



Greece 2005

# Pathways to social integration for people with mental health problems: the establishment of social co-operatives



Minutes

Peer Review Meeting  
Athens, Greece  
6-7 October 2005

on behalf of





## 1. Welcome and opening

### **Anthi Kritikou, ESF Actions Co-ordination and Monitoring Authority, General Secretariat for the Management of Community Funds, Ministry of Employment and Social Protection**

Ms Kritikou welcomed participants, and introduced herself. She monitors all actions for the social integration of disadvantaged groups, and is a member of the committee of the EU's Programme to Combat Social Exclusion.

### **Professor Spyros Vliamos, Secretary General for the Management of Community Funds, Ministry of Employment and Social Protection**

Professor Vliamos welcomed participants to this experts' meeting, organised by the European Commission to exchange information on the social integration of socially vulnerable groups, and to evaluate best practices and their transposition to other countries. The peer review programme is overseen by the committee of the EU's Programme to Combat Social Exclusion, on which the Ministry of Employment and Social Protection is Greece's representative.

The meeting today is going to evaluate the effectiveness of the actions implemented so far to promote limited liability social co-operatives (KoiSPEs). KoiSPEs aim to integrate mental patients socially, economically and professionally as a means to contribute to their treatment and economic independence. The discussions are based on four main objectives, adopted by Europe's leaders in Lisbon and Nice in 2000:

- facilitating employment and access to resources, rights, goods and services
- preventing the risk of exclusion
- helping the most vulnerable
- mobilising all relevant actors

### **Dimitris Kontos, Secretary General for Employment, Ministry of Employment and Social Protection**

The European Council in December 2000 acknowledged that promoting social cohesion requires a multi-faceted approach, that relies on tools such as social dialogue, the European Social Fund and social justice. Social cohesion is within the competence of EU Member States, and progress is made not so much



through harmonisation as through co-operation. Member States co-operate through the Open Method of Co-ordination (OMC). The main elements of this are the definition of common objectives, the formulation of National Action Plans, the setting up of networks and the development of best practices. This is all the more important today, when social policy is at the top of the European agenda and the European social model, social inclusion and social protection are much debated:

- the UK presidency has included it as a topic on the agenda of the meeting of the ministers of employment and social affairs;
- social policy is going to be the subject of a communication by the Commission at the end of this year.

The OMC needs to be strengthened to face new challenges and facilitate an exchange of best practice and knowledge in all fields of social protection, inclusion, health and retirement. The national social plan adopted in December 2001 supports the OMC with a view to encouraging co-operation among Member States in the fight against social exclusion. To date the Community programme has financed a number of action such as the peer review programme, a set of transnational projects, networking and meetings. It is important for these actions to be enlarged to involve even more partners and agencies. The mutual learning programme is particularly important as it disseminates good practices, focuses member states' attention on achieving our common goals and strengthens social dialogue.

As regards social cohesion and the fight against poverty, Greece is unfortunately in a dismal position. We have 20% of our population in this category, as against the European average of 16%. Our spending on this objective is at the EU average level, although its impact is not quite as strong. In preparing its National Action Plan for 2005-2006, the government has revised its policies for the fight against poverty and social exclusion, basing them on social dialogue, employment and development. We have four horizontal priorities:

- a new development policy
- national co-ordination of social policy
- strengthening the family
- support of all other vulnerable persons that are not in a family unit

We want to promote these four priorities, and ensure that all measures that are implemented help reduce poverty.



In the 2005-2006 period, we decided to strengthen the 'third sector' of the economy, which is definitely the answer to a number of problems related to poverty and social exclusion. We know that we have a weak tradition in this field. However the last few years have seen the development of social enterprises and the limited liability social co-operatives that are the main topic on today's agenda.

Maintaining and modernising the European social model is a challenge that will be met only by supporting development, employment and social cohesion. This in turn requires action to create new and better jobs and to develop human resources. The fight against poverty also relies on retirement and social security schemes, and viable high quality health services.

**Spyros Vliamos:** The Secretariat General for the Management of Community Funds focuses very attentively on issues related to the social economy. A few days ago we held a round table in which agencies and experts took part. We hope to have the minutes of the meeting available very soon which will be at the disposal of anyone interested.

KoiSPEs fall under the responsibility of the Ministry of Health and Social Solidarity, and are cofinanced by the European Social Fund, which is managed by the General Secretariat for the Management of Community Funds. This evaluation meeting is held with the co-operation of both ministries. I would now like to introduce Mrs Fotini Dalaveri from the Ministry of Health and Social Solidarity, who will present a brief welcoming address on behalf of my colleague the Secretary General of the Ministry.

**Fotini Dalaveri, Head of the Management Authority of the Operational Programme "Health and Welfare 2000-2006", Ministry of Health and Social Solidarity**

It is a pleasure and an honour for me to be here today at this important meeting. I would like to bring you the support of the Secretary General of the Ministry of Health and Social Solidarity, **Meletis Tzaferis**.

The Secretary General and the Ministry welcome this meeting and look forward to the conclusions you draw. The Ministry of Health is keen to promote all aspects of mental health reform from the policy as well as the practical point of view. For a number of years now we have progressively implemented



actions to make the transition from a closed to an open model. This change will lead to the inclusion of mentally ill people into society as a whole. More recently the Ministry's actions have become quite visible and in the very near future we believe we will achieve the goals set out in the *Psychargos Action Plan*. Psychiatric wards are closing progressively, thanks to the support we receive from the European Social Fund and its representatives, including Mr Smyrniotis.

We support the patients who leave hospital, and the task of ensuring that they are included in society is made easier thanks to the social co-operatives (KoiSPEs) that are going to be discussed today. The legal framework facilitating the practice of training patients under real working conditions was established in 1999 as part of the modernisation of the mental health services. This legal framework provides the prerequisites for the setting up and operation of KoiSPEs. They are going to be created in each geographic sector of the country, and this shows how seriously we take the objective of social inclusion. The development of KoiSPEs provides for ongoing therapy in parallel with training. Moreover the possibility to steadily develop the co-operatives' activities by admitting new members, and the emphasis on economic viability, means that these organisations will be stable and strong. KoiSPEs offer real working conditions and facilitate the inclusion of mental patients.

Measure 2.3 of the Operational Programme for Health and Welfare contains, among other things, actions to support the social inclusion of mentally ill persons. In particular, it provides 75% ESF cofinancing for the creation of a number of KoiSPEs and sheltered workshops. The Ministry is also very glad of the work carried out within the EQUAL initiative, and considers its work absolutely crucial. The Ministry is represented here through Mrs Mavratziotou, Director of the Mental Health Department, as well as by several members of the Monitoring and Support Unit of the *Psychargos Phase B' Programme*. I wish you all success.

**Hugues Feltesse, European Commission, Directorate General for Employment, Social Affairs and Equal Opportunities, Unit E/2**

First let me express my deep appreciation to the Greek authorities for making this contribution to the social inclusion peer review programme, on the topic of pathways to social integration for people with mental health problems. This is the first time that the peer review programme has dealt with this very important



issue. Why should this be? The Mental Health Declaration for Europe, signed by the EU Member States and the World Health Organisation in January 2005, recognised the damaging link between mental health problems and social marginalisation, unemployment, homelessness, and alcohol and other substance use disorders. It stressed the need to collectively tackle stigma, discrimination and inequality, to empower and support people with mental health problems and their families, and to develop community-based services to replace care in large institutions for those with severe mental health problems.

Increasing the integration of groups with a high risk of being a victim of social exclusion – such as people with mental health problems – is among the seven priorities of the European social inclusion process, as emphasised by the last joint report on social protection and social inclusion adopted by the European Council in March 2005. As the discussion paper stresses, the last generation of NAPs/inclusion and the implementation reports received during this summer highlight that people who used to live in care institutions such as psychiatric hospitals have a high risk of social exclusion, because of the lack of alternative community-based services for rehabilitation and support, as well as difficulties in overcoming stigmatisation and fear from other people.

Many of them end up constituting a significant part of the homeless population. I am convinced that this review on social integration for people with mental health problems, focusing especially on the establishment of social co-operatives, will be very useful to other Member States who are trying to improve their systems of mental care and to support the social integration and employment of people with mental health problems.

### **The peer review programme**

As you know, the EU is based on fundamental rights and freedoms, and the rule of non-discrimination. It is a Union where all citizens have the right to be treated equally, and which strives to combine economic competitiveness and prosperity with social justice and the promotion of an inclusive society.

For those new to the peer review exercise, let me recall its three main objectives:

- Our first goal is **mutual learning**. This means that the representatives of peer countries expect to learn with their Greek partners about how they have fared with their ambitious objective of achieving social integration for



people with mental health problems. They expect nothing less than a frank and objective account not only of what works well but of what does not work as intended – or even does not work at all. However our hosts can also learn from the critical remarks of peers, as well as from experiences that have been carried out elsewhere.

But while it is important, the objective of reaching a better understanding of Member States policies in poverty and social inclusion, in this case the establishment of social co-operatives as a means of social integration for people with mental health problems, is not sufficient.

- A second objective of the peer review is to **improve the effectiveness of policies and strategies** in this area. This is indeed a vital challenge. It is no secret that social inclusion policies still face scepticism – if not open criticism – in many circles, which tend to see economic and employment goals not only as a condition but as the only way to reduce poverty and exclusion.
- The third and most ambitious goal of the peer review programme is to facilitate the **transfer** of key components of policies, institutional arrangements, approaches, methods and organisational frameworks that have proved effective in combating poverty and social inclusion.

Each participant in today's seminar, and in particular those closer to policy-making at national level, therefore bears a special responsibility. Their privileged access to information makes them the key actors in enabling the effective transfer of policy.

But the transfer of policy can also be supported through the wide dissemination of the results of this seminar. This is done through the short report presented in the newsletter, online access to the comment and discussion papers and minutes on the programme's website and the wide dissemination of the synthesis report – a wealth of freely available information.

Let me remind you that the object of the peer review programme is not competition; we are not interested in ranking the policies – it is not a 'hit parade' exercise. What we want to do is examine how policies that have succeeded in certain conditions can be replicated elsewhere – if appropriate care is taken in adapting them to different cultural, institutional and economic contexts. Therefore even if 'success' is a word to be used sparingly, the peer review programme is looking for success stories – or at least inspiring stories. Mutual learning and the exchange of good practice are *raison d'être* of the open method of co-ordination.



The OMC in social inclusion has reached full maturity: all the mechanisms supporting the OMC are now fully operational. As the Secretary General mentioned, the peer review seminars are not the only instrument of mutual learning and action under the OMC. Two other instruments are already in operation:

- The transnational action programme supports the exchange of good practice in a given thematic area among partners from at least three different Member States sharing similar interests or policy backgrounds. Thirty-one projects supported under this programme in 2004-05 are now in their concluding stages. They have mobilised more than 150 local authorities, research centres, NGOs and service providers, and more than 1,000 organisations were involved in submitting proposals. At the beginning of next year 25 new transnational projects – including one concerning the social inclusion of people with mental health problems – will start. The goal of the programme is to promote networking, the dissemination of information, the exchange of good practice and the mobilisation of actors on a wide basis.
- After the presentation of the National Action Plans for Social Inclusion and implementation reports we will work with the Member States, through the Social Protection Committee, to obtain information on the challenges and strategic actions of each Member State and assess how each country has managed to translate the EU common objectives into national policies.

Let me conclude by saying that I and my colleagues in the Commission, as well as the consultants and members of the programme committee present, will follow this seminar attentively, not just because we want to learn more about the pathways to social integration for people with mental health problems, but also because we try with each seminar to improve the work process within the open method of co-ordination. For this purpose we count on your evaluation of this seminar, and I invite you to complete the form provided at the end of the meeting.

We also count on your feedback from an evaluation survey we will carry out towards the end of this year to find out what the real results of this process are in your countries and at EU level.

**Spyros Vliamos:** Before leaving, I wish you a very fruitful and constructive dialogue during the next two days. Already from the first interventions we see that Europe's social image is at stake here. Though there are those who doubt it, I believe that Europe has a social policy, and that it is only by strengthening it that we will build the European social model we all aspire to.

**Anthi Kritikou** took the chair.



## **2. Introduction to the Greek social co-operative programme for people with mental health problems**

### *2.1 The policy background*

#### **Calliope Mavratziotou, Director of Mental Health, Ministry of Health and Social Solidarity**

Social co-operatives for people with mental health problems – KoiSPEs – have been developed within the framework of policy for the social inclusion and integration of mentally ill persons. I will not touch on operational aspects, but simply present the general environment within which we work and plan our mental health services. Within this framework social co-operatives obviously hold a very important position.

Like the Roman god Janus, social co-operatives have two faces: one is turned towards providing a mental health service, and the other towards economic activities. This challenge is what makes them so interesting. As you know, over the last 20 years our country has made a huge effort in mental health reform, in particular to support people with mental problems to become active citizens living in their families and working. This might seem to be a very easy objective, which amounts to leaving people in their existing situation, but anyone who has faced such problems knows that the contrary is true. In the past, these people were taken out of their family and social surroundings and were confined in institutions, usually situated far from their homes. It has proved to be very difficult to reverse this situation, at least in Greece. In any event we need specific tools and very careful interventions if we are to achieve a positive result. One of the tools needed is the laws, national and international – the statutory environment within which we define and design our actions and goals. We try to work on the basis of a 10-year horizon, a 6-year plan, and a 2-year monitoring cycle.

#### **Legal framework of mental health reform**

The national statutory framework is generally thought to be quite adequate and to adequately protect the rights of patients. Article 21 of law 1397 of 1983 establishing the national health system provides for beds for mental health patients to be made available in general hospitals, and for community services to be provided through the Mental Health Centre.



In 1992 another Act (Act 2071) set out a framework for these services and specified the terms and conditions for the involuntary treatment of people with severe mental health problems. These provisions are still in force, although in 1999 an integrated act (Act 2716) provided for the development and modernisation of mental health services. With this act the Greek state tried to introduce the comprehensive management of mental health reform. This act – which has been our tool till now and hopefully will still be one in the future – empowers the minister to issue regulations organising our services. It lays down conditions for the organisation and operation of mental health units and other units through which mental health services are provided. Greece is also a signatory to international conventions protecting the rights of mental health patients and maintains close relations with the WHO in this field.

### **Principles**

The institutional environment I described provides for some general principles that must be met when we design and implement mental health services. These principles are specified in the first two articles of Act 2716; the principle of sectoral organisation, the need for continuity in the care of these people, priority to primary care and outpatient care, deinstitutionalisation, psychosocial integration and rehabilitation, the protection of patient rights and finally information and voluntary community assistance for promoting mental health.

Perhaps I should explain a couple of these principles: *sectoral organisation* means we divide the country into approximately 56 catchment areas (mental health sectors). Within these 'sectors' we set up a network of services that guarantees *continuity of care*. We start by opening a few beds in the general hospitals and setting up mental health centres and centres for psychosocial rehabilitation. Later we gradually implement a more complete range of units, such as mobile units that will provide homecare. This is in accordance with the general rules of the WHO.

### **Types of mental health unit**

According to Act 2716, mental health services may be provided by:

- special psychiatric hospitals
- psychiatric wards within general hospitals
- mental health centres that normally cover primary care and sometimes cover secondary care



- pedagogic and medical centres that serve adolescents and children
- specialised care centres including day hospitals, day centres and crisis intervention centres (patients in the day hospitals and day centres attend during the day and go home at night)
- home care
- mobile mental health units, which are a good way of meeting the needs of people living in inaccessible mountain areas and islands
- psychosocial rehabilitation units, including homes, hostels and protected apartments that cover the temporary or even lifelong existence of people who need to live in a protected environment. These include productive workshops which are the precursors of social co-ops
- finally the culmination of mental health services is the limited liability social co-operatives – KoiSPEs.

### **The *Psychargos Action Plan***

To co-ordinate action over the entire country, the Ministry of Health and Social Solidarity has adopted the 10-year *Psychargos Action Plan*, through which we try to develop the majority of the services laid down in Act 2716.

The prevention and promotion of mental health is the role of mental health centres and pedagogic and medical centres. There are also services for specific population groups such as autistic people, senile people and Alzheimer patients, as well as complex services, for instance short-term care while a family is in a period of crisis unconnected to the patient.

The action plan explicitly includes the abolition of five of the country's nine outdated psychiatric hospitals, as the alternative facilities progressively come on line. We have already closed one hospital, and the second will close next year. The other four hospitals, the larger ones, will be downsized. When the hospitals are abolished, the staff and their experience is not lost, but redeployed within the community health services. They monitor patients who move to hostels, boarding houses etc., they contribute to the social co-operatives, and so on as the need arises.

The action plan also provides for the initial and lifelong training of mental health professionals. There is also a quality control function, and we are in the process of elaborating the necessary criteria.



## *2.2 The institutional framework*

**Dimitris Ziomas, national expert, Researcher, National Centre for Social Research**

### **Why social co-operatives?**

The *Psychargos* action programme is an integrated process of psychiatric reform which supports mentally ill people to get back into society, and its actions must reinforce one another. We need to close down some of our large mental hospitals, and reduce the size of the others, but in order to do this, we need to provide proper community services to those people already living in the hospitals, as well as to potential patients. Therefore proper accommodation and treatment services need to be available in the community, outside the mental hospitals.

Moreover, in order to live an independent life, people need to be active, which nowadays means having some kind of employment. We are therefore dealing with a dynamic situation, not a static one in which you take some people out of their misery, provide them with better conditions and leave them there. We are talking about making them not objects but subjects and protagonists in their own lives. So we consider that we need to reinforce the processes of social inclusion that give them the right of citizenship, and surely participating in employment is a crucial element in their acquisition of citizenship. So our emphasis has been to provide alternative forms of economic activity, so that mentally ill people can join the workforce, albeit within a protective environment, at first or for a longer period of time.

Some people support the view that economic growth can only be achieved at the cost of social exclusion, because we are living today in a paradox where the economy is growing but social exclusion keeps on rising. Indeed evidence suggests that the number of people on the margin of our societies is increasing. Yet, on the other hand, there are others who say no, you can find forms such as social co-operatives and other social enterprises, which show that entrepreneurial activities can be compatible with social aims. That is the case with the social co-operatives for mentally ill persons (KoiSPEs).

I want to emphasise that our work with social co-operatives is not carried out in isolation from the other actions to support mentally ill people. It is part of a



package of measures, an integrated action plan for improving the status of these citizens, who are under-represented in society, certainly in comparison with physically disabled people. Social services that are provided for other population groups should also take account of people with mental health problems – we don't want to have segregated and fragmented services for these people.

### **Legal structure of KoiSPEs**

As regards the legal basis, its unique feature is that it is both a firm and at the same time a mental health unit. The challenge is to manage both these objectives in balance and not promote one at the cost of the other. There is a working hypothesis according to which social enterprises combine economic and social elements, and I think that KoiSPEs meet the nine criteria for a social enterprise.<sup>1</sup> Why an enterprise? Because they are managed on a business basis. Why social? Because they operate in the field of social policies and aim to achieve results of a social nature, not to maximise profit.

The social co-operative is an organisation which allows the reciprocal enrichment of the principles of entrepreneurship – organisational efficiency, innovation, efficient use of resources – with those of social intervention, such as helping the needy, sharing, promoting participation and mutual aid and creating social links.

Briefly, the KoiSPE status has the following characteristics:

- it can carry on any economic activity
- each member holds one voting share (some may hold additional investment shares)
- the board of seven contains two mentally ill people

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<sup>1</sup> The nine criteria for social enterprises posited by the EMES research network (see [www.emes.net](http://www.emes.net)) are:  
Four economic criteria:

1. continuous activity in producing and/or selling goods and services
2. a high level of autonomy
3. a significant economic risk
4. a minimum number of paid workers

Five social criteria:

5. an explicit aim of community benefit
6. citizen initiative
7. decision making not based on capital ownership
8. participatory character, involving those affected by the activity
9. limited distribution of profit



- at least 35% of members must be mentally ill people (along with up to 45% mental health professionals and up to 20% other members)
- employees may be paid a salary without losing their welfare benefit

You may ask why not use the legal framework that already exists, in Greece and in other countries, that of the association? The answer is that:

- social co-operatives (and social enterprises), because they are businesses, can accomplish something associations cannot, that is they can have a real managerial democracy;
- they have greater administrative transparency since they must fulfil all the civil and fiscal obligations of firms;
- there is the continuous management of productive activities, and in particular work to integrate disadvantaged people. Most associations do not have such a continuous activity – they tend to limit themselves to tasks given them by public authorities;
- social enterprises and social co-operatives are supposed to have a high degree of innovation in products and processes, because they have to compete.

So these are the main differences that make social co-operatives more conducive to the aim of providing mentally ill patients with the conditions for getting back into life.

### **Key elements**

Two key elements are partnership and democracy. KoiSPEs aim to involve mentally ill persons in all stages of planning and management (whether this aim will succeed is a challenge that lies ahead of us). This is important insofar as it determines power relationships and the type and degree of participation. (Incidentally years ago there was no thought that a mentally ill person could participate, could really get involved in power relationships.) They aim at some degree of economic equality, and aim that mentally ill people should share in decision-making power as well as in the economic benefits of the enterprise. This may sound very ambitious but we have to see it that way. They provide an income for people that would not otherwise be able to earn anything, and they promote social relationships, not only between the members of the social co-operative, but between the members and the rest of local society. In other words the rationale behind the KoiSPE is to provide a way for mentally ill people to satisfy their basic needs but also the needs for protection, affec-



tion, understanding, participation, identity, creativity, learning and freedom. If we succeed in doing that then we could not ask for more.

There are other important elements such as the vocational training that is provided by working in the social co-operative. Vocational training is an important element and an instrument which can curb and reverse the trend towards exclusion from the labour market. And of course employment creation is the overriding objective of social co-operatives, not only for mentally ill people but for other socially vulnerable groups.

In Greece, social co-operatives for mentally ill people are the only institutionalised form of social enterprise. There are agricultural co-operatives that cannot undertake other activities, and there are the so-called urban or civil co-operatives that can undertake only certain activities. We expect this new institution of the KoiSPE to be the forerunner of other new forms of the social enterprise type to be established in Greece, which will trigger modifications of the existing legal framework so as to cover other socially vulnerable groups. Social co-operatives exist in an environment where the social economy sector is still underdeveloped in Greece. So, to some extent, it may be said that the KoiSPE is paving the way for the development of the social economy sector, which is long-awaited in Greece.

### **Success factors and problems**

The first success factor for social co-operatives is that they need a local context conducive to their establishment and growth. The island of Leros has a favourable environment because its specific conditions and the existing mental hospital meant it needed to find alternative forms of economic development, whereas big cities like Athens or Thessaloniki do not have such a favourable local environment.

Another factor that determines its success is a good organisational structure, in which economic and financial management skills are coupled with participation and collective responsibility.

Thirdly, we need a favourable administrative and legal context. The law recognises and to a certain extent facilitates the establishment of social co-operatives. Nevertheless, there are a number of administrative arrangements stemming from other ministries that have to be harmonised with the legal basis of the social co-operative.



Lastly, exchange and support networks, both within Greece and all over Europe, are crucial and will determine the future success of social co-operatives.

As regards the problems, I would just mention two. The first is the risk of isolation, both from other social co-operatives and from local society, and social co-operatives in Greece are facing this problem right now. Secondly, there is the problem of obtaining credit: commercial firms can obtain loans and even subsidies, whereas social co-operatives have an ambiguous status: they are therapeutic units – and how can a therapeutic unit get a loan for business? – yet at the same time they are businesses. So this is an issue that has to be resolved very soon.

### *2.3 Implementation and first results*

**Anthi Kritikou:** Leros is a small and beautiful island in the Dodecanese, in the Aegean Sea between Samos and Kos. It was very well known for being the location of one of the largest psychiatric hospitals in the country. The local economy was very closely linked to the presence of this hospital, so the local inhabitants did not view the hospital's closure in a very favourable light. I initially had the idea of holding today's meeting on Leros, however transport links are too infrequent.

#### **Christos Goutidis – Chairman of the board of directors of the Leros KoiSPE**

The Leros KoiSPE was created three years ago, after a decade of preparation. Next month the board of directors will complete its first three-year mandate and there will be elections.

First, some statistics. We have 457 members, and of these 194 (42%) are mentally ill persons and 159 (35%) are 'mental health professionals', which is important because of the role the co-operative plays in the island's economy. There are also 104 (22%) other members – both individuals and organisations – from Leros and other islands in the Dodecanese. Leros is 300 kilometres from Piraeus, so membership is very centred on the Dodecanese. We have a healthy bank balance, and employ 30 people from the mentally ill category and 20 from the professional category (18 full-time and 2 part-time).



## Activities

The social co-operative has developed a number of activities: a pastry shop, agricultural products and cultivation, including approximately 100 stremata (10 hectares) under glass, and other land which is rented. We have launched a new activity of producing, processing, packing and distribution of honey. We signed an agreement with the Ministry of Agriculture which enabled us to invest €50,000 in state-of-the-art equipment. We have obtained quality certification and a certificate of origin, and registered the 'Artemis' trademark. Of the 54 investments linked to the LEADER programme in the Dodecanese, the Ministry of Agriculture judged us to be the best, and so we can expand nationwide.

We are also currently doing feasibility studies for a development project in partnership with the municipality of Leros. We will start with a unit for raising partridges and then continue differentiating our activities in fields such as biological waste disposal. We also expect to be able to provide mental health support services within the municipality.

The KoiSPE has made a number of partnerships with local farmers so as to increase production in several sectors, including honey. This is an example of the KoiSPE's parallel role in supporting local economic and social development. Such collaboration helps local people to understand how the psychiatric hospital works. The island has 8,000 inhabitants and suffers from a general economic crisis. It was a 'monoculture' – everyone depended on the hospital: not only the people who worked directly in the hospital, but also those in supply and support jobs. We therefore felt it was important to help the local population to understand what the KoiSPE was doing.

## Results

The scaling down of the hospital created a major shock wave on the island. It had opened in 1957, so for nearly half a century the local people tied their future to it, and did not strive to create alternative livelihoods. The hospital was a huge employer that absorbed a large part of the local workforce, including many unskilled personnel, people who were farmers or fishermen rather than health professionals. The scaling down therefore caused enormous stress which had a knock-on effect on employees' families. We have therefore to be sympathetic when we judge the islanders' reaction: they are not actually reacting to the closure of the hospital. We should not forget that 26 outpatient



units have been created on the island – the highest ratio of units to residents in Greece. This was not the problem – the main objection of the Leros inhabitants had to do with the forcible removal of a number of patients to other parts of Greece in the early 1990s.

The Leros Social Co-operative has achieved some very positive social and economic results. Our work for our patients has led to the creation of new jobs which benefit the entire community. At the same time this promotes the social cohesion that the island so needs. I do not believe we can measure all the benefits in pure market terms, and it is not only market results that matter. Nevertheless we have a €300,000 turnover, resulting in a net profit over three years close to €110,000. This shows clearly the business viability of this endeavour, which helps us to achieve social cohesion and integration. This is a tool we should use in the best possible way.

### **Problems**

One of our most intractable problems is the lack of personnel: though there are provisions in the relevant law, in the last few months our personnel has been decreasing rather than increasing. We have 30 working patients and 20 non-patient workers, and it is difficult to maintain the balance between the patients and the health professionals.

A second problem, which one may expect with any kind of innovation, was that local residents were suspicious of the KoiSPE because they were ignorant of it. Fortunately, we were able to reassure them and make them understand that the future could not be seen in terms of the hospital's existence, and now this is not so much of a problem. However it is more of a problem when we see that disbelief and lack of acceptance comes from the ministry officials, because they are the ones that decide policies.

Another problem is the island's geographical position, which hinders networking and product distribution. Rhodes, the capital of the prefecture of the Dodecanese, is 10 hours away. The costs of this isolation wipe out our 20% profit margin.

In this first three-year period, during which the KoiSPE has been launched and administratively structured, things have gone quite smoothly. Unfortunately the incoming board of directors will have to take a number of business decisions,



and this may prove difficult as boards of directors are often selected on the basis of criteria other than entrepreneurial skills.

Allow me to conclude by saying that laws often have some shortcomings. We have already highlighted some gaps and submitted our proposals to the Ministry. It is important for us to know where we stand and what is going to happen in the future: we need legal certainty if we are to be able to sign contracts with confidence. The government must tell us whether the philosophy of Act 2716 still stands and if it is going to continue being implemented and supported.

Finally, let me say that I should be very happy to host a future meeting in Leros.

## *2.4 Questions*

### **Cost**

**Pip Bevan, FEANTSA:** When the UK moved from having large mental hospitals to care in the community, some time ago now, it was thought that this would be a better way for people with mental illness to be treated near their families. The problem was that in a sense the old mental hospitals were more able to deliver mental health services at a certain cost. Community care is more expensive, and I am wondering whether Greece has put enough money behind this move, not just for the co-operatives themselves, but for the mental health services that will support them.

**Calliope Mavratziotou:** Our planning is based on the resources available, and we might have done more if we had had more resources – not only money but skills. It is difficult to find all the specialists necessary to operate a more extensive programme. We do what we can, given the money and human resources we have available. As far as cost-efficiency is concerned, running a big hospital may seem cheap, but taking the quality into account it is actually very expensive. The good quality of community care leads to better results and in this sense the results are cheaper. However, during the transition, there is a heavy financial burden.

**Dimitris Ziomas:** It is a matter of short-term and long-term benefits. In the short run you will probably find the community care system more complex and expensive. In the long run, taking into account the conditions for mental



health patients as well as for those working in the mental health services, and the cultural effects – you have a change in the culture and attitudes of society – I would say that community care services will be much less costly than hospitals.

The EU has cofinanced this mental health reform in Greece for years now, and this is very important. Nevertheless the Greek state has to ensure the viability of the system when the European Union's financial support comes to an end.

### **Professional roles**

**Jean Furtos, Observatoire National des Pratiques en Santé Mentale et Précarité, France:** What is the status and role of the mental health professionals in the co-operatives? What do they do exactly? Do they work alongside the patients, do they assist them at the same time, does their professional conduct change?

**Dimitris Hatzantonis, expert on social co-operatives:** The role of mental health professionals in the operation of KoiSPEs is to support patients in their productive activity, help them to participate in work and offer the relevant healthcare services, so that they progress towards integration. Their role is indispensable in avoiding unforeseen problems and ensuring that working mental patients are properly monitored.

**Nikos Gionakis, Psychargos Programme Monitoring and Support Unit:** On the subject of role of mental health professionals in KoiSPEs, I should like to look at their role in other mental health institutions that are taking over from hospitals. In the hospitals, most staff are guardians, whose role is simply to guard the patients. That is all they did because the only role of the hospital was the survival of the patients. Now when these people go out into the community, it is not only the patients who change status, but the workers too. They used to guard patients – but what do they do now? This issue is not peculiar to social co-operatives, but is a general situation for mental health professionals who have been accustomed to work in psychiatric hospitals. When these ideas first started to be discussed in Greece, their role was debated. There was a debate about whether the social co-operative would provide employment and therapy; would there be a mental health team that would offer support within the social co-operative, and if so, what would the role of the remaining mental health services be? Were we to adopt such a practice, wouldn't the



social co-operative become another closed system where everything would be contained within it? Might it not be preferable if the role of the mental health professionals – psychologists, psychiatrists etc. – was to ensure people had access to the mental health services they actually needed?

Let me add that many hospitals had workshops, had hired carpenters, technicians etc., and these worked as a type of trainers. These people can now become co-workers, alongside patients, in order to get the job done better in a purely technical sense, as foreman, so to say. We have also realised that we must also ensure production, so that if a person relapses, there must be someone who can fill in if no other patient can – and not the psychologist!

Staff working in unskilled jobs in psychiatric hospitals often had skills which were unused, but which in a social co-operative they are able to use. So they have to make the transition from the role of a guardian to the role of someone who uses a range of skills and competences to help mental patients.

This is still an open discussion, an unresolved issue. When a co-operative selects the model it wants to use – that is whether the mental health professionals will work inside the co-operative or outside it, I think that the choice of the model will greatly affect the image and operation of the co-operative.

**Christos Goutidis:** The trainers we have today are all competent in the particular field – all but one of them have over 15 years' experience. As to our patients, 80% of them work and have developed friendly relations with the trainers. These are the people who deal with the patients on a daily basis – we are talking about farmers who work in the fields, women who work in the pastry shop etc. The 20% of patients who are not able to work because they have become institutionalised are offered the relevant support. The professional in charge is in constant touch with other staff members, and knows what medication is given.

### **Workforce composition**

**Wolfgang Schlegel, peer review manager:** The social co-operatives are presented as having as their principal objective to generate opportunities for the labour market and social integration of mentally ill people. But I learnt from the Leros presentation that there is another objective on the 'hidden agenda' which is to generate employment opportunities for the people who would otherwise



lose their jobs, the so-called 'mental health professionals'. Does the composition of the workforce in the social co-operatives meet their business and therapeutic needs, or is it a compromise in order to avoid redundancies?

**Dimitris Hatzantonis:** I have been through the Leros experience, and I can say that in developing social co-operatives in Leros we have two clear goals:

- first to create occupational opportunities for patients – and this is a very difficult objective because in Leros most patients are living in the psychiatric hospital and therefore we have to work towards the transition from the hospital to the co-operative;
- secondly to offer job opportunities to the local population and see how hospital staff can find a job once the hospital shuts down.

Leros is a special case because the hospital is linked to the island economy and the social co-operative is taking over this role. We believe we will be able to create work opportunities in fields beyond mental health, and thus absorb those people who will no longer be able to find work at the hospital, such as administrative and secretarial staff. The labour market is very difficult because Leros is an island, so it is difficult to find alternative jobs. So we have a major imbalance in the labour market and we believe the social co-operative can bring about some solutions.

**Christos Goutidis:** For Leros, social acceptance is very important. We have a dual objective, but it is obvious that the social co-operative cannot solve the problem of unemployment on the island. We would like to promote a specific economic activity, we receive a lot of applications and we have to turn some people down, because it is hard work: in fact three people resigned because they could not stand the pace.

To clarify what Dimitris Hatzantonis said, except for one woman from Lakki, our patients come from inside the hospital. We have a substantial task before us as we have 570 patients with an average life expectancy of 75 years, and no community health services.

**Dimitris Hatzantonis:** The question is whether social co-operatives solve employment problems. Let me give a simple answer, by explaining what has happened with the economies of remote areas of Greece. Nobody invests in Leros any more – the last investment was about five years ago, when a small hotel was set up. The only activity comes from the social co-operative. It might be



limited today, but let's hope it will be bigger in the future. We have to face the reality on the island – private initiative has ceased to exist for a number of years now, and our hopes for the future are pinned on this social co-operative.

**Anthi Kritikou** closed the session and participants divided into two groups for the site visits. National delegations split so that one member of each delegation visited each site.

### 3. Peer country questions and comments

**Mugur Ciumageanu, Romanian Community Psychiatry Association:** It was interesting to visit a social co-operative and I am going home with new ideas, but several points are still not clear:

- What happens if a social co-operative goes bankrupt?
- Is there not a risk of the non-patient workers in the co-operative becoming stigmatised?
- What is the motivation of the people with mental health problems who have bought a share in the co-operative but do not have a job there? How can we, as mental health professionals, persuade mental patients, who as we know are poor, to pay for a share when they do not get a job?
- Employees might leave their jobs, either because they relapse, or because they think they have found another job. How long does the job stay open for them in case they change their mind and want to come back?

**Petros Gianoulatos, National School of Public Health, Greece:** On the first question, social co-operatives can file for bankruptcy like any other enterprise, and the members are protected by its limited liability status.

As for the professionals, the majority coming from public psychiatric hospitals are already stigmatised and cannot be further stigmatised by working in a social enterprise. The transfer from a hospital to a social co-operative is one of destigmatisation.

Thirdly, the initial rationale of a social co-operative, at least in the eyes of the legislator, is that first and foremost it has a function of solidarity, and as such solidarity amongst users or patients is of the highest priority. Participating as a shareholder is already a very important step in the direction of self-destigmatisation. If a patient does not have the funds to buy a share, what usually



happens is that everyone chips in to cover the cost of this person's share. The idea is that the co-op should serve the needs of all people who need assistance. Obviously some people will work and others will not. The co-op is also a way to build a bridge between generations, and we have some members who are past retirement age: they join out of social solidarity. What we have not yet managed to overcome as yet is to give the position of the chairman of the board to a mental health patient.

On the fourth question, seen from the public sector point of view, the jobs offered to mental health patients are jobs given to people who have trained and prepared for this position, and not jobs that could be given to anyone. The whole concept is that the patient is prepared and the job is adapted to the patient's abilities. The same holds true of professionals. KoiSPEs can be set up by public agencies or by NGOs. To strengthen them, public sector employees can work in a KoiSPE even though their salary is paid by a hospital or other state mental health organisation. Consequently if a patient is absent from work because of a relapse, a professional can cover, so the job can be held open for the patient. NGOs are usually more flexible.

### **Accommodation**

**Jean Furtos:** A social co-operative cannot be a complete substitute for a psychiatric hospital, because such hospitals were mainly places to live long-term, so an alternative to them is long-term accommodation in the community. Is accommodation for the mentally ill being developed along with social co-operation, and if so how?

**Nikos Gionakis:** Social co-operatives do not see themselves as the alternative to psychiatric hospitals. What the alternative will be is a network of services comprising accommodation, occupation, leisure, training and education etc.

As psychiatric hospitals prepare for their abolition, we have seen the creation of 146 residential facilities for rehabilitation over the last three years. They offer different levels of protection. We have:

- boarding houses or long-term residential facilities, for people that need round-the-clock intensive care, usually people having a dual diagnosis – both psychiatric problems and disabilities – or elderly people;
- so-called 'foyers', transitional structures for younger people;
- apartments, which have support but no staff.



People making the transition from hospital to society are offered several options, in terms of both occupation and accommodation. Social co-operatives are not the only answer as regards occupation. We also provide sheltered workshops for people who cannot be productive but need to do something to occupy their time or to get ready for something else. The team that visited the technical support unit today visited such a workshop, a non-profit company selling its products and slowly working towards becoming a social co-operative. Mrs Mavratziotou also described other types of units such as day centres. The combination of these different types of unit, both existing and new, is slowly replacing the psychiatric hospitals.

**Jean Furtos:** You are right in theory but in practice it is extremely difficult to avoid major side effects in terms of accommodation, as we saw in Italy and France. We closed a large number of beds in psychiatric hospitals without providing sufficient alternative places, and found ourselves in great difficulty. We have learnt that even if we know what to do in theory, if we close a very big hospital there is a very big problem.

**Nikos Gionakis:** I think we have learnt a lot from the experience in Italy, France, the UK and elsewhere. We are trying to avoid creating homelessness, so we are moving gradually, not only for chronic patients but also young people. The planners of the Psychargos programme allowed for this. For example the next hospital that will close is the one in Hania in Crete. It currently houses only 15 chronic inpatients, the last people who remain to be moved out to external accommodation in a community residential facility. The only part of the hospital that is still operating is the acute or emergency wards, and this is because we do not yet have this facility in the four general hospitals in Crete. The psychiatric hospital will close down when these wards, as well as mental health centres and mobile units, are ready.

**Dimitris Ziomas:** Let me assure you that the number of beds provided outside the hospitals is three or four times the number of employment places. The main emphasis of the deinstitutionalisation process over the last decade has been on providing as many sheltered apartments and hostels as possible. This has been a continuous trend over the period and is forecast to continue. Unfortunately, less attention has been paid to providing job opportunities, so it is about time that something is done on this aspect of rehabilitation.

I remember that when some agricultural work was organised in Leros, I remarked what a good thing it was that the people, after so many years of isolation and



segregation, could work in the fields. But the psychiatrists there said that this was ineffective unless accommodation was also provided outside the hospital. Otherwise, the patients go to the fields and feel somehow free, and go back to a kind of prison, which takes them backwards. That is why at the start of the 90s the European Community provided financial support to rent apartments because it was recognised that it was crucial to provide proper accommodation outside the hospital if people are to find a socio-economic role again.

### **Selection for job places**

**Martin Jarolimek, Czech Association for Mental Health:** What would happen if the parents of a mental patient would like their child to be employed in a social co-operative, but the co-operative managers do not want to accept them because of their mental state?

**Pelagia Nikolaou, Panhellenic Union for Psychosocial Rehabilitation and Work Integration:** I cannot answer on behalf of all co-operatives, but as far as my co-operative is concerned, the idea of having a family bringing the user along in order to get him or her a job is not very good in terms of their autonomy. We would rather the user came to us after a period of preparation via a series of workshops to develop future work prospects and job promotion groups. When the time comes, the option of co-operative or not must remain a personal decision. If a user comes from the community at large and has not undergone all these phases of preparation, we will not ignore him or her, we will try to integrate the person through progressive steps leading to a level of maturity that will enable him or her to join the co-operative. We have therefore set up a series of steps that will lead a person to take a personal decision, with the support of the therapeutic team.

Now if a person is not fit for work, then Mr Gianoulatos's answer answers you. We have a second objective: to develop an environment of solidarity through which we assist a user to achieve integration. The whole process of becoming a member, taking decisions along with others, and participating within a structure that has a social care aspect but is also a business venture, is in our eyes already a major step toward social integration. We therefore see the user as someone who could be a member but might not be fit for work – yet.

As to the Ev Zin co-operative, we try to make sure that the largest number of our partners possible are also workers there. The 24 users of our co-operative



will eventually hold the 24 jobs that are going to be created within this three-year period. We ensure that this integration process is not detrimental to the process of production.

### **Psychiatric beds in general hospitals**

**Hubert Kaszynski, Institute of Sociology, Jagiellonian University, Kraków:** In Europe we are discussing the next phase of psychiatric reform. In the expert milieu, psychiatrists and other professionals have not yet solved the problem of job access for people with mental health problems. I think that here in Greece you have made a substantial advance in the treatment of people with serious mental health problems. I am really impressed, and it is noteworthy that the Ministry of Health takes full responsibility for the transformation of the psychiatric system. For me it is an excellent model of dehospitalisation, because one of the biggest problems is not just to reduce the number of beds, but that the people who work in the hospitals fear that they will be unemployed when the hospital is downsized. I think setting up co-operatives is a solution not only for the client but also for the wider community and the professional staff.

A question: are you opening psychiatric beds in general hospitals to replace those closed in psychiatric hospitals?

**Martin Jarolimek:** I agree – but don't forget that the Greek Ministry has acted only under pressure from the European Commission. Perhaps the same sort of pressure will be needed in much more recent EU Member States like Poland and the Czech Republic.

**Calliope Mavratziotou:** Even before 1983, when the law was passed setting up the national health system, the university hospital in Alexandroupolis in Thrace had opened a psychiatric ward. But this law (law 1397) gave us the possibility to develop on an institutional level. We saw the benefits of treating mental health patients in this way, so we included psychiatric care in the organigram of general hospitals. Psychiatric beds appeared in general hospitals as early as 1983, and we also saw the development of Day Hospitals and Mental Health Centres, which are decentralised units that work within the community. Today, we are ready to open about 20 psychiatric wards across the country.

**Petros Gianoulatos:** It is true that it is something that came about through the joint efforts of Greece and the European Union, as regards both time and money,



and also with support from the WHO. Although our job is not yet finished, we are now in the position to contribute to the reform in the Balkans.

### User involvement

**Athena Frangouli, Confederation of European Social Firms, Employment Initiatives and Social Co-operatives (CEFEC):** Two points interest us in relation to KoiSPEs that we have discussed for a number of years. First of all the board of directors: we know that each region will have a KoiSPE, which means that it will become an arena of political confrontation. There will be very little scope for people who are really interested in the rehabilitation of mental health patients. This is something of the highest concern to us. We are afraid that these people will not have the necessary leeway to do what they are supposed to do.

**Petros Gianoulatos:** It must be admitted that anything which is dependent on public sector procedures will always experience some problems – for instance if the hospital should decide to withdraw its support from the KoiSPE. The political system is slow to react and this might threaten the KoiSPE's survival. Corrective measures are needed, whether political or administrative.

**Athena Frangouli:** Secondly, how are we going to enable mental health professionals to give room for manoeuvre to the actual users?

**Petros Gianoulatos:** This involves both the public sector and NGOs. It is a major challenge and has nothing to do with the institutional framework or with the law. It has to do with the staff and how they view users. Users must be seen as individuals, even in their weakest moments. As a mental health unit we must ensure ongoing monitoring from the organisations for the protection of patient rights.

### Training

**Marianne Storogenko, Direction Générale de l'Action Sociale, Ministère de l'Emploi, de la Cohésion Sociale et du Logement, France:** The social co-operatives are at an experimental stage. Does Greece envisage giving legal recognition to the people who work in such co-operatives, because I fear that without such recognition they may quickly become burnt out. In France we have a lot of problems with personnel and we are beginning to give them some support. One thing that helps is to give them a recognised status.



**Doris Gauci, Richmond Foundation, Malta:** We heard that mental health users are trained over a period of two years. Are the mental health professionals also trained for the switch from an institutional to a community care setting?

**Mugur Ciumageanu:** I am a mental health professional, and I am very bad at business – maybe that is why I am a mental health professional and not a businessman! In a social co-operative, the users, even if they had been successful in business, lose this capacity because of their illness. So who provides the business skills, if both constituencies of the co-operative are by definition bad at business? When we thought about this in Romania we wondered how to attract people who know how to build a business, and interest them in working with us, because we are not a good business for them! This is quite a paradox, so how do our Greek colleagues attract people from the business world to teach them how to make a ‘fair business’ rather than a ‘success business’?

**Petros Gianoulatos:** The general answer is that half of mental health professionals are not suited to work in co-operatives, particularly if they have been in that job for a long time. The people you need to train are the younger professionals who are less set in their ways and are ready to accept an innovative approach. Secondly, you cannot impose anything on anyone; you ask them – some people will respond and others will not. The training must be continuous and specialised.

As to management, this has been discussed for over 20 years. There are two solutions:

- the Anglo-Saxon model is that you take a manager from the market and you teach him what a mental health patient is;
- the Italian/Mediterranean/southern approach is to take a mental health professional who is not burned out and you teach him how to be a businessman.

Both options have pros and cons, and you should not think that one option is the only solution possible. However social co-operatives will not have a management problem for a long time, because of their size. Their field of activity and their size means they are not high-risk enterprises. Certainly you need good organisation and financial management, and a lot of involvement from users. If a person can work for one hour he must be there for one hour. And pricing is important – but do not think of it as a huge risk.



**Pip Bevan:** I enjoyed my visit to the technical support structure and was impressed by the quality of the work produced, particularly the bookbinding (my own hobby). The work being done was of very high quality. As regards the mental health professionals working there and their transition from working as guardians in the hospital, do they totally relinquish that role now they work in the workshop? How are they enabled to change their role? Particularly if they have been working as guardians in hospitals for maybe 15 years, it is a very big change.

**Nikos Gionakis:** To clear up any possible misunderstanding, the group that visited the support structure also visited a sheltered workshop. This is not a social co-operative, but a protected environment for people who live in their own homes in the community, and they work there, doing this high quality work.

The staff there do not come from the hospitals, they are young people who have never worked in a mental hospital. We are lucky enough to have a new generation of professionals who have worked from the start in the community. We are closing down those remnants in which exploitation and manipulation is common. For example, as you will see in the film to be shown later, there is a printing press in the Athens mental hospital that prints every piece of paper the hospital uses – yet the patients are paid not one penny. Their only reward is some food or clothes occasionally. Till some years ago, in our psychiatric hospitals, it was the patients who did the heavy work – and I think this happened in all asylums.

So the problem is, when we close the hospitals, how can we enable people who have worked there for 10 or 20 years to change their attitude and style of work, and go to work in the community? One of the measures in the Psychargos programme is staff training. Large amounts of money are devoted to training new staff and retraining existing staff. I do not think this kind of training is enough, because in our work we also need continuous training to meet changing needs – for instance the needs of immigrants from other countries, or of people with a dual diagnosis, when someone is homeless, drug addicted, alcohol addicted etc. We cannot continue to use psychiatric hospitals as sinks for all these problems. Needs change and we need continuous training and support – both mutual peer support and support from academic and other structures. The Psychargos programme takes this issue seriously and a whole measure is devoted to it.



## **Business skills**

**Toby Johnson, rapporteur:** On the issue of how to bridge the gap between the business and the therapeutic mentalities, there seems to be one set of actors which is missing from the equation – the economic development sector. In many European countries there is the concept of inclusive business development, there are co-operative development agencies that are involved in developing businesses for people who are disadvantaged in the labour market. In Austria for instance chambers of commerce are involved in supporting social co-operatives. So it seems there are some possible actors who do have a social motivation to do business, yet they are not involved in this programme.

**Petros Gianoulatos:** Chambers of commerce can support this development, but in Greece they are not very familiar with the concept, and changing this is one of the objectives we have set for ourselves.

**Jannis Kakoulas, KoiSPE Klimaka:** One of the disadvantages of the very idea of KoiSPEs is that they are often seen in a fragmentary way: some see them as mental health units while others see them as enterprises. But it is not a case of either/or: KoiSPEs are mental health units that have a business nature and activity. Obviously these concepts are incongruous and some people might not understand how mental health patients can at the same time be workers. Equally, people might find it difficult to understand that someone can combine the roles of mental health professional and businessman. I believe that these co-operatives must be seen in an integrated way – as a coin with two sides. We must look at social co-operatives as wholes, and not try to separate the two aspects.

## **Exploitation**

**Carmen Manu, General Directorate for Social Assistance Policies, Ministry of Labour, Social Solidarity and Family, Romania:** Is there a risk that mental patients working in co-operatives might face manipulation or exploitation, in agriculture for example? After all, 'business is business'.

**Calliope Mavratziotou:** What we fear more than that is the risk of exploitation within hospitals, by health professionals.



**Petros Gianoulatos:** We even have to bear in mind the risk of exploitation within families. As for the possible exploitation of mental patients in their role as workers, they are protected by the same labour laws as everybody else.

**Dimitris Hatzantonis:** social co-operatives should not be seen as operating outside reality – being above suspicion and with no obligations and no risk of failure. Social co-operatives do face risks, as do any other enterprises. Certainly they have problems in finding managers – but any small enterprise in the world faces the same problems. As to exploitation, let us compare the risks we have to manage. So far in Greece we have the experience of therapeutic workshops in which working patients, more often than not, do not even have a nominal working relationship, and nor do they receive a nominal fee or wage. We can thus ask ourselves whether these people are treated as ordinary workers. In this respect, the KoiSPEs are a major step forward, because mental patients working in them are entitled to the same rights as any other worker, and are therefore protected by labour laws.

#### **4. Film – *We Can Do Many Things***

Wolfgang Schlegel then thanked participants for the debate and introduced the film *We Can Do Many Things* made by the Synergia Development Partnership in the EQUAL Community Initiative. Directed by Stavros Psillakis, the film features interviews with people working in social co-operatives and sheltered workshops in various parts of Greece. It sets out to show two things: first that people with mental health problems – even serious ones – can work. Second, that social co-operatives are a valuable tool in stopping exploitative work.

#### **5. Feedback from site visits**

For the second day of the meeting, peer review manager **Wolfgang Schlegel** took the chair and explained that the thematic expert Erwin Seyfried was unfortunately unable to attend owing to illness. He asked Dimitris Ziomas to summarise the results of the site visits.

##### *5.1 Group 1*

**Dimitris Ziomas:** I think both the site visits were fruitful in different ways. One group visited a newly created social co-operative, Ev Zin ("Good Life"), which



is taking over a series of small-scale activities from an organisation with a different organisational form, a non-profit association or civil society organisation. It seems that the new legal framework, the limited liability social co-operative or KoiSPE, is more appropriate to the challenge of creating jobs for mentally ill people. In contrast to some other co-operatives, for instance the one in Leros, Ev Zin has no connection with any psychiatric hospital; rather it is linked to the Mental Health Centre, which is the state body responsible for mental health care in the community. Of course this makes a difference in many respects.

The visit clarified a number of issues: even Greeks find that this new and innovative legal framework takes some effort to understand. Ev Zin is a small social co-operative that does not have a wide range of business activities – yet. It is developing step by step, its concern being how to get bigger and better, so as to provide more jobs for its users.

**Mugur Ciumageanu:** Apart from Malta we peer countries are not islands, and we have big cities. So after discussing the Leros co-operative yesterday, it was interesting to see how a social co-operative works in a big city like Athens. We discovered this structure was a mixture of all the vocational rehabilitation programmes you can find in a handbook! It offers:

- pre-vocational training – workshops that aim to give users the skills to find a job in the free market or work in the co-operative;
- sheltered workshops – the workshop ‘Do It With Us’ was a sheltered workshop before becoming part of the co-operative;
- a drop-in centre – the so-called ‘social club’ which is sometimes a very good pool for choosing users to become part of a vocational training programme.

The thing that was missing was the next step after the social co-operative – supported employment programmes. We should discuss these, as they seem to be the future of vocational rehabilitation.

We also saw how the social co-operative idea was built up. What was very pleasing was the focus on user involvement. Users were involved in choosing the programme, developing it, taking decisions and participating in the leadership of the social co-operative. I think this is in accordance with the Helsinki Declaration and with all the recent declarations of user rights – a very interesting example of what vocational rehabilitation should be. As professionals we might have very good ideas, but we should always keep in mind that users



have their own needs and wishes to fulfil, and user involvement should be a priority for us.

Another strong point was that there was a very effective focus on developing the business concept and marketing ideas. The idea we should take home is that the preparation of the Ev Zin social co-operative took two years, and this is how things should be done. Building up affirmative industries, social firms or supported employment is a good idea, but on one hand you need skills among the people involved and on the other side you need very thorough preparation. If you do it in a hurry you risk that users will get disappointed and disempowered, professionals will get confused, and everybody will get a little bit fuzzy. We saw that this was a good idea, well prepared and with a good chance of functioning as a successful business.

## *5.2 Group 2*

**Dimitris Ziomas:** The other visit was to Synergeion, the structure which supports the establishment and further development of social co-operatives – because they will need ongoing support for some time. There was also the opportunity to visit a sheltered workshop – a non-profit association – located in the same premises. This workshop is also taking the initial steps towards conversion into a social co-operative. Thus the two groups saw various stages of the development of social co-operatives in both visits.

**Carmen Manu:** We visited the headquarters of the EQUAL Development Partnership 'Synergia' which is located in a research institute. They presented what they are trying to do to support the establishment of social co-operatives. Their support focuses on giving advice and consultancy, to all the stakeholders and people interested in developing such initiatives. This consultancy focuses on administrative, organisational, managerial and financial issues. They also try to develop various tools and guidelines as well as supporting existing co-operatives in developing their activities. And of course they evaluate and monitor what is happening.

What is interesting is how difficult it has been to convince not the mental patients but the people from the community that this initiative can be successful. However now, after two or three years, the community is open to such projects and very interested in supporting them.



We also met a very committed team of vocational rehabilitation experts, who explained how they had worked with mental patients over the last 30 years, and what they are doing now. Along with them we met some patients who work in a shop in Athens which sells craft projects. They explained that they could survive because they sold to higher-priced outlets such as duty-free shops. They are trying to put the co-operatives together to create a real network, which will give them more strength.

## 6. European context – presentation of key issues

**Wolfgang Schlegel** presented the summary of the peer country and stakeholder comment papers that had been prepared by the thematic expert, **Erwin Seyfried**.

### **Deficits in national mental health care systems**

- deinstitutionalisation of psychiatric asylums is a major concern in new Member States
- rights-based approach for people with mental health problems still not applied in many Member States
- risk of homelessness when psychiatric asylums are closed

### **Trends in mental health care reform**

- plans for mental health care reform have been set up in some Member States but are not / only partly implemented so far
- where implemented, community based mental health services are weak and suffer from lack of co-ordination
- professional standards of staff in mental health care are usually low
- general lack of research, lack of follow up and evaluation

### **Employment for people with mental health problems**

- declining role of occupational therapy
- people with mental health problems are often excluded from employment policies in favour of disabled people
- their access to sheltered employment is often denied or restricted
- a strategic approach for their integration into employment is lacking
- people with mental health problems are a widely neglected group; their integration into employment is a challenging goal.



### **Transferability**

- mental health issues to be included in strategic EU documents on social inclusion to support national mental health care reforms
- coherent legislative framework for national mental health care systems is needed
- social co-operatives need a supportive network of mental health services
- transfer of legal status of Greek social co-ops (independence, tax exemptions, member participation) is a crucial element
- social co-ops are regarded as one option for employment, to be complemented by other options
- training needed for mental health professionals and business people
- external support system (umbrella body, business advice) is needed

### **Questions – policy background**

- how to put mental health care on the European agenda for social inclusion? How to make sure that the NAPs/inclusion make reference to people with mental health problems?
- how to make sure that EU Member States implement a coherent approach to mental health care, encompassing accommodation, medical treatment, social integration, employment?
- how to co-ordinate resources from different national ministries?

### **Questions – social cooperatives**

- social co-operatives – part of the public sector or part of social economy?
- how to keep the balance between the social and economic objectives of the co-operatives?
- feasibility of creating supportive working conditions?
- status of the mental health professionals in the social co-operatives?
- how to avoid the creation of new institutions / new ghettos?
- what are the next steps in developing the KoiSPE in Greece?

### **Questions – the workers**

- how to avoid the 'benefits trap'? How to combine existing benefits and wage income?
- what about transition of disabled workers into conventional enterprises?

### **Questions – external support**

- what kind of external support structures do social co-operatives need?
- how to improve co-operation and the exchange of experiences between social co-operatives in Europe?



## 7. Working groups on key issues

**Wolfgang Schlegel** proposed three subjects for the working groups to consider, drawn from the comment papers, and these were discussed, in particular what was meant by 'network'. He clarified that the idea is not to further discuss the Greek experience, but to jointly discuss the experience of all participants, and come up with conclusions to be presented to the whole group.

### Presentation of working group results

#### *7.1 Working group 1 – moderator Toby Johnson, rapporteur Doris Gauci*

#### **Economic viability versus therapeutic role and function of social co-operatives**

Conditions for success:

- ensure demand exists for product – do market research to find out what market niches exist
- analyse the skills needed to satisfy the market, carry out individual skills analysis to find out what skills are available, then carry out training to bridge the gap
- users must feel comfortable with the business idea
- highlight strong points of mental health users and their potential to develop other skills
- need for mixed team

Other recommendations:

- make use of endowments such as existing skills and trust relationships where these exist between users and staff
- bear in mind local development role of co-operative
- there should be businesslike behaviour and wage incentives
- access Structural Funds and networks

The co-operative needs compensation for the integration job it fulfils. This can be made in a number of ways:

- subsidy of the co-op globally (but there is a risk of institutionalisation)
- fixed grant per user
- tax and/or social security exemptions
- access to public procurement contracts



- secondment of human resources
- corporate social responsibility of private companies
- employment training grants

Need to evaluate the social added value not just the economic value of social co-ops:

- recognise the benefits to the community and to the workers
- community care may be better value than hospitalisation in the long term, if all factors are considered
- value of relieving the emotional burden placed on the family if the mentally ill person is at home

The concluding feeling was that the business is subsidiary to the therapeutic value of social co-operatives. The workshop concentrated on human resources, and did not cover the issues of premises or finance. **Dimitris Ziomas** asked if the need for a technical support structure was discussed, but there had not been time.

## *7.2 Working group 2 – moderator Dimitris Ziomas, rapporteur Hubert Kaszynski*

### **What different services alongside the creation of social co-operatives need to be provided as part of the deinstitutionalisation of mental health care?**

The workshop discussed what kind of activity is needed to support social co-operatives. This has two aspects:

- the reform of the psychiatric system – we talked about concrete institutions that can support social co-operatives;
- integration – we talked about institutions that try to solve unemployment by intervening in the market.

Recommendations:

- The first step in working with mentally ill clients is to establish a coherent integration system, comprising for example short-term beds for use during crises, community houses, workshops, mobile teams and so on;
- Secondly, it is sometimes a problem that existing institutions are closed to people suffering from mental health problems: for instance programmes exist to combat unemployment among disabled people, but they do not work for our target group. We have to establish specific psychiatric institutions which are open and ready to co-operate with other institutions;



- Co-operation is needed between the health sector and the employment sector. It is unrealistic to think that one department alone can solve unemployment among our target group;
- The next point is important for Greece but for Poland too: social co-operatives should be mentioned explicitly in law, so that ministries are obliged to support such businesses;
- Occupational therapists face discrimination in the professional sphere, for example in comparison with social workers. We need to raise the status and qualifications of people working in social co-operatives;
- We have to integrate in our approach a specific education programme for politicians – it is they who decide the laws and regulations;
- We must raise awareness and educate members of civil society, because without individual motivation nothing can be done.

**Dimitris Ziomas** added that an integrated approach encompassing housing, employment, health etc. appears to be more effective when responsibility is devolved to the local level – nevertheless for funding we need to approach central government.

### *7.3 Working group 3 – moderator Wolfgang Schlegel, rapporteur Jannis Kakoulas*

#### **The changing role and status of mental health professional in social co-operatives and the training needs of these professionals and other workers**

The workshop examined not only the changing role and status of mental health professionals in social co-operatives, but the place of clinical work itself. Clinicians from peer countries participating in the group felt strongly that if empowerment is the social co-operatives' leading principle – and it is indeed a fundamental principle – it would certainly be a great waste if, at the same time, clinical work and knowledge were neglected.

This lively debate started with vivid arguments coming from all sides, which demonstrates the interest in this subject, and also shows that the role of health professionals in social co-operatives is under redefinition and is far from being clear-cut. Three main conclusions are:

- it is important that clinicians in social co-operatives have a very rich clinical experience;
- they must be allowed to take a wide view of their role, and not act as specialists;



- they must be able to adapt to the entrepreneurial and operational needs of social co-operatives.

Social co-operatives are mental health units, but ones that operate partly according to the terms of the market. They are not static but dynamic organisations, and workers in them must adopt flexible strategies.

**Mugur Ciumageanu** added that the workshop did not have the chance to discuss the underlying **values** other than work, such as empowerment and recovery. Work is not the most important therapeutic factor in a social co-operative – changing the role of the users and acting differently towards them is the main therapeutic factor. The workshop did not agree on the values behind the social co-operative because the time was too short and the passion was too intense.

**Martin Jarolimek** commented that training is not the end of the matter, and asked what the situation is with regard to the **professional supervision** of mental health professionals.

**Calliope Mavratziotou** replied that if the multidisciplinary group thinks it is justified, health professionals can bring in external experts to provide supervision as well as training. This can serve to adjust therapeutic plans and to relieve the burden and stress that people working with psychotic individuals face. Many of our staff ask for such services. The situation in the regions may be different.

## 8. Peer country comments and possibility of transfer

**Wolfgang Schlegel** asked for feedback on the Greek programme and comments on the possibility for transfer of elements of this programme to their country.

### **Czech Republic: Martin Jarolimek**

In the Czech Republic there is quite a big movement of sheltered workshops, and also about 15 'social firms', mainly cafés or pubs run by professionals and users together, which are worth a visit. They are operated by NGOs, with the enthusiastic support of professionals, users and the general public. However state support is short-term, and its renewal is never guaranteed. A secure legal



framework is needed. With the help of the European Commission we need to try to promote a law to support these facilities. I hope we can do this over the next decade.

**Marketa Holeckova** finds that Greece offers a good example of co-operation between ministries. Social co-operatives are an example of good practice not only for mentally ill people but for other target groups of the social services. The meeting has provided a lot to think about and to discuss with other ministries.

**Estonia: Maire Koppel and Piret Kokk**

Greece's experience has been most interesting for us and has given us many ideas which we can use. We cannot yet transfer the experience of social co-operatives, as we have no appropriate legal framework. In the past five years Estonian mental health services have developed very rapidly, and as the mental health organisations have relatively small boards, it has been possible to take quick decisions. Services will continue to be launched according to users' needs. However legislation would be needed before social co-operatives could be introduced.

**France: Marianne Storogenko**

The integration of people with mental health problems is a real difficulty for every country, and raises philosophical, economic and health issues. As for the transfer of the idea of social co-operatives for mental ill people to France: yes and no. 'Yes' as regards the philosophical dimension – it is necessary to get these people out of psychiatric hospitals and include them in society. But maybe 'no' as regards the economic challenge of the social co-operatives. In France people who have mental problems are very protected by the law, and I am not sure that the social co-operative approach can be accommodated within French law.

On a philosophical level, the first need of someone with mental trouble is to be cured. If work is a sort of treatment, then 'yes'. If inclusion in society is a treatment, we agree. But if it is only an economic solution, we cannot accept it.

**Latvia: Irina Rulle**

Latvia is not yet ready to transfer the example of social co-operatives as, like Estonia, we do not have the necessary legal framework. However the meet-



ing has been very useful, as the cabinet of ministers is discussing the mental health policy guidelines at the moment, and out of this an action plan will be developed. It has been important not only to listen, but to really experience what these co-operatives are and how they work. We hope that it is not so long before we can introduce this kind of service in Latvia too.

**Malta: Jesmond Schembri**

As regards transfer to the Maltese context, our main challenge is to address the dilemma between identifying the particular needs of persons with mental health problems, while at the same time mainstreaming our policies for these people. What I shall take back home with me is the idea of networking with colleagues from other ministries to see how the rights of the users of the mental health services can be enhanced. Better networking is needed among ministries – especially those for health, social welfare, competitiveness and finance – so that service users, like other citizens, are seen as being the responsibility not just of one ministry, but of ministries throughout government.

**Poland: Hubert Kaszynski**

I think the way Greece involves the concept of employment in its health system reform is perfect. This is important for people suffering from serious mental illness as well as for professionals working in the hospitals. In Poland, we started our reform in 1994 and have established a very good community model. But unfortunately vocational therapy and specific training, which was an important assumption before 1994, was then cut out of our legislation. The outcome is that at the moment mental health institutions do not take the work-related needs of our target group seriously. Something we need to do in Poland is to rediscuss this and change the law.

**Romania: Mugur Ciumageanu**

It is one of my dreams that Romania will join the mainstream of vocational rehabilitation for people with a mental health disability, and I have been struggling for this for the last four or five years. I am one of the very few mental health professionals who think in this way, and so this meeting has been a huge opportunity to exchange experience with people working in this field in other countries and to think what we could do back home.

One thing is very clear: there are no ready-made solutions for vocational rehabilitation: as I know from the experience of our Czech, British and German colleagues, each country finds its own path. We too have to find our own



path. I do not know at the moment whether social co-operatives, supported employment or sheltered workshops will be a solution for Romania, but this meeting has given us the impetus to start something at home. We have already made plans to start a discussion group, draft an outline for a five-year strategic direction and run some pilot programmes.

**FEANTSA: Pip Bevan**

KoiSPEs are an excellent model for social inclusion in employment, and one that could be extended to other target groups, especially homeless people, though there would need to be interventions on alcohol and substance dependency. The model has good underlying safeguards, both for the individuals, in safeguarding benefits as well as their employment prospects, and also for the enterprises as regards tax exemptions.

I think it is very important in the devolved framework of mental health services that every mental health clinician is supervised – it is dangerous not to do this.

I might add unofficially that I would think that prospects for transferability to the UK are good, given some minor changes: clinicians would probably remain separate from the social enterprises, and this side of the work would be supervised by employment professionals as an integral part of the partnership.

**Mental Health Europe: Mary van Dievel**

MHE will certainly promote the idea of social co-operatives and include it in our various projects on social inclusion. The meeting was an excellent opportunity for networking and for promoting collaboration. Our project has ten partner organisations in ten different countries, and we will encourage them to work with the participants here.

**CEFEC: Athena Frangouli**

Over the years the KoiSPE has been discussed among the social co-operatives and social firms that are CEFEC's members, and the most important element is the working environment it offers. We have found that this is easily transferable. A lot of experience is exchanged at our annual meetings, and although we cannot say that the KoiSPE law is transferable as a whole, everybody has gained from elements of it.



## 9. Conclusions

**Wolfgang Schlegel** thanked the speakers for their surprisingly short comments and made three brief conclusions:

First, the subject of this peer review is highly relevant for all Member States and especially for the new Member States. They all said they were about to discuss similar issues or will do so in the near future. So it was obviously a very good decision of the Greek government to propose this as the subject of a peer review, and of the Commission for accepting the proposal.

Secondly the issue of employment in the context of mental health services is a very important one, and social co-operatives make a good contribution on this issue. The other Member States, and especially the new Member States, have to carry on an internal debate on how the issue of employment can be better considered in the context of mental health reform. The Greek model is interesting here.

Thirdly, and this is quite unusual, is the positive position of the European NGOs. They usually play a critical role in the peer reviews, and say, "this is interesting, but...". In this case they said, "this is a wonderful programme, and we would like to extend it". Greece can be proud of this, because governments are usually, in a very diplomatic way, criticised by the European NGOs. In this case we can say they are in full agreement with what you are doing in Greece.

He then offered participants the chance to comment on the Greek experience or offer suggestions on how it might be improved. This feedback is an important part of the peer reviews, because even the best experience can be improved.

### **Awareness raising**

**Timotheos Smyrniotis, European Commission, Directorate General for Employment, Social Affairs and Equal Opportunities, Unit H/1:** I think that KoiSPEs have demonstrated their high added value, above all as mental health units. But I wonder if this achievement is well known enough inside Greece, and if more should be done to make it better known to politicians, to civil society, and to decision makers. Maybe the Structural Funds could support an awareness raising campaign that would encourage more people to take initiatives in this field.



**Dimitris Ziomas:** Yes, raising awareness is crucial. If we are to succeed in developing KoiSPEs and making this institution sustainable in the future, we need to raise awareness among the public and among officials. The National Centre for Social Research, in an effort to contribute to the job of promoting social co-operatives and providing employment prospects to the mentally ill, has organised meetings in various areas of Greece, where representatives of local authorities, enterprises, public services, NGOs discuss:

- what their attitudes are towards mentally ill persons
- whether they have any experience of sheltered workshops or other forms of employment involving mentally ill persons
- how they can contribute to facilitating the vocational and social reintegration of mentally ill persons

We try not only to inform them about the potential of mentally ill persons, and thereby put an end to their fear of them, but at the same time to make them think whether, if various conditions are met such as the right support by mental health professionals, they could offer jobs in their enterprises, local authorities and so on, and whether social co-operatives, if they were established in their area, would take off.

The results are interesting. The first finding is that they know almost nothing about mentally ill persons and are unaware that they can work. A public awareness initiative has to be implemented, involving the health and employment ministries at least. Talking of awareness, you may not have realised that the catering at this very meeting is being provided by the Ev Zin social co-operative!

### **Champions and other target groups**

**Pip Bevan:** This whole framework of employment is a key element in enabling people who risk being socially excluded and marginalised – not only on mental health grounds but a number of other marginalised societies within our nation states – to have a better self esteem and feel that they are making a contribution to society. They need a champion within each ministry, at both national and local levels, who will help to ensure that the messages that NGOs utter are heard.

Secondly, I would stress that social co-operatives are a model for the social inclusion of many groups, for instance homeless people and asylum seekers with leave to remain.



### **Support mechanism**

**Pelagia Nikolaou:** I would like to thank all our friends because such positive feedback is very supportive and encourages us to continue our work. During this exchange of views, I heard a lot of colleagues from other countries saying: “we do not have the legislative framework”. We didn’t have the legal framework either, and it was a group of mental health professionals who took the initiative without having the legal framework. We certainly had a lot of difficulties, and this led us to press for an appropriate legal framework. We saw the need for change, we moved forward and others followed. We are at a crucial point now. We must ensure that the success of this initiative is safeguarded and multiplied. And at least at the beginning we must support social co-operatives, but without turning them into state-supported units.

Social co-operatives need support, at least initially, and it should be made clear that there is no longer such a support mechanism in Greece. There was such a mechanism during the first phase of the EQUAL initiative, but unfortunately this is now over. I can see that the ministries want to work together, and I hope that they will be able to give co-ordinated backing for a support mechanism. This is very important for the social co-operatives.

The type of support mechanism that is needed is one that will push bottom up from all directions towards the centre. It can draw on the existing experience of many structures, individuals and experts. I represent the national association for vocational rehabilitation, and its 250 members of this scientific association are just one organisation that is in support of this.

### **User involvement**

**Mary van Dievel:** At Mental Health Europe we have the philosophy of always including users of mental health services, people with mental health problems, in our discussions, projects and seminars. I wondered if it would not have been appropriate to have representatives of the users’ movement at this meeting too. I don’t know what the situation is at the national level – are people with mental problems included in your work?

**Calliope Mavratziotou:** I have to admit that this is one area in which we are lagging behind. However it is not that there are no organisations representing



users. We started with organisations of friends and supporters, then went on to family associations, and recently the ministry helped to set up an association of users.

We also have an authority for the protection of the rights of mentally ill people, and two of its members are people suffering from mental disorders or their families. However the minister has in fact appointed users themselves, rather than relatives. Thus, the committee that was elected two months ago includes two people with mental disorders.

In addition, social co-operatives have two users on their board; in fact the initial draft of the law provided for more. It was the mental health professionals who objected, and said that we might be putting too much responsibility on their shoulders, given that they have to develop their entrepreneurial skills etc.

We have also tried to learn from the situation in other countries, and I know that some CEFEC members do make a practice of including users in all activities. We are developing this dimension.

**Dimitris Hatzantonis:** To sum up, we have tried to describe both our achievements and the problems we have faced in establishing social co-operatives. Some things may be more interesting than others to the peer country representatives, but what is certainly transferable is the following: all that we have achieved in terms of laws, institutions and jobs for mental health users has depended on the practical contributions of groups of citizens – people working in the hospitals or in society at large. If we had not had this contribution the results would have been much poorer.

We have gone beyond the isolated initiatives of citizens, and involved public bodies, NGOs and private companies in building social capital. We have not been successful everywhere: local authorities participate in some areas and not in others. In some cases there is a bridge to the private sector, in other areas this is not the case. However I think we have reshuffled the cards and wrought a long-lasting change. This sends the message that in the European family there is hope, vision and potential. We can create in a different way, endeavour in a different way, and succeed in the difficult task of helping our disadvantaged fellow citizens to have a fair position in society and in employment.



## 10. Résumé and closure

**Anthi Kritikou:** As the discussion showed, an important factor in the rehabilitation of mental health patients is interministerial co-operation – in this case between the ministries of health and employment. It is not that we have an ideal working relationship, but we do make joint efforts, and one example is our common presentation of social co-operatives. Whilst I would agree that a policy cannot simply be adopted by all countries – each country has to find its own way – nevertheless I think our example has helped the peer countries to enrich their practice. I should like to thank everyone very much for their comments and participation.

**Hugues Feltesse:** First I would warmly thank our hosts, the Greek authorities, for their kind hospitality, and for the good organisation and involvement they have devoted to this peer review. Numerous persons with busy schedules and onerous responsibilities have given us a lot of their time to share their experience, transmit information and enable us to have a high level of debate. I hope that they too have gained something from this meeting.

I would also thank all the participants for the wealth of information they shared and for the quality of the comment papers. I would ask Wolfgang Schlegel to thank Erwin Seyfried in everybody's name for his expert contribution in absentia.

We all agree that what has been presented is a good practice, but this is not the end of the story. We have further work to do in seven dimensions:

- The **deinstitutionalisation** process: we know this process of change is difficult to manage, and that there is an issue in measuring the costs and benefits; the Commission is just thinking of launching a study on this to give us a better European view;
- The **specific target group**: people with mental health problems are taken into account only partially in the NAP/inclusion process – through the issues of homelessness and health care – but not as a specific target group. We have to increase the visibility of the discrimination and social inclusion problems these people face, and focus more clearly on this group in the assessment, preparation and implementation of the NAPs/inclusion;
- **Multidimensionality**: this peer review has clearly shown that only a holistic approach respects the dignity of this target group, and takes all their needs into account. These needs have a social and health dimension but



also concern work, playing a role in society, interacting with other people, and being empowered – being responsible for one’s own life and regaining some control over one’s life.

There is also the dimension of social capital that was stressed a few minutes ago: people can be isolated from living with other people, and one of the major outputs of social co-operatives is not only employment but also social capital.

We need a crosscutting approach, and as Anthi Kritikou mentioned this implies inter-ministerial co-operation, and at European level inter-DG co-operation. It also implies partnership, between administrative bodies and between different services and agencies, and it implies networking on the ground to deliver a joint approach, not several parallel approaches;

- The **legislative framework**: what we have seen here is an experimental process. To ensure it is sustainable, it needs to be backed up by a legislative framework, for at least two purposes. First, to protect vulnerable people from exploitation and discrimination and to ensure continuity of care; and secondly, to build the capacity of local actors to develop this kind of solution which strikes the necessary balance between the social, therapeutic and economic dimensions. Here we need an integrated policy and legislative framework, covering not only health and employment policy, but also fiscal policy – exemption from tax and social charges – housing policy, and benefits policy – one important feature of the good practice presented, that was stressed in the comment papers, was the possibility for people to keep their social benefit as well as earning some salary.

We also need to examine the professional framework. This peer review has highlighted some changes in professional roles, and we need to look at the requirements this imposes at EU level. Maybe a new diploma or some adaptation of a diploma is needed, which will enable professionals to exercise mobility within Europe. Professional recognition and support for changing professional needs is a very important issue.

- **Technical support**: social co-operatives need support structures which can arrange the appropriate training for all employees, can create the relevant tools and guidelines, and can build the capacity of new promoters. We also need to support the networking of these social enterprises and social co-operatives all over Europe. We should not take a top-down approach: it is certainly better that these initiatives grow from the bottom up. We should not try to shape every detail all over Europe; rather we should give people the tools and capacity to create their own organisations at the local level.



- **Public awareness:** nothing will really develop without the support of politicians, and politicians depend from public opinion. We therefore have to address public opinion, not only elected politicians, and raise the visibility of this kind of practice. In so doing, we need to take the time dimension into account. This meeting demonstrated that promoters of social co-operatives must take the time that is needed to prepare a new initiative. Success demands not only determination, but also patience.
- **Monitoring, evaluation and research:** we need better information from the monitoring process. We need longitudinal studies, to see what happens to people a few years afterwards, and we also need a clear follow-up of the implementation of the policy and its results – what is the real performance, what is the efficiency of different aspects and so forth.

To conclude, there are four actions that need to be taken:

- We need to see clearly how the ESF and the Structural Funds can give support in the future to this innovative process;
- We need to look at how the peer review programme can go more deeply into this issue, and maybe organise some follow-up. Many of the peer reviews require some follow up, and it should not just be a one-shot process;
- We need to have real capacity to capitalise results and methodological approaches through transnational projects. One example, as was mentioned, is the Mental Health Europe project that is just starting on best practices for combating social exclusion for people with mental health problems. I expect that this specific good practice about social co-operatives will be an important part of that project.

Next year will see the preparation of the new Progress programme, which has several dimensions – anti-discrimination, social inclusion, social protection and employment – all of which are present in this case. It may be possible to issue a call for proposals to increase our capacity to cope with this specific organisational approach;

- In the preparation of the next generation of NAPs/incl. for 2006-2008, we will examine more closely with the Member States if this specific dimension – the integration into the labour market of people with mental health problems – can be taken into account more effectively. We will focus on this issue in the preparation of the Joint Report, and feed it into in the general message that the Commission and European Council give about building better links between health and employment policies for people with mental health problems and other target groups.