition towards supported housing with fuller rights to people, restoring empowerment tools and skills to enable the social component through a continuous inclusion process. Conversely, when it loses the push "outward" and the focus on

increasing users' bargaining power, it blocks the process and ultimately ends up freezing users to their role of eternal guests and never "hosts", offering people with living solutions ill fit to true housing rights.

Healthcare Budget

Starting in 2006, the Mental Health Department of Trieste introduced a tool called Budget di Salute/Progetto Personalizzato (health budget/personalised project) that allowed the re-allotment of resources bound to residential care, developing individual plans starting from personal needs and aimed at housing solutions.

The individual health budget tool is the summary of all economic, professional and human resources needed to trigger a process aimed at restoring an individual – though an individual rehabilitation process – to an acceptable social functioning. The individual, his/her family and the community all partake in it (Starace, 2011; Monteleone, 2005). It is a ground-breaking funding method within the public/private mix the complex welfare crisis and social/healthcare integration scenario has generated, which shifts the economic resources around the person. Antecedents of this policy were developed in the USA in the field of child disabilities, and in Canada as a service brokerage model; direct payments for personal assistance services were the focus of independent living leadership for disabled adults, programs like "Money follows the person" (Kirchener & Moseley, 2007, cit. in Racino, 2013), and individual therapy/psychiatrist in mental health are other examples (Racino, 2013). Australia and then the UK decided to experiment individualized funding (Department of Health, 2009), while in Italy the first programs of healthcare budget already started in the 90's in the process of deinstitutionalisation of psychiatric care and are now disseminated in several regions and areas (Righetti, 2013; Starace, 2011). Anyway these are tools for reform policies in housing and support for adults with disabilities, children residential services, support to families for community participation and employment as "long-term services and supports" in the community (Racino, 2013). We can quote a british definition: *"A personal budget is an allocation of social care or NHS resources or an integrated allocation of both that is controlled by an individual and can be used to meet identified goals. PBs and PHBs give individuals and their carers greater say over how their health and social care needs are met. They do this by transferring control of public resources to individuals rather than having the state commission services on their behalf".* (Alakeson and Perkins, 2012).

When this program goes beyond a mere "voucher" for the individuals in order to "buy" services, it also stands as a form of 'co-production', term coined in the USA by 2009 Nobel Prize for economy Elinor Ostrom (Ostrom & Baugh, 1973; Parks et al.,1981). "Co-production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change" (Boyle and Harris, 2009). It implies recognising people as assets, promoting reciprocity, giving and receiving (trust between people and mutual respect) and building social networks, because people's physical and mental well-being depends on enduring relationships (Boyle and Harris, 2009).

Methodology

The purpose of this paper is, on the one side, to describe the practical and conceptual shift from residential facilities to personalised supported housing processes, defined based on the needs observed by services and/or explicitly and autonomously expressed by individuals. On the other, it investigates the consequences and effects the personalised approach to all interventions has produced in the system comprising of Mental Health Services, private non profit organisation and all stakeholders. The assessment of personal outcomes is under way in the form of a follow-up study, which is not among the objectives of this paper.

The structures

In Trieste residential community care adopted 3 types of programmes:

1) Therapeutic-rehabilitative dwellings**,** for people with severe mental health problems and in the absence of a supportive family network. In each house from 3 to 8 people are accommodated. There are 7 group-homes for a total of 42 users.

2) Transitional dwellings, used as temporary housing solutions. Currently hosting 18 people, distributed in 7 small group-apartments.

3) Supported Housing, that is, personalized support at people's own homes, of varying intensity depending on individual needs. Currently 64 people are living in 20 apartments.

Support is provided by private non-profit operators (social co-operatives A and B); in partnership with the Healthcare Unit, they co-manage each single project. The DSM, through the SAR (Rehabilitation and Residence Service) and on close connection with Community Mental Health Centres (CSM), coordinates and supervises the residential facilities, while promoting initiatives and seeking strategies aimed at housing qualification. It also develops rehabilitation/training plans for those who – either for a fixed or long-term period – live in residential facilities and promotes innovative projects within the framework of supported housing.

The process

The Personalised Plan / Personalised Healthcare Budget is the tool for a fundamental transformation in the area of supported housing, allowing the re-allotment of resources invested in residential facilities in order to address home support.

The main features of PB developed in Trieste are:

1. The personalised care plan is at the basis of PB. It is like a bespoke suit and therefore requires that measures be taken and the person to agree to them. It becomes the main tool to give voice to those directly affected. It identifies needs/goals, expected results, interconnection of services, resources required, role/duties of professionals and services, verification and evaluation (when & how). A whole range of community resources are implemented in an integrated way, while services based on a personalised care plan shift from rigid, preconceived programmes to flexible and diversified ones.

2. The personalised care plan and related healthcare budget are the main tool for affirming the central role of people and their needs and guaranteeing care continuity. This tool stresses the user's consent and participation in the plan. "*The value of professional treatment and intervention lies in supporting self-care and the pursuit of individual ambitions"…* "*Personal health budgets provide a tool to enable this individual journey, recognizing and nurturing individuals in their many different roles, with aspirations for the future and talents to contribute. Services that embed the principles of recovery and personalisation must offer hope and challenge, not limiting people to the confines of their disorders, but supporting them to define and realise a life that they choose and value"*(Alakeson and Perkins, 2012).

3. The personalised care plan simultaneously addresses the three axes that are the basis of the social functioning of individuals and the essential social support to be a whole person with bargaining power: home, work, socialization. The organization of the service is articulated along these three axes through supported housing; socialization and participation; training and work inclusion. These correspond to social determinants of health (Marmot, 2006; WHO, 2008, 2104). Main determinants of health, and social supports, are needed in order to exercise bargaining power and to avoid institutionalization. They also represent fundamental elements in the most recent definition of psychosocial rehabilitation (WAPR-WHO, 1996; WHO, 2001).

4. "The economic investment defined as health budget represents a synthesis of economic, professional and human resources required to trigger a process to restore a person" (Rotelli, 1993), through an individual rehabilitation and treatment plan, acceptable social functioning, the production of which involves the same person and the community. This is an innovative method of

financing mix of public/private resources, moving the same resources closer to the person. The mixture includes various resources that act as exchange multipliers. This is also to promote advanced models of shared public/private management (co-management), through new outsourcing tools, because the significant resources that social and health interventions require, are converted and become a multiplier of the resources of subjects, families and the community (Monteleone, 2005).
5. This process can be conceived in the area of what has been defined as "co-production", as defined in the introduction (Boyle and Harris, 2009). *"The involvement of peer workers and third sector organizations in the delivery of services could allow clinical professionals to become more focused on those tasks where they have unique skills and expertise"* (Alakeson and Perkins, 2012). Individual budgets are not forms of co-production when they ignore the need for supportive social networks, replace relationships with market transactions for the person, 'buy solutions' or consume passively, rather than have an active stake in devising and delivering their own solutions.
Co-production has instead the capacity to transform public services; it has to be potentially transformative, not just for the individuals involved as active and equal partners, but also for the professionals and the system, which are required to change their attitudes, priorities and training, and act as facilitators. "In order to be effective, it must enable everyone to participate, not just those who are already more able, articulate and socially advantaged" (Boyle and Harris, 2009).

Characteristics of PHB (Alakeson and Perkins, 2012)

1. A simple, fair resource allocation system
2. Effective recovery planning (combined with effective support when required)
3. New approaches to opportunity and safety
4. A more diverse workforce
5. Monitoring on the basis of outcomes not spending
6. A new evidence base
7. A more diverse market
8. Sustainable funding

Results

At the inception of the healthcare budget method an initial test period was set for a total of 66 healthcare budgets, corresponding to guests in the DSM residential facilities managed by A-type social co-operatives, where the contracts drawn up from a previous tender was about to expire. Moreover, some of these users had already been involved in project assumptions targeted at shifting from residential facilities to supported housing, projects which would have been supported by re-allocation to healthcare budget of those resources already invested for residential purposes. The importance of the healthcare budget method, as translated in the design of a special set of specifications "for the co-management of health budgets – personalised therapeutic-rehabilitative projects aimed at promoting mental health and recovery", stands out in overall management processes as a driver of change in terms of the use of resources and the approach to service outsourcing.
The main quantitative results may be summed up as follows:
1) After 8 years from the from the introduction of this technology, it was possible to move from 66 to 140 health budgets of varying intensity, with an average yearly turnover rate of 33%. The use of the health budget tool was targeted, in approximately 77% of the available resources, on a severe mental disorder target, as assessed through standard tools (Honos - Roma, FPS, CAN).
2) We moved to 2 partners only – which were initially trusted with residential services (A-type social co-operatives) in 2006, to a current number of 10 (A and B-type social co-operatives and associations).

3) In this timeframe, four facilities were closed, which had hosted 32 people for over 10 years. Moreover, through a project re-design exercise, it was possible to single out alternative solutions focused on the housing approach and aimed at people with complex needs, within the treatment and care processes in place by the CSM. At the same time it was possible to prevent from resorting to residential solutions (new demand) by starting personalised projects in bundle with the City and the ATER (Regional Social Housing Agency), which were capable of promoting new supported housing paradigms and fostering new forms of housing support. Currently 42 people live in DSM residential facilities, against 88 people in total in 2005 (see Table 1).
4) Between 2002 and 2012 70 people were discharged from residential facilities to be assigned to small ATER apartments (as assignees) and supported with low, mid or high intensity housing projects, which were adjusted over the course of time depending on the needs and the developed autonomy (see Table 2).
5) Since the activated projects – as integrated between multiple services – strengthen the care of people with complex needs as performed by CSM, selecting overall life projects going beyond the mere more or less supported housing solution allowed to tackle the most severe conditions with the heaviest burden of care, and welcome the four remaining people from Trieste who were still interned in Forensic Hospitals, while preventing new assignments (e.g. two of those cases were currently taken up by two social co-operatives).
6) It was possible to re-allocate resources bound for 24-hour Therapeutic and Rehabilitation Facilities by selecting alternative solutions also for people with high care requirements, without producing a sizeable budget increase and by using shared funding between mental health and welfare services (FAP, Fondo per l'Autonomia Possibile) meant to foster co-design and social-healthcare integration for groups at risk of social exclusion (see Table 3).

Table 1. Development of people in high-intensity residential facilities between 2002 and 2012

	No of facilities	Beds	Deceased	Transferred to nursing homes	Transferred between facilities	No. of supported housing projects
T0 - 2002	**12**	**93**	**-**			**-**
T1 - 2005	**12**	**88**	**8**	**9**	**27**	**21**
T2 - 2012	**8**	**42**	**6**	**10**	**44**	**49**
10-year summary	**- 4**	**-51**	**14**	**19**	**71**	**70**
		Reduction --55%	**9.60%**	**13.00%**	**49.00%**	**48.00%**

Table 2. Type of support in favour of 70 people who, between 2002 and 2012, were discharged from residential facilities

HIGH INTENSITY (up to 24 hours/die) – with health budget	**People**
Cohabitation groups (max 3 people)	**3**
Personalised housing (domicile)	**2**

Progetto Villa Carsia (domicile)	**9**
MID INTENSITY (Up to 14 hours/die) – with health budget	**5**
LOW INTENSITY (max 32 hours per week) – with health budget	
Personalised support at home	**25**
Foster family	**2**
CSM support – without health budget	
Exclusively CSM operators	**24**
TOTAL	**70**

Table 3. 2005-2012 cost comparison

	DSM BUDGET	Residential costs	Supported housing costs	Home support cost
2005	**€ 2,961,691.40**	**€ 2,806,969.40**	**€ 0**	**€ 154,722**
2012	**€ 3,458,666.90**	**€ 1,755,646.90**	**€ 575,500**	**€ 1,127,520**
Difference	**+17%**	**-37%**		
	Increase €496,975.5	**Re-allotted share € 1,051,322.50**		

Qualitative evaluation

In order to assess the complex system shift at play it is necessary to refer to the qualitative evaluation concept, which determines the consequences in terms of social, relational, social capital and intervention quality improvement production, as applied to the involved individuals at all levels: service users, services, private non-profit organisations (Ridente and Furlan, 2011).

a) People

The reduction in residential-related interventions and the simultaneous increase in actions supporting housing and variable-intensity approaches (strongly adjusted interventions in terms of support and time, on the selected need and with a more and more frequent assignment of the budget directly to users), determine the validity of the tool as regards the re-allotment of resources from costs for high intensity to mid and low intensity of care. This proves the increase of people's autonomy and the higher personalisation of the interventions, aimed at a whole life approach (Jenkins and Rix, 2003; Mezzina, 2014). Moreover, higher project personalisation and the chance of providing responses that are more relevant to the needs are elements that potentially guarantee the overall improvement of intervention quality, more specifically where they include and strongly

consider the remarks expressed by people directly involved, thus activating and fostering the personal recovery process (Mezzina, 2006; Mezzina et al., 2006a,b).

b) Service system.

The use of the health budget method brought about significant changes is the way resources are used and in the personalised intervention culture within Service working groups, thus fostering transparency, clarity as regards investments, and more awareness in the use of resources and care for rationalising the turnover of the same resources. Economic resources are no longer invested in facilities as much as in the processes underlying the project. A more dynamic system allowed to dramatically reduce the time between the need and the response, even where the services involved were multiple. The health budget tool allowed to match operations and resources around individuals and their life context, even where there was a lack in terms of protocols and understandings among different organisations and services, therefore helping to overcome the risk that the necessary integration among multiple institutional subjects could cause a delay in the response time.

c) Partnership relations.

There was, since the date of inception of the experiment, an increase in numbers and a differentiation among the types of community organisations (NGOs) involved in the co-management of health budgets with the Trieste DSM. A change in the working style of third sector partners is testified to by a rather flexible approach to interventions in the light of a higher personalisation of the projects. Another important result we saw was a closer collaboration among different third sector agencies, stimulated by the simultaneous involvement of several partners in the same project. Finally the supervisory and evaluation groups, which include DSM operators and partners involved in different projects, are a very helpful tool to foster the development of a more shared co-design and co-management culture and language.

Conclusions

With the introduction of this procedure it was possible to attain an increase in the opportunity of direct participation of those who suffer from mental disorders in the definition of projects involving them personally and to the life of the service they are recipients of. As regards DSM service, the health budget method introduced a number of significant changes in the way resources are used and in the intervention personalisation culture within working groups. The focus on personalised projects introduced the common practice of rewriting life-stories involving all actors, thus increasing the project individualisation culture ("one person at a time", Davidson et al., 2010) against pre-defined packages of care, driven by cost-efficiency, as usual in service outsourcing processes.

Partnership relations developed – within the participatory co-design culture – by offering a new form of relations with private non-profit organisations. This model, subject to close examination, has shown remarkable advantages in terms of management efficiency, effectiveness in-the-practice and ultimately cost-effectiveness. More specifically, it showed to be a viable tool to re-qualify and make social and healthcare spending mode dynamic in the new welfare community (Righetti, 2013). The process of shared decision-making that brings together these two types of expertise, allowed to shift from a 'gift model' to a 'citizenship model' with the individual at the centre of the service system (Duffy, 2010).

This allowed to take responsibility back in the integrated management of services, with the clear and open goal of fighting traditional service institutionalisation dynamics, which go together with specialised intervention in the healthcare setting. This is done to contrast a mono-dimensional 'reductionist' approach whose risk would be to objectivise the recipients of the measures. Now, in this light today it seems crucial that community services, in organising their action, follow the idea of promoting, valuing, and actively supporting the ability to empower and involve users, their families and the expression of social participation stemming within local communities, for the purpose of building together the answer to different needs. The philosophy behind the health budget

model lies in the awareness that external resistance to exercising learning, education, social relations, employment and housing rights are the elements that ultimately turn a vulnerable or "at risk" person into a "case". The health budget model, then, guarantees flexible performance, defined not on the characteristics of the available offer, but based on real needs and "citizenship rights" of individuals, towards an approach to life as a whole. This tool allowed the Trieste DSM to attain a full enhancement of its care programmes, enabling – through the personalised adjustment of integrated social and healthcare interventions – adequate therapeutic and rehabilitative responses in the community and a real improvement in the quality of life of people, who would otherwise be destined, in other contexts, to institutional solutions of containment and restraint.

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