“The future of psychiatry may be social”
Some lessons from the Italian mental health system in the post-institutional era

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«The greatest enemy of knowledge is not ignorance,
it is the illusion of knowledge»

Stephen Hawking

1. Half a century of de-institutionalization in the Western world

- Progressive reduction of psychiatric hospital beds
- Policies and implementation of community based mental health care services
- Heterogeneous ways across and within countries, in terms of local policies, resources, speed of change and depth
- However, across Europe a high proportion of psychiatric beds are still located in psychiatric hospitals.
- We do not really know why community care is now returning to what a nineteen century editor called ‘bricks and mortar humanity’ (Wynter, 1859).

2. The 70's. Two major turning points under the umbrella of the bio-psycho-social paradigm

Neo-kraepelinian credo

- Target: chemical imbalance.
- The imperative of Evidence-Based Medicine and the progressive "decline" of psychotherapy in the treatment of severe mental disorders
- Psychiatry: Clinical Neuroscience

Social model of disability

- Target: the iatrogenicity of psychiatric institutions
- People are disabled by barriers in society, not by their impairment or difference.
- Focus on the «whole life», rather than on symptoms and deficits
- Psychiatry = Community Mental Health

3. The fate of two great expectations
The bio-medical paradigm (1)

Expectations

- Mental disorders commonly regarded as brain diseases caused by chemical imbalances that are corrected by disease-specific drugs.
- Sharply increasing of use of psychiatric medications

Facts

- The biomedical model era has been characterized by a broad lack of clinical innovation and poor mental health outcomes.

4. The fate of two great expectation
The bio-medical paradigm (2)

Consequences

- At least one third of people with severe mental illness do not respond to treatment and manifest complex long-term care needs
- Decline of the recruitment of the new generation of doctors into psychiatry, observed in many western countries
- Decline of pharmaceutical companies' investment in psychiatry, since the late 1990s
- Client criticism: from the "survivors of psychiatry" which implies that psychiatry should not exist at all, to other forms of discontent, criticizing psychiatry "as it is".

5. The fate of two great illusions
The social paradigm (1)

Expectations

- «Freedom is therapeutic»
- Expectation that overcoming the total institution would produce a substantial reduction in dependence, social exclusion and chronicity.Facts
- Progressive increase in the number of "non-recovered" patients, with poor personal and social functioning, high risk of social exclusion, high family burden.
- Development of a new discipline, internal to psychiatry, psychosocial rehabilitation, that considers **social inclusion as its ultimate goal**.

6. The fate of two great illusions
The social paradigm (2)

- Gradually, the need for long-term rehabilitation "pathways" emerges, rather than only targeted and time-limited interventions.
- Need of specialized places from which to carry out these paths, and in which, in addition to technical interventions, the focus is on "therapeutic" factors of an environmental nature: "positive" and welcoming emotional climate, tolerance of symptomatic behavior, "greenhouse effect".
- Since the 90s there has been a progressive expansion of these structures and becomes evident the risk that they betray their original mission, reproducing situations of social exclusion.

- **Consequences**
- Residential care seems to reproduce new forms of institutionalization, rather than social inclusion.

7. Has community care really produced greater social inclusion?

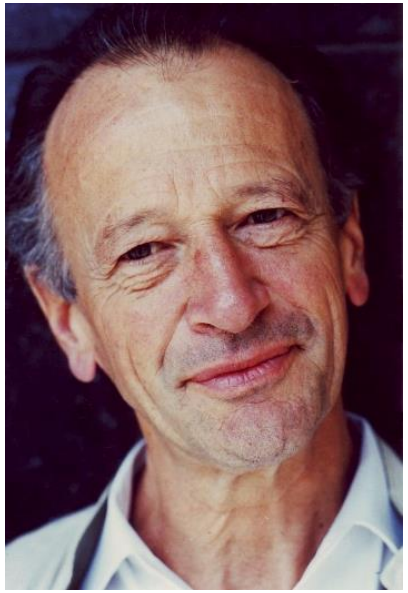
- Some "heavy" segregating and iatrogenic factors of the psychiatric hospital have been overcome
- Rights have been better recognised and the quality of care has improved, albeit more in intention than in deeds. But we can't get a precise idea.
- As long-term outcome studies have told us, up to two-thirds of patients achieve some form of social recovery (optimism that contradicts traditional therapeutic pessimism).
- **But this optimism underestimates the fact that for a third of patients a dramatic public health challenge remains open.**

8.

"... That is the conclusion. We don't like it: it was thought that you could do rehabilitation, and then not think about it anymore.

That's not true.

We need, in the long term, intermediate and residential services, also for a large percentage of patients that we have tried to reintegrate..."



Luc Ciompi, pioneer of psychiatric rehabilitation, 1998

9. Post-institutional geography

For about 30% of patients with severe mental disorders, complex rehabilitation interventions are considered necessary at some point in the course, **often in residential settings**.

Although these patients represent only a small fraction of the users in charge of services, residential care represents an important and predominant share of the total budget.

Rehabilitation outcomes, in terms of social inclusion and reduction of institutional dependence, are collectively perceived as determinants in assessing the overall effectiveness of mental health systems.

10. Residential facilities as the new scenario of long-term psychiatric care

11. Re-institutionalization in the Western Countries (1)

Papers

Reinstitutionalisation in mental health care: comparison of data on service provision from six European countries

Stefan Priebe, Alli Badesconyi, Angelo Fioritti, Lars Hansson, Reinhold Kilian, Francisco Torres-Gonzales, Trevor Turner, Durk Wiersma

Abstract

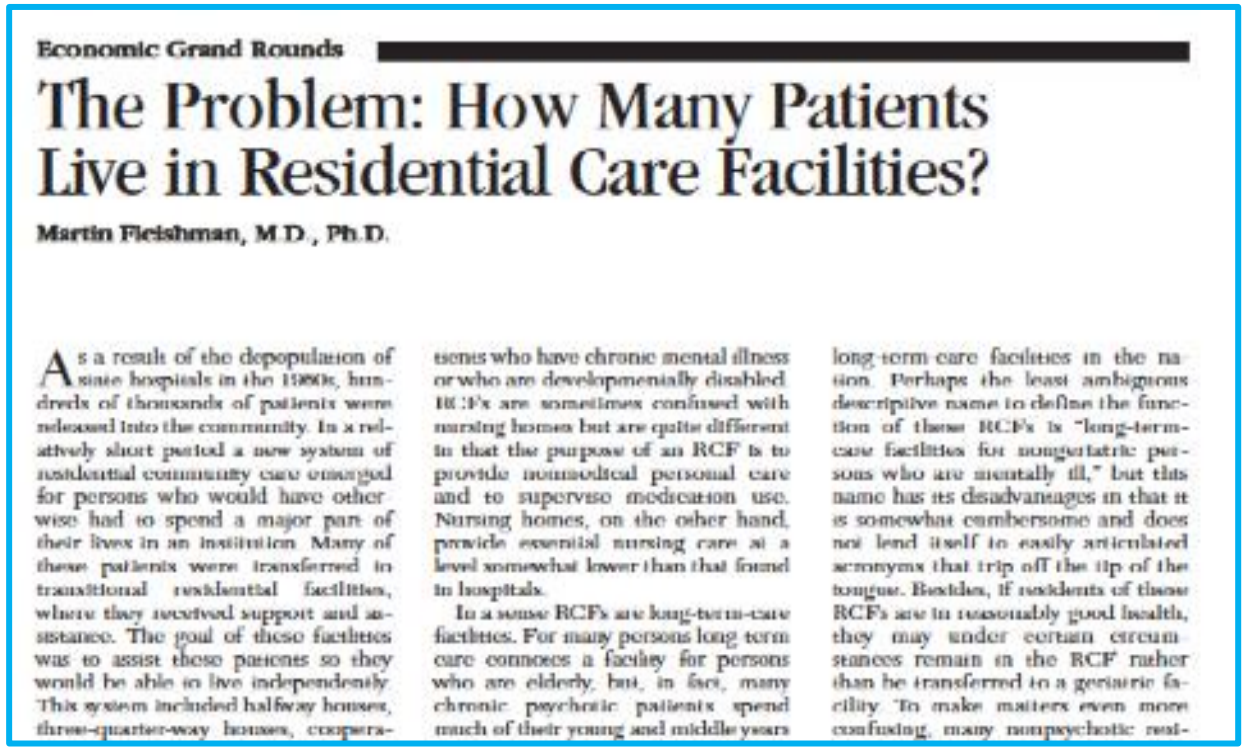
Objective To establish whether reinstitutionalisation is occurring in mental health care and, if so, with what variations between western European countries.
Design Comparison of data on changes in service provision.
Setting Six European countries with different traditions of mental health care that have all experienced in supported housing. However, the argument has as yet not been based on systematic and precise figures.

This paper presents data from six European countries representing different traditions of health care. We aimed to establish whether reinstitutionalisation is taking place and, if so, to what extent and with what variation between European countries. We also wished to investigate whether reinstitutionalisation compensates for the loss of conventional psychiatric hospital beds and

Priebe et al. *British Medical Journal,* 2004

- Reinstitutionalisation is taking place in European countries with different traditions of health care.
- The precise reasons for the phenomenon remain unclear.
- General attitudes to risk containment in a society, may be more important than changing morbidity and new methods of mental healthcare delivery.

12. Re-institutionalization in the Western Countries (1)



Economic Grand Rounds

The Problem: How Many Patients Live in Residential Care Facilities?

Martin Fleishman, M.D., Ph.D.

As a result of the depopulation of state hospitals in the 1960s, hundreds of thousands of patients were released into the community. In a relatively short period a new system of residential community care emerged for persons who would have otherwise had to spend a major part of their lives in an institution. Many of these patients were transferred to transitional residential facilities, where they received support and assistance. The goal of these facilities was to assist these patients so they would be able to live independently. This system included halfway houses, three-quarter-way houses, cooperatives who have chronic mental illness or who are developmentally disabled. RCFs are sometimes confused with nursing homes but are quite different in that the purpose of an RCF is to provide nonmedical personal care and to supervise medication use. Nursing homes, on the other hand, provide essential nursing care at a level somewhat lower than that found in hospitals.

In a sense RCFs are long-term-care facilities. For many persons long term care connotes a facility for persons who are elderly, but, in fact, many chronic psychotic patients spend much of their young and middle years long-term care facilities in the nation. Perhaps the least ambiguous descriptive name to define the function of these RCFs is "long-term-care facilities for nongeriatric persons who are mentally ill," but this name has its disadvantages in that it is somewhat cumbersome and does not lend itself to easily articulated acronyms that trip off the tip of the tongue. Besides, if residents of these RCFs are in reasonably good health, they may under certain circumstances remain in the RCF rather than be transferred to a geriatric facility. To make matters even more confusing, many nonpsychotic resi-

Although there was a great deal of initial optimism that returning chronically hospitalized patients with mental illness to community settings would facilitate rehabilitation, it became apparent over the course of time that many of these patients were unable to achieve their hoped-for independence.

Consequently, **many of the community residences that were originally conceived of as transitional became permanent.**

Fleischman, 2024, *Psychiatric Services*

PSYCHIATRIC SERVICES ♦ ps.psychiatryonline.org ♦ May 2008 Vol. 59 No. 5

Commentary

Interpreting Data on "Institutionalization": Not Simply Counting Beds

Matt Muijen, M.D., Ph.D.

The brief report by Priebe and colleagues (1) attempts to demonstrate that institutional care for people with severe mental disorders has in-

community services, including residential care facilities, which left patients who would previously have been institutionalized at high risk of

Priebe and colleagues is in regard to the diversity across even fairly homogeneous Western European countries—no single variable is moving in

We are not dealing with an overdevelopment of beds but, as a result of inadequate planning, with a lag in time between hospital closures and the availability of residential places.

ic definition in the report by Priebe and colleagues matters. Nobody would deny that people need houses to live in and beds to sleep in. It is unhelpful to group all places available for people with mental disorders and categorize these as institutions. Data

hospital closures and the availability of residential places.

The increase in the number of forensic beds in some countries is a different issue. Such beds were established by governments in response to public pressure resulting from high-

slipping back to widespread institutionalization, and this report serves an important purpose in keeping us aware. However, a more urgent challenge is alluded to at the end of the report. By chance, just before reading the report, I read brief accounts of two

14. Residential care
Unexpected consequences (1)

- Progressive increase in beds
- Costs: The care of 3-4% of all users accounts for more than half of the overall mental health budget
- Most people do not move on from residential care within the expected time frame
- Out of place: Many patients are placed in facilities very distant from their communities, losing contact with families and social networks
- Trans-institutionalization: The step after discharge from a Residential Facility is often followed by a replacement in another facility, and the patient remains indefinitely in the institutional circuit.

15. Residential care
Unexpected consequences (2)

- Out of control: For many privately managed facilities real practices and quality of care are difficult to monitor
- Lack of social support after discharge (*forgotten patients*)
- Mismatch between clinical profiles/disability and actual placement in the appropriate facilities
- To the extent that the place of life continues over the years to coincide with the therapeutic and rehabilitative function, these two dimensions end up overlapping and confusing each other.
- It follows that the mere need for housing risks being systematically interpreted as a need for assistance.

16. A crucial issues: Assessing needs, planning responses, measuring outcomes

- Several attempts to reliably assess needs have been made, through assessment tools. They are applied in research, but rarely in routine practices.
- Response planning is entrusted to multiple hierarchical levels (policies, legislations, funding, providing, organizing, implementing, delivering…). Each of them has its own "reading" that hardly integrates and coordinates with the others, given the complexity and elusiveness of the object "psychiatric disability"
- The evaluation of outcomes is recommended in routine practice, and has many validated tools, but very often it is reduced to a mere bureaucratic exercise.

17. Assessing needs
Desired outcomes: by whom?

Remission as perceived by people with schizophrenia, family members and psychiatrists

European Psychiatry 27 (2012) 426–431

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Original article

Remission as perceived by people with schizophrenia, family members and psychiatrists

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on behalf of the EGOFORS initiative

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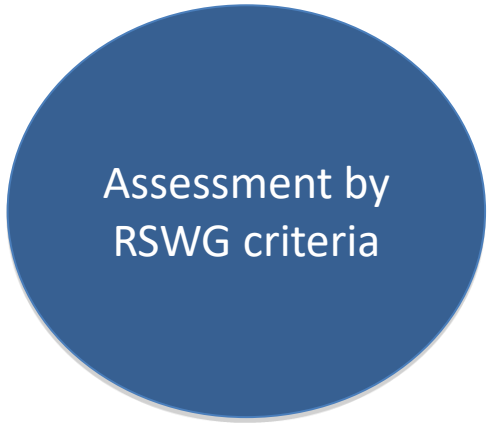
ABSTRACT

Introduction. – Studies indicate that patient-rated outcomes and symptomatic remission as defined by the remission in schizophrenia working group rely on different assumptions. The aim of this observational study was to assess symptomatic remission by patients with schizophrenia, family members and psychiatrists and to compare their assessments with standardized criteria and clinical measures.
Methods. – One hundred and thirty-one patients with schizophrenia (DSM-IV), family members and psychiatrists assessed remission within the European Group on Functional Outcomes and Remission in Schizophrenia (EGOFORS) project. Symptoms (Positive and Negative Syndrome Scale [PANSS]), functional outcome (Functional Recovery Scale in Schizophrenia [FROGS]), subjective well-being (SWN-K) and demographic characteristics were investigated.
Results. – Remission assessed by psychiatrists showed the best accordance with standardized remission (80%), followed by remission assessed by family members (52%) and patients (43%). Only in 18%, patients, relatives and psychiatrists agreed in their assessments. Good subjective well-being was most important for remission estimated by patients, good subjective well-being and symptom reduction by family members, and finally better symptom scores, well-being and functioning by psychiatrists.
Discussion. – Self- and expert-rated clinical outcomes differ markedly, with a preference on the patients' side for subjective outcome. Symptomatic remission as assessed by the standardized criteria plays a secondary role for patients and relatives in daily clinical practice. A more thorough consideration of patients' and caregivers' perspectives should supplement the experts' assessment.

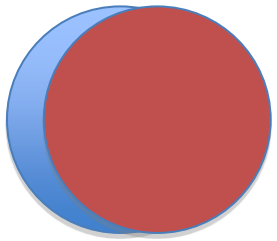
1. Introduction

Subjective processes play an important role in the formation and maintenance of delusional thoughts and hallucinatory experiences in patients with schizophrenia [5]. Nevertheless, the consideration of the patient's perspective on her or his symptoms

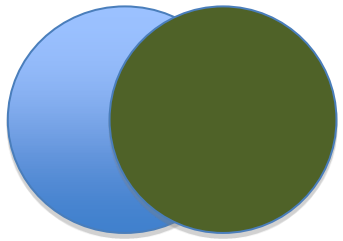
The definition of symptomatic remission of the remission in schizophrenia working group incorporates the absence of relevant positive and negative symptoms such as hallucinations, delusions, blunted affect or social withdrawal [1,35]. With that definition, the working group explicitly focussed on the core symptoms of schizophrenia and decided to leave out other symptom clusters



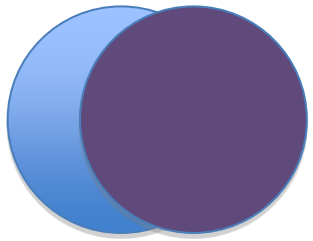
Concordance of points of view



PSYCHIATRISTS
80%

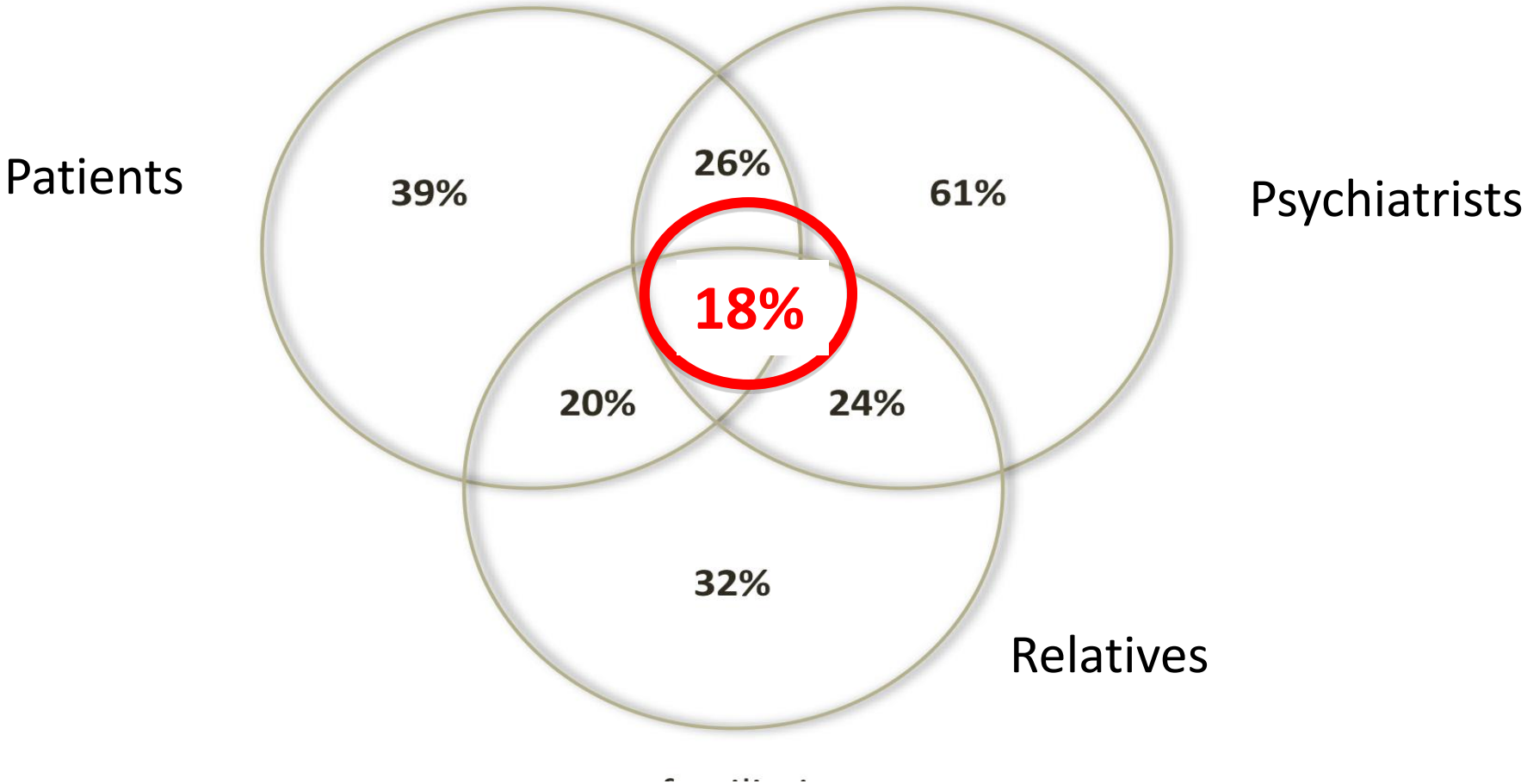


PATIENTS
43%



FAMILY
MEMBERS
52%

19. Assessing needs
Desired outcomes: by whom?



Karow et al., 2009

20. Planning responses

- Although structures with differentiated levels of care/restrictiveness are planned, there are large overlaps.
- In the various studies it appears that from 30 to 60% of patients placed in 24-hour facilities could live in more autonomous housing situations
- Significant percentage of patients stay for long periods in 24-hour facilities mainly due to the lack of alternatives, a place to live, and supports to live more independently, and not because their disability.

21. Assess functional recovery

- The instruments for measuring the functioning provide a snapshot of the situation, with little predictability in the long term: should the assessment be repeated every two weeks?
- And how much could repeated and frequent administration of tests compromise the reliability of the answers?
- Furthermore, instantaneous valuation cannot account for the important difference between acquiring a capability and whether it will actually be spent in the real world.
- "Try to assess the function of a man who lives alone, generally free of symptoms, does not work, has few social contacts, but is satisfied with his condition»

Mausbach et al., 2009

22. Implementing rehabilitative interventions

- Although trials on formalized rehabilitation interventions have demonstrated some evidence-based effectiveness, their actual implementation in the real world is very poor.

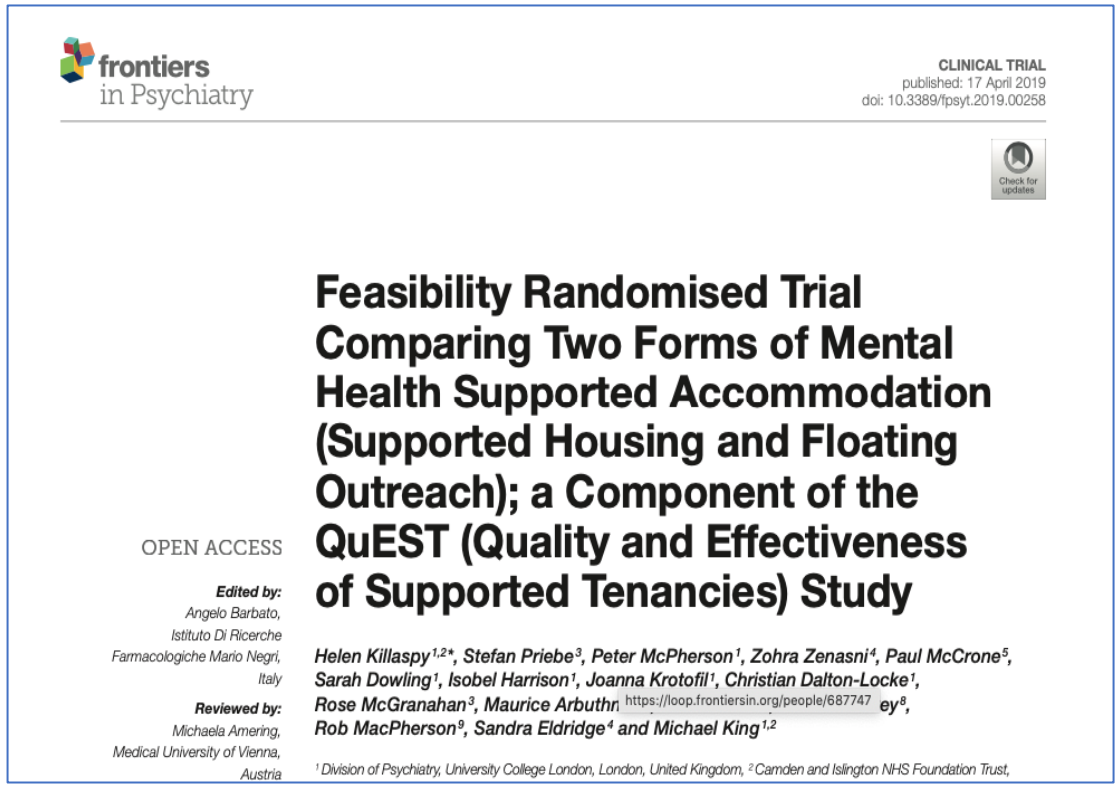
23. Research on psychiatric residential facilities

- In countries with the highest rate of de-institutionalization, the outcomes of residential rehabilitation pathways have been the subject of epidemiological studies, evaluation of outcomes and costs.
- The evaluation of outcomes is particularly complex and elusive, due to the high variability and heterogeneity of clinical pictures, the low predictability of the courses and the factors related to the contexts.

24. In search of "evidence"

- The numerous confounding factors inherent in naturalistic studies systematically compromise the possibility of establishing which factors really favor transitions towards autonomy. Some studies seem to identify them in the 'quality' of care; especially:
- respect for users' rights*
- the recovery orientation of services*.
- To increase, even if only up to a certain point, the degree of evidence, randomized controlled trials should be used.

*Killaspy et al. 2019



frontiers in Psychiatry

CLINICAL TRIAL
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Feasibility Randomised Trial Comparing Two Forms of Mental Health Supported Accommodation (Supported Housing and Floating Outreach); a Component of the QuEST (Quality and Effectiveness of Supported Tenancies) Study

OPEN ACCESS

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Randomized controlled study on the effectiveness of transits from residential facilities to supported housing

1432 patients selected
Only 17 agreed to participate
Only 8 consented to randomization

Reasons for failure:
Operators and users did not accept the randomization process
Enormous logistical difficulties in this type of studies

Killaspy et al., 2019

26. «A desperate need for evidence»

The British Journal of Psychiatry

Editorial

Research into mental health supported accommodation – desperately needed but challenging to deliver

Helen Killaspy and Stefan Priebe

Summary

Around 100 000 people live in mental health supported accommodation in England, at considerable cost to the public purse, but there is little evidence to guide investment in the most effective models. We consider the various barriers to research in this field and offer suggestions on how to address them.

Keywords

Rehabilitation; outcome studies; qualitative research; randomised controlled trial.

Helen Killaspy (pictured) is a rehabilitation psychiatrist and researcher who leads national and international studies that aim to enable recovery for people with complex psychosis. **Stefan Priebe** is a psychologist and psychiatrist who leads research programmes that investigate how social interventions can reduce mental distress.

Housing and mental illness

self-contained, individual tenancies, with the aim of reducing support over time to zero.[3]

Costs of supported accommodation services

Across the country, it is estimated that around 30 000 adults with mental health conditions live in a residential care home, around 29 500 in supported housing (5% of all people in supported

Killspy & Priebe, 2020

27. The focus on «moving on»

- Studies evaluating outcomes in terms of quality of life and personal and social functioning have so far not provided conclusive data.
- Although in general there is a certain (predictable) gradient of the level of quality of life, autonomy and social inclusion in relation to the level of care intensity, these data are not always consistent.
- The indicator considered most significant of rehabilitation effectiveness is the pragmatic one, relating to compliance with the expected transition times to less intensive levels of care.
- The outcome generally considered "optimal" is housing independence with some form of long-term support, hopefully tending to "zero" over time.

28. Long-term evidence?

- In any case, it is doubtful that a randomized controlled trial lasting two or three years would provide us with reliable indications on the actual long-term outcome, that is, on socially complex phenomena.
- The courses thus evaluated would always be influenced by independent and poorly measurable factors, such as life events, unpredictable variability of courses, etc.
- In a wider time frame, perhaps more significant associations could be investigated, even if only in descriptive terms, not necessarily causal.

29.
Twenty-two years cohort retrospective study (2001-2022) on post-discharge transitions from two residential facilities of Department of Mental Health «Roma 1»*(Preliminary results)

Psychiatric Residental Facility «Sabrata», Rome, 16 beds

Psychiatric Residental Facility «Sabrata», Rome, 14 beds

- Patients discharged from 2001 to 2022
- Total eligible cases: 177 (73+101)
- Age at entry, diagnosis, hospitalizations in the previous three years
- Length of stay
- Reconstruction of post-discharge pathways
- Placement of care intensity level at follow-up
- Assessment of Life Skills Profile at the follow-up

*Antonio Maone, Barbara D'Avanzo, Tommaso Poliseno, Bozena Goldos, Innocenzo Crudo, Federica Occhipinti, submitted

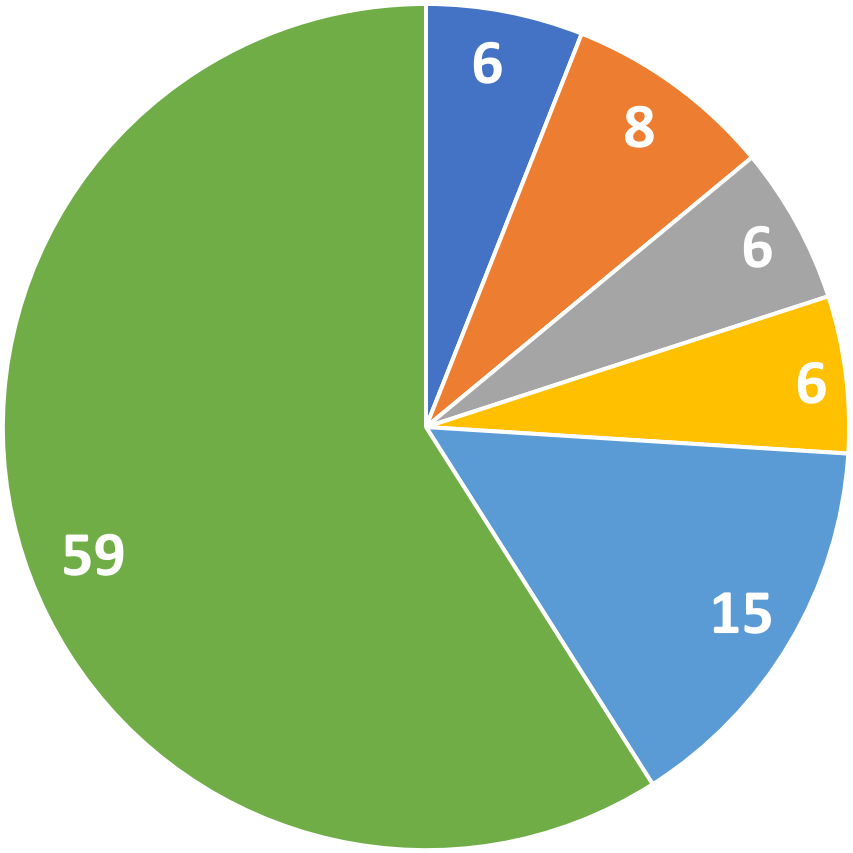
29/A. Characteristics of patients and total eligibility: N=177

	Placement at follow-up			
	Autonomous		Non autonomous	
Lenght of stay in years	average	DS	average	DS
	2,1	1,5	2,8	2,4
Duration of follow-up after discharge	8,1	6,9	9,3	5,6
Age at discharge	37,9	9,8	39,5	9,3
Diagnosisi (%)				
• Schizophrenic Spectrum Disorders	70			
• Other	30			
• Offenders	11			

30. Post-discharge pathways(N= 177) 2001 - 2022

	Categories of placement (2022)	Sabrata	Monte santo	totale	%	%
A	Backwards	5	6	11	6	14
	High staffed residental facility (24h)	4	10	14	8	
B	Low staffed residential faciility (<12 h)	9	2	11	6	13
	Caregiver family	8	3	11	6	
C	Non-caregiver family	9	17	26	15	73
	Independent housing supported	36	53	89	50	
	Resilient (independent dwelling with one or more episodes of hospitalization)	6	10	16	9	

31. Placement (%) at follow-up 2022 (N= 177) for individual categories



Backwards

24 h staffed residential facility

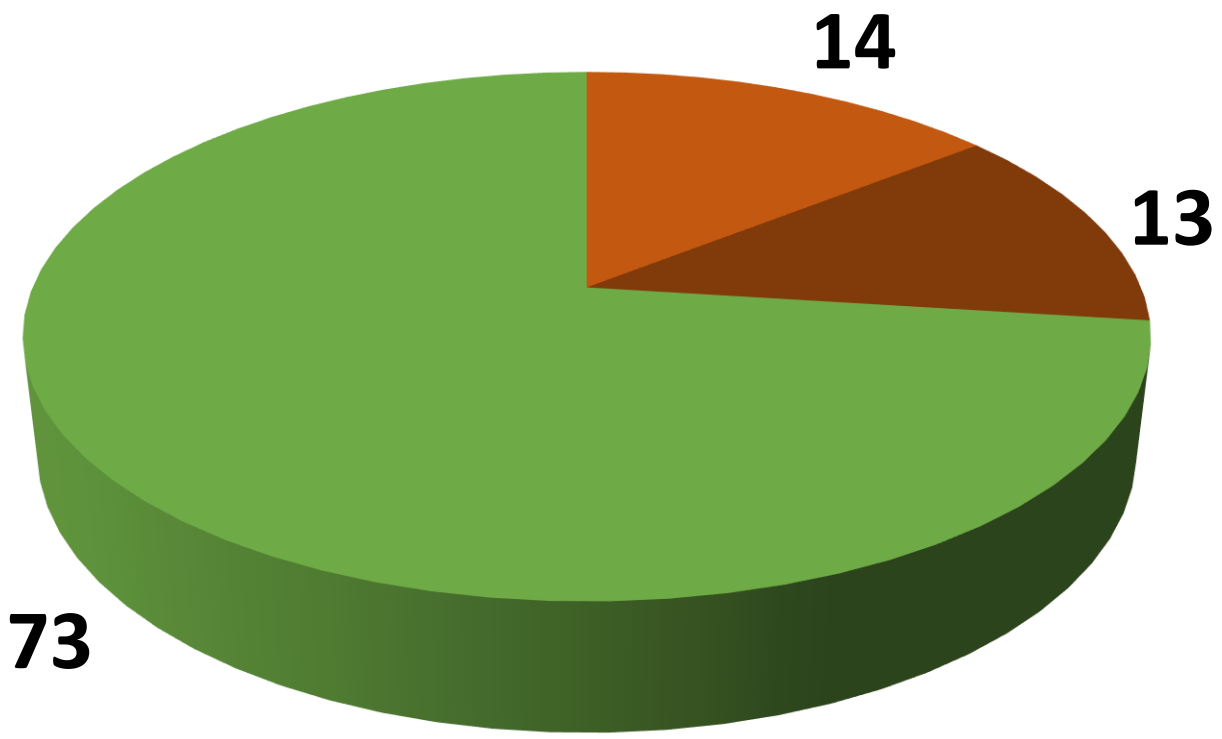
Low staffed Residential facility

Family caregiving

Non caregiving family

Independent ordinary housing with flexible support (0-4 hours per week)

32. Placement (%) at follow-up 2022 (N= 177) by macro-categories
Average duration of follow-up: 8 years



A – Non recovered – Long stay h24 Residential Facility

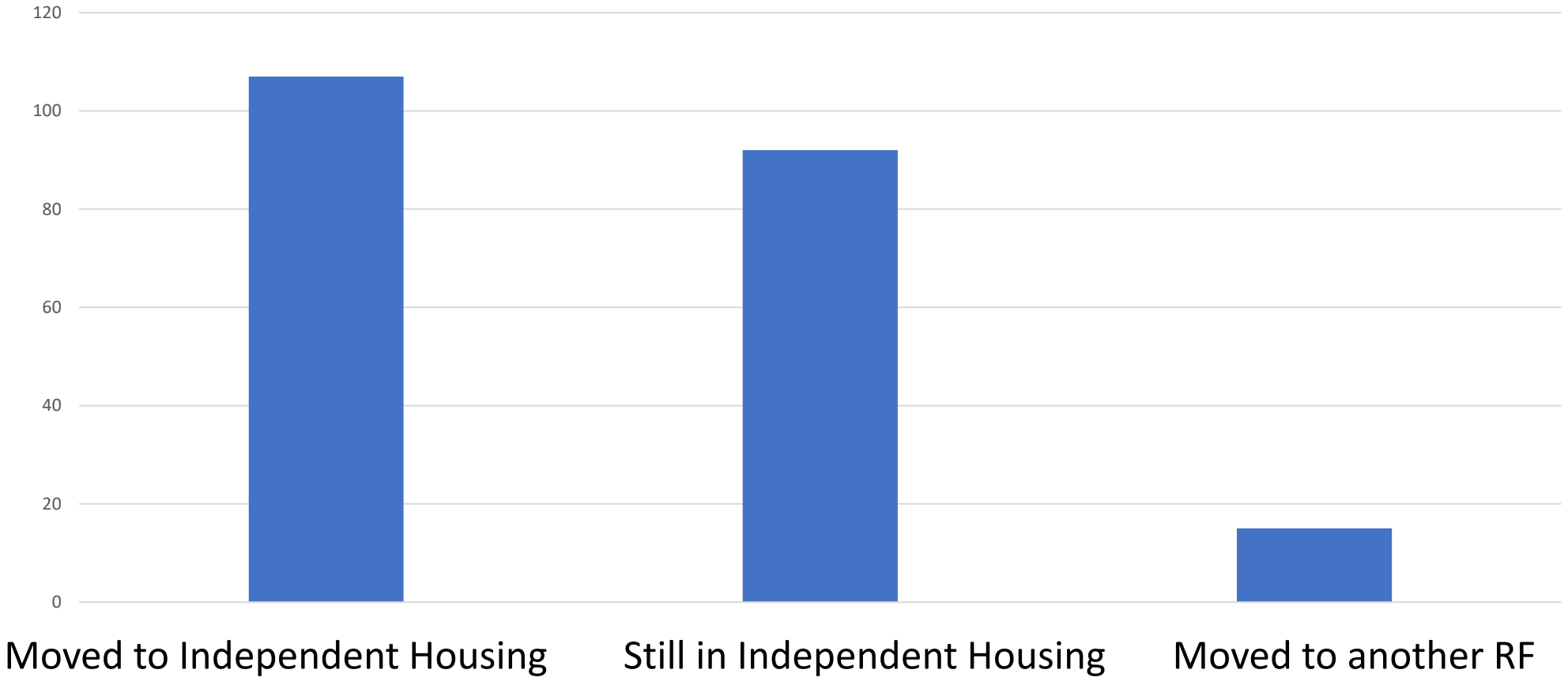
B – Moved to low staffed Residential Facility < 12 h

C - Resilient and Recovered (not placed in institutional settings)

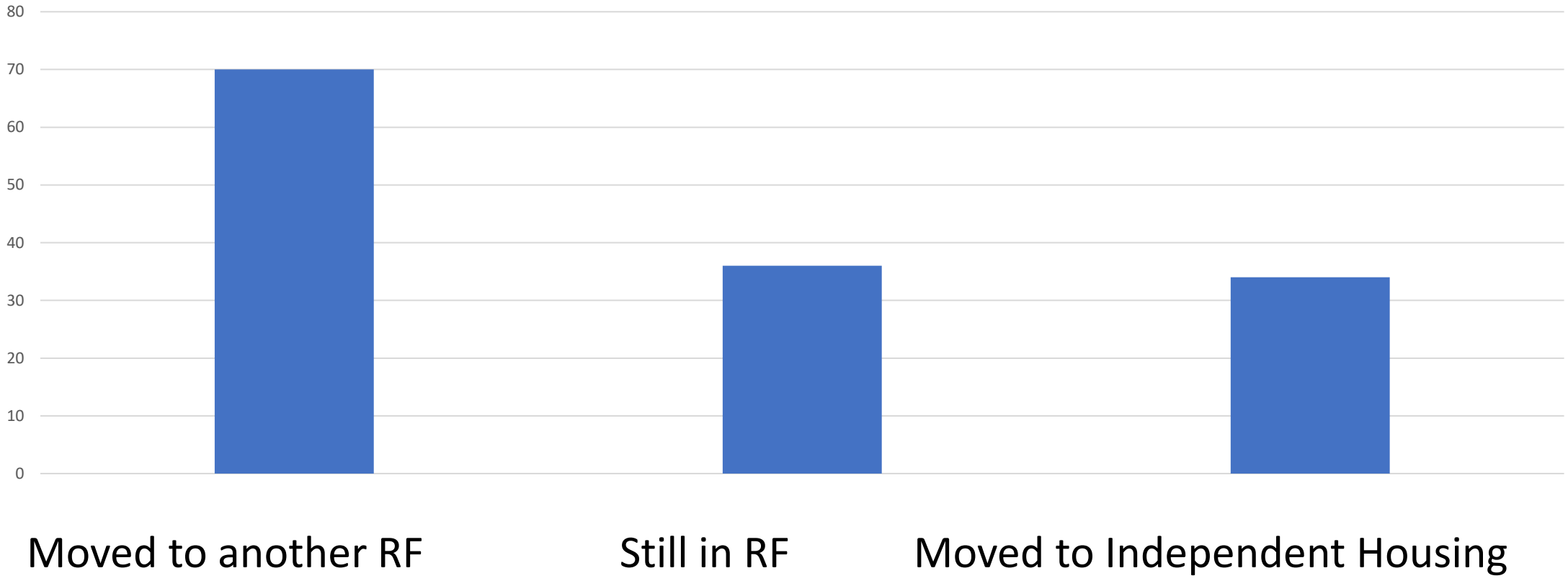
33. Post-discharge transitions at follow-up (N= 177

Discharged to independent housing	**107**	**Still in indepenent housing**	**92**	**Then moved to another residential facility**	**15**
Discharged to another facility	**70**	**Then moved to independent housing**	**36**	**Still in independent housing**	**34**

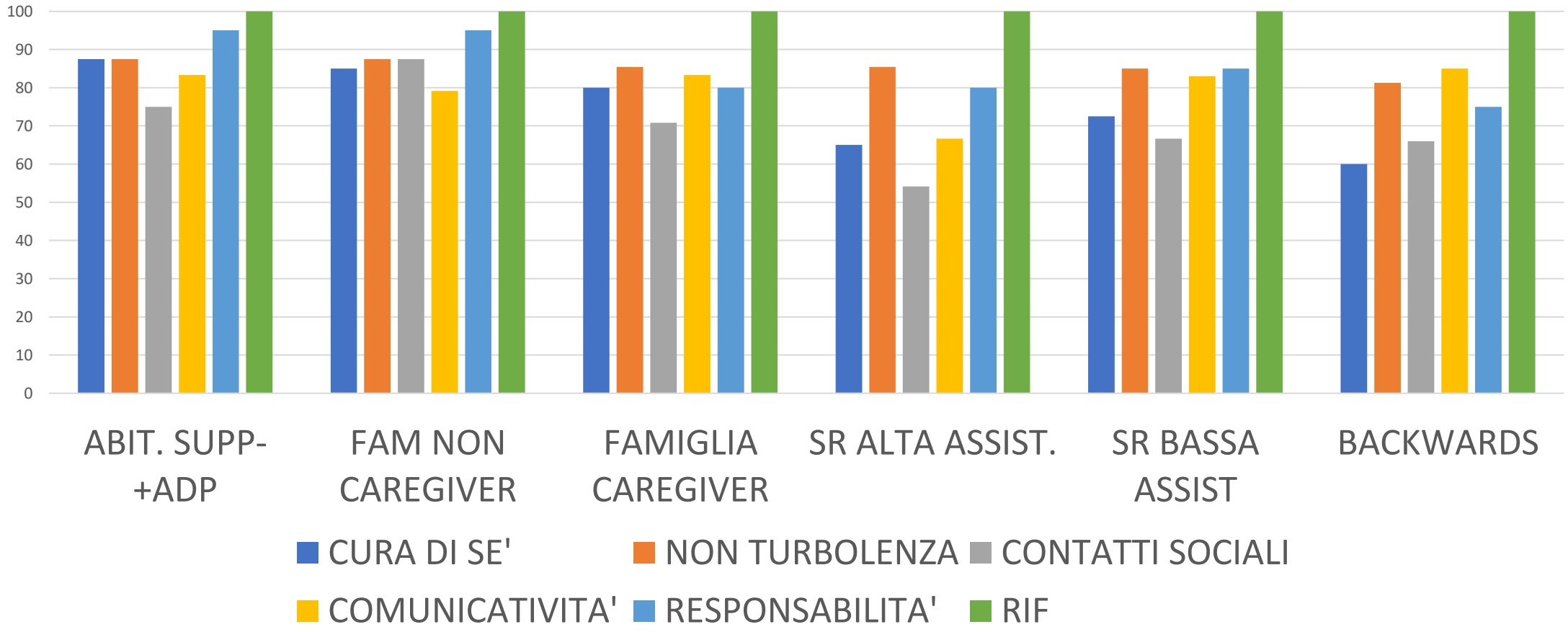
34. Follow-up of patients discharged from RF and moved to a (2001-2022)



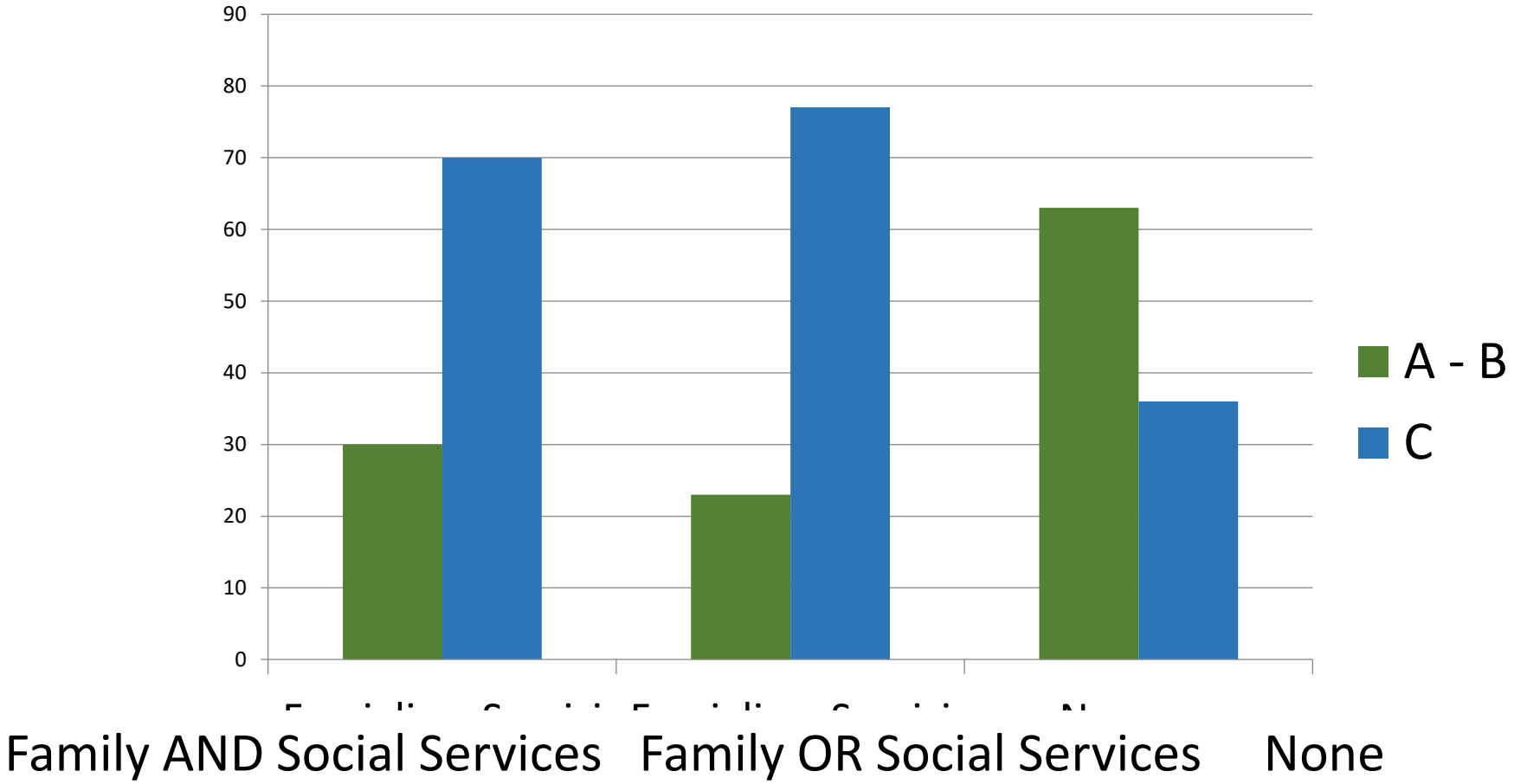
35. Follow-up of patients discharged from RF and moved to Independent Housing (2001-2022)



36. LIFE SKILLS PROFILE at follow-up



37. Collaboration of social services and family members in post-discharge pathways



38. Factors influencing the probability of success of the transition to supported housing

	Odds ratio (95% CI)	Statistical Significance
Male	0.50 (0.25-1.03)	Poor
Age at discharge from RF	0.97 (0.94-1.00)	Poor
Longer duration in RF	0.84 (0.70-1.00)	Indicative, but weak
Longer duration of post-discharge follow-up	0.95 (0.90-1.01)	Indicative, but weak
Collaboration in post-discharge projects		
• **Families or social services**	6.79 (1.75-26.33)	High
• **Both**	6.04 (1.42-25.75)	High
=< 1 hospitalization in the three years prior to entry the RF	0.36 (0.18-0.75)	High
=< 1 Compulsory Treatment in the three years prior to entry into RF	0.30 (0.11-0.79)	High

39. Social inclusion: «Clues» of efficacy

Process indicators:
Respect for patients' rights
Recovery-oriented practices
Amount of time spent with the patient
Personalization of care

Pragmatic indicators:
Moving on from institutional environments
Involvement of family members
Active collaboration between mental health and social services
Activation of social networks (associations, volunteering, etc.)

Killaspy et al., Slade et al.

40. Side effects of psychiatric rehabilitation (1)

- Psychiatric rehabilitation has evolved from generic humanitarian practices to formalized technical interventions.
- Inadvertently, it assimilated the medical paradigm, focused on the symptoms and deficits to be repaired.
- Rehabilitation programs are based on the vulnerability-stress model, that is, through intermediate objectives: only when a goal has been achieved can one proceed to the next one, towards the final one of social inclusion.
- However, these techniques have had little implementation
- Over time, the priority problem becomes "where to place" the patient

41. Side effects of psychiatric rehabilitation (2)

- Inpatient Rehabilitation units are heterogeneous and difficult to control in terms of quality of practices and outcomes.
- Along these paths, external and internal stigma strengthens the identity of "psychiatric patient".
- In other words, they can become toxic and erosive to the patient's sense of Self, that is, antitherapeutic.
- The ambiguity of the mandate risks fuelling stigmatizing attitudes even among operators.
- **About three-quarters of the most relevant studies report that the biases of mental health workers do not differ from those of the general population, or are even more negative.**

42. Inpatients rehabilitation units are institutions, cut off from the wider community

«The organization it self ends up subverting meanings and treating personal identities as something highly impersonal.

If this occurred dramatically in the old institutions, it cannot be avoided by simply dismantling them.

Indeed, community services also run this risk, and moreover they do not see the effects adequately, because they do not expect them; Indeed, everything seems to contribute to the attempt to deny this inevitable disillusionment.»

Hinshelwood, *Psychoanalytic Essays on Psychosis,* Taylor & Francis (2004)

43. Reconceptualizing psychiatric disability: The *Personal Recovery* paradigm (1)

- Mental illness as a "catastrophic event"
- Rehabilitation as "rebuilding a life" beyond the catastrophic effects that the disease has produced on the identity of the person
- Clinical and rehabilitative treatments can promote but also hinder recovery
- Personal recovery orientation implies the assumption that people learn from real experiences **when they are concretely available, not after demonstrating an improvement in symptoms and functioning**

44. Reconceptualizing psychiatric disability: The *Personal Recovery* paradigm (2)

- Psychiatric disability not as a degenerative process due to the persistence of an imbalance or injury that results in dysfunction, but as an effect of repeated failures of attempts to recover the sense of self, of a planning, of a positive identity.
- Chronicity as an effect of "broken dreams".

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Personal View

RMH

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Scenarios for the future of mental health care: a social perspective

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Social values and concepts have played a central role in the history of mental health care. They have driven major reforms and guided the development of various treatment models. Although social values and concepts have been important for mental health care in the past, this Personal View addresses what their role might be in the future. We (DG, PH, and SP) did a survey of professional stakeholders and then used a scenario planning technique in an

Lancet Psychiatry 2016

Unit for Social and Community Psychiatry, WHO Collaborating Centre for Mental Health

Giacco tr al, Lancet Psychiatri, 2016

Scenarios in which the social aspect is central:

- Mental health care will be patient controlled;
- It will target people's social context to improve their mental health;
- Access to care will be regulated on the basis of social disadvantage.

46. Lesson learned from the «evidencies»

«We will never be able to have a medical science as long as we keep separate the explanation of pathological phenomena from the explanation of the normal phenomena of life»

Claude Bernard, Founder of Experimental Medicine, 1865

«Mental disorders cannot be conceived except in a social field. Even the most skeptical cannot fail to recognize the abundant evidence about the importance of interpersonal relationships in determining both the causes and cures of mental disorders»

Stephan Priebe, Tom Burns, Tom Craig, British Journal of Psychiatry, 2016

47. Orient and polarize the social field towards concrete goals

“In the best of cases the social field of the schizophrenic patient will be poorly structured and confusing; in the worst it will be rigidified and severely counterproductive.

In all cases, we might compare effective therapy to the action of a magnet on a field of scattered iron shavings: the entire field must be polarized so that a clear pattern and lines of orientation are created along which, in the end, all the participant will be able to proceed.

In other words, the primary aim of therapy must to be establish explicit and specific common goals for the patient, such as moving into his own apartment.”

Luc Ciompi, 1982

Lessons learned (1)

- In the field of mental health (and not only) the separation between health needs and social needs, between health and social services, is simply improper and harmful.
- People with severe mental illness want the same things everyone in society aspires to: a place to live, money to spend, trusted friends, make choices according to their preferences, and have control over their lives.
- If this is taken seriously, they can regain a positive identity and self-determination.

Lessons learned (2)

- Family members can become from obstacle to resource, if they are treated with kindness with the respect due to their wounds and also to their "dysfunctionality".
- Mental health professionals need not only technical skills, but above all relational skills: empathy, touch, patience, tolerance of limits and imperfection
- The course of mental illness is unpredictable, in the long term there can be surprising evolutions. This requires the need to accompany the patient in the long term, through multiple setbacks, regressions and recoveries.