INTRODUCTION

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Treatment of schizophrenia has recently undergone radical changes, not only in terms of our understanding and use of effective and appropriate interventions but also in shortening the gap between research and routine clinical practice. These aspects are very relevant as they reduce the gap between pure research and the real-world. A researcher can be a clinician, with all the intrinsic complexities that involves, and a clinician can contribute to the development of new knowledge that is useful for different cohorts of patients and in different settings of care. Ultimately, both evidence and experience find new and fruitful points of convergence that can lead to effective, appropriate and sustainable treatments and interventions. In this sense, psychiatry has become a modern science and assumes the contradictions and challenges of modernity by increasing its ability to pursue rehabilitative therapeutic approaches. Such changes allow for reflection on the different techniques and interventional settings:

- techniques are important in the effort to combine psychopharmacological, psychotherapeutic and psychosocial interventions into a truly integrated approach that considers real scientific evidence together with new clinical evidence (through practice monitoring tools, from clinical records to case reports and audit of clinical systems);
- interventional settings are important, not only as places, but also as networks and treatment pathways that are flexible in relation to the stage of disease, treatment goals, contexts and the individual characteristics of the patient.

In this sense, a 'new' clinic cannot avoid tests of its appropriateness. Such a concept in health care develops within the sphere of the epistemological theory of complexity and its effects in the field of public health. In this dimension, appropriateness emerges as an indispensable feature of health care interventions, integrating efficacy and efficiency, and can be defined as "a component of the quality of care that refers to the technical-scientific validity, acceptability and pertinence (relative to individuals, circumstances, places and the current state of knowledge) of health care". In particular, clinical appropriateness refers to the indication or performance of a health care intervention in a way that the chances of benefits outweigh the potential risks. If it is evident that ineffective intervention may not be appropriate, clinical appropriateness measures the individual effectiveness of the patient's needs and clinical complexity, as well as the expected effectiveness on population cohorts based on clinical issues, setting and abilities of health care systems.

Such a clinical approach departs from the limitations of merely waiting and becomes an active clinic, capable of combining an "individualized" approach with a "public health" approach, i.e. considering both public health and the population. It is capable of defining priorities, not only of an individual treatment but also of service policies; e.g. early

treatment and intervention in adolescence and pre-adolescence.
Thus, it is possible to assess the success of new approaches in adherence, patient knowledge and active participation of patients in treatment, as well as resistance to treatment (which cannot be easily explained by lack of response to a drug, but often by a complexity of genetic factors, on which significant results from pharmacogenomics research can be expected towards greater personalization of treatment, based on individual settings), "recovery", intended as finding oneself and in the experience of suffering and disease.
Thus, clinics will have to take greater responsibility in activating processes that give more weight to these issues, which may have the peculiar effect of breaking pessimistic and stigmatizing dogma regarding psychiatric disorders and psychiatric patients, which is still widespread in the population, and even among health care providers.
This clinic takes on the challenge of mind-body unity, considering various forms and pathways related to the organization of services, care and protection of the body: attention to lifestyle, especially in psychiatric patients with severe mental illness; complete protocols for monitoring side effects and/or adverse events, with attention to individual and hereditary risk factors as well as those related to treatment (from drugs to cognitive psychotherapies), refusing to refer to a hierarchy of "acceptability" of the disability, but defining it with the patient and his or her culture and identity.
Up to now, the main goal in the treatment of schizophrenia has been rapid reduction of symptoms in the short term and reducing the risk of recurrence, together with the burden on physical, social and economic factors, because recurrences and re-hospitalizations increase refractoriness to treatment, modify brain morphology and progressively reduce the possibility of the patient returning to baseline levels of functioning. However, the introduction of atypical or new-generation antipsychotics and long-acting injectable (LAI) formulations, such as the current available LAI (paliperidone palmitate) administered quarterly, has been, and will be, a remarkable step forward in the pharmacological approaches to schizophrenia. With this class of drugs, clinical trials have begun to look beyond pure symptomatic efficacy to include cognitive aspects, social functioning and quality of life, leading to the adoption of broader and more ambitious therapeutic targets. Indeed, today, remission of symptoms and, ultimately, functional autonomy and social functioning represent higher goals in the longer term, but nonetheless achievable in the treatment of schizophrenia. The picture that has emerged shows a significant advantage of maintenance therapy for schizophrenia, especially in terms of being more effective on negative and affective symptoms, recovery of social skills and reduction of adverse effects. Pharmacological treatment, in particular with atypical antipsychotics in LAIs, represents the therapeutic means to not only achieve remission but, together with psychosocial interventions such as family psycho-education, social skills training and cognitive behavioural therapy, also significantly decrease symptom recurrence and promote functional recovery of patients with the ultimate goal of rehabilitation.