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THIRD PARTY INTERVENTION
JOINT OBSERVATIONS BY L'ALTRO DIRITTO ODV (ADIR), LA SOCIETÀ DELLA RAGIONE ONLUS (SDR) AND FONDAZIONE FRANCO E FRANCA BASAGLIA
Application no. 8436/21
Lavorgna v. Italy

Introduction

1. With a letter dated 21 March 2022 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. 8436/2021. 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 Involuntary Treatment - IT (*Trattamento Sanitario Obbligatorio - TSO*) and the mechanical restraint from a sociological, ethical and legal perspective. In the legal framework we will deepen the analysis of the *legal ratio* of the Corte di Cassazione's *Mastrogiovanni* judgement. We will also give information and analysis on the number of cases of Involuntary Treatment (IT) and mechanical restraint. We will assess the situation in the Tuscany region and try to provide an explanation for these phenomena. We will also compare this situation to the national data provided for the National Ombudsman of people deprived of their liberty.

3. We will therefore describe the ethical issues and guidelines and policies about mechanical restraint, through the analysis of the Italian National Committee for Bioethics Opinion and the Ministry of Health Action Plan 2021-2023 (**Section I**), *Basaglia* law and the involuntary treatment legal status (**Section II**), the mechanical restraint legal status (**Section III**), the connection between IT and restraint (**Section IV**), the national and regional data on Involuntary Treatment for mental illness (**Section V),** data about restraints and the recommendations of the Ombudspersons (**Section VI**), application practices of IT and restraint by the Courts (**Section VII**), Rights Effectiveness and lack of remedies (**Section VIII**).

Section I - Ethical and legal issues: the 2015 Opinion by the Italian National Committee for Bioethics (NCB)

4. The Opinion, *La Contenzione: problemi bioetici*, issued in 2015, addresses the question of mechanical restraint in hospital psychiatric wards (HPW)[1], the services within the general hospitals entitled to provide psychiatric patients in the acute phase of the illness with treatment and care. It also examines the use of mechanical restraint[2] in the care of older adults as well in other wards of the general hospitals. Though focusing on the controversial legitimacy of mechanical restraint, pharmacological restraint is also explored, particularly in the connection with mechanical restraint. The risks of pharmacological restraint are stressed and the correct use of drugs in the appropriate dosages for therapeutic purposes is highly recommended. The National Committee for Bioethics (NCB) Opinion examines the practice of mechanical restraint both under the ethical and the juridical points of view.

[1] In the Italian healthcare system, there are two kinds of structure: wards and services. The services have a maximum number of 15 places, the wards can host a higher number of patients. In this intervention, we use the term "ward" to make the comprehension easier for an international reader. What we call "hospital psychiatric ward" is more properly a "service" because of its limited number of 15 beds.

[2] The CPT recognized four kinds of restraint: physical restraint (staff holding or immobilising a patient by using physical force – "manual control"; mechanical restraint (i.e. applying instruments of restraint, such as straps, to immobilise a patient); chemical restraint (i.e. forcible administration of medication for the purpose of controlling a patient's behaviour) and seclusion (i.e. involuntary placement of a patient alone in a locked room). We follow this categorization, using mechanical restraint for the coercive practice that implies the use of instruments.

5. As for the ethical aspect, the Italian NCB, while condemning *the widespread use of mechanical restraints*, establishes that "*restraint is to be considered a violation of the fundamental human rights*". In addition, a similar statement by the Danish Committee for Bioethics is quoted. The Danish Committee, in a document issued in 2012, stressed "*that coercion invariably represents a violation, independently of the reasons for which it is applied*"[3].

6. As the NCB Opinion highlights: the fact that in specific and limited high risk situations mechanical restraint may be implemented as a sort of exceptional "last resort" (allowing *"staff to depart from the mandate of avoiding to restrain patients against their will"*) neither is in opposition to the ethical ban of the practice nor does weaken the general no-restraint mandate for the services. Moreover, the "last resort rule" should not be absolutely interpreted as a licence to a routine use of restraint, as it has unfortunately and extensively happened in the services.

7. In the NCB Opinion, the ban of mechanical restraint stems from the harms this practice brings to the patient's health and his/her human dignity, with important consequences under the ethical principles of medicine (respect for patient autonomy, beneficence, non- maleficence, justice). Because of the above quoted harms to health, mechanical restraint cannot be justified in the name of the principle of beneficence. As a result, the assumption of the necessary prevalence of the principle of beneficence on the principle of the patient's autonomy is insubstantial. In conclusion, the ethical principles of medicine should be followed in mental health care as in all the other sectors of medicine: the respect for patient autonomy is an essential requisite in a valid therapeutic intervention.

8. As for the juridical issue, doubts arise about the legitimacy of mechanical restraint in healthcare – the same NCB Opinion states (See, following section III).

9. In the final recommendations of the quoted Opinion, the NCB, while reaffirming that mechanical restraint can only be tolerated as a last resort, advocates the reduction until eliminating the practice. It also shows the national government and the Regions a pathway to the final goal, suggesting a set of "good practices": in particular, the implementing of an effective monitoring and of specific programs addressed to mental care professionals.

The Ministry of Health Action plan to eliminate mechanical restraint in three years (2021-2023)

10. In April 2021, the Ministry for Health issued a document entitled "How to eliminate mechanical restraint in mental health care". The document addressed to the Regions, after reviewing the most important documents and statements by national and international authorities, comes to some conclusions and to a set of "recommendations and actions aimed at eliminating the mechanical restraint in three years (2021-2023)".

11. Among the conclusions, the Ministry document states that:

- Mechanical restraint neither is a "sanitary" nor a "medical" act, in the absence of any therapeutic or diagnostic or pain relief purposes
- Mechanical restraint is harmful to the psychological and physical conditions of the person and such a harm may result in his/her death
- Mechanical restraint confirms the violent nature of psychiatric treatments. As such, while increasing the stigmatisation of people with mental illness, increases the patient's resistance to be enrolled in mental health care programmes.
- Mechanical restraint does not comply with the principles of the Italian Constitution and the UN Convention on the rights of Persons with disabilities
- *The final elimination of mechanical restraint can be achieved by a set of actions, such as: monitoring the phenomenon; promoting the training of mental health professionals; identifying quality standards in mental health care; promoting the evaluation of interventions; assuring the transparency of mental health services.*

12. As for the Action Plan, seven recommendations are listed:

- raising public awareness on restraint as a breach to fundamental rights of the person (instead of a "sanitary practice")
- monitoring the phenomenon
- promoting the rights and the dignity of people in mental health care: training courses and meetings with professionals from no restraint services and with patients and their families are suggested
- promoting a community approach to health care, with mental health services well connected and integrated with the whole network of community health and social services
- ensure high quality standards of care and of "transparency" in services (in particular, an easy access to services by volunteers , families and citizens is essential to improve the relationships and challenge the segregation of patients).
- Promoting team working and networking
- assuring appropriate training to all the professionals.

Section II – Basaglia Law and The Involuntary Treatment Legal Status

[3] The document by the Danish Ethics Committee *Power and powerlessness in psychiatry* was released in 2012.

13. Since 1978, Italy has no more a specific law on mental illness and health. The old previous law (n. 36 of February 14, 1904) and its Implementing Regulation (R.D. 615, August 16, 1909) have been abolished by the Law n. 180 of May 13, 1978, a few articles of law on psychiatric treatment and mental hospitals. Six months later, on December 23rd, the law establishing the National Health Service (Law n. 833/1978) was approved and Law n.180/1978 was incorporated, with some minor changes, into that law. Therefore, articles 33, 34 and 35, Law 833/1978 regulate voluntary and involuntary treatment for mental illness, and article 64 establishes the closure of the existing mental hospitals and bans the construction of new ones. Therefore, Italy has no specific law on mental health and psychiatric treatment must follow (see §17-28) the same rules as any other health treatment, and mental patients have the same rights as any other patient, even in case of involuntary treatment.

14. The four articles of Law n. 833/1978, that guide health and mental health treatments since 1978, are often called "Law 180", as the law that has remained in force six month only, but even more commonly are called "Legge Basaglia", "Basaglia's law", from Franco Basaglia (1924-1980), the Italian psychiatrist who led the movement to abolish mental hospitals and to change the law and culture on mental disease. In this paper, the four articles of the Law 833/1978 which constitute the set of principles on health and mental health treatment, will be indicated from now as "Basaglia's law".

15. These are the pillars of "Basaglia's law":

a. the general principle that health treatment for any disease (mental disease included) must be voluntary and the rules for IT, as a special case;
b. the principle that prevention, treatment and rehabilitation of the mentally ill normally be carried out in community services. The law also establishes the creation of hospital psychiatric wards within the General Hospitals, which can have a maximum of 15 beds each;
c. the ban on building new mental hospitals and on admitting new patients to the existing ones, which had to be gradually phased out and used for other purposes.

16. The Italian Constitution (especially after the Constitutional Reform n. 3/2001) provides a great regional autonomy in health matters. As a result, the characteristics, quantity and quality of the health services are very different from one Region to another, with different grades of Basaglia Law principles' fulfilment. Nonetheless, the Ministry of Health maintains tasks of direction and coordination of health policies, and must ensure equality in the provision of health services. Recently the Ministry has promoted a national conference that took place in Rome, 25-26 of June 2021, whose title was "For a Mental Health Community Oriented"[4] and built a plan document to abolish mechanical restraint in three years (see section I).

Involuntary Treatment (IT)

17. As mentioned before, article 33 of Law n. 833/1978 regulates voluntary and involuntary treatment for any illness, and art. 34 voluntary and involuntary treatment for mental illness. This last article states that involuntary treatment for mental illness must follow the same principles as art. 33, and namely that IT:

a. "must be implemented respecting people's dignity and their civil and political rights, including, as far as possible, the right to the free choice of a doctor and of the place of treatment";
b. "it must be accompanied by initiatives to ensure the agreement and participation of the person receiving involuntary treatment";
c. "During the course of IT, the patient has the right to communicate with anyone he/she deems appropriate."

18. IT is requested by two doctors from different health services and ordered by the mayor or by a delegate[5] and it is authorised by the tutelary judge, who is entrusted with the jurisdictional safeguard of such treatment. IT for mental illness can be done in the hospital psychiatric wards and also in the Mental Health Community Centres.

19. If IT exceeds 7 days, and in cases of further extensions, the psychiatrist must follow the above mentioned procedure (mayor + judge) and give a written explanation for any such extension.

20. Two issues of these provisions need to be focused. First: the reason for IT for mental illness is no longer the patient's dangerousness but that s/he needs and refuses help. In the words of the law, IT in the HPW must be provided if and when "the mental condition of the person requires urgent treatment that the person does not accept, and if conditions and circumstances are not met to take timely out-of-hospital measures" (paragraph 4, art. 34, 833/1978).

21. This has some important consequences:

a. the refuse of treatment by a person is no longer considered as a hint of his/her dangerousness;
b. psychiatrist is no longer obliged to control and repress social dangerousness;
c. obliging a mentally ill person to receive an unwanted health treatment is not a security measure any longer : the patient retains his/her personal rights and the limitation of freedom only concerns the sphere of medical treatment.

[4] Conference *Per una salute mentale di comunità* https://www.salute.gov.it

[5] in the Italian legal system, the mayor is the local health authority

22. Most of the legislation, even the ones stating the respect for human rights, consider social dangerousness the reason to apply an IT, keep the existence of mental hospitals and the legitimacy of seclusion for the mentally ill citizens. Those legislations protect the rights of mental patients by limiting and controlling the psychiatrists' work - i.e. making distinctions between compulsory treatment and the compulsory drugs administration, by supervising seclusion and some specific treatment.

23. The Italian legislator has considered that control on involuntary treatment cannot be fully effective in protecting the rights of patients as soon as mental illness continue to have a "special statute" among illnesses, and psychiatrists continue to be responsible for controlling and repressing social dangerousness.

24. As a result, under Italian law, this last responsibility is entirely given to the police and to the institutions of the criminal justice system.

25. In case of need, psychiatric services and police can or must act together, but each on its own specific responsibility.

26. It is clear that this law has required and requires substantial changes in the mental health services organisation and in the professional cultures. In Italy such changes have occurred in numerous local health units[6], and they demonstrate how it is possible to take care of persons with mental disorders respecting their dignity and rights. However, looking at the panorama of mental health services nationwide, the distance between law principles and the services and policies still remains very large in most of the Regions. The use of IT is exemplary.

Section III - The mechanical restraint in the Italian legal system: an illicit practice.

27. The mechanical restraint of psychiatric patients or elderly and disabled people has to be considered an illicit practice in the Italian legal system. Indeed, this kind of acts are qualified as *safety measures* (not therapeutic or diagnostic acts) allowed only in those exceptional circumstances in which there is a concrete and current danger of serious harm to the patient or the other people and only for the time strictly necessary.

28. Specifically, the Italian Constitution provides that «nobody may be forcefully submitted to medical treatment except as regulated by law». The law 833/1978, at the articles 33-34-35, clarifies the conditions and the procedure for the involuntary treatment. Nonetheless, the medical act practised following the *ars medica* rules in absence of the patient consent could be justified as an activity aimed at protecting the health recognized as constitutional value under article 32, in cases such as the one in which during a surgical intervention, the surgeon decided to practice a different operative intervention with positive effects on the patient's health conditions (Cass. Pen., S.U., January 21, 2009, n. 2437). But mechanical restraint could never be justified by this constitutional defense, because it is not a therapeutic treatment but a mere restriction of personal freedom.

29. Under article 13 of Italian Constitution «no form of detention, inspection or personal search nor any other restriction on personal freedom is admitted, except by a reasoned warrant issued by a judicial authority, and only in the cases and the manner provided for by law». The mechanical restraint nowadays is no longer provided by the law (as it was in the past when the "Law on asylums and people of unsound mind" Law 36/1904 and the settlement R.D. 16 august 1909 at the article 60 regulated the mechanical restraint as an exceptional measure) so it must be considered forbidden.

30. This reconstruction shows that there is not a legal vacuum. A practice which limits the personal freedom of a person and is not provided by any law is not admitted neither under article 32 nor under the article 13 of the Italian Constitution.

31. Furthermore, in light of the principles of the *Basaglia* Law (L. 180/1978, then included in the Law institutive of the National Sanitary System, L. 833/1978), which regulated the involuntary treatment, closed the asylums, cancelled the concept of psychiatric patient as a dangerous individual and changed the custodial approach to the mental health, the coercive techniques or means could not be legitimated except when they represent the only instrument to avoid a serious damage to the health of the patient.

32. The conduct of restraining may constitute certain types of offence, such as "false imprisonment" (article 605 criminal code) or "private violence" (article 610 criminal code).

33. The Italian criminal code provides some statutory defence (in particular, the "state of necessity" defence provided by article 54 of the Italian criminal code), which can justify the mechanical restraint only in exceptional cases in which there is an objective risk of impending serious harm to the patient or the other people.

34. This interpretation is confirmed by a settled national case-law of *Cassazione* Supreme Court, which in the decision on the *Mastrogiovanni* case (Cass. Pen., sez. V, November 7, 2018, n. 50497) stated that mechanical restraint is not a medical act but a form of deprivation of personal liberty with a mere precautionary function (in the same sense, Cass. Pen., sez. V, December 17, 2019, n. 50944; Cass. Pen., Sez. V, June 20, 2018, n. 11620; Cass. Pen., Sez. VI, September 27, 2021, n. 35591). Moreover, the Court rejected the thesis that mechanical restraint had to be considered as a component of the care process ancillary to pharmacological therapy (*Mastrogiovanni case).*

[6] Italian name of those "local health unit" is "azienda sanitaria locale", literally "local health enterprise"

35. In the *Mastrogiovanni* case, the Supreme Court also affirmed that the psychiatrist's obligation of preventing harmful acts of his/her patient (so called *posizione di garanzia* under article 40 co. 2 criminal code) cannot be considered a justification for the mechanical restraint, except for the extraordinary cases of "current danger".

36. Furthermore, the *Cassazione* Supreme Court recognized that the typical conduct of the mechanical restraint, tying a not self-sufficient patient to a bed, an armchair or a chair, could integrate the offence of "false imprisonment" (Cass. Pen., sez. I, October 28, 2004, n. 409).

37. The mechanical restraint– the Supreme Court reminds us – could only be justified in a situation of state of necessity. That is a condition in which there exists a danger of serious damage for the patient or the other people. This danger had to be current and forthcoming (Cass. Pen, April 30, 2010, n. 26159; Cass. Pen, Sez. V, April 14, 2015, n. 2874) and isn't sufficient that the danger is possible or feared (Cass. Pen., Sez. V, April 14, 2015, n. 2874). Therefore, the mechanical restraint couldn't be applied as a precaution (mentioned *Mastrogiovanni* case).

38. The mechanical restraint could be justified and not considered an offence if and only if it is the unique means to safeguard the patient's health and no other alternative means are useful to prevent an unavoidable danger (mentioned *Mastrogiovanni* case). In no case the mechanical restraint may be used for punitive or pedagogical functions.

39. The response to this exceptional danger has to be proportionate (for example not tying all the limbs, or using the less invasive means) and limited in time at the strictly necessary.

40. Some of these principles are to be applied to the chemical restraint that has to be used in exceptional cases too. The chemical restraint – in many cases added or subsequently applied to the physical or mechanical one – is a coercive means, not compatible with the principles of Italian laws. The pharmacological therapy shouldn't have a coercive effect, except in extraordinary circumstances

Beyond the criminal code

41. From a legal point of view, the theme of the lawfulness of the mechanical restraint is relevant beyond the fact that the conduct of restraining is qualified as an offence and relevant from a criminal perspective.

42. Indeed, the restraining practice is often the extreme effect of deficiencies of the health system, lack of care and failure to comply with constitutional, legal and international convention's principles.

43. Particularly, article 32 of the Italian Constitution guarantees the fundamental right to health and provides that sanitary treatments have to be voluntary as a rule. The cases and procedure for involuntary treatments are regulated by Law 23 December 1978, n. 833 "Establishment of the National Health Service". This law lays down some principles and rights: involuntary health tests and medical treatments are exceptional; in cases of involuntary health checks and medical treatments, the person preserves his/her rights and dignity; during the involuntary treatment the person have the right to communicate with anyone he/she wants; before and during these treatments and checks it is necessary to implement all the initiatives to assure the participation and consent of the person.

44. In this framework, restraint cannot find justification and the affirmative actions aimed at ensuring the rights and maximum participation of the person have a key role.

45. This setting is also confirmed by some international Conventions Italy has signed, in particular the UN Convention on the Rights of Persons with Disabilities (CRPD) and Optional Protocol, ratified by Law 3 March 2009, n. 18.

46. Specifically, under subsections c) and i), article 4 CRPD, the States Parties have to take «all appropriate measures to refrain from engaging in any act or practice that is inconsistent with the present Convention and to ensure that public authorities and institutions act in conformity with the present Convention» and «to promote the training of professionals and staff working with persons with disabilities in the rights recognized in the present Convention so as to better provide the assistance and services guaranteed by those rights». This article poses a positive obligation for the State which has to provide the means and instrument to implement the effectiveness of the Convention's rights.

47. Moreover, the article 12 CRPD provides that States Parties «shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life» and «shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity». The measures relating to the exercise of legal capacity shall «respect the rights, will and preferences of the person». Under article 13 «States Parties shall ensure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age-appropriate accommodation».

48. Finally, Article 14 provides that «States Parties shall ensure that persons with disabilities, on an equal basis with others […] Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty».

Section IV – The connection between IT and restraint: how the IT guarantees can be a safeguard against abuses of restraint

49. All the principles established by the *Mastrogiovanni case* must be applied when a doctor decides about the use of mechanical restraint on a psychiatric patient. They must likewise be applied when restraint is carried out with drugs. As shown in the cases described in Section V, mechanical restraint of psychiatric patients happens at the start or during an involuntary healthcare treatment, showing a *de facto* linkage between these two different practices. At the start of an involuntary treatment, physical restraint - also in the form of mechanical restraint - may be applied to immobilise a person who runs away, in similar way to the arrest of a person on police grounds. At that moment the proportionality in the use of force and the technical ability in holding the patient, for the time limited to the minimum necessary, are decisive in order not to harm the person and not to abuse the use of force. There are cases of abuse of force, as the **Andrea Soldi case**. He was suffocated in a restraint manoeuvre of three municipal police officers and a psychiatrist, during his daily sitting on a bench in his favourite garden in Torino. He was known by mental health services and he didn't want to accept the long acting drug that the service had imposed on him for some time. The four have been sentenced five year later, in 2020[7]. When restraint is used during an involuntary treatment the only reasons for which it may be applied are those indicated by the judges in the Mastrogiovanni case.

50. In casuistic analysis we have realised in which circumstances the *de facto* linkage emerges. We will show here that if Involuntary Treatment (IT) procedures are used lawfully, they are able to protect liberty in case of abuse of mechanical restraint. In some reported cases, restraint is not applied for a short period of time, but it continues, sometimes for several days. In these cases, people subjected to restraint often are in a condition of segregation and are subjected to pharmacological in addition to mechanical restraint. As a result, in these conditions they are completely unable to express their will. If the Guardian Judges would periodically visit the hospital psychiatric wards to verify the conditions of the patients, the patients willing to file a complaint would be really able to appeal to the judge. For the patients, it is even more difficult to appeal to the judge, because usually parents, relatives and friends of the people restrained are not allowed to visit the patient, in full violation of the Basaglia Law. Family and friends could be a useful help to protect the rights of people in a condition of vulnerability, but they are prevented from doing so. In addition, the Basaglia Law provides for a maximum length of 7 days for an Involuntary Treatment (IT) but this period of time may be postponed, as it often happens. In the case of delayed times for IT, only a formal control by the Guardian Judge is provided by the law. The **Wissem Ben Abdel Latif** case demonstrates this dynamic. He was a 26 years old man from Tunisia, arrived in Italy by boat on 2 October 2021, dead on 28 November after 60 hours of mechanical restraint and heavy sedation in the Psychiatric Ward of San Camillo Hospital in Rome. The IT procedure had not even started, the hours of restraint were badly noted in the register, the autopsy was carried out without informing the family or the embassy. The judge has opened an investigation, the National Ombudsman for the Rights of people deprived of their liberty has opened an investigation and Abdel Latif family together with several associations set up a Committee in his name[8].

51. The failings in implementing the Basaglia Law correctly, as shown above, have created an environment (a mix of professional culture, habits, beliefs about what exactly the law requests) which helps the use of restraint, in clear opposition to the ratio of the law. This is evident, in a contrario reasoning, by examining the good practices as implemented in the no restraint services or in the services with a low rate of mechanical restraint : when principles and rules of the Basaglia Law are fully respected and adequately implemented, restraint is not applied or seldom applied as extrema ratio. Though mechanical restraint and Involuntary Treatment (IT) involve different ethical and juridical issues and justifications, the guarantees provided for the IT, if fully implemented, would also preserve patients from the abuse of mechanical restraint.

52. In conclusion, a better compliance to the norms about IT is required. To better explain this idea some data about application of Involuntary Treatment (IT) would be useful.

Section V – National and regional data on Involuntary Treatment for mental illness: a great variability

53. Data about IT are provided by the National Ombudsman for the Rights of people deprived of their liberty, in its annual reports to the Parliament[9]. Data are based on discharges of patients released from a hospital after an IT: as a result, these data might be overnumbered because some people might be hospitalised more than one time and possibly subjected to more ITs. For an in depth consideration of the question, we will also show Tuscan data from the Regional Ombudsman for the Rights of people deprived of their liberty of Tuscany Region. The 2020 and 2021 Annual Reports of the National Ombudsman published data about 2016-2019. The IT total number was 7.995 in 2016 (Tuscany 291; Lombardia 831). 7.649 (Tuscany 221; Lombardia 945) in 2017 7.446 in 2018 (Tuscany 228; Lombardia 933), 6.774 in 2019 (Tuscany 204; Lombardia 819).

[7] Matteo Spicuglia *Noi due siamo uno. Storia di Andrea Soldi, morto per un TSO*, Add editore, Torino, 2021

[8] www.facebook.com.comitatoperwissem

[9] All the reports of the National Ombudsman are available at:
https://www.garantenazionaleprivatiliberta.it/gnpl/pages/it/homepage/pub_rel_par/

54. The Annual Report of the Regional Ombudsman of the Tuscany Region[10] adds information about the medium hospitalisation period, in the years 2015-2018 equivalent to: 12,8 days in 2015; 16,9 days in 2016; 18,6 days in 2017; 14,2 days in 2018.

55. Though these data only provide an elementary information, nevertheless they shed light on the different models in care in the psychiatric services of Tuscany from three main areas (Toscana Centro, Toscana Nord-Ovest and Toscana Sud-Est). The North West area (Massa Carrara, Lucca, Pisa, Livorno) has a considerably higher number of IT than that of Central Tuscany (Florence, Prato, Pistoia, Empoli), though this area has a higher number of inhabitants (1,500,000 for Florence, 1,200,000 for the coast). In 2018: 99 people in IT on the coast, against 52 in the Florentine area. Southeast Tuscany (Siena, Arezzo, Grosseto) also has more IT than Florence (60 people in IT in 2018, in an area with only 850,000 inhabitants). In addition, a correlation can be shown between the higher rates of IT and the length of hospitalizations (17 days of average hospitalisation for the coast, almost 14 for the south-east area, compared to 11 in the Florentine area). This difference could be ascribed to different medical approaches and/or different models of the services organisation.

56. The 2021 Regional Annual Report published data about years 2019-2020, but they are even more inadequate than in the past, since only the absolute numbers were provided. The Ombudsman makes two more considerations: the absolute overall numbers of ITs have increased compared to 2018, they are 368 for 2020; the distribution of ITs with respect to the resident population is more homogeneous than that recorded in previous years, otherwise the incidence (on 100,000 residents) is overall higher. The 2022 Annual Report (about to be released) publishes data about 2021 and shows the same critical issues of the past Report. The absolute number of ITs in 2021 increased: 426 for 2021. The distribution of ITs with respect to the resident population is less homogeneous than in 2020.

57. In 2021 and 2022 Annual Reports, the Tuscan Ombudsman has also gathered information from the Guardianship Judge. Two interesting considerations have emerged from this feedback. As for the former: Data provided by the Judiciary result higher than those of the sanitary ones: 515 vs. 368 in 2020; 553 vs. 426 for 2021. As for the latter: the appeals, the judicial remedy IT procedure provides for against its application, are rare, almost nonexistent: they are 0 on 629 requests validated in 2019; 2 on 515 requests validated in 2020; 0 on 553 requests validated, in 2021.

58. The Ombudsman stated that it would be necessary to investigate the reasons for the almost total lack of litigation regarding TSOs, given that the judicial review procedure is established by law to guarantee the right to individual freedom. For more considerations see Section VIII about the lack of effective remedy.

59. The data on the distribution of IT by Regions show the differences in the quality of mental health services. Following **data from Health Ministry processed by experts from Italian Society of psychiatric epidemiology**, in 2019, the IT national rate was 13,0/100.00, slightly down compared to 2018 (14,6/100.000), 2016 (16/100.000), and to 2015 when the rate was 17,3/100.000. This decline may be considered a good sign, but if you look at the data from the regions, a serious problem emerges: a great and persistent variability in the use of IT, so abnormal in some regions as to require information and in-depth intervention from the Health Ministry. The data we offer here are recent, but this problem is not recent indeed.

60. **In 2019** the number of **IT varies from 4/100.000** in the Province of Bolzano, the region Friuli-Venezia Giulia and Basilicata (all -69,2% of the average rate) **to 30/100.00** in Umbria. Values higher than the average value are recorded in southern as well as in northern Regions: Sicily has +100,0% of the average rate, Emilia Romagna +92,3%, Sardinia and Abruzzo +61,5%. Values below 50% of the average can be found in Tuscany, Molise and Campania, all -53,8%[11]. **In 2018** the number of **IHT varies from 3.5/100.000** in the Province of Bolzano up **to 29,9/100.00** in Sicily. Values higher of the average value are recorded in southern as well in northern Regions (Sardinia +64,6%, Emilia Romagna +66,2%) and values below 50% of the average can be found in Tuscany (-50,4%), Friuli-Venezia Giulia and Basilicata (-71,6% both) [12]. The **2016** shows a similar picture: **4 IHT/100.000** in Friuli-Venezia Giulia, **29/100.000 in Sicily**; +50% of the average value in Emilia Romagna (+68,8%), Valle d'Aosta (+75%), Umbria and Calabria (+50%); -50% of the average value in Bolzano, Basilicata (-68,8), and Molise (-56,3)[13].

61. It is highly probable that such variability is related to the regional policies, to the type of services and the professionals' culture rather than to the characteristics of the user population. As stated earlier, a high number of IT is an indicator of poor quality of services, and this poor quality endangers both the health and the rights and dignity of users, and sometimes their life too.

[10] All the reports of the Regional Ombudsman are available at: https://www.consiglio.regione.toscana.it/garante-detenuti/default.aspx?nome=relazioni

[11] AA.VV *Siep – Quaderni di epidemiologia psichiatrica*, n.8/2021, pag. 32

[12] AA.VV *Siep – Quaderni di epidemiologia psichiatrica*, n.6/2020, pag. 30

[13] AA.VV *Siep – Quaderni di epidemiologia psichiatrica*, n.2/2018, pag. 32 https://siep.it

62. In conclusion, data on the use of IT are poor: they are not reliable in quantity and scarcely detailed in quality. They also show great differences among regions. A clearer accounting of IT is needed. Data on lack of appeals show the need of implementing measures for access to justice in IT procedure.

Section VI - Data about restraints and the recommendations by the Ombudspersons

63. In this paragraph we will show the use of mechanical restraint of psychiatric patients. Data is provided by the National Ombudsman for the Rights of people deprived of their liberty, in its annual reports to the Parliament. The National Ombudsman has presented data regarding specific contexts, such as Residences for Execution of Security Measures ((*Residenze per l'esecuzione delle misure di sicurezza, REMS*) and health and social care homes, but neither general data are available, nor specific data about hospital psychiatric wards. The National Ombudsman recommended all psychiatric services to adopt a register of restraints, in order to make data available and allow their control. The tool of the register of restraints was indicated by the National Guarantor of persons deprived of personal liberty in its 2018 Report, as a necessary tool for monitoring the restraints. The National Guarantor also warned of the possible use of restraint as a "disciplinary tool within a system whose function is instead of taking care, maintaining and enhancing subjectivity and not compressing it" (Report 2019).

64. We will focus on data published by the Regional Ombudsman for the Rights of people deprived of their liberty of Tuscany Region, in order to deepen the question. The Regional Ombudsman of Tuscany Region in its 2019 Annual Report did not present data on restraints, because they were not provided even if they were specifically requested. The managers of the services specified that there was no register of restraints because there is no legal obligation to keep these registers. The Ombudsman commented it would be desirable for the Tuscany Region to provide for the obligation to keep these registers in its DSM and regulate their implementation and the specific procedural procedures for keeping them.

65. The 2021 Regional Annual Report shows only the data from the South-East Local Health Unit (ASL), in which the number of restraints carried out was 4 in 2019 and 3 in 2020. The ASL Toscana Centro and Toscana Nord Ovest stated that they were not aware of the numbers relating to the restraints. In their responses to the Ombudsman, the three ASL stated that "there is no obligation to keep records of contentions". The Ombudsman comments on the fact that this statement appears inappropriate when the 2018-2020 Regional Integrated Social Health Plan places among the actions to be developed during its validity that of "promote the monitoring (in particular through the register of restraints) of the functioning of psychiatric services with particular attention to limitation practices of the freedom of patients, identifying all the indicators necessary for the purpose "(p. 169 of the Plan). The Ombudsman also reminded the Tuscany Region to provide for the obligation to keep these registers in its DSM.

66. The 2022 Annual Report shows some data more on restraints: Careggi Hospital: 298 (not only in psychiatric services), ASL Toscana Nord-Ovest: 37; Pisa Hospital: 3; ASL Toscana Sud-Est: 18. Instead, ASL Toscana Centro and Siena Hospital do not have provided data on this issue. In general, the three ASL make the same statements of the previous year, and the Ombudsman recommends the same remedy.

67. In conclusion, data on the use of mechanical restraint of psychiatric patients are poor: not reliable in quantity and scarcely detailed in quality, showing the need for implementation of measures for regular monitoring, such as the registry of restraints. Coalitions of users and professional associations have proposed the introduction of an Annual Report on IT and the use of restraint, that the Health Ministry could present to Parliament, on the model of monitoring provided for Law 194/1978 (on voluntary termination of pregnancy) and for Law 309/1990 (on drugs addiction).

Section VII - Application practices of IT and restraint by the Courts

68. In the Italian legal system, the procedure of Involuntary Treatment (IT) does not provide an active intervention of the Guardianship Judge who only carries out a formal control of the measure that is taken by the Mayor of the city where the person lives. According to "Basaglia Law", it is not explicitly foreseen that the person concerned is personally heard by the Mayor or by the Guardianship Judge at any stage of the procedure. Moreover, the current legislation provides that the Judge has only 48 hours to validate the measure after the Mayor sends his decision. The very short term of 48 hours does not allow the Judge to hear the patient, his lawyer or the doctor. Therefore, the role of the Guardianship is usually restricted to checking the presence of medical certificates and the compliance with the procedure. Given the limitation of personal freedom inherent in the IT, these forms of verification and guarantees are aimed at avoiding improper restrictions on the patients' autonomy and, in any case, at guaranteeing the protection of their rights. Nevertheless, substantial control is granted only when the patient or any other person involved can file an appeal before the Court against the motion approved by the Guardianship Judge. To ensure the substantial control in the procedure, before the validation, it would be necessary to modify the law 833 of 1978 providing a longer term for the Judge to validate the decision. Above all, the hearing of the patient could be foreseen as mandatory adding to the art. 35 that the Judge validates the decision with the mention "patient heard".

69. Since IT is an extreme measure of deprivation of liberty, it should be considered as a last resort, when no other options appear to be available. Considering the strict ethical and juridical limitations in IT and the negative moral evaluation of the compulsory treatments, paradoxically, many psychiatric services try to limit the number of IT procedures, finding ways to achieve the result of involuntary treatment of people with mental disabilities, by different means. Where IT requirements are not found, a request of a legal guardian (or an "administrator" according to the law 6 of 2004) is frequently carried out by these services to bypass the IT procedure. Regularly, the request of a guardian could become a way to obtain a forced institutionalisation of the patient. Indeed, in cases of forced restraint of the elderly or disabled people, the guardian signature or the Guardianship Judge authorization allows to overcome the refusal of the person to enter in health and social care homes or to accept a medical treatment. These are illegal practices of deprivation of liberty, leading to a *de facto* segregation and involving a non-voluntary medical treatment without the guarantees and the procedure of the IT. The Guardianship Judge must pay attention to these cases and verify the legal requirements of the measures.

70. In a recent decision concerning the appointment of a temporary guardian, the Judge has underlined the impossibility to force the will of a person entering in a health facility through the signature of a legal guardian (Court of Chieti, 22.1.2022). This decision highlighted that, when the person is affected by a disease which does not eliminate his ability to understand and take action, and therefore, the possibility of expressing a valid refusal of the institutionalisation, the consent of the guardian is not sufficient and *the Guardianship Judge authorisation should not be released*. Even though the guardian is given the power of exclusive representation in health care decisions, he/she cannot replace the absence of the person-involved consent. Otherwise, this mechanism would subvert the constitutional principles (art. 32 of Italian Constitution) and those at the basis of law 180 of 1978. Indeed, the guardian, after the appointment, should aim at starting a path of a shared care project, to acquire the person-involved consent as the legal protection represents a valid tool to seek the consent of the beneficiary to the necessary therapeutic programmes.

71. In some circumstances, doctors also ask the guardian to give consent or authorisation for a mechanical restraint on the interdicted person. This practice has to be monitored by the Guardianship Judge, reminding that he/she is not allowed to do so. Indeed, depending on the terms of the appointment, the guardian can be authorised to make financial and health care decisions on behalf of the ward. However, the mechanical restraint of a patient is not a medical treatment, therefore it is not included in the powers given to the guardian by the law and the Judge.

72. It is interesting to note that the Court has already discussed the Italian system of IT in the case *Patience Azenabor v. Italy*, no. 25367/11, 8 October 2013. The ECtHR declared the appeal inadmissible because it had been lodged without an appeal to the Court of Cassation and therefore after the internal remedies having been "exhausted". However, in its reasoning, it expressly dealt with the issue, stating that the GJ should actually make use of his/her powers/duties of investigation by going to the hospital to see the person concerned, possibly requesting a specialist opinion. He based his indications, in particular, on the 3/12/2004 report of the European Commissioner for the Prevention of Torture, who recommended that the validation by the GJ of the Mayor's IT measure should always require a hearing at the hospital with direct contact with the parties. As expressly affirmed by the Court: "21. With regard to the complaints concerning the applicant's inability to be seen or heard by the guardianship judge before he/she decided to validate the IT, the Court is not convinced that such a situation arises from the law. Indeed, while it is true that the applicable provisions do not require the guardianship judge to take such a step, it is also true that he or she has the power of enquiry. As the court pointed out, the guardianship judge may, among other things, go to the hospital and see the patient. He may also ask an expert doctor for an alternative medical opinion. The Court is aware of the importance of these steps, which every guardianship judge should take in order to be able to really and correctly assess the situation before deciding."

73. The Court has already made clear under which circumstances the decision of the GJ could be assessed as conventionally correct. As of today, we can affirm that the material situation of the vast majority of GJ decisions do not meet the standards set by the Court's case law in terms of correctness of the assessment of the situation. In this respect, the validation procedure lacks the pivotal requirement in terms of effectiveness of rights' protection and poses a serious risk of undermining the same conventional lawfulness of the IT.

Section VIII – Rights Effectiveness and lack of remedies

74. In cases in which the mechanical restraint is applied during the Involuntary Treatment, a remedy against the restraint is represented by the appeal against the IT, provided for by article 35 of the Law 833/1978. According to the function of the IT procedure as a procedural guarantee also against abuses of restraint, as better described in Section IV, the remedy for abuses of restraint has to be found in the remedy provided by that procedure, that is the possibility of filing an appeal to the Guardianship Judge in order to demand the termination of the IT. This appeal allows the Guardianship Judge to enter the hospital psychiatric ward and check the conditions of the patient.

75. As we have shown in section V, the number of appeals is almost zero. That is a clear demonstration that the remedy is not accessible, therefore ineffective. Indeed, the expression "effective remedy" means that the remedy must be sufficient and accessible, fulfilling the obligation of promptness (*Paulino Tomás v. Portuga*l (dec.), 2003; *Çelik and İmret v. Turke*y, 2004, § 59).

76. The Tuscan Ombudsman stated that it would be necessary to investigate the reasons for the almost total lack of litigation regarding IT, given that the judicial review procedure is established by law to guarantee the right of individual freedom. What is missing is the same act of initiation of the procedure (the appeal), and this circumstance suggests that there are obstacles, for the person subjected to IT, in formulating his/her own criticisms and grievances in terms of rights. Being aware of his/her own rights is the first step to implement them. For this reason, departments of mental health are urged to adopt information measures regarding the rights of people undergoing IT. In particular, the patient should have basic information accessible at any time, including the address of the competent judge, a telephone number, a pre-printed form that the person can fill in on their own, information on how to file an appeal and on how to be helped to do it (eg the number of an association that can deal with it). All this information should be clearly written in a poster placed in an accessible place inside the hospital.

77. There is a total lack of affirmative actions aimed at ensuring the effective access to justice, inconsistently with the provision of article 13 of UN CRPD, which stated that the «States Parties shall ensure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age-appropriate accommodation».

Conclusion

78. Under the constitutional, legal and conventional principles, mechanical restraint has to be considered an illicit practice justified only as a *last resort* in the exceptional cases in which there is a real and imminent danger of serious harm to the patient or to other people.

79. The Italian Government, through the Ministry of Health Action Plan in April 2021, has expressed the political will to eliminate mechanical restraint in mental health care in three years (2021-2023). As stated in the Action Plan, this objective can be achieved by a set of actions, such as: monitoring the phenomenon; promoting the training of mental health professionals; identifying quality standards in mental health care; promoting the evaluation of interventions; assuring the transparency of mental health services.

80. Nowadays, the practice and case law of Italian GJ show a total lack of effectiveness in terms of rights' protection. On the one hand, the GJ simply does not exercise his/her power of inquiry in the validation procedure. On the other hand, the total lack of litigation against the restraint shows the incapacity of the Italian system to take into account and deal with the special vulnerability of persons involved in IT procedure. This special and contextual vulnerability is the main impairment to the enjoyment of the right of access to a lawyer and access to the court which is at the very basis of the Conventional system of rights' protection. Affirmative actions reducing this vulnerability are urgently needed in order to meet the standard of effectiveness required by the Court's case law.

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