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An innovative model for career counselling services to mental health NEETs

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Partner Organizations

PEPSAEE
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1 INTRODUCTION

As assed by the Italian National Institute for Statistics (Istat, https://www4.istat.it/en/) the information sources regarding Mental Health (MH) in Italy are various, usually refer to different bodies/institutions and therefore are not easy to be treated jointly. Also, Italy has unsatisfactory information about the offer and quality of services provided, which undoubtedly differ from North to the South of the country. Nevertheless, there is no validated information regarding the quality of work integration of people with special needs related to a total or partial physical, mental or sensorial disability as data refers to number of placements and not to experiences and challenges overcome/to be overcome.

Most of the national literature consider all special needs as one only category (‘*people with disabilities*’) and analyses the support system and its strong and weak points from this general point of view. Very few of the literature is devoted to career counselling and work integration of MH people (except reports describing the functioning of specific projects – with no information regarding impact in terms of employability), and nothing specific about MH NEETs is available. In order to be consistent to the project topic, CESIE specifically looked for those resources that deals with Mental Health needs and specific support and initiatives provided to people with these specific needs.

CESIE conducted extensive research, which consisted of:

- Thorough examination of scholarly articles, books and websites focused on research and interventions for education/work integration of MH people;
- Listening to local experts of the topic who provided personal and expert insight into possible sources of information about the Italian system.
- Reaching out to its international network of education/training/guidance providers in order to select relevant resources providing information about experiences in other countries.

CESIE ensured that all articles, papers and books came from credible resources.

Finally, CESIE selected: 6 articles, 2 books, 1 handbook, 1 report. Most resources are related to the Italian experience of professional guidance and insertion of people with Mental Health needs (available in Italian). 2 articles are related to practices in Québec and 1 to a specific research conducted in France (available in French). The Handbook is related to the Belgian experience after the implementation of community-based Reform (available in English, French and Dutch). However, this Report will be focused on the state of art of the Italian system only and other resources were necessary in order to provide comprehensive information about it (see ‘References’ section).

2 KNOWLEDGE GAPS

The approach introduced by the National Mental Health Law 180/1978 (aka Law *Basaglia*) in Italian psychiatry was that of a true community-based model of mental health care, which aimed at the integration of the patient into his or her living environment, psychiatric care carried out in close collaboration with the territory, sanitary structures, social work, public and private social agencies, and third sector. In this sense, Italian psychiatry was undoubtedly innovative and revolutionary.

However, the "liberation" of psychiatric patients from places of care has not been able to take into account their needs and their experiences: the support structures and mechanisms in the territory are

deficient and disconnected; people who do not want or do not have the tools to live in society find themselves alone, poorly supported or unable to leave the care system.

2.1.1 Counsellors' or Mental Health Professionals' knowledge gaps in the fields of career intervention for MH patients / NEETs

Mental Health (MH) professionals typically have identities in psychiatry, psychology, MH counselling, professional counselling, or related fields (psychiatrists, psychologists, licensed clinical social worker), while Career Counsellors often have identities in law, human resources, economics, political science, psychologists or education (the strong need for qualified guidance in Italy is not matched by an equally clear discipline of this profession. Until few years ago there were not many formal training possibilities).

Within Career Counselling, the first difficulty is **encouraging MH users to engage in the career counselling process**. Emotional support and encouragement to autonomy, choice and self-efficacy within the context of an ongoing career counselling relationship are productive strategies for MH users. Yet career counselling services do not have an environment in which such a sensitive helping relationship can develop. New ways must be found of facilitating supportive, non-superficial, ongoing relationships.

As for MH professionals, their approach is generally **a protective/paternalistic approach**: you cannot expect significant contributions from the user, because only professionals have the knowledge and expertise. The user is required to be a good patient, docile to prescriptions and indications. In this sense, MH **professionals are not well versed in career issues or may lack enthusiasm for career counselling**; career-related issues and career life planning rarely receive the same kind of urgency that MH-related issues do: in their view, frustration arising from job-seeking and obstacles in access to work could completely prevent or greatly slow down healing processes. Clinical services may be over-cautious about what can be achieved vocationally, and influence clients to underestimate the potential benefits of work, education, training or volunteering. This perception does not improve because of the Italian economic situation where in addition to high unemployment rates there is precarious and poorly paid work.

A common challenge for both categories is related to the **assessment of the suitability for a job of the MH user**. Generally, the assessment of task suitability is aimed at preventing the development of an "occupational" disease as a result of job activity, but also to avoid that a pathology of the worker, even if not related to exposure, gets worse because of it. For MH workers, the scenario is different: psychopathologies are not caused by exposure, but their specific features may prevent the worker from performing their job properly (psychological limits that negatively affect their functioning and productivity), or even make them take dangerous behaviours that make them "risky" not only to themselves, but also to other colleagues, third parties and for what surrounds them (equipment, machineries, etc.). However, psychiatric diagnoses can be poor predictors of employability; previous work history and current attitudes are more reliable indicators when assessing potential and MH users particularly benefit from having their attention drawn to their skills, strengths, experience and resources. Furthermore, when judging the suitability of a MH user to a job, this judgment cannot be immediate: it requires a monitoring of the MH worker's "compliance" with the work and the adaptability of the work to the MH worker so that from this positive interaction between work and

worker derives an advantage for him/her (fulfilment as an individual and social being) and for the organisation.

For Career Counsellors, one particular challenge is due to **organisation and (lack of) flexibility of the career counselling process**, especially given the intermittent and dynamic nature of MH issues, their tendency to co-exist with other challenges, and the potential for some service users to conceal their condition. Also, within Career Counsellors there's a general **lack of expertise to assist users for whom MH issues are primary,** especially for those professionals who have no knowledge and competences regarding mental health. In addition to issues of developing the helping relationship, main gaps are usually related to:

- *Mental health awareness*: An understanding of the nature of MH conditions, including their diversity, their overlap with other categories of social disadvantage, their variability over time, the aspirations of clients, and similar factors that may impact on guidance.
- *Crisis management*: Understanding of how to support someone who is in a state of distress, even if such events may be rare.
- *Stigma*: Negative stereotyping associated with mental illness continues to be an issue in wider society in spite of progress and media campaigns in recent years, and as such may affect Career Counsellors, who may benefit from reflection on their attitudes. Awareness of employer's attitudes is also necessary, and its effect on MH workers' self-esteem and perceived employability, and the anticipation of discrimination by clients.
- *Personal safety*: The vast majority of people with MH conditions represent no threat, and a characterisation as dangerous is often part of the process of negative stereotyping. However, a very small minority may present challenging or threatening behaviour. Career counsellors should be mindful of their personal safety, particularly when working in isolation.
- *Setting boundaries*: Career counsellors usually are not too keen to go beyond their expertise and handle challenging attitudes or distressing behaviours of their clients. Unable to handle the emotional demands of the work, they tend to discourage MH users or refer them to MH services.

2.1.2 Counsellors' or Mental Health Professionals' knowledge gaps in the fields of the educational and employment systems

In Italy, career guidance services are a regional competence and are provided at local level by the Employment Centres (CPI). They are in charge for managing the careers guidance services for adults and NEETs, while the delivery of careers guidance to students is entrusted to schools and universities. Careers guidance services adopt a dual approach based on:

- *Information* (with no or limited involvement of an officer): the supplying of available printed materials/websites/data banks, welcome interviews and information meetings (individual or in group) on vocational and training opportunities.
- *Advice*: in-depth interviews or skills profiling to assist the client with drawing up a realistic personal action plans or analyse the client's situation through or group sessions and courses, on themes such as job search techniques or how to choose a career.

In truth, in Italy, the work of career guidance services is essentially that of profiling job seekers and encouraging them to actively seek work (instead of relying on the service). Staff are mainly concerned with administrative tasks, and just a few of them have been retrained to deliver information services and engage in active labour policies (mostly Youth Guarantee, the European plan to combat youth unemployment, https://ec.europa.eu/social/main.jsp?catId=1079&langId=en).

In Italy, most of the staff are middle aged, with minimum ICT skills, only 26% have a university degree (only 17% in the South), 56% has a high school diploma and 13% barely has completed primary education. Given this data, it is evident that they are **not trained enough to proficiently perform in-depth user analysis and guidance activities**. Therefore, most of the advice careers guidance services provide are usually delivered by external personnel belonging to organizations specialized in career guidance whose work is funded through European Social Fund calls (https://ec.europa.eu/esf/home.jsp).

Also, generally career guidance services lack connection with other services and do not have a wide knowledge of available opportunities support services or education/training providers, not even from the labour market (information available is related to their region only). In advising, no accurate analysis of the professional profile is made, neither a study on the trend of the economic sector in which the user wants to be employed and in case there is interest to undertake a training course, the services have no knowledge of those that offer quality education/training or statistically better chances of placement.

Career Counselling keeps on being based on the personal knowledge, skills and discretion of an adviser who designs an Individual Activation Plan in relation to the user 'characteristics identified through standardised questionnaires and tests and summarised in the Personal and Professional Data Sheet of the worker. This approach has critical points: first of all the **discretion of the adviser in defining the professional profile of the user and the subsequent professional path** – which rely purely on the competences of the single professional and their subjective evaluation; the evaluation could be vitiated by incorrect or missing information, which may in the medium term produce displacement effects (or Lock in) of the beneficiaries in the labour market.

For MH job seekers (as well as for other kinds of special needs related to a total or partial physical, mental or sensorial disability[1]), **the Italian law promotes a "targeted placement",** meaning the provision of technical and support tools that allow a proper job skills assessment and a convenient placement, through analysis of workplaces, support measures and solutions to problems related to

[1] According to Italian Law 68/1999 – "Regulations for the right to work of people with disabilities" people who have one of these requirements can sign up for specific targeted employment services:

- People of working age suffering from physical, psychic or sensory impairments and intellectually handicapped people with reduction in working capacity equal to or greater than 45%;
- Bearers of a physical or mental disability equal to or greater than 33% due to accident at work;
- Bearers of a sensory disability (deaf-mute - blind);
- People whose ability to work is permanently reduced to less than 1/3 due to illness or physical or mental impairment;
- Bearers of a war invalidity or invalidity due to military service.

environments, tools and interpersonal relations in everyday workplaces and relationships. Anyway, the official mission of the competent services is to facilitate and support the meeting between employers and job seekers with special needs and not to "find work for them", so in any case a personal activation of the user and an interest of employers is needed.

Also, it is not enough to be a MH patient to benefit of targeted placement. MH job seekers in order to be supported by this service must have a proven reduction in working capacity of more than 45%, assessed by a competent commission for the recognition of civil invalidity.

2.1.3 Lack of theories and methods for facilitating work integration of MH NEETs

In Italy there is no unified / organic and validated information regarding the integration of people with impairments/disabilities/handicap in the labour market; in fact, there is no monitoring system of the work adaptation and integration. Existing databases are quantitative, providing data on the single placements but **almost no data on the effective work integration**. There is also a lack of a transparent database on the different types of challenges, barriers or discrimination that people with special needs face in performing their work.

Integration policies have supported access to the world of work – especially through the implementation of a compulsory/incentive system for organisations – but professional development has been neglected. In fact, **discrimination increasingly lies in the "quality" of job placements rather than the "quantity".** Cultural approach to people with special needs related to a total or partial physical, mental or sensorial disability is hard to change: "normal" workers are involved in lifelong learning processes, in career paths, outplacement in case of crisis, while people with special needs are 'only' granted the fact they have special needs; they are less likely to be involved in the normal system of professional growth and guarantee of career progression within an organisation.

2.1.4 The neglected role of informal carers in people's career development

In Italy, informal carers, i.e. those relatives or cohabitants who take care of a person who due to illness, infirmity or disability, chronic or degenerative, is not self-sufficient and needs long-term are are 8.5 million (17.4% of the population). 53.4% dedicate less than 10 hours a week, while 25.1% exceed 20 hours and 19.8% carry out care activities for at least 10 hours a week (data from Il Sole 24 Ore, Italian national daily business newspaper owned by Confindustria, the Italian employers' association). **The current dimension of patients and informal carers is made of loneliness and social indifference**, because disability is still seen as a private fact and not as a social problem. In Italy, there is a chronic lack of public social and territorial care facilities and evident economic shortcomings which are also exacerbated by a complicated and slow bureaucracy: families are generally "alone" in the laborious management of a chronically ill person, who is often unaware of their condition and who can have alternating but continuous clinical manifestations. It is easy for both patients and informal caregivers to feel isolated and abandoned by the care system.

According to most recent Italian law, informal caregiving is considered as a voluntarist action, provided for free for 54 hours a week including night watch. Those who register as a "family caregiver" are entitled to 3 years of paid social security contributions (only). However, **informal carers are not volunteers: they do not choose, they become by necessity**. In addition to the excruciating emotional pain that their situation generates, their condition is made of days divided between general care,

nursing tasks (such as administering medication) and bureaucratic tasks, sleepless nights, inability to call in sick or enjoy a 'holiday' from the continuous and exhausting task of assisting, loss of professionalism due to inability to reconcile work and caregiving activities, social isolation, loss of income. In Italy, 66% of caregivers had to leave their jobs. 10% asked for part time and10% had to change jobs. Caregivers who leave work to provide care stay out of work for an average of up to 10 years.

One aspect not to be overlooked is the gender differences in caregiving. The informal carer is often a woman (74% of informal carers), not infrequently alone, with low level of education and poor job experience.

Informal carers are forced into their role because they cannot afford continuous or even part-time professional or residential services or they do not want to put their significant others in residential care. Accompanying allowances and invalidity pensions (paid only when there is a 100% certified disability), surely do not match a carer's salary. They are generally so poor that they are unsuitable to cover the costs of professional services. They are intended only for the patient, not for the family, which also has other needs in addition to those of caring for its weakest member.

Three years of paid social security contributions is a really poor benefit considering the intense and permanent needs of some patients. The moral duty to care does not extinguish after 3 years. Also, registration automatically cancels the entitlement of working family members' to extra paid holidays (max 3 working days a month) to care for their relatives, thus aggravating the burden on the Informal Carer's shoulders.

3 Supported Employment and Career Counselling for MH NEETs

In Italy, there are laws and regulations that frame the issue of disability in an innovative way compared to the rest of Europe, so much so that some countries are taking inspiration from Italian Law 68/1999 – "Regulations for the right to work of people with disabilities" which aims at the integration and employment of people with disabilities, as well as those suffering from MH issues, in order to guarantee their right to work through targeted support and placement services – to take action on the subject. But when looking at the facts, Italy is lacking in implementation and consistency across the different regions. The programs for the inclusion of people with MH problems in training and/or work programmes are very heterogeneous: each region uses different measures and stakeholders in relation to the various economic and industrial realities that characterize their territory.

Italian Law 68/1999[2] has introduced **the "targeted placement" methodology**: people with special needs related to a total or partial physical, mental or sensorial disability who meet prescribed

[2] According to Italian Law 68/1999 – "Regulations for the right to work of people with disabilities" people who have one of these requirements can sign up for specific targeted employment services:

- People of working age suffering from physical, psychic or sensory impairments and intellectually handicapped people with reduction in working capacity equal to or greater than 45%;
- Bearers of a physical or mental disability equal to or greater than 33% due to accident at work;
- Bearers of a sensory disability (deaf-mute - blind);
- People whose ability to work is permanently reduced to less than 1/3 due to illness or physical or mental impairment;

requirements (for MH users: reduction in working capacity equal to or greater than 45%, assessed by a competent commission for the recognition of civil invalidity) can enrol in appropriate lists held at Employment Centres (CPI), which records job skills, abilities, skills and inclinations, as well as the nature and degree of disability on a special form and then analyses the available offers to match the user with a suitable placement. Placement is made through a ranking whose criteria are: seniority of enrolment; economic condition; family size and kind of special needs; difficulties in moving around the territory; further elements identified by the regions according to territorial needs. For those users having more difficulties integration may be supported through: direct hiring (the employer can hire a specific user from the lists), an internship period for training and guidance, a fixed-term employment contract or a longer probationary period.

National Law 381/1991 on Social Cooperatives has opened the chance for **MH users to become social workers for a cooperative**. These Social Cooperatives perform various economic activities (agricultural, industrial, commercial or service) through employing people with a work disadvantage (for MH issues: people bearing psychic disabilities, former inmates of psychiatric institutions and persons under psychiatric treatment), thus joining the work integration goal with general interests of the community[3]. But very few cooperatives have hired or have developed self-sustainable projects (Social Firms) aimed at employment. Most cooperatives keep on relying on internships or grant assisted jobs and often close as soon as the public funding received is over.

Therefore, for the majority of the MH users, vocational training, internships or work in cooperatives represent a “revolving door”: they could stay there for years, passing from workshops to classroom training to internships to very short job experiences (until the project is over or the cooperative closes) and continue on with no real chance of being hired or effectively integrated into the real job market. In some cases, training providers repeat over the years the same type of training offers, meeting the needs of institutions “to tick boxes” in terms of diverse and inclusive recruitment and training practices rather than those of the users.

The commitment of cooperatives and non-profit organizations cannot work miracles in regions where unemployment is already high for everyone. Over time experiences of workshops, internships and casual work are not even useful to manage anxiety or self-esteem issues. Internships and casual work on projects (part-time, low-paid, short-term) still is marginal employment: it does not provide the health benefits that secure, well-paid meaningful work can deliver.

In this sense, the most innovative practice in Italy is the **Individual Placement Support (IPS) method**, which focuses on users’ personal empowerment and taking of responsibilities in searching the job they want and in line with their aspirations. Career guidance services adopt a non-assisting approach where they do not mediate anymore with employers but rather support the MH user in independently and correctly carrying out their seek for training/employment: MH users are supported in CV writing, job searching, handling interviews. Success of this method relies in employers not being aware of the health issue: being an autonomous search, the prejudice that usually exists towards a person with a

- Bearers of a war invalidity or invalidity due to military service.

[3] According to Law 381/1991, "Disadvantaged persons must constitute at least 30% of the workers and, compatibly with the cooperative’s characteristics, be members of the Cooperative itself".

MH issue is not triggered in the employer, and users have more chances to be hired. If the career guidance service steps in, employers would refuse to hire or they would propose an internship, fearing the MH issue would cause problems.

Unfortunately, **in Italy there are few examples of companies that have found the right place for workers with special needs.** Many still think that it is merely a matter of adapting workstations. But technology is not enough: the path of inclusion is not only made by devices; it is much more complex. Adjustments must include the ability to reorganize the work and its timing, training of the staff, defining a suitable job description, and only afterwards the adaptation of the workstations. This process allows to build the identity of a worker and not the identity of the person with special needs.

According to Italian law, private and public organisations with 15 to 35 non-temporary employees are required to employ at least 1 person with special needs related to a total or partial physical, mental or sensorial disability while organisations with 36 to 50 employees are required to employ at least 2. Organisations with more than 50 employees must reserve 7% of the total number of employees. Those who do not comply with the regulations are subject to sanctions. Plus, organisations can benefit from tax advantages: for hiring people with MH needs, organisations have the 70% of their salary covered for 5 years or for the whole duration of the contract (minimum 1 year). However, there are contradictions: among exemption measures, law allows organisations that believe they are not in a position to hire to pay a fine that contributes to a regional fund devoted to labour inclusion policies (ex. Internships). Several companies prefer paying the fine instead of hiring, because hiring a person costs more than the fine for the regional fund.

4 Working with the Labour Market

In a workplace a combination of undefined responsibilities, poor support from the company, unclarity of job duties and careless management can create a very risky environment for a MH worker. When justifying their “lack of conditions” for hiring/keeping a MH person, employers usually claim their organisation lacks resources, time, and expertise to address the MH issues of workers. There is a lack of or infrequent training to increase awareness about MH issues among employers, human resources and their managers. So, they lack the confidence to recognize warning signs of declining performance due to mental illness. Also, the pressure for productivity can lead to failure on the supervisor’s part to recognize early warning signs of declining performance due to MH issues.

Raising-awareness and sensitisation initiatives are not homogeneous at national level. They usually consist of:

- Information actions concerning the opportunities offered to workers with total or partial physical, mental or sensorial disability and employers (which are generally focused on tax benefits for employers);
- Training courses for public and private operators involved in the employment of people with special needs related to a total or partial physical, mental or sensorial disability;
- Interventions for the sensitization of the working environment, monitoring the initial stage of job placement (organisation characteristics, tasks and duties, work environment) and related services aimed at mobility, including through family involvement.

5 DISCRIMINATION AND STIGMA

5.1.1 Discriminating behaviour or structural discrimination by employers

The main barriers to employment of people with MH issues are both the inadequacy of job offers and the complexity of providing support systems, but above all stigma and discrimination. Employers' attitude towards MH job seekers is generally that of closure and distrust, both generated by prejudice against the MH person. Main concerns are related to accommodation costs and training time (for MH workers, HR staff and co-workers) as well as time to dedicate to supporting MH workers who are unable to meet expectations in performance and quality levels because of their MH issues.

To sum up, 5 **assumptions contribute to MH people discrimination**:

- the assumption of incompetence (related to both work performance and compliance with social rules in a work environment),
- the assumption of dangerousness and unpredictability (ex. attendance issues, inequality issues in the respect of those workers who have no accommodation for their needs),
- the belief that mental issues are not a legitimate illness,
- the belief that working is stressful and unhealthy for persons with mental issues, and
- the assumption that employing these individuals represents an act of charity inconsistent with a profit organisation's needs.

MH people are still today considered strangers and far from the world of profit work and seen as good only for those kinds of placements (internships, workshops, work in cooperatives) offered by welfare system and having rehabilitative purposes. This attitude denies the possibility of valuing people and making the best use of their abilities.

5.1.2 Self-Stigma

Sometimes the MH person puts themself in a self-discrimination perspective, believing their contribution to society – possible only by welfare measures – is merely residual. A labour market that puts people in a position of marginality (through scarce access to employment) and residuality (through relegation in part-time, low-paid and short-term placements or meaningless workshops) leads to demotivation to look for a job or even to work, since people with MH issues are pushed to look at themselves starting from their disabilities rather than on their skills and often to consider themselves a burden within an organisation.

5.1.3 Mental health professionals' low expectations

Very often the patient is regarded as a bearer of illness, disability, personal and social malfunction, emotional fragility – at constant risk of breakdown and to be preserved from frustration and failure; in the majority of cases, it is considered not wise to propose to the user the search for a real job in the free market. For this reason, users are offered only assisted pathways and gradual steps of training and transition to work, waiting for an evolution of clinical conditions and a growth in the user's professional and relational skills, because they "can't make it" or "are not ready". This creates further discrimination, as training or placement projects promoted by MH services often employ the same MH persons. In order to assess the success of the initiatives, MH professionals tends to give these chances to

patients/service users who have proved themselves able to fit in and carry out the expected activity till the end of the project.

6 EMPOWERMENT

For MH persons, empowerment means making choices, gaining control of their life. The process starts with defining their needs and ambitions and focuses on the development of capacities and resources that support autonomy and self-determination.

6.1.1 Methods of testing / assessment of personal characteristics

The process of empowerment should include a reclaiming of the MH person's sense of competence. The focus should not be on diagnosis or impairments, but rather on the possibility of strengthening and activating the personal resources of the MH person. However, the "targeted placement" of a person with special needs requires the assessment by a medical-forensic committee which focuses first of all on the diagnosis, assessing the functional impairment of the MH person's psycho-physical and sensory state (based on clinical data and medical documentation) and then on the person's social and working profile (living environment, family situation, education, work experience) in collaboration with technical experts. The process is aimed at identifying the activities and tasks that can be carried out with the "residual work skills".

Italy was the first country that used the **International Classification of Functioning, Disability and Health (ICF)**, and according to Law 68/1999 ICF is meant to be used as a reference to develop specific procedures and tools to assess the condition of the job seekers with special needs related to a total or partial physical, mental or sensorial disability and accurately document the skills and competencies which make them employable in the labour market. These procedures and tools vary according to the Region or the single Employment Centres (CPI).

Other assessments methods are part of Foundations' or Third sector organisations' know-how as they were developed for specific services or projects, and they are usually not publicly shared.

6.1.2 Methods of empowerment of MH NEETs

Empowerment is related to both strengthening of the person's skills and competences and active participation in the life of the community. At the individual level, MH patients need to take back control by developing or strengthening ways of coping with their difficulties (e.g. through personal recovery planning) and live their life to the fullest with their MH issue, which may well include housing, employment, education, enhanced family roles and relationships. The best form of assistance is the one aiming at self-efficacy of the MH persons — the confidence that they can set, work towards and accomplish their ambitions and goals and master everyday tasks.

But if, on the one hand, the culture of inclusion is promoted as possibility for people with special needs of making life choices and express self-determination, on the other hand the initiatives remain linked to a welfare logic imbued with paternalistic intentions. In Italy independent living projects revolve around the figure of the "personal assistant", who is responsible for performing all those functions that the MH person cannot perform independently. But public contributions are unable to cover these expenses (which vary according to the level of need).

Third sector has constantly intervened but its activities are limited not only geographically but also in their scope. As they work on social and relational skills as well as on self-perception and confidence, there are not many possibilities for MH people to actually apply their skills as discrimination keeps on preventing access to what could really impact on their wellbeing: housing, work, social life.

7 WORKING WITH INFORMAL CARERS

The most important approach is always with the family, which must be helped to face the situation, to become aware of it in terms of possibilities and limits, to build together a realistic path for the MH person. The family of a MH patient is often characterized by great fragility and loneliness; therefore, it needs great acceptance, support on adjusting their life and coping with the various problems.

Attitudes oscillate between the denial of MH needs to over-investment in the role of carers.

Some carers may go through a phase of rejection, in which they are convinced that no intervention will change the situation or improve the quality of life of the MH relative or the family itself. They may not accept the condition of MH need as permanent, with which everyone will have to cope, or they may find difficult to accept eventual problematic behaviour, due to incapacity or difficulty in managing it. In general, it represents a reaction of defence dictated by fear of facing a situation without feeling prepared to do so. This kind of carers systematically fail to realistically assess the MH person's limits and potential: they may see only the negative and problematic aspects, tending to underestimate the possibilities for improvement, setting very low goals, thus creating a self-fulfilling prophecy where the MH ends up behaving in a way that reflects others' expectations. Or, on the opposite, carers set unrealistic objectives or high expectations with respect to the real abilities of the MH person, creating a potentially frustrating situation, in which they come result constantly disenchanted. Finally, for other carers, the rejection may result in almost total delegation of the MH persons to professionals or institutions.

Some other carers invest exaggeratedly in their role, in constant need of a solution. They unconsciously pursue an unrealistic goal of perfection. Their difficulty is to find the right balance between investment and spaces of autonomy. In this situation, the risk for the MH person is to remain dependent and have no chance for their developmental potential to emerge.

All carers bear a considerable emotional stress. An important area of support is the **development of coping skills**, i.e. those strategies and skills to cope with the stressful situation circumstances dictated by the MH person's condition and to create a personal network to prevent isolation that often leads to a darker depression. The construction, development, increase and maintenance of all possible family resources must be activated to successfully manage the situation. These resources reside within the family nucleus (*intra-family resources*) but also in the fabric of supportive and helpful relationships that the family experiences with relatives, neighbours, friends, etc. (*extra-family resources*, social support)

Therefore, elements of an adequate support must necessarily include:

- *Psycho-pedagogical support*: it is functional to the activation of a "normalisation" process through which relatives learn to care for all family members and not only for the MH one through the activation of their resources and skills.

- *Acceptance and re-elaboration of disability*: education and awareness of the existence of healthy parts in the MH person and to not fear and demonize the deficient aspects.
- *A relieving of the burden of anxiety/time dedicated to the MH person*: informal caring is automatically associated with sacrificial choices that distort life and future plans of the carers.
- *Promotion of socialization with other informal carer*: a space for emotional sharing and support in finding coping skills.
- *Creation of synergies and collaborations in the territory*: activation of a support network of competent organisations which can provide assistance (ex. educational and rehabilitative interventions, home care, etc.)

For MH users with very poor social and educational background, family tendency could be to rely on social welfare and its economic benefits rather than ask for support measures for job searching and integration into the labour market. The support work should focus on behaviour change: encouraging the giving-up to passive assistance and allowing the evolutionary process of the MH person towards achievable goals.

8 CONCLUSIONS

Provision of employment related services for people with MH needs is patchy and inconsistent across Italy. Despite a common legal framework and placement methodologies and a variety of interventions that encourage and support the inclusion of MH in the labour market and the workplace, the whole system is lacking as interventions' impact is not relevant or properly enforced by employers. There are, however, evidence of successful approaches and case histories of MH people's engagement with education and work.

The challenge is to overcome the logic of "matching" MH job seekers with available training and placements and performing a merely informative and economic incentives action towards organisations for them to hire people with special needs related to a total or partial physical, mental or sensorial disability. Instead there should be more work to ensure a real function of "guidance and accompaniment" is set up and effectively implemented to build learning and working environments that actually correspond to the characteristics, aspirations and needs of people.

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