8 Treatments and Recovery to Enhance Employment Outcomes for People with Schizophrenia and Other Major Mental Disorders: An Innovative Clinical and Organisational Model of Work Inclusion in Milan and Surrounding Area

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8.1 Introduction

This chapter is aimed at clinical and social workers who work in mental health services and deal with workplace inclusion for patients with schizophrenia and other major mental disorders. It is based on the guiding principles underlying the 2007 UN Convention on the Rights of People with Disabilities (specifically Article 8 and Article 27) [1], which focuses on raising awareness of the real contribution that people with disabilities make to the productive economy and on promoting specific programmes for workplace inclusion. However, to date, access to work opportunities and the social integration of people with mental disabilities have been only marginally successful, as a result of stereotypes and cultural prejudices and because of the lack of connections between the work and health services sectors.

Encouraging dialogue between different sectors and fostering a more nuanced view of disabled job applicants—understood as citizens, patients and workers—can promote a culture of inclusion and disseminate appropriate models of intervention, including at the organisational level.

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Following an analytical review of the most widespread models of inclusion for people with mental disorders in work settings, this chapter outlines the experiences of the Mental Health Department of the Fatebenefratelli Sacco Hospital. Since 2006 the department has carried out a project financed by regional funding based on a clinical and organisational model titled 'The application and dissemination in the Metropolitan City of Milan of operational models for the inclusion of people suffering from mental disorders'.

8.2 How to Improve Employment Outcomes for People with Schizophrenia and Other Major Mental Disorders. A Brief Introduction to the Main Models and Issues

Vocational rehabilitation for people with severe mental illness has a history spanning approximately 70 years, encompassing programme innovation and informal experimentation by many psychiatric rehabilitation programmes all over the world. Over the last three decades, a limited number of vocational rehabilitation approaches have proved to be the most effective in Europe and the United States in leading people into competitive employment [2, 3]. A modern approach to vocational rehabilitation focuses on eligibility, based on the patient's own choices, integration between mental health and employment services, competitive employment, and individualised and continuous job support [4]. Many different types of vocational rehabilitation programmes have been developed and implemented, but many researchers refer to two broad categories—pre-vocational training and supported employment—[5] according to expected outcomes. Some vocational programmes (i.e. hospital-based programmes, sheltered employment, psychosocial rehabilitation) consider work a means to achieving specific personal outcomes, such as better treatment compliance, symptom reduction, and improved quality of life. Vocational approaches, such as supported employment, include outcomes such as full-time competitive employment, the acquisition of job-related skills, percentage of time in paid employment (full-time or part-time, competitive or sheltered), total earnings, level of work (unskilled, skilled, etc.), job satisfaction, and job performance. *Pre-vocational training* or '*train and place*' refers to an approach focused on training and developing individual skills prior to seeking competitive employment. Systematic reviews have proved that pre-vocational training is less effective than supported employment in helping mentally ill people obtain competitive employment [6], although it is not clear to what extent different pre-vocational training approaches can affect patients' ability to re-enter the workforce or influence longer job tenure after placement[1] [6, 7]. *Supported Employment*, or '*place, then train*' focuses

[1] Some research findings indicate that cognitive deficits, rather than psychiatric symptoms or other clinical or demographic factors, seem to be the strongest clinical predictors of a poor response to supported employment [3]. Could 'pre-vocational training' be more effective for people with cognitive deficits and psychiatric conditions?

on getting people into competitive employment first, followed by training and support on the job [8]. Using a community-based approach, supported employment aims to facilitate the transfer of skills into real-world settings. The best-known model of supported employment is Individual Placement and Support (IPS). IPS uses a quick job search based on the patient's choices, matching their interest and skills with employment opportunities. Integration between the employment team and a multidisciplinary mental health team is emphasised as a means to facilitate finding a job. The mental health team and vocational specialists (VS) must share the values, aims and methods of the IPS model, as the VS and their clients must proceed together in an intensive job search for quick placement.

Nevertheless, there is no shared definition of what can be considered 'work' in terms of vocational rehabilitation. Approaches to VR differ between countries [9]: important cultural factors influence approaches to disability [10] and consequently to disability services and their goals. Can only competitive employment in integrated settings be considered successful? The modern job market and advanced welfare economies offer a great variety of opportunities (jobs in social enterprises, short-term placements, sheltered employment, etc.) that can hardly be defined as unsuccessful. Bachrach [11] asserts that the differences in interests, skills, talents, physical abilities and limitations of people with severe mental illnesses fit more appropriately within a broad definition of 'work'.

There is broad consensus on the effectiveness of supported employment models; however, ratings regarding the integration of people with mental illness in the labour market remain unsatisfactory. In recent years, researchers have tried to understand why, in spite of being supported by good scientific evidence, IPS has not been widely implemented in clinical practice [12]. Many studies have attempted to identify the critical factors affecting the development of IPS in Mental Health Services, and a number of issues have emerged:

- Inconsistent knowledge of IPS among healthcare professionals, and inability of some healthcare and employment support services to work together [13].
- Beliefs held by medical care teams regarding the value of IPS [14], fears that it will lead to relapses [15], or that all symptoms need to be addressed before any progress can be made [14], or employment—as an outcome—not being seen as a priority for recovery, or not a realistic one [13].
- Strategy of wider psychosocial approaches in the community agreed on at the local level between providers and commissioners, to support vocational specialist teams over longer periods [16].
- The role of employment support specialists, who are more effective when working directly with clients, employment services and agencies, and employers, and indirectly with care coordinators [12].
- Cost issues and lack of funding, particularly with regard to supporting IPS services over time and maintaining quality, in a context of increased demands on secondary services in national health systems [16].

- The importance for services and clients of having direct and fast access to job opportunities, as local unemployment rates, work labour characteristics, local policies and welfare regimes impact the effectiveness of IPS [17, 18].

In conclusion, the key issues that need to be addressed to increase the effectiveness of a supported employment service in the community seem to be (1) having an evidence-based vocational rehabilitation approach, (2) managing the implementation of the service at the local level, (3) sustainability over time, (4) having common views, beliefs and shared practices, from the vocational specialists to the medical teams and local stakeholders, and (5) being able to access job opportunities. Moreover, some studies highlight the importance of defining common inclusion criteria, which can influence the effectiveness of work inclusion programmes [17, 18].

8.3 Supporting Employment in an Advanced Welfare Context. Treatments, Recovery, Regulatory Changes and Methodological and Organisational Issues in the City of Milan

Based on observations in the city of Milan since the early 2000s, there appear to be widespread communication difficulties between the worlds of mental health and productive work, resulting in a cycle of non-cooperation. On the one hand, companies are wary of hiring individuals with mental illness and distrust care services. On the other hand, care services, and often the non-profit sector, give work experience a primary purpose of care and rehabilitation. These communication difficulties, combined with the economic situation in Milan over the last decade, have imposed a particularly complex framework of intervention on the city, characterised by the following critical points:

– A confused proliferation of opportunities, in a city network not connected by a genuine collaborative culture.
– Dispersal and fragmentation of resources that are not evenly accessible to patients.
– Professional skills not being optimised and utilised as part of a network.
– Lack of a method of care that would provide applicants with programmes to select, train for, support and maintain their jobs while respecting the health of the worker and the company's needs.
– Confusion between different types of work inclusion paths and actual employability of the person.

In addition to this complex picture, there are frequent and continuous changes in the legislative, administrative and organisational aspects that greatly influence the practices of job inclusion, and consequently the overall character of psychiatry

services that the wider region of Lombardy offers patients in the area of vocational rehabilitation.

Over the last 20 years new labour policy scenarios at the European level have had a significant impact in Italy both on existing legislation and on the reorganisation of public employment services. Specifically, Law 68 from 1999 significantly changed the logic according to which the employment service for disabled people was managed: the concept of a disability quota was accompanied by that of 'targeted hiring', which was intended to be implemented through a set of agencies matching employers' needs to the individual characteristics of people with disabilities or other protected groups.

This was followed by national regulations that reorganised the institutional structure of social services and labour policies, empowering regions, provinces and municipalities in the planning and coordination of integrated social policies.

Further legislative change was implemented through a gradual increase in the application at the provincial level of Article 14 of legislative decree 276/03 [19]. This law makes it possible to shift part of the disability quota to social cooperatives, which carry out productive activities aimed at inserting people with physical or mental disadvantages into the labour system, in an attempt to foster a virtuous circle of introducing disabled people into companies.

Thanks to the multiplication at the national level of projects and good practices designed to facilitate inclusion in the workplace, a change in how work is conceived in mental healthcare has been possible: it is no longer seen as a substitute for care but as a means of fulfilment for the individual during a process of genuine recovery and social inclusion.

8.4 The Development of Regional Innovative Programme TR-106 Between 2009 and 2019 and Its Impact

In June 2004, the region of Lombardy issued the new Regional Plan for Mental Health in order to promote 'a community psychiatry that operates in a context rich in resources and opportunities, with treatment programmes based on effective and evaluable models, across a territory conceived as a large, functional whole—not a rigidly delimited area—with the possibility of integrating various services, including health and social, public, private and non-profit services, and to collaborate with the informal existing network, in a real opening to civil society'.

It is within this context that the region of Lombardy financed the TR-106 Regional Innovative Programme (PIR) in 2006. The purpose of the programme is 'the promotion of a permanent network for the work inclusion of psychiatric patients' and to establish an innovative way of supporting, reorganising and optimising the network to implement the measures taken by the ASL (Local Health Authority) of Milan to facilitate inclusion in the workplace. The PIR originated at the Sacco Hospital; since 1997 a second-level specialised service (ALA-Sacco) belonging to the Mental Health Department (DSM) of the Luigi Sacco Hospital has

dealt with the evaluation, design and delivery of sustainable pathways towards work inclusion for patients of psychiatric services. The ALA-Sacco intervention methodology considers the therapeutic value of the paths themselves as a foundation and the integrated management with the referents of care (health) and work (companies) to be fundamental. The culture within the ALA-Sacco has always been to orient itself towards the larger territory, involving different DSMs.[2] The PIR fits into this experience, focusing on the study of a networked organisation system that can respond to some of the patients' and their families' essential needs on their path towards the workplace, as well as the needs and priorities of companies. The first choice was to involve all the DSMs of the city of Milan, which have thus become effective partners in the project, both in terms of sharing aims and in an equable use of resources and tools. In addition to the DSM of the Sacco Hospital, the following were therefore involved: DSM Niguarda Hospital, DSM Policlinico Hospital, DSM Fatebenefratelli Hospital, DSM San Paolo Hospital, DSM San Carlo Hospital.

At the same time, a technical committee was set up that involved DSMs as well as local stakeholders, including municipal and provincial labour inclusion services, business associations and trade unions.

The key objectives have been (and remain):

- To contribute to maintaining a coordinated network of services between health services and businesses, which responds to all the opportunities in the area for the person with mental illness, who is simultaneously a citizen, a patient and a worker.
- To promote efficient and effective responses capable of combining individualised support and coordinated overview, translatable into evaluable outcomes.
- To apply problem-solving to the nodes of the network that prevent the use of resources.

The organisational model has therefore been created through the construction of operational products that can respond to different emerging needs on work inclusion paths, including assessment and monitoring tools and sustainable agreements between different agencies. These agreements were approved by all heads of department, giving rise to new and monitored procedures between services. The connections between the different network actors were made possible thanks to the creation by the project of a specific professional role: that of the *network coach*. In the literature we find the figure of the vocational specialist, who supports patients in finding and keeping jobs [13]. The *network coach*, on the other hand, is a specialist trained to match the needs of the individual

[2] The Department of Mental Health (DSM) is the set of facilities and services that are responsible for taking charge of the demand related to the care and protection of mental health within the territory defined by the local health authority (ASL). The DSM includes day care services (Mental Health Centres—CSM), semi-replacement services (Day Centres—CD), Residential services (separate residential facilities (SRs) in therapeutic-rehabilitation and socio-rehabilitative residences), Hospital Services (Diagnostic and Care Psychiatric Services (SPDC) and Day Hospitals—DH).

candidate with the network of local opportunities. This figure actively collaborates to develop the network systems in the constant process of innovation that the healthcare and social contexts require. The complexity of this intervention requires that the *network coach* be supported by a cross-territorial functional team, which has the task of being guarantor of inter-institutional agreements as well as of the clinical value of the intervention. The focus is therefore not on the coach-patient pair, but on the directing of network skills that the coach and patient go through and nurture together. If it were centred on the coach-patient pair, the quality of the relationship would be optimised but energy would be wasted, since the operator would have to build and rebuild a network suited to each candidate. Furthermore, this system does not promote equity in the usability of the services by candidates because it is too closely tied to each individual's subjective skills. The establishment of a team of cross-territorial coaches has, instead, promoted:

- The optimisation of resources
- The creation of a culture of cooperation fed by constant exchanges

In the Milanese experience, the group performs a needs analysis and plans, designs and builds ad hoc procedural tools with managerial figures who act as guarantors of the process by collaborating with the network coach. The organisational system also enables the systematic collection of data, so that evaluation systems consistent with the range of indicators agreed with the region and local health authorities can be applied.

For these reasons, the PIR promoted by ALA-Sacco has primarily favoured centralised management, supported by the principle of subsidiarity, which was expressed in the creation of a technical working group that included all the subjects involved in the Milan ASL workplace inclusion group; the working group was supported and enhanced by the Milan ASL. The three overarching objectives of the working group were to:

- Intervene in existing relationship models
- Build consensus and cooperation
- Solve problems collaboratively [20]

In order for the network to be participatory, the following innovative organisational tools were adopted:

- A model (see Fig. 8.1), inspired by that of Mills [21], divided into clusters. This organisational structure enables networking, with regard to agreed objectives and actions, between services. The aim is to create targeted opportunities for job applicants, supported by a staff of operators who specialise in mediation between the different languages of the social and work sectors (network coach). This organisation enables work centres (*Poli Lavoro*) to support the process and allows for the creation of these in the DSM, where they were not yet present. By

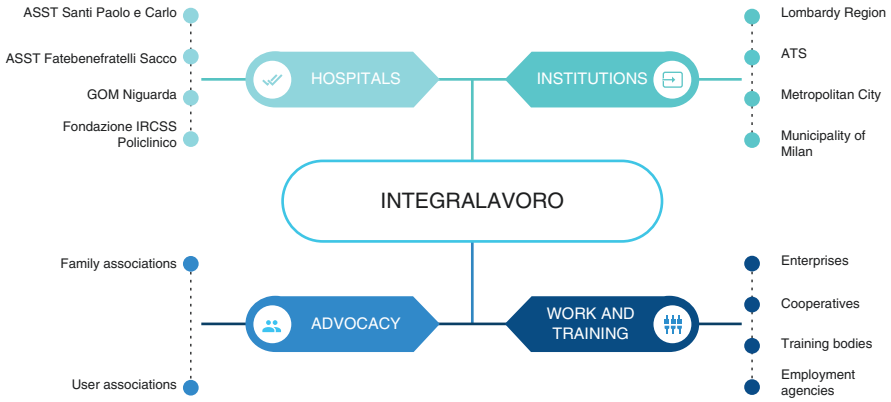

Fig. 8.1 Network of contacts with public institutions and non-profit sector

work centre we mean an agency inside the Department of Mental Health that specialises in evaluating, managing and maintaining patients in the department during the workplace inclusion process.

- The implementation of a method for building agreements based on mutual trust, between the DSM and institutions, inspired by the ORGI method [22], a problem-solving model for organisations that includes holding meetings to express needs, formulate questions, construct intervention hypotheses, distribute actions between entities and verify interventions.
- Network devices: three types of network devices have been identified. They are characterised and differentiated according to the level of involvement of the network subjects, degree of structuring of work processes and long-term expendability (technical work groups, platforms and procedures).
- Process consultancy in order to promote and maintain organisational development.

Network platforms are the network devices that involve different agencies and services in a specific area that can also include multiple work processes; in the last 8 years they have reached a good degree of structuring, with both operational and institutional agreements in place. They can also be supported by online IT tools. The programme has activated the following platforms (see Fig. 8.2):

- ALA-Sacco Information System (SIAL)
- Integralavoro [23]
- Informative Training Groups

SIAL is a candidate assessment tool that collects and correlates personal data and clinical and functional information related to the individual and their previous work experience, and also tracks the project phases of the patient's career path. It is a web-based platform, accessible to all operators at the work centres in the city of Milan, built based on the DSM's previous experience of workplace inclusion. The SIAL was designed to share the assessment of patients referred by their psychiatric

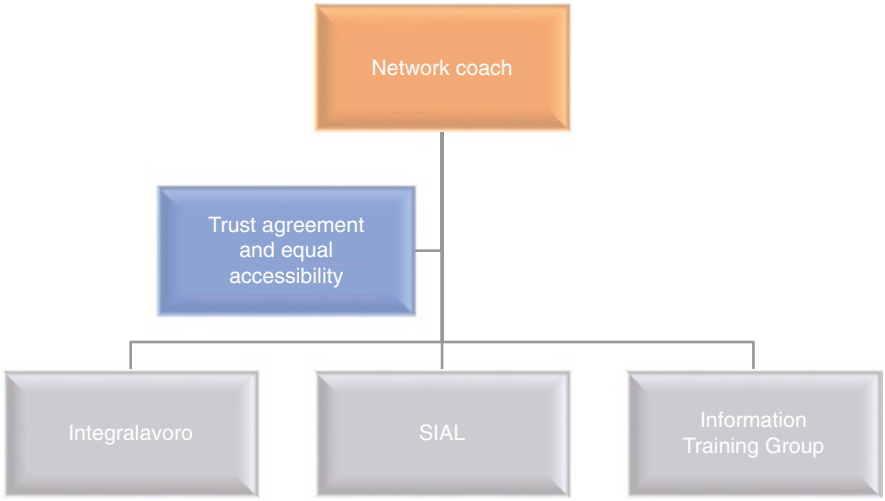

Fig. 8.2 Network platforms

team. This tool was devised to identify homogeneous and comparable placement criteria that are currently shared, to guarantee both the candidate's welfare and congruity with the needs of the production context. In addition to this objective, the system is designed to perform data analysis, which enables epidemiological observation and an assessment of the effectiveness and efficiency of our interventions.

Closely connected to this platform is Integralavoro, which is a point of reference for training and employment needs and opportunities for our clients and the world of work. Integralavoro is also a board composed of one delegate for each work centre of the Milan ASL.

The Integralavoro platform has set itself the goal of sharing experiences, good practices and professionalism from all the DSM's poles in Milan. Here, too, a web-based platform was chosen to facilitate communication between operators working at the different DSMs and to make it possible to share the available workstations. This platform also includes resources obtained from the programmatic agreements and procedures made available online by all the organisations that deal with job placement for members of disadvantaged groups.

Integralavoro has therefore become the heart of the PIR, which over time has taken on the function of connecting, monitoring and therefore evaluating the functioning of the operating practices agreed with the network actors. This governance, which is simultaneously centralised and participatory, makes it possible to collect and disseminate information regarding trends in opportunities found online and to build innovative strategies from time to time in relation to changes in the territory.

The most recently created platform is that of Informative Training Groups, designed to offer patients who are candidates for a work project the opportunity to acquire specific skills to start or stay on workplace inclusion paths. The training groups at work are cross-territorial interventions, built in collaboration with the DSM of the city of Milan based on the departments' experiences. Admission and

evaluation criteria for each group were determined based on shared placement criteria. Most groups intentionally carried out the activity in a location outside the place of treatment, allowing users to experiment in new contexts.

8.5 Sample Description and Outcome

Between 2012 and 2019, every year the PIR TR-106 collected the data of clients in the care of all the work centres of the city who, for various reasons, benefited from the platforms and resources made available by the programme (see Table 8.1). The total number of admissions to the PIR TR-106 programme of people with psychiatric diagnoses between 2012 and 2019 is 2142 (60.8% males). The mean age in the final sample was 45 years (SD = 9.4).

Table 8.1 Client characteristics

Client characteristics (Total admissions to the programme between 2012 and 2019 = 2142)
Mean age: 45 years. (DS: +/− 9)
Distribution by age (%): – 18–24[a]: 3% – 25–34; 27.4% – 35–44: 36.4% – 45–54: 27.7% – 55–64: 5.5%
Sex (%): – Female: 39.2% – Male: 60.8%
Diagnoses (%): – Schizophrenia and other psychotic disorders: 39.0% – Personality disorders: 25.3% – Mood disorders: 22.2% – Neurotic disorders: 9.3% – Others: 4.4%
Job hiring per year: – 2012: 7.9% – 2013: 11.6% – 2014: 15% – 2015: 17% – 2016: 10.5% – 2017: 20.3% – 2018: 22.7% – 2019: 22.8%
Hospitalisation (mean): 4.08% Drop out (mean): 1.37%

[a] For the population aged 18–24 a separate project for workplace inclusion has been developed

Table 8.2 Clients with schizophrenia or other psychotic disorders

Total admissions with diagnoses F20-29 between 2012 and 2019 = 836
Mean age: 45 years (DS: +/− 9)
Distribution by age (%): – 18-24[a]: 3% – 25–34: 28.9% – 35–44: 36.8% – 45–54: 25.1% – 55–64: 6.1%
Sex (%): – Female: 37.3% – Male: 62.7%
Job hiring per year: – 2012: 7.4% – 2013: 9.2% – 2014: 12.1% – 2015: 11.8% – 2016: 13.1% – 2017: 21.3% – 2018: 21.4% – 2019: 28.7%
Hospitalisation (mean): 4.18% Drop-out (mean): 1.31%

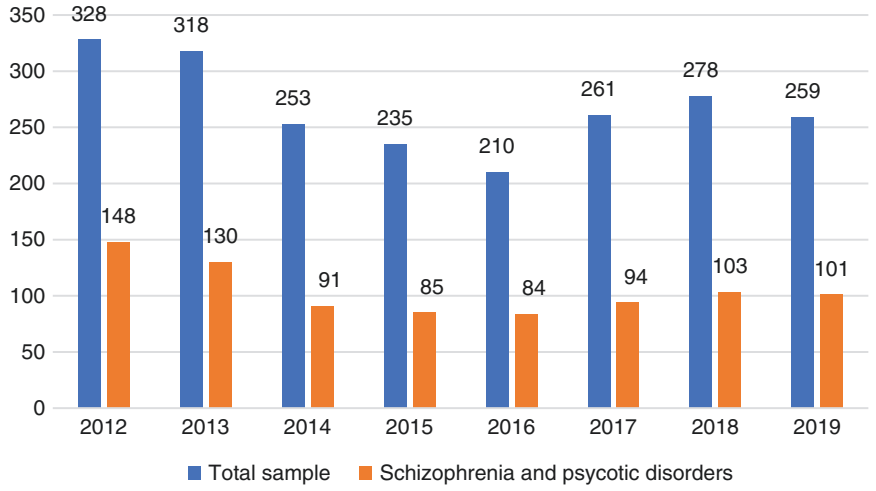

Fig. 8.3 Sample distribution per year (*n*)

Although the programme is not aimed at a specific diagnostic category, our sample does contain a preponderance of clients with schizophrenia or other psychotic disorders (see Table 8.2).

Most of these clients have gone through the programme for many years (see Fig. 8.3).

The programme wants the evaluation of its impact to focus on the process rather than on outcomes. As can be seen in the two tables, the more the programme is rooted in the territory, the more the outcome in terms of hiring has improved, both for the general population and for patients with schizophrenia. The more the network system has taken hold, the more hiring has increased. Drop-out and hospitalisations are, respectively, 1.3% and 4% in cluster F20-29.

8.6 Perspectives, Critical Issues and Conclusions

Work inclusion is a fundamental aspect of the care pathway for patients in the care of the territorial services of the Departments of Mental Health, as an integral part of healthcare and advanced rehabilitation that aims to promote a sense of personal self-efficacy and subjective well-being [24–27].

The programme has promoted and supported an organisational network model that provides, from a cross-territorial and city perspective, central and participatory management, as well as a coordinated and effective overall vision shared by health institutions, social institutions and the world of work, which:

- Provides access for individuals with psychic discomfort to all the resources the territory can offer in terms of workplace inclusion.
- Favours the optimisation of the opportunities already available in terms of integration, homogenisation and appropriateness of interventions.

The objective of the programme, in terms of detection of outcomes, is to evaluate both the candidate and the system. With both aims in mind, we can say that the PIR had an impact on the following aspects:

- Reduction of the fragmentation of interventions for workplace inclusion for people with mental illness in territorial services and consequent reduction of costs.
- Reduction of the heterogeneity of the services offered by the Mental Health Departments to patients in terms of usability and accessibility of the resources the territory has at its disposal to favour social inclusion and more appropriate interventions.
- Transitioning from a culture of competition between services to a culture of sharing, while prioritising the well-being of the candidate.

These results, obtained over time—due to the very nature of the programme, which proposes a community and participatory approach—require constant monitoring and review in the face of continuous changes at the organisational (new institutional arrangements at the territorial level), legislative (updates to labour policies) and workplace levels (characterised by rapid transformations that are often out of sync with treatment times).

We would like to emphasise here how difficult it is to work towards methodological and cultural changes with working groups that are accustomed to using

self-referential methodological systems, and how deeply enriching it is to eventually achieve changes, defined by the contributions of the different actors. The cultural change that this perspective requires is challenging: trust must be established between the DSM and the world of work. However, we believe that trust must first be established when pooling resources and optimising skills within public services before it can be demanded in the world of work.

Genuine and mutual integration between the business world and the healthcare community can be achieved by enhancing governance and safeguarding public health services and promoting constant dialogue between health, social and labour policies.

The network system, as it has been conceptualised, can be flexibly applied to deal with states of discomfort that are widespread in the world of work and thus be supportive to companies and workers, even in connection with welfare systems.

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