Co-funded by the Erasmus+ Programme of the European Union

Work4Psy

An innovative model for career counselling services to mental health NEETs

IO1 – LITERATURE REVIEW NATIONAL REPORTS - SYNTHESIS

PEPSAEE / APRIL/ ATHENS, GREECE

Partner Organizations

PEPSAEE PanHellenic Association for the Psychosocial Rehabilitation & Work Re-Integration

HdBA Hochschule der Bundesagentur für Arbeit University of Applied Labour Studies

cesie the world is only one creature

STOWARZYSZENIE POMOST

eMundus

Co-funded by the Erasmus+ Programme of the European Union

INTRODUCTION

The literature review was conducted by the project team's four partners: HdBA, PEPSAEE, POMOST, CESIE, using national and international articles, national reports and statistics. The review revealed some interesting findings, the implications of which will be discussed below, along with the subsequent conclusions and corresponding recommendations.

1 PART I – NATIONAL REPORTS

1.1.1 National Report DE – HdBA

a) INTRODUCTION

Young people termed as "NEET" (Not in Education, Employment and Training) constitute a persistent and significant problem for themselves as individuals, their future social and working life as well as for society, which faces costs and additional problems (Bynner et al., 2002; OECD, 2016). In the German context, the acronym NEET is rarely used. More common is the term "benachteiligte Jugendliche" (disadvantaged young people). However, societies and especially labour market services and professionals are trying to find ways to reduce the problem and to help more young people stay in the system or to be re-integrated into the system (Tamesberger et al. 2015).

In light of a stable labour market and demographic change, especially since 2005 (12,5%) and onward, the unemployment rate for young people has shown a continual decrease (5,6% in 2019)[1]. On the one hand, we can assume that the overall NEET problem is strongly linked to the unemployment rate. On the other, we argue (and there is evidence) that specific vulnerable groups are disadvantaged, even during periods with a less robust labour pool. Young people with psychological problems and especially mental health disorders (MH youth) are one of these groups, and one in which the numbers are growing (Künemund/Weiser, 2018; TKK 2019).

The literature review is based on a search in German data bases containing literature on education, vocation, rehabilitation and employment. We systematically searched for key-words such as "mental health youth", "disadvantaged youth", etc. In addition, we searched for statistics and materials published in the employment and health context focusing on the MH youth topic.

b) KNOWLEDGE GAPS

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

The basis for answering the question is weak. Literature about curricula seem to be particularly rare. Künemund & Weiser (2018) present a European Project that developed such a curriculum to describe

1 https://de.statista.com/statistik/daten/studie/440534/umfrage/jugendarbeitslosenquote-in-deutschland/ (2020-03-06)

knowledge and learning pathways for practitioners. This might build upon differentiated knowledge analyses. Only little literature directly links the topic MH patients / NEETs. Rather, it is necessary to derive possible topics from existing studies. These can be compared with existing curricula. The following topics can be identified from the reviewed literature:

- Differentiation criteria and definition of the target group (cf. Hilliger et al., 2011; Reissner et al., 2011).
- Knowledge about disease patterns (cf. Hilliger et al., 2011; Reissner et al., 2011, Oschmiansky et al. 2017).
-) and the effects of MH problems with learning, training and work (cf. Krug, 2008). Special interest might be placed on the development of disorders over time/longitudinal and to distinguish between disorders and developmental problems or to take into account gender specific developments (cf. Klasen u.a., 2016).
- Statistics on those affected by MH problems and their characteristics and statistics about those MH young people who are not diagnosed (cf. Hilliger et al., 2011; Reissner et al., 2011; Klasen u.a., 2016; Oschmiansky et al. 2017)). In Germany, different statistics about MH in the population are published frequently (cf. Grobe/Steinmann, 2017 on MH problems in the vocational training field).
- Statistics on integration in education, Vocation and Employment (cf. Brattig, 2013; Oschmiansky et al. 2017).
- Knowledge about programs and measures (and obstacles) to integrate the target-group (cf. Deuchert et al. 2011; Brattig, 2013), to prevent the target-group from dropping out (Vuori et al., 2008; Robertson; 2012) or to support their health condition by education, training or employment (cf. Robertson; 2012; Oschmiansky et al. 2017).
- Knowledge about the combination of career interventions with other treatments, therapies and measurements (cf. Robertson; 2012).
- Knowledge about the special needs of the MH youth target group, e.g. in school or vocational training (cf. Krug, 2008).
- Knowledge about counselors' attitudes and qualifications (cf. Krug, 2008; Oschmiansky et al. 2017) as well as declarative and experience-based knowledge (Strasser/Gruber, 2014; Künemund/Weiser, 2018[2]).

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

The fields of educational and employment systems are constantly developing. Nevertheless, professionals require knowledge about principles relevant to the employment system and the educational system. Actual changes in Germany are linked to the concept of "inclusive education" and "inclusive vocational training" (cf. Brattig, 2013). However, the integration of MH youth is not achieved to a large extent. Parallel systems of special schools and sheltered work or sheltered vocational training are still in place and of high importance.

[2] Künemund/Weiser (2018) presenting a Erasmu+ Project called INDIVERSO. The project developed 18 learning models for practitioners working with MH Youth https://www.donbosco-aschau.de/Aktuelles/Projekte/Abgeschlossene-Projekte#Indiverso (2020-03-06).

- What are employers' expectations of young people ? How do employers react to young people with mental health problems? (cf. Deuchert et al., 2011)
- What kind of economic incentives (or other incentives) are used to support employers in their decision to employ mental health youth? Do they work? (see chapter 3).
- What perspectives (education, training, employment) exist outside the "first" labour market and the inclusive school system.

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

In the Literature Review we did not find many articles describing theories about work integration of MH NEETs. Such a search should include micro-economic theories (cost-benefit-ratio). From the employer's standpoint, we can assume rational behaviour when hiring people. Both micro-economic as well as HR concepts, theories and data can inform our understanding of the problems inherent to the integration of MH NEETs. Deuchert et al. 2011 describe the reluctance of employers to hire this target group. In Chapter 3 (supported employment) we describe existing measures in the German context.

Methods for the facilitation of young people might be classified in different categories:

- Prevention programs to avoid MH problems or to identify mental disorders at an early stage (early diagnosis) (cf. Richter-Werling, 2017). This might also contain measures in schools to normalize the attitude of school, teachers and students toward young people with MH problems (cf. Richter-Werling, 2017).
- Direct support of young people (NEETs) by counselling, guidance, case-work (for instance offered by "Jugendberufsagentur"[3] (basically a one-stop agency for young people at risk) and PES in Germany as well as by projects and services (Vuori, 2008 ("Towards the working life group method"); GIB/NRW, 2016).
- Integrated support of young people alongside other treatments (combination of therapy and vocational guidance etc.) (cf. Vuori et al., 2008).
- Training programs etc. that support MH youth to develop relevant strengths and to support their integration (cf. Krug, 2008; cf. Vuori et al., 2008; see examples in chapter 3). Johnson & Klaes (2016) discuss a model to support young people with specific MH problems (Reactive Attachment Disorder) before and during the integration process (Johnson/Klaes, 2016). A particular topic might be the effects of such programs (cf. Oschmiansky et al. 2017).
- Rehabilitation programs (Hilliger et al. 2011; Reissner et al., 2011), sheltered or supported vocational training or employment (see examples in chapter 3).
- Incentive systems for employers to hire MH youth (often in combination with support like coaching, guidance during the training) (e.g. ASA).

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

- No literature has been found yet.

---

3 In Germany about 200 of these agencies are in operation. The agencies are cooperations between PES, youth services, migration services, legal services and others. https://www.sgb2.info/DE/Themen/Jugendberufsagenturen/Hitergrundbericht/leitartikel-jugendberufsagenturen.html;jsessionid=07EA4A552F2459E8C13A64F06DEB21F9 (2020-03-30).

c) Supported Employment and Career Counselling for MH NEETs

In Germany we have two methods for the integration of mental health individuals into work: „First-train-then-place“ and „First-place-then-train (chapter 4):

Firstly, a short description about „First-train-then-place“. People with disabilities are first trained within a protected framework or trained before they are placed in the general labour market: 1. Occupational therapy (mainly takes place in the context of mental-inpatient work; Training in various functions that are intended to facilitate later work, for example, problem-solving skills), 2. Day clinics (individuals stay there during the day; weekends and evenings at home, Structured daily routine, 3. Day-care centers: (Programmes can either support everyday life activities (e. g. cooking), leisure activities (e. g. joint excursions) or occupational therapy (e. g. trying out job-related skills), structured daily routine), 4. Vocational training centers (BBW), 5.Vocational promotion agencies (BFW) and 6. Vocational training centers (BTZ) (development specifically for people with mental impairment, Offer vocational training, assessment measures and preparation for training or retraining)

Best practice in Career Counselling followed by the question: Which factors are helpful in dealing with people with mental impairment within the rehabilitation process? These are: 1. Establishing a fixed contact person with a positive and optimistic attitude (Ensures motivation), 2. Procedures are carried out in small steps (Ensures that performance fluctuations can be taken into account), 3. Mistakes are re-interpreted as experience, 4. Longer-term measures are preferred or smooth transitions are created, 5. Frequent aborts or Changes are a great burden and 6. Comprehensive advice/support is also provided for the employer

(Haerlin,Plößl, 2018, p. 146 ff.) recommend seven steps for a best counselling: 1. The patient is the expert of his life path, 2. A holistic concept of work, rehabilitation and integration is observed, 3. The special interaction in the process between family, work and the effect of the disease defines the quality of the consideration, 4. No professional advice without a supportive caregiver, 5. The counsellor demonstrates an optimistic perspective and recommends concrete steps, 6. The original written result is presented to the client. They also emphasize the so-called “Kölner Instrumentarium, which counsellors can use in their settings and the MH NEETS can study further at home by involving their families = empowerment (Haerlin, Plößl, 2018, p. 105) They also recommend two instruments; Osnabrücker Arbeitsfähigkeitenprofil (O-AFP) and “Zusammenhang zwischen Erkrankung, Rehabilitation und Arbeit” (ZERA) (Haerlin,Plößl, 2018, p. 107).

d) Working with the Labour Market

In Germany the current possibilities in the first labour markets are („First place then train“) (Brieger et al. 2012, p. 128ff. and Deuchert et al, 2013, p. 25):

- integration projects (§ 132 SGB IX)
  - Integration companies that view sick people as if they were healthy workers
  - Should have 60 to 70 % of the capacity of a healthy worker
  - Local or standard wages
  - Predominantly permanent employment relationships
  - Employees’ remuneration is subject to social insurance contributions
- Supported employment (§ 38a SGB IX)
  - Characterized by an individual, company-based qualification

- Job coaching and „place and train"-strategies -> Direct route to the first labour market
- People are treated like healthy employees
- Special needs are attended to by a Job Coach

A special opportunity are the Sheltered Workshop for disabled people (WfbM). People with mental impairments have often already completed vocational training. The vocational training area of the WfbM therefore focuses on restoring basic work skills relevant to the workplace (e. g. concentration and organization) and building self-confidence. The percentage of people with mental impairments in the WfbM work area was around 21 % in 2018.

They recommend that the companies (in the first labour market) and the clinics work together in an more intensive way and provide relevant examples of this. Networking itself must be improved in general (Alsdorf et al, 2017, p. 241ff and Brieger et al. 2012, p. 128ff., and Sommer et al. 2019, p. 91).

Hommelsen recommend a special tool for employees called "H-I-L-F-E concept". It offers suggestions to support people with mental health problems in the company setting. (Hommelsen in Mecklenburg/Storck 2010, p. 239).

e) Discrimination and Stigma

Discriminatory behaviour or structural discrimination by employers

In connection with a return to work, affected people often reported that they were afraid of possible concentration or performance problems or difficulties with colleagues and superiors. There is great uncertainty, for example, regarding an open approach to the disease. In addition, stigma due to illness or a health relapse was often feared (Oschmiansky, et al. 2017, p. 225f.)

One of the research results of Deuchert et al is that non-cognitive dysfunctions related to psychological disorders are the main deterrents. These results are in line with the medical literature arguing that a substantial part of the costs of mental illnesses for an employer is driven by presenteeism (i.e., when the person is at work). (Deuchert et al, 2013, p.25).

Self-Stigma

Many adolescents with mental illness struggle with the decision whether to disclose their mental illness to others; due to public stigma or self-stigma and shame, Mulfinger et al state that disclosure and nondisclosure are associated with risks and benefits. They work with a peer-led group program called Honest, Open, Proud (HOP). It is a condensed three-session program. They have had good results so far. HOP showed positive effects on stigma and disclosure variables as well as on symptoms. It supports participants with disclosure decisions in order to reduce the impact of the stigma. (Mulfinger et al, 2018, p. 684-691).

Mental health professionals' low expectations

The qualitative research of Loos et al examined the perceptions of health care among young people with mental health problems in Germany. The discussions highlighted an overall concern of a lack of compassion and warmth in care. When they come into contact with the system, they often experience a high degree of dependency which contradicts their pursuit of autonomy and self-

determination in their current life stage. Another result is that the transitioning of young patients from child and adolescent to adult mental health services when indicated, often results in the interruption or termination of service. Service gaps occur (Loos et al. 2018, p. 1-10).

f) To Strengthen Competencies in Health Literacy and Empowerment

Methods of testing / assessment of personal characteristics

Some examples of German testing in the event of preparation for vocational integration are (Haerlin,Plößl, 2018, p. 107):

- MELBA - Characteristic profiles for the integration of performance-converted and disabled people in work
- IDA - Tools for diagnostics of work skills
- O-AFP - Osnabrück work ability profile
- ZERA - Relationship between illness, rehabilitation and work (see chapter 6.1.2)

Methods of empowerment of MH NEETs

One model we discovered focuses on the change in the organization where career support is offered (Job-Centres). In this model the concept of "resilience-oriented support" is proposed as relevant for interactive work with the target group (GIB/NRW, 2016).

As previously mentioned, the "Kölner Instrumentarium" in counsellors' settings can also be used by the MH NEETS at home even by involving their families = empowerment (Haerlin, Plößl, 2018, p. 105 and Plößl, Hammer in Mecklenburg/Storck 2010, p. 137). Pößl and Hammer also recommend the empowerment tool „ZERA" as being very effective. ZERA training (ZERA = connection between illness, rehabilitation and work); ZERA is a means of promoting empowerment; ZERA is a group training program with a total of seven sub-programs, approx. 20 sessions, ZERA's goal is to support the target group to identify the individual optimal level of stress and thus to avoid as much as possible, excessive and inappropriate demands in the professional arena. (Plößl, Hammer in Mecklenburg/Storck 2010, p. 51 ff.)

g) Working with Informal Carers

As previously mentioned, the use of the "Kölner Instrumentariu" in the counsellor's setting can also be used by the MH NEETS at home even by involving their families = empowerment (Haerlin,Plößl, 2018, p. 105). Experts also maintain that professionals should involve relatives in treatment and therapy. In crisis, a MH NEET tries to change his disturbed view of the world, therefore it is worthwhile getting to know the „other side" and at least listen to relatives regarding medical history, treatment and aftercare

Even though "talking medicine" should be an essential element of psychiatric treatment, many professionals argue not having enough time for such discussions (Straub, Möhrmann, 2015, p. 8). Relatives have to take care of themselves to not become mentally ill either (see also Möhrmann, 2010). Relatives are organized on the regional, county and state level, f. ex. BApK = Federal

Association of Relatives of Mentally ill People (https://www.bapk.de/der-bapk.html, 26.03.2020) and on the European Level http://eufami.org/, 26.03.2020).

The research of Loos et al demonstrates the importance of informal carers. MH NEETS described the need for personal closeness to the provider, to their friends as well as to daily life. The development of individualized bonds and the experience of personal support and engagement with providers was an element of the care process that participants appreciated with particular emphasis ("need for closeness") (Loos et al, 2018, p. 6).

h) CONCLUSIONS

Mental Health People

According to current research results, almost one third of the population between the ages of 18 and 79 develops a mental disorder during the course of a year in Germany. This includes all mental illnesses regardless of their severity. In addition to diseases with a slight manifestation, e. g. for example, in the case of a mild depressive episode, more severe forms of illness such as schizophrenia or recurrent depressive disorders were also recorded. It is assumed that about one to two percent of the adult population between 18 and 65 years of age are seriously and chronically mentally ill. Mental illnesses are often accompanied by serious impairments of psycho-social functions, which in turn make it difficult for those affected to participate in various areas of life. For example, mental illnesses are often associated with considerable negative effects on the work and employment situation of those affected (Oschmiansky, et al. 2017, p. 8).

Vocational rehabilitation

In Germany, in the year 2013 the MH NEETS (19 %) stopped their vocational rehabilitation more frequently than for other groups. The reasons are: longer periods of illness or the transition to medical rehabilitation (Reims et al. 2016, p. 7). There is also an increasing number of MH NEETS (2009: 15 %, 2014: 21 %) (Reims et al. 2016, p. 4). Supported Vocational Education and Training seems to be a cost-effective alternative to standard (mainly institutionalized) vocational training for young people with mental illnesses („First place-then train"-Method). Job coaching is important. However, very few employers are willing to train apprentices with special needs although there are no direct costs for the employer (Deuchert et al, 2013, p. 25).

Clinical rehabilitation/health services

There is often an interruption or termination of services for adult mental health services by young patients and adolescents (Loos et al. 2018, p. 1-10).

Solutions

Loos et al argue that research and clinical practice should focus more on developing needs-oriented and autonomy-supporting care practice. This should include both a shift in staff training towards a focus on communicative skills, and the development of skills training for young patients (Loos et al. 2018, p. 1-10). Local authority services, voluntary organizations and charities have a duty in supporting the development of both physical and mental health of young people (Howard, 2018, p. 121). Mecklenburg/Storck say that MH NEETS need f. ex. more opportunities through paid work

niches such as virtual workshops, combination wage models, part-time work opportunities, etc. which are also interesting for highly qualified, mentally ill people. Networking with all target groups is a primary issue and to use the recommended instruments like the empowerment instrument ZERA for mental health individuals, the HILFE-Concept for employees and the cologne instrument for counsellors and mental health individuals and their families (empowerment) (Mecklenburg/Storck 2010, p. 51 ff., p. 137, p. 239). Providing additional incentives to employers, for example in the form of subsidies or legal requirements in order to offer more MH NEETS Supported Vocational Training (Deuchert et al, 2013, p. 25). Informal careers, mainly relatives, should be involved in treatment and therapy (Straub, Möhrmann, 2015, p. 8). HOP seems to be a good program for MH NEETS to cope with stigmas and self-stigma (Straub, Möhrmann, 2015, p. 8).

1.1.2 National Report GR – PEPSAEE

a) INTRODUCTION

The Literature Review was conducted by PEPSAEE's project team, mainly by searching in online scientific journals and databases. The result of the review was 10 papers (9 articles and 1 national report). The team decided to choose papers in English, since there is a lack of literature in Greek, but also in order to provide access to them to a broader audience.

b) KNOWLEDGE GAPS

It is very important to mention that a lack of literature regarding the work and educational integration of young people facing severe mental health problems (MH NEETs) was noted at once. From the 10 papers collected, only 1 refers exclusively to MH NEETs, while 6 refer to people with mental health problems in general and 4 refer to adults with mental health problems, specifying an age range (e.x 18-64) that also includes young people.

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

All of the career counsellors and mental health professionals participating in the research appear to specialize in the field of work integration of people with mental health problems or work in bureaus/agencies specialized in providing this type of service. Thus, an important knowledge gap in this field is not mentioned, although the lack of availability of this type of specialized professionals and services is strongly reported in almost all the articles. One article also suggests that "the availability of supported employment should be expanded to reach individuals who lack the confidence to enrol in a specialized supported employment programme but who might be willing to receive such services in a less formal, more spontaneous way from generalist staff they already know well".

In the case of counsellors or mental health professionals working with MH NEETs, one article mentions that the challenge "is to find ways to sensibly combine evidence-based practices from mental health care, early intervention and specialised employment and supported education domains". It seems that when it comes to MH NEETs, the challenge for professionals and counsellors

is to move from traditional rehabilitation activities to evidence-based practices, especially when people express a preference for employment or a return to formal education.

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

Only two articles refer to support regarding educational needs and give information about the "Supported Education" model. It is reported that, although supported education has been shown to improve work status, educational status and quality of life, and even though the evidence suggests that supported education ought to be a standard component of community mental health care, "evidence-based supported education for people with psychiatric disabilities is not widely available".

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

As mentioned above, the lack of theories for the facilitation of work integration of MH NEETs is more than obvious in the literature. This has as a result that young people with psychiatric disabilities feel less hope of attaining a relatively normal life. They report the loss of self and life dreams as key issues. The main challenge remains to combine existing evidence-based practices from mental health care, with early intervention and specialized employment and supported education domains, in order to create a new method for the specific target group of MH NEETs.

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

Although it is highlighted that informal carers and particularly the family network of people with mental health problems play a significant role in the recovery and rehabilitation process, including work and education integration, only 3 out of 10 articles chosen refer to the important role of social network and informal carers for people with mental health problems' and MH NEETs' work and education integration. It is also reported that the few existing articles have several limitations. Thus, it seems that a large knowledge gap exists in this domain. This knowledge gap can severely restrict the ability of professionals to access the valuable resources that these networks may be able to provide. It can also limit the ability of professionals to determine the nature, level and combinations of support participants in employment programs that are needed to achieve successful employment outcomes. The big challenge for counsellors and mental health professionals is to understand the importance of involving informal carers in this process and to determine the most suitable ways of involvement, in order to maximize the vocational rehabilitation results.

c) Supported Employment and Career Counselling for MH NEETs

A large number of existing methodologies and interventions for the work integration of MH patients are mentioned in the existing literature:

1. Sheltered Employment / Work
2. Pre-vocational / Vocational Training
3. Transitional Employment / Work Experience
4. Supported Education
5. Supported Employment
    a. Assertive community treatment model
    b. Transitional Employment

c. The Job Coach Model
d. Individual Placement and Support (IPS)

6. The Club House Model
7. Social Firms
8. Opportunities for volunteering
9. User employment programmes

Among the 10 articles gathered, 4 compare the effectiveness of some of the models above. All of them conclude that Supported Employment and especially Individual Placement and Support are the most effective methodology for the work integration of people with mental health problems.

The existing programmes that have been evaluated as effective are the following:

- "Choose-Get-Keep (CGK)"
- "Early Psychosis Intervention Program" (Liverpool)
- "Training for the Future (TFTF)" (Boston)
- "Empowerment of Mental Illness Service Users: Lifelong Learning, Integration and Action (EMILIA)"

Regarding MH NEETs there is no specific methodology or intervention described. One article suggests that the intervention should include:

- Early intervention
- Supported Education
- Individualized assistance and ongoing support to maintain employment or education
- Ongoing support to employers
- Vocational counseling and assessment
- Skills training

More specifically, a useful approach for occupational therapists to use is a recovery framework combining evidence-based employment and educational assistance with mental health care, provided in parallel with short-term vocational counselling, illness management skills, training in stigma countering and disclosure strategies, context-specific social skills and skills in social network development.

d) Working with the Labour Market

Techniques and tools regarding how to approach employers and raise their awareness are not really reported in the papers gathered. Two articles offer some vague suggestions about the work that should be done with employers.

At the level of raising awareness, it is considered essential to educate employers about mental illness in order to address their fears, ignorance and stigma. General workplace education programmes (e.x

including the topic of mental health in the workplace, managing stress and positive working relationships) could be more effective than programmes that focus specifically on individuals.

On top of that, knowing that ongoing support is available could positively influence the hiring decisions of employers. When a user starts a new job or returns to his previous position, the following organisational on-site interventions are recommended:

- Ensure that a formal period of induction of sufficient length is routine practice for all new employees
- Embed attention to employees' ongoing development in routine workplace practice through formal supervision and appraisal procedures
- Team building aimed at creating a welcoming workplace where difference is accepted and employees' strengths are valued
- Training and other learning opportunities, for example learning sets for managers covering mental health and safety at work.

e) Discrimination and Stigma

Discrimination and stigma seems to be one of the main reasons that keep people with mental health problems outside the labour market.

Discriminating behaviour or structural discrimination by employers

One of the factors that lead to unemployment for people with mental health problems is negative employer attitudes. The attitudes of employers towards people with mental illness may reflect the ignorance and stigma prevalent in the wider community. Negative attitudes can also be a result of low mental health literacy or to employers being unaware of how a particular mental disorder can be successfully accommodated in their workplace. Employers often underestimate the capacities and skills of people with mental health problems and overestimate the risk of hiring them. At the same time, the stigma associated with mental disorders may make workers reluctant to disclose their condition, and disclosure is necessary if employers are to make accommodations in the workplace. Besides stigma, the labour market itself poses obstacles, as some industries and jobs have only full-time opportunities, require shift work, use overtime extensively or do not offer flexible hours of attendance. Rejection by employers not only leads to unemployment, but can also erode self-esteem and self-efficacy for employment. Negative career experiences can disrupt hope of one day restoring a suitable career path.

Self-Stigma

No significant findings.

Mental health professionals' low expectations

Unpredictably, the international literature shows that mental health professionals also create barriers to the work integration of people with mental health problems, mostly due to low expectations. Mental health professionals and General Practitioners often underestimate the capacities and skills of mentally ill people, overestimate the risk to employers and believe that people with mental health problems tend to have unrealistic work expectations and goals. However, direct surveys of

consumers have revealed mostly realistic and informed job preferences. One article reports that health professionals' low vocational expectations of mental health service consumers prevented the majority of people from receiving vocational rehabilitation and supported employment services. Another obstacle found to be posed by professionals is their reluctance to work with the family network due to preconceived notions that families cause or exacerbate mental illness.

f) EMPOWERMENT

Vocational evaluation and assessment is mentioned in two articles as a very important and at the same time, difficult procedure. Although there are multiple dimensions that need to be evaluated at the beginning and during the vocational counselling and planning process, it seems that the outcomes will be determined by a combination of the following factors and it is suggested that the assessment must begin by their examination:

- Historical Factors (work history, skills, previous work performance)
- Individual Factors (confidence, motivation, personal aims and objectives)
- Setting factors (expectations of staff, opportunities for training and development, etc)

Regarding these factors, the research has shown that:

1. Detailed work histories are most useful in assessment than are most clinical measures, such as diagnosis or traditional psychometric testing (IQ etc). These measures have very limited predictive value when it comes to occupational performance.
2. Individual factors, such as motivation, confidence and personal objectives have consistently been shown to be highly predictive. The willingness of people to work, their motivation, skills and the work subject they are interested to pursue seem to be the main components of success.

Methods of testing / assessment of personal characteristics

Instruments of situational assessment proposed:

- Standardized Assessment of Work Behaviour
- Work Adjustment and Interpersonal Skills Scales
- Job Performance Evaluation Form
- Work Behaviour Inventory (WBI)

Methods of empowerment of MH NEETs

No significant findings.

g) WORKING WITH INFORMAL CARERS

As mentioned above, the involvement of informal carers (which most of the times are family members) is a neglected field in the area of work integration of people with mental health problems. The little existing literature (only 3 articles found) reveals that a lot of challenges arise in work with

family members: Firstly, because families experience significant anxiety and burdens even during the recovery stage of their relative's illness, especially when recovery involves employment and secondly, because in many cases professionals are unwilling to work with the family network due to preconceived notions that families cause or exacerbate mental illness. Nonetheless, research also shows that family-dominated networks, can be supportive and have valuable resources to offer for the success of rehabilitation programs, despite their limitations. So, the main challenge for professionals is to acknowledge that families and informal carers are not always completely effective and have issues of stress, carer burden and lack of resources to provide support, but at the same time are indispensable components and need to be involved in the work integration process of the person with mental health problems. A summary of the needs of informal carers and proposals for their involvement and support, as suggested in the literature, are the following:

- Acknowledge issues of overprotective and critical and intrusive behaviours by informal carers and work on them
- Provide education about important issues, such as:
  - The person's capacity to work
  - The benefits if the person works
  - What to say to employers, if needed, when the person is sick
  - Recognizing signs of stress and relapse and contacting the professional early to prevent job loss
- Provide support to alleviate anxieties about:
  - Relapse and loss of income
  - Periodic respite from the burden of care

1.1.3 National Report IT – CESIE

a) INTRODUCTION

As assessed by the Italian National Institute for Statistics (Istat, https://www4.istat.it/en/), the information sources regarding Mental Health (MH) in Italy are varied, usually refer to different bodies/institutions and therefore cannot be treated uniformly. Moreover, Italy lacks satisfactory information about the offer and quality of services provided, which undoubtedly differ from the North to the South of the country. Furthermore, 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 sensory 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 a single category ('*people with disabilities*') and analyses the support system and its strong and weak points from this general point of view. Very little 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 with 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 placement 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 focus on the current Italian system only and other resources which were necessary in order to provide comprehensive information about it (see 'References' section).

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

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

Mental Health (MH) professionals are typically certified in psychiatry, psychology, MH counselling, professional counselling, or related fields (psychiatrists, psychologists, licensed clinical social worker), while Career Counsellors often hold degrees in human resources, economics, political science, psychology or education (the strong need for qualified guidance counselling in Italy is not matched by an equally defined discipline for this profession. Up until a 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 for autonomy, choice and self-efficacy within the context of an ongoing career counselling relationship are productive strategies for MH users. However, career counselling services do not constitute an environment in which such a

sensitive helping relationship can develop. New ways must be found to faciliate 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 the specific pathology of the worker, even if not related to exposure, worsening 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 cause them to exhibit dangerous behaviours that make them "risky" not only to themselves, but also to other colleagues, third parties and to the immediate environment (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 monitoring of the MH worker's "amenability" to the work and the adaptability of the work to the MH worker so that this positive interaction between work and worker produces an advantage for him/her (fulfilment as an individual and social being) and for the organisation.

For Career Counsellors, one particular challenge is caused by the **organisation of 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, among 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 competencies regarding mental health. In addition to issues around developing the helping relationship, the 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 the wider society, in spite of progress made and media campaigns in recent years, and as such may affect Career Counsellors, who may benefit from reflection upon their own 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 of them as being 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 own 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 on the part of their clients. Unable to handle the emotional demands of the work, they tend to discourage MH users or refer them to MH services.

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 the local level by the Employment Centres (CPI). They are in charge of managing the career guidance services for adults and NEETs, while the delivery of career guidance to students is entrusted to the schools and universities. Career 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 informational 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 plan or analysing the client's situation through group sessions and/or courses, on themes such as job search techniques or how to choose a career.

Fundamentally, 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 services). Staff are mainly concerned with administrative tasks, and only 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% have a high school diploma and 13% have barely 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 career guidance services provide is 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).

Moreover, generally speaking, career guidance services lack connection with other services and do not have wide knowledge of the opportunities that are available, offered by support services or education/training providers, not even information regarding the labour market (available information is related to their region only). In advising, no accurate analysis of the professional profile is made, neither a study of the trends which prevail in 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 continues to be based on the personal knowledge, skills, and the discretion of an adviser who designs an Individual Activation Plan in relation to the user's 'characteristics' identified through standardised questionnaires and tests and summarised in the Personal and Professional Data Sheet of the worker. This approach has several critical aspects: 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 competencies of the particular 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) for 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 sensory disability[4]), **the Italian law promotes a "targeted placement",** meaning the provision of technical and support tools that allow a proper job skills assessment and a suitable placement, through analysis of workplaces, support measures and solutions to problems related to environments, tools and interpersonal relations in everyday workplaces and relationships. Nevertheless, the official mission of the competent services is to facilitate and support a meeting between employers and job seekers with special needs and not to "find work for them", so in any case the personal activation of the user and an interest on the part of the employers is needed.

Also, it is not enough to be a MH patient to benefit from 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.

---

4 4 According to Italian Law 68/1999 – "Regulations on the right to work for 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, mental, or sensory impairments and intellectually handicapped people with a reduction in working capacity equal to or greater than 45%;
- People who have a physical or mental disability equal to or greater than 33% due to a workplace accident;
- People who have 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;
- People who have a war invalidity or invalidity due to military service.

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

In Italy, neither uniform nor validated information exists regarding the integration of people with impairments/disabilities/handicap into the labour market; in fact, there is no monitoring system for work adaptation and integration. Existing databases are quantitative, providing data on single placements but **almost no data on 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".** The cultural approach to people with special needs related to a total or partial physical, mental or sensory 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 that they have special needs; they are less likely to be involved in the normal system of professional growth and a guarantee of career progression within an organisation.

The neglected role of informal carers in individuals' 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 care, 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 marked by 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 regional care facilities and evident economic shortcomings which are also exacerbated by a complicated and slow bureaucracy: families are generally "alone" in facing the burdensome management of a chronically ill person who is often unaware of their condition and who can have both alternating and continual 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 so by necessity**. In addition to the excruciating emotional pain that their situation generates, their condition is made up 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% requested part time work 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 a 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. Supplementary allowances and invalidity pensions (paid only when there is a 100% certified disability), certainly 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 extremely 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 placed on the Informal Carer's shoulders.

c) 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 at 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 highly heterogeneous: each region uses different measures and stakeholders in relation to the various economic and industrial realities that characterize their region.

Italian Law 68/1999[5] has introduced **the "targeted placement" methodology**: people with special needs related to a total or partial physical, mental or sensory disability who meet prescribed 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 maintained at Employment Centres (CPI), which record job skills, abilities, skills and inclinations, as well as the nature and degree of disability on a special form and then analyzes the available offers to match the user with a suitable placement. Placement is made through a ranking whose criteria are: seniority of enrolment; economic situation; family size and type of special needs; difficulties in moving around the region; further elements identified by the regions according to regional needs. For those users having more difficulties, integration may be supported through: direct hiring (the

[5] 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".

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 opportunity 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 with mental disabilities, former inmates of psychiatric institutions and persons under psychiatric treatment), thus uniting the work integration goal with the general interests of the community. However, very few cooperatives have hired or have developed self-sustainable projects (Social Firms) aimed at employment. Most cooperatives continue to rely on internships or grant assisted jobs and often close as soon as the public funding received is finished.

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-term 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) is still 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 their taking responsibility to search for the job they want, in line with their aspirations. Career guidance services adopt a non-assisting approach where they no longer mediate with employers but rather support the MH user in independently and correctly carrying out their search for training/employment: MH users are supported in CV writing, job searching, handling interviews. The success of this method relies on employers not being aware of the health issue: as it is an autonomous search, the prejudice that usually exists towards a person with a MH issue is not triggered in the employer, thus 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. However, technology is not enough: the path of inclusion is not only made of devices; it is much more complex. Adjustments must include the ability to reorganize the work itself and its timing, staff training, defining a suitable job description, and only afterwards the adaptation of the workstations. This process allows for building the identity of a worker and not the identity of a 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 sensory 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 70% of their salary covered for 5 years or for the whole duration of the contract (minimum 1 year). However, there are contradictions: among the exemption measures the law allows organisations that believe they are not in a position to hire such a worker 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.

d) WORKING WITH THE LABOUR MARKET

In a workplace, a combination of undefined responsibilities, poor support from the company, lack of specified 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. Therefore, they lack the confidence to recognize the 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 uniform at the national level. They usually consist of:

- Informational actions concerning the opportunities offered to workers with total or partial physical, mental or sensory 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 sensory 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 even family involvement.

e) DISCRIMINATION AND STIGMA

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. An employer's attitude towards MH job seekers is generally that of unapproachability and distrust, both generated by prejudice against the MH person. The main concerns are related to accommodation costs and training time (for MH workers, HR staff and co-workers) as well as time dedicated 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 discrimination towards MH people**:

▪ 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 respect to 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-seeking organisation's needs.

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

Self-Stigma

Occasionally the MH person puts themself in a self-discriminatory perspective, believing their contribution to society – possible only through 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 to 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 made to view themselves from the standpoint of their disability, rather than that of their skills, and often to consider themselves a burden within an organisation.

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, needing to be protected from frustration and failure; in the majority of cases, it is considered unwise to propose the user 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 in 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 tend to offer these opportunities to patients/service users who have proved themselves able to fit in and carry out the expected activity till the end of the project.

f) 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.

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 sensory 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.

Methods of empowerment of MH NEETs

Empowerment is related to both strengthening of the person's skills and competencies 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 living 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 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 a possibility for people with special needs to make 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).

The third sector has continually intervened, but its activities are limited not only geographically but also in 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 continues to prevent access to what could really impact on their wellbeing: housing, work, social life.

g) WORKING WITH INFORMAL CARERS

The most important approach always includes the family, which must be supported in facing the situation, to become aware of it in terms of possibilities and limits, to build a realistic path together for the MH person. The family of a MH patient is often characterized by great fragility and loneliness; therefore, it needs great acceptance, support in 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 it difficult to accept eventual problematic behaviour, due to incapacity or difficulty in managing it. In general, it represents a defence reaction dictated by fear of facing a situation without feeling prepared to do so. These kind of carers systematically fail to realistically assess the MH person's limits and potential: they may only see 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 relative ends up behaving in a way that reflects others' expectations. Or, on the other hand, carers set unrealistic objectives or high expectations with respect to the real abilities of the MH person, creating a potentially frustrating situation, in which as a result, they come away feeling completely disenchanted. Finally, for other carers, rejection may result in almost total delegation of the MH persons to professionals or institutions.

Some other carers excessively invest 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 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 circumstances dictated by the MH person's condition and to create a personal network to prevent isolation that often leads to deep 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 adequate support must necessarily include:

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

▪ R*elieving of the burden of anxiety/time dedicated to the MH person*: informal caring is automatically associated with sacrificial choices that distort the life and future plans of the carers.

▪ *Promotion of socialization with other informal carers*: a space for emotional sharing and support in finding coping skills.

▪ *Creation of synergies and collaborations in the region*: activation of a support network of competent organisations which can provide assistance (ex. educational and rehabilitative interventions, home care, etc.)

For MH users with a very poor social and educational background, the 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 behavioural change: encouraging the relinquishment of passive assistance and allowing the evolutionary process of the MH person towards achievable goals.

h) CONCLUSIONS

Provision of employment related services for people with MH needs is patchy and inconsistent across Italy. Despite a common legal framework, placement methodologies and a variety of interventions that encourage and support the inclusion of MH individuals in the labour market and the workplace, the whole system is lacking as intervention impacts are not relevant or properly enforced by employers. There is 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 taking actions towards organizations that merely provide information or stress economic incentives in order for them to hire people with special needs related to a total or partial physical, mental or sensory disability. Instead, work should be done to ensure that the genuine function of "guidance and accompaniment" is set up and effectively implemented to build learning and working environments that actually correspond to people's characteristics, aspirations and needs.

1.1.4 National Report PL – POMOST

a) INTRODUCTION

The POM0ST team reviewed the literature by mainly searching internet sources in English, and as a result 10 articles were selected. There was a lack of literature in Polish.

Adolescence and early adulthood is a crucial period in which skills development and social roles are initiated. Young people who are 'Not in Education, Employment or Training' (NEET) are important to

clinicians, policymakers and researchers as this signifies an absolute disengagement from both the labour market and a major avenue of human development.

Participation in education and employment is considered crucial to the transition to successful adult well-being. Employment and education provides both manifest (eg, income) and latent (eg, time structure, social contact, sharing of common goals, status and activity, social and occupational support) benefits to an individual with low educational attainment and/or limited employment experience who faces the greater likelihood of social exclusion, disability and isolation, in addition to the impacts of low income: poorer quality of life, increased illness and disease, decreased access to healthcare, increased levels of psychological distress, and maladaptive lifestyle behaviours such as substance abuse and criminal activity. Chronic unemployment is associated with severe levels of disadvantage and carries a significant economic cost to both the individual and society, including lost earnings and taxes, as well as the increased burden on welfare and healthcare systems.

b) KNOWLEDGE GAPS

In the analysis process, it was observed that there are many articles available on young people with NEET status who exhibit general mental health problems, however, there is a lack of research on the subject of vocational and educational integration of young people who are also struggling with serious mental health problems.

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

From the literature analysis, no particular knowledge gap in the field of career intervention was evident. However, lack of access to career counseling specialists is emphasized.

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

No literature found.

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

One of the key problems in facilitating the work integration of individuals with mental problems appears to be the lack of clearly defined methods of operation, which translates into insufficient opportunities to implement their aspirations to achieve success in gaining a well-positioned job as well as realizing educational goals.

The neglected role of informal carers in individuals' career development

No literature found.

c) Supported Employment and Career Counselling for MH NEETs

Employment embodies recovery for people with severe mental illness especially among young adults recently diagnosed with a psychiatric disorder. Various studies suggested that work rehabilitation and employment can result in greater income, community integration, and improvement in symptom severity, increased self-esteem, and quality of life.

Recent research indicates that in a growing number of countries worldwide, SE, especially the individual placement and support model (IPS) was found to be more effective than traditional approaches. After estimating expected outcomes of evidence-based supported employment it was determined that the majority of IPS participants obtain competitive employment at a far higher rate than clients enrolled in other vocational services.

IPS is the most comprehensive and standardized approach to vocational rehabilitation for persons with severe mental illness. IPS helps people with severe mental illness work at regular jobs of their choosing.

In addition, the following methods of professional support for people with mental disorders are listed in the literature:

- Sheltered Employment
- Short-term placements
- Voluntary employment
- User Employment Programme
- Pre-vocational Training
- Vocational Training
- Transitional Employment
- Supported Education
- Supported Employment
- Individual Placement and Support
- The Club House Model
- Social Firms
- Social Enterprises

d) Working with the Labour Market

There are many ideas and approaches on how to support employers in the process of employing people with mental disorders. However, they are not included with clear instructions that can be used in most cases.

It is apparent from the research evidence that employers do not have enough information on mental health, how to support people with mental health conditions, and the impact of this on work. Given

the paucity of information, it may not be surprising that employers who have not had direct experience employing someone with a mental illness, may not understand what the implications are of particular mental illnesses for them and for their employees.

Education and training to improve mental health literacy in this area may help to improve employers' understanding of mental health, and how people can be supported.

Evidence suggests that employers would like to receive more support to improve the way they deal with mental health in the workplace.

e) Discrimination and Stigma

Despite evidence of the benefits of employment for people with mental disorders, their keenness to work, and the development of interventions which address the impact of symptoms, this population remains severely underrepresented in the workforce.

Arguably, the most prominent non-clinical reason for this is the considerable stigma people with severe mental health conditions experience in society. Stigma attached to serious mental illness is so powerful that avenues to social inclusion, recovery and employment are often closed shut, even for people who are well or have their symptoms reliably under control.

Discriminating behaviour or structural discrimination by employers

Discrimination by employers and co-workers, has been identified as a major barrier for individuals with mental disorders in gaining and maintaining employment. It has been indicated that employers' negative attitudes have led to reluctance to employ people with mental health conditions, and particularly those with a severe condition.

Employers indeed hold strong beliefs about the impact of severe mental illnesses on an individual's ability to work. Employers reported they were uncomfortable employing a person taking anti-psychotic medicine and being uncomfortable taking on people with a previous mental health related hospitalisation or uncomfortable employing a person being treated for depression.

The above attitudes result from lack of education in the field of mental health and lack of knowledge that mentally ill people also have a considerable spectrum of skills and talents.

Stigmatization also translates into the employee's hiding their real mental health condition from the employer which affects the further development of the employee and maintaining the workplace.

Self-Stigma

Self-stigma derives from societal stigma.

A European study looking at self-stigma and recovery found over 40 per cent of participants reporting moderate of high levels of self-stigma, and almost 70 per cent reported moderate or high perceived discrimination.

A cross-sectional study with people with schizophrenia across 27 countries found that 64 per cent anticipated discrimination when applying for work, training or education. More tellingly, over a third of participants anticipated discrimination in job seeking when none had been experienced. As a result of the stigma from others, people may be dissuaded from pursuing the kind of opportunities that are fundamental to achieving their life goals because of diminished self-esteem and self-efficacy.

Even without the barriers of stigma, motivation to work can be difficult to maintain given the amount of rejection that someone with mental disorders is likely to face when seeking employment.

Mental health professionals' low expectations

Even though healthcare professionals often claim that they believe that people with severe mental health conditions can work, when they are asked about the capacity of their own clients, they are less likely to see work, particularly paid work, as a possibility. Thus it is likely that mental healthcare professionals are no less susceptible to stigmatizing beliefs than the general population.

Among healthcare professionals, barriers to employment are their low expectations, a low appreciation of the importance of work as a desirable outcome, and concerns for individual wellbeing. The views from healthcare professionals , however, were more reflective of the evidence which showed that there was considerable belief among clinicians of the abilities of people with psychosis to enter some form of work, with some indicating that this might, however, mean non-competitive work (i.e. voluntary or sheltered).

f) EMPOWERMENT

Although many employers feel drastically ill-equipped to employ people with a mental health diagnosis and vocational evaluation is perceived as a very complex procedure, one can mention the following factors facilitating the outcome:

- The employer should seek information on severe mental health conditions and how they can be managed in work
- Develop an open, friendly work environment to enhance disclosure
- Be prepared to make adjustments at work to accommodate the needs of people with mental disorders
- Gather detailed work history
- Ask about personal preferences, motivations and aims

Methods of testing / assessment of personal characteristics

No literature found.

Methods of empowerment of MH NEETs

No literature found.

g) WORKING WITH INFORMAL CARERS

Family strategies attempt to reduce environmental stresses on people with mental illness, whilst promoting social functioning. Psycho-educational family interventions, as an adjunct to medication, are thought to reduce the rate of relapse, improve symptomatic recovery, and enhance psychosocial and family outcomes. Nevertheless, they seem to be a frequently neglected area in terms of work integration of people with mental health problems.

h) CONCLUSIONS

In most cases, very little attention is paid to health or disability factors. Given that mental ill health is the primary cause of disability among people in OECD countries, addressing NEET status among young people with mental illness is a key concern. Importantly, young people often exhibit substantial levels of disability prior to a complete manifestation of a mental disorder, reflecting either the putative prodrome of an illness or the consequences of disengagement from employment and education.

A range of youth-focused services are needed to be established to improve clinical outcomes. These services should also be predicated on the notion that investment in early treatment and selective prevention would produce long-term socioeconomic savings.

The National Mental Health Commission recommends that improving social participation should also be a key outcome of such services, suggesting that clinical care must now focus on improvements beyond symptomatology. Currently, most knowledge about improving social functioning in this area is derived from studies of those with early psychosis and severe mental illness (eg. IPS: Individual Placement and Support for early psychosis). In order to best target current and future primary health services, it is important to understand the risk profile of NEET among young people who are seeking help from these services. Such knowledge might help improve service delivery, providing opportunities for the services to intervene in other life domains, such as employment and training, which are negatively affected by mental illness.

2 PART II – TRANSNATIONAL SYNTHESIS

2.1.1 Introduction

The four partners' thorough literature review revealed a lack or paucity of literature concerning the work and education integration of young people with mental health problems. Most partners reported findings concerning mental health people in general but not specified for MH NEETS. Also, country -specific literature about NH NEETS was fairly scarce; most literature came from international sources.

2.1.2 *Knowledge gaps*

Taking into account the aforementioned, several knowledge gaps were identified.

In the subject of career counsellors and MH professionals and their involvement in career interventions, educational and employment systems, and the implementation of theories and methods for facilitating work integration of MH NEETS:

Greece and Poland report that there are few career counsellors and mental health professionals specialized in the field of work integration of people with mental health problems in general. Additionally, there is lack of evidence-based practices in supported work and education integration with MH NEETS specifically. Italy stresses the lack of formal education of professionals regarding career counselling with MH people and therefore the relevant services are provided by other professionals (e.g. psychologists). Germany reports important gaps in the inclusive integration of young people in education and vocational training as well as a lack of professionals' practical knowledge in the employment and educational systems. All partners report a lack of theories and methods for facilitating the work integration of MH NEETS, although Germany reports some methods proposed in the literature regarding prevention programs, direct and integrated vocational support alongside other treatments, training programs and incentive programs for the employers.

In the subject of the role of informal carers in the career development of MH NEETS:

All partners report that an important knowledge gap exists in this domain. Informal carers' role is restricted mainly to providing for everyday issues. They rarely get involved in supporting their family member in his/her work integration although they could be a valuable resource for support in this issue.

2.1.3 *Supported employment and career counselling for NH NEETS*

All partners report insufficient findings about methodologies and intervention programs for MH NEETS. However, there are a lot of methodologies and interventions concerning MH patients in general. Greece, Italy and Poland report that the most effective seems to be the IPS (Individual Placement and Support) which is a model of Supported Employment. However, Italy reports that although intervention programs and methodologies (such as IPS, "targeted placement" methodology and Social Cooperatives) exist for the inclusion of MH patients in work and education, they lack in implementation and consistency across the country. Germany reports two methods used effectively for the integration of MH patients in general: "First-train-then-place" and "First-place-then-train", which consist of specific steps and procedures followed by professionals and involve several expertise organisations. Also, two sets of good practices are proposed and used which involve professionals and their families and consider as important the active involvement of the MH patient. Italy reports that although intervention programs and methodologies exist for the inclusion of MH patients in work and education, they lack in implementation and consistency across the country

Other methods that were found effective, are the following:

- Short-term placements
- Voluntary employment
- User Employment Programme

- Pre-vocational Training
- Vocational Training
- The Club House Model
- Social Firms / Enterprises
- Sheltered Employment / Work
- Transitional Employment / Work Experience
- Supported Education
- Supported Employment
    - Assertive community treatment model
    - Transitional Employment
    - The Job Coach Model
    - Individual Placement and Support (IPS)
- User employment programmes

2.1.4 Working with the labour market

All partners' findings show that techniques and tools regarding approaching employers, raising awareness and supporting them in the process of employing people with mental health issues are deemed important. However, few specific tools and techniques in the form of clear instructions are mentioned in the literature. Nevertheless, Germany reports two proposed methodologies and a special tool for employers: integration and supported employment projects in which the training occurs after the placement and the employers and clinics work together in an intensive way and the "H-I-L-F-E concept" tool that offers suggestions to support people with mental health problems in the company. Also, Italy reports awareness raising and sensitisation initiatives for employers, albeit not homogenous at national level or specific for MH patients, that include: information actions concerning opportunities (mainly tax benefits), training courses for employers, interventions for the sensitization of the working environment.

2.1.5 Discrimination and stigma

All partners report that the most important factor that contributes to the unemployment of MH people and even their own reluctance to seek paid work, is the discrimination and stigma they experience from employers. One important reason for this discrimination is limited knowledge on the employers' part, about:

- mental health issues in general,
- the abilities and skills of MH people,
- the actual risk of hiring MH people
- how a particular mental disorder can be successfully accommodated in their workplace
- the impact of severe mental illnesses on an individual's ability to work

Other concerns, refer to:

- employers' reluctance to dedicate resources for training MH workers, other staff and managers and providing support to MH workers who are unable to meet expectations in performance and quality levels because of their MH issues.

- perceived dangerousness and unpredictability of MH workers
- the belief that work is stressful and unhealthy for MH people
- the belief that employing people with MH issues is charity as they cannot perform high quality work

As a result of societal stigma and a labour market that marginalises MH people, MH people seem to be dissuaded from job seeking or applying for training and education and perceive themselves as people with disabilities and not as workers, Poland and Italy report. As a result of public and self-stigma and shame, many MH adolescents struggle with the decision to disclose their MH issues to others, Germany reports.

Finally, all partners report findings that the MH professionals themselves create barriers in the work integration of MH people, due to:

- low expectations
- underestimation of the capacities and skills of MH people
- overestimation of the risk to employers
- the belief that MH people have unrealistic work expectations and goals
- a low appreciation of the importance of work to MH people
- the belief that only voluntary or sheltered work is suitable
- offering of only assisted and gradual steps of training and transition to work which creates frustration to MH people since they enter an endless circle of training and transition placements
- a lack of compassion and warmth and a high degree of reluctance to accompany MH people towards autonomy

2.1.6 Empowerment

Empowerment for MH people means taking control of their lives, which means acknowledging their needs and ambitions and developing and strengthening those capacities and resources that support their autonomy. A targeted work placement for MH people, requires an assessment of their functionality in a psycho-physical and sensory state and their social and working profile.

For these functions, Italy uses the International Classification of Functioning, Disability and Health tool (ICF), which documents the skills and competencies that make people employable. Germany reports several tools in existence for this function such as MELBA, IDA, O-AFP and ZERA which is a tool found effective in promoting empowerment using seven sub-programs and aiming at supporting MH people to determine their optimal level of stress and thus to avoid excessive and inadequately supported demands in the professional arena as much as possible. Poland proposes the following factors that support the vocational evaluation of MH people: a) the employer should seek information on severe mental health conditions and how they can be managed in the workplace, b) develop an open, friendly work environment to enhance disclosure, c) be prepared to make adjustments at work to accommodate the needs of people with mental disorders, d) gather detailed work history, e) ask about personal preferences, motivations and aims. Greece proposes that the procedure of assessment be facilitated by combining the following factors: historical factors (such as

work history, skills), individual factors (such as motivation, confidence) and setting factors (such as expectations, opportunities for development). The following tools of assessment are also proposed: Standardized Assessment of Work Behaviour, Work Adjustment and Interpersonal Skills Scales, Job Performance Evaluation Form, Work Behaviour Inventory (WBI).

All partners report little or no specific references for MH NEETS empowerment.

2.1.7 Working with informal carers

All partners report that the role of informal carers (mainly the family) is an important one in work rehabilitation, but a sorely neglected one. They are usually overlooked in their involvement in MH people's growth and even in their own needs for support. Greece reports a summary of informal carers needs for involvement and support: Acknowledge issues of overprotective and intrusive behaviours and work on them, provide education about important issues, provide support to alleviate anxieties. Poland reports that psycho-educational family interventions, as an adjunct to medication, are thought to reduce the rate of relapse, improve symptomatic recovery, and enhance psychosocial and family outcomes. Germany highlights the importance of closeness of MH NEETS to the informal carers and also mentions the use of the "Kölner Instrumentarium" tool, which is used in empowering MH NEETS at home by involving their families. Italy proposes five elements that, to provide adequate support to informal carers should include: 1. Psycho-pedagogical support, 2. acceptance and re-elaboration of disability, 3. relieving of the burden of anxiety, 4. promotion of socialisation with other informal carers, 5. creation of synergies and collaborations.

All partners report little or no references for the specific needs of MH NEETS.

3 PART III – CONCLUSIONS – IMPLICATIONS – CHALLENGES – RECOMMENDATIONS

3.1.1 Conclusions and Implications

As is evident from the above, there are several gaps that have arisen, which lead to several implications in the work and education integration of MH NEETS.

Firstly, the lack of specific literature concerning MH NEETS itself, implies that career counsellors and MH professionals do not have the necessary tools and methodologies to work with this population. Most of the research, the methodologies and tools that have been developed concern the MH people population in general and even though there is an abundance of choices for the MH general population, with the most promising and prominent being the supported employment methodology such as IPS (Individual Placement and Support), there is little or none specifically for MH NEETS. The special needs and characteristics of the MH NEETS population have not been identified or attributed the proper significance. Consequently, this results in career counsellors and MH professionals overlooking the MH NEETS special needs in their practice and even when they don't, there are little or no evidence-based practices they can use to address them. It seems that methodologies that involve the family members and various expertise organisations which can focus on MH NEETS, albeit scarce, have better results.

Career counsellors and MH professionals seem to lack the proper education and practical knowledge about employment and educational systems and thus they are deficient in facilitating the work and educational integration of young people with MH problems. Moreover, they seem to adopt a patronising, overprotective attitude towards MH NEETS that does not promote autonomy, engagement and activation, skills that are profoundly important in the recovery of young people with MH problems. Another important issue in professionals' attitudes is their low expectations about the work and educational integration of NH NEETS as well as their limited understanding of the value of work for the recovery of mental health illness, which elicit work practices on their part, that may even cause frustration to MH people, such as placements below their capacities and different from their talents, placements in a continuous cycle of short internships, workshops and trainings that occur under the perspective of offering something to them, but in truth it never leads to any useful work experience or meaningful vocational training. Such attitudes on the part of career counsellors and professionals have significant implications in the promotion of the low self-esteem, self-value, confidence and the self-stigma that young people with mental health issues experience and may lead to the validation of the low expectations and expectancies they already have of themselves.

Considering the above, the empowerment of MH NEETS seems to be a difficult matter, taking also into consideration the lack of assessment techniques and tools that could facilitate the exploration of the capabilities, talents, desires, interests and abilities. Since there are little or no tools available, professionals use the ones available for MH people in general, which are mostly based on the assumption of previous education or work, factors that do not apply to MH NEETS and thus cannot facilitate their assessment. Or, they do not use tools at all and place MH NEETS in whatever available education, training and work experience programs exist, completely ignoring their capabilities and skills and driven solely by the assumption that MH young people will have limited skills and needs. All these, result in meaningless placements, contribute to drop-outs and do not facilitate the empowerment of young people with MH issues.

Another important factor in the support of MH NEETS is the role the informal carers, family and close friends, play in their work and educational integration. Research shows that the family has been neglected in the involvement of MH people's growth, even though family interventions have proven to be of significant value. There are various reasons for this: professionals do not give enough effort to working with families since they believe that they cause or exacerbate mental illness, the families themselves experience a lot of stress and anxiety and do not receive the support they need, professionals do not give or have the time for family involvement and intervention, families experience denial about their family member's mental health and do not see a reason to be involved, family members have unrealistic objectives and expectations (high or low) about the MH person or they do not deem themselves equipped enough to get involved in their recovery and work integration. As a result of the above, MH young people lose a source of support that can be profoundly valuable in their work and educational integration and family members remain powerless, uninvolved and distant in the lives of their family member. Moreover, their lack of involvement keeps them under the radar of professionals and thus they do not receive the support they need, which impacts not only on their own mental health but also on the quality of general support they offer to their family members.

It seems that the labour market and employers also play their part in impeding MH NEETS work and educational integration. The main reason appears to be the inadequate offering of work opportunities, mainly due to limited knowledge on mental health issues, their concept of MH individuals' capabilities and the risk they undertake by employing them and the lack of support that there is available in accommodating their processes to include people with mental health issues. To add to these, professionals seem to have limited tools, techniques and methodologies to help them approach the labour market in order to gauge the impact. In the case of MH NEETS, these seem to have a great impact since opportunities for placements to gain actual and meaningful work experience are scarce which, in its turn, adds to young people 's frustration in entering the labour market, to their own self-stigmatization, further placing obstacles to acquiring an actual job instead of remaining endlessly in temporary secured placements. Moreover, the labour market loses a work force that could prove valuable to businesses.

3.1.2 Challenges and needs

It seems that the support the MH NEETS receive for their work and educational integration is rather limited, whether it be by people (professionals and/or informal carers), the lack of tools and techniques or the workings of the labour market itself. The challenges that emerge are various and correspond to several levels.

The most important challenge that arises is the empowerment of professionals, career counsellors and mental health professionals, with the appropriate techniques, methodologies, tools and even attitudes. Several needs and challenges emerge:

- The methodologies and techniques for the work and educational integration available for the general population of MH people, need to be tailored to the needs of MH NEETS.
- The aforementioned finding implies another challenge: research needs to focus more specifically on identifying and acknowledging MH NEETS needs and on the ways that these can be met.
- New tools and interventions need to be created that focus on the specific needs of MH NEETS. These tools should be evidence-based so that they will be meaningful both for the professionals that use them but also for the young people that they are addressed to.
- Assessment techniques and tools need to be created. These tools should focus on the particularities of MH NEETS and enable professionals to investigate and identify these young people's abilities, skills, talents, interests, areas that are in need of improvement.
- Training programs for professionals that focus on familiarizing them with the educational and employment systems of their country and the opportunities they offer, so that they can provide meaningful suggestions, co-create with the young people realistic work and educational plans and goals.
- A shift in professionals' attitudes towards training programs that promote awareness of mental health issues in young people, the value of cooperation and autonomy in young people's work and educational integration and the benefits of work in their recovery.

- Techniques and methodologies for approaching the labour market and employers that facilitate work and work experience placements, vocational training and general awareness of mental health issues.

The challenge is to equip career counsellors and mental health professionals with tools and techniques that will create a successful successive-result circle: the tools will promote and facilitate the work with MH young people so that, in turn, they will experience positive results from their efforts and the feeling of value in their work, which will contribute to their change of attitude which, in turn, will promote good results.

Another important challenge that arises is the greater involvement of informal carers in the work and educational integration of their family member that is experiencing mental health problems. This gives rise to various challenges and needs:

- The change of attitude of career counsellors and mental health professionals towards an inclusive practice that pertains to the involvement of informal carers in the work and educational integration processes of their family member and on the other hand, in their own support.
- The provision of tools and techniques that informal carers can use on their own that raise awareness of what it means to have a family member with mental health problems, that address issues of denial and expectations and promotes the importance of education and work in the recovery of their family member.
- The provision of tools and techniques that informal carers can use on their own in order to support themselves and their family member in the process of recovery and work integration.

Another significant challenge that remains is the involvement of the labour market in the work integration of MH NEETS. The needs that arise are several:

- Employers need to be educated on mental health issues so as to reduce or eliminate stigma, the capabilities of the people with mental health problems, the realistic risks that a business undertakes by employing people with mental health problems and the added – value that young people could provide to businesses.
- Employers need to receive support in integrating young people in their businesses and in accommodating their processes to include MH NEETS.

Considering the above, the main challenge, of course, remains the empowerment of young people with mental health problems and their successful integration in education and work, so that they can lead autonomous and meaningful lives.

3.1.3 Recommendations

The challenge that the project team has undertaken is to offer a toolkit that provides and promotes awareness and addresses most of the challenges/needs identified above. The project team has identified the target groups (career counsellors and mental health professionals, informal carers, MH

NEETS) that are involved in the work and educational integration of MH NEETS and aspires to address their specific needs of support, through the sections of the toolkit.

A significant issue that needs to be addressed, is the awareness of mental health issues that relate to work and educational integration of MH NEETS, to all the target groups involved and the dissemination of best practices that take place in the career intervention field, often undetected by the larger community of professionals and mental health services users:

We stress the importance of an overview of the issues faced by all target groups, in the work and educational integration of MH NEETS, that is, the knowledge gaps that have arisen from studying national and international literature and thus identify and acknowledge the issues faced.

Since the supported employment methodology is the one that prevails in the results internationally, we propose bringing more awareness to it by dedicating a part of the toolkit, where the methodology of supported employment and more specifically the IPS model, can be further presented and explained and evidence – based examples and case studies can be given.

Best practices and career interventions for mental health people, are realized at national levels with very good results but are often limited to specific regions of the countries and not widespread and widely known. Our proposal is to offer detailed descriptions of those, to compile them in order to offer a pool of ideas and evidence – based methodologies to career counsellors and professionals and to bring awareness and knowledge that can be widely used. Supplementary to that, career interventions that have been specifically used for MH NEETS at national levels, will be described.

Furthermore, we propose a model for career counselling and supported employment, specifically for MH NEETS, to address the issues of lack of methodology and techniques.

The challenges that have arisen for working and networking with the labour market are significant ones and carry important implications. We propose to address this issue in the following manner:

We aspire to raise awareness regarding the benefits of work in the recovery of MH NEETS and how the labour market can support the effort at MH NEETS work integration while gaining in the process, an important but neglected work force: that of young people with willingness and longing to learn and work, to contribute, with aspirations, hopes, dreams and ambitions.

We will stress the importance of networking in this effort and the role the career counsellors and mental health professionals play in connecting the labour market with the youth work force. We propose a practical guide for professionals to support them in networking with potential employers, to give them access to the tools needed for enabling and facilitating their work in that department.

Since the view of the employers is not to be neglected but on the contrary emphasized, we propose to bring awareness to the benefits of employing people with mental health problems in the labour market, by documenting the experiences of various employers with mental health employees. In addition to promoting awareness, this could also provide ideas, tools and techniques that have already been used successfully in employing people with mental health problems, to career counsellors and mental health professionals and indeed to other employers or even private and public organisations.

Discrimination and stigma are identified as major challenges since they occur in all the target groups that have been acknowledged. We propose to shed some light on the workings of discrimination and stigma in mental health, by bringing into focus how they function in career counsellors and mental health professionals, what implications they have and how this prevents them from obtaining successful results in their work. Self-stigma is also a noteworthy challenge that people with mental health problems and even professionals, face. By speaking about it, how it occurs, what causes it and how it can be confronted, we aspire to foster awareness and a reduction in its impact. Discrimination and stigma in the workplace are to be treated separately and we propose to describe how these are manifested in all of the key actors in the working relationship, that is, employers, the labour market in general, professionals and even mental health people themselves. We hope that by understanding this aspecy and by proposing ways to fight it, we will support each component member of this relationship.

The recovery and empowerment of mental health people in general and MH NEETS specifically, is one of the core challenges that we aim to address. We intend to describe what recovery means for mental health people and MH NEETS explicitly, how it can be achieved, who are the people that take part in that process and what are the ways that young people can be empowered to join the education and work field and achieve autonomy and meaningful lives. Apart from raising awareness around recovery and empowerment issues, we aim to provide professionals and mental health people with a pool of ideas and tools, and offer another perspective to the issue of mental health and on how people with mental illness can live their lives when their focus is not on their mental illness.

The neglected role of the informal carers, family and friends, is an issue we aim to bring attention to, by identifying and acknowledging its importance. We will describe the implications that their absence of involvement causes to their family members, but also to themselves since they stay out of their loved ones' lives and also remain unsupported. We aspire to describe ways and techniques that can be used to get informal carers involved in the important task of education and work integration of young people with mental health problems and how professionals can take part in their involvement and support. A vital component in raising awareness and supporting the involvement of informal carers is the perspective of the informal carers themselves. Therefore, we aim to facilitate the expression of their own opinions, points of view, experiences and ways of coping. It would be a good idea to ask an association of carers to provide insight on the subject.

In order to facilitate all of the above, we aim to create and recommend tools and activities that are addressed specifically to the target groups involved in the education and work integration of MH NEETS. The tools and activities will pertain to the challenges and needs that have been identified with an goal of providing innovative practices and facilitating the process of educational and work integration of young people with mental health issues.

For career counsellors and/or mental health professionals such tools and activities could comprise activities and tools that:

- explore their own expectations and possible views of stigma
- Explore the importance of work and autonomy in the recovery of MH NEETS

- raise awareness on mental health issues
- help identify young people's interests, talents and skills, e.g. narrative life path activities
- help raise awareness among employers
- help in the involvement of informal carers
- help support informal carers in their difficult task of supporting their family member
- enable them to familiarize themselves with the educational and employment systems of their countries and discover organizations for referrals,
  etc

For MH NEETS such tools and activities could comprise:

- tools to explore their own views of their condition, its limitations and ways to advance, despite the difficulties, that is, self-awareness activities
- tools to raise self-confidence
- narrative activities of creating their own path
- activities that help identify hopes, dreams and set goals
  etc

For family members and informal carers these tools and activities could comprise:

- ways of supporting themselves, identifying their own support circle and making use of it
- exploring their own views on the limitations and advantages of their family member
- ways of exploring their expectations and confronting denial and its impact
  etc.

Finally, it is worth mentioning that several other recommendations that pertain to larger scale interventions that could be led by state or large private organisations, such as awareness campaigns, benefits and tax alleviations for employers, seminars for professionals, etc, are extremely significant but beyond the scope of this project.