

IS REHABILITATION A SOCIAL ENTERPRISE ?

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SUMMARY

The experience in Trieste proposes a comprehensive definition of rehabilitation as a program of restitution and (re)construction of full rights (political, civil, social) and citizenship for individuals disabled by mental illness, and the material construction of these rights. This implies an articulated approach that aims at:

a) the legal recognition of civil and social rights and the material means to exercise them through diversified strategies which b) acquire resources (houses, jobs, goods, services, relationships) primarily through a deinstitutionalization which reconverts total institutions to community services and c) improve access to resources, mainly by developing user capabilities (primary users first, and then family members). This in turn requires:

- training (living and vocational skills, education);
- information (psycho-educational, social awareness and information about rights and resources - when, how and where); as well as the creation of social support networks that facilitate the delivery of resources, and which are managed by comprehensive community services totally alternative to mental hospitals.

In order to achieve these goals, it is essential to:

- empower primary consumers;
- provide support for family members;
- re-skill and re-orient professionals;
- provide health education and bring about a cultural change in attitudes, especially in those directly involved in providing services.

All these actions must minimize the limitations and social barriers which contribute to produce handicap and stigma, and which reinforce ill behaviour (long-term institutionalization, forensic hospitals).

Based on these aims and principles, the community services in Trieste have developed a "social enterprise" strategy which: (i) reconverts and re-uses the human and economic resources of the

mental hospital in community services; (ii) solicits and encourages the local administration in delivering resources directly to users (benefits, job-wages, housing); (iii) promotes the identification of other resources (institutional, N.G.O.) and collaborators present in the social environment; (iv) creates productive, integrated cooperative societies that combine diversified job opportunities and vocational training with user involvement in the economic and decisional structure of the various enterprises, thereby bridging the gap between the labour market and welfare system, and providing an alternative to the inefficiency, ineffectiveness and unproductivity of welfare services.

1. Introduction: The three levels of rehabilitation as the (re)construction of rights.

If we accept the idea that rehabilitation should act on the whole experience (Redlich, 1983), then it is our opinion that a rehabilitation process should always take place, not in a closed setting, which signifies a partial reality (Saraceno et al. 1986) where the subject is compressed into schemes, situations, rigid power relations, but in conditions of real experience, and therefore in the subject's psycho-social environment.

This means it is necessary to exploit even the residual proposals of a severe patient, in order to give him a positive image of his potential in return, so that he might take possession of this image in his inner being and build it up, not as an "institutional object", but as something that belongs to him.

A too rigid use of "disability-damage" objectification in rehabilitation sometimes risks excluding the social and communication aspects of "illness". Resistance to change is often the result when the service does not recognize the patient's meaning. We therefore agree with May (1983), who defines rehabilitation as the subject's personal sense retrieval (as well as production role retrieval) within his social context.

The experience in Trieste aimed at a full realization of welfare principles in psychiatry through a deinstitutionalization process capable of transforming the relationship between institutions and their patients such that the latter were no longer "objects" but subjects in this relationship.

We affirm that mental health rehabilitation must be redefined as the restitution and reconstruction (at times, construction) of the full rights (political, legal, social) of an individual and the material acquisition of these rights (Rotelli, 1994).

Rehabilitation strategies must constitute a single process and project in which the various interventions are valid because they form part of a unified whole. If this is not the case, they will go astray and never reach their goal.

The rehabilitation process must actively pursue the realization of the individual's rights; in fact, it consists precisely in that pursuit.

Whereas political and legal rights, and a coherent legislation which supports, recognizes and pursues them, are essential, social rights (housing, education, work, an acceptable income, free sexuality, free opinion, self advancement, quality of life) constitute the

chosen, concrete ground of rehabilitation practices. In speaking of social rights, we obviously intend a whole array of ties and resources, and it is upon these specific realities that rehabilitation must bring its actions and resources to bear.

In order to do this, suitable strategies, adequate and concrete interventions which form the heart of the rehabilitation process are necessary and must operate in a twofold manner: on the one hand, determining the availability of resources (houses, jobs, money, possible training facilities, possible social relations, etc.), on the other, determining the right to and feasibility of user access to a given resource.

Thus, legal strategies (first aspect) and strategies for resource availability (second aspect) are essential to the third aspect, which is determining the user's access capability. The rehabilitation project seems best able to increase this capability through training and information.

Too often, rehabilitation is considered only in terms of this third aspect, ignoring the essential importance of the first two. This is both the cause and result of numerous distortions in the rehabilitation process, and renders the process itself unlikely and generally inefficient.

As regards the first two aspects (legal actions, actions to obtain resources), it must be stressed that due to their essential role in rehabilitation, they must be considered as an integral part of that process. Though rightly considered as political objectives, they nonetheless fall into the area of intervention and must receive the full attention of health services and professionals.

For example, legislative changes in treatment, compulsory care, treatment facilities, client rights, job, health and social interventions, etc. are essential to any rehabilitation strategy: they can either nullify or support it, hinder or promote its implementation.

Mental health professionals must dedicate their time, skills, and energy to these two aspects and their concomitant objectives. Omitting them means reducing rehabilitation practice to a thing of little weight and consequence, and renders its actions generally ineffective and greatly falsified.

2. The rehabilitation/deinstitutionalization nexus: the strategy to reconvert institutional resources.

The instrumental and material resources which currently enable the community mental health services in Trieste to carry out their territorial activity became an integral part of a network, which combines human resources operating in the service and determines the substance, orientation and meaning of relations, during the course of an historical process. We say "historical" because these resources were not "givens", and their nature and quality are the result of the intentions and purposes for which they were requested, developed and obtained. In our experience, they were profoundly influenced by deinstitutionalization, a process correctly defined as homeopathic since through an epistemological and practical break-up of elements forming the total institution, it re-

used them in order to provoke a transformation by a combination process which deeply modified its trend (Rotelli et al. 1986).
(see table n.1).

In line with this philosophy, the first step to rehabilitation in Trieste was the phasing out and reconversion of the mental hospital into a totally alternative network of community services operating full time, 24 hours a day, 7 days a week (Dell'Acqua & Cogliati Dezza, 1985; Rotelli et al. 1986; Bennett, 1985).

Community work began with the sectorization of the hospital, in conjunction with a profound change in its organization, culture and operative models in favour of the reconstruction and re-valuation of in-patients as individuals with a personal and social experience. This effort implied the reconversion of hospital resources and the creation of CMHC's between 1975 and 1980 (year in which the mental hospital, with 1200 in-patients, was officially shut down). Its aim was to accelerate discharges and the social reintegration of former inpatients while simultaneously preventing new admissions through rapid intervention in acute crises.

In this way, we learned to demand and obtain resources from the local administration but, most of all, we learned to transform and reconvert existing institutional resources and find new and qualitatively different ones.

We can attempt to summarize this complicated process by describing several general areas of intervention, or institutional steps.

1. FOSTERING PATIENTS' SOCIAL CIRCULATION while:

1b. IMPROVING THEIR CONDITION in the community by re-using institutional resources, converting them to instrumental resources which patients can access directly, ie: guaranteed minimum income through benefit payments (or pensions), housing (from popular housing to group-flats), vocational training and job opportunities in cooperatives.

2. CREATING 24-HOUR COMMUNITY MENTAL HEALTH SERVICES able to meet patient needs, with primary needs placed first. These services should be viewed as elements of a "welfare state" which offers guarantees and life-support in the community.

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At the same time:

2b. FINDING WAYS THAT PERMIT AND FACILITATE PATIENT USE OF SERVICES (ACCESSIBLE, USABLE) replacing the idea of something "inside" of a total psychiatric institution where a patient's life shortens with something "outside", in society; creating

¹services, cooperation with local health, welfare and legal agencies. In addition, there is a psychiatric first-aid station in the general hospital (which generally does not admit patients, but refers them to the CMHC) 36 group-homes within the city and on the grounds of the former mental hospital, 5 co-operative societies, several workshops and art laboratories for rehabilitation purposes.

places which might be "crossed" or encountered during the course of ordinary living to meet one's needs. In conjunction with this, it was necessary to take the following steps:

2c. DESTIGMATIZING SERVICES, overcoming their separation from the social world through initiatives (innovative cultural initiatives promoting marginalized cultures); creating non-specific spaces (libraries, movies, medical and pediatric dispensaries) in order to promote access and favour a "normal" response of social services that support a patient's social life (assistance to elderly people, nursing homes, economic aids).

2d. "CONTAMINATING" ADJOINING CIRCUITS BY MODIFYING THE RIGIDITY AND PREJUDICE towards psychiatric patients that still exists in social, health and judicial institutions (the so-called "persistence effects of asylums") and which is the result of the same exclusion logic which nourished and justified psychiatric institutions as 'social dumping grounds'. This approach often required direct interventions aimed at modifying those institutions which still practice exclusion (popular housing).

3. When necessary, especially in situations of serious disability or marginality (or handicaps resulting from both) organizing forms of SOCIAL ACCOMPANIMENT which provide daily life support (assisting and teaching self-management skills such as cooking, housecleaning, self-care) and service use. Or, alternatively:

3a. Creating appropriate SOCIAL NICHES, protected situations (group-flats) for those who need more support and substantial help in their social integration.

3. Access capability - some critical points about rehabilitation.

The degree to which the information and training process of the user as a whole (i.e. the user, family members, secondary circuits, health professionals, services) is successful, is marked by numerous indicators which evaluate the various expressions of the user's access capability. Personal autonomy, education, vocational training, social skills, empowerment, ability to express oneself, are the indispensable objectives which must be pursued in order to form access capabilities, together with information regarding where and how resources are to be obtained.

Strategies which do not aim at these results are unsuited to the rehabilitation process. For example, "time-filling" activities in a mental hospital or day-center are often defined as "rehabilitative". And yet it is difficult to understand what the production of useless objects has to do with the rehabilitation process.

Current models of psychiatric rehabilitation are often based upon a power relationship which imposes a protocol upon the patient, who must then either accept it passively or refuse it. In this way, the institution seeks to establish a pedagogical relationship based on the offer being counter-balanced by some sort of sanction in case of refusal, with abandonment as the end result for hopeless cases.

In this respect, those strategies which trade-off work for freedom appear very uncertain in their results, as do all forms of "work-therapy". If the "working" capabilities obtained in certain closed settings (if "work", or the production of real goods for a real market, can be used in this context) are exchanged for freedom, they can often lead to an inability to exercise full rights rather than to real rehabilitation. Behind the appearance of "rehabilitation" flatly and reductively identified with ability to obtain and do a job, a regressive mechanism creating disability is produced instead, and as a result the correct goal of rehabilitation, or exercise of full rights, becomes very unlikely.

Likewise, strategies to distribute resources which the patient is then unable to use, even as a consumer, in a situation of social exchange, appear as inadequate. Exclusively tutelary and welfaristic actions which do not develop acquisition skills or teach the user how to reach certain objectives or perform certain activities on his own, are also improper. Of these, perhaps only those activities which develop a consumer (of goods) role or which are meant to stimulate new or unexpressed needs in the user can be considered as rehabilitative (Basaglia, 1982). In general, strategies and behaviour which result in passivity, in merely following orders or delegating actions to others instead of performing them oneself, are certainly not rehabilitative.

In going beyond the asylum and internment institutions, we wanted not only to restore to individuals their freedom and subjective rights, but also to reconstruct their bargaining power and the resources needed for social exchanges. In the passage from the status of patient to that of user/client, the aim was not only to exercise one's civil, but also one's social rights. The intention was to break up those ties of deprivation that traditionally perpetuate institutional dependence.

An example is provided by the birth of the first cooperative society. This had been already set up by patients supported by professionals for cleaning the mental hospital in 1973. At that time, we asked the Administration to recognize the patients' right to associate and negotiate a contract for the maintenance of the hospital. When the administrators refused, the patients went on strike with the support of the nurse's union, which was fighting for a new contract and duties. A few days later, the Administration capitulated and the so-called "work-therapy" patients became members of a cleaning cooperative and began working for the same hospital in which they were interned, under union rules and salaries. They were no longer inmates, but workers with jobs, salaries and rights. They had become subjects inserted into a social/working context.

Other ways in which the resource productivity is increased is by financing socially useful activities and "work-grants" (a Local Health Unit subsidy given directly to the user in exchange for a 20 hours per week vocational training in a cooperative or regular business), and by the growing use of resources activated and organized by patient groups and the community, in effect promoting and protecting the user's self-help capabilities and autonomy, his "faculty of acting" (Sen, 1988).

For a summary of the discussion thus far, refer to the analysis of the process of "rehabilitation of psychiatry" in Trieste, in Table No.3

Table No.3

Rehabilitation in Trieste - exposition of the discussion thus far.

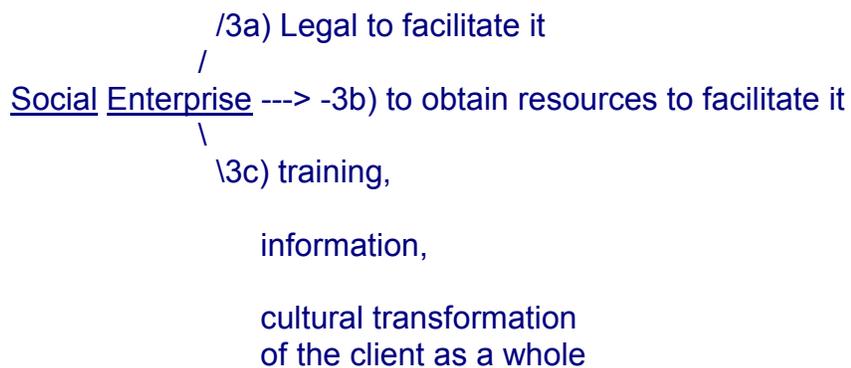
Actions for full rights

- a) Political
- b) Legal
- c) civil

Actions for resources

- 1) Legal
- 2) to obtain resources
- 3) to achieve access opportunities

Actions for access capability



4. The network of relations - The service as a mediation for social exchange.

The discovery and participation of communication and exchange elements long forgotten and disregarded requires diligent observation and a difficult engagement, as well as a self-transforming attitude on the part of the new community services in the post-asylum era.

In psychiatry, we often misunderstand, underestimate or under-exploit the human resources we encounter, which are themselves frozen and ensnared in the windings of mental illness. By "human resources" we mean the exchangeable abilities and use values of subjects and their relations. The problem is identifying and activating these resources in order to promote mental health, a strategy which requires the input of a surplus of resources, such as specific helps, economic resources and, primarily, the service's therapeutic work.

A subject's social skills are linked with his willingness to establish relations (social exchange). The possibility of operating in the social environment depends on power, both in terms of internal elements, or the subject's condition, and of external ones (resources). In this regard, resources are a particular class of external powers by which a person can reach his goals.

Rehabilitation thus takes place within a complicated system of relations, at many levels, between the subject (his beliefs, faith, goals, abilities) and his environment: and both aspects must be taken into account by the intervention.

To integrate and modify resources, the development of relational networks between acting social subjects (the user "as a whole" and institutional ones) should be fostered (Mezzina, 1991).

If an individual participates in a social network, or an interwoven series of relations, he can use the resources of others to reach his goals (the so-called "adoption", Castelfranchi, 1990); but the social environment should also be modified in order to promote resources being put at the user's disposal ("affordance" in cognitive psychology). Such relations include many aspects of communication and information as well as power aspects, and can be interpreted by means of social support theories (Cohen & Syme, 1985).

In Trieste, the rehabilitation practices of the community mental health services have tried to maximize the use of individual abilities and, more generally, of human resources, allowing the user to participate at different levels in service activities and in the elaboration of therapeutic programs. As a result, a social support network based on participation to help users in their own environment has been produced. This prevents forms of severe disability and institutionalization and develops social and "health" abilities.

The third aspect of rehabilitation (access to resources) can be described as a range of options within this network. As such, it requires a project place (or "mind") to act as identifier and multiplier of resources (Dell'Acqua, Mezzina, 1991). This place can only be the community service, for the crucial factor is the development of a tight therapeutic relationship between service and user, based primarily on the principle of continuity of care.

We point out the importance of creating opportunities open to the "imagination of the living being" (Maturana and Varela, 1980). These options and opportunities are theoretically infinite and allow the subject to choose his own way, while obliging the service to take "risks".

These strategies can be implemented according to the theoretical fork outlined above (Anthony and Libermann, 1986) as (i) subject intervention, and thus on capacities, and the network into which the user is integrated and (ii) environmental intervention, including the possibility of supplementary resources (iii). (see table n.2)

(i) In our opinion, it is extremely important to use the community mental health services (24-hour center, day hospital) in subject intervention, such that they become actual places where and by which an individual's life-time and relation time can be temporarily but considerably modified.

In this case, social support is offered by instruments (offer of resources) and/or relations (to go/be with the user) and service facilities are interpreted as areas of social exchange (Mezzina et al. 1982). This implies, among other things, conceiving the community mental health center as a place in which different subjects meet and interweave relations (and we could go on to describe at great length all the moments of social re-learning and support).

Outside institutional facilities, the promotion of self-help groups, self-organization and aggregation activities for young patients (Mezzina et al. 1992), arts and expression workshops, vocational training in integrated cooperatives (Gallio, 1991; De Leonardis et al. 1994), education and cultural programs (a special school project involving psychiatric patients and youth at risk has already been started) represent other forms of intervention to reinforce and develop subjects.

(ii) As regards environmental interventions, we emphasize those aimed at the family burden and which go beyond mere family "counselling", in particular the psycho-educational and self-help groups involving the relatives of long term patients (Dell'Acqua et al. 1992).

For users, we offer experiential opportunities outside the family, such as cohabitation (especially for young users), which are followed and supported by the service or which involve volunteers or attendants in flats which are not "residential facilities" of an institutional nature, but "temporary" life-places. We also organize activities for socializing and spare-time and encourage patients to attend day programs in order to limit the "face to face" contacts between users and relatives and to de-referentiate family attitudes, thereby encouraging forms of progressive emancipation.

(iii) This approach can be supported by supplementary resources when users are unable to act autonomously, whether due to severe disability or mechanisms of social exclusion, or because of personal resistance and difficulty in adhering to programs which imply a therapeutic change in their lives.

Examples of possible "support integrating services" are the designation of a "key-worker", or professional who undertakes a special relationship of continuity with a single user; utilizing attendants and volunteers as "therapeutic assistants" to make home visits

and permit the user to go out (Arieti, 1981); or the possibility of long-term integration in a protected group-flat.

5. The passage to social enterprise: institutional unproductivity and the residual resources of users.

In what direction is the deinstitutionalization process moving today?

How can a public service, even a strong one, confront the emerging needs and growing "contractual power of the user" when unemployment is increasing and social disaggregation is producing a growing uneasiness in ever wider sectors of the population, and when the State's only answer to the "crisis of the Welfare State" is further cuts in public spending? (De Leonardis & Goergen, 1988).

Our experience suggests working on two complementary aspects:

a) facing the institutional crisis, as exemplified by the fiscal crisis and the criticism of waste and bureaucracy. In this case, deinstitutionalization can turn crisis into a productive opportunity by increasing effectiveness. Our experience in dismantling the mental hospital shows that a transformation in the quality of existing resources and their reconversion is not only possible but productive;

b) facing the effects of institutional irresponsibility, and the dependence and parasitism allegedly resulting from the "service society" created by social and welfare reform. Here, deinstitutionalization highlights that such problems derive from policies decided at the highest level, and not from the base, and that they are not the result of welfare in general but of its present conception and implementation. The new mental health policy is concerned with "the culture of needs and resources" in which citizens, local communities and users all work together and organize themselves to find solutions and innovations within working institutional structures.

In this regard, a new field for innovation, a new challenge has been taken up in Trieste: inventing a service sector, a sector invented daily and which took its start from areas abandoned by a failed social reproduction; which is able to create a new distribution because able to endow abandoned resources with value; which is neither entirely public or private, but can be described as a collective enterprise of social reproduction.

In our opinion, the concept of social entrepreneurship is the one best suited for taking all necessary operational strategies into account. And here some questions arise:

Was social enterprise an important element in the productive transformation of the service within the emancipation and individualization process, or was it destined to fill a gap in the welfare system, a gap caused by the progressive decrease in population, resources and initiatives on the part of public services?

Can "productivity" be a training as well as therapeutic model? Will the confrontation with the risks of enterprise and the marketplace inevitably lead to the selection of users, excluding those who are too ill, or weak, or unproductive? Or can a situation without the

links, rigidity and bureaucratic structures typical of the public sector cause a transformation in individuals?

Perhaps we are reaching the stage in which the "user" becomes a "producer" taking part in a social production enterprise.

Hence the perspicuity of the term "Social Enterprise" and the enormous need for underlining the central nature of this issue (Rotelli, 1994).

The challenge, prudently hidden in the early 80's with the first experimental cooperatives "inventing" new activities and involving new subjects - poets, actors, young people - became our choice and responsibility, both institutional and personal, in 1987 when the E.E.C. Social Fund designated the cooperatives in Trieste as the reference point for the "youth at risk" vocational training projects. The goal was to offer the general training and necessary assistance in order to give the categories at risk a fair opportunity to compete for supplementary jobs and/or create such jobs.

To the original cleaning cooperative, four other cooperatives have been added, with a wide range of activities: cleaning and building maintenance, portage and transport, furniture and design, cafeteria and restaurant services, agricultural production and gardening, handicraft, carpentry, photo, video and radio production, computer service, serigraphics, theatre, administrative services, assistance to elderly and handicapped people or AIDS patients at home.

The purchasers are public agencies as well as private citizens. The number of persons presently working in these cooperatives are about 280, of which 180 are members and 100 have training work-grants; 40 are "normal" workers, the rest are previous users of mental health, drug addiction or handicap services or are considered "youth at risk". A user's social route can be redesigned apart from the stigma of illness; the mediation between disability and the world of work seeks, as one of its goals, to erode the binomial illness/unproductivity.

The social (integrated) cooperative is subject to specific legislation which requires at least 40% of its members to be handicapped or disadvantaged. The law also provides for individual tax exemptions and the profits are divided among the workers. The organization is based on acting groups composed of service staff working either as managers or as mental health specialists, of teaching experts and collaborators for the specific sector (members of the "Intelligentsia" open to the enterprise), and ordinary members who are called upon to participate in the creative process.

Because they are forms of "treatment", cooperatives can be considered "a service". At the same time, they are a workshop for vocational training and a system for the creation of new jobs which offer the opportunity for an independent income. The most important goal is growth in an individual's autonomy, in their social exchanges and in their relationship with institutions and therefore with the psychiatric services - an autonomy which is both therapeutic and economic (self sufficiency).

6. Criteria of a social enterprise.

We will now try to set forth the most important elements (or criteria) of our social enterprise, which can be developed through daily work (De Leonardis et al. 1994).

(1) Synergies.

Our enterprise is a mix of different economic aspects and its resources come from various sources. It is supported by public and international financing (E.E.C. social fund) and by normal allocations for local health authorities (operators' wages, as well as newly created payments such as wages for vocational trainees). We also employ and take advantage of volunteer and second-job experiences and, of course, there are the revenues from our enterprise (which operates in the marketplace).

(2) Enterprise risk.

Working and earning are not a reward for therapeutical improvement, but are a pre-condition for that improvement.

The first step in making people independent is to give them value, that is, credit. This is the opposite of work-therapy: everybody has the right to risk. Risk is therapeutical, or better, the cultural and material resources which make risk possible are therapeutical, because they entail change, research, new horizons.

In this approach, risk is privileged in respect to the idea of a "safe job". Of course, we consider a job not only as necessary to survive, but also as a means for self-realization.

(However, "risk" remains relative. If a sector is unproductive the workers are re-employed elsewhere and there are numerous social "parachutes" in terms of benefits etc. to protect the individual).

(3) Training and working.

Since, according to the EEC directives, we must create self-sufficient economic firms which can guarantee permanent jobs for cooperative members, the different stages - preparation, vocational training, work - cannot be separated.

In particular, vocational training takes place during the performance of one's activity, while they work.

This training is not limited to providing specific professional abilities, or a job, but also aims at supplying a managerial capability. Meetings and other forms of participation are opportunities to show responsibility and decision-making.

(4) Diversification and multiplication of activities.

In enterprise, as in the service sector, the strategy of multiplying and diversifying activities provides real opportunities for finding the job best suited to an individual. A good outcome is increased by personal interest and commitment and this translates into productivity.

It is not so much a question of the right person in the right place as finding a real space for everybody. Furthermore, this strategy enables us to attract and exploit resources typical of the marketplace and economic system (resources deriving from the self-interest and not the benevolence - in A. Smith's words - of other economic players), thus increasing the above-mentioned synergies. Other actors can take part in this enterprise

aimed at opening new areas for the social reproduction of all. In this context, creativity (ideas) plays a key role.

(5) Small dimensions and synergy between various productive units.

The smallness of our enterprise is the result of the choice to start actions based on personal initiatives, where their inventors are users, professionals, or anyone at all.

Public places, restaurants, shops became an area for those who wanted to discover what quality is, to understand it and reinvent it.

Running a discotheque, driving a lorry, designing a bag or a dress, and then advertising and selling such products are important elements for the development of one's identity.

The small dimension is therefore a starting point, and presents certain advantages: fewer risks as far as human and economic resources are concerned; fewer management problems: a clearer decision-making process and more contractual power for the individual in respect to the organization as a whole.

Smallness also has some limitations (limited internal scale economy, more importance given to supporting organizations).

But such problems can be solved if cooperation between all the different sectors is stressed from the outset; synergy becomes an economic advantage and is in continuous expansion.

(6) Product quality, working place and environment.

Quality derives not only from this aspect, but also from what has been said before.

Product quality means the quality of working for oneself and sets free creativity.

Accepting that quality is necessary in one's life and work leads to improving the quality of one's products. Quality is the challenge to improve the search for and use of better professional resources in order to exploit one's capacity and creativity. When one individual manages to attain a standard of quality and transfer it to his products and projects, then the competitiveness and creativity of the whole organization increase.

(7) Cultural transformation as the basis for professional transformation.

Every organization is a loosely bound system, an "organized anarchy" (Weick, 1976; March, 1981). Our enterprise wishes to treasure this aspect, and aims at an organization where the individual is at the top, is the entrepreneur, the one who takes initiatives. A network of individual projects which becomes a common heritage, setting free all personal initiatives within a common, innovative project, can become a means to stop society's progress towards self-destruction, for we discover the value of what is neglected only when we must recover it.

(8) The use of the best and most innovative resources within the territory.

The integration with productive forces outside psychiatry increased the mixing of knowledge and professional know-how.

We tend to consider cooperation as an area in which "the other's resources are no longer a threat but a great potential" (Axelrod, 1985). Robert Axelrod suggests that what renders cooperation possible is the possibility that the two partners can meet on another occasion. Therefore the future can influence the present. Through such cooperation we can revisit the relationship between what is private and what is public, between individual and State, between those who are marginalized and the most positive forces in society.

The future depends on the "hour of intelligence" that we ask everybody to dedicate to our project. The only general contribution we ask of administrators, architects, nursery-people, furniture-makers, salespeople, skippers, builders, entrepreneurs, teachers, intellectuals, artists, stylists, plumbers, clerks is one hour of their intelligence for a more general Social Enterprise (Rotelli, 1992).

(9) Restoring the nature of the productive activity.

Repetition, fatigue, violence, limits of knowledge, of language, of points of view produce useless work and waste. Our little fruit and vegetable shop at the entrance of the former mental hospital is a first act of "restoration", as are the many other activities that will give new value to the entire institution. Restoring all wasted energies, initiatives, individual and existing resources is useful.

(10) The effects of entrepreneurship on public services.

Cooperation among all parts involved, awareness of the nature of needs, desegregating the principle of job-wage that neglects wasted resources are all necessary steps. The cultural transformation and increased contractual power of those who take part in this process produces a transformation in community services and their professionals. The social enterprise affects and transforms individual identities, breaks down rigid schemes and interacts with the services, making them more dynamic and less "institutional".

We know for a certainty that this breaking down of individual and collective rigidity can only take place at the same time.

7. Conclusions: rehabilitation must be a social enterprise.

1. For those working in psychiatry, the pre-condition for coping with the suffering of human beings is clearly the multiple task of facing, overcoming, transforming and eliminating the total institution of the mental hospital. This is the best way to give the patient a social identity, a recognized power in social links and alliance. To put it another way, the possibility of changing his situation depends upon the need to change institutions, such that the patient is transformed from "an object of institutional care" to "a subject with social and contractual power" (market, demand, needs, social rights); in short, the user of a mental health service.

It is at this stage that the problem of rights emerges. We totally disagree with those who seem to believe that "a right is something one must deserve", as well as with those who declare that "a right must be granted to those who prove they can exercise it". We believe a right to be a universal good which belongs to all, without distinctions of class, income, sex, age or health conditions. We further believe that no one can be denied a right considered universal and which constitutes full citizenship and which must, in any case, be recognized a priori.

Rehabilitative actions cannot aim at "deserving" or obtaining a right by acquiring the capabilities to manage it. The right must be given "a priori". Rehabilitative actions must limit themselves to enabling the user to fully exercise their rights when they are unable to

or have lost this capability, and to render realistic and feasible rights which have been arbitrarily denied or are not yet supported by the real situation.

It is in its concrete practice that rehabilitative action encounters the effective limits of a universal principle of rights which, in a democracy, is usually accepted "in principle", or abstractly, but which is far from being fully applied in concrete terms.

2. We therefore feel confident in saying that the first (and endless) task of a rehabilitation strategy should be the "rehabilitation of rehabilitation institutions".

The stress on deinstitutionalization is linked to an economic project which considers the old (but widespread) organization of psychiatric institutions the result of backwardness and a cause of waste because deprived of the energy and resources of the users and which, in fact, often actively creates this deprivation.

In order to reach these objectives, it was necessary to create (invent) a community service "from the bottom up". In practice, this meant working from within an institution already containing economic and human resources, which had to be (re)used in creating the new service.

A community service must be strong enough to substitute the mental hospital completely and guarantee the irreversibility of this trend, i.e. to guarantee through a complete organizational overhaul the patient's right to be the user (client) of a service which must meet all his demands (needs) because it is those very demands which motivate the existence and organization of the service.

In this process we dealt with such issues as: emergence of needs, improvement of competencies, growth of professionalism, increasing the user's contractual power, progressive quality of the service, capacity for self-transformation and learning on the part of the team per single operator, progressive dechronicization.

3. We have already discussed the possibility of overcoming the limits of a public service through a widespread and extra-institutional social practice aimed at producing individual initiative and subjectivity: not recovery but emancipation, not restoring but social reproduction.

This resulted in an increased awareness that other resources present and available in the service's "new territory" had to be set free in order to activate new income sources for subjects so they could enter the social exchange process: recycling, reconversion and transformation of financial facilities, and existing competencies, as the criteria listed above attempted to show.

With this in mind, we can say that those rehabilitative actions which must be realised or expressed in the "real world" can be defined as "social enterprise". Rehabilitative action in western societies today seems to coincide with the necessity for "social entrepreneurship", and this should be what distinguishes anyone committed to this action, in order to bring about the concrete realisation of principles.

The term "social enterprise" includes a series of meanings to which we attach great importance. Firstly, it is based on the premise increasingly evident today that the (central) issue of resources must be proposed in new terms, as indeed has already been occurring for some time. It is increasingly clear that the inadequacy of resources for effectively realising the principle of universal rights, while remaining a problem, can no longer be posed in the same way as it was in the '60s. The problem seems to be the lack, or apparent lack of resources; and yet perhaps it is more a question of how those resources are used or, when available, why they remain unused. It is certainly legitimate to harbor doubts as to the actual insufficiency of resources, since up to this time they have been so poorly used.

To speak of social enterprise means to raise the well-known issues of inefficiency, ineffectiveness and most especially (and in the face of reason) the function of the present health-welfare system and the current institutions of the "welfare state". These institutions continue to be seen more as instruments of social control (often violent: prisons, asylums, juvenile jails, etc.) rather than as "rehabilitative" in the sense we have described, and therefore "emancipative". The costs-benefits ratio of the system's rehabilitation and emancipation objectives seems enormously negative. Quite often, costs are not only too high as compared to the benefits gained, but are intended for results contrary to rehabilitation and emancipation (once again prisons, asylums, but also much of medical practice and culture, drugs, etc.).

Keeping the objective of full rights and citizenship in mind, we can say that many extremely costly state interventions are aimed more at denying or reducing these rights than in achieving them.

Even in cases where the effective aim is the enlargement of the real exercise of rights, this almost always involves procedures, institutions, provisions, organisms and actions which are, at the very least, irrational when analyzed in terms of costs-benefits. We pose the question of the enormous waste both of economic and human resources this entails, while continuing to actively seek responses to the destruction of the resources of welfare beneficiaries (the handicapped, the old, the mentally ill, the unemployed, the marginalized, etc.), even when these resources are only "residual".

We can conclude by saying that, indeed, the aim of Social Enterprise is to intervene in the radical gap between labour and welfare worlds that exists in advanced societies today. The immense task involved in turning this situation around is clearly evident. What must be questioned is the concept of productive normality, which even as it changes with time, continues to define the borderline between the two worlds.

CRITERIA OF A SOCIAL ENTERPRISE

Social enterprise:

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

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