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The lexicon of restraint: ethnic bias, institutional coercion, and structural harm in the Italian mental health system — the preventable death of Abderrahim Fakir

Abstract

This article reconstructs, through a multidisciplinary analytic approach, the events leading to the recent death of Abderrahim Fakir, a 43-year-old Moroccan man living in Italy, which demonstrates how a profoundly mishandled psychiatric crisis resulted in a preventable fatality. Fakir was a husband and father in precarious social and economic conditions with documented medical vulnerabilities, including episodes of psychological distress with no consistent follow-up. His crisis unfolded within a context marked by isolation, limited access to care, and the structural difficulties experienced by many minority groups and immigrants. The reconstruction draws on forensic findings, verified video documentation, eyewitness accounts, and contemporary psychiatric and human-rights literature.

Fakir's death needs to be contextualized within a broader landscape of systemic incoherence: a mental-health system weakened by chronic underfunding, decades of health-care cuts, and the erosion of social determinants of health, a crisis-response apparatus overly reliant on police intervention, and custodial institutions where pharmacological and physical restraint have come to replace relational care, capable of interpreting distress as a result of precarious psychosocial conditions and not as a threat.

The article introduces the concept of custodial biopolitics to describe the medicalization of control in prisons, migrant detention centers, and psychiatric wards, where sedation and containment are used to compensate for structural deficits rather than to address human suffering.

It examines how structural violence, ethnic bias, ethical failures, and the erosion of relational, trauma-informed, and culturally competent practice converge to produce coercive responses and misinterpretations of distress. Drawing on international crisis-response models, the analysis highlights Italy's critical absence of peer-support specialists and relational infrastructures capable of de-escalating crises before they become fatal.

The analysis also aligns with ongoing civil society efforts—such as those advanced by Diritti alla Follia ("Rights to Madness"), a grassroots organization that documents coercive psychiatric practices and advocates for rights based, culturally competent crisis response reforms. Their work illustrates how community driven advocacy can complement structural change, including proposals for safer psychotropic tapering, improved crisis interpretation, and reform of involuntary treatment procedures.

Fakir's death reflects a deeper ethical drift. The article concludes with structural recommendations to rebuild crisis response around dignity, relationality, cultural competence, peer-support infrastructures, outlining a pathway toward a system capable of understanding distress rather than reproducing harm.

Keywords: custodial biopolitics, coercive psychiatry, ethnic bias, involuntary treatment (TSO) reform, peer-support specialists, crisis intervention, structural violence, Italian mental-health system, social determinants of health

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Introduction: A system that misinterprets distress

Italian psychiatry is defined by a profound contradiction. The Basaglian revolution dismantled the asylum and opened the possibility of a psychiatry grounded in dignity, relationality, and social justice.[1] Basaglia's project—often described as democratic psychiatry—culminated in the 1978 reform law (Law 180), which closed psychiatric hospitals and established community-based care as the ethical and institutional foundation of the national system. Yet the decades that followed have witnessed a slow erosion of that vision.[2] What remains today is a hybrid model that invokes Basaglia's legacy while simultaneously operating through a biologically driven framework that has consistently failed to interpret or respond to emotional distress in a relational, contextual, or ethically grounded way.[2] The promise of relational care has been displaced by a system that manages symptoms, regulates behavior, and compensates for institutional fragility through pharmacological and custodial interventions.[2,11]

This drift is visible across the entire mental-health system. Services are fragmented and chronically underfunded,[2] leaving community infrastructures unable to sustain continuity of care. Emergency departments absorb crises they were never designed to interpret, functioning as default psychiatric triage sites despite lacking the relational, interpretive, and clinical capacities needed to understand distress within its experiential, interpersonal, and cultural dimensions.[2]

Residential Facilities for the Execution of Security Measures (REMS) operate near capacity, struggling to balance therapeutic aims with custodial pressures.[3] Community mental health centers, weakened by limited staffing and inconsistent protocols, are forced into reactive rather than relational modes of intervention.[2] In this vacuum, police have become de facto first responders to psychological suffering because the system has failed to build alternative pathways for crisis interpretation.[4] Within this environment, distress is routinely filtered through custodial logic, vulnerability is reframed as a threat, and coercion becomes normalized as an institutional reflex rather than an ethically grounded response to suffering.[4,11]

The death of Abderrahim Fakir exposes this drift with painful clarity. Fakir died on July 19, 2026, while under police restraint in Bologna, Italy.[6] The publicly available video documenting his final minutes shows him face down, restrained, showing clear difficulty in breathing, while officers hold him down and paramedics stand nearby.[6] His life, like that of many migrants subjected to structural marginalization, was shaped by a context of social exclusion, bureaucratic obstacles, and the chronic erosion of the social determinants of health.[5]

The video's relevance lies in how clearly it illustrates the mechanisms shaping the intervention: rapid escalation in the absence of clinical assessment, reliance on physical immobilization, and failure to recognize the well-documented physiological risks associated with prone restraint.[7] It is essential to acknowledge the possibility of ethnic bias, not as a rhetorical gesture but because international and Italian research consistently shows that individuals from minority or immigrant backgrounds are more likely to have their distress interpreted through the lens of dangerousness.[8]

In psychiatric and crisis-response practice, dangerousness is frequently shaped by institutional habit that misclassifies emotional dysregulation, fear, or confusion as threats requiring containment. This is a structurally abnormal practice, unsupported by clinical evidence and sustained by custodial logics.[8]

This interpretive paradigm is extensively documented. Studies from the United States, the United Kingdom, and several EU countries show that minority individuals are between two and four times more likely to be subjected to coercive interventions during mental-health encounters.[8] Italian data mirror this pattern: national and regional analyses confirm that foreign nationals are disproportionately represented in episodes involving physical restraint, emergency sedation, and police-mediated psychiatric transport.[8] Research from Lombardy, Emilia Romagna, and Lazio further demonstrates that immigrant patients are more frequently triaged as "agitated" or "potentially aggressive," even when their clinical presentations do not differ significantly from those of Italian nationals.[8]

These findings matter because they show how rapid, pressure-driven judgments—often made without adequate relational or clinical evaluation—distort the meaning of distress.[4,8,11]

This article reconstructs Fakir's final hours using forensic data, verified video documentation, eyewitness accounts, and contemporary psychiatric and human-rights literature.[9] But reconstruction alone is insufficient. Fakir's death must be understood within the structural landscape that made it possible: a landscape shaped by custodial biopolitics,[10–12] ethnic bias,[8] misinterpretation of distress,[8] and the medicalization of control.[10,11]

Background and initial presentation

Emergency calls reported a man in acute distress near a central intersection in Bologna. Witnesses described Fakir as agitated, disoriented, and shouting—behaviors consistent with a severe psychological crisis.[6] Several bystanders attempted to engage him, but he appeared unable to process their efforts or regain behavioral control.

Fakir lived with documented medical vulnerabilities—cardiac fragility, prior myocardial stress, and episodes of respiratory difficulty[7,16]—and significant psychological distress that was never understood within his experience with health care services, given his social and migratory background.[6] These intertwined conditions did not make his death inevitable, they made a trauma-informed, clinically competent response indispensable.

Police arrival and misinterpretation of distress

Police arrived within minutes. Their initial approach was cautious but lacked any structured de-escalation strategy. No mental-health crisis team was present—an absence consistent with national patterns in which police, not clinicians, become first responders to psychological distress.[4]

Verified video documentation shows Fakir in acute psychological distress: frightened, disoriented, and repeatedly seeking assistance.[6] His behavior reflects a state of severe dysregulation—agitated, confused, and unable to regain control—but it is not aggressive or threatening. Contemporary forensic and clinical evidence confirms that he was experiencing a psychophysiological crisis rather than a violent episode.[7,9,16]

His distress was nonetheless interpreted through a lens of danger rather than vulnerability. A trauma-informed approach—which recognizes that fear, disorientation, and dysregulation often reflect prior adversity and require calm engagement, grounding, and relational safety—was entirely absent. Officers clearly lacked trauma-informed training, structured crisis-intervention protocols, and culturally competent frameworks to understand the meaning of his behavior.[4,14,15,18] Instead, their actions followed a custodial logic that prioritized containment, immobilization, and control over assessment, de-escalation, or clinical interpretation.[10–12]

The restraint procedure

Eyewitness accounts and video evidence converge on a critical point: police intervention transformed a survivable crisis into a fatal one.

The video shows Fakir already on the ground, prone, his chest pressed against the asphalt. Two officers are positioned on his back and hips. His arms are restrained behind him. A passerby is enlisted to hold his ankles. Paramedics stand nearby but do not intervene.[6]

Fakir repeatedly cries "Basta, aiuto" ("Stop, help"), his voice weakening as his respiratory distress intensifies until it ceases entirely.[6]

No officer repositions him. No one checks his airway. No one rolls him onto his side. No one monitors his breathing. No one responds to his distress.

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Clinical mechanisms of collapse

The clinical mechanisms that place individuals at risk during prone restraint were all present in Fakir's final minutes. Modern forensic and physiological research shows that the combination of prone positioning, chest compression, heat exposure, and intense emotional agitation creates a high-risk scenario for collapse.[7,9,16] Prone restraint restricts diaphragmatic movement and chest wall expansion, producing progressive ventilatory inefficiency, severe fear and dysregulation amplify autonomic arousal and metabolic demand, underlying cardiac fragility increases susceptibility to arrhythmia when hypoxia and acidosis develop, and the catecholamine surge triggered by terror, physical struggle, and respiratory compromise can precipitate myocardial stress and destabilize cardiac rhythm.[7,9,16]

These mechanisms are not abstract physiological possibilities—they describe the conditions under which Fakir was restrained. His observed deterioration—slowing movements, weakening, and eventual cessation—corresponds to the onset of ventilatory compromise and impending collapse. Yet the restraint was maintained without modification, allowing these well-documented pathways of physiological failure to progress unchecked.

Autopsy findings

The autopsy findings align directly with the clinical mechanisms described in the previous section. The report confirms that positional asphyxia, thoracic compression, and acute cardiac decompensation were the immediate contributors to Fakir's death.[7,9,16] These are the same physiological pathways activated when a person with pre-existing cardiac fragility, respiratory vulnerability, and acute psychological distress is placed in a prone, weight-bearing restraint. Modern forensic literature shows that such restraint impairs ventilation, increases the work of breathing, and destabilizes autonomic and cardiac function—effects that are amplified in individuals already experiencing fear, agitation, or metabolic stress.[16]

In Fakir's case, the restraint procedure interacted directly with his known vulnerabilities, producing a cascade that the autopsy documents with clarity. He did not die from an underlying disease process. He died because the intervention applied to him was physiologically incompatible with his medical condition and ethically incompatible with any trauma-informed standard of care.

A preventable death and the systemic failures that enabled it

International comparisons help clarify the dynamics at play. The killing of George Floyd in Minnesota shares critical features with Fakir's death: misinterpreted distress, race-based assumptions about behavior and personal history, prone restraint, chest compression, and lethal immobilization. Both cases demonstrate how custodial logics and physiologically dangerous restraint techniques converge with interpretive biases shaped by race to produce preventable fatalities.

At no point did the system activate a coordinated crisis pathway. No trauma-informed de-escalation was attempted. No clinician intervened to assess cardiopulmonary risk. No peer-support specialist was present to interpret distress through relational knowledge. Instead, the response relied on force, improvisation, and a custodial logic that treats dysregulation as defiance and vulnerability as threat. The failure to identify the critical transition—from restraint to respiratory compromise—reflects a profound absence of clinical judgment and engagement.[7,9,16]

The reconstruction of Abderrahim Fakir's final hours reveals more than an individual tragedy. It delineates an institutional environment in which distress is routinely misread and coercive procedures are triggered in place of clinical assessment. These patterns reflect a system shaped by underinvestment, conceptual drift, race-based assumptions, and the erosion of relational infrastructures. Fakir's death must therefore be understood not only as a clinical event but as part of a broader continuum of restraint that spans psychiatric wards, emergency departments, public streets, prisons, and migrant detention centers.

Chronic underinvestment is the first structural mechanism shaping this continuum. Italy allocates only 2.69% of its national health budget to psychiatry—far below international standards[13] and insufficient to sustain a system capable of responding to complex psychosocial distress. Decades of liberal austerity policies have further deteriorated the social determinants of health[5]: unstable housing, labor precarity, fragmented care pathways, and limited access to culturally competent services. For migrants like Fakir, these conditions amplify vulnerability and reduce access to preventive care.[5]

Yet coercion does not arise solely from scarcity.

As Giorgio Antonucci long argued, coercion persists when distress is interpreted as threat. This dynamic aligns with the custodial drift identified in the Italian deinstitutionalization literature[2] and with contemporary evidence from carceral psychiatric settings.[11]

Underinvestment intensifies this pre-existing custodial logic: emergency departments become the default entry point for crises,[4] psychiatric wards operate under pressure,[2] REMS facilities struggle with capacity,[3] and police are routinely summoned to manage situations requiring clinical, relational, and cultural competence rather than force.[4] In such a landscape, escalation is not an exception, it is structurally predictable.

A second mechanism is the biomedical orientation that has come to dominate Italian psychiatry. Over the past two decades, the system has drifted toward a biologically weighted model in which psychotropic medications are used not only to treat illness but to regulate behavior, maintain order, and compensate for institutional deficits.[11] Sedation becomes a substitute for relational care, diagnostic focus replaces contextual understanding. This drift stands in tension with Basaglia's insistence that diagnosis must never eclipse the person,[1] and with Antonucci's broader critique of psychiatry as a system that medicalizes suffering rather than interpreting it.

The work of Diritti alla Follia has been crucial in documenting how pharmacological drift harms individuals, families, and communities. Evidence from Italian institutional mental health settings shows that coercive interventions remain embedded in routine practice. Trattamento Sanitario Obbligatorio (TSO), Italy's procedure for involuntary psychiatric treatment—typically involving compulsory hospitalization and medication, often with police transport— together with forced sedation and mechanical restraint, continues to operate beneath the surface of a system that claims to have moved beyond the asylum.[11,14] This pattern underscores the need for safe tapering protocols and psychosocial interventions capable of addressing relational and cultural dimensions of distress rather than merely suppressing symptoms.

A third mechanism is the misinterpretation of distress, particularly when expressed by immigrants and individuals from racial minority backgrounds. Epidemiological data show that involuntary treatments range from fewer than five to more than thirty per 100,000 inhabitants,

with higher rates among immigrants.[8] Mechanical restraint occurs in four to twelve percent of psychiatric admissions, again with disproportionate representation of foreign nationals.[8] In prisons, immigrants constitute 32% of the population despite being 9% of the general population.[11] In Centri di Permanenza per il Rimpatrio (CPRs), Italy's immigration detention centers used for holding individuals pending deportation, sedatives and antipsychotics are frequently administered without adequate diagnostic evaluation, often as a response to distress or protest rather than clinical need.[11]

These patterns reveal a structural landscape in which ethnicity influences clinical thresholds for coercion—a dynamic consistent with international human rights literature, including reports by the United Nations Special Rapporteur on Torture and the Council of Europe's Committee for the Prevention of Torture (CPT).[4] Distress expressed by marginalized ethnic groups is more likely to be feared, misinterpreted, and met with force.[8,17]

For Fakir—an immigrant man with respiratory vulnerability, episodes of psychosocial distress, and limited access to consistent medical care—these structural biases shaped how his crisis was interpreted. His agitation was read as aggression,[6] his confusion as defiance,[6] his vulnerability as threat.[8] Ethical failures amplified this misreading. In the absence of cultural competence, trauma-informed training, and relational infrastructures, institutions interpret behavior through fear, routine, and institutional habit rather than understanding.[14,15,18] The lack of peer-support specialists further intensifies this dynamic.

Custodial biopolitics further shapes this landscape. In Italian prisons and CPRs, psychotropic medications are routinely used as instruments of containment rather than care.[11] Sedation becomes a behavioral-management strategy, antipsychotics are administered without adequate diagnostic evaluation, mechanical restraint substitutes for relational intervention. As documented in the article *Sedated Behind Bars,* individuals in acute distress are frequently medicated without follow-up, without continuity of care, and without any attempt to understand the social determinants driving their suffering.[11] Medicalization thus silences symptoms rather than addressing causes.

These mechanisms converge to produce a continuum of restraint that spans psychiatric wards, public streets, prisons, and migrant detention centers. Diagnostic frameworks that pathologize distress, institutional cultures oriented toward control, structural underfunding, racial bias, pharmacological overreliance, ethical failures, and the absence of evidence-based implementation all contribute to this continuum.[4,8,10–12] Fakir's death exposes how this continuum functions: misinterpretation, escalation, coercion, and fatality.[6,7,9,16] His respiratory fragility, agitation, and physiological stress were not recognized,[7,16] his distress not understood,[6] and his personhood not acknowledged.

International models demonstrate that this continuum is not inevitable. Programs such as CAHOOTS (Eugene, USA), Street Triage (UK), and PACER (Australia) were created precisely because inappropriate police use of force had led to preventable deaths.[18] Their results show that when crises are met with relational knowledge rather than force, outcomes change dramatically. The common thread across these models is the presence of peer-support specialists—individuals whose lived experience, cultural humility, and relational insight allow them to interpret distress from the inside rather than through institutional fear.

Italy has no comparable infrastructure. Peer-support roles remain marginal, underdeveloped, and insufficiently integrated into crisis response—a longstanding tendency within Italian psychiatry to underestimate the potential contribution of peer workers.[14,15] Their absence leaves a vacuum in which misinterpretation becomes structurally embedded.

This analysis points toward the need for structural reforms—protocols, training, cultural competence, peer-support integration, and the systematic elimination of coercive practices.

Toward structural reform

What is required is a transformation of the conceptual, cultural, and relational foundations of Italian psychiatry. The system must rebuild infrastructures capable of interpreting distress within its social, cultural, and migratory context—and capable of responding without reproducing coercion. This section outlines the clinical, institutional, and policy reforms needed to move toward a crisis-response system grounded in dignity, relationality, and care.

Clinical reforms: Re-centering psychosocial and relational care

A shift toward psychosocial approaches is not an ideological preference, it is a clinical necessity. Distress emerges from social conditions—poverty, migration, trauma, discrimination, isolation—and cannot be medicated away. Over the past two decades, Italy's social determinants of health have deteriorated under liberal economic policies, austerity measures, and repeated cuts to the national health system.[5,13–15] These cuts have weakened community supports and fostered a mental-health landscape increasingly reliant on biological and pharmacological approaches.[11] When social infrastructures collapse, psychiatry is left to manage the consequences of poverty, exclusion, and precarity through medication rather than relational care.

Reform must therefore begin with investment in community-based supports capable of interpreting distress within its sociocultural context. This includes trauma-informed care, culturally competent clinical training, and relational infrastructures able to respond to suffering without reproducing violence.[4,14] The introduction of peer-support specialists is central to this transformation.

Institutional reforms: Integrating peer-support specialists

Peer specialists bring forms of knowledge that cannot be produced through traditional clinical training: lived experience, cultural humility, relational insight, and the ability to interpret distress from the inside rather than through diagnostic abstraction. Their presence changes the meaning of crisis. It interrupts escalation. It humanizes suffering. It creates a bridge between institutions and communities.

In many parts of the world—Canada, the United States, Australia, New Zealand, the United Kingdom—peer specialists have become integral to crisis response, community mental health teams, and recovery-oriented services.[18] Their impact is measurable: reductions in coercion, improved crisis outcomes, enhanced cultural competence, and increased trust between communities and institutions.[18]

Italy has not yet embraced this model. Peer-support roles remain marginal, underdeveloped, and insufficiently integrated into crisis response.[14,15] This absence reflects a deeper cultural hesitation: a reluctance to recognize lived experience as a form of expertise, and

a persistent belief that psychiatric knowledge must remain within the boundaries of professional authority.[2,11] But the evidence is clear. Without peer specialists, Italy cannot build a crisis-response system capable of interpreting distress relationally, culturally, and ethically. Their introduction into the fabric of mental health services is not an accessory to reform, it is foundational.

Policy reforms: Addressing sociocultural determinants and restructuring coercive practices

Reform must also address the sociocultural determinants of distress. Italy's mental health system has long operated as if suffering were primarily biological, ignoring the ways in which migration, racism, poverty, trauma, and social exclusion shape psychological vulnerability.[5,8] The deterioration of social determinants—housing instability, labor precarity, erosion of welfare supports—has intensified this vulnerability.[13–15] The death of Fakir reveals the consequences of this neglect.[6] A crisis-response system that does not understand the cultural meaning of distress will misinterpret behavior, escalate unnecessarily, and reproduce harm.[4,8,17]

The introduction of peer specialists with cultural training—individuals capable of interpreting distress within its social and migratory context—would represent a profound shift toward a more humane and effective model of care.

Implementing policies such as the TSO reform proposal requires not only legislative change but also the cultural and material infrastructure to support it. Proposals emphasizing independent oversight, culturally competent assessment, strict limits on forced sedation, documentation of alternatives, and mandatory involvement of peer-support specialists cannot function within a system dominated by pharmacological logic and weakened by austerity.[11,14,15] Rights-based approaches require relational pathways, community supports, and recovery-oriented infrastructures capable of transforming how institutions interpret distress.

International experience shows that recovery-oriented systems—those in which peer specialists play central roles—are precisely the systems that succeed in reducing coercion, improving crisis outcomes, and shifting institutional culture away from control and toward care.[18]

A three-part policy direction

Policy development must move in three coordinated directions, each addressing a different layer of the system's current failures.

Reducing psychotropic reliance — Crisis response must shift away from sedation-based management and toward psychosocial interventions that can engage the relational, cultural, and contextual dimensions of suffering.[11] Medication should support care, not substitute for it, and pharmacological restraint must no longer function as the default response to distress.

Building a national peer-support infrastructure — Peer-support specialists should become a stable component of crisis teams, community services, emergency departments, and psychiatric wards.[14,15] Their presence introduces lived-experience knowledge into settings where relational understanding is often absent, and helps counteract the interpretive biases that escalate distress into coercion.

Investing in sociocultural competence — Clinicians, police, and emergency responders need training that enables them to interpret distress without reproducing bias or violence.[4,8,17] Sociocultural competence is not an accessory to care, it is a prerequisite for accurate assessment, ethical practice, and non-coercive crisis intervention.

Conclusion: A system that must learn to understand distress

The death of Abderrahim Fakir exposes a profound ethical and structural crisis within Italian psychiatry and its crisis-response institutions. His final hours—reconstructed through forensic evidence, verified video documentation, eyewitness accounts, and contemporary psychiatric literature—reveal not an unpredictable tragedy but the foreseeable outcome of a system that has lost the ability to interpret distress. Fakir's death is not an anomaly. It reflects a structural landscape in which misinterpretation, fear, institutional habit, and racialized assumptions converge to produce coercion rather than care.

Across the sections of this article, a clear pattern emerges. The collapse of the Basaglian vision has left behind a hybrid system that gestures toward relationality while operating through biomedical dominance and custodial control. Chronic underfunding and decades of liberal health-care cuts have hollowed out the mental health infrastructure, weakening the social determinants of health and fostering a psychiatric landscape increasingly reliant on biological and pharmacological approaches.[5,11,13–15] Emergency departments are overwhelmed, REMS facilities strained, and police function as de facto first responders to psychological suffering.[4] Distress is interpreted through diagnostic abstraction rather than relational understanding. Sedation substitutes for care. Mechanical restraint replaces de-escalation. Ethnic bias further distorts crisis interpretation, rendering immigrants and minority individuals disproportionately vulnerable to coercive interventions.[8,17] In prisons and CPRs, psychotropic medications are used to manage behavior rather than address suffering, revealing how custodial biopolitics transforms medical authority into a mechanism of control.[11]

The reconstruction of Fakir's final hours shows how these structural failures converge in real time. His distress was misread as a threat. His vulnerability was reframed as danger. The absence of trauma-informed training, cultural competence, and relational infrastructures left responders unable to recognize the physiological danger of prone restraint or the human meaning of his agitation. The dynamics of immobilization captured in the video—slow, ritualistic, unchallenged—reflect a lexicon of intervention that has become normalized across multiple settings. Fakir's death is one expression of it, but it is not the only one. It belongs to a continuum of restraint that spans psychiatric wards, emergency departments, public streets, prisons, and migrant detention centers.[4,8,10–12]

Yet this continuum is not inevitable. International models demonstrate that crisis response can be rebuilt around relationality, cultural competence, and non-coercive intervention. Programs such as CAHOOTS in Eugene, Street Triage in the United Kingdom, and PACER in Australia emerged from tragedies similar to Fakir's.[18] Their success shows that when crises are met with relational knowledge rather than force, outcomes change dramatically. These models share a common feature: the presence of peer-support specialists, individuals whose lived experience, cultural humility, and relational insight allow them to interpret distress from the inside rather than through institutional fear.

Italy has not embraced this approach. Peer-support roles remain marginal, underdeveloped, and insufficiently integrated into crisis response.[14,15] This absence reflects a deeper cultural hesitation—a reluctance to recognize lived experience as a form of expertise and a persistent belief that psychiatric authority must remain confined

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to professional boundaries.[2,11] But without peer specialists, Italy cannot build a crisis-response system capable of interpreting distress relationally, culturally, and ethically. Their integration is not optional. It is foundational.

The reforms outlined in this article—reducing reliance on psychotropic containment, building national peer-support infrastructures, investing in trauma-informed and culturally competent training, strengthening the social determinants of health, and replacing custodial logic with relational care—are not abstract ideals. They are practical, evidence-based, and aligned with international best practices.[18] They would reduce coercion, improve crisis outcomes, and rebuild trust between institutions and communities. Most importantly, they would honor the ethical imperative at the heart of psychiatry: to respond to suffering with dignity, understanding, and care.

Fakir's death must not be remembered only as a tragedy. It must be understood as a structural event—a mirror held up to a system that has drifted from its ethical foundations. His final hours demand a transformation in how Italy interprets distress, responds to crisis, and understands the human beings at the center of suffering.

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