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THIRD PARTY INTERVENTION

JOINT OBSERVATIONS BY L'ALTRO DIRITTO ODV (ADIR) AND LA SOCIETÀ DELLA RAGIONE ONLUS (SDR)

Application no. 368/21

Ciotta v. Italy

Introduction

1. With letter dated 3 September 2021 the President of the First Section allowed us to intervene as third parties under Article 36 § 2 of the Convention in the Court's proceedings concerning the Application no. 368/21. The decision was made in the interest of the proper administration of justice, as provided in Article 36 § 2 of the Convention.

2. Through this intervention we would like to provide an analysis of the historical and legal process of the reform that led to the abolition of Psychiatric Forensic Asylums (*Ospedali Psichiatrici Giudiziari*, OPG) in Italy, as well as to offer an interpretation of its social and political reasons. We will draw a sociological understanding of the implementation and practical functioning of the reform, stressing the risk of the so-called "net widening" effect[1].

3. By broadly illustrating the principles underpinning the reform which has established a new system of care based on the new Residences for Execution of Security Measures (*Residenze per l'Esecuzione delle Misure di Sicurezza,* hereinafter, REMS), we will explain the practical application of the reform, *i.e.* the "law in action".

4. We will therefore describe the legal framework of the reform aimed at the abolition of Psychiatric Forensic Asylums - OPG (**Section I**), its effectiveness and prospects (**Section II**), the REMS model (**Section III**), the provision of adequate mental health care as the main criterion of choice among different security measures according to the Italian Constitutional Court's settled case-law (**Section IV**), how the reform is currently at risk (**Section V**), the conditions of detention in prisons and the offer of mental health care in prisons in Italy in the light of Articles 3 and 5 of the Convention (**Section VI**).

5. Lastly, we wish to critically discuss the capacity of a "total institution", such as a prison institute, to offer adequate mental health care, particularly in case of serious psychiatric diseases. As we will explain, the patient's informed and free consent is in close relationship to his/her compliance to the treatment, which is essential to its success. These conditions are in patent contrast with the control-based approach typical of total institutions. This applies in prisons (where it is evident) as well as in REMS, if these facilities are not connected with the social and health care services operating in the community. Therefore, the enforcement of the *extrema ratio* principle for custodial measures, interpreted in the light of the Italian Constitutional Court's (hereinafter, ICC) settled case-law, is essential to effectively implement the reform, avoiding one of the most relevant risk: the shortage of beds in REMS and the "waiting list" phenomenon.

6. We will final suggest general measures of intervention, focusing on the reasons underlying the phenomenon of the shortage of beds in REMS (such as the increased attitude of the Judiciary to use custodial measures instead of non-custodial ones).

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[1] Stanley Cohen, *Vision of Social Control* (Polity Press, Cambridge, 1985), p.41-42

Section I - The legal framework. The principles underpinning the reform and the abolition of Psychiatric Forensic Asylums (OPG).

7. In order to understand the background of the issues posed by the case *Ciotta v. Italy*, it seems fundamental to outline the current legal framework and underline the great changes produced in Italy by the reform, started in 2012, which has abolished Psychiatric Forensic Asylums (OPG). The Italian criminal system provides two different responses to crime through the so called **"double track" system** (*sistema del doppio binario*): **penalties** for "mentally sane" offenders and **security measures** for "mentally insane" offenders, acquitted by reason insanity and contextually considered "socially dangerous" (pericolosi socialmente).

8. Until the **ICC's decision n. 253/2003**, the only measure that could be applied to socially dangerous mentally ill offenders was the confinement in OPG. The OPG was a total institution, similar to a prison institute, in which the person could be detained for an indeterminate period of time. The appalling material conditions of life in this kind of institutions were denounced by journalists, NGOs, national and international institutions, such as the CPT[2], as in violation of Article 3 of the Convention. Moreover, the OPGs were not capable to offer adequate mental health care, particularly if compared with the standards of mental health care available in the community mental health services.

9. In 2003 the Italian Constitutional Court (ICC) declared that the placement in OPGs (as the only solution for offenders acquitted by reason of insanity), was unconstitutional and affirmed two principles: **the *extrema ratio* of custodial security measures (measure of last resort principle) and the primacy of the right to health over social protection needs**. As we will see (section IV), the ICC stated that the right to health of the insane offenders cannot be restricted for any social protection reason, and hence an adequate health treatment (at least equal - however not worse than - the offer of treatments in the outside society) has to be provided, even when the most restrictive measure is applied. In this way the ICC established the preeminence of the right to health over social protection needs principle at the core of (and as an internal limit to) the "extrema ratio" principle of custodial security measures (custodial measures as last resort). The ICC suggested to widen the offer of security measures with **non-custodial security measures called "*libertà vigilata*"** and ruled that the **non-custodial measure should always be preferred over the custodial one.**

10. As a result, in 2012, the Italian Parliament abolished the OPGs and established a new system of "community mental health care", in which REMS were included as a "last resort" custodial measure. Offenders acquitted by reason of mental insanity are now primarily considered patients: their right to health should be protected following the principle of equality with all the other citizens. This means that mental health care in the community services should be provided as a rule, following the principle of the best available care. This is why **these offenders should be treated in therapeutic facilities or should be treated at home, following the therapeutic planning and under the supervision of the Community Mental Health services.**

11. The reform (Law n. 9/2012 and subsequent Law n. 81/2014) pursues some basic principles in contrast with the "old model" of OPGs. First of all, the law implemented the **principle of *extrema ratio* of custodial security measures** to ensure, whenever possible, a treatment free from deprivation of liberty. As a consequence, the judge should apply the non-custodial measure called "libertà vigilata", a measure that can be individually tailored and adjusted by means of provisions and prescriptions able to take into account and deal with the specific degree and kind of social dangerousness. Only when no other measure is fit to the social protection aims in each and every individual case, **the judge may resort to a custodial measure, if, and only if, this is adequate to the most appropriate treatment for that person**.

12. In this context, the REMS facility represents the **liminal institution of a complex system of care for the mentally ill offenders, focused on a community-based, holistic and recovery oriented approach**. Moreover, the law has established a **maximum length for the measures**. In the new model, the confinement in the REMS should not only be exceptional, but also limited in time and functional to a personalized treatment program (**Individual Therapeutic Rehabilitative Plan**) aimed at the release and social rehabilitation of the person. Moreover, the law determined that REMS should be put **under the responsibility and management of the regional healthcare system** (instead of the Ministry of Justice), with a staff of Health professionals, without any police inside the facility. Finally, REMS should allocate a

[2] See the Council of Europe – European Committee For The Prevention Of Torture And Inhuman Or Degrading Treatment And Punishment Reports: 31 janvier 1995, CPT/Inf (95) 1; 4 décembre 1997, CPT/Inf (97) 12 [Partie 1]; 29 janvier 2003, CPT/Inf (2003) 1; from 14 to 26 september 2008, CPT/Inf (2010) 12; from 14 to 18 June 2010, CPT/Inf (2013) 30 [Part 1];

limited **number of patients** (maximum admissible concentration principle) for each facility, fixed by law and inviolable in order to ensure a good level of care and a lower degree of institutionalization.

Section II – Effectiveness and perspectives of the reform.

13. The reform represents a real rights-based advancement in the treatment of offenders acquitted by reason of insanity, even higher than the European standards. A lot of national institutions and organizations, such as Superior Judicial Council (CSM)[3], National Bioethics Committee (CNB)[4] and the Constitutional Court (sentence 99/2019) have acknowledged the positive effects of the reform.

14. The core principles of the reform (such as the admission to REMS as *extrema ratio,* the sanitary management of REMS, the maximum admissible concentration principle, the fixed time limits for the security measures) have helped not to replicate the systematic violation of rights for offenders acquitted by reason of insanity.

15. However, the system is showing some flaws in the practical application of the law. The number of custodial security measures in REMS decided by the Italian judiciary has constantly increased during these years and the **percentage of preventive custodial security measures** have reached the level of 43,7% out of the total security measures, as of 30th November 2020[5]. It is worth noting that in 2012, 1094 persons were held in OPGs[6] but not all of them were executing security measures[7]. As of 2021, 621 persons are held in REMS and another 770 are included in waiting lists[8]. These data show a paradoxical situation where the **total number of people under custodial security measures today appears to be higher than the same number at the beginning of the reform process**. Besides, in order to better understand the consistency of that number, we should take into account the fact that the turn-over of people interned in OPGs used to be extremely low (such as the phenomenon of "lifelong sentence" security measure, so called "*ergastoli bianchi*", showed), whereas the turn-over in the REMS system is much higher, as data show. Since the opening of REMS facilities (from 01/04/2015 to 11/03/2019) until March 2019, 1580 people have been admitted to REMS, while 1029 persons have been dismissed (that means 65,1% of those admitted). Total "re-entries" were 51 (the 3,2% of those admitted)[9].

16. The **principle of *extrema ratio* seems to be scarcely and misleadingly applied**. A research recently carried out by La Società della Ragione on a sample of psychiatric reports of patients held in the REMS of Castiglione delle Stiviere, shows that the judge ask to the expert questions about the most adequate measures to apply to the offender only in 54% of the cases. We can therefore assume that quite often judges do not consider the possibility to apply a non-custodial measure and tend to use custodial security measures as a first option. Unfortunately, this trend risks to jeopardize the rationale of the reforms, the nature of this kind of facilities and the lawful application of *extrema ratio* principle.

17. As of 19 April 2021, 770 people were included in the waiting lists to be admitted to a REMS, and 65 of them were unlawfully detained in prisons[10]. These figures do not allow a satisfactory and comprehensive assessment of the situation: from data collected from the Regions monitoring, we know that most of the people in the waiting lists are receiving mental health care in community facilities (therapeutic communities in particular) and none of them has been left without health care. **The most important shortcoming appears to be the lack of a national monitoring system, which could improve the coordination of the offer of beds in REMS at the national level, so as to significantly reduce the waiting lists**. The high number of people in waiting lists does not mean that the available places in REMS are insufficient or that REMS facilities should increase the number of patients, abandoning the "maximum admissible concentration" principle. Not only **this solution would be ineffective, more importantly it would be illegitimate**. As the UNODC *Handbook on strategies to reduce overcrowding in prisons* affirms: "As

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[3] See Consiglio Superiore della Magistratura, *Direttive interpretative e applicative in materia di superamento degli Ospedali Psichiatrici Giudiziari (OPG) e di istituzione delle Residenze per l'esecuzione delle misure di sicurezza,* 19 aprile 2017.

[4] See Comitato Nazionale di Bioetica, *La cura delle persone con malattie mentali: alcuni problemi bioetici,* 21 settembre 2017.

[5] See Progetto di ricerca Smop, Università degli Studi di Torino.

[6] Data of Minister of Justice.

[7] In the old OPG facilities, there could be confined persons under security measure and prisoners who developed mental diseases during the detention in prison.

[8] Data from Garante Nazionale dei diritti delle persone detenute o private della libertà personale, *Relazione al Parlamento 2021.*

[9] S. Cecconi, P. Pellegrini, "Osservatorio sulle REMS: primo report", in F. Corleone (a cura di), *Il muro dell'imputabilità. Dopo la chiusura dell'Opg, una scelta radicale*, Fiesole, Fondazione Michelucci Press, 2019, p. 72

[10] Data from Garante Nazionale dei diritti delle persone detenute o private della libertà personale, Relazione al Parlamento 2021. As said, the most of these people are receiving mental health care in community facilities, while waiting to be admitted to a REMS . See F. Corleone, *Seconda Relazione Semestrale sulle attività svolte dal Commissario unico per il superamento degli Ospedali Psichiatrici Giudiziari*, 2017, p. 45.

appealing as it may seem, building additional accommodation has proved to be a generally ineffective strategy for addressing overcrowding. Evidence shows that as long as the shortcomings in the criminal justice system and in criminal justice policies are not addressed to rationalize the inflow of prisoners, and crime prevention measures are not implemented, new prisons will rapidly fill and will not provide a sustainable solution to the challenge of prison overcrowding. Therefore, the lack of prison infrastructure should not be regarded as the principal 'cause' of overcrowding, but often as a symptom of dysfunction within the criminal justice system".

18. If we want to **focus on the causes,** we should **take into account the prevalent attitude of the Judiciary to choose the custodial security measures to manage offenders affected by mental disorders as well as the hypertrophic number of provisional custodial security measures**. These obstacles could be eliminated by fully implementing the principle of *extrema ratio*, read in the light of the principle of appropriateness stated by ICC case law (as better explained in Section IV), so as to comply with the core principles and contents of the reform.

19. A further step to solve this problem is to reform the "double track" system. It is relevant to inform the Court that a bill, concerning the criminal liability of mentally ill offenders, has been presented to the Italian Parliament (Camera dei Deputati) on March 11th 2021. The bill (A.C. 2939) will be discussed in the next future. This reform of the Italian criminal code is a relevant perspective in order to determine a possible general measure able to solve the issue of unlawfully detained psychiatric patients. On a wider perspective, the bill addresses the general issue of mental health care in prisons, providing a valid response to all persons with psychiatric disorders detained in prisons, according to the principle of the equal access to health care inside and outside the prison. Furthermore, affirming the penal liability of mentally ill offenders, the bill recognizes the **equal right to justice of disabled people, mentally disabled included, consistently with the provisions of the United Nations Convention on the Rights of Persons with Disabilities** (2006)[11].

20. Recently, the president of the Scientific Committee of La Società della Ragione, Franco Corleone, has been appointed (by Ministerial decree of 22 September 2021) as a member of a new public body of coordination of the REMS system (namely *Organismo di coordinamento relativo al processo di superamento degli ospedali psichiatrici giudiziari*). This body gathers members from the Ministries of Health and of Justice, as well as members from regional authorities, with the task of monitoring and coordinating regional action about the REMS system in order to fully implement the reform that led to abolition of Psychiatric Forensic Asylums (OPG). This is a relevant perspective if we consider that some of the analysis and proposal included in the present opinion will constitute the core debate within the works of this body.

Section III – The REMS model.

21. We firmly believe that REMS have a therapeutic quality that the prison is not able to offer. REMS have been designed with the aim at **providing high quality standards of mental health treatment and care**, following the model of **community-based mental health services**. These facilities have been inspired by the Italian anti-asylum movement which led to the elimination of the psychiatric asylums in 1978. The therapeutic approach followed within the REMS is based on the **'recovery model**, where physical restraint is discouraged and communitarian activities are promoted, both inside and outside of the REMS premises. This approach is founded on the belief that **the healing of patients can be only accomplished by minimizing the restraint practices**[12].

22. A very original and complex model has therefore been designed and is still in progress. Its mission for the near future is to take steps towards the overcoming of contradictions already existing in the REMS system, such as the **care/custody possible contrast** against the application of health bioethical principles of informed consent and participation in the choice of care by the patient, because a **real change can happen only in a freedom of will context**[13].

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[11] See art. 5, 1 e art.12, 2 of the Convention (*the State parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life). Article 12 guarantees the right to enjoy legal capacity, including both the capacity to have rights and the capacity to act (to exercise rights and responsibilities and make decisions in everyday life*, as explained in the *Implementation Manual for the United Nations Convention*, February 2008.

[12] See C. Di Lorito, L. Castelletti, I. Lega, B. Gualco, F. Scarpa, B. Völlm, "The closing of forensic psychiatric hospitals in Italy: Determinants, current status and future perspectives. A scoping review", *International Journal of Law and Psychiatry*, 55 (2017) 54–63

[13] See P. Pellegrini, "Quale futuro per una 'rivoluzione gentile'?", in F. Corleone (a cura di), *Il muro dell'imputabilità. Dopo la chiusura dell'Opg, una scelta radicale*, Fiesole, Fondazione Michelucci Press, 2019, p. 43-68.

23. As said, REMS are informed by the principles of **community health care**, the **maximum admissible concentration principle** and **external-only control** as laid down by Article 3-ter of Law 9/2012, integrated by Law 81/2014. The community **health care principle** means that REMS must host people living in the regional area where the facility is located in order to keep the inmates in the same physical and social environment where they come from (and will come back to). The community health care principle is also useful to support social rehabilitation, because of the proximity to social services, family and social contacts. The maximum admissible concentration principle means that the allowed number of patients in every facility is determined by law (the ministerial decree 1° October 2012 has established a mandatory maximum of **20 beds in every facility**). When a person is to serve a custodial security measure in a REMS facility with no vacancies, he/she must be put in a waiting list, without placing him/her in the structure by joining beds or compressing spaces. The **external security** control principle means that inside the structure only health professionals are allowed , without any security staff. Surveillance must be carried out outside the facility only.

24. However, as the Italian health care system is organized on a regional basis, **these principles are differently implemented within the different Italian regions**. The REMS system is therefore attributed to the regulatory regional competence, and consequently characterized by a great variety of health care models. Starting from the formal respect of the principle of closed number, some regions have decided to institute different modules inside the same facility in order to multiply the places available. The paradigmatic example of this approach is the REMS of Castiglione delle Stiviere, a system consisting in several modules one next to the other, where 151 people were placed as of 30 November 2020[14] (the whole number of places was 120 in 2018, and people placed were 159)[15]. Other examples are offered by different regional systems where 2 to 4 REMS facilities have been built and are operative (i.e. Campania region: 4 REMS with 88 places, now reduced to 2 REMS with 40 places; Lazio region: 4 REMS with 91 places; Sicily: 2 REMS with 60 places). Other Regions have built only one REMS (ex. Veneto: 1 REMS with 40 places in 2 modules; Trentino Alto-Adige: 1 REMS with 10 places, Sardinia: 1 REMS with 16 places)[16].

25. Moreover, **people in waiting lists are unevenly distributed among regions**. In Sicily 125 persons are currently placed in waiting lists, 122 in Campania, 81 in Lazio, 81 in Calabria, while in other regions the number of people in waiting lists are very low: 10 in Veneto, 5 in Trentino Alto-Adige and 11 in Sardinia [17]. These differences are not in direct relation with the resident population, rather they seem to be related to different health care and judiciary approaches. A very interesting relationship emerges from the analysis of these different models: **regions where more beds are available in REMS, also have more people in the waiting lists**[18].

26. This demonstrates that the **shortage of beds in REMS does not stem from a wrong assessment of needs and consequential insufficient planning**. On the contrary, this shows the so called "net-widening effect": **the more beds are provided, the more beds will be requested**. The need of beds in REMS originates from the institutional dynamic of the provision of beds in REMS. To explain this process, we need to focus on the differences between health care models. A more in-depth research on the functioning of these systems is desirable in order to confirm the hypothesis. While the higher number of beds in REMS seems to be in relationship with approaches that delegate most part of the mental health care to custodial facilities for people bearing mental illness, the more limited number of beds in REMS places is related to approaches that give priority to community-based mental health care within society. A fact is, anyway, evident: **regions with higher waiting list numbers have a low turn-over from the REMS to the community health care services**[19]. Different institutional and medical cultures have given birth to different models, and they still continue to produce differential results.

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[14] P.A. Allegri et al., Progetto di ricerca SMOP - Rapporto di ricerca 2020, p. 19 https://frida.unito.it/wn_media/uploads/reportsm_1619608492.pdf

[15] See E. Tavormina, *Il quadro nazionale delle REMS,* F. Corleone (a cura di), *Il muro dell'imputabilità. Dopo la chiusura dell'Opg, una scelta radicale*, Fiesole, Fondazione Michelucci Press, 2019, p. 41

[16] See E. Tavormina, cit., p. 41; P. Pellegrini, *Liste di attesa per l'esecuzione delle misure di sicurezza detentive: analisi e possibili soluzioni*, in Diritto Penale e Uomo (DPU) - Criminal Law and Human Condition, 3, 2021, ISSN 2704-6516

[17] See Garante Nazionale dei diritti delle persone detenute o private della libertà personale, *Relazione al Parlamento 2020*, 2020, Parte II, Tab. 4.8, p. 240

[18] See P. Pellegrini, cit., p. 6

[19] Ivi, p. 7

Section IV - On the provision of adequate mental health treatment and care as the main criterion of choice when a security measure is to be applied according to the ICC's case law.

27. The protection of health, conceived as an individual right to health care, has played a pivotal role in the reform, and stands as a basic cornerstone of the current legislation. REMS are high quality facilities because of the principles shaping them, but also the whole health care system operating inside prisons is directly engaged in offering (and has the duty to offer) an adequate psychiatric health care to people with mental illnesses, should they be detained in prisons or in REMS. The establishment of the REMS system, indeed, has occurred in the context of a more general reform of the health care system in prisons, previously managed by the Prison Administration, with sanitary staff directly employed by the Ministry of Justice. The process of reform, started in late 1990's and accomplished in 2008, aimed at transferring the competence on the penitentiary health care from the Ministry of Justice to the Ministry of Health and to the regional administrations, in order to make effective the principle of equality of care. Nowadays, health care for any person, both in liberty and in detention, is clearly provided in accordance with the art. 117 Cost., 3° par. of Constitution[20].

28. Furthermore, a fundamental contribution to the shaping of the reform has come from the ICC's case law. From the early 2000s, the ICC has decreed on the legal nature of security measures for offenders affected by mental disorders, focusing on the pivotal role of the right to health care[21]. This has constituted a turning point in interpreting the function of security measures, and it has represented the basic principle for subsequent regulatory changes. The ICC affirmed the therapeutic aim of the security measures (both definitive and provisional) for offenders with a psychiatric disease. The Court has ruled that **the security measures must no longer be seen as primarily aimed at providing security and social protection, but rather at protecting the health of persons with mental disorder.** The core of its reasoning came from its precedents on mandatory health measures to protect public health[22] and on the **principle that the need to protect the community could never justify measures directed to harm, rather than to benefit, the individual's health and well-being**. In the Court's words: "if in practice the coercive measure of internment in a judicial psychiatric hospital proves to be such as to presumably cause damage to the mental health of the patient, it could not be considered justified, even in the name of these needs" (253/2003). The Court put the preeminence of the right to health at the core basis of, and as an internal limit to, the *extrema ratio* principle.

29. As a matter of facts, in these early judgments we find the first statement of the *extrema ratio* principle (later introduced by law 9/2012, art. 3-ter, examined above) affirming that a custodial security measure should only be applied after assessing every other possible option of non-custodial security measures. Even in the case of custodial measure, this must be matched with the most appropriate tratment for that person (**the internal limit of the preeminence of the right to health**). As we have already pointed out, this is the legal leading principle of the whole reform: **the right to health of the individual can never be subordinated to the needs of social protection of the community**. Individual health and collective security are interests that must be balanced in the adoption of security measures: even when the judge adopts a security measure in light of the social dangerousness of the individual, the health protection aim must always be present. This judgment requires an accurate evaluation of the health conditions of the person when deciding to apply a security measure: **the result of the evaluation on the treatment needs of the person should always be reported,** as an essential parameter, in the reasoning drafted by the judge. We are of the opinion that this is the safest way to keep the net widening effect under control, limiting the need of additional places in REMS.

30. Eventually, the normative framework is very clear: in applying the security measure, the judge's choice must be guided by the *extrema ratio* principle, *i.e.* **assessing the most adequate measure for the specific health condition of each patient**. As a consequence, in order to determine the adequateness of a measure, the judge has to know the **individual health needs** through a psychiatric expertise including a comprehensive overview of the available offer of treatment and care in the community (**therapeutic offer**). Starting from this knowledge, provided by the health professionals coming from the community health care

[20] See Law of delegation n. 419/1998, that gave the directive (art. 5) of reorganize penitentiary health care system in order to inscribe it in the national health care system, and legislative decree 230/1999, that gave implementation to delegation and affirmed the principle of equality in the provision of health services between inmates and free individuals. See also DPCM 1st April 2008, that gave complete implementation to the reform and started the transfer of health care services inside the OPG to the regional health care services. The Annex C (Allegato C) to DPCM gave to regions and to Penitentiary Administration, the guidelines to pass the OPG to new regional management.

[21] See, *inter alia*, Italian Constitutional court judgments nn. 253/2003, 367/2004 e 208/2009.

[22] Particularly judgments nn. 307/1990, 258/1994, 118/1996.

system and by psychiatric reports, the judge can determine the most adequate security measure to the specific health care needs of the individual and, only at this point, assess whether the measure is suitable **to manage her/his social dangerousness**. Only if a custodial measure is suitable to this aim, the judge will choose it, always taking into account the health needs and the therapeutic offer.

31. This makes clear that the availability of a psychiatric assessment with the indication **of a suitable therapeutic program**, as well as the **knowledge of the therapeutic characteristics of the available therapeutic facilities** are essential starting points and premises for a judge's decision in order to properly apply the *extrema ratio* principle.

32. With judgment n. 99/2019, again the ICC has addressed the issue of the protection of health for persons deprived of their liberty. The Court has given its comprehensive evaluation of the REMS reform by affirming that this reform represents a **new approach to mental illness, which can be summarised in the transition from mere custody to real therapy**.

33. The ICC has once again underlined the centrality of the protection of the individual's right to health while in detention, with reference to mental health: two conditions in which the constitutional rights are particularly relevant because of the specific **"double vulnerability condition".** The ICC affirmed that **when the illness (and mental illness, particularly) is of a certain severity, the person must have the opportunity to be treated outside the prison, through alternative measures to detention.** Care based on the free and informed consent of the patient is a distinctive element of the ICC's approach, which affirms the dimension of health as an individual right, rather than a duty to be treated. This approach means that the free and informed consent of the person detained is an essential requisite for the application of psychiatric treatment and care, as stated in the program annexed to alternative measure to detention.

34. The ICC's case law on security measures as primarily aimed at protecting the health of person with mental disorder has to be read in the light of the protection of liberty from unlawful detention, as affirmed in Article 13 of the Italian Constitution. Not only Article 13 establishes that **the cases of deprivation of liberty are to be provided by law**, but also **the procedures of the deprivation have to be clearly defined by law**. Each kind of deprivation of liberty has its specific procedure of execution and procedures are not interchangeable, under penalty of violation of Article 13. So, in light of the ICC's case law, the only legal procedure of deprivation of liberty as a result of the application of a security measure is the provision of a treatment aimed, primarily and necessarily, at protecting the health of the person with mental disorder. Only this kind of treatment can be considered in accordance with the constitutional protection of liberty as provided for by Article 13. Only starting from the ICC's interpretation of the legal nature of security measures for criminal offenders with mental disorders, *i.e.* measures with a prevalent therapeutic aim, those measures can be enforced in accordance with the law. As a consequence, the ordinary procedure of execution should be a therapeutic treatment carried out through a non detention measure (such as "*libertà vigilata*") or in freedom status, while the custodial measure can only be applied in exceptional and very residual cases and supported by a psychiatric assessment which should include a suitable therapeutic program.

35. Any decision that does not make reference to the psychiatric assessment, with the therapeutic program included, should be considered unlawful with reference to Art. 13.

36. Unfortunately, the poor information judges usually receive from the Health system makes it quite difficult for decide on the ground of a full the psychiatric expertise. Lack of counselling and support by psychiatric health services and lack of information about the therapeutic offer in the community facilities are unfortunately very common. **A better coordination between the Judiciary and Health Care institutional bodies should be implemented. The lack of such a cooperation is the most important reason for the excessive number of custodial measures in REMS**.

Section V – The reform at risk.

37. The excellent new regulatory framework created by the reform described above is presently at risk of disruption. A new provision of law, introduced in December 2020[23], provides for funding (not very substantial, but symptomatic of a certain political will) devoted to **increase the number of places in REMS, by building new facilities**. The provision of additional places seems to be an **easy remedy to the waiting list problem**, but it would leave the issues underlying the functioning of the reform unsolved, undermining the basic principles of the same process.

[23] Decreto-legge 28 ottobre 2020, n. 137 "Ulteriori misure urgenti in materia di tutela della salute, sostegno ai lavoratori e alle imprese, giustizia e sicurezza, connesse all'emergenza epidemiologica da COVID-19", converted with modifications by the Law 18 dicembre 2020, n. 176: art. 23 quinquies.

38. A question of constitutionality raised by the Court of Tivoli is currently pending before the ICC, challenging the constitutionality of the legislation about REMS. This question aims at **eliminating the maximum admissible concentration and the community-based health care principles, undermining the centrality of the right to health in the treatment of mentally ill offenders, as represented in the exclusive management of REMS by public health authorities.**

39. We believe, on the contrary, that **the centrality of the right to health in the treatment of offenders acquitted by reason of insanity, is the core principle of the whole REMS reform**, which is clearly **embedded in the ICC's case law** as referred above. Moreover, it is the **key principle to the implementation of the reform**. In the centrality of the right to health, we can find a source for the development of practices, regulations and legislation in harmony with the Constitution.

40. Furthermore, we believe that **the idea of increasing the number of beds in REMS is inadequate.** It is sufficient to look at the data on availability of beds and the extent of the waiting lists in different regions as described in Section III, par. 24 and 25. These **data show a direct relationship between the provision of beds in the REMS and the extent of the waiting lists: the higher the number of beds available in REMS, the higher the waiting list numbers and the need of more beds in REMS. This appears to be a clear example of net-widening logic.**

41. Following its first hearing on 26th May 2021, the ICC issued Order 131 of 9th June, deposited on 24th June, focusing on acquiring an in-depth understanding of the REMS system and its functioning. The order asks the main institutional authorities in the field (the Minister of Justice, the Minister of Health and the Regions) a list of questions within three areas of investigation. The first group concerns quantitative and qualitative data on the confinement (letters from a) to f). The second group concerns the identification of specific problems and difficulties in the functioning of the REMS system and about the specific roles of the Ministry of Justice, the Ministry of Health and the Regions, respectively (letters from g) to m). A final question concerns the existence of reform bills (letter n). The institutional authorities have been given a deadline of 90 days to answer (the deadline is currently pending). It is essential to **reaffirm that Italy has to maintain the high standard of protection of rights as provided by the reform, by observing its core principles. This means that increasing the number of beds in REMS and/or opening new REMS cannot represent the effective solution** to the violation of Conventional and Constitutional rights of the applicant (as well as of others in the same condition).

Section VI - Conditions of detention in prison facilities and mental health in Italy in light of Article 3 of the Convention

42. As the Court has reiterated: "in determining whether the detention of an ill person is compatible with Article 3 of the Convention, the Court takes into consideration the individual's health and the effect of the manner of execution of his or her detention on it"[24]. It has then recognised that **detainees with mental disorders are more vulnerable than ordinary detainees** in light of the exacerbated risk that prison life poses to their health, with increased risk of suffering from **feeling of inferiority, stress and anxiety**.

43. It seems relevant, both to decide on the individual case and to reflect on possible general measures, to assess the conditions of detention in Italian prisons and how they are able to affect the special vulnerability of mentally ill inmates.

44. First of all, as a further intertwined dimension of Article 3 and Article 5 § 1 of the Convention, it is appropriate to consider **how much the perception of being detained *sine titulo* in a prison facility (or otherwise unlawfully deprived of liberty) can directly influence and aggravate the risk of feelings of inferiority, anxiety and stress**, even in light of the **inability of fully complain**, for instance due to the lack of effective remedies, about one's condition.

45. The Italian prison system is still suffering from an **overall persistent overcrowding in most prisons**, as showed by the data provided by the Ministry of Justice. Before the spread of the COVID-19 pandemic, on 29 February 2020, the prisons population amounted to 61.230, compared to the 50.931 available accommodations (thus showing the ineffectiveness, in the long run, of the reforms enacted by the Italian Government after the *Torreggiani* pilot judgment). As of today, and due to *ad hoc* reforms specifically conceived for the emergency, the overcrowding rate has been reduced (with a prison population of 53.557, on 31 August 2021). Unfortunately, even the real number of available accommodations has been reduced to an extent which is not entirely taken into account in the official data (due to different reasons, one, very relevant, being the need for special sections dedicated to the detention of persons in quarantine, or

[24] *Rooman v. Belgium*, [GC], Application no. 18052/11; 31 January 2019, §145.

Covid units for the detention of paucysymptomatic or asymptomatic prisoners affected by the virus). Moreover, based on our experience, many prison facilities still face **the problem of multi-occupancy cells designed for 2 prisoners, occupied by 3 prisoners** with an available space of less than 3 square metres of floor space available (or, at best, between 3 and 4 square metres).

46. As for the **material conditions of detention,** very few interventions have been made to improve the structural deficiencies of the Italian penitentiary system. Based on *L'Altro diritto* experience on the field, most prisons show an **advanced state of dilapidation, with widespread damp, lack or inadequacy of basic furniture (such as a closet and locked space), deficient state of hygiene, heating and ventilation appliances reaching the minimum threshold for a violation of Article 3 of the Convention**, especially when coupled with minimum space available and with the total lack (or minimum quantity and quality) of activities available in Italian prisons (and therefore with the majority of the time spent inside the cell or in the corridors of the sections). These conditions are able to affect and deteriorate the living conditions as well as the physical and mental health of ordinary prisoners. This context is even more inadequate for prisoners affected by mental disorders.

47. As regards the **medical treatment**, while mental health issues constitute the majority of health-related issues in Italian prisons[25], Italian prison facilities cannot guarantee a comprehensive therapeutic strategy aimed at treating persons affected by mental disorder due to the dilapidated context and the shortage of mental health professionals. The main problem about the lack of adequate medical treatment and care in prisons stems from the fact that the **security aim always prevails over the therapeutic aim.**

48. The accommodation of a prisoner affected by mental disorder is managed in a variety of settings (from ordinary units to clinical units, from psychiatric units to ATSM[26]), but all of these accommodations have certain **detrimental common factors**: usually a **closed-door regime** is in force, with a very **limited (or no) access to activities** (hence the majority of the time is spent in the cell or at best in the section and not outside) and **CCVT surveillance equipment** (including in the sanitary annexes), metal grilled door closed with a reinforced one open during the day, the **environment is rather carceral due to the strong presence of penitentiary staff throughout all shifts**[27]. Another relevant issue is the use of 'piantoni' as one of the main forms of control and support to prisoners with physical, but also with mental disabilities. The role of 'piantone' in the Italian prison system is hardly describable as care-giver. 'Piantoni' are ordinary prisoners employed by the prison and paid a minimum monthly salary. No requirements of any kind are officially requested for the job of 'piantone, and, what is even more critical, no training or education are provided for by the Prison Administration. Every ordinary inmate can become a 'piantone', as constantly denounced by the CPT[28]. Each of these factors cannot be said to be in conformity with a mentally deteriorated state of health.

49. **As for the treatment**, in the majority of prison facilities the number, presence and quality of mental health professionals are totally lacking. Even in the very few structures where the offer of psychiatric care is adequate, the issue remains the therapeutic aim of the structure. As constantly reiterated by the Court, "the mere fact that detainees are seen by a doctor and are prescribed a certain form of treatment cannot automatically lead to the conclusion that the medical assistance is adequate"[29]. What is completely lacking is **the provision of a comprehensive therapeutic strategy** aimed at **adequately treating** the detainee's psychiatric issues, **preventing their aggravation, rather than addressing the symptoms only.** Furthermore, treatment and care provided within prison facilities must follow the rule (expressed both at a European and at a domestic level) of **equality of care**. This is absolutely impossible in prisons: while the treatment of persons affected by mental disorders in Italy follows a community-based, holistic approach,

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[25] See Agenzia Regionale di Sanità della Toscana, *La salute dei detenuti in Italia: i risultati di uno studio multicentrico*, aprile 2015, pp. 58-59.

[26] As of today, only 34 ATSM are operating within prison establishments at the national level and even if Article 65 of the Prison Law provides for the creation of specialized health-care units within prison establishments, no specific legal text makes reference to ATSM, so that it is not clear where lies the legal basis for the creation of such units which present an uneven scenario in terms of numbers, therapeutic quality and standards. Moreover, no Minimum Standards of Health care (so called *Livelli Essenziali di Assistenza*, LEA) are provided for this kind of facilities. Important is to remember that these units are designed to accommodate mentally ill inmates who have developed a psychiatric disorder during imprisonment or after the commission of the crime (not for person awaiting the security measure of REMS). It is imperative to stress the fact that ATSM does not constitute a lawful manner and an adequate structure for the accomodation of persons waiting for the execution of a custodial security measure.

[27] See, CPT Report to the Italian Government on the visit to Italy carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 8 to 21 April 2016.

[28] See CPT Report to the Italian Government on the visit to Italy carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 13 to 25 May 2012.

[29] *Rooman v. Belgium* ([GC], no. 18052/11, §§ 147-48, 31 January 2019.

aiming at the recovery of the patients, in prisons the aim is only the containment of the auto and hetero aggressive behaviour of inmates, **chiefly relying on pharmacotherapy through the administration of psychotropic drugs**, while **no suitable treatment and care are provided and no therapeutic programs are drafted in view of therapeutic alternatives to incarceration.**

50. **The inadequacy of treatment and care constitutes a systematic hindrance to both human dignity and the lawfulness of the deprivation of liberty**. As already mentioned above with respect to Article 13 of the Italian Constitution, the case law of the Court on Article 5§1 of the Convention clearly shows that there exists a close link between the "lawfulness" of the detention of persons suffering from mental disorders and the appropriateness of the treatment provided for their mental condition. The material conditions, the carceral environment, the inadequacy of the proposed treatment, the unequal access to mental health care makes the deprivation of liberty in penitentiary facilities of offenders acquitted by reason of insanity unlawful according to both the Italian Constitution and the European Convention of Human Rights.

Conclusion

As a result of our considerations, we can outline some proposals to solve the "structural" problem of offenders acquitted for reason of insanity waiting to be admitted to REMS:

I. Introducing **new types of non-custodial security measures**, ordered by the judge. A wider range of non-custodial security measures could allow a more adequate offer of treatment and care in the community outside "total institutions" *i.e.* the offer of treatment and care in therapeutic communities or at home, following individualized therapeutic plans drafted by the Mental Health Community Services ;

II. Improving the **collaboration and coordination among the Judiciary and the Health Care Regional system** (Servizio Sanitario Regionale), so as to give judges a full overview of the therapeutic facilities available in the community. The coordination should be implemented through official protocols and guidelines. This could allow the judges to appropriately assess the medical condition of each person so as to choose the most suitable available accommodation, either in REMS or in therapeutic community according to his/her specific individual health needs;

III. Working for a **larger implementation of the principle of free and informed consent of the patient**, based on full information about the characteristics of the disease and the therapeutic offer, in order to raise the patient's awareness on the protection of his/her own health

IV. **Re-evaluating periodically the social dangerousness of persons included in the waiting lists** with special attention to the time of admission to the REMS;

V. Providing a coordination board between the Judiciary, the REMS directors and community services to quickly respond to emergency of people in conditions of Mr. Ciotta;

VI. Reviewing the legislation on the provisional custodial security measures in light of the principle of *extrema ratio,* in order to reduce their implementation.

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