Social-work inclusion: the "Small Social Laundry" Project

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Abstract

Numerous scientific evidence demonstrates that people with a mental disorder suffer not only from the disorder itself, but also, and perhaps above all, from the consequences that the disorder produces in the work and social spheres. The improvement of mental health, from a Recovery perspective, is in fact based on the possibility of obtaining an improvement in the clinical, social, subjective and functional areas. The main aim of the experiment was to investigate how much the "Piccola Lavanderia Sociale" project favored the development of a functional therapeutic-rehabilitative path and the socio-work inclusion of people with serious mental health problems. It was possible to analyze these elements through the following evaluation tools: the Personal and Social Performance Scale (PSP), Life Skills Profile and direct observation. Funding, such as that remove this obtained thanks to the announcement published by the Waldensian Church, allows people with mental disorders to abandon the "role" of a psychiatric patient in favor of the consequent reappropriation of the sense of person and citizen which fully exploits their residual abilities and builds new ones. These results offer promising preliminary evidence of the fact remove this that highly structured social inclusion pathways can guarantee better results than basic therapeutic-rehabilitative pathways.

INTRODUCTION

L'Organizzazione Mondiale della Sanità (OMS) ha definito il concetto di salute come "Una -- The World Health Organization (WHO) has defined the concept of health as "A condition of complete physical, mental and social well-being and not exclusively the absence of disease or infirmity"; this institution also outlines what is meant by mental health: "state of well-being in which each individual realizes replace by "reaches" his or her potential, is able to cope with stressful life events, work productively and fruitfully and make a contribution to their community"; health, therefore replace by "defined as", not only as the absence of disease, but as the ability to develop one's potential with positive repercussions on the social context in which the subject is inserted. The WHO, on replace by "for" the occasion of Word Mental Health Day, declared in 2019 that "there is no health without mental health", in fact it is an integral part of health and well-being.

In the DSM-V, mental disorder is described as "a syndrome characterized by a clinically significant alteration in an individual's cognition, emotion regulation, or behavior, which reflects a dysfunction in the psychological, biological, or developmental processes underlying functioning. Mental disorders are usually associated with a significant level of distress or disability in social, occupational, or other important areas. A predictable or culturally approved reaction to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behaviors (e.g., political, religious, or sexual) and conflicts that arise primarily between the individual and the society are not mental disorders, unless the deviance or conflict is the result of a dysfunction within the individual, as described previously" [1]

The stress-vulnerability model allows us to explain the onset, course and outcome of symptoms in mental disorders. According to this model, in some people, the combined effect of genetic vulnerability and stressful factors causes the individual threshold of biopsychosocial adaptation to be exceeded and favors the appearance of the characteristic symptoms of a disorder. Psychobiological vulnerability can, therefore, translate into symptoms when stressful events, environmental, family or work tensions exceed the subject's ability to cope with them (coping). The Stress-Vulnerability Model was developed by psychologists Joseph Zubin and Bonnie Spring in 1977 [2], it is based on two key concepts:

- Stress: imbalance that is created between stressful factors (stressors) and the individual's ability to cope with them. There are two types of Stressors: everyday life events (living in a chaotic environment, or without services, having too many commitments, having no commitments at all, arguments at home or at work, missing the bus, weight of responsibilities work, not being satisfied with your job, deadlines to meet, forgetting to do something, traffic, bills to pay,) and important life events (learning about one's own or someone else's illness, bereavement, loss of a job or start of a new job, promotion at work, new relationship, marriage, separation, divorce, birth of a child, relocation, loss of home, moving to a new home, arrest or release from prison, admission to or discharge from the SPDC, being the victim of a crime, etc.).
- Vulnerability: set of characteristic traits of

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a person; it is the result obtained from the combination of bio-psycho-social and environmental factors. These factors can mainly be traced back to 3 categories: environmental factors (family, work environment, socioeconomic status, cultural limitations, social class, etc.), psychological and social experiences (learning style, trauma, dysfunctional attachment, maladaptive behaviors, coping skills, social support, family history and values, scholastic path, character fragilities, personality traits, etc.) and internal biological forces (genetics, neurophysiological, neuropsychological, metabolic systems, therefore congenital hereditary or partly acquired predispositions, dysfunctions pre-existing brain disorders, anomalies in the metabolism of some neurotransmitters, etc.)[3].

Vulnerability factors alone are not sufficient for the onset of a disease, just as the presence of stressful factors alone does not necessarily imply the development of the disease: a disorder occurs only if the predisposed subject is faced with demands that are excessive compared to his replace by "their" adaptability. Each of us attributes replace by "associates' a specific load of stress to life events, for this reason, an individual's personality, coping skills and skills possessed by the person can become "Protective Factors" to replace by "for" the development of the disorder, together with: replace by "as well as," family environment, social support network, humor, satisfying job, etc. The protective factors that allow you to improve your vulnerability threshold to stress can be divided into two categories: replace by "that allow the improvement of the vulnerability threshold"

1. PSYCHOLOGICAL AND SOCIAL: structured psychosocial interventions carried out with mental health professionals (psychoeducation, SST, PS, CRT, psychotherapy, INT, etc.), family and peer support, use of coping strategies, the adoption of a "new" lifestyle (sleep hygiene, abstinence from alcohol and substances, correct nutrition), reintegration into work, identification of personal and pleasant goals, etc.
2. PHARMACEUTICALS: constant intake of drug therapy.

It is therefore possible to raise the threshold of vulnerability to stress thanks replace by "due" to protective factors; these replace by "they" are defined as protective both remove this because they create a sort of preventive barrier and because they act by reinforcing the individual's poor ability to counteract socio-environmental stressors, reducing morbidity (frequency of a disease in the population) and disability induced by the disorder. [2]

Multiple scientific studies have demonstrated the positive influence of prevention and health promotion on the incidence of diseases and mortality, with important positive consequences: replace by "such as" reduction of costs for the National Health System, greater psycho-physical well-being and better quality of life. Among the functions of the Istituto Superiore di Sanità (ISS) there is data collection, aimed at identifying lifestyles and behaviors that can have effects on health, and at identifying and disseminating intervention models for health promotion [4,5,6].

The right to health is recognized by the Universal Declaration on Human Rights (art. 25) and in Europe by the European Social Charter, which establishes that European States are obliged replace by "obligated" to take measures to promote health and to provide medical assistance in case of illness (art.11). As anticipated, a further fundamental aspect for the right to health is the active and conscious participation of the population regarding health decisions taken for the community, at a local, national and international level [7].

With the term prevention, the Istituto Superiore di Sanità refers to the set of actions and activities aimed at reducing mortality, morbidity or the effects due to certain risk factors or pathologies, promoting individual and collective health and well-being. The ultimate goal of preventive medicine is to maintain the state of health of individuals through disease prevention and health promotion interventions.

The National Prevention Plan (PNP) 2020-2025, placing the person and the community at the center of the health project and valorizing replace by "promoting" the outcomes remove this rather than the processes remove this, defines that the objectives pursued through prevention are:

- health promotion, which includes interventions that enhance positive determinants and control negative ones;
- risk identification, including both population screening and predictive medicine;
- management of the disease and its complications, through the adoption of diagnostic, therapeutic - rehabilitation protocols based on evidence of effectiveness, according to quality standards [8].

Prevention interventions can be aimed at the entire population or be aimed at particular groups of people; There are three levels of prevention, divided on the basis of objectives and methods adopted:

- *Primary prevention*: it is the classic and main form of prevention that is aimed at the entire population; it has the priority objective replace by "purpose" of reducing the incidence of disease through the adoption of interventions and behaviors towards healthy subjects to eliminate or at least limit the possibility of exposure to causes and risk factors for the onset of diseases. Almost all health promotion activities aimed at the population are primary prevention actions aimed at reducing the risk and consequently the incidence of a specific disease through actions at a behavioral or psychosocial (psychological and psychoeducational) level. The Ottawa Charter defines health promotion as "the process of enabling people to exercise greater control over over what? and improve their health". Some examples are replace by "can be,": remove this vaccinations and immune prophylaxis activities, education, awareness and health information meetings (e.g. nutrition education in schools, sleep hygiene), psycholo-

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gical and psycho-educational interventions to modify risky behavior and incorrect habits (anti-smoking campaigns), environmental interventions (water and air quality controls), legislative interventions to ban or control the use of dangerous products (e.g. asbestos) or to impose safety practices (use of helmet or seat belt).

- *Secondary prevention*: is directed at apparently healthy subjects replace by "subjects appearing healthy" who are in a clinically silent phase of the disease; it refers to the early diagnosis of a pathology, thus allowing early intervention on it, without avoiding or reducing its appearance. The main tool to pursue the aforementioned objective is screening, it replace by "which" allows for the implementation of early interventions that facilitate access to treatments and reduce the negative effects of the disease in its progression. Secondary prevention therefore, even if it has no effect on the incidence of a disease, makes it possible to reduce mortality, in proportion to the effectiveness of the intervention itself and reduce the prevalence of those diseases that can culminate in complete recovery. Some examples of secondary prevention are screening programs such as mammography, Pap tests, testing for occult blood in the stool, measurement of blood pressure and glycemic pressure, periodic checks of moles, and other screening related to cystic fibrosis, to metabolic diseases, hearing problems, etc.

- *Tertiary prevention* deals with interventions aimed at sick individuals which are aimed at controlling and containing the more complex outcomes of a pathology (risk of complications, relapses or death); this third typology therefore also includes interventions aimed at managing functional deficits and disabilities resulting from a pathological or dysfunctional state. Tertiary replace by "The third" prevention allows for accurate clinical-therapeutic control of chronic or irreversible diseases, and has the aim of replace by "aims on" guaranteeing the best possible quality of life. Examples of tertiary prevention are all those rehabilitation and welfare measures aimed at the family, social and work reintegration of the patient, some examples are: remove this motor rehabilitation measures, psychological support, psychosocial interventions, cognitive rehabilitation, taking drugs (such as hypertensive drugs or useful for managing diabetes). Very often, in fact, remove this tertiary prevention overlaps with therapy as in the case of the diet for a person with diabetes [9].

The identification and implementation of preventive actions can take place through territorial or residential interventions; for replace by ". For" some people it is sufficient to carry out interventions at a local level (Mental Health Centre, SeRD), for others it is necessary to outline a more structured and intensive path through the activation of therapeutic-rehabilitative paths at Day Centers (CD) or Communities of Psychosocial Rehabilitation (CRP). The activation of residential programs makes it possible to take action that is aimed at recovering skills lost or never acquired due to the onset of a psychiatric disorder through the identification of effective coping strategies for the patient and his replace family. The aim, therefore, remove this is to regain a good quality of life, returning to one's living environment, also thanks to an improvement achieved in the training and/or work area [3,10].

MATERIALS AND METHODS

Regulatory framework

In the Molise region with law n. 30 of 6 November 2002 regulates the activities relating to the promotion and protection of mental health in the Region, the organizational aspects of the structures, their functions and checks; all actions aimed at achieving the "health objectives" defined by the National Health Plan, the Regional Health Plan, the "Project - objective (1998-2000)". This law allowed the creation of Mental Health Centers for each Mental Health Department, of remove this Day Centres, the creation of Type B Cooperatives intended to deal with work reintegration, the creation of Associations of family members and users, implementation of preventive campaigns in mental health,
Specifically, among the functions of the DSM there is the creation of intervention programs aimed at favoring extra-hospital solutions, therapeutic continuity, replace by "and" the integration of patients into the social fabric. The DSM is made up, in addition to the CSM and the CD, also by residential structures for high, medium and low (Apartment Groups) therapeutic-social-rehabilitative activities. These structures, previously defined as Psychiatric Recovery Centres, are renamed with Law 30 : Psychosocial Rehabilitation Community [11].
The National Action Plan for Mental Health (PANSM), approved by the State Conference Regions in the session of 24 January 2013, plans, among its objectives, to address the issue of psychiatric residency, proposing specific actions aimed at differentiating the offer of residency for levels of rehabilitation and care intensity in order to improve treatments and reduce inhomogeneities. Also in Molise, the transition from CRP to Psychiatric Residential Facilities (SRP) is currently underway.
It involves adopting a methodology focused on care pathways, which is based on the need to work for specific and differentiated intervention projects, based on the assessment of people's needs, aiming to renew the organization of services, working methods of the teams, the clinical programs offered to users.
The differentiation of residential facilities, still uneven at a national level, aims to promote, within the mental health departments' offering system, a residential system that is functional to individualized pathways and structured both in terms of inten-

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sity of treatment (from intensive treatment to socio-rehabilitative support) , both for programs and types of intervention related to the pathology and the complexity of the needs.
The type of psychiatric residential facilities is distinguished based on:

- level of therapeutic-rehabilitative intervention, correlated to the level of impairment of the patient's functions and abilities (and its treatability),
- the level of care intensity offered, correlated to the overall degree of autonomy.

Based on the rehabilitation intensity of the programs implemented and the level of care intensity present, three types of residential structure are identified:

1. Psychiatric residential facility for intensive therapeutic rehabilitative treatments (SRP1). These are facilities in which patients with serious impairments in personal and social functioning are welcome, for whom high-intensity rehabilitative interventions are considered effective, to be implemented with programs with different degrees of protective assistance, and which may be appropriate for a range of different situations, which also include psychotic onset or post-acute phases.
2. Psychiatric residential facility for therapeutic-rehabilitative treatments extensive (SRP2). These are facilities that welcome patients with serious or moderate but persistent and disabling impairments in personal and social functioning, for whom therapeutic, rehabilitative and protective assistance treatments are considered effective, to be implemented in medium-intensity rehabilitation programs (also aimed at consolidating functioning adequate to personal resources).
3. Psychiatric residential facility for socio-rehabilitative interventions (SRP3), with different levels of care intensity, divided into three subtypes, with socio-health personnel present 24 hours, 12 hours, by time slots. These are structures that welcome patients who cannot be cared for in their own family context and with variable levels of self-sufficiency and impairment of personal and social functioning, for which interventions to be replace by "are" implemented in low-intensity rehabilitation programs are effective [12].

Objectives of the residential path and the "Small Social Laundry" project

In Molise there are currently 13 residential facilities which are replace by "that are" undergoing a gradual change regarding their nomenclature and differentiation based on rehabilitation and care intensity. The aim of psychiatric residential facilities is to offer all patients the useful tools for recovering replace by "to achieve" a good quality of life, through a Recovery process. The Substance Abuse and Mental Health Services Administration (SAMHSA) has established the following definition of Recovery: "a process of change through which an individual improves his or her health and well-being, lives in a self-directed manner, and commits to living his or her best life of their potential." The health services offered by psychiatric residential facilities are oriented towards recovery, in fact, the interventions carried out favor: partial or total remission of diagnostic symptoms (clinical recovery), better cognitive and socio-work functions (functional recovery), increase in self-esteem, sense of self-efficacy and self-determination (subjective recovery) and the reconstruction of a family and community social support network (Social Recovery) with consequent elimination of stigma. [3].
Since 1988 the Cooperativa Sociale Dialogo has managed the Psychosocial Rehabilitation Community based in Campolieto, a small town in Molise; the other twelve psychiatric residential facilities are located in other small towns in Molise. The structure is accredited for 13 beds; the patients included have various psychiatric disorders (psychotic disorders, mood disorders, personality disorders); patient admissions and discharges take place together with the Mental Health Department of Campobasso. The residential facility and the Mental Health Center identify and monitor the objectives of the Individual Treatment Plans and Personalized Therapeutic Rehabilitation Projects of the patients in their care. The objectives pursued by the residential structure allow the implementation of Recovery-oriented treatment paths, aimed at promoting mental health, safeguarding the patient's quality of life, pursuing objectives aimed at eliminating stigma and social reintegration into one's own community. belonging? Thanks to both new coping strategies and greater personal, social, relational, training, work skills, etc.
In 2022 the Cooperativa Sociale Dialogo decided to participate in a tender? aimed at potentially obtaining funds for the implementation of a project conceived by the structure's team; the project sent and financed by the Otto per Mille of the Waldensian Church (www.ottopermillevaldese.org) was the following: "Small Social Laundry". The Waldensian church finances projects in Italy and around the world; in 2023 the funds were used to finance 396 projects abroad and 869 projects in Italy in the educational, humanitarian, socio-health and cultural fields, for a total of 1265 projects. All the funds received are used to finance healthcare and health protection projects, to combat social hardship and job insecurity, educational, cultural and integration interventions, development support programs and responses to humanitarian, environmental and climate emergencies [13].
The "Small Social Laundry" project lasted 12 months, from January to December 2023. The project had the aim of starting a social entrepreneurship experience in Campolieto which is based on the creation of an ergo therapeutical service of laundry, ironing and small sartorial repairs, with a strong social connotation. The term Ergotherapy indicates a method that consists in re-educating patients about social life through targeted activities; these

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activities allow us to measure replace the degree of responsibility, attention, respect, and also the sense of belonging to the community where the person lives [14].

This is where the project idea was born, it has the aim of promoting the full inclusion and realization of the 8 patients involved through a series of theoretical and practical actions; the intention of the multi-professional team is to offer a training opportunity and to expand the possibilities of being included in the world of work, promote social inclusion and facilitate actions to raise awareness and combat stigma in favor of patients with mental disorders.

The phases of the Project

The implementation of the "Small Social Laundry" Project occurred through the implementation of multiple phases, during which the continuous presence of the patients involvement was necessary, the participation of expert operators in the sector, for the training part, and the support from the professionals within the residential facility, also for the evaluation of outcomes. The multi-professional team that took care of the project was made up of: a Social Worker, a Professional Educator, a Psychiatric Rehabilitation Technician, a Psychologist, a project manager and two reference operators. There were five steps followed:

1. Training activity: The training course allowed the participants to acquire numerous technical and professional skills through specific instructions to follow during the washing and stain removal processes, greater manual skills in using the machines and management programs, specific skills aimed at organizing and run a business. The micro objective of this first phase was to provide the skills necessary to start a social enterprise. The training activity was carried out by a professional training body based in Campobasso. The training course lasted 40 hours during which the participants followed 4 modules in person: safety at work, business management, washing and stain removal processes, use of machines and management programs. Participation in the theoretical part made it possible to obtain a qualifying qualification? for the profession "qualification of dry cleaners and laundry operators".
2. Setting up the laboratory: Setting up the Social Laundry in a wing adjacent to the residential structure. The patients had access to the Laboratory after finishing the theoretical training course because the project idea is based on two learning strategies:

- *Learning by Doing*: Learning method based on learning something by doing it; this learning method allows you to give the right importance to the theoretical part carried out and learn to apply the new skills in a real laundry [15].
- *Cooperative Learning*: Individual learning method through a process that involves the group, the team is seen as a resource and stimulus for each member. The group becomes a mediation tool and has allowed the individual patient to perform the best possible performance, improve social relations between group members, encourage help between members, enhance the sense of personal achievement, enhance diversity and encourage the process which is increasingly inclusive. The financing obtained allowed the purchase of professional tools including washing machines, dryers, dryers,? irons and ironing boards; the project favored equipment that could guarantee the greatest possible environmental sustainability [16].

3. Professional training: At the end of the theoretical and practical activity, the four most deserving trainees were identified and they obtained a work grant, i.e. an economic remuneration through which they could carry on the social enterprise that was started through the creation of this project.
4. Communication: The dissemination activity is aimed at broadening the customer base and implementing an awareness-raising action to eliminate stigma, thus promoting the social inclusion of the people involved. The communication actions carried out were the following: creation of a conference that will deal with the issues of re-integration into work, creation of a photographic exhibition aimed at recounting the project experience, publication containing the story of the project experience through the Mass channels Media (television, radio, YouTube channel, Facebook page).
5. 5) Monitoring: The action involves the verification of the results obtained by the psychiatric rehabilitation technician. Evaluation in the therapeutic rehabilitation field is a crucial aspect as it outlines the rehabilitative action. Outcome indicators allow you the recording changes at the end of the intervention compared to the starting point. The measurement and evaluation of outcomes are the fundamental strategy for good quality in rehabilitation terms. The 8 participants in the project underwent standardized assessments using the Life Skills Profile tool and the Personal and Social Performance Scale (PSP).

- *The Life Skills Profile* (LSP) is a tool that aims to assess strengths as well as areas of disability in psychosocial adaptation. Each item corresponds to a score of 4, 3, 2, 1, from the positive extreme, on the left, which corresponds to the greatest level of adaptation, to the negative extreme, on the right, passing through the intermediate scores. It is possible to calculate a total score, adding the scores to all 39 items, and 5 distinct scores relating to as many scales identified on the basis of factor analysis: Self-care (personal hygiene, clothing, money management), Non-turbulence (irritability , problems living with other guests, legal problems), Social contact (social isolation, friendliness, hobbies, inactivity, maintaining social relationships), Communicativeness (communication skills to start and maintain a conver-

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sation) and Responsibility (adherence to the therapeutic rehabilitation process , taking care of one's mental health) [17].

The evaluation of functioning allows the acquisition of an exhaustive range of information on the user/guest allowing the attribution of a score on global functioning through the examination of 4 main areas: socially useful activities (including work and study), personal relationships and social issues, care for appearance and hygiene and disturbing and aggressive behaviours. The degree of dysfunction in the above areas can vary from mild, evident but not marked, marked, severe or very severe. The PSP score derives from the definition of the 4 areas, it can fluctuate from 0 to 100, at intervals of 10. A score of 0 indicates that there is not enough information for the evaluation, the subsequent intervals progressively indicate increasingly milder dysfunctions (dysfunctions severe in all areas, in part of the areas, marked dysfunctions in one or more areas, up to more than good functioning in all areas) [3].

RESULTS AND CONCLUSIONS

The project idea was born from the desire to promote personal and social autonomy, psychophysical well-being, the best quality of life, citizenship rights and social and work integration through an ergo therapeutical laundry service aimed at people included in the Campolieto psychiatric residential facility. The multi-professional team had the opportunity to monitor the objectives outlined during the drafting of the project: training opportunities, expansion of the possibilities of finding a job, promotion of social inclusion and actions aimed at raising awareness and combating stigma.

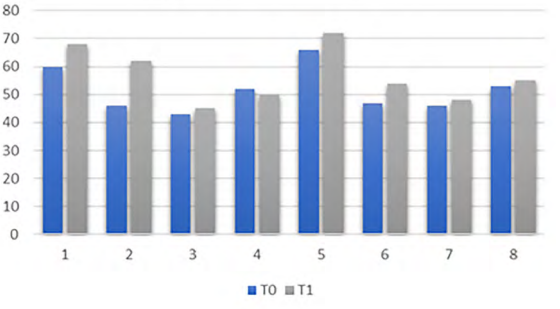
The half-yearly reports and the comparison of the results obtained from the standardized assessments allow us to acquire multiple information on the 8 participants. This information allows us to outline the effects and objectives actually achieved:

- Patients have acquired verified technical-professional washing and stain removal skills thanks to the creation of the laboratory, and subsequently of the social enterprise;
- They have acquired specific entrepreneurial skills that they can include in their Curriculum Vitae;
- They have obtained the qualifying certificate for the profession of "Laundry and dry cleaner operator", expanding the range of job opportunities during and at the end of the therapeutic-rehabilitative process;
- They have acquired skills and manual skills that can also be used in their daily lives; feeling skilled in everyday life and feeling useful for others promotes the strengthening of self-esteem and a sense of self-efficacy;
- Learning by Doing and Cooperative Learning also made it possible to outline the load of responsibility with respect to the role of worker that the patient found himself covering;
- Project participants report feeling a greater sense of belonging to society. This perception derives from the occasions in which patients related to the customers of the Social Laundry; this opportunity facilitated the social inclusion of the people involved with the community they belong to;
- Following the Social Skills training during the various phases of the project, improved communication skills were recorded. Expressing pleasant feelings, expressing unpleasant feelings, making a request in a positive manner and active listening are the essential elements of effective communication;
- The elimination of stigma was measured through: the number of services received by laundry operators (requests for washing and stain removal received from individual citizens and from some housing communities for the elderly, requests for small repairs from citizens or small businesses), the number of participants at the conference, the number of visitors to the photographic exhibition, as well as the appreciation received on social media following the sharing of the television report dedicated to the Project.

The above replace allows us to explain the improvement obtained by patients both with respect to their personal and social functioning and with respect to their greater psychosocial adaptation capacity (PSP); the main areas in respect of which there was a notable improvement were the following: problem solving, search and maintenance of social relationships, personal hygiene, cooperation, emotional regulation, use of social skills, adherence to the therapeutic rehabilitation process and care of one's mental health as well as in the training and work area.

The results are easily visible in the two graphs shown in Figure 1 and Figure 2. The Fig.1 allows us to compare the personal and social functioning of each of the 8 participants at the beginning (T0) and at the end (T1) of the "Piccola Social Laundry". At T0 the average score obtained was equal to 51.6, at T1 the average score increased and was found to be equal to 56.7. From the evaluation of the PSP Scale it emerges that the improvement recorded is mainly attributable to an improvement in the "Socially useful activities" area and that of "Personal and social relationships".

Fig. 1: Score PSP's Scale



The graph contained in Fig.2 allows you to observe the average score obtained in the 5 areas evaluated and the total average score at the beginning and at the end of the project.

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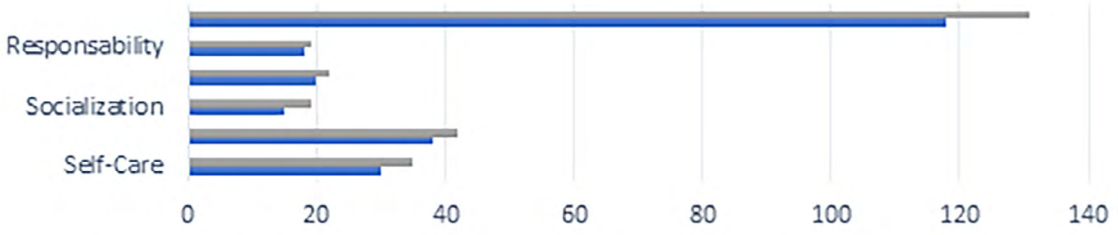
Fig.2: Average Score of the LSP



	Self-Care	Non turbulence	Socialization	Communication	Responsability	Total score
T1	35	42	19	22	19	131
T0	30	38	15	20	18	118

An improvement was recorded in the self-care, non-turbulence, social contact, communicativeness and responsibility scales; the area in which there was a less marked improvement is that relating to responsibility, however this data highlights that the participants already at T0 were adhering to the pharmacological treatment and were attentive to the care of their psycho-physical health, in fact the maximum score attributable in this scale is equal to 20. The specific Items indicate that the participants are: more attentive to their personal hygiene, they are able to manage the economic resources available more adequately, they are able to solve practical and interpersonal problems more effectively, they have broadened their range of their interests, the social relationships between the participants appear to be more supportive and the social network is also wider than in the period preceding the start of the Project.

The improvement of mental health, from a Recovery perspective, is in fact based on the possibility of taking advantage of socio-professional contexts in which users and operators have the opportunity to experience significant and emotionally invested relationships, rebuilding a social support network capable of conveying Personal empowerment and to encourage cultural and civil evolution which can, in turn, translate, for each user, into a form of existence that is as rewarding and satisfying as possible, starting with the improvement of the quality of life, through the care and support of emotional relationships and job placement.
This cooperative firmly believes that activities such as the "Small Social Laundry" can improve the quality of life of people with mental illnesses. The co-presence of this type of project with interventions based on scientific evidence is essential so as remove this to be able to guarantee an effective recovery-oriented path that actively promotes the patient's reintegration into the relevant social and working context.

In conclusion, the experiment highlighted that theoretical-practical training courses and participation in a corporate organization promote social cohesion and desensitization to prejudice and exclusion. Through work, man not only satisfies his material needs but also his most intimate and profound ones. Through work there is the abandonment of the "role" of psychiatric patient in favor of the consequent reappropriation of the sense of person and citizen which completely exploits residual abilities and builds new ones. The only criticality replace found is the organizational one. These projects should be activated by the national health service and not by individual bodies, this over time translates into "good recovery paths" like wildfire which determines a diversification of social and health services received based on the region or facility where the person with a mental disorder is placed.

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