WORK AND RECOVERY: FROM POLICIES TO INDIVIDUALS

Trabalho e Recovery: das políticas para os indivíduos

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ABSTRACT: The current international context of vocational rehabilitation and job placement includes health and legal implications, encompassing WHO documents, the research on social determinants of health, the UN Sustainable Development Goals (SDGs), the Convention on the Rights of Persons with Disabilities, State policies. The social enterprise is described as a universe of organizations based on the primacy of people over capital, which includes organizational forms such as cooperatives, foundations and associations. It is aimed at bridging the gap between welfare and productive worlds and at enhancing the potential of service users and other citizens with disabilities or social disadvantage toward emancipation. Italian laws provided a framework for this development of "real work for a real pay" and especially Trieste is an example of integration of social cooperatives in the rehabilitation and social inclusion strategies of mental health. Among available quantitative research data, qualitative research based on first person's accounts focuses on the role of work opportunities in the recovery process and provides a more nuanced view. Work can be stressful at times, but it anchors the individual to reality and provides social inclusion per se. The prospect of a wider approach, as the one offered by social enterprise, with its social values linked to a different kind of employment, confirms those individual perspectives, while it combines community engagement and coproduction.
Keywords: Work and Recovery. Social Cooperatives and Enterprise. Trieste Mental Health Service. Social Determinants of Health. Human Rights.

RESUMO: O atual contexto internacional de reabilitação profissional e colocação profissional inclui implicações legais e de saúde, abrangendo documentos da OMS, a pesquisa sobre determinantes sociais da saúde, os Objetivos de Desenvolvimento Sustentável da ONU (ODS), a Convenção sobre os Direitos das Pessoas com Deficiência e Políticas de Estado. A empresa social é descrita como um universo de organizações baseado na primazia das pessoas sobre o

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capital, que inclui formas organizacionais como cooperativas, fundações e associações.
Tem como objetivo preencher a lacuna entre o mundo do bem-estar e o produtivo aumentando o potencial dos usuários dos serviços e outros cidadãos com deficiência ou em desvantagem social para a emancipação. As leis italianas forneceram uma estrutura para este desenvolvimento de “trabalho real com remuneração real” e, Trieste, especialmente, é um exemplo de integração de cooperativas sociais nas estratégias de reabilitação e inclusão social na saúde mental. Entre os dados disponíveis de pesquisa quantitativa, a pesquisa qualitativa baseada em relatos em primeira pessoa, concentra-se no papel das oportunidades de trabalho no processo de recovery e fornecendo uma ampla visão. O trabalho às vezes pode ser estressante, mas ancora o indivíduo à realidade e proporciona a inclusão social per se. A perspectiva de uma abordagem mais ampla, como a oferecida pela empresa social, com seus valores sociais vinculados a um tipo diferente de emprego, confirma essas perspectivas individuais, ao mesmo tempo que combina engajamento comunitário e coprodução.
Palavras-chave: Trabalho e Recovery. Cooperativas e Empreendimentos Socais. Serviço de Saúde Mental de Trieste. Determinantes Socias de Saúde. Direitos Humanos.

1 PREMISES

The article is mainly aimed at presenting the results of qualitative research about work experiences as means to recover. We are anyway concerned about real-life implementation of inputs and suggestions which emerge from this field. Trying to outline a more general framework, we will start to discuss the value of work and vocational rehabilitation in a human rights perspective and within the efforts to improve social determinants of health and mental health. Its definition within international declaration of UN and its bodies, e.g., International Labor Office (ILO) and the World Health Organization (WHO), has to be articulated into current policies and practices. We will describe some examples especially from Europe and Italy, as pioneered in Trieste. The long-lasting development of social cooperatives and the wider concept of social enterprise could represent useful ways to set up a range of options and possibilities for recovery pathways. These practices are supported by quantitative data related to economics but also to health outcomes that we will recall. Anyway, we need the viewpoint of people with lived experience, and some of the most interesting insights emerged during their personal recovery process in the above- mentioned qualitative survey. They can

better contextualize the previous general description and quantitative results. It is especially relevant to focus on individual accounts on their experience of job opportunities provided by the so called “social economy”. In this way it could be better understood how to match individual preferences and aspirations with feasible, affordable programs, which are successful on a large scale, but need to be actively supported by effective and high-quality health and welfare policies and services.

2 REHABILITATION, RIGHTS AND OPPORTUNITIES: the issue of work

In the perspective of community mental health, the possibility of work has become an essential element in the constitution of a social identity of people with mental disorder, in their tension towards full integration and a meaningful life, in the challenge to prejudice about their inability and unproductivity. It has been central to the experiences of deinstitutionalization and rehabilitation.

A Consensus Statement on psychosocial rehabilitation (World Association for Psychosocial Rehabilitation – WAPR, & WHO, 1996) recognized Vocational Rehabilitation is as an essential part of it, “as a process that facilitates the opportunity for individuals – who are impaired, disabled or handicapped by a mental disorder – to reach their optimal level of independent functioning in the community”.

For any person with disabilities or at risk of discrimination for his / her own condition, the right to work, as exemplary enshrined in the UN Convention on the Rights of Persons with Disabilities (CRPD), in connection with vocational rehabilitation, has strong political implications. “States Parties shall take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. To that end, States Parties shall organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services” (UN CRPD 2006).

The World Health Organization (HARNOIS & GABRIEL, 2002) already described the principal barriers to the employment of individuals with severe mental illness:

- Lack of choice in employment services and providers.
- Inadequate work opportunities.
- Complexity of the existing work incentive systems.
- Financial penalties of working.
- Stigma and discrimination.
- Loss of health benefits.

As in any attempt to systematize useful strategies in this area, vocational rehabilitation strategies emphasize individual training and the acquisition of skills, and related insertion and support techniques, while others have focused on creating integrated job placement, up to the definition of a "social economy" field of which mental health refers. While the former received constant attention from the scientific literature, the latter, due to their hybrid and complex nature, made up of programs, business initiatives, practices and policies, have been systematized to a much lesser extent, despite the great interest aroused and the relevant economic aspect associated with them.

The two parts don't speak easily each other, generating confusion between the level of treatment and the level of job creation and insertion of vulnerable people, with the first ones rooted in psychiatric literature and the others in the economic and sociological one. The strict link between social and health policies and practices is paramount, given that the former has direct and visible effects on health indicators.

Thus, the need for a multisectoral approach, defined as "a comprehensive and coordinated response for mental health requires partnership with multiple public sectors such as health, education, employment, judicial, housing, social and other relevant sectors as well as the private sector, as appropriate to the country situation" (WHO, 2013). The *Objective 2: To provide comprehensive, integrated and responsive mental health and social care services in community-based settings* declares that "…a multisectoral approach is required whereby services support individuals, at different stages of the life course and, as appropriate, facilitate their access to human rights such as employment (including return-to-work programmes), housing and educational opportunities, and participation in community activities, programmes and meaningful activities." (WHO, 2013). Moreover, the connection between economic

development and health once again raises the issue of the need to develop society's human potential, not just to focus on individuals.

As the theory of social determinants of health demonstrates (MARMOT, 2005), mental disorders lead to reduced income and employment, which entrenches poverty and in turn increases the risk of mental disorder. A dominant hypothesis linking social status and mental disorders focuses on the level, frequency, and duration of stressful experiences and the extent to which they are buffered by social supports in the form of emotional, informational, or instrumental resources provided by or shared with others, and by individual capabilities and ways of coping. Those lower on the social hierarchy are more likely to experience less favorable economic, social, and environmental conditions throughout life and have access to fewer buffers and supports. These disadvantages start before birth and tend to accumulate throughout life, although not all individuals with similar exposures have the same vulnerabilities (WHO-GULBENKIAN, 2014).

In order to provide access to real and innovative work opportunities, the so-called "social economy" represents a possible alternative that mobilizes and involves social actors and resources and envisages a number of solutions for the job market. "Social economy enterprises refer to a universe of organizations based on the primacy of people over capital, such as cooperatives, mutual societies, non-profit associations, foundations and social enterprises. They operate a very broad number of commercial activities, provide a wide range of products and services across the European single market and generate millions of jobs. Social enterprises are also the engine for social innovation." The aim is social and economic cohesion by creating jobs, providing socially innovative services and goods, facilitating social inclusions and promoting a more sustainable and locally anchored economy. They are based on solidarity and empowerment principles (Council of the European Union, 2015).

As pointed out from the 90's by those who pioneered social enterprise (ROTELLI et al. 1994), it is increasingly clear that the inadequacy of resources for effectively realizing the principle of universal rights, while remaining a problem, can no longer be posed in the same way as it was when the welfare state crisis begun. The problem, even in developed countries, still seems to be the lack, or apparent lack of resources; and yet perhaps it is more a question of why they remain unused or, when available, how those resources are used, i.e.,

as regards to the function of the current institutions which continue to be seen more as instruments of social control (often violent like prisons, asylums, juvenile jails). How can a public service, even a strong one, confront the emerging needs and growing "contractual power of the user" when unemployment is increasing and social disaggregation is producing a growing uneasiness in ever wider sectors of the population? (ROTELLI et al. 2002).

A new mental health policy should be concerned with a "culture of needs and resources" in which citizens, local communities and users all work together and organize themselves to find solutions and innovations in the deinstitutionalization process. That is inventing a service sector, which took its start from areas abandoned by a failed social reproduction; which is able to create a new distribution because able to endow abandoned resources with value; which is neither entirely public or private, but can be described as a collective enterprise of social reproduction. This sets a stage in which the "user" becomes a "producer" taking part in a social production enterprise. Hence the perspicuity of the term "Social Enterprise" and the enormous need for underlining the central nature of this issue (ROTELLI et al. 2002).

Table 1 - The Italian vision theory of social enterprise (De Leonardis, Mauri & Rotelli, 1991)

Social enterprise:
- actively seeks out and produces synergies between the productive and welfare worlds.
- finds its focus and dynamic in the utilization of concurrent professional training and work processes.
- constructs areas of risk as well as safety nets for the participants.
- conquers and combines energies in the local environment.
- builds on small dimensions and the diversification of its scope of action.
- produces quality: of products, processes, social habitat.
- restores local resources and individual capacity.
- changes the standard of welfare assistance.

3 SOCIAL COOPERATIVES: The italian case

Social cooperatives are one of first and most relevant examples of social enterprise. The history of social cooperatives in Italy represents a vital part of the deinstitutionalization movement that led to the closure of all psychiatric hospitals in two decades (1978-1999).

In 1991, following the pioneer development of the cooperatives finalized in the field of social integration from the 70's, in Trieste and then in many other places in Italy (LEFF & WARNER, 2006), the national government established (by Law n. 381, of "Discipline of the Social Cooperatives") that these enterprises have the aim of pursuing "the general interest of the community for human promotion and social integration of citizens" through: (1) management of socio-health and educational services (type A cooperatives), (2) carrying out different activities (agricultural, industrial, commercial and service) aimed at to the employment of disadvantaged people (type B cooperatives) The type B Coops are the work integrated social enterprises. According to the law, disadvantaged persons must constitute at least 30% of the working members.

Public bodies have the possibility to stipulate agreements with type B cooperatives aimed at creating job opportunities for disadvantaged people, e.g., the supply of goods and services. They can provide them with contributions for the purchase of equipment suitable for use by disadvantaged persons and flat-rate taxes for disadvantaged people. While law n.68 of 1999 fostered individual supported pathways of vocational training and job placement, another important law (n. 328 in year 2000) put it into the framework of an integrated system of healthcare and welfare services aimed at social integration. More recently, in 2017 social cooperatives were included into the "Third sector" and officially acquired the status of social enterprises. These legislative measures have introduced some innovations, including the social report and the social impact assessment, which serves to bring out and make known the social added value generated, the social changes produced and its sustainability. This underlines the public commitment nature of the cooperatives and the mandatory effect; of repercussions of their action on the territories and on all stakeholders, from the direct beneficiaries of the service to the public administration, from other local businesses, to the community, and to the environment. Both economic development and social cohesion are thus pursued. What is required is not just

individual orientation and search for job, e.g., through employment agencies, but also job grants, internships, work training contracts, business creation.

The current Italian situation shows a constant increase in the demand for work by disadvantaged people, but just a stable but small number of people regularly employ themselves through traditional schemes and the rules available (Law 68/99). There is a slight growth of the people employed through the law 381/93. Despite economic crisis, from 2011 to 2015 the n. of social coops in Italy increased from 11.264 to 16.125 (43% higher). Social coops type B were 3671 out of 13604 (source: INPS). They show an increase of 8,5% of disadvantaged members from 2008 to 2014.

It can be easily noted that main partners of Mental Health Departments (for 80% of them) are social cooperatives type B, which provide on-the-job training and support. The job placement is targeted to people with mental health issues with a predominant diagnosis of psychosis (49%). Outcomes show high quality of life (65%), good satisfaction (59%), clinical Improvement (57%). To become employed is considered the main outcome, and it encompassed 1448 individuals, that is 10% of the sample Main determinant of the presence of job training programs is the activity of social coops, while main determinant of good outcome is the economical regional context (BRACCO et a., 2013).

It has to be noted that also the best studied program of supported employment, e.g., the Individual Placement and Support (IPS; BOND et al. 2012; BURNS et al. 2007), is now widespread in the country and it acts synergically with social cooperation. Data of the year 2016 in the Emilia-Romagna Region show 768 people included in individual place-and train, of which 476 (62%) have actually worked (FIORITTI, 2018).

3.1 An exemplary experience: Trieste

The case of Trieste is an exemplary demonstration of the trends of social enterprise strategy undertaken by a public service. The first cooperative society was established during the process of deinstitutionalization by patients themselves, supported by professionals, for the economic recognition of the work they were doing to clean the psychiatric hospital (1972). The patients' right to associate and negotiate a contract for the maintenance of the hospital. A strike with the support of the nurse's union happened. Eventually the Administration capitulated, and patients involved in the so-called "work-therapy" became

members of a cleaning cooperative under union rules and salaries. They were no longer inmates, but workers with regular jobs, normal wages and belated rights. They had become subjects inserted into a social/working context. In the following years, Social coops started to grow as a National as well as an International movement. The main programs developed are shown in the table n. 2.

TABLE 2 - Cooperative activities developed in Trieste (1973-2019)

• cleaning and building maintenance • street sweeping • canteens and catering, incl. home service for elderly people • porterage and transport • laundry services • tailoring • informatic archives for councils, etc. • furniture and design • recycling • cafeteria and restaurant services • hotel • bathhouse • front-office and call-center of public agencies • museums 'staff • agricultural production • gardening • handicraft • carpentry • photo, video and radio production • computer service, publishing trade, multimedia production • serigraphic • theatre • administrative services • human services (personal budgeted projects for elderly, educators for adolescents, group-homes)

Their purchasers are public agencies as well as private citizens. The number of persons presently working in these cooperatives in the city are about 600 in type A and 600 in type B coops. In type-B coops 50% are disadvantaged members and more than 100 people have work-grants for their training.

Service staff work either as managers or as mental health specialists; teaching experts and collaborators for each specific sector (members of the "Intelligentsia" open to the enterprise); ordinary members. It is provided an individual tax exemption for 2 years according to current laws. Profits overcoming the enterprise's breakeven point must be reinvested. The most important goal is growth in an individual's autonomy, in their social exchanges and in their relationship with institutions and therefore with the psychiatric services - an autonomy which is both therapeutic and economic (self-sufficiency).

In many ways the members "own" the cooperative, e.g., having the right to vote in an assembly that makes any decision and elects the directive committee. Coops can even represent a chance for a job career, such as becoming managers of sectors like in the "F. Basaglia" Coop – canteen, catering, cleaning, transport, laundry, book-bindery – where many managers of the sectors are "disadvantaged" people. In the partnership with mental health services, in the job search, a series of opportunities are discussed, and then a training "contract" is signed among the client, the service and the coop. Job placement is achieved through an approach that can be defined as "natural support" (VERDUGO ALONZO, 2003) on the job: shared tasks, mutual support, cooperation in the literal sense.

In Trieste 282 people (in the year 2017) have been included in "place and train" individual projects with job grants and 15 achieved stable employment during the year. 11 coops (A and A+B) are involved in the personal budgets system (A+B), they offer home supports and human services, including job training and placement. There are also Type B n. 8 coops (Franco Basaglia, La Collina, Querciambiente, Confini, Cassiopea, il Melograno, Agricola Monte San Pantaleone, Lister). New projects were developed such as "Hubility" – for creative re-cycling and art objects, "Oltre i Grembani" – biodynamic cultivation, wellbeing and quality cuisine workshop. Even if the experience in Trieste did not mix the idea of social cooperatives with self- and mutual help, that has been achieved instead through client and citizen associations as partners the Mental Health Department, recently (2014) a number of Peer support workers were trained in a special course and most of them are now employed as members of Type A coops for human services. Many of them work with the Community Mental Health Centers' Teams as social inclusion workers for the "diffused day care

centre", and involved in any form of coproduction, e.g., recovery house, empowerment college, etc. The use of personal budgets for life projects is now relevant in the issue of work (RIDENTE & MEZZINA, 2016; MEZZINA, 2014).

Even if the ways and approaches used by social cooperatives are not formalized and standardized in a method, they proved to be successful. Of course, the evidence base is weak, no rigorous and systematic research has been done, apart from local investigation that confirm good outcomes not only in terms of occupation, but also in the quality of life, improved relationship with the mental healthcare system, with the therapeutic programs including a decreased use of medications, with the family and social network, etc. (DEL GIUDICE, 2000).

4 WHAT DO PEOPLE SAY? Aspects of work in the recovery process

All these theories, related programs and experiences of implementation we described so far are focused on advantages and results of a co-production strategy between public service and third sector, that is aimed at improving the social conditions and the quality of life of individuals with mental health issues. Therefore, it is relevant to investigate in depth in order to test the convergence between these hypotheses (as they remain as such till they are not verified by research, or even these can be accused to be just ideologies, ideal representation of real-world hard facts) and the point of view (the perceived quality of care and the perceived outcomes) of those who are beneficiaries of the above.

Looking at the subjective point of view of people with lived experience, interviews were done within two qualitative studies on recovery factors, the first in Trieste with people who had had an intense relationship with mental health services and considered themselves recovered or recovering; the second, with the same inclusion criteria, in the multicentric study with partnerships of the United States, Norway, Sweden and Trieste.

Interviews were collected over an extended period of time (from 2000 to 2002) and included both exploratory open questions on one's path, what had helped and what not, and a track of complementary questions to explore the relationship with services, with one's own life context, etc. It is important to point

out that interviews were not specifically addressed at the issue of work, and the specific theme has been extracted from a categorical re-analysis made in 2013.

In Trieste, the research on recovery took place in the early 2000s and 15 people aged between 28-59 were interviewed. Almost all of the respondents at the time of the interview had a job, with the exception of one person who was retired; many of them were included in the field of social cooperation, both as members or as trainees. Three people worked as clerks (one of them on an internship with an insurance company), while others worked in a school setting.

From the interviews collected both in Trieste and in the international research on recovery, we extracted some testimonies that can illustrate this aspect.

We can say that people who took part in the research were experts both in their recovery experience and in the work theme which, to various degrees, marked their path. In the testimonies of people who have gone through the experience of mental distress and who have completely or partially recovered, the work is presented as a dimension in which difficulties and subjective experiences find a connection to reality, both in positive and in negative terms.

On one hand, work helped reconstructing oneself and one's social identity (acquiring autonomy, having a positive image of oneself, improving quality of life and relationships, etc.). On the other, it was a way of perceiving oneself and of measuring oneself with malaise: lack of role, of recognition and training, with possible consequences of renunciation, resizing, withdrawal.

We choose to organize those accounts and statements in three sections:

4.1. the sense of reality

4.2. the role of work as a moment of crisis and as a recovery factor

4.3. the facilitating contributions of the service

4.1. The sense of reality

People have had to deal with different aspects of training and working, as reality testing and verification of the ability to stay within the given conditions.

All interviewees had an intense relationship with mental health services, such as people with high burden for a severe psychotic disorder. They tell of having lost, in a sudden or sometimes insidious way, contact with themselves and with the things that made sense to them: relationships, study, work.

The strenuous process of recovery has meant, as we will see, accepting their own fragility and daily challenges, learning to manage their emotional difficulties, planning their life and fighting for more certainty, in short, having a sense of their own reality.

Annica, looking for work, expresses in this regard the awareness of her own fragility: “We are more vulnerable and fragile than normal people. We are not as good at managing our existence when the storm rises, as can happen with any healthy person. Since we are more sensitive people, we need to fight twice as much as a healthy person to achieve our goals”.

Accepting the challenge of every day is the challenge that Franca, as a teacher, has had to face and support for years: “Every day was as if it were the first. On the one hand, it was fine, because of the commitment I put into teaching, but on the other it was a shocking psychological strain. However, despite my shyness in having to face the class, I did not dream of not going to school, until I finished my school career. "

The crisis that Nina went through during her training internship made her learn to manage her own emotions as a factor of maturation and take responsibility: "Perhaps the last was the most constructive crisis I had, because it allowed me to face a whole series of situations that before I didn't know how to deal with the right way, and therefore left me a great experience, even emotional. Although I don't like the world of work so much, I would have found it more stimulating to continue studying, but it created a school of responsibility, a school of life more real than that in the family I had not had. "

For Chiara, the reality of a working member of a social cooperative has allowed her to plan her life on a practical ground: “My path has been a very material path. In my delusions I had a spiritual path and instead I began to make contact with reality: I found a home, I began to work, to earn. My life is now planned on a very specific basis. I work, run home, have lunch, look after the children ... ".

Being on a job grant for training and waiting for a job meant for Giuseppe, for the first time in his life, having certainties: "... I remember once I was struck by a phrase by Franco Basaglia that I had heard again when I was working with Radio Fragola. In a movie from the 70s, he said of a Calabrian proverb that is as simple as it is true: "WHO HAS NOT, IS NOT". For me this proverb means, in its

disconcerting simplicity, that those who do not have certainties cannot hope for a better future". He specifies: "Better to have few certainties than many suppositions, which when you try to verify whether or not they correspond to reality, can turn out to be very fallacious. When I was young and still inexperienced in life, I realized that many times one supposes, one makes castles in the air and then, *pluf*, everything collapses. Or, one makes it very easy, and instead, later ... one realizes that it is not easy at all".

4.2. The role of work as a moment of crisis and as a recovery factor

Emotional frailty and difficulty holding up work (e.g., relational context, perception of lost productive capacity,) can be triggers of psychological distress. Work forces you to adapt, to confront others and to react in different ways, stimulating your resources and favoring your recovery path. These life-stories describe moments in which people had to implement strategies to try to reduce stress, decrease work commitment or choose to quit their job. As we will see in the quotes.

For Paola, an employee, it meant undergoing a conflict that made her feel bad but to which it was necessary to return with greater awareness: "To set a beginning, one could say that it was the conflict with a person, in the area of employment relationships. After so many years, it seems even trivial, perhaps I was simply not ready to face conflicts. Since that time, I have disintegrated as a person". Conversely, the loss of his job caused Antonio to retire, which he then resumed with a job grant: "When I had psychic problems I was depressed for this reason: I was used to having a pay, holidays, going around with friends and all of a sudden I missed everything. With the education I have always received based on work, losing a steady job is like a Japanese doing hara-kiri".

In the recovery process, however, work represents an important step, sometimes full of meaning. It is a continuity with respect to one's own existential path, or it means being able "to be there" in social relationships, feeling as a whole person.

Pietro underlines the fact that a part-time job, as a part-time employee, allowed him a gradual return to life: "It was fundamental to have found a solution at work. The hypothesis of adopting a part-time schedule that would have prevented me from excessive fatigue, while changing the place of work. I still cannot say that I feel healed, because it is not possible to get out of the malaise

overnight. I prefer to talk about an improvement that has allowed me to return to being a man. "

The transition from unemployment to commitment to work and relationships was a fundamental recovery factor for Marco, part-time cook: “I have been working for about three consecutive years and above all to move from a situation of total lack of work to a situation of continuous work commitment, that is a big difference. It is a good help for improving mental and physical health. Because inaction, physical and mental non-effort to react to real situations of suffering can be overcome in more than one way: with the help of doctors or caregivers or even alone. But alone you need to have a commitment to reality and reality is work and social life ... "

Overcoming a condition of disability with the desire to be independent is emphasized by Carol, employed in an advocacy agency: “Finding a job is not so much a step in personal development as a way to build life as you want. I don't want to remain a civil invalid for the rest of my life, but to be able to say that I have returned to work and that I have made my life”.

4.3. Support from the service

The role of mental health service has been important for many and in many ways. The support received by the individual is considered as important as it has promoted framework, context and tools for social inclusion.

These are tools that allow a person to experience and get stronger and then start over again, such as a job training grant, an economic subsidy aimed at training and experiencing, mediation with the employer to find new solutions for returning to work, or support for finding and retaining a job.

Experiencing simple commitments was for Matteo, then a member of a social cooperative, a first help from the mental health center and which allowed to build an alliance: "Immediately after the month of stay at the Community Mental Health Centre, they made me work as a switchboard operator and this served to play down the 'wall against wall' that had been created, because at the beginning the situation was 'psychiatry against the patient' […]. I answered the phone, I went to look for the nurse, the psychiatrist, the psychologist, running around the center. So, in the first few months it was more of a 'move'. Doing something that might have seemed easy, but it wasn't. "

Moving from a focus only to his illness to self-confidence and trust in the possibility of working was for Marco the result of the therapeutic path: "You start living when you begin to pay attention not only to illness or health but to something else, from work and other interests as well. I lived through a period in which, due to the mental crisis, I had few reactions to reality, to life. I needed encouragement, from other people to understand my depression, my malaise. I avoided facing the problem day by day, expecting to feel more confidence in myself, because if you have particular fears or deep anxieties, you lose confidence and self-esteem and you need the help of others too much. I waited to feel good, to improve, and then slowly the moment came when I pushed myself, alone, in one direction: to start working ".

Through the support received, it is possible to regain confidence in the future according to Giuseppe: "Everyone helped me a little, I don't think there was a person who completely washed his hands ... now, among other things, I will be hired in cooperative and, also thanks to a better salary, I will be able to look even more confidently into my future, also improve my living conditions, the tenor of my social relations ".

Chiara underlines the moment in which she regained control of her life through work, finally managing to be more autonomous: “The operators helped me to find a job and also to keep it. I then walked alone with my legs. "

5 CONCLUSIONS

Occupation, work and education are among the most important tools for recovery and emancipation. Work is seen as need, as right, and as self-realization. Job placement is definitely part of care, and of recovery, while it responds to needs, and beyond that it can lead to social inclusion, impacting on the social determinants of mental health. The income generated by work improves the overall quality of the person’s life. Beyond improving the material conditions of life and providing a new social role, it can ensure a real change in the life of a person with mental health problems, overcoming the passive condition of being a patient.

A large number of questions are raised by the convergence of these different viewpoints about work and mental health, whereas It was recognized there is an extraordinary contradiction in social enterprise between ‘productivity’

and ‘vulnerabilities’ or ‘disabilities. They operate within a system of exchange, based on the acceptance of the labor market with all its regulations, but they also propose a less alienated work condition (e.g., small dimension, choice, creativity, social habitat).

Theories and international statements summarized here - as those provided by the UN and its bodies, such as WHO - especially in scenarios of global economic crisis, are encouraging but too generic and require practical steps and opportunities for their implementation.

Place-and-train schemes are supported by evidence, but they require a social economy too, in order to provide opportunities and also change and successfully adapt work conditions. Studies on a specific approach, such as IPS, in the simplicity and clarity of its principles and constituent elements, manage to be attractive because it measures how much these tools can improve the holding on the job and influence clinical outcomes or at least process targets and indicators (e.g., hospital admissions). It is much more difficult to grasp the emancipative, transformative, rehabilitative, relational and social elements that can be determined in a social enterprise project, as the one provided by social cooperatives. They work within the economic local context and are promoted by (and collaborate actively with) the public mental health service. Aspects of co-planning, sharing, co-management, of economic impact constitute new elements that mobilize and animate the framework of social initiatives in these areas. These and other partnerships with the statutory sector, public bodies and institutions, within the framework of a new “welfare community”, are the means for the no-profit sector to be really effective for its aims. The Italian case shows an interesting combination of policies and practices that widens the definition of social enterprise.

It can offer alternatives to traditional jobs, often inadequate in work conditions, which is as much the cause of failure as the inability of users to meet the demands of the open labor market. Its collective nature, with the sense of belonging to a common project, can offer a sense of ownership and identity for people with mental health issues, while promoting citizenship and human and social development. Last but not least, social enterprise can challenge stigma by beating the prejudice of unproductivity for people with psychosocial disabilities. It is particularly true when users become entrepreneurs, members of social

cooperatives, and then protagonists of social inclusion. Coproduction between formal and informal services, a growing participation, cooperation and involvement can ensure the empowerment of people with mental health issues and of all other stakeholders in this field.

Qualitative research based on the perspective of people involved in job placement are needed to verify the theoretical premises and the value base. The limitation of our research data is due to the small size of the sample and the indirect investigation about work, whereas its role has been raised by the interviewees. Nonetheless, we point out the enrichment of theoretical viewpoints that is offered by those first-hand accounts.

According to cross-cultural researches we conducted, work proved to be one – or even the most - important way-out from the psychiatric “circuit” and to strengthen social roles and personal identities. Anyway, occupation is not linked to a progression, as a mere goal; better to see it as an instrument, a chance during the pathway of recovery and emancipation. Vocational training opportunities are needed in a discovery of self, as means for self-exploration.

Work is a meaningful activity that combats isolation, loneliness, and empty time: being able to socialize and make new friends through one’s job, being able to make mistakes and try different things without failing or being rejected, having successful employment experiences reflect a person’s progress or improvement and the development of a positive social role that relates to feeling valued or needed by others. While work was also acknowledged to be stressful at times, people with mental health issues learn how to modulate and manage these kinds of stresses to be an essential component to getting their lives back.

These research data offer a more nuanced approach to the issue and value of vocational training and work, while it confirms the relevant role of the social innovation practices to provide co-produced work opportunities as arenas for lived experience.

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