



Greece 2005

Erwin Seyfried
Dimitris Ziomas

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



on behalf of





Table of contents

Introduction	3
A Description of the main elements and results of the policy	4
A.1 Background and national context	4
A.2 The goals and target groups of the policy	6
A.3 The legal, financial and human resources provisions to implement the policy	8
A.4 Institutional arrangements, stakeholders involved and procedures of implementation	10
B The results so far	11
B.1 The quantitative results of the policy so far, in relation to the baseline situation and to the goals and targets	11
B.2 Other results and achievements of the policy	12
B.3 An assessment of the obstacles and constraints encountered	13
C The policy debate	15
C.1 Current European policy development on the issue	15
C.2 Relevant practices and experiences in other Member States	22
C.3 Assessment of arguments of different interest groups	27
C.4 Components for mutual learning and transferability to other contexts	29
Annexes	33
Annex 1- Overview on the mental health reform programme "Psychargos"	33
Annex 2 - An overall view of Social Cooperatives of Limited Liability (Koi.S.P.E.)	34
Annex 3 - Experiences in other Member States	38
Annex 4 - Case illustrations of Greek social cooperatives	43
References	49



Introduction

It is generally accepted that the culture of integration of the disabled has changed radically in the last decades and has moved towards the acceptance of the diversity and the right of a full citizenship of the handicapped. The main steps of this evolution of the attitude could be summarized as follows:

- The disabled have been recognized as people with equal rights and dignity
- The conception of therapy has moved from an attitude largely based on the isolation to a therapy focused on the community services
- The focus of social and job integration activities has moved from the affliction of the disabled to his potentiality.

Overall, it may be said that this evolution highlights a new way of looking at people with disabilities with their rights and duties, needs and aspirations in mind, while it underlines the need to abandon the old “stereotypes” accompanying these people, let alone the need to reduce drastically the various sources of “stigma”. For, especially as regards the persons with mental health problems, a new attitude towards them requires an end to regarding them as persons to fear, isolate and cut off from the rest of society.

Nevertheless, let us consider the third step of this evolution. That is, the change of focus of social and job integration activities for the disabled. For some years now, the aim of intervention has increasingly been directed towards the development of skills and abilities of the disabled, while taking into account the therapeutic aspects. In other words, the vocational training and job creation activities for the disabled are considered as an “investment” rather than just a “repair job”, an attitude which is largely shared. Indeed, this approach is explicitly advocated by the European Commission and is clearly reflected in specific interventions, supported by the EU’s main financial instrument in the social field, namely the European Social Fund. Over recent years, the emphasis as regards the interventions by the ESF aimed at addressing the needs of people with disabilities is being increasingly directed towards developing comprehensive and co-ordinated package of measures which form a pathway to economic and social re-integration.

Unfortunately, despite the new approach, it is indeed the job integration activity that remains the largest unrealised aspect for a full citizenship of people with disabilities. The growth in unemployment has had a particular impact on the physically or mentally handicapped along with those least fit for work or



those who suffer from problems of socialisation. Indeed work opportunities, never easy for people with mental health problems, especially those leaving mental hospitals, have become increasingly difficult in the present unemployment situation, in which people with disabilities compete with the unemployed (who are frequently highly qualified) for positions traditionally filled by disabled in the past.

Thus to raise the opportunities to those people, many problems have to be faced for whom the social exclusion risk remains high. Promoting and supporting their re-integration into the labour market it is thus considered a crucial factor for eliminating various "labels", "prejudices" and the "stigma" which are attributed to people with disabilities and especially to those with mental health problems. It is in this context that the **Social Cooperatives of Limited Liability (Koi.S.P.E.)**, which have been recently established in Greece, are considered an important development, constituting a new pathway to social integration.

A Description of the main elements and results of the policy

A.1 Background and national context

It was not until the beginning of the 1990's that Greece was faced with the social problems accompanying the rapid process of macroeconomic adjustment. An increase in unemployment, widespread long-term unemployment and marked regional differentiation in the effects on employment were and still are among the characteristics of this adjustment. In addition, the great increase of migration to Greece in that period, due to geopolitical developments in the Balkans and Eastern Europe, which continued throughout the 1990's, together with other societal developments, such as: the ageing of the population, the steady trend towards the weakening of family support mechanisms etc. triggered an increase in situations of social exclusion and poverty. These situations began to affect increasingly and in various ways different socioeconomic groups and individuals and, in particular: unemployed, disabled persons, ethnic minorities, immigrants, repatriated Greeks, elderly persons, low-income employees, ex-prisoners, etc. And, these developments have accentuated even more the serious challenges the Greek state faced in the social policy related areas.

Social policy in Greece has played, by and large, a residual role until very recently, mainly filling the gaps left by the family in the provision and distribution



of welfare. That is, the public system of social welfare and services provision was for too long dominated by a traditional mode of functioning, mainly based on monetary benefits and provision of care in institutions, while facilities and programs for open social care and protection were hardly available. Moreover, the mechanisms of matching supply and demand for labor were also relying on traditional measures and procedures, rendering thus their role insignificant.

However, the implications and the serious challenges posed by developments such as the persistent problem of unemployment and the emerging situations of social exclusion in the 1990's, brought to the forefront of public discussion and concern the need to adjust social policy to address the new social problems, and to move away from the traditional and antiquated mode of functioning of social welfare and service provision. To this end, efforts have been under way to improve and extent social policy measures as well as to improve the delivery of social policy, through the adaptation of the relevant administrative structures.

These efforts are clearly reflected in the wide range of measures and actions presented under the successive Greek National Action Plans for Social Inclusion. In this context, one observes that particular emphasis has been placed on improving the employability of the social vulnerable groups as well as on the creation of structures providing social care to those population groups in need, at the level of municipality. Moreover, specific policy interventions taking the form of "Integrated Action Plans" have been planned over recent years in Greece for specific categories of vulnerable population groups, and which are currently under implementation. These focused policy interventions, apart from being targeted at specific population groups, are being underpinned by an integrated approach, which is expected to render these interventions, undoubtedly, more effective.

And of course, these directions are congruent with the emphasis placed over recent years by the European Social Fund as regards, in particular, the interventions aimed at addressing the needs of people with disabilities. That is, as mentioned in the introduction, the emphasis has been increasingly placed on developing a comprehensive and co-ordinated package of measures, which should form a pathway to economic and social re-integration of specific population disadvantaged groups.

An Integrated Action Plan that is reflecting the abovementioned directions, and which can serve the purposes of this paper, is the Integrated Program



for the de-institutionalization and the socio-economic integration of persons with mental health problems in Greece, the so-called “PSYCHARGOS”-Mental Health Reform Program.

A.2 The goals and target groups of the policy

Historically, mental health provision - in Greece as elsewhere - was largely based on asylum-like psychiatric hospitals. Thus, until the early 1980's the Greek mental health care system was dependent entirely on institutional care in ten overcrowded hospitals/asylums (including one residential institution for children) unevenly distributed in the country, leaving some regions without access to local psychiatric services of any kind. This, together with the absence of any alternative extra-mural services and the severe lack of qualified personnel, were the main features of mental health care provision in Greece. In contrast, a decreasing reliance on large psychiatric hospitals as sole providers of mental health services and an increasing utilisation of community-based services were the main goals of mental health reforms that were in progress in many European countries since the 1970's.

In the early 1980s, with assistance from the World Health Organisation (WHO), the Greek government undertook a review of the mental health care system and developed a national policy based on the provision of comprehensive community-based psychiatric services in accordance with the WHO health for all policy. The legal foundation for this effort was established by Article 21 of Law» No 1397/83 concerning the National Health System and was reflected in a five-year programme (1984-1988). This programme, which incorporated the recommendations of a committee of international experts set up by the Commission, was presented on 29 May 1984 to the European Commission and served as a framework of actions to be co-financed by the European Community. The resulting Council Regulation (EEC) No 815/84-Programme “B” provided for an exceptional financial support to Greece in the social field and, in particular, for the reform of the psychiatric care system.

The main problems of the Greek mental health care system which were addressed by this Regulation can be summarised as follows:

- Uneven spread of services with regard to both infrastructure and medical and nursing personnel in which large parts of the country had no public mental health care at all;
- a number of large overcrowded institutions in major population centres, particularly Athens, which had no serve the whole country and which ne-



cessitated people being moved from their home areas; for many this meant losing touch with their communities and permanent incarceration;

- a medical/custodial framework of care in which the basic tasks were performed by untrained staff whose main role was containing their charges within the institution.

In order to tackle these problems, the Regulation 815/84 – Programme ‘B’ intervention aimed at:

- the provision of services in some of those areas where none previously existed, by the construction of mental health centres, psychiatric units in general hospitals, hostels, etc. This intended to reduce the pressure on the large institutions and permit the sectorisation of mental health;
- the creation of community based services around the large institutions with a view to reducing both the frequency and the duration of admissions;
- the implementation of training programmes to help staff learn different models of care and thus make effective use of the new facilities;
- the implementation of pilot projects from which new ways of care would emerge, including programmes aiming at the rehabilitation and social integration of long-stay patients.

Action under the Regulation 815/84 was initially planned to cover the period 1984-1989, but it was subsequently revised and extended to cover the period up to 1995. This was mainly due to the delays occurred in its implementation, relating partly to administrative difficulties and to the fundamental nature of the changes involved.

To ensure the continuity of psychiatric reform in a coherent and systematic way, the Greek authorities compiled in 1998 a **10-year National Action Plan**, which was initially designed to cover the period 1998-2007, but, following implementation of Phase “A” over the period 1998-2001, this plan was revised and extended to cover the period up to 2010. This plan forms an Integrated Action Programme for the mental health reform in Greece covering the period 2001-2010. It entails a wide range of actions still required for the continuation and consolidation of the psychiatric reform. Particular emphasis is being placed on the development of a sectorised, efficient network of community based mental health units for prevention, immediate intervention, care provision and for facilitating the return of long-stay patients to the community and their re-integration into the labour market.



The “PSYCHARGOS” Mental Health Programme

This Integrated Action Programme, which has been under way since 1999, aims at the de-institutionalisation and the socio-economic integration of persons with mental health problems: a) by creating of prevention led and therapeutic mental health services and facilities based in the community or in general hospitals and b) by providing pre-training, training, employment opportunities, temporary housing, psychological support, health care, access to cultural events, etc, being based on an individualised approach. Regarding the actions envisaged to be implemented in promoting employment opportunities, the setting up of social cooperatives, among other actions, is considered an innovative measure per se. Overall, it may be said that this programme represents a new pathway to social inclusion for this vulnerable population group, while its coverage is spread all over Greece. The graph in the Annex to this paper provides both an overview on the activities to be undertaken and the relationships among them.

The ultimate aim of this programme is to succeed by the year 2010 in closing down some of the large psychiatric hospitals of the country and in reducing significantly the size of the remaining hospitals by limiting at the same time the scope of their operation and by upgrading the services provided. Moreover, it is envisaged that efforts will be continued and maintained for the creation of alternative forms of employment, in particular the creation and development of social cooperatives all over Greece.

Finally, it should be pointed out that the wide range of actions implemented under the “PSYCHARGOS” Programme serve to a great extent all four Nice objectives of the European Process for Social Inclusion and, in particular: facilitating participation in employment, facilitating access to services, preventing the risks of exclusion and helping the most vulnerable as well as mobilising all relevant bodies.

A.3 The legal, financial and human resources provisions to implement the policy

The basic aim of the social cooperatives is the socio-economic re-integration and vocational re-insertion of mentally ill persons, contributing in this way to their therapy and to the greatest possible extent to their economic self-sufficiency. In the pursuit of this overriding objective, social cooperatives are considered commercial organisations and can develop and perform any economic activity in an entrepreneurial manner.



Overall, it may be said that the establishment of social cooperatives reflect the widely felt need to shift the focus of social and job integration activities from the affliction of the disabled person to his/her potentiality. That is, the need to promote initiatives that take into account both therapeutic aspects and the development of skills and activities of the persons with special needs. In addition, they reflect the widespread tendency to create work situations where the disabled persons are mixed with the non-disabled persons, thereby avoiding the creation of traditional sheltered workshops for the disabled.

The legal basis

The Greek Law No 2716 of 1999 concerning the "Development and Modernization of Mental Health Services", provides among other things, for the formation of **Social Cooperatives of Limited Liability** (Koi.S.P.E.), which are legal entities of private law. The social cooperatives, as provided by article 12 of the above mentioned law, are a specific cooperative, given that apart from being basically productive and trade oriented organizations are being considered at the same time Mental Health Units supervised by the Ministry of Health and Social Solidarity.

Note should be made of the fact that there is a restriction with regard to the number of Social cooperatives that can be established in each Mental Health Sector – "catchment" area, which is usually geographically based: that is, in each Mental Health Sector, usually covering one Prefecture, only one social cooperative can be established.

The social cooperatives have an autonomy in decision-making through their democratically elected organs. However, the state (and in particular the Ministry of Health and Social Solidarity) has supervisory powers with regard to the legal aspects of its operation, while it monitors the development of social cooperatives.

Overall, the legal framework of social cooperatives resembles to a certain extent to the existing framework provided for the agricultural and urban type of cooperatives established in Greece. For, it provides for the formation of an organization which possesses the following distinctive features: it requires the joint effort of individuals with a common purpose or problem; it aims at the realization of a mixture of economic and social objectives; it is not under state control but under collective control and democratic management through



democratically elected (one member, one vote) bodies; it can undertake entrepreneurial activities with the emphasis on the production of socially useful products and services; and finally, its operations are funded mainly from the sales of its products and services, while it can receive some donations or state grants.

The new elements for the social cooperatives introduced by article 12 of Law No 2716/1999 are the following (for further elements of the legal framework see Annex 2) :

- it states that the social cooperative can serve many purposes and perform any economic activity, in contrast to existing regulations governing urban and agricultural type of co-operatives in Greece;
- it gives the right to mentally ill people to undertake any economic activity;
- it defines the membership shares allocated to each participating group;
- it envisages the participation of two mentally ill persons on the Administrative Board (consisting of seven members) of the social cooperative;
- it envisages a salary for mentally ill persons employed by the social cooperative, ensuring at the same time their right to receive any disability payments provided by the state.

A.4 Institutional arrangements, stakeholders involved and procedures of implementation

Under the influence of European Community's Regulation 815/84, most psychiatric hospitals in Greece in the early 1990's began to be engaged in the task of preparing mentally ill patients for social rehabilitation, including the provision of employment opportunities, as well as the provision of housing facilities which would allow the mentally ill persons to lead an independent or semi-independent life in the community.

It was in this context that a number of work integration initiatives for the mentally ill persons living in psychiatric hospitals or in mental health hostels located in the community were established in the first half of the 1990's. These initiatives took mainly the form of either informal "productive sheltered workshops" or informal "cooperative therapeutic units". The operation of the latter, though not based on an existing legal framework, was based on an internal regulation which provided, that it would be run by an Administrative Board composed by hospital personnel and by patients employed in the unit. In addition to these



initiatives, a number of small scale productive units for the mentally ill persons began to emerge, taking the form of either “civil society” organisation or of the “urban cooperative” or “agricultural cooperative”. So, a small number of such initiatives, being characterised by a relative autonomy from the psychiatric hospitals and by an entrepreneurial orientation, employing mentally ill persons living outside the hospitals, came into operation. However, the legal framework used by these initiatives was not flexible enough and lacked specific provisions which were required for setting up a “social enterprise”, capable of facilitating the re-integration of the mentally ill into employment and of ensuring conditions in which discrimination against them is eliminated.

The need for an appropriate legal and institutional framework led to the adoption of article 12 in the Law No 2716 of 1999 which provides for the establishment of Social Cooperatives of Limited Liability, and it is designed to be conducive to the creation of alternative facilities with respect to both vocational rehabilitation and work activities geared to the needs of people with mental health problems. The provisions of article 12 have taken into account experiences from other European Member States, in particular from Italy.

B The results so far

B.1 The quantitative results of the policy so far, in relation to the baseline situation and to the goals and targets

By 1950, the entire inpatient care facilities in Greece for the mentally ill persons consisted of five public mental hospitals, together with a few local private hospitals. By the mid 1950s, the severity of overcrowding in the public sector mental hospitals led to an increase in beds in the existing hospitals and in the opening of four additional public hospitals, among which the Mental Hospital of Leros. The latter was, in fact, to cater for an overflow of patients from other mental hospitals. By the mid ,70s the number of patients had increased further: the Mental Hospital of Attica had more than 2.500 patients and the number of patients in Leros had reached 1.900.

During the period 1984-1995, through the implementation of Programme ‘B’ of Regulation 815/84, a substantial reform effort was achieved in the country involving the creation of prevention led and therapeutic mental health services and facilities based in the community or in general hospitals. This is partly re-



flected in that the number of patients who were residents in public psychiatric hospitals in 1995 has been deduced to 5.118 persons in relation to the 8.149 patients who were residents in 1982. Moreover, provision was made for the development of social and vocational rehabilitation units throughout the country, which was reflected in the undertaking of a number of work integration initiatives, taking mainly the form of either informal "productive sheltered workshops" or informal "cooperative therapeutic units" for the mentally ill persons living in hospitals or in mental health hostels located in the community.

The first social cooperative was established in November 2002 in Leros island with mentally ill persons from the Leros psychiatric hospital as well as persons from the local community. In total, it employs 54 persons of which 32 are mentally ill persons. Four more social cooperatives have been established recently in Athens (2), Corfu island and Chios island, which nevertheless are not as yet in full operation of all their forecasted activities. In addition to these five social cooperatives, five more are to be established within the next two or three months. It is difficult to make an assessment of their operation and their impact to date on the socio-economic integration of the mentally ill persons, given that they are still at an early stage of development.

B.2 Other results and achievements of the policy

Following expiry of Regulation 815/84 some action in the field of psychiatric reform continued under the 1994-99 European Community Support Framework (CSF) for Greece, implementation of which was prolonged until 2001. The action taken was mainly in the context of interventions to combat exclusion from the labour market and in the context of the Community Initiative "HORIZON". Action during that period was concentrated mainly in the de-institutionalization of large psychiatric hospitals, which involved the establishment of hostels in the community and the creation of various forms of "sheltered productive workshops", along with action for upgrading the living conditions in these hospitals.

Achievements towards 2001 included the provision of 55 accommodation units (hostels and apartments) for the mentally ill located in the community and the creation of a large number of "sheltered productive workshops" (approximately 75 in total). The establishment of partnership arrangements between the psychiatric hospitals and the general hospitals, health centres, local authorities' agencies etc, has contributed greatly towards these achievements.



Note should be made of the fact that the action implemented during the latter period 1998-2001, constituted phase "A" of a ten-year National Action Plan, which was compiled by the Greek Ministry of Health and Social Solidarity, but it was subsequently revised and finalised to take the form of a National Programme covering the period 2001-2010. In addition, it should be pointed out that the new Mental Health Law which was adopted by the Greek Parliament in May 1999 not only contributed to the implementation of action under Phase "A", but it also facilitated the widest possible engagement of public and private interest in attitudinal changes in society, fostering thus a more favourable understanding of the needs of the mentally ill persons.

B.3 An assessment of the obstacles and constraints encountered

In the following, the obstacles and constraints which are encountered with the establishment of the Koi.S.P.E. are addressed along the road which led to the adoption of the legal framework for this institution. For the previously established informal "sheltered productive workshops" and the "cooperative therapeutic units", the lack of a properly legal resulted into taxation problems and to a peculiar production status, impeding the proper selling of the products to the market. Financial efficiency was limited and employees, including mentally ill persons, were frequently disappointed. The difficulty to promote the products of the productive workshops to the free market not only caused a feeling of introversion to the personnel but it also restricted their operation inside the founding institution, i.e. the psychiatric hospital.

- Achieving an adequate organizational status

These informal organizations occupied both mentally ill persons living in "asylums" and less mentally ill persons living in the community. Hence, due to the characteristics and the low educational level of the mentally ill workers, they were mainly engaged in the production of handicraft and agricultural products and, far less so, in the provision of services. They exhibited a limited use of new technology and methods of organization, administration and promotion. The most financially developed sheltered workshops were usually those that performed activities in the retail sales sector (small and cheap items, cigarettes), which, however, apart from bringing in limited profits were occupying only a small number of people.

These characteristics, which continue to prevail even today in most of the "sheltered productive workshops" still in operation, have rendered these initiatives



to be regarded as ergo-therapeutic care structures and less as productive units. The mental health professionals or the responsible skilled personnel-craftsmen remain the persons in charge of the workshops, without support or training in organizational, administrative and accounting issues. The workshops operate without any particular planning and their organizational structure is far from being an effective model.

Due to their limited financial independence, in parallel with the low financial efficiency, these units can only cover operational expenses and do not create a surplus for distribution to the patients. This causes a feeling of disappointment to the employees with disability, since in most cases, following the end of the financial support provided by various programs, the workshops reduce both the number of skilled personnel and the number of mentally ill workers.

Overall, the sheltered workshops operated as units of ergo-therapy with some kind of "employment" for a large number of mentally ill persons, but they have been short in achieving the objective of vocational rehabilitation and job integration. In comparison, the "urban-type cooperatives" as well as some "agricultural-type cooperatives", which were created in 1999 and 2000 under the financial support of the Greek Operational Program "Combating exclusion from the labor market" and the Community Initiative "HORIZON", have developed a more commercial and financially efficient profile, mainly because of their deregulation from the founding psychiatric institutions but also because their legal framework provides a certain autonomy. Still though, they have a disadvantage, as they cannot be directly supported by the founding institutions nor can they make use of the mental health facilities, like the "sheltered productive workshops" do.

- Achieving economic viability

The "urban-type cooperatives" mainly occupy mentally ill persons from the community with characteristics different from those who work in the "sheltered productive workshops". The employees have a higher educational level and they are able to adapt more easily to the production requirements. While they have a relatively limited percentage of mentally ill persons employed, at the same time they have a more participating character since these persons take part as members of the cooperative. The quality of the employment is clearly better than this of the "sheltered productive workshops", since most mentally ill "employees" have a formal work arrangement and they all have a kind of wage.



Note should be made, that the majority of their products are related with craftsmanship as it is the case of the “sheltered productive workshops”, though to a lesser degree. The main difference is that they are engaged in the promotion and trading of their products to the open market. The most financially developed “urban-type cooperatives” are engaged in the production and sale of gift goods, the manufacturing of furniture and retail sale.

However, evidence suggests that they have not been development oriented: most of them have failed so far to create the necessary conditions for an for an economically viable operation. In most cases the work offered resembles to ergo-therapeutic practices, the status of the patients is “informal” and they are poorly rewarded. Only few organizations have developed some kind of interconnection and networking both at the level of production relations and promotion.

In summary, the sheltered workshops and urban cooperatives have proved short of constituting a viable prospect for the employment of the mentally ill persons, however, these shortcomings have triggered the need for an appropriate legal framework that facilitates adequate and effective organizational forms of work integration activities for the mentally ill persons and the adoption of the legal framework for the Koi.S.P.E.

C The policy debate

C.1 Current European policy development on the issue

Mental health and work

In our times, working life places less physical but greater mental demands and relevant pressures on employees and all too often there is a gap between these mental demands and the capacity of people to cope with them. This causes stress as well as profound mental health problems such as anxiety and depression, the two most common mental health disorders in Europe today.

On the other hand, a life of very low demands, caused for example by unemployment, also seems to impair mental well-being. Thus, a connection has been found between unemployment and the number of people seeking help for the first time because of mental health problems. Also, the number of ad-



missions to psychiatric hospitals has been shown to increase in parallel with unemployment.

Across Europe it is widely recognised that severe mental health problems often appear in parallel with additional individual handicaps and social disadvantages, and in particular a significant part of the homeless population suffers from mental health problems.

Today, many people of working age who have mental health problems are not employed, although many would like to work according to their capacities. It is no coincidence that there is a long tradition of treating mental illness by providing meaningful work. There are examples of psychiatric hospitals being nearly self-supporting by including their inmates in all the activities which are necessary to run such an institution. Before the widespread usage of modern pharmaceutical drugs work was probably the most powerful therapeutic instrument in the treatment of mental illness.

The relationship between work and mental well-being is even deeper. It is widely acknowledged that work has a number of other benefits besides providing an income. Work is of great significance for most individuals and many essential ingredients for mental health are related to work. Work imposes a time structure on the day and enforces regularity of activity. Work unites people in striving for collective goals. Work gives a feeling of belonging to society, it confers social status and a sense of identity. Finally it is also a criterion of recovery from (mental) illness.

Traditionally, in Europe, people with mental health problems have been segregated – quite often for life - in closed psychiatric asylums and due to their long-lasting exclusion from society they have often been stigmatised and regarded with fear by the population at large. In recent decades the tradition of institutionalised exclusion from society has been replaced in many European countries by greater or lesser trends towards psychiatric de-institutionalisation with relating efforts to close or at least to down-size psychiatric asylums, to avoid re-admissions of new patients to these institutions and to transfer present inmates into newly created local structures.

In Greece the reform of the psychiatric system started with some delay after the accession of the country to the European Communities, with the EC regulation 815/84 acting as a major stimulus to replace the asylum model through a community model of psychiatric treatment.



However, despite these encouraging developments which have taken place in many countries there still exists stigmatisation and fear and a challenge for the social inclusion of people with mental health problems, with a necessary precondition being the creation of flexible community-based systems for rehabilitation and support. According to the current state of the art, such a community-based system for mental health care consists of psychiatric units in general hospitals or centres for mental health, daytime hospital centres, supervised community housing structures, mobile units and – last but not least – possibilities for gainful employment. In this sense, social cooperatives are part of a community-based system for mental health care, with their specific function of supporting the integration of people with mental health problems into employment.

Social cooperatives – part of the system for mental health care or part of the world of business?

A major challenge which faces all the services of the community model for mental health is to avoid creating new institutions of segregation. For the social cooperatives the relevant question is about their link to the mental health system. What is their identity? To what extent are they built as institutions of care and in what sense do they belong to the system of care? Or, from the opposite perspective: to what extent do they belong to the world of business and how do they fulfil their employment and integration functions?

Policies in favour of people with mental health problems at European level

There is no specialised strategy for the social and vocational integration of people with mental health problems at European level. However, mental health issues are addressed both in European health policies as well as in policies to promote employment and social inclusion.

In the field of health policies the “Mental Health Declaration for Europe,” signed by the Ministers of Health of European Member States and the WHO in January 2005, has been a major step forward, all the more because this declaration recognizes “the damaging association between mental health problems and social marginalization, unemployment, homelessness and alcohol and other substance use disorders.”¹ This statement draws our attention to the fact

1 Mental Health Declaration for Europe. Facing the Challenges, Building Solutions. WHO Europe, EUR/04/5047810/6, 14 January 2005.



that “mental health problems” show up in quite complex symptoms creating more than just an artificial problem of definition but also sometimes resulting in considerable difficulties when it comes to practical policies in favour of the relevant target group.

The priorities set in the Mental Health Declaration for Europe for the next decade include a mention of the need to “collectively tackle stigma, discrimination and inequality, and 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.”

In the field of non-discrimination, new rights have entered into force across the EU with the ground-breaking anti-discrimination directive which was adopted in 2000.² This legislation assures that a “rights-based” approach towards (amongst others) people with “a particular disability” is firmly anchored in the EU and at national levels.

People with mental health problems – people with disabilities?

Clarifying the relationship between “mental health problems” and “disability” is an important issue at stake. As shown above, the rights for people with disabilities are clearly recognised all over Europe, whereas the notion of people with mental health problems is relatively vague. Addressing people with mental health problems as disabled persons will provide them with the legal rights of this group and will allow them to participate in the support measures which are undertaken in favour of disabled persons. On the other hand there is also resistance to designating people with mental health problems as disabled people. Many people with mental health problems reject being characterised as disabled, because the episodic character of mental illness means that it is difficult to accept this label as part of your personal identity. Given these tensions, much of the answer to this question will depend on national laws and regulations concerning both groups.

Overcoming discrimination and increasing the integration of people with disabilities and other groups at high risk, such as people in or leaving institutions, is also among the seven key policy priorities of the European social inclusion process.³ In addition, the Joint Report on Social Protection and Social Inclu-

2 Council Directive 2000/78/EC of 27 November 2000 establishing a general framework for equal treatment in employment and occupation.

3 European Commission: Joint Report on Social Protection and Social Inclusion. Luxembourg: Office for Official Publications of the European Communities 2005 a



sion also points to the need to develop integrated and co-ordinated strategies at local and regional levels in order to overcome the disadvantages of these groups.

In general, the NAPs/inclusion highlight that - among other groups - people with disabilities, the homeless, as well as people in or leaving care institutions face very particular risks of social exclusion because of their difficulties with integration into gainful employment. A first look at the Joint Report on Social Protection and Social Inclusion 2005, at the NAPs/inclusion of the Member States and the implementation reports 2003-2005 reveals, however, that activities in favour of people suffering from mental illness are not very profiled. In several cases, people with mental health problems are not even mentioned as a special target group.

In the Report on Social Inclusion in the 10 new Member States 2005, a broad range of legislative initiatives, policies, approaches and measures in favour of disabled persons is addressed, whereas there is only one good practice example from Malta reporting on a programme which aims to integrate people with mental health problems into employment.⁴ A similar impression is provided by the Joint Report where activities to support people with mental health problems are reported only for Sweden.⁵ A more detailed picture finally emerges when we look more closely at the individual NAPs/inclusion of the Member States:⁶

Several countries address the special needs of people with mental health problems and mention different efforts to improve their systems for mental health care. Against this background

- Belgium, Denmark, the Czech Republic, France and Hungary make special reference to the mental health needs of homeless people, drug-addicts or people living in institutions (multiple diagnosis)
- Cyprus and Greece emphasize their broad efforts towards de-institutionalization of psychiatric asylums and the creation of community-based alternative services

4 European Commission: Report on social inclusion 2005 – An analysis of the National Action Plans on Social Inclusion (2004-2006) submitted by the 10 new Member States. Luxembourg: Office for Official Publications of the European Communities, 2005 b

5 European Commission 2005 a, see footnote 3

6 See the NAPs/inclusion of the relevant Member States which are available on the following web-site: http://www.europa.eu.int/comm/employment_social/social_inclusion/naps_en.htm



- The Swedish government appointed a psychiatry coordinator to improve cooperation between treatment, rehabilitation, accommodation and employment for the mentally ill
- The NAPs of Estonia, Malta, Latvia and Finland even consider mental health issues, although in different degrees as a cross-cutting subject and articulate the demand for a more or less detailed general strategy.

Recognising that employment is a key factor for social inclusion, not only because it generates income but also because it supports social participation and personal development, some NAPs/inclusion are additionally addressing in more detail the efforts to improve integration into employment for people with mental health problems.

- In Denmark people with mental illness will be one out of five prioritized target groups of a job placement initiative.
- Lithuania is preparing a law on social enterprises to support the employment of disabled persons and the most vulnerable groups in the labour market; before implementing the relevant law the target groups of persons to be employed in social enterprises and the procedure to employ them have to be defined, and the rights and responsibilities of social enterprises have to be regulated.
- In Poland a law on social cooperatives has already been introduced; the adoption of a support system for newly created cooperatives is also foreseen, together with comprehensive legal provisions for non-profit enterprises.
- Sweden has announced further modifications of existing rules to promote social enterprises which have proven to be an effective means of integrating the most vulnerable groups into the labour market. Necessary changes apply especially to the administration of various subsistence allowances which sometimes act as a disincentive to participation in work. Furthermore, the Swedish government supports a number of cooperative development centres; their purpose is to provide information and advice in order to encourage people to start cooperative enterprises and to promote the development of entrepreneurship in the social economy.

Additionally, several countries confirm their readiness to promote access to stable and quality employment for all women and men who are capable of working “by using the opportunities for integration and employment provided by the social economy”, thus referring to the common objectives for the second round of National Action Plans as commonly agreed by the Copenhagen European Council.⁷

⁷ Council of the European Union: Fight against poverty and social exclusion: Common objectives for the second round of National Action Plans. Brussels 2002, 14164/1/02



The Social Economy

In fact in almost all Member States of the European Union a remarkable growth of the “third sector” or the social economy can be observed, whereby these terms refer to all those socio-economic initiatives that belong neither to the traditional private business sector nor to the public sector. However, both the legal frameworks for the social economy and the historical experiences and traditions vary considerably from country to country. Some organisations in this sector have deep historical roots, particularly in the church and trade union fields, although thousands of new initiatives have been created throughout Europe over the past thirty years.

In spite of their different characteristics, the organisations of the social economy pursue a number of common goals, which for the most part also apply to the Greek Koi.S.P.E.. These can be characterised in the following way:

- Economic and social objectives are pursued equally
- Economic activity is non-profit oriented
- The initiatives are economically independent
- Whether at national or regional level, the initiatives are often loosely networked with each other in order to provide mutual support and joint representation of interests
- The initiatives tend to include their employees in decision-making processes.

Social cooperatives for people with mental health problems – part of the social economy?

As we have seen, considerable shared ground exists between the Koi.S.P.E. and the social economy. Are there also any differences, and if so, what do they consist of? What significance do these differences have? What conclusions result from the common ground? How could these common factors be made more fruitful?

As shown by many studies, including the famous CIRIEC study, the enterprises of the social economy promote not only the social integration of disadvantaged social groups, but are also capable of developing innovative products and services as well as mobilising latent resources.⁸ As a result they impart a new dynamism to initiatives for the common good by wakening civic entrepreneur-

8 CIRIEC International: Report on Third Systems and Employment. Université de Liège 2000.



ship as well as the readiness on the part of the citizens to become involved, a factor of major importance in ensuring the continuity of the European social model.

Support for social cooperatives through European programmes

During the second half of the Nineties there were many projects inside the Horizon and Integra strands of the Community Initiative Employment which in broad terms supported the growth of the social economy and specifically also aimed for the establishment of social cooperatives for people with mental health problems.

Thus, inside the Horizon programme a transnational network, the Marienthal project, was funded which was aimed to create supporting structures for social enterprises in several European countries (Finland, Germany, Greece, Italy, Netherlands, Spain, UK). The network developed a number of tools such as models for business plans, national directories of social enterprises, and tailor-made training programmes for managers and employees.

More recently the EQUAL Initiative has provided considerable support for these objectives not only in Greece, where it worked as a catalyst to implement the first Koi.S.P.E., but also in other European Member States (mainly in Austria, Germany, Italy, Finland, and UK). Up until 2003, for example, 11% out of 7,500 beneficiaries of the national EQUAL programme in Austria were people with a physical or mental disability or mental illness.

Altogether, the relevant partnerships funded under EQUAL have produced valuable knowledge on social entrepreneurship (Finland, UK), including the creation of national or regional thematic networks to support social enterprises for people with mental health problems.

C.2 Relevant practices and experiences in other Member States

Across many countries in Europe there have been significant changes in the treatment of people with mental illness in the last decades. This change is mainly due to the process of de-institutionalisation of large psychiatric hospitals which was started by Franco Basaglia and his team first in Gorizia and later in Trieste (Italy) in the beginning of the Seventies of the last century and lead to the emergence of a range of community-based services for people with men-



tal health problems including the creation of options for gainful employment in business-like environments which are described differently from country to country - social cooperatives, social enterprises, integration firms, social firms – but which are all united by a common denominator, namely the aim to combine commercial interests with the social objective of providing suitable employment for people threatened by exclusion.

This formula also applies to the Greek national mental health reform programme of 1999 called Psychargos, which promotes both the de-institutionalisation of psychiatric services and the socio-economic integration of persons with mental health problems.

The following table provides a quantitative overview on the number of social cooperatives and their respective number of employees in certain European countries. As shown in the table, in all countries non-disabled regular employees are working together with disabled or socially disadvantaged people who, for most of the cooperatives, are primarily employees with mental health problems. These employees are often difficult to categorize because of the mixture of mental, social and physical problems they suffer from. The number of workers with disabilities is around one third, with the exception of Germany, where this group forms about half of the employees. It should also be mentioned that a significant proportion of the disabled workers are in part-time rather than full-time employment in accordance with their (changing) individual capacities. Given the low wages that result from these arrangements employees of this type cannot stand on their own but are constantly dependent on additional pensions and / or social welfare support. Nevertheless, being an employee is an important part of their personal identity.

Table 1: Social cooperatives, employees, employees with mental health problems or other disabilities in selected European countries

	Number of social cooperatives	Number of employees in total	Number of employees with mental health problems or other disabilities
Italy	8,000	60,000	20,000
Germany	520	16,500	8,250
Sweden	90	1.400	500
UK	50	960	300

Sources: IRES 2003, BAG Integrationsfirmen 2005, Stryjan 2001, Social Firms UK 2005



In many European countries similar developments are taking place in order to support the social inclusion and, more specifically, the integration into employment of people with mental health problems by the setting up of social cooperatives or specific enterprises. The following section aims to summarize common elements, to point to some of the differences and to note a number of open questions for further debate.

Although there is a common social background and a common denominator for all initiatives the development of these types of employment and businesses depends heavily on the legislation and the supporting measures which are available in the different countries. An overview is given in the following table no. 2. For further details see the country descriptions in Annex 3.

Table 2: Legislative frameworks, financial resources and support in selected European countries

	EL	IT	DE	FI	SW	BE	UK
Legal frame for social cooperatives	x	x	-	-	-	-	-
Legal frame for social enterprises	-	x	x	x	x	x	x
Subsidies for coops / enterprises	x	x	x	?	?	-	-
Privileged public service contracts	-	x	-	?	?	-	-
Wage subsidies f. disabled workers	x	x	x	x	x	x	-
Assistance to disabled workers	x	x	x	-	?	-	-
Incentives for workers transition	-	-	-	-	-	x	-
Business consulting services	x	x	x	?	x	-	-
Dividends to private investors	-	-	x	-	-	-	x

In common with many other initiatives and enterprises active in the social economy, social cooperatives are characterized by a double function with regard to their general objectives, in so far as they are businesses which use their market-oriented production of goods and services to pursue a social mission, i.e. to provide employment for people threatened by social exclusion.

Most social enterprises work in the service sector, a small part is active in – mostly subcontracted - industrial production, some enterprises provide jobs in recycling or environmental businesses, with the latest being set up in the field of travel and tourism. To summarize, social enterprises have mainly been established in those economic sectors and branches where not much investment capital is needed but where potentials for growth nevertheless exist.



The transition rate from social enterprises into jobs in the open labour market is quite low in most countries. This is probably not due to the type of work which is provided but rather to the supportive atmosphere in the workplace. For the social cooperatives there is also the issue of ownership which might give additional value to the disabled employees.

In respect to the different needs of their employees, social cooperatives fulfil a triple function, as they provide

- durable full employment for disabled and non-disabled workers with regular payment of wages permitting them an independent living
- part-time jobs providing additional income for disabled workers who due to a highly reduced ability to work are mainly reliant on disability pensions or social welfare allowances
- arrangements for periods of participation in vocational trainings, rehabilitation programmes and work experience thus permitting gradual accustomisation to regular work and transition into durable employment.

The status of the worker

Social enterprises offer long-term jobs with regular contracts and market-rate salaries for full-time and part-time workers. In what ways is support provided for the personal development of the employees? Which methods have been devised to allow the employed individuals to shape their own future? What incentives exist for transition into jobs in other enterprises (according to the regulations in Belgium)? What is the significance of the training measures? What role is played by empowerment and ownership, i.e. the inclusion of the workers in decision making structures?

Social enterprises in the Member States of the European Union differ quite considerably in terms of their legal and organisational characteristics. Greece and Italy favour a particular legal form in order to do justice to the social function of such enterprises. Cooperatives in these countries enjoy a number of advantages, particularly in their access to public tendering. German “integration firms” merely have the same support mechanisms at their disposal that are also open to all other firms. In this case the level of financial support is solely dependent on the restrictions in the individual working capacity of the disabled workers. And in the UK the CIC even attempt to involve private capital in the social economy in the expectation that the social enterprises could increasingly be in a position to make profits.



A unique legal framework to employ people with mental health problems?

Compared to the approaches which are applied in other countries, Greece has created a unique legislative framework for the inclusion of people with mental health problems into employment. Whilst this might assure that the acknowledged needs of the target group are in fact met, on the other hand in other countries there is good reason for the fact that social enterprises are also open to other marginalised groups, as mental health problems quite often consist of a mixture of social and personal handicaps. What are the advantages and disadvantages of a specialised legal framework?

In all the Member States the social enterprises that have been created form part of a new community-based approach directed against institutional segregation. The motivation behind the social inclusion of people with mental health problems is to reduce discrimination and to promote integration into the everyday life of the local community. The anchoring of the social cooperatives in the local community is an important tool in this process. The social cooperatives want not only to be part of the new mental health care system, but also, and from their perspective more importantly, to maintain and promote their contacts with the rest of civil society and its organisations, other enterprises of the social economy as well as with the world of the profit-oriented economy. In the long term this approach is able to generate more support than dependence on the public authorities and their funds. Thus for example, in Sweden the social enterprises can rely on local development centres which provide them with advice and which promote entrepreneurship in the social economy.

Networking and local / regional integration

Of decisive importance for the degree of social integration and for the economic sustainability of the social cooperatives is thus the question of how they are connected to their local milieu. What kind of contacts do they have with other initiatives in the social economy sector? To what extent are the Koi.S.P.E. networked amongst themselves? To what degree are they accepted in their local milieu? What other external support structures, whether from the field of regional development or from the field of the competitive economy, can they make use of?



C.3 Assessment of the arguments of different interest groups

The need to create adapted, suitable and non-stigmatised employment opportunities for people with mental health problems at community level as an alternative to institutional segregation is widely recognised all over Europe.

It is also agreed that in order to ensure the creation of community-based social cooperatives common actions have to be undertaken by different actors and decision-making bodies. All stakeholders – people with mental health problems, their families, relevant NGOs, public authorities and the social partners – are asked to work together to put in place appropriate and effective policies and to bring an end to prejudice and stigmatisation as well as to discrimination and social exclusion.

However, accepting the right for employment for people with mental health problems should not be understood as an obligation to work. Therefore, individuals with mental health problems must have an option to determine the degree of their participation in the working world according to their personal capacity. Where an individual chooses to take up employment, remuneration should be according to the regular wage standards which may vary from country to country.

Whilst the initiation of equal opportunities in all aspects of employment is a guiding principle for the establishment of social cooperatives, these basic ideas are fully recognised as success factors for integration by the European social partners, too: “In the field of employment, it is crucial to find tailor-made solutions, which take into account factors such as the type of disability of the person, the size of the business, the nature of the sector, and the occupation. Indeed, these factors influence what measures can and should be taken to match the ability of the individual with the specificities of the tasks to be performed.”⁹

At European level many different interest groups exist which are involved, from a number of different perspectives, in the promotion and creation of suitable employment for people with mental health problems or disabilities.

9 Declaration of the Social Partners for the European Year of People with Disabilities: Promoting equal opportunities and access to employment for people with disabilities. 2003



In the health field “Mental Health Europe” (MHE-SME) should certainly be mentioned, a NGO which in the broad sense is promoting positive mental health in all spheres of life but which is also concerned about the improvement of care and the protection of human rights of users of mental health services. In this context MHE-SME also places special emphasis on ensuring that the rights and special needs of employees in social cooperatives are adequately taken into consideration.¹⁰ Set against the background of traditional psychiatry this is a concern of central importance which MHE-SME also shares with the organisations of users and ex-users of psychiatric institutions.¹¹

The social cooperatives and enterprises for people with mental health problems have also created their own European representation of interests, by the name of CEFEC (Confederation of European social Firms, Employment Initiatives and social Cooperatives for people with mental health problems and disabilities).¹² The efforts of this NGO range from the transformation and de-institutionalisation of psychiatric institutions and sheltered workshops, support for the creation of employment in social enterprises, provision of accompanying services to support integration into competitive employment in regular enterprises, to sensitisation of the society at large for the rights and the needs of people with mental health problems. Given this background their main arguments are about establishing and maintaining empowering standards in the quality of the working environment in order to enable the individual to take an active place in society. Based on the experience that most of the non-disabled personnel in social cooperatives stem from the psychiatric care system, vocational training of the staff in skills for business planning, financing, marketing and management is seen as another essential factor in order to successfully run the cooperatives.

Many organisations and initiatives exist in the social economy sector that also represent the interests of the sector at European level. Examples of this type of organisation are CEGES (Conseil des Entreprises, Employers et Groupements de l’Economie Sociale) and CECOP (European Confederation of Workers’ Cooperatives, Social Cooperatives and Participative Enterprises).¹³ Both NGOs see their main task in the field of networking and cooperation and in the creation of partnerships within the social economy as well as with affiliated partners. Another major concern is to reinforce the territorial dimension of the social

10 For further information see: www.mhe-sme.org

11 For an overview see for example: www.iaapa.ch

12 For further information see: www.cefec.org

13 For further information see: www.ceges.org; www.cecop.coop



economy by addressing such legislative preconditions like devolution of political power, decentralisation of decision-making competencies, and redistribution of authority, responsibility and resources between the national, regional and local levels.

Summarized concerns of the different interest groups

What is the status of the employees in social cooperatives? Are their rights guaranteed? What are the working conditions like? What opportunities exist for individual development?

To what extent are the cooperatives embedded in the social economy and the local community?

How well does cooperation between the local stakeholders function?

Is the local level equipped with the competences, decision-making powers and resources required to promote its territorial development and hence support civic entrepreneurship in general as well as social cooperatives in particular?

Do the non-disabled staff have the required qualifications, particularly with regard to the business management of the cooperative?

C.4 Components for mutual learning and transferability to other contexts

1. The target group

Whereas much progress has been achieved at European level for disabled persons and their social integration, this does not apply to the same extent for people with mental health problems. In many areas of life, social sensitivity has been raised in the meantime for the special needs of people with physical handicaps, e.g. by improving the accessibility of transportation facilities or providing adaptations of IT equipment. In comparison to these achievements the social inclusion of people with mental health problems seems to be a widely neglected issue, even though a growing number of European citizens are suffering from mental illness. In future therefore, the social and vocational integration of this target group should be tackled with a higher priority.



2. The policy agenda

Despite the developments with the de-institutionalisation of psychiatric institutions the social integration of people with mental health problems is still poses a major challenge. Many national governments have adopted relevant policies but a lot still has to be done in terms of their practical implementation. National governments could support their own policies with detailed actions plans complemented by clear and measurable objectives and a monitoring mechanism to enable them to review achievements and the progress which has been made.

3. A multi-dimensional policy approach

The term “mental health problems” often serves to conceal a whole complex of physical, mental and social problems, often associated with homelessness and drug dependency. The complex needs of people with mental health problems can most readily be met by a system of community-based mental health care services, in which medical and social treatment, rehabilitation services, accommodation facilities and last but not least suitable employment provisions are provided in a holistic and coordinated way.

In order to implement such a multi-dimensional approach at local level several preconditions have to be fulfilled:

- better coordination of the relevant policies for health care, social protection and social affairs, insurance and pension systems, rehabilitation, education and training systems, and – of course - labour and employment policies which must be cross-cutting through the isolating silo-mentality of the individual policy departments
- closer cooperation between the national Ministries which are responsible for the design and implementation of the relevant policies
- a clear division of tasks and clarification of responsibilities between national, regional and local public authorities, with the general aim of extending decision-making competences at local level
- Closer cooperation between different stakeholders at community level, including the (ex-) users of mental health care services, their families, the staff of these services, NGOs, civil society, the social partners and the local authorities
- Closer cooperation between the services for mental health care and in particular between the public services and the business sector.



4. A legal framework enabling empowerment and supported by resources

A legal framework is needed for the employment of people with mental health problems in social cooperatives. A number of different legal constructs are conceivable in this context.

- Ensuring the status and rights of the disabled employees and taking their special needs and individual development perspectives into consideration will be of decisive importance.
- In order to do justice to the often limited working capabilities of their employees, social cooperatives require a certain financial compensation. Various models are available to ensure their social function or the type and degree of financial support.
- Employees and management staff should receive constant professional training in order to maintain and improve their skills and qualifications as well as the quality standards of the cooperative. The qualifications of the management staff should encompass not only skills to support the individual rehabilitation and personal development of the employees but also the relevant business skills for the economic leadership of the cooperatives.
- Training can furthermore play an important role in the social cooperatives' formative stage; the European Social Fund has proven to be an extremely important and effective means for the achievement of the relevant human resource development goals.

5. Networking and cooperation

Social cooperatives cannot survive in isolation. They need to be embedded in the local communities, the rest of the social economy and also in the world of competitive business. They need overarching support structures. These can be specialised business consulting agencies, but also centres for regional economic development that are open to the social objectives of the cooperatives. Networking with other cooperatives, enterprises of the social economy or regular businesses can contribute considerably to the economic stabilisation of the cooperatives. The supplementation of delivery chains can result in the creation of synergy effects, the dissemination of information about innovative products and successful business models and possibly even access to capital and new markets.



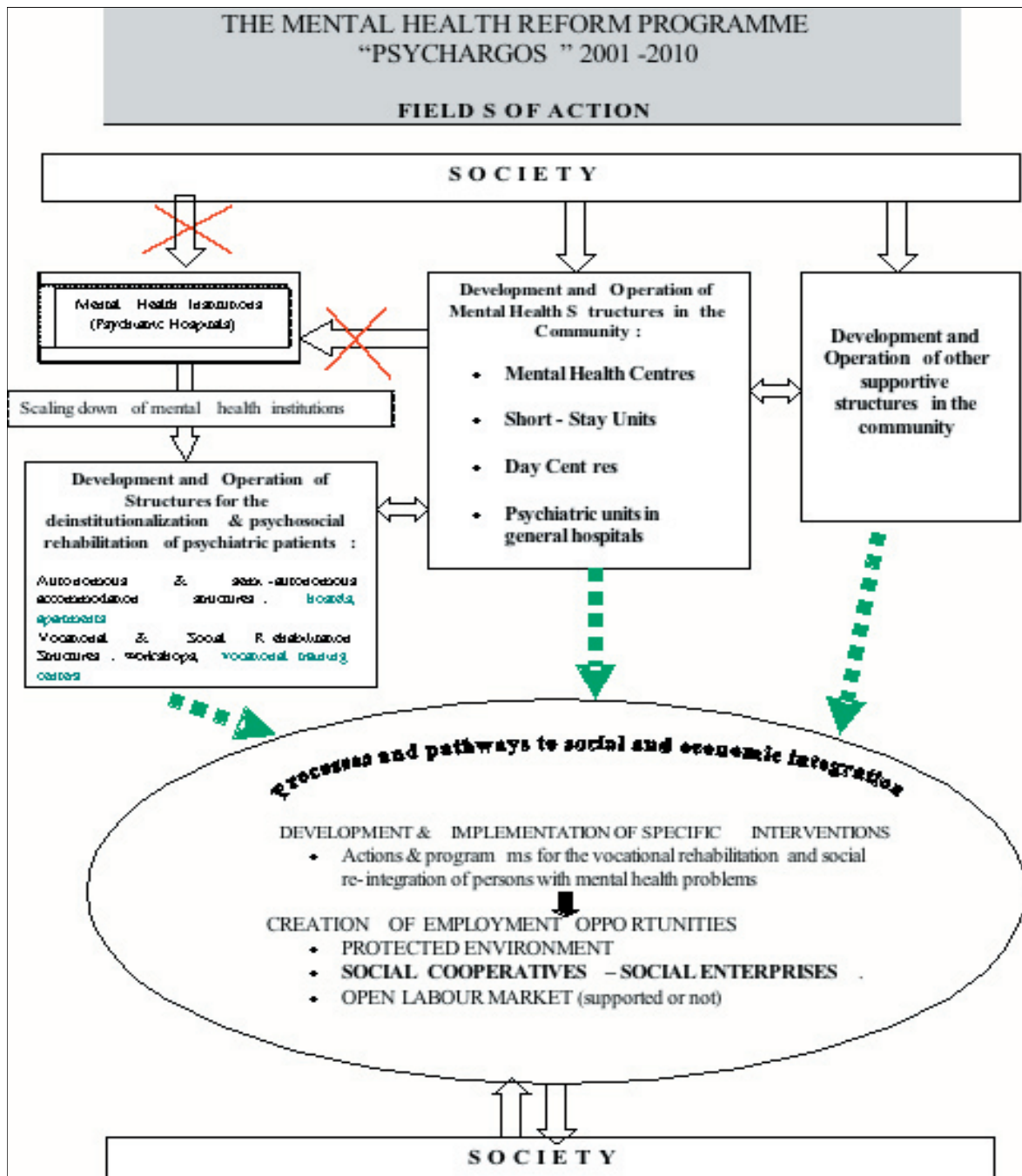
6. A local culture of civic entrepreneurship

Finally it is important that the social cooperatives find acceptance and a supportive culture of civic and social entrepreneurship in their local milieu. The creation of links between the cooperatives and their local environments is useful not only in terms of the economic survival of the cooperatives, but can also contribute to a dynamic and coherent development of the territory as a whole, and last but not least are a precondition for the overcoming of the stigmatisation of people with mental health problems and a step towards their social inclusion.



ANNEXES

Annex 1: Overview on the mental health reform programme "Psychargos"





Annex 2: An overall view of Social Cooperatives of Limited Liability (Koi.S.P.E.)

The Social Cooperative is a specific form of cooperative which is underpinned by a specific aim, serving both therapeutic and entrepreneurial purposes. In particular, social cooperatives provide the opportunity for their members to regain „unused“ skills or to acquire new ones through on-the-job training and work experience and eventually to acquire a permanent job in a somehow „protective“ environment or in the regular labour market. At the same time, members of the cooperative learn to work on a collective basis and take some responsibility relating to the performance of the cooperative’s activities. It should be pointed out that in these cooperatives, work activities are carried out by both mentally ill persons and non-mentally ill persons, thus avoiding the creation of a „sheltered“ work situation. Furthermore, this initiative has begun to paving the way for similar legal arrangements to be made in order to facilitate the establishment of social cooperatives by other vulnerable population groups and, in general, the development of the social economy sector in Greece.

The main innovative elements characterising social cooperatives

- It is a new organisational form
- It ensures compatibility between economic and social objectives
- It strengthens and promotes partnership relations and arrangements
- It enhances the mobilisation of the local actors and the local community at large
- It facilitates and promotes a ‘bottom-up’ approach
- It constitutes part of the de-institutionalisation process of mentally ill persons
- It is underpinned by an integrated approach
- It exploits the potentiality of social capital development in a specific territorial context

Composition of membership

The potential members of the social cooperatives are divided into three distinct categories:

- the mentally ill persons, above the age of 15 years old. It is obligatory that the persons of this category represent at least 35% of all members of the social cooperative.



Mentally ill, aged 15 and above, irrespective of diagnostic category, the stage of illness and their residence without the requirement of them being capable of legal transactions or not. The members that fit in this first category constitute 35% of the total number of members. These members can be employed by the Koi.S.P.E. and get paid according to their productivity levels and time of work. In the event of them receiving some form of pension, allowance or other form of benefit, they do not lose these benefits but continue to collect them concurrently and in addition to their Koi.S.P.E. salaries. If they are not insured, the social cooperative provides insurance for them in the respective insurance agency.

- the mental health professionals and, in general, those working in the area of mental health. Members of this category cannot exceed the upper limit of 45% of the total number of members:
Mental health personnel like psychiatrists, psychologists, nurses, occupational workers, trainers and other mental health professionals. Public servants, psychiatrists or psychologists working at the NHS. (National Health System) can also be members of the Koi.S.P.E. The members of this second category should not be more than 45% of the total number of members. These members can work at the social cooperatives full-time or part-time. Specifically, the Koi.S.P.E.-members that work in a Mental Health Unit (MHU) of a Mental Health Sector that collaborates with that particular social cooperative can work concurrently in both services (MHU and the Koi.S.P.E.) or be internally transferred to that Koi.S.P.E. In case they are internally transferred they do not get paid by that Koi.S.P.E.
- Other persons as well as legal entities of public or private law. Agencies and organisations such as local authorities, hospitals, public organisations, etc., as well as individuals such as: unemployed persons, persons from other vulnerable social groups, etc. Membership of this category cannot go beyond the upper limit of 20% of all members of the Koi.S.P.E.

Employment arrangements and regulations in the social cooperatives

The mentally ill persons can be employed in the social cooperatives and get a salary in accordance with their productivity and the hours worked. This salary is added to any benefit or pension that the mentally ill person is entitled to receive. If the person is lacking social insurance, the social cooperative is required by law to provide social insurance coverage.



Cooperative shares

Compulsory cooperative shares: Each member receives, upon enrolment, a compulsory cooperative share as defined in the Articles of Social Cooperatives of Limited Liability. The cooperative share is the same and of equal value for all members.

Optional Cooperative shares: Each member has the option of obtaining up to five optional shares and legal entities of public equity or non-profit legal entities of private equity (public or private sector) have the option of obtaining an unlimited number of optional shares, if there is such a provision in the Koi.S.P.E. articles.

Organisational Aspects / Management

The managing bodies of the Koi.S.P.E. are the following:

- a) the General Assembly, which is the highest decision-making body for all matters concerning the Koi.S.P.E., composed of all its members;
- b) the Management Board (or Administrative Council), which is composed of seven members elected by the general assembly and which is responsible for the management and operation of all activities of the Koi.S.P.E.;
- c) the Supervisory Council which is composed of three elected by the General Assembly and which is responsible for the supervision and monitoring of the activities of the management board.

It should also be stressed that all social cooperatives are based on the principle of democratic management, which in turn is based on the clause 'one member-one vote'.

Resources

- Funding from the Regular State Budget or the Public Investment Program exclusively for co-funding programs from the European Union or International Organizations.
- Funding from National Organizations, the Investment Program, Development Programs, E.U. or International Organizations.
- Legacies, donations and surrender the use of property
- Incomes from economic activities of the Koi.S.P.E.
- Incomes from Koi.S.P.E. property utilization



Association with legal entities of public law

The state, public organizations, local authorities as well as their respective legal entities are supplied with goods and receive services from the Koi.S.P.E. In that case, the supply of goods/services offered can take place by contracting with the Koi.S.P.E. The above-mentioned bodies are allowed to give away to Koi.S.P.E., for the purpose of use only, assets (landed property or real estates) and any other form of facilities.

Tax Reductions

Koi.S.P.E. are exempted from any kind of taxation, direct or indirect, except VAT.



Annex 3: Experiences in other Member States

Italy

The development of social cooperatives for people with mental health problems in Italy can be traced back to the 1970's when, after the closure of psychiatric asylums, a need for alternative service facilities for the former inmates was emerging. Today, the culture of social cooperatives is recognized as the largest in scale in quantitative terms and in qualitative terms as the strongest in Europe. Consequently, in many countries the concept of social enterprises has been derived from the Italian approach and this also applies to the Greek Koi.S.P.E..

In Italy, social cooperatives are characterized by certain elements which make them unique in comparison to similar approaches in other countries. The legislative ground for the social cooperatives was laid in 1991 with the law no. 381/1991, in which a difference was made between regular cooperatives (Type A) and social cooperatives (Type B). Cooperatives of Type A deal mainly with social services such as health care, education or care for elderly persons. For cooperatives of Type B the nature of the activities is much broader; their aim is to create employment in any sector of business. However, this second type is required to restrict the number of normal employees to 70% of their total number of employees, and to reserve a minimum of 30% of their workplaces for disabled or socially disadvantaged workers. In this context the term socially disadvantaged encompasses physically and mentally handicapped persons, people with mental health problems, drug addicts, alcoholics, discharged prisoners and young people from social risk groups. In practice, the major group of disabled workers in the Italian social cooperatives are people with mental health problems.

The employment requirements of Type B cooperatives have certain advantages in comparison to regular cooperatives:

- Social cooperatives do not need to make payments to state insurance systems for their handicapped employees
- Social cooperatives receive a 25% reduction on land and mortgage taxes
- Social cooperatives are prioritized in the awarding of contracts for public services from local, regional or central state authorities.



The management system of the Italian cooperatives is also different to regular enterprises as it emphasizes equity and encourages workers to play an active role in the organisation. Members are empowered to participate in decisions and every worker has a share in the organisation and has an individual vote. The executive board and the president of the cooperative are elected by the majority of member votes.

Besides the public subsidies mentioned above the European Social Fund is the most important source for additional support. This is mainly used to provide vocational rehabilitation programmes for the disabled workers of social cooperatives and training courses in business management for the executive board. Furthermore there are a number of consultancy agencies run by regional consortia which provide additional support in business and administrative affairs.

Germany

Compared to Italy there was less pressure to create opportunities for social inclusion of people with mental health problems because the processes of de-institutionalisation of psychiatric asylums had been much slower and less dynamic. Nevertheless, social enterprises (Integrationsfirmen) for people with mental health problems experienced a steady and sustained growth in Germany which started in the beginning of the Eighties and is still going on. This development is mainly due to the relatively generous financial funding schemes which provide support for the integration of disabled people into employment. In Germany, social enterprises have been steadily growing because they succeeded in opening up those funding schemes from different public resources to people with mental health problems and were able to bundle these schemes, which in principal are available for all employers, into a coherent concept for social enterprises and to use them systematically. In detail they can rely on the following public support schemes:

- Public grants to make the necessary investments into equipment and machinery in order to employ a disabled person
- (degressive) subsidies for the wages of the disabled employees are paid for a limited time in order to cover the loss of productivity (with a maximum funding period of four years starting with a subsidy of up to 70% and a reduction of 10% each year)
- Public grants to cover the costs for personal assistance to the disabled workers.



Furthermore in recent years a specialized business consulting agency for social enterprises has been created which is also subsidized by public grants. Apart from this overhead structure, in Germany social enterprises are regarded in the same way as any other business, in spite of their social objectives. There is no special legal framework and there are no binding obligations for their internal management structures and decision making processes. Nevertheless social enterprises will normally apply structures which support the empowerment of their workers.

Similar to Italy, some social enterprises in Germany have created common consortia at regional level in order to strengthen their cooperation, to support each other with certain business services such as electronic book-keeping, or to further diversify their businesses by complementing the delivery chain of their services.

Sweden

The roots of social enterprises in Sweden are different to those in other European countries. Here, those people who encountered difficulties in fitting into ordinary businesses because of personal handicaps were traditionally accommodated in a nationwide public network of sheltered workshops called "Samhall" where - subcontracted from industry - simple assembly and packaging tasks were carried out. The former inmates of the disbanded psychiatric institutions who had been relocated into local communities could hardly handle the demands of such structured work-places. Changes occurred with the decline of traditional industries, forcing Samhall to scale down and to move away from industrial work into the service sector, a development which has opened up new opportunities to employ people with mental health problems in more enterprise-like environments.

In parallel, actors from within the field of mental health care (staff, patients and ex-patients) initiated on their own accord the creation of social work-cooperatives. In the formative stage of these cooperatives training played an important role both as a financial tool and as an instrument to develop the relevant skills needed to run the future business, which in general is an interesting lesson to learn.

The development towards social cooperatives gathered momentum during the mid-90s, once suitable funding schemes had been found. A substantial



percentage of workers receive disability pension or are on early retirement benefits and their contributions may therefore be considered as a voluntary input to the cooperatives.¹⁴

Finland

In Finland, a special act on social firms came into force on 1 January 2004 which defines a social firm as aiming – just like any other business company – to make a profit but in which at least 30% of the employees must be disabled, or consisting of a mix of disabled and long-term unemployed people. Companies which stick to these rules are inscribed in a special register of social firms. They receive subsidies like any other company which employs disabled persons but public compensation for loss of performance is paid over a longer time.

A number of efforts are currently being undertaken to further strengthen the position of social firms in Finland, including the creation of a model for social firms as part of the municipal services, developing vocational training programmes for the employees of the social firms, and creating an accounting model for the gross economic efficiency of social firms in order to support their position in the public procurement processes.¹⁵

Belgium

Traditionally, “les entreprises d’insertion” in Belgium provided training and jobs only for a limited period of time in order to prepare long-term unemployed people for the transition into a job on the open labour market. In more recent times, the legislative framework for these enterprises has been widened in order also to allow the creation of permanent employment posts for people with severe social and professional difficulties. Wages for these workers are subsidized, but financial incentives are also paid for successful placements of such workers into jobs in regular business enterprises.

UK

In the UK a “Social Enterprise Strategy” was published in 2002 in which the government defined three priorities for action:

14 Stryjan, Y.: Sweden: The Emergence of Work-integration Social Enterprises in Sweden, in: Borzaga, C., Defourny, J. (eds): *The Emergence of Social Enterprise*. London and New York, Routledge 2001, p. 220-235

15 Pöyhönen, E.: *Developing Social Firms in Finland*. Helsinki, Stakes 2004.



- Creation of an enabling environment for social enterprises – i.e. improvement of the existing legislative framework to support social enterprises
- Making social enterprises better businesses – i.e. launching activities to support social enterprises in becoming more market-oriented and economically effective
- Establishing the value of social enterprises – i.e. recognition of the added value of social enterprises and dissemination of information.

In January 2005 a new law entered into force which provides a new legislative framework for social enterprises. The new “Community Interest Company” (CIC) is defined as a business for social purpose” and thus retains the social objectives of existing charity organizations. But the main intention is to allow the CIC a better access to private money, mainly from “philanthropic” investors who want to engage socially and agree to lower interest rates. The new CIC has therefore been enabled to pay (limited) dividends to private investors out of its profits.



Annex 4: Case illustrations of Greek social cooperatives

The case of Leros Island

Leros is a small island in the south-eastern part of the Aegean Sea, the economic life of which has been, for decades, closely linked with the existence of the large public mental health hospital. The hospital remains, even today, the largest employer on the island. At the same time the differentiation of the island's economy is confronted with its geographical isolation and with serious difficulties in any attempts for integration into the national and international markets of both products and services.

However, over the last few years, efforts are directed towards the "de-institutionalisation" of the island's economy through the establishment and operation of a support structure (unit); based on a programming contractual arrangement between the mental health hospital and local organizations, aiming to provide information, support, training and other accompanying services for the promotion of initiatives relating to local development and to new economic activities. The most important project of the support unit has been the establishment of the first social cooperative in Greece, on the basis of the new legal framework, mainly through the encouragement, mobilization and support of the various groups (stakeholders) that constituted the partnership or the cooperative.

The social cooperatives can be considered, in general, as an important public policy for the reintegration of persons with psycho-social disabilities while at the same time, in the case of Leros in particular, it may serve the urgent need for the restructuring of the island's economy, by creating new and favourable conditions for the development of innovative and entrepreneurial initiatives and for absorption of surplus of human labour in new economic activities.

Given the above, a number of issues can be raised which can be the subject of future assessment:

- What role can the recently established Social Cooperative play in the case of Leros' island where the large psychiatric hospital is gradually closing down?
- What role in particular can it play in the restructuring of the local economy and the local society in general?
- In which way a „cooperative of social purpose“ can be articulated with efforts for global economic development of the island?



Leros Social Cooperative

Name	Social cooperative of the Dodekanissa Islands' mental health sector (Leros Social Cooperative)	
Location	Leros island, where Leros Psychiatric Hospital is still in operation	
Date of establishment	2002	
Size and composition of membership	Total number of members	457
	Mentally ill persons	194
	Mental health professionals	159
	Other persons and agencies/organizations	104
Size and composition of employees	Total number of employees	54
	Mentally ill persons	32
	Mental health professionals	22
	Other persons	-
Main Productive activities	<ul style="list-style-type: none"> • Cultivation and distribution of agricultural products • Operation of pastry-making shop • Operation of snack-shop • Operation of the processing, packaging and distribution of honey 	

Chios Social Cooperative

Name	Social cooperative of the mental health sector of the Prefecture of Chios (Chios Social Cooperative)	
Location	Chios Island	
Date of establishment	2003	
Size and composition of membership	Total number of members	125
	Mentally ill persons	56
	Mental health professionals	51
	Other persons and agencies/organisations	18
Size and composition of employees	Total number of employees	25
	Mentally ill persons	19
	Mental health professionals and other persons	6
Main productive activities	<ul style="list-style-type: none"> • Operation of canteen • Linen washing operation • Cultivation of organic products - farming • Social club – club house 	



Corfu Social Cooperative

Name	Social Co-operative of Corfu "New Horizons"	
Location	Corfu island, where Corfu Psychiatric Hospital is still in operation	
Date of establishment	2005	
Size and composition of membership	Total number of members	163
	Mentally ill persons	75
	Mental health professionals	63
	Other persons and agencies/organisations	25
Size and composition of employees	Total number of employees	32
	Mentally ill persons	32
	Mental health professionals and other persons	Not available
Main productive activities	<ul style="list-style-type: none"> • Building maintenance service • Cleaning of interior and exterior areas service • Production and distribution of hand-crafted items • Restoration and protection of the environment • Production and distribution of snacks and small meals 	

Athens Social Cooperative "Ev Zin"

Name	Social Cooperative "Ev Zin"	
Location	Athens (West Attica)	
Date of establishment	2005	
Size and composition of membership	Total number of members	40
	Mentally ill persons	22
	Mental health professionals	12
	Other persons and agencies/organisations	6
Size and composition of employees	Total number of employees	34
	Mentally ill persons	30
	Mental health professionals and other persons	4
Main productive activities	<ul style="list-style-type: none"> • Catering • Maintenance of urban and suburban grounds and environment • Club house and social, political and tourist activities 	



Athens Social Cooperative “Diaplous”

Name	Social Cooperative “Diaplous”	
Location	Athens	
Date of establishment	2004	
Size and composition of membership	Total number of members	138
	Mentally ill persons	81
	Mental health professionals	46
	Other persons and agencies/organisations	11
Size and composition of employees	Total number of employees	Not available
	Mentally ill persons	Not available
	Mental health professionals	Not available
	Other persons	Not available
Main productive activities	<ul style="list-style-type: none"> • Bakery • Catering • Washing and ironing of linens • Printing house • Coffee house • Mini-market 	

Athens Social Cooperative “Climax Plus”

Name	Social Cooperative “Climax Plus”	
Location	Athens	
Date of establishment	2005	
Size and composition of membership	Total number of members	40
	Mentally ill persons	20
	Mental health professionals	15
	Other persons and agencies/organisations	5
Size and composition of employees	Total number of employees	10
	Mentally ill persons	10
	Mental health professionals	-
Other persons	-	
Main Productive activities	<ul style="list-style-type: none"> • Furniture and office chair making operation • collection and re-selling of paper for recycling 	



Chania Social Cooperative

Name	Social Cooperative "Chania"	
Location	Chania, Crete island	
Date of establishment	2005	
Size and composition of membership	Total number of members	127
	Mentally ill persons	51
	Mental health professionals	50
	Other persons and agencies/or- ganisations	26
Size and composition of employees	Total number of employees	Not available
	Mentally ill persons	Not available
	Mental health professionals	Not available
	Other persons	Not available
Main productive activities	<ul style="list-style-type: none"> • Cultivation and trading of agricultural products • Production and trading of handcrafted items • Operation of a cafeteria • Tourist services • Car wash facilities 	



An overview of Social Cooperatives in Greece

Name	Location	Date of establishment	Composition of Members	Composition of Employees
Social Co-operative of Leros	Leros island	2002	a) mentally ill persons: 194 b) mental health professionals: 159 c) Other persons as well as legal entities of public or private law: 104 Total: 457	a) mentally ill persons: 32 b) mental health professionals: 22 c) Other persons: - Total: 54
Social Co-operative of Chiou	Chios island	2003	a) mentally ill persons: 56 b) mental health professionals: 51 c) Other persons as well as legal entities of public or private law: 18 Total: 125	a) mentally ill persons: 19 b) mental health professionals and other persons: 6 Total: 25
Social Co-operative "New Horizons"	Corfu island	2005	a) mentally ill persons: 75 b) mental health professionals: 63 c) Other persons as well as legal entities of public or private law: 25 Total: 163	a) mentally ill persons: 29-32 b) mental health professionals: n.a. c) Other persons as well as legal entities of public or private law: n.a. Total: 29-32
Social Co-operative "Eu zin"	Athens-Attica	2005	a) mentally ill persons: 22 b) mental health professionals: 12 c) Other persons as well as legal entities of public or private law: 6 Total: 40	a) mentally ill persons: 30 b) mental health professionals and other persons: 4 Total: 34
Social Co-operative "Diaplous"	Athens-Attica	2004	a) mentally ill persons: 81 b) mental health professionals: 46 c) Other persons as well as legal entities of public or private law: 11 Total: 138	a) mentally ill persons: n.a. b) mental health professionals: n.a. c) Other persons: n.a. Total: n.a.
Social Co-operative "Climax Plus"	Athens-Attica	2005	a) mentally ill persons: 20 b) mental health professionals: 15 c) Other persons as well as legal entities of public or private law: 5 Total: 40	a) mentally ill persons: 10 b) mental health professionals: - c) Other persons: - Total: 10
Social Co-operative "Chania"	Chania (situated on the island of Crete)	2005	a) mentally ill persons: 51 b) mental health professionals: 50 c) Other persons as well as legal entities of public or private law: 26 Total: 127	a) mentally ill persons: n.a. b) mental health professionals: n.a. c) Other persons: n.a. Total: n.a.



References

- Borzaga, C., Defourny, J. (eds): *The Emergence of Social Enterprise*. London and New York, Routledge 2001.
- CIRIEC International: *Report on Third Systems and Employment*. Université de Liège 2000.
- Council of the European Union: *Council Directive 2000/78/EC of 27 November 2000 establishing a general framework for equal treatment in employment and occupation*. Brussels, 2000.
- Council of the European Union: *Fight against poverty and social exclusion: Common objectives for the second round of National Action Plans*. Brussels 2002, 14164/1/02
- Declaration of the Social Partners for the European Year of People with Disabilities: *Promoting equal opportunities and access to employment for people with disabilities*. 2003
- European Commission: *Joint Report on Social Protection and Social Inclusion*. Luxembourg: Office for Official Publications of the European Communities, 2005 a.
- European Commission: *Report on social inclusion 2005 – An analysis of the National Action Plans on Social Inclusion (2004-2006) submitted by the 10 new Member States*. Luxembourg: Office for Official Publications of the European Communities, 2005 b.
- Mental Health Declaration for Europe. *Facing the Challenges, Building Solutions*. WHO Europe, EUR/04/5047810/6, 14 January 2005.
- NAPs/inclusion of Member States are available on the following web-site: http://www.europa.eu.int/comm/employment_social/social_inclusion/naps_en.htm
- Pöyhönen, E.: *Developing Social Firms in Finland*. Helsinki, Stakes 2004.
- Stryjan, Y.: *Sweden: The Emergence of Work-integration Social Enterprises in Sweden*, in: Borzaga, C., Defourny, J. (eds): *The Emergence of Social Enterprise*. London and New York, Routledge 2001, p. 220-235

Further internet-sources:

www.mhe-sme.org
www.iaapa.ch
www.cefec.org
www.ceges.org
www.cecop.coop