Cooperatives as a social enterprise in Italy: a place for social integration and rehabilitation


This article analyses the history and development of an integrated cooperative established in 1981 in northern Italy. Integrated cooperatives, otherwise known as social enterprises, are among the most interesting activities developed in the area of social assistance and rehabilitation in recent years in Italy. In particular, they acquired relevance in the care of mentally disordered people by providing them with job opportunities, which is an important rehabilitative and integrative factor. The aim of social enterprises is two-fold. They have the economic goal of offering remunerative work just as any other commercial enterprise, as well as the social mandate of promoting the physical, social, and mental health of their members. A positive coexistence between market competition and rehabilitation is therefore constantly pursued. This research aimed at analysing the working and social experience of people employed by the cooperative during its 10-year life. The study was limited to those who had a social or health problem when entering the cooperative. The investigation was promoted by cooperative members, who felt the need to document their experience and to undertake initiatives towards evaluating the rehabilitative value of the social enterprise. The results show that cooperative members come from different marginalized areas of social and health distress, of which the two largest are social service users and psychiatric service users. There is a noticeable turn-over rate, which underlines one function of the cooperative as being a transitional working context from which users can gain access to other more rewarding job opportunities in the labour market.

In Italy the first cooperatives integrating users and professionals came into being at the end of the 1970s on the wave of the great transformation of psychiatric hospitals. In many mental hospitals, especially in northern Italy, interesting rehabilitation processes were set in motion with the institutional changes. With the enactment of law 180 in 1978, it was decreed that psychiatric hospitals had to be closed. Assistance had to be provided by mental health services in the community, and compulsory admission could be pursued only by the agreement on treatment of two doctors and the town mayor. A 15-bed psychiatric ward for every 200,000 population was provided in general hospitals for compulsory admission.

Mental health services found themselves having to deal with a new group of psychiatric patients, which added to the large number of long-term patients left trapped in the psychiatric hospitals. One of the first objectives was to activate a psychosocial process directed at re-integrating patients into the community. Rehabilitation through work is one of the most suitable tools for re-acquiring social abilities, practical skills, a job and, most of all, a new relationship with one self and the world. An individually and socially recognized system of measurement is money. To have genuine value, work has to be paid; otherwise it is ergotherapy or exploitation.

These considerations gave rise to the need, on the part of the mental health services, to establish integrated cooperatives. Such cooperatives are nonprofit businesses, and the consumers or members are joint...
The philosophy behind the movement for cooperative work in Italy is one of normalization. The focus is on health rather than on illness. It is an attempt to develop and improve the healthy components of individuals. The cooperative provides marginalized people with work opportunities that otherwise are difficult to find in the labour market. It acts as an intermediary between users and market to the same extent as any employer would: it undertakes contracts that are then carried out by users. Wages are in accordance with standard union contracts for each category of work.

Mental health, social services and cooperatives always keep tight connections. Work issues are usually dealt with within the cooperative whereas health, social, and housing issues are competence of services.

In Italy there is an ever-increasing tendency to delegate social welfare functions to the so-called private social sector. In recent years, hundreds of cooperatives have sprung up, run by professionals with various qualifications, selling welfare services to public centres. Such developments fill in the vacuum caused by welfare policies that have been ineffective in providing marginalized members of society with the opportunity to enter the labour market (1, 2).

Currently there are about 2215 cooperatives of the most varied sizes and characteristics in Italy. Their output is mainly in the handicraft or service sectors. The management structure, the number of people employed and the variety of jobs on offer vary from one cooperative to another. For more accounts and examples of cooperatives in Italy, see (4–7).

National legislation in Italy sets specific parameters for the establishment and development of integrated cooperatives. Among these, the necessary condition for a cooperative to be integrated is that at least 30% of the employees are disadvantaged people. Disadvantaged people are those who have physical disabilities, former psychiatric hospital inpatients, mentally disordered, drug-addicted, alcohol-addicted, minors with family distressing conditions and prisoners to whom a treatment alternative to imprisonment has been allowed.

Special tax exemptions are allowed by the state to integrated cooperatives for running their business (8).

The integration between normal healthy people and people with disabilities has the aim of both avoiding a ghetto situation, and of guaranteeing standard levels of production, in that if a member is temporarily unproductive, the others will produce instead.

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The research had two main objectives:

- to identify people assessed as at risk for marginalization and employed by the cooperative between 1981 and 1991 following referrals from welfare and health services. Official records were not available on how many people and with what social and health characteristics had been cooperative members. It has been a cooperative’s policy to keep records that do not distinguish between members’ social origins.
- to elaborate an archival system about the following information:
  - biographical and social information on members;
  - social/health services that referred the client to the cooperative;
  - type of social or health issue causing distress to the person;
  - notes on client’s social and family life;
  - date of employment and/or departure from the cooperative;
  - jobs undertaken after the experience in the cooperative, and present status (employed/unemployed).

This information was useful for a description of cooperative consumers which answered the following questions: Who are they? Where do they come from? How long did they work as cooperative members? Where do they go after leaving the cooperative?

Material and methods

The cooperative on which this research was conducted is a representative example of the evolution that took place in the sector. This social enterprise was created under the initiative of the psychiatric services, and service professionals and clients are currently part of its management committee.

The cooperative was established in 1981 with 9 members. In 1991 it provided work for 410 people, the majority of whom are social outcasts sent by the welfare and health services. The cooperative, originally providing cleaning services, has over the years diversified its productive sectors. Currently, the existing sectors are the cleaning, upkeep of parks, and assistance.

There are several reasons for the diversification of productive sectors: to occupy free niches on the market, to give more people the chance to work, to make a profit, and to provide members with interchangeable work opportunitites.

The cooperative sells its service mostly to public bodies, and competes with local businesses in the sector. Local administrations, by buying from the cooperative a service that they need at no extra cost, offer work to social outcasts who would otherwise be a fiscal burden.
The present research aimed at gathering methodological indications for the evaluation of the rehabilitative function of the cooperative on users’ disabilities. This was pursued by identifying the degree of users’ vulnerability prior to employment in the cooperative and the quantity and the quality of results obtained according to categories of disability following employment.

The psychiatric and social services workers were asked to identify, from the cooperative’s general records, people whom they referred to the cooperative for jobs. State documents that certify the vulnerability of an individual (literally at risk condition) to render him or her eligible for financial help were used too for the identification of cooperative consumers with the most marginalized positions.

The analysis of administrative records about employment and dismissal procedures was intended to provide information about turnover.

The main methodological problem was in fact the identification of at-risk people, as the cooperative’s records listed people with no mention of their social origins. However, we considered this approach as having a noticeable normalization effect on people’s lives.

Results

Who are they?

A total of 420 people were identified, of whom 51% are women and 49% are men. Among the people referred from drug and alcohol services and prisons, the majority are men. Women prevail in referrals from family advisory services and mental disability services. Psychiatric services and welfare services referred an equal number of male and female users. Almost half of the sample are single, a quarter of them are married, and another quarter are separated, divorced or widowed.

Currently, only 14% (59) of people live by themselves; the majority of the sample live either with the parental family, with partners, children, or friends. The level of education is prevailing low: 86% (359) have the elementary or secondary school diplomas, 13 (3%) are illiterate, and only 29 (7%) have a secondary school diploma.

When referred to the cooperative for employment, 40% had an average age of 30 years and 30% were more than 40 years old.

These last data are particularly interesting, as they highlight a role of the cooperative in employing people over 40 years, usually marginalized from the labour market.

Where do they come from?

Social and welfare services referred 203 people (48%) to the cooperative; 113 people were referred from community mental health centres. The percentage of people coming from drug and alcohol services, family advisory services, mental disability services and prison represent a very small minority of the sample. Fig. 1 indicates the type of social or health issues characterizing cooperative members at the time of referral.

The social and health issues that characterized people at the time of integration to work were specifically linked to the service areas of referral: 132 people had basic financial needs; 47 people came from different areas of social distress. They had all been referred by social and welfare services. Among psychiatric service users, the majority had a diagnosis of psychosis (61 people), followed by those with neurosis or personality disorders (36) for a total of 23% of the sample. The issue of alcoholism crossed all services, and not only the drug and alcohol services. This means that people with a social or mental health problem also presented a problem area in alcohol abuse.

There was an average length of employment in the cooperative of 2 years and 4 months. More than 40% of people worked for the cooperative for 1 year, 17% from 1–2 years, and 40% for more than 4 years. The cooperative sectors that employ the largest number of people are the cleaning and the upkeep of parks sectors. The turnover is higher for men than for women: 54% of the women sampled still work in the cooperative, compared with only the 28% of men.

The relationship between length of stay and services’ referrals presents interesting insights: 55% of people referred by social and welfare services are still employed by the cooperative, whereas two thirds of people referred by community mental health centres and drug and alcohol services dropped out. Diagnosis does not appear to be a relevant variable for dropping out in the case of mental health users. About 32% of people diagnosed with psychosis are

<table>
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<td>14.6</td>
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<tr>
<td>financial need</td>
<td>31.4</td>
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Fig. 1. Type of social/health issues of cooperative members. (%)
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the age for retirement or as a result of being provided with better financial support from their families (6%).

Discussion

Because the cooperative is not subsidized by the state and is not a voluntary agency, it becomes vital to be able to complete in the labour market. This is the reason for the limited variety of jobs on offer for members. The two most financially rewarding sectors are cleaning and the upkeep of parks, and this choice does not always meet users’ career goals and expectations. There would therefore be a need for developing more creative and varied activities for which a space in the market place has to be found.

Sometimes the low productivity of users with highly at-risk conditions put obstacles in the way of the rehabilitative programme set up by the services. As a consequence, there is a demand for services to provide more professional resources to better support users’ work experience.

In this respect, it may be useful to underline that users who prove not to be productive cannot be employed or maintain a job in the cooperative. The cooperative acts as any other employer in the market. The job is a means to implement normalization and develop solidarity and integration but is not social assistance in itself.

The size of the cooperative is sometimes an issue. The bigger the cooperative becomes, the more difficult it is to promote members’ identification. This may affect the rehabilitative function of work and therefore the users’ wellbeing. Again, there is a role for services to better support and monitor clients’ experiences within the cooperative.

Finally, it is necessary to develop research models for the evaluation of the rehabilitative function of the cooperative on users. There is a need for the development of macro and micro indicators that take into account the evaluation of the quantity and quality of the relationship between services and cooperative. It is also important to elaborate qualitative tools of analysis that allow a better understanding of the individual experience in the cooperative world.

Conclusion

During its ten-year life, the cooperative expanded considerably. This proves that it is possible to reconcile the world of production, with its specific laws, and the slow, complex, and delicate world of rehabilitation. Reconciliation is not an easy process. Giving a contract of employment represents not only the achievement of a client’s desired goal, but it is also a means by which he or she establishes a contractual relationship between him or herself, the ser-
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vice that referred her or him and the cooperative. Harmonization between these three parts is the most difficult to obtain.

The results show that this has not always been possible and that, in particular, the passage of information about individual therapeutic programmes between social enterprise and services is defective. It has not been possible to retrieve information about 33% of those who had dropped out.

The cooperative tends to be used as an employment area mainly by the social-welfare services and psychiatric services. Clients coming from such services belong to various areas of marginalization which have as common characteristics those of including people with a low degree of education and with family or parental situations characterized by disintegration. That these are the most relevant issues for social and economic marginalization is demonstrated by the fact that, among the reasons for dropping out, diagnosis is not a relevant variable. Clients diagnosed with psychosis have in fact the same length of stay as clients diagnosed with neurosis. Mentally distressed people have, on the other hand, a higher rate of turnover than people from social services or family counselling services. This outlines indeed a space for mental health service action, perhaps in coordinating and supporting users' job experience better.

Overall, the cooperative appears to be a transitional context that allows people a space for experimenting and developing their skills. Above all, it is a place where differences are accepted and legitimated, as well as suffering and its care. As a matter of fact, the social enterprise is currently the only working context which has an organizational structure able to absorb, in terms of market strategies, such an high turnover.

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References