d. inspection procedures

118. All establishments visited by the delegation were regularly inspected by the regional branches of the Department of Prison Administration (*proveditore regionale*).

As regards external inspections, the role of the supervisory judges in principle also included the function of overseeing various aspects of imprisonment.

However, from the information gathered during the visit and, in particular, from the consultations the delegation had with a supervisory judge, it became clear that the scope of the judges' role[69] and their consequent workload made it virtually impossible for the oversight function to be performed thoroughly and in a proactive way. The sheer number of prisoners falling within a single supervisory judge's remit, together with many other elements of the work, ensured that most matters were dealt with exclusively by written procedure.

**The CPT recommends that the Italian authorities review the functions and resources of supervisory judges in order to ensure that the oversight of prisons is carried out in a proactive way. Those exercising the oversight function should talk with prisoners and staff in the detention areas and carry out spot checks of practice and conditions.**

## D. Psychiatric establishments

### 1. Filippo Saporito Judicial Psychiatric Hospital, Aversa

a. introduction

119. Filippo Saporito Judicial Psychiatric Hospital (OPG) is located in the small town of Aversa, about twenty kilometres north of Naples. It is one of five establishments of this kind in Italy[70], two of which have already been visited by the CPT in the past[71]. This large complex, originally an asylum built in 1876, includes many buildings and residential units, most of which are old and dilapidated, as well as some tree-planted spaces and gardens, all within an enclosed area.

At the time of the visit, the hospital was accommodating 268 male adult patients for an official capacity of 259 beds (and a so-called "tolerable" capacity of 306 beds). It is noteworthy that the maximum number of patients had been exceeded in 2007 and 2008 (there were over 300 patients). At the time of the visit, the Aversa OPG was accommodating 31 patients of foreign nationality.

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69 For instance, in the context of remission of sentence, exits and leave, earned privileges according to risk assessment by the establishment, and emergency leave, medical transfers, complaints, and appeals of the disciplinary process.

70 The others are the OPGs in Barcellona, Castiglione delle Stiviere, Montelupo Fiorentino and Reggio Emilia.

71 The Napoli San Efremo OPG (1992 and 1996) and the Montelupo Fiorentino OPG (2000).

120. The patients' legal status could be analysed as follows:

- 100 patients declared criminally irresponsible and involuntarily placed in an OPG under Section 222 of the Penal Code[72];
- 66 patients whose provisional placement in an OPG had been ordered under Section 206 of the Penal Code[73];
- 7 sentenced prisoners requiring psychiatric care placed in the OPG under Section 148 of the Penal Code[74];
- 64 patients declared partially criminally irresponsible and placed in a "care and detention centre" (*Casa di Cura e Custodia)*[75] under Section 219 of the Penal Code[76];
- 31 patients provisionally placed in a *Casa di Cura e Custodia* under Section 206 of the Penal Code.

The Aversa OPG has not accommodated prisoners under psychiatric observation for nearly four years, as this procedure now takes place at the San Egliano Prison Medical Centre.

121. Since its first visit to Italy, in 1992, the CPT has been following the debate on the reform of prison health care, including with regard to the situation in the OPGs. Following a period of some years' experimentation in a number of regions, responsibility for health care in prisons was permanently transferred from the Ministry of Justice to the Ministry of Health under the law of 24 December 2007 (cf. paragraph 87). The OPGs were also included in this huge transfer process, regulated by implementing decrees issued in the course of 2008, and specific instructions were issued on 19 March 2008. The date set for the effective transfer of responsibility was 1 October 2008, just a few days after the end of the CPT's visit to Italy. Responsibility for the Aversa OPG itself was transferred to the Caserta 2 Local Health Care Agency (ASL).

122. The delegation's visit to the Aversa OPG accordingly took place at a critical juncture when the establishment was half-way through this difficult process, and many uncertainties surrounded the arrangements for the transfer to the Ministry of Health. For instance, the OPG's Medical Director had not yet been officially appointed and had had only a very brief meeting with the Director of the Caserta 2 ASL; the staff were in a state of uncertainty about their contractual situation, since only one information session had been organised for them in July 2008; the continued availability of funds after 1 October 2008 was not certain. All the information at the delegation's disposal, gathered from many sources, seems to indicate that this reform of the OPGs – while deemed essential by the CPT and long-awaited – seemed to have been ill-prepared, badly planned and implemented without any real consultation or information taking place at the level of the regional and local authorities, or the establishments themselves.

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72 Under Section 222 of the Penal Code, persons declared criminally irresponsible for their acts shall be placed in a judicial psychiatric hospital for a minimum of two, five or ten years. The duration of their stay can subsequently be reduced or prolonged on the basis of the danger to society which the person concerned represents.

73 Under Section 206 of the Penal Code, defendants who become a danger to others shall be transferred to a judicial psychiatric hospital under a provisional security measure; this measure shall be revoked when the judge considers that the person concerned no longer represents a danger to society.

74 Under Section 148 of the Penal Code, prisoners who develop a mental illness following their conviction may be placed in an OPG by court order (at the same time, the execution of the prison sentence may be postponed or suspended).

75 A *Casa di Cura e Custodia* is legally speaking a distinct establishment from an OPG.

76 Under Section 219 of the Penal Code, persons with limited criminal responsibility shall be placed in a *Casa di Cura e Custodia* for a minimum of six months, one year or three years.

Furthermore, the transfer of the OPGs to the Ministry of Health rather paradoxically seems to have presented the opportunity for the prison authorities to "recover control" of the OPGs through the appointment of "Prison Directors" within these establishments, who were to be assisted by "Medical Directors". The former were given overall responsibility for the establishment (in particular the administrative, accounting and security aspects), while the latter were entrusted with the strictly therapeutic aspects. An approach of this kind seems inconsistent with the initial aim pursued, that of reinforcing the health-care and therapeutic aspects of these establishments. **The CPT would like to receive the comments of the Italian authorities in this respect.**

123. In any event, the CPT very much hopes that the transfer of responsibility for health care from the Ministry of Justice to the Ministry of Health will provide the opportunity for a genuine overhaul and complete re-examination of the foundations and organisation of the health-care arrangements for prisoners suffering from mental pathologies. One long-term solution might be to go beyond the very concept of OPGs and move towards high-security psychiatric hospitals where only health-care staff are present. **The CPT wishes to receive a detailed evaluation of the process underway, as well as information on the Italian authorities' medium- and long-term plans.**

b. ill-treatment

124. During its visit, the delegation received no allegations of ill-treatment of patients by the establishment's staff, whether health-care or prison personnel. On the contrary, it observed that good relations existed between patients and the various categories of staff, and it wishes to acknowledge the dedication to duty shown by the latter.

125. Brawling between patients (often linked to trafficking/theft of cigarettes) was, however, very common. These incidents were usually settled by transferring patients from one residential wing to another; in exceptional cases they could result in a patient's transfer to another OPG. Intensive use of transfers subsequent to incidents, as observed by the delegation, is scarcely conducive to the establishment of a stable, high-quality therapeutic relationship between patients and health-care (and custodial) staff. In addition, it does not indicate an appropriate approach to overcoming and managing interpersonal and group conflicts in such establishments, not to mention the therapeutic benefits that the patients themselves could derive from such an approach. **The CPT invites the Italian authorities to review the policy applied in these matters and to develop procedures for managing conflicts between patients (and possibly between staff and patients) that are more appropriate to the specific environment of a health-care establishment such as an OPG. These procedures should be an integral part of the training given to staff working in OPGs (both basic and in-service training).**

126. At this time, the CPT would like to underline the totally unacceptable situation at the OPG at Aversa, concerning the conditions and procedures followed with regard to the physical restraint of patients. In the view of the CPT, the situation observed appears tantamount to inhuman and degrading treatment. This subject will be dealt with later in the report.

c. material conditions and regime

127. The OPG had a total of six residential units, namely the "*Nuovo Reparto*" unit (sectors A (30 patients), B (33 patients), C (36 patients) and D (28 patients)); Unit No. 3 (16 patients); Unit No. 5 (36 patients); Unit No. 6 (43 patients); Unit No. 8 bis (43 patients) and Unit No. 9 bis (21 patients)[77]. The residential units accommodated patients of all categories, regardless of their pathology or legal status. Moreover, assigning patients to units was apparently the responsibility of the custodial staff (and seemed to be based primarily on the number of places available). At best, an attempt was made to group together the most seriously affected patients in the "Nuovo Reparto" unit (opened in 2004), those with jobs in Unit No. 3 and the most stable, least dependent ones in Unit No. 9 bis (where the regime was one of so-called reduced supervision (*custodia attenuata*)). The OPG also had a unit used solely for the observation/isolation of arrivals who were new to the institution (Unit No. 4, with three single rooms).

128. Patients' material conditions varied considerably depending on the unit in which they were accommodated. They could be qualified as generally good in Units Nos. 3 and 5, which had both been recently renovated. In these units, patients were accommodated in dormitories offering an acceptable amount of living space and with satisfactory access to natural light, artificial lighting and ventilation. The beds and bedding and the various pieces of furniture (tables, chairs, cupboards, etc.) were in good condition and sufficient in number. In addition, the rooms were equipped with television sets and a call system. The sanitary facilities were well-equipped, clean and in good condition.

129. Material conditions were, however, unsatisfactory in the other units, and even very mediocre in Unit No. 6 and the *Nuovo Reparto* unit. The living space in the dormitories was smaller (some even had bunk beds, contrary to the prison authorities' guidelines), and they were less well-equipped (the number of cupboards, chairs and tables was insufficient) and sometimes disgustingly dirty. Further, the sanitary facilities were generally in a very poor condition (no hot water, leaking waste-water pipes, etc.). The presence of rats had even been reported in the exercise yard and certain sectors of the *Nuovo Reparto* unit. In a great many dormitories, the lack of furniture, apart from beds and shelves, and in particular the almost total lack of any personal belongings and decorative objects, gave the premises a very austere, impersonal quality.

130. The day-to-day regime offered to patients in the OPG was restricted and monotonous. The daily routine revolved essentially around meals, the taking of medicines and exercise (four hours per day), which, moreover, took place in yards with a fairly oppressive atmosphere. The patients therefore spent most of their time in the dormitories or the corridors of their respective units, watching television, reading or simply lying in bed. Some 25% of them performed small paid jobs (cleaning, meal preparation, etc.). The Aversa OPG had neither the facilities nor sufficient staff to provide a daily programme of activities for the vast majority of the patients. The day-to-day regime offered to patients fostered idleness and did little to encourage the development of autonomy.

Attention should be drawn to the efforts being made by groups of volunteers, working under the educators' supervision, although they can in no way replace the health authorities in a role which is first and foremost their responsibility.

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[77] At the time of the visit, Units Nos. 8 and 9 were closed for renovation work.

131. The CPT also asks itself whether accommodating patients placed in OPGs together with patients who are the subject of a *Case di Cura e Custodia* placement is appropriate and legally founded. **The CPT would like to receive clarification regarding this subject.**

132. To sum up, the delegation observed a material environment with hardly any therapeutic value, which, combined with a very limited daily regime, is, in the opinion of the CPT, likely to worsen the condition of patients, most of whom have serious problems regarding contact with reality and relations with others.

**The CPT recommends that the Italian authorities:**

- **re-examine forthwith the running of the Aversa OPG with regard to both the material conditions and the patients' daily regime. The aim should be to establish a therapeutic environment, with residential structures based on single rooms or small units, which can facilitate the allocation of patients to relevant categories for therapeutic purposes;**

- **pursue their efforts to improve the number and variety of day-to-day activities offered to patients;**

- **improve the conditions under which patients take outdoor exercise and make it possible for patients to pursue supervised recreational and sports activities.**

133. Special mention must be made of the few bedridden and/or incontinent patients present in the establishment. As the CPT delegation could see for itself, for lack of appropriate equipment, the staff were reduced to using makeshift solutions, which required them constantly to change the foam mattresses and sheets. Such expedients are unacceptable in a hospital, which should have suitable equipment, in particular, beds with mattress protectors and/or mattresses suited to the patients' condition. The CPT was subsequently informed that the Director of the OPG had submitted a request along these lines to the local health authorities[78]. **It would like to be informed of the follow-up to this request.**

134. More generally, the standards of hygiene in certain residential units left much to be desired. The delegation noted that the OPG's management had attempted to improve the situation in 2008 by recruiting six cleaning staff. However, the CPT considers these efforts to be completely inadequate, albeit praiseworthy. Mentally ill patients can scarcely be required to look after their rooms (and their residential units) in the same way as ordinary prisoners. **The CPT recommends that the number of cleaning staff working in the establishment be increased with the aim of attaining hospital-level hygiene.**

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[78] See the letter dated 14 November 2008 from the Italian authorities to the CPT.

135. The delegation also finds it regrettable that the renovation work in progress or planned at the OPG did not afford the opportunity for the authorities to review the arrangements for accommodating patients in dormitories. This type of structure is indeed hardly conducive to the implementation of a programme of rehabilitation and care aimed at gradually fostering the patients' autonomy (apart from the possible problems of lack of privacy and of mixing patients with different pathologies and legal status). **The CPT trusts that this will be taken into account in future renovation projects.**

d. treatment and rehabilitation

136. The primary aim of a patient's stay in an OPG should be, with regard to the objective criteria that led to his/her placement, to provide a positive therapeutic environment conducive to the patient's rehabilitation (and his/her discharge from the establishment). However, at the Aversa OPG, the conditions for such a care approach are far from being met. The time during which psychiatrists are present is manifestly insufficient: an average of 330 hours per month for over 250 patients in the first quarter of 2008, reduced to 250 hours in June (giving one hour of attendance per patient per month)[79]. In addition, only two full-time psychologists monitored the hospital's 268 patients, which made any personalised therapeutic work unrealistic. Nor were there any dedicated staff on site to take charge of occupational therapy activities and, as already mentioned, the few activities of this kind were run by outside volunteers[80]. More generally, it should be noted that no individualised treatment plans were drawn up for patients by the health-care teams; treatment therefore consisted essentially of pharmacotherapy.

A situation with failings of this kind is likely to call into question the purpose of the "therapeutic" role played by this type of establishment. In the CPT's opinion, it is necessary to enhance considerably the treatment options offered to patients in the Aversa OPG (in particular occupational, group and individual therapies) and, first and foremost, to draw up individualised treatment plans for all of the hospital's patients. This would clearly necessitate a considerable reinforcement in the number of health-care staff in the establishment (see paragraph 145). **The CPT recommends that the Italian authorities draw up individualised treatment plans for all patients and further develop therapeutic activities in parallel, in the light of the above remarks.**

137. General medical care was dispensed by a team of five house physicians, each of whom had been allocated one or more residential units. On working days, these physicians held three-hour morning surgeries in the residential units. In addition, a doctor was on duty around the clock within the OPG. A team of seven general practitioners took turns to be on duty. Because one of these doctors was always present in the OPG, they de facto ensured the continuity of somatic and psychiatric care in the establishment (including decisions concerning emergency admission to an outside hospital and the use of means of restraint).

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79 In response to this situation, the OPG's Director issued a staff notice requiring the psychiatrists to ensure a total of 380 hours' presence per month, as from July 2008.

80 20% of the patients participated in therapeutic activities on a more or less regular basis, such as music therapy (4 patients); drama therapy (11 patients); animal therapy (3 patients); film discussion group (10 patients).

138. Specialist care was also available at the infirmary (cardiology, ophthalmology, dermatology, surgery, orthopaedic care, radiology, ultrasound scans). Dental care was also provided (there were one or two surgeries per week). That said, **both the radiography equipment (over 35 years old) and the dentist's chair (over 15 years old) were outdated and should be replaced.**

139. With regard to the medical files, the diagnostic and monitoring notes were generally satisfactory, **but the psychiatric notes were quite brief and incomplete.** Medical confidentiality was respected throughout the establishment.

140. Lastly, the OPG had recently (2007-2008) recorded a significant number of suicides (five in fourteen months). The establishment's medical practitioners had discussed the situation and a number of criteria had been identified. However, it did not seem that a genuine suicide prevention programme had been put in place following these discussions. The CPT naturally takes into account the remarkable work done by the Italian prison authorities in this field over many years; however, it considers that a study of the particular situation of OPG patients should be undertaken at national level, which would lead to the introduction of a specific suicide prevention programme adapted to OPGs. **The CPT invites the Italian authorities to take the necessary steps to this effect.**

e. staff

141. The Aversa OPG had a team of eight registered psychiatrists, each of whom held surgeries for between 30 and 60 hours per month. Each of these psychiatrists monitored the patients of a given residential unit, which amounted to an average of about forty patients each. As already mentioned in paragraph 136, this number of surgery hours did not adequately cover the needs of a population of over 250 persons suffering from mental pathologies, especially since some of the psychiatrists stated that they spent a not inconsiderable part of their time preparing assessment reports for the judicial authorities (in connection with the review of placement measures), rather than caring for patients.

142. With regard to staff qualified to run therapeutic activities, two full-time psychologists (working 34 hours per month) looked after about 130 patients each, allocated on an alphabetical basis. A team of four educators co-ordinated the work done by the volunteers (some thirty in all, usually trainee psychologists), who regularly organised activities both inside and outside the OPG. That said, the bulk of the educators' work was of an administrative nature[81]. It should also be pointed out that linking the activities of the psychologists and the educators with the psychiatrists' work was difficult due to the latters' intermittent presence and the lack of formal meetings (see paragraph 149).

[81] In particular, they co-ordinated the preparation of the files needed for various hearings, whether of an administrative nature (Assessment Board hearings) or judicial (hearings by the judge supervising the execution of sentences).

143. A team of about fifty nurses provided day-to-day nursing care. Unfortunately, the number of nursing staff was clearly insufficient for the needs of a psychiatric hospital with over 250 beds. At best, it merely allowed the presence of one nurse per residential unit[82] (in addition to one custodial staff member per unit, who had just been added to the team), although the nurses were not allocated to a particular unit. Furthermore, none of the OPG's nurses had apparently received specialist psychiatric training. The delegation was, however, informed that efforts were being made at a local level to ensure that nurses working at the hospital received some in-service training.

144. Lastly, the CPT has also taken note of the lack of a pharmacist at the OPG, the role being fulfilled by one of the general practitioners.

145. To sum up, the limited number of hours during which the psychiatrists were present, combined with the small number of psychologists, educators and nurses and the lack of occupational therapists, considerably restricted the possibility of giving patients access to therapeutic activities, and impeded the establishment of a therapeutic environment based on a multidisciplinary approach. Consequently, **the CPT recommends to the Italian authorities:**

- **that the psychiatrists' attendance hours be substantially increased, so as to ensure adequate cover every day in each unit, and a psychiatrist on call for the OPG around the clock;**

- **that the number of nursing staff be considerably increased so that three nurses (or two nurses and one medical orderly) are present during the day-shift in each residential unit;**

- **that the team of qualified specialists responsible for running the therapeutic and rehabilitation activities be reinforced, by increasing the number of psychologists and recruiting occupational therapists;**

- **that the educators be relieved of the administrative duties that are not part of their job and that additional social workers be recruited to liaise with the external social services.**

Further, **the problem of the management of the pharmacy in the OPG should be resolved.**

146. As regards the practice whereby the psychiatrists fulfil the dual role of treating doctor and expert for the judicial authorities, **the CPT wishes to emphasise that, in the interest of safeguarding the doctor/patient relationship, psychiatrists should not be required to draw up psychiatric reports on their own patients for judicial authorities.**

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[82] Plus a co-ordinating nurse in certain residential units.

147. Lastly, the hospital had a total of 118 custodial staff[83], members of the prison service, who were responsible for order and security in the residential units and for guarding the hospital's perimeter. It is regrettable that these members of staff, as they themselves pointed out, had received no specific training before beginning to work in the psychiatric hospital (they were apparently given only a very brief training session upon taking up their duties). Working with the mentally ill will indeed always be a difficult task for all categories of staff involved. Bearing in mind the challenging nature of this work, it is of crucial importance that staff performing security-related tasks in an OPG be carefully selected and that they receive both appropriate training before taking up their duties and in-service training. Further, during the performance of their tasks, they should be closely supervised by qualified health-care staff. **The CPT recommends that the Italian authorities take the necessary steps to comply with the above principles. In particular, training schemes for prison service staff working in judicial psychiatric hospitals should be developed.** This will reduce the risk of conflict between the care and custodial functions inherent in the current system.

148. In this connection, the delegation noted that certain members of custodial staff were concerned about the transmission by the medical and paramedical staff of strictly necessary information on the condition of patients, enabling them to perform their duties in an optimal manner (and also to give the health-care staff feedback on developments in the condition of patients). **A solution should be found making it possible to safeguard medical confidentiality, while providing the custodial staff with appropriate information.**

149. The delegation was struck by the general lack of formal meetings of health-care staff within the establishment[84], whether multidisciplinary (within each residential unit) or cross-sectoral (between all the psychiatrists in the OPG, for example). Informal communication plays an important role in a health-care establishment. However, proper medical management inherently involves certain formal elements, including the holding of regular meetings (for clinical, team, managerial, multidisciplinary or other purposes). **The CPT recommends that such meetings be introduced at all levels within the OPG.**

f. means of restraint and seclusion

150. In any psychiatric establishment, the use of means of restraint on agitated and/or violent patients may on occasion be necessary. This is an area of particular concern to the CPT, given the potential for abuse and ill-treatment.

151. At the Aversa OPG, patients who showed auto- or hetero-aggressive behaviour or who were seriously disturbed were immobilised on a restraint bed using cloth straps and/or were given sedatives. Patients were immobilised by order of the duty doctor/psychiatrist or, in cases of emergency, a nurse, subject to approval by the duty doctor/psychiatrist. The delegation was informed that the custodial staff could be called to assist nurses in immobilising a patient.

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83 Two directors, six inspectors (for eleven intended posts), 19 sub-intendants and 91 officers (out of 69 intended posts).

84 Except for meetings of the Assessment Board, discussed later in the report.

152. The three restraint beds were located in a room at the end of the corridor in Sector A of the *Nuovo Reparto* unit. Fixed to the floor, these beds had a foam mattress with a rubber cover and a central opening allowing patients to relieve themselves when necessary. A bucket to collect the excrement was positioned under the opening in question.

The patients were attached to the bed with cotton straps; those used to secure their hands were sewn in place around the wrists with a big needle that resembled an upholsterer's needle. The straps at the wrists and ankles[85] and the chest band were never removed, not even at meal times. In consequence, a nurse hand-fed the patient. Furthermore, the patient was not washed during the whole period of his restraint. In addition, he stayed fixed to the bed, wearing just a vest; the lower half of his body was naked and covered only with a sheet.

The initial information gathered by the delegation was that the episodes of restraint did not generally exceed 24 to 48 hours, and that patients were checked on very regularly by the nurse (every 30 minutes) and regularly by the duty doctor (every two to three hours). Consultation of the registers and medical files in Sector A and speaking with patients soon demonstrated that the checks were much less frequent, that is to say, the nurse visited two or three times a day, and the doctor, once a day at best. The rest of the time, the patient was apparently left unattended. In addition, it emerged that the restraint beds were occupied virtually all the time[86] and that very long periods of restraint (of up to 9 or 10 days at a time) had been applied[87]. The CPT considers that the material conditions in which the restraint is applied in the Aversa OPG, the duration of the measure observed, the absence of human company, and the sporadic clinical monitoring of patients, are tantamount to inhuman and degrading treatment.

153. As already indicated in paragraph 3, the CPT's delegation also visited the Naples (San Eframo) OPG, which is temporarily housed in a wing of the Naples-Secondigliano Prison, in order to enquire into the conditions and procedures in force there regarding the use of means of restraint. Contrary to what had been observed at the Aversa OPG, the material conditions were better here and the episodes of restraint much less frequent (approximately five cases per month, of which about a third lasted more than 12 hours, without, however, exceeding 48 hours). In addition, a guard was present the whole time very close to the restraint room (seated at a table, near the door), and a nurse came to check on the patient every two hours. One of the patient's arms was regularly freed to allow him to drink and eat, and a bedpan and a urinal were close by. That said, certain shortcomings had been observed, in particular a recording that had not been completed of information relating to episodes of restraint and rather superficial monitoring by a psychiatrist.

154. At the end of the visit, the delegation made an immediate observation to the Italian authorities, under Article 8, paragraph 5, of the Convention, requesting a complete revision of the seclusion and restraint procedures in force at the Aversa OPG based on the CPT's established standards in this matter. It asked to be informed within 30 days of the decisions and measures taken. In a letter dated 14 November 2008, the Italian authorities announced that the management of the OPG had approached the local health authorities with the aim of bringing the Aversa OPG's procedures in this matter into line with those applied in public health establishments.

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85 There were "tightening devices" at the end of the fastening, close to the bed, but these were no longer used.

86 Nonetheless, to its credit, as far back as 2004, the management of the Aversa OPG had initiated a review of the use of seclusion and restraint measures, which had led, inter alia, to a drastic reduction in the number of restraint beds (from ten to three).

87 As an example, the beds were in use for 29 days in January 2008, 28 days in February 2008, 14 days in March 2008, 23 days in June 2008, 24 days in August 2008… for average durations of 5 to 7 days, the delegation having noted a maximum duration in 2008 of 9 days (from 27 July to 4 August 2008).

155. The gravity of the situation observed at the Aversa OPG calls for a more determined response from the Italian authorities, preferably at national level. This response must, inter alia, be founded on the principles established by the CPT with regard to the use of means of restraint[88], which should serve as a base for the drawing up of a clear policy on this matter. **The CPT recommends that immediate steps be taken to this end.**

156. The delegation was informed that seclusion of patients was, in principle, not practised at the Aversa judicial psychiatric hospital[89]. The CPT welcomes the fact that there is a clear trend in favour of no longer resorting to seclusion of violent or otherwise "unmanageable" patients.

Nonetheless, during the visit, the delegation noted that one patient had apparently been kept alone in a single room, in de facto permanent isolation from the other patients, for at least seven months, if not a year. This patient's case was discussed at length with the care and custodial staff. The patient, who suffered from a chronic respiratory disorder and who had uncontrollable cravings to smoke, had been placed in isolation for reasons that remain unclear, since the reasons advanced were scarcely convincing and in some respects contradictory. In addition, the patient was allowed only 30 minutes' exercise per day.

The CPT considers that this patient's case is symptomatic of the quantitative and qualitative shortage of care-staff in the residential units. The patient's situation should be reviewed, in particular the reasons for secluding him and the conditions under which he is confined to a single room. **The Committee recommends that immediate measures be taken along these lines**. In addition, **this patient should be allowed the same exercise time as other (non-secluded) patients**.

g. safeguards

157. The CPT will not revisit in detail the legal basis for placements in OPGs or the procedures in force, since they were described in its previous visit reports (1992, 1996 and 2000)[90]. It nonetheless wishes to raise a number of questions which aroused the delegation's concern while it was visiting Aversa. In this context, the CPT also has in mind the considerable differences that exist between the relevant legislation and safeguards concerning civil patients (the TSO procedure – see the following section) and those concerning forensic patients[91].

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88 "Means of restraint in psychiatric establishments for adults", CPT/Inf (2006) 35, paragraphs 36 to 54, and in particular the cases of recourse to restraint, the means used, permanent monitoring of patients by qualified staff, staff training, etc.

89 This of course does not concern other grounds for isolating patients, as in the case of certain infectious diseases.

90 The Italian Penal Code establishes the legal basis for the involuntary placement of persons deemed not to be criminally responsible for their acts or who have developed a mental illness after having committed an offence. The prolongation, modification or termination of these persons' placement in a judicial psychiatric hospital is decided by a judge supervising the execution of sentences on the basis of a recommendation issued by a board (known as the Assessment Board) composed of psychiatrists and other hospital staff (psychologists, social workers, educators). The patient, his/her family or his/her legal representative can appeal against the decision and can also request an independent opinion from an outside psychiatrist. During the period of hospitalisation, the application of the security measure is regularly reviewed within time-limits determined by law.

91 Not to mention the considerable difference in human and material resources, since a "civil" patient costs more than 200 Euros per day, and a "judicial" patient just over 50 Euros.

158. The first question concerns a matter of principle, the possibility for a "judicial" patient to refuse to be treated without his/her consent. The CPT considers that placement of a patient in a judicial psychiatric hospital[92] does not necessarily allow the health-care staff to disregard the generally recognised rule of "free and informed consent" to treatment. However, during the visit it came to light that, from to time, the health-care staff administered treatment by force (even if this took place in a very small number of cases).

In the case of civil psychiatric patients, this question has been settled by means of Law No. 180, which lays down a specific procedure designed to safeguard patients' rights. It can legitimately be asked why the general principles relating to the forced administration of treatments are not applied in the OPGs. This observation is all the more relevant since there currently seems to be no legislation expressly authorising health-care staff to proceed in this way. The recent transfer of the OPGs to the Ministry of Health should be an opportunity to launch a substantive debate on this subject. **The CPT would like to receive the Italian authorities' comments on this matter.**

159. The second question is a recurring one, already raised by the CPT and which has clearly still not been resolved in a satisfactory manner. It concerns the fact that, as the psychiatrists themselves acknowledge, some 20 to 30% of the patients held in OPGs who no longer pose any danger to society and whose mental condition no longer requires them to be detained in a psychiatric establishment, remain in the OPG due to a lack of adequate care and/or accommodation in the outside community (whether within their families or in an institution). This phenomenon seems all the more acute when it concerns patients who are being treated far from their place of residence, or patients of foreign nationality. The CPT wishes to recall emphatically that for persons to remain deprived of their liberty solely as a result of the lack of appropriate external facilities is a highly questionable state of affairs[93]. **The CPT recommends that the Italian authorities take the appropriate steps to ensure that patients are not detained in OPGs for longer than their mental condition requires.**

160. In the same context, the CPT delegation noted that the various concepts of "dangerousness to society" (expressly mentioned in the legislation), criminal dangerousness (the risk of recidivism) and psychiatric dangerousness (linked to mental pathology) influenced, and interacted with, the supervising judges' decision-making processes when reviewing a patient's placement in an OPG. Since they are not well-defined, these concepts lend themselves to very broad, subjective interpretations, and to patients sometimes remaining in an OPG for lengthy periods (so-called "*ergastolo bianco"*)[94]. This situation increases further the need to introduce into the judicial process advice from independent psychiatric experts who do not have medical links to the patient (cf. paragraph 146). **The CPT would like to receive the Italian authorities' comments on this subject.**

161. On a strict point of procedure, the CPT delegation noted that, in a number of cases, patients were apparently kept in the Aversa OPG even when their respective placement orders had expired (the prolongation by the supervising judge having been issued retrospectively, several weeks later, and in one case nearly one year later). Such a state of affairs is again highly questionable and raises questions under the European Convention on Human Rights. **The CPT recommends that immediate steps should be taken to put an end to such situations.**

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92 Or a *casa di cura e custodia.*

93 Cf.*, mutatis mutandis*, the recent judgment *Scoppola v. Italy* (Application No. 50550/06 of 10 June 2008).

94 Five patients had been detained for over 20 years, three for over 15 years and seven for over 10 years.

162. Generally speaking, the information given to patients leaves a great deal to be desired. The majority of the patients interviewed had received no written information on the rules in force in the OPG (patients' rights and obligations). **The CPT recommends that a brochure describing the running of the hospital and the patients' rights and obligations be issued to each patient and his/her family at the time of admission. Patients who are unable to understand this brochure should be provided with appropriate assistance.**

163. Lastly, certain situations brought to light in this report (and in the past, concerning the other OPGs visited by the CPT) fully justify that the OPGs (and the *Case di Cura e Custodia*) be subject to inspections by the specialist inspection bodies already active in hospitals. Particular mention should be made of the *Nuclei Antisofisticazioni e Sanita* (NAS – sanitary inspection task force) attached to the *Carabinieri*. **The CPT recommends that the NAS be authorised to carry out regular, unannounced visits to OPGs and *Case di Cura e Custodia*.**

### 2. Psychiatric Diagnosis and Treatment Department (SPDC) at San Giovanni Bosco Hospital, Naples

164. Supplementing its visit which focused on the Aversa OPG, the delegation made a very brief visit to the SPDC at the San Giovanni Bosco Hospital in Naples, in order to monitor any developments which might have occurred in the context of the legislation on involuntary medical treatment (TSO), as regulated by Law No. 180 of 13 May 1978. In this context, it should be recalled that the CPT had, at the end of its visit in 2004 to the SPDC at San Giovanni di Dio Hospital in Agrigento, made a number of recommendations to the Italian authorities regarding the procedures implemented in application of the said law and, in particular, regarding the safeguards offered to patients who are involuntarily hospitalised and treated without their consent[95].

165. The SPDC at San Giovanni Bosco Hospital in Naples is a small health-care facility with 12 beds[96], which is part of ASL Napoli 1. Located on the premises of the hospital of the same name, it is physically separated from the rest of the hospital, mainly for security reasons. Overall, the premises are clean and bright. There is one male ward (4 beds) and two female wards (each with 4 beds), with adjoining bathrooms. A common room/refectory (with a television set and a public telephone) and a small enclosed garden complete the facility, offering patients satisfactory material living conditions. The daily routine revolves around meals, exercise, treatment and visits from families.

166. At the time of the visit, the SPDC was accommodating eight patients (three men and five women), only one of whom was the subject of a TSO measure. The patients being cared for at the SPDC (whether they were TSO patients or not) all benefited from abundant care, in accordance with an individual treatment plan based on pharmacotherapy and backed up by psychotherapy. Changes in the clinical condition of patients were regularly reviewed, as was their treatment. It should be noted that physical restraint (other than manual) was not practised at the SPDC.

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95 Cf. CPT/Inf (2006)16, paragraphs 145 to 159.

96 During 2007, the management team had reduced the number of beds in use to eight, as it wished to have an adequate nurse/patient ratio to provide quality care, namely "a minimum of one nurse for every three patients".