RESST | Rete di Supporto per le persone Sopravvissute a Tortura

Italian Network for the Support of Torture Survivors

in collaboration with ActionAid

Submission to the United Nations Committee Against Torture regarding the Committee's Seventh Periodic Review of Italy

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About the Submitting Organisations

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The **Italian Network for the Support of Survivors of Torture (ReSST - Rete per il Supporto ai Sopravvissuti a Tortura)** is a national platform that brings together local services, public and private entities, and NGOs providing specialised support for survivors of torture and severe intentional violence. Its mission is to strengthen the national system of protection and rehabilitation and improve institutional and social responses to extreme trauma.

The Network promotes information and awareness-raising on torture and its physical, psychological and social impacts, fostering better public understanding and compliance with international standards. Through collaboration among its members, ReSST works to expand and improve dedicated services and to promote long-term, multidisciplinary rehabilitation pathways essential for survivors' recovery. It also supports access to complementary forms of protection, support and reparation, recognising the multiple dimensions of harm caused by torture.

https://controlatortura.it/en

RESST comprises public and private bodies operating in Italy to support the rehabilitation of survivors of torture and other serious forms of intentional violence. The following associate members are part of the Network: **Multiethnic Cultural Association "La Kasbah" | Caritas Rome | CIAC – Centre for Immigration, Asylum and International Cooperation | Doctors Against Torture | MEDU – Doctors for Human Rights | MSF – Médecins Sans Frontières | NAGA.**

RESST observers are organisations and experts committed to the prevention of torture, without directly running rehabilitation programmes for survivors: **A Buon Diritto, Amnesty International, Antigone, SIMM - Italian Society of Migration Medicine.**

The report was developed in collaboration with

actionaid
REALIZZA IL CAMBIAMENTO

1. Introduction

This contribution focuses on Italy's implementation of Article 14 of the UN Convention against Torture. In particular, the briefing summarises analyses and recommendations regarding compliance with the obligation to provide the necessary means for *'as full rehabilitation as possible'*, understood as a form of reparation aimed at restoring the physical, mental, social and professional autonomy and capacities of torture victims, thereby ensuring their full reintegration into society.

In light of the regulatory framework and the comprehensive guidelines set out in *General Comment No. 3*[1], the submitting organisations intend to analyse the extent to which Italian practices regarding the rehabilitation of victims of torture deviate from international standards, highlighting the degree of non-compliance with the requirements relating to the adoption of a *'long-term integrated* approach' and the guarantee of specialist services for victims that are *'available, appropriate and readily accessible'.*

The observations presented in the document make explicit reference to rehabilitation obligations relating also to victims of acts of torture perpetrated outside Italian jurisdiction, given that the organisations of the ReSST are primarily engaged in support programmes aimed at migrants and refugees who have survived torture in their countries of origin or along migration routes to Europe.

From a methodological perspective, the document summarises the reflections and insights emerging from the consultations and numerous *focus groups* conducted in recent years by the Network, which involved practitioners and experts engaged in the design and evaluation of the activities conducted. In preparing this report, this wealth of knowledge and experience was used to draw up a thematic outline, which was subsequently submitted to a group of experts from organisations affiliated with ReSST and to a sample of around 800 practitioners active in the fields of healthcare and the reception of migrants and refugees. These practitioners were asked to complete a self-administered questionnaire comprising 22 questions designed to reveal, amongst other things:

- the perception of their ability to identify and assess the needs of torture victims
- the existence and use of clinical and psychological protocols
- the level of specialist training received
- collaboration with the National Health Service (NHS)
- the services provided and the methods and continuity of funding.

167 practitioners responded to the questionnaire. The responses must be interpreted bearing in mind that the participants belong to the Network's organisations or take part in their activities. This implies, in all likelihood, greater awareness and activism on the issue, a circumstance that may have influenced the nature and quality of the responses provided.

2. Migrants, refugees, and victims of torture: some background data

For at least two decades, Italy has been one of the main points of entry into Europe for migrants and asylum seekers from Africa, the Middle East and the Indian subcontinent. In a global context characterised by increasingly restrictive and punitive migration policies, most people are forced to take irregular routes, relying on trafficking networks and facing extremely dangerous journeys by land

[1] See UN Committee Against Torture, *General Comment No. 3. Implementation of Article 14 by State parties,* 2022 (CAT/C/GC/3).

and sea. Against this backdrop, torture and inhuman or degrading treatment have become structural elements of the migration experience.

Italy is the leading European country for arrivals by sea. Following the peak recorded in 2023 (around 158,000 arrivals by sea), a marked reduction was observed in 2024 (66,000 arrivals, down 57.9% on the previous year). In 2025, arrivals by sea remained largely stable: 66,000, a decrease of 0.5% compared to 2024. In the two-year period 2024–2025, Libya once again became the main country of departure for Italy[2]. The systematic nature of violence along the transit routes suggests a high number of survivors of torture and ill-treatment among those reaching the country.

The progressive deterioration of migration conditions has made violence and torture structural elements of the migration experience[3]. Those crossing Libya or travelling the Balkan route are frequently exposed to cruel, inhuman and degrading treatment. Women face an additional burden of violence, resulting from a combination of racism and sexism[4].

Libya remains the epicentre of a widespread system of subjugation, exploitation and violence. In a recent joint report, UNSMIL and OHCHR denounced the persistence of widespread and systematic violations and abuses against migrants, asylum seekers and refugees, perpetrated by traffickers, smugglers, armed groups and state-affiliated actors involved in migration and border management[5]. In recent years, numerous organisations have repeatedly documented prolonged torture, arbitrary detention, enforced disappearances, sexual violence and exploitation by state and non-state actors, in a context of almost total impunity. Tunisia, too, having become one of the main transit countries to Italy, is the scene of systematic violence against migrants and refugees: torture, physical and sexual abuse, structural racism and practices of abandonment in the desert on the borders with Libya and Algeria are attributed to military and police forces.

In 2018, the UN Special Rapporteur on Torture cited a study on the prevalence of torture victims among undocumented migrants, indicating that this percentage can reach 76% depending on the context, with an estimated average of 27%[6].

Italy, the main country of arrival along the Central Mediterranean route, receives a significant number of people who have survived torture or ill-treatment in their countries of origin and transit. Based on average figures from the literature, we can estimate that only last year there may have been around 17,800 migrants and asylum seekers who arrived in Italy after suffering violence and torture during their journey, although clinical evidence suggests a much higher prevalence. According to estimates by Medici per i Diritti Umani, over 80% of migrants assisted in Italy over the last nine years reported having suffered torture or serious abuse in their countries of origin or transit[7].

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[2] Just consider that 88% of arrivals recorded in the first eight months of 2025 originated from this country. This shift has also affected the composition of the flows: in 2025, those departing from Libya were mainly citizens of Bangladesh (35%), Eritrea (15.4%) and Egypt (14.7%), whilst those departing from Tunisia were Tunisians (32.1%), Guineans (28.9%) and Ivorians (9.3%).

[3] See F. Perocco, "Torture, Structural Violence and Migration" in F. Perocco (ed.), *Migration and Torture in Today's World*, Edizioni Ca' Foscari, 2023, pp. 3–50.

[4] See G. Berta, F. Perocco, "Les violences sexuelles contre les migrantes en Amérique Centrale et en Libye, un exemple d'économie politique de la violence", in F. Moussa-Babaci, *Trajectoires de femmes migrantes*, L'Harmattan, pp. 99–118.

[5] See UNSMIL, OHCHR, *Business as Usual: Human Rights Violations* and Abuses Against Migrants, Asylum-Seekers and Refugees in Libya, February 2026.

[6] Sigvardsdotter E, Vaez M, Rydholm Hedman AM, Saboonchi F., *Prevalence of torture and other war-related traumatic events in forced migrants: A systematic review,* Torture. 2016; 26(2):41–73.

[7] MEDU, *Migrazione, trauma e salute mentale: una risposta possibile*, 2024. Available at: https://mediciperidirittiumani.org/frammenti-webreport/

In addition to the violence suffered prior to arrival, there are critical issues within the Italian system itself. The length and complexity of asylum procedures, the inadequacy of the reception system, accelerated border procedures, detention in repatriation centres, and exclusionary administrative practices can create contexts that cause further suffering, disproportionately affecting people who have already survived torture. Such conditions contribute to the creation of contexts permeable to systemic violence, 'torturous environments' that exacerbate pre-existing vulnerabilities. Physical, verbal, psychological and sexual violence is also found throughout the entire return process – from arrest to detention, from internal transfers to the return flight to the country of origin[8].

3. Italy's transposition of the obligations set out in Article 14 of the Convention and the protection of victims

The formal acts of the Italian State and the extent of their implementation

As clearly indicated in its Seventh Periodic Report, Italy has chosen to implement the obligations arising from the provisions of Article 14 of the Convention primarily by entrusting the Ministry of Health (MOH) with the adoption of specific Guidelines[9], which constitute the organisational and methodological framework of the Italian system.

Drawn up by an inter-institutional technical working group, the Guidelines[10] aim to guide the NHS in reorganising services for the early identification of the needs of asylum seekers and refugees. To this end, the document sets out operational guidelines on case management, promotes a multidisciplinary approach, with the health system acting as the coordinating body, and an integrated network of health, social, legal and linguistic-cultural mediation services. The overall objective is to facilitate access for victims of torture — who are often vulnerable or invisible — to appropriate care and rehabilitation pathways.

However, the adoption of the Guidelines cannot fulfil the positive obligations regarding rehabilitation set out in the Convention, as the document serves as a guideline and requires legislative transposition by individual regions to be effectively implemented. The regions are also required to put in place adequate organisational, funding and monitoring measures for the services.

Precisely to assess the level of implementation five years after their adoption (and a few months after the drafting of Italy's Seventh Periodic Report), Médecins Sans Frontières has carried out a

[8] See European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, *Report to the Italian Government on the visit to Italy carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT),* 2024, CPT/inf(2024) 34.

[9] Article 27(1-bis) of Legislative Decree 251/2007, as amended by Article 1 of Legislative Decree 18/2014, provides that the Ministry of Health shall issue guidelines with the explicit aim of *"providing guidance on the implementation of appropriate and uniform measures throughout the national territory (…) ensuring continuity between the refugee reception system and the social and healthcare assistance system*".

[10] Ministry of Health, *Linee guida per la programmazione degli interventi di assistenza e riabilitazione nonché per il trattamento dei disturbi psichici dei titolari dello status di rifugiato e dello status di protezione sussidiaria che hanno subito torture, stupri o altre forme gravi di violenza psicologica, fisica o sessuale*, Rome, 22 March 2017, p. 6.

comparative analysis of the various Italian regions[11], measuring the state of implementation of the Guidelines and the practices developed locally in the absence of their full application.

The analysis and mapping exercise has revealed a situation characterised by poor regional regulatory implementation and the presence of initiatives by the voluntary sector, which often largely or completely make up for the lack of public services dedicated to the rehabilitation of torture victims.

Only three regions have formally transposed the Guidelines through specific decrees[12]. This failure to comply is not merely a dysfunction or organisational shortcoming but represents, from a legal perspective, a crucial issue. Under the Italian constitutional framework (Article 117 of the Constitution), the protection of health is in fact a matter of concurrent legislation with respect to state legislation. Where the Guidelines have not been implemented, the practical availability within the local social and healthcare system of the services provided for the rehabilitation of victims of torture is effectively non-existent.

Subsequently, on 21 June 2023, the Ministry of the Interior (MOI) drew up and published the *"Handbook for the identification, referral and care of vulnerable individuals arriving in the country and entering the protection and reception system"*[13] *(*Vulnerability Handbook). This is an operational tool designed to propose uniform procedures and instruments to be adopted at all stages of reception, in accordance with current legislation[14]. However, in the absence of a legally binding framework for the social and health services responsible for the rehabilitation of torture victims, as provided for in the Guidelines, these procedures remain, so to speak, "suspended in a vacuum", serving merely as non-binding operational recommendations, particularly for public administrations not under the MOI, such as health services and local social welfare services outside the reception system.

The Prefectures have been invited to establish coordination between institutional actors, involving also entities not directly engaged in reception (*the* so-called *Vulnerability Roundtable*), in order to define standard operating procedures (SOPs) at the local level for the implementation of the Vulnerability Handbook. Regarding the identification and care of victims of torture, the Handbook refers to the MOH Guidelines, without introducing further operational guidance.

To date, most Prefectures have established the *Vulnerability Roundtable*, but few have finalised the SOPs most relevant to their local context and the priorities on which to develop any thematic analyses. Furthermore, in the SOPs published so far[15], there are no specific sections dedicated to victims of torture.

A further administrative measure of an implementing nature, which is considered of essential importance, is the Service Specification of the MOI (Ministerial Decree of 4 March 2024), which

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[11] Médecins Sans Frontières, *Attuazione delle Linee Guida per Assistenza e Riabilitazione delle Vittime di Tortura e Altre Forme di Violenza. Mappatura e analisi*, 2022, at https://www.medicisenzafrontiere.it/news-e-storie/news/vittime-tortura-rapporto/.

[12] Lazio (Resolution 590/2018), Tuscany (Resolution 1007/2020) and Piedmont (Regional Council Decision 437975/2018). A reference also appears in Sicily's Regional Health Contingency Plan for Migrants, although no other specific implementing measures are recorded. Finally, in the Marche region, a regional resolution has defined procedures for the care of forced migrants who are victims of physical, sexual or psychological violence, as well as physical or psychological torture, thereby indirectly implementing the national guidelines.

[13] The text is available at: https://www.interno.gov.it/sites/default/files/2023-06/vademecum.pdf.

[14] It should be noted, however, that the general failure to transpose and implement the Guidelines highlights not only the existence of an insufficient level of concrete implementation of the obligations under the Convention, but also constitutes a serious failure to comply with these international obligations, which cannot be remedied in any way by the adoption of purely organisational instruments such as the Vulnerability Vademecum.

[15] Agrigento, June 2025; Palermo, December 2025; Messina, February 2026.

governs tenders for the award of contracts for the management of reception centres, and which will be discussed in detail below. The primary legislation stipulates that the assessment of vulnerability, necessary to determine appropriate reception measures, is carried out based on the recommendations set out in the MOH Guidelines[16]: the failure of almost all regions to implement this document renders the primary legislation entirely ineffective. It is therefore clear that the regulatory framework provided for by Italian domestic law is fundamentally unsuitable for complying with the obligation laid down by the Convention, which requires States to establish a legal system guaranteeing effective access to the means and services necessary for *'as full a rehabilitation as possible*'.

Critical issues

Given this regulatory framework, the analysis conducted highlights that, although dedicated multidisciplinary teams exist in certain areas and exemplify good practices[17], significant systemic issues persist across most of the national territory. These issues can be grouped into three main thematic areas: 1) the organisation of the system, 2) the training of staff, and 3) the impact of these shortcomings on the actual provision of care for victims of torture.

1) Organisational aspects

In most areas, NHS facilities or other recognised institutions with specific expertise in treating post-traumatic conditions in migrants and refugees are not yet available. Across both Regions that have implemented the MOH Guidelines and those that have not, interventions are predominantly carried out through informal networks built up over time in collaboration with third-sector organisations, with public health services often participating only in a complementary role or for administrative purposes. Formal networks for assisting victims of torture exist only in Lazio and Emilia Romagna.

Although there are examples of good practice in collaboration between public services, reception centres and specialist organisations, there remains a critical and significant lack of specific funding allocated to local health authorities to ensure adequate support for victims of torture[18].

Healthcare services face numerous difficulties in liaising with the reception system, hindering the continuity of care required for the identification of torture-related trauma, which should be facilitated by a seamless handover from reception staff to social and healthcare workers, as stipulated in the Guidelines. In fact, only in a few exemplary cases is there structural collaboration between the healthcare system, local authorities responsible for reception projects, and the bodies managing SAI or CAS centres[19], with clear pathways for the identification of trauma, diagnostic assessment and

[16] See Article 9(4-ter) of Legislative Decree 142/2015: *"The assessment of the existence of special needs and specific situations of vulnerability, including for the purposes of the transfer of the applicant referred to in paragraph 1-bis and the adoption of appropriate reception measures referred to in Article 10, shall be carried out in accordance with the guidelines issued by the Ministry of Health, in consultation with the Ministry of the Interior and any other administrations concerned, to be applied in the centres referred to in this Article and in Article 11".*

[17] In particular, Milan, Rome, Trento, Tuscany, Veneto, Emilia-Romagna and Sicily

[18] The sample of practitioners interviewed highlighted the great difficulty in ensuring continuity of contracted services. Only 38.4% of respondents believe that there are no difficulties in this regard.

[19] The SAI (Reception and Integration System) is the standard reception system, operational since 2002 as a network of local authorities implementing integrated reception projects with the support of the third sector. The CAS (Extraordinary Reception Centres) are temporary facilities set up by the Prefectures to accommodate asylum seekers. Created to respond to extraordinary needs, the CAS have become by far the most important reception network.

subsequent care. In this regard, the perception of the practitioners interviewed for the preparation of this report is significant: only 24.3% believe that the contents of the Guidelines are regularly applied[20].

The backbone of the Italian reception system is represented by the CAS centres, intended solely for the reception of asylum seekers[21]. These facilities make up the vast majority of existing reception structures. However, as will be highlighted in detail below, the range of support services they offer is very limited, rendering CAS centres inadequate for the reception and care of vulnerable individuals, such as victims of torture. The legislator itself acknowledges this limitation, specifying that CAS centres meet only essential reception needs and that that the more structured SAI system is intended to deal with vulnerable cases, subject to the availability of places. The number of places and the availability of adequate services within the SAI – designed to accommodate all vulnerable groups (families with children, single women, people with disabilities, victims of torture) – is, however, critically insufficient, to the extent that the system itself has left over 4,700 people on the streets[22].

Finally, some of the recent regulatory proposals appear highly concerning as they restrict access to adequate reception facilities and risk affecting people with special needs, creating conditions of exclusion and reducing the chances of identification and access to care and effective support[23].

Further concerns are also raised by the legislative amendments[24] which introduced the possibility of placing children aged 16 or over in adult reception centres (CAS) for a maximum period of 90 days (a period which, following amendments made during the conversion of the decree into law, has been extended to as long as 150 days). This decision, whose legitimacy under European asylum law and the UN Convention on the Rights of the Child is highly questionable, exposes minors to factors or situations that lead to re-traumatisation.

In addressing the health needs of torture victims, a distinction should be made between public centres or private third-sector facilities offering specialist rehabilitation services, and general public health services. As the Guidelines have been implemented in very few areas, and multidisciplinary teams have therefore not been established in every health authority, many requests for treatment remain entirely

[20] Conversely, 6.54% believe they are never applied, 48.6% believe they are rarely applied, and 20.56% were unable to answer.

[21] According to data from the 'Centri d'Italia' project by ActionAid and Openpolis, government-run centres have, since 2018, never accommodated fewer than 68% of those in need of shelter. For further information on the reception system, see ActionAid – Openpolis, *'Accoglienza al collasso,* 2025' https://migrantidb.s3.eu-central-1.amazonaws.com/rapporti_pdf/centri_ditalia_accoglienza_al_collasso.pdf .

[22] This figure is derived from the difference between the reports from the Prefectures and the actual placements made by the Servizio Centrale (data obtained by ActionAid from the Italian MOI and not yet made public). Between 2023 and November 2025, there were 55,697 reports and 50,972 admissions to the SAI, leaving 4,725 applications pending and an equal number of eligible individuals outside the second-level reception system, with the paradoxical result of excluding from the system—which offers decent reception standards—those who have been granted some form of protection and vulnerable asylum seekers. Furthermore, the SAI recorded an average occupancy rate of available places (January–November 2025) of 97.9%: a saturation that limits flexibility for rapid placements, not least because vacant places for vulnerable persons during the same period accounted on average for 0.15% of the total number of active places.

[23] Among these, it is worth mentioning at least Decree-Law 145/2024 (Article 15-quinquies), which introduces a new provision for an accelerated procedure (Article 28-bis of Legislative Decree 25/2008, letter e-bis) for those who do not submit an application within 90 days of entry, and provides for exclusion from reception measures (Article 1, paragraph 2, letter a-bis, Legislative Decree 142/2015). It is envisaged that the Prefect's decision shall take into account conditions of vulnerability pursuant to Article 17 and that the rules shall not apply to vulnerable persons. However, this presupposes an effective and timely capacity to identify vulnerability, which – as will be seen – is in practice implausible and structurally fragile.

[24] Introduced by Decree-Law 33/2023, converted with amendments into Law No. 176 of 1 December 2023.

unmet[25]. Where dedicated centres do exist, they may face formal or implicit limitations in the scope of specialist healthcare services provided or in the duration of interventions, often due to their project-based nature. These limitations first affect the ability to coordinate with healthcare services capable of delivering integrated specialist interventions, and second, they risk disrupting the continuity of care in long-term rehabilitation pathways. Overall, these shortcomings are compounded by an unfavourable staff-to-user ratio, increasingly strained by reforms and administrative decisions in recent years (see Annexes 2 and 3).

2) Staff training

Issues relating to staff training concern both staff working with the reception system and those in the NHS. Within the reception system, staff do not always have adequate preparation to recognise the symptoms of post-traumatic reactions in victims of torture. In particular, basic curricular standards are often insufficient for the tasks required, and high staff turnover reduces the effectiveness of training activities in consolidating knowledge and skills at a systemic level. These limitations impact the ability to correctly identify individuals who should be referred to competent health services or specialised centres for psychological care and support, thereby negatively affecting overall case management. Epidemiological evidence continues to show lower access to mental health services among people of foreign origin compared to the native population, due to both subjective and internal factors (views on health and care, language skills, etc.) and objective and external factors (lack of linguistic and cultural mediation in healthcare facilities, conditions of marginalisation, etc.).

Significant training gaps are also observed within public health services. The Guidelines clearly set out the methodology and essential content of training; however, their lack of implementation prevents the systematic delivery of curricula, except for isolated, commendable cases linked to local initiatives. For healthcare professionals, these shortcomings relate less to the identification of symptoms and diagnostic assessment of torture-related suffering, and more to other aspects of intervention, such as the appropriate use of linguistic mediation and the management of mental health issues resulting from traumatic experiences. Diagnostic, therapeutic and rehabilitative interventions for mental disorders rely much less on systems for objectifying symptoms independently of the linguistic medium, instead depending on verbal exchange to build a therapeutic relationship and effective care alliance. Training deficiencies also affect the ability to account for sociocultural factors in diagnostic assessment and therapeutic processes, as well as the skills needed to implement appropriate therapeutic and rehabilitative interventions.

Within reception centres, particularly CAS facilities, the reorganisation of personal services introduced in the new Service Specification has removed the role of psychologist from the list of mandatory professional roles, incorporating it instead under the very general designation of ‘social worker’.

[25] The Guidelines require Health Authorities to consider setting up multidisciplinary teams comprising (depending on the specific case to be managed) a general practitioner/paediatrician of the patient’s choice; a child psychiatrist/neuropsychiatrist; a psychologist/developmental psychologist, a nurse, a midwife, a social worker (social worker, reception worker, community educator), a legal practitioner, and a linguistic-cultural mediator. Depending on requirements, other specialist healthcare professionals (e.g. gynaecologist, infectious disease specialist, physiotherapist, orthopaedic surgeon, neurologist, dentist) may be required, as well as sociologists and anthropologists where appropriate, and provision should be made for an adequate number of female staff. Attention is drawn to the importance of identifying and implementing the Case Management (CM) function, aimed at ensuring support throughout the social and healthcare pathways and at improving the effectiveness and quality of the services offered, as well as the efficiency in the use of resources (Guidelines, para. 3.2).

Consequently, there are situations where the role of psychologist is entirely absent, or present with insufficient hours, or even assigned to professionals lacking adequate postgraduate specialisation, sometimes limited to holding only a bachelor's degree. The Service Specification also stipulates that the social worker must promptly report such situations to the centre's medical officer, who is responsible for taking charge of the case and identifying the most appropriate care pathways within local services. However, this provision creates an obvious vicious circle: the public system already faces limitations in providing adequate healthcare responses coordinated with the reception system, whilst the centres themselves lack internal psychological support services.

3) Provision of care

The Vulnerability Handbook stipulates that, upon entry into the reception system, all immediately observable elements should be identified and recorded, such as any physical marks on the body and/or manifest psychopathological behaviours. Apart from the detention of obvious physical signs, the identification of vulnerabilities not immediately visible *icto oculi* is rarely possible in reception facilities or CAS centres, due to the lack of services capable of detecting profiles that can only be recognised through careful observation and active listening.

Finally, there is limited long-term follow up: after the initial assessment, care pathways are often interrupted when individuals leave the reception system. This is particularly frequent in cases where vulnerable persons, who have been accommodated as asylum seekers, cannot access the SAI system after being granted protection, due to a lack of available places.

We have already noted the unsatisfactory level of staff training and how this makes it more difficult to identify post-traumatic conditions. Similar consequences arise from the fact that intercultural mediation is often absent or unstructured within general healthcare services, resulting in the exclusion of part of the user population. This occurs, for example, where there is no mediation available in the languages spoken by the residents of reception facilities, or when only a single 'generalist' mediator is present, with predictable effects on the quality of consultations and the ability to detect complex vulnerabilities. In such a context, even a formally available healthcare service may be practically inaccessible. Incomplete medical histories, misunderstandings regarding symptoms and treatments, barriers to recounting trauma, inability to explain rights and procedures, and difficulties in obtaining informed consent are just some of the potential consequences.

In practice, insufficient or inadequate mediation can prevent individuals from understanding questions and rights, hinder the building of trust, and drastically reduce the likelihood that traumatic experiences (torture, violence, trafficking) will be disclosed. Without confidentiality and continuity in the relationship with the mediator, disclosure may be interrupted or distorted. At the same time, ad-hoc solutions - in particular the use of other residents as interpreters or relying on vehicular language - expose individuals to misunderstandings and the risk of re-traumatisation. The practical result is a delayed or missed identification of vulnerabilities and care provision that, when it occurs, is fragmented and often limited to emergency interventions.

Linguistic and cultural mediation is therefore a cross-cutting prerequisite: without adequate mediation integrated into clinical and psychosocial pathways, suffering risks becoming chronic, interfering negatively with language and vocational training offered to residents, being misinterpreted - leading to inappropriate healthcare responses (e.g. post-traumatic somatisation mistaken for internal medical conditions, or post-traumatic psychomotor agitation misdiagnosed as psychotic disorders), and prompting counterproductive 'self-treatment' attempts (e.g. using alcohol to cope with post-traumatic insomnia).

Forensic medical legal certification of the physical and psychopathological consequences of torture is often generic and does not meet the specified requirements, such as a multidisciplinary approach, adequate training and competence of practitioners, an appropriate setting, and the protection of confidentiality and all the rights of the applicant. For these reasons, the MOH Guidelines stipulate that *"it is necessary for this process to take place within centres recognised by the NHS, whose activities can be monitored and adequately assessed*". Such certification is not provided for within the Essential Levels of Care (LEA) and is therefore not guaranteed; it is implemented by a few local health authorities not by virtue of a legal obligation but based on decisions taken at local level according to specific sensitivities.

Finally, it should be noted that a residence requirement is sometimes imposed for the issue of a health card, and the subsequent allocation of a GP for access to specialist services. This results in severe exclusion for those in vulnerable situations who find themselves outside the reception system or in precarious housing conditions, leaving emergency medical care as the only recourse.

4. Levels of Care in Reception Facilities as Set by the MOI

A significant part of the issues described above stem from the provisions of the Decree of the MOI of 4 March 2024 which, as previously noted, governs the tendering process for the management of reception centres. Essentially, the decree sets the qualitative and quantitative standards for the services that vulnerable migrants can receive within the reception system. The following section examines the major limitations of this framework and its negative impact on the effectiveness of rehabilitation interventions for victims of torture.

Time constraints and their impact on the needs assessment process

Analysis of the Service Specifications, particularly with regard to the minimum staffing requirements, alongside empirical observation – for instance, reports by the "National Guarantor for the Rights of Persons Deprived of Personal Liberty", acting as the National Preventive Mechanism (NPM) under OPCAT[26] – indicate that the minimum services provided do not allow for effective identification and care of vulnerabilities, particularly among victims of torture. This inadequacy is evident both in 'small' centres (where, in theory, attention to the individual should be at its highest) and – even more drastically – in large centres, where the theoretical per-capita daily time allocated for individual services collapses to levels compatible only with formal compliance and emergency management[27].

In this context, beyond the ill-advised removal of the professional role of the psychologist described above, the limited number of social workers assigned to residents is also significant. Consequently, the time devoted to each resident is on the order of only a few minutes – or even seconds per day. This means that, even is the system operates with good intentions, it will tend to identify only immediately visible vulnerabilities (such as pregnancy, obvious disabilities. or minor age) while failing to detect latent and complex ones (torture, psychological trauma, sexual violence, undeclared trafficking). As a result, vulnerability risks becoming a selective filter, shifting from a tool for protection to a mechanism of exclusion from the reception system.

The above confirms the risk that safeguards are in fact only activated when the person is already able to 'demonstrate' the need, while the system itself does not create the conditions for such needs to

[26] See Annex 1, which provides a schematic overview of the findings of the NPM over the years.
[27] For a detailed analysis, please refer to Annexes 2 and 3.

emerge. This effect is structurally more severe in large centres and detention settings, where the lack of privacy and understanding of reality, along with conflict and coercion, can aggravate or reactivate pre-existing trauma, as well as generate new ones.

The same critical issues arise with regard to the presence of linguistic and cultural mediators. In this case, the per-capita, per-day analysis highlights the difficulty of ensuring continuity of the relationship (deployment not "on-call"), adequate coverage of the languages spoken, confidentiality, gender matching where required, and integration into clinical and psychosocial pathways[28].

Workload and expansion of professional responsibilities

Social workers operating in reception centres are required to carry out tasks that can only be performed as part of a multidisciplinary team: needs assessment, guidance, support, liaison with external services, assistance with accessing healthcare and legal protection, and monitoring of critical situations. As already indicated, the Service Specification requires that the social worker – in coordination with the medical staff and the centre's management – contributes to case management and reports indicators of vulnerability to the relevant authorities and the local mental health service network, thereby activating appropriate care and support pathways. It also provides for training programmes that the managing entity must guarantee; however, whilst providing *'specific training* […] *on the identification, detection and case management of vulnerable* individuals', the social worker cannot, on their own, replace a full team with specific skills and professional expertise. Furthermore, per-capita indicators show that capacity is the variable that most rapidly undermines these functions[29].

Even in small centres, where services for individual are of a higher quality, social workers are still required to cover a broad range of activities – often in the absence of services and, systematically, of a stable integrated mediation system – making it difficult to carry out constant monitoring aimed at identifying and managing experiences of torture or trauma.

The effect is predictable. When vulnerability detection relies on understaffed generalist figures, identification becomes episodic, dependent on individual competence and 'opportunity' (a crisis, hospitalization, or legal dispute), rather than a structured process. For torture survivors, who often avoid disclosure in contexts perceived as unsafe or coercive, the result is systemic under-detection and absent – or, at best, delayed – case management.

Inadequate healthcare

The Service Specification describes healthcare in the centres as "complementary" to the NHS and provides, in addition to core activities, the supply of medicines and other healthcare services (specialist consultations, prostheses not covered by the NHS, therapies, etc.) within a maximum budget of €500 per contracted place per year – equivalent to roughly € 1.37 per day, irrespective of turnover. Considering the rotation of residents, the actual average per-capita expenditure is even lower.

[28] In large CAS facilities, for example, the average time spent per person per day drops to 66 seconds; in CTRA centres and large hotspots, to around 77 seconds.

[29] In large centres (600 places), the social worker has approximately 26 seconds per person per day; in the largest centres (900 places), approximately one and a half minutes; in medium-sized facilities (300 places), approximately one minute and 43 seconds. In large CTRA centres and hotspots, the time available for a psychologist and social worker is in the order of 1 minute or less; in CAP facilities, there is a complete lack of psychosocial staff.

This framework creates a structural disincentive to the provision of additional healthcare services that entail costs, particularly in contexts where vulnerability may not be immediately apparent or may emerge in a non-linear manner, and where "healthcare demand" is heavily influenced by language barriers, fear, and coercion[30].

Structural limitations to screening

Both the MOH Guidelines and the MOI Vulnerability Handbook highlight the need for accurate screening at points of arrival and border contexts, including the search for signs of trauma and/or the effects of torture, and that for victims of torture, early identification should begin as soon as possible through medical-psychological interviews, with the activation of specialist pathways.

The absence of a psychological service in CAS centres and the very limited per-capita assistance times in all types of reception facilities – except for the SAI system, and including the crisis points where foreign nationals are accommodated following disembarkation operations (*Consolidated Law on Immigration*, Art. 10-ter) – suggests a failure to systematically identify victims of torture, with such cases remaining unseen or only coming to light, as previously noted, during crises or critical events[31].

Regarding prevention and protection obligations, independence is crucial: the possibility of conducting medical examinations and assessments free from the influence of the managing entity. In the context of detention measures at Repatriation Centres, the NPM has expressly stated[32] that the assessment of suitability for detention is the exclusive responsibility of the NHS, even where the managing entity has its own medical facility.

In the vast majority of reception facilities, for the reasons outlined in this report, health protection risks being merely formal and effectively dependent on medical staff employed by the managing entity: without effective and reliable coordination with the NHS and local services, 'case management' risks being reduced to an internal oversight function focused on control rather than protection, with particularly serious consequences for torture survivors and people suffering from mental distress.

The Service Specifications, when read in conjunction with the minimum provisions and per-capita daily time allocations, do not provide for a mechanism equivalent to continuous trauma-informed screening. Consequently, the identification of torture survivors is postponed or left to critical events (crises, self-harm, disputes), i.e. reactive situations that increase the likelihood of inhuman or degrading treatment due to omission of protection and continuity of care.

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[30] On the progressive blurring of the lines between initial reception and detention upon entry, see ActionAid-University of Bari, *Trattenuti. Una radiografia del Sistema di detenzione per stranieri*, 2023. Consider also the relevant increase in detained asylum seekers, who in 2024 account for over 45% of those entering a detention centre, 21% of whom are deprived of their personal liberty without having received a removal order, and are detained precisely because they are seeking protection (source: *Trattenuti* platform, https://trattenuti.actionaid.it/)

[31] The NPM's findings also appear to confirm this: in the report on the Taranto hotspot (2023), the Ombudsman notes that the initial health form is extremely generic and does not provide for the detection of any signs of torture or ill-treatment, nor does it include adequate information on mental health; in the report on the CPR in Milan (2023), the initial medical examination is described as generic and not focused on mental health or signs of trauma.

[32] See: NPM, *Opinion on Article 3 of the CPR Regulation*. The Guarantor also emphasises that the provision whereby the Centre Director establishes the rules of the facility has an even more decisive impact in hotspots and government-run initial reception centres, as in such contexts there is no general and uniform regulation of detention procedures analogous to the CPR Regulation.

The identification of torture victims in cases of detention

Although this report does not specifically address the management of the Closed Pre-removal Centres (CPRs) or the protection of the rights of those detained there, we nevertheless feel compelled to express serious concern regarding the conditions of those held in these facilities, particularly in light of the consistent findings of numerous detailed independent reports[33] . The number of asylum seekers held in these facilities is rising sharply (2,565 people in 2025, approximately 43.5% of the total), making it realistic to assume that victims of torture are among them. Notably, the Council of State, in judgment no. 7839/2025[34], partially annulled the tender specifications for the CPRs due to shortcomings relating to health protection and the prevention of suicide risk, requiring their revision.

In compliance with this ruling, the MOI updated Annex 5-bis of the Service Specifications related to CPRs[35]. However, this amendment does not amount to establishing an effective operational framework. What is critical is the presence of clinical and organisational protocols, the traceability of assessments, coordination with the NHS and mental health services, and the implementation of an effective screening and care system – not merely registers or formalities. The revision by the MOI appears largely limited to contractual clarifications. Instead, it is necessary to verify whether the minimum services provided, and the operational model truly enable the identification of vulnerabilities, the suspension of detention pathways incompatible with psychological and physical conditions, and the guarantee of therapeutic continuity. Per-capita analyses, in conjunction with findings from the NPM visits, indicate that the risk of reactive, crisis-driven management remains extremely high[36].

Furthermore, the delegation of day-to-day operations and healthcare service organisation to the managing entity raises concerns regarding the independence and uniformity of standards, particularly for the assessment of complex vulnerabilities. Suicide and self-harm prevention in CPRs cannot be ensured through registers or ad hoc measures. Given the structure of administrative detention, it is unlikely that a structured framework – including standard operating procedures, training, multidisciplinary teams, mediation and referral mechanisms - consistent with obligations to prevent inhuman or degrading treatment, will be introduced.

Visits conducted between September and December 2025 by delegations from the Asylum and Immigration Civil-Society Platform, involving doctors and healthcare professionals, paint a rather alarming picture. The report highlights widespread failure to enforce the requirement that detention

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[33] See in particular: ActionAid, University of Bari, Trattenuti. Una radiografia del Sistema di detenzione per stranieri, Rome/Bari, 2024; Amnesty International, *Libertà e dignità: le osservazioni di Amnesty International sulla detenzione amministrativa di persone migranti e richiedenti asilo in Italia*, 2024; Tavolo Asilo e Immigrazione, *CPR d'Italia: Istituzioni Totali*, 2026.

[34] https://www.biodiritto.org/Biolaw-pedia/Giurisprudenza/Consiglio-di-Stato-sentenza-n.-7839-2025-the-decree-approving-the-tender-specifications-for-the-management-of-the-Centres-for-Permanent-Stay-for-Repatriation-CPR-is-partially-unlawful

[35] https://www.interno.gov.it/sites/default/files/2025-11/attestazione_esecuzione_sentenza_10_novembre_2025.pdf

[36] The latest findings from the NPM show that, even following institutional calls for action and tragic events, systemic shortcomings persist. In 2025, there is still a lack of protocols for the care of vulnerable individuals and for the prevention of suicide risk. These factors are particularly relevant for victims of torture, for whom detention can re-trigger trauma and exacerbate psychological suffering, increasing the risk of self-harm in the absence of a structured therapeutic pathway. In summary, the NPM's findings highlight a structural shortcoming: the lack of procedural mechanisms (SOPs, protocols, training, clinically oriented traceability and coordination with the NHS) renders the capacity of reception and detention facilities to identify and protect vulnerable individuals, including victims of torture, inherently fragile. The Specification Scheme contains only 'abstract obligations' that do not translate into binding and verifiable operational requirements.

be subject to a medical certificate confirming compatibility with the individual's state of health or vulnerability[37]. Analysis of the fitness certificates issued during the visits revealed that these *"are usually based on pre-printed forms to be completed, designed to rule out the presence of infectious diseases that are contagious and dangerous to the community, psychiatric disorders, and acute or chronic degenerative conditions, and are generally issued by infectious disease specialists, forensic doctors, A&E doctors or prison healthcare staff. These fitness certificates are usually drafted inadequately and/or superficially, without conducting thorough examinations or investigations, and without considering the conditions of detention and the serious, long-term damage to the mental health of detainees caused by administrative detention. Fitness assessments are usually described as rushed, lacking cultural mediation, with the person unaware of the meaning or purpose of the assessment, and in the presence of law enforcement* officers"[38] . The European Committee for the Prevention of Torture (CPT) had also reached similar conclusions in its report at the end of 2024[39].

In light of the above, there is a systemic risk in all Italian reception facilities, including the CPRs, of inadequate protection, discontinuity of care and reactive management of suffering – particularly psychological suffering – with potentially serious implication for obligations of prevention, protection and rehabilitation under domestic, European and international law.

6. Conclusions

Against the backdrop of a formally existing regulatory and policy framework, the implementation of the obligations arising from Article 14 of the Convention appears to be deeply inadequate. The failure of regional authority to incorporate the MOH Guidelines has rendered the primary provision largely ineffective, preventing the integration into territorial service planning of the care and rehabilitation interventions required for victims of torture.

Within this framework, even the limited measures envisaged under the AMIF Regional Health Plans[40] and the MOI *Vulnerability Handbook* remain largely dependent on project-based approaches and local initiatives, rather than on the full institutionalisation of the right to rehabilitation.

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[37] Article 3 of the MOI Directive "Criteria for the organisation and management of CPRs provided for by Article 14 of Legislative Decree 286/1998 and subsequent amendments" (19 May 2022, known as the "Lamorgese Directive") stipulates that *"the medical certificate must, in any case, attest to the compatibility of the foreign national's health or vulnerability, within the meaning of Article 17(1) of Legislative Decree No. 142 of 18 August 2015, with living in restricted* communities"

[38] Asylum and Immigration Roundtable, *op. cit.*, p. 57.

[39] *"The vast majority of medical examinations consisted of a cursory review of the main vital signs of the detained person, with no specific reference to their adaptability to a secure environment or signs of possible mental disorder. The medical certificates issued and reviewed by the delegation reflected the cursory nature of the examination and ranged from a brief statement certifying the "adaptability to a secure environment" to a modular checklist signed by the ASL doctor. Such certificates were issued by general practitioners in the community, doctors in emergency departments of civil hospitals and prison doctors, with unknown familiarity with the challenges and specific conditions of a CPR." in* European Committee for the Prevention of Torture, *Report to the Italian Government on the visit to Italy carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment*, December 2024, p. 24.

[40] The AMIF Regional Health Plans are regional programming instruments funded under the EU Asylum, Migration and Integration Fund (AMIF) to support migrants' access to healthcare and strengthen services for vulnerable groups.

This results in highly varied territorial arrangements, in which access to specialist services, the presence of multidisciplinary teams and the availability of treatment pathways depend almost exclusively on local initiatives or the commitment of individual professionals.

The absence of shared protocols and procedures defining an integrated operational model across different services leads to inconsistent interventions, undermining the coherence of responses even in areas where examples of inter-service collaboration have emerged.

As a consequence, a form of "territorialisation" of rehabilitation has developed, which risks coming into tension with the universal nature of the obligations established by the Convention. In this context, victims of torture who develop post-traumatic disorders often face significant difficulties in accessing specialist care.

The situation is further compounded by the weakness of early identification mechanisms, which still rely on operational practices not always supported by binding protocols and widespread specialist training. In the absence of a systemic trauma-informed approach, the identification of situations of vulnerability may be delayed or remain incomplete, thereby compromising timely access to rehabilitation pathways.

The reliance on AMIF Health Plans as the main lever for implementation also highlights the risk of a "project-based" approach to the right to rehabilitation. Whilst these instruments have fostered an initial awareness among services, their temporary nature tends to place rehabilitation interventions within a pilot or experimental framework, rather than integrating them structurally into the ordinary levels of care.

In clear divergence from relevant international standards and from the principles set out in *General Comment No. 3* (2012) of the UN Committee against Torture, the Italian system reveals a persistent asymmetry between the international obligations undertaken and the capacity for their concrete domestic implementation. The participation of the victim in the choice of service provider – identified as essential under international standards – is not guaranteed. Moreover, the holistic and integrated approach that should characterise rehabilitation remains far from fully realised in a context marked by fragmentation, discontinuity and insufficient training of the professionals involved. No system of evaluation has been established by State authorities to assess the effective implementation of rehabilitation programmes and services, using appropriate indicators and benchmarks.

It should also be emphasised that no national law has been adopted to guarantee the right to full and effective rehabilitation by providing, for this purpose, the necessary resources, mechanisms and structured programmes. The current framework relies instead on a series of administrative acts or, at best, simple operational practices.

Unless territorial disparities and reliance on project-based instruments are overcome, there is a significant risk that the right to rehabilitation enshrined in the Convention will remain a variable and conditional safeguard, dependant more on the organisational capacities of individual territories than on an effective, uniform guarantee provided by the State.

7. General and specific recommendations

7.1. General recommendation

In view of the clear breach of the obligations imposed by Article 14 of the Convention, it is necessary and imperative to ensure, as soon as possible, that all regions transpose the MOH Guidelines and subsequently draw up programmes to implement them.

Given that these Guidelines are merely an administrative policy document, legislative action would be appropriate to elevate the current inadequate level of regulation of interventions to primary legislation. The desired legislation should define the procedures for implementing the criteria set out in the *General Comment No. 3* (2012) and ensure the necessary financial coverage to guarantee the concrete and uniform implementation of a national programme of assistance for victims of torture, in coordination with all regional health systems.

7.2. Specific recommendations

Early identification

- Implement Psychological First Aid (PFA) interventions at all disembarkation points and hotspots, in order to provide immediate psychological and informational support and facilitate the early identification and *referral* of people with specific needs.
- Train reception staff, healthcare workers – particularly those in primary care and mental health services – and social services staff in the early identification of indicators of vulnerability.
- Promote psycho-educational sessions at all initial reception centres to raise awareness among both those being received and staff of the potential consequences of traumatic experiences, providing information on the most common symptoms and the care and support services available in different areas.

Reception

- Invest in terms of both quantity and, above all, quality in initial reception, first and foremost by reintroducing psychological and legal assistance services in all centres that were removed by Decree-Law 20/2023, converted into Law 50/2023, known as the 'Cutro Decree'.
- Abandon once and for all the CAS reception model, which relies predominantly on large and medium-sized collective centres providing only essential services, in favour of the approach characterised by the SAI model, based on small-scale facilities (generally not collective centres but private homes integrated into the local social fabric) and equipped with adequate legal information and advice services and social assistance.
- Entrust the management of reception services to specialist organisations staffed by personnel with proven training, prioritising technical expertise over financial savings – a factor that leads many managing bodies to secure contracts through even drastic reductions in management costs.
- Introduce independent monitoring systems, including through third-party organisations and universities, to assess the quality and effectiveness of reception service management.
- Enhance the capacity of CAS centres to identify, reception and care of vulnerable situations, ensuring through precise regulatory provisions that all vulnerable cases are promptly transferred to the SAI system – which must therefore be significantly strengthened – and that, pending such transfer, whether they are applicants for international protection or beneficiaries of a form of protection, those in reception are not deprived of reception measures and left on the streets, as frequently happens
- Increase the number of SAI places dedicated to asylum seekers and refugees with specific needs, including mental health vulnerabilities. It is, however, important to ensure that this

does not turn such facilities into stigmatising places that are separate from the general system of local social and health services. It is also important to dedicate part of the available places to women who have survived sexual and gender-based violence, with specialised and adequately trained staff.

Linguistic and cultural mediation

- Strengthen and ensure the effective delivery of cultural mediation services in reception centres and key health services, particularly local health centres, primary care services and mental health services.
- Invest in the training of cultural mediators and in refresher courses, particularly focusing on the systemic approach, issues of health protection in the context of migration, and mental health.

Rehabilitation intervention method

- Establish, through the creation of the multidisciplinary teams provided for in the Guidelines, a model of integrated care – combining clinical and psychosocial support – that encompasses all levels – from information and prevention to therapy and rehabilitation pathways, monitoring and supervision – and is based on systematic collaboration between the public and private social sectors.
- Ensure that psychological support and legal information and advice services are structural services available across all segments of the reception system.
- Ensure the adoption of an integrated, multi-level rehabilitation model between local primary care services and specialist services, implementing the recommendations contained in the Guidelines.
- Ensure the training of mental health professionals working in public services on psychotherapeutic, psychopharmacological and rehabilitative treatment methodologies for survivors of torture and inhuman and degrading treatment, which are effective, specific and culturally sensitive.
- Ensure the training of forensic doctors and practitioners in the forensic certification of the consequences of torture in accordance with the Istanbul Protocol, so as to guarantee an adequate number of such professionals and a widespread, well- d presence across all regions, as well as continuous training on the cultural and diagnostic specificities of trauma-related disorders among the migrant and refugee population, with the aim of facilitating accurate and early identification and avoiding inappropriate diagnoses.
- To provide for long-term funding mechanisms, in order to move beyond the temporary and emergency nature of transitional solutions and to integrate the new tools required by the complexity of the phenomenon, which are useful for ensuring training in various fields with progressive levels of specialisation and the effective implementation of the recommendations contained within the Guidelines.

Transparency

- Ensure transparency regarding data relating to the public reception system as a whole by publishing an annual report that provides a snapshot of the actual state of the Italian system.

- Provide for the annual publication of a national report on the system of public support measures implemented for victims of torture and, more generally, for vulnerable groups as referred to in Article 17 of Legislative Decree 142/2015

ANNEX 1

Summary of the NPM's interventions on the identification and support of vulnerable individuals and victims of torture/TID (2019–2025)

Document (NPM)	Relevant evidence on vulnerability/torture	Doc. / p. / link
Taranto Hotspot (2023)	'Extremely generic' health assessment form; no fields for signs of torture/ill-treatment or for clinical mental health assessment.	Report on the visit to the CPRs in Bari and Brindisi and the Taranto Hotspot (31 January–3 February 2023), p. 20 https://www.garantenazionaleprivatiliberta.it/gnpl/resources/cms/documents/7d0819819ccff5d81fbe541b4ab46f10.pdf
Milan CPR (2023)	'General' initial assessment; does not include a mental health assessment or assessment of signs of trauma/injuries.	Report on the visit to the CPR in Milan (February 2023), p. 7 https://www.garantenazionaleprivatiliberta.it/gnpl/resources/cms/documents/8043b943f60a2fa054e121a579495634.pdf
CPR visits 2019–2020	No notes on signs of possible violence/abuse; cooperation between the Prefecture and the Local Health Authority remained 'unimplemented across the board'.	Report on visits carried out in CPRs (2019–2020), p. 20 https://www.garantenazionaleprivatiliberta.it/gnpl/resources/cms/documents/b7b0081e622c62151026ac0c1d88b62c.pdf
Turin CPR (2021)	"Little attention" paid to evidence of previous abuse; scars noted without taking statements or assessing compatibility with beatings.	Report on the visit to the Turin CPR (2021), p. 11 https://www.garantenazionaleprivatiliberta.it/gnpl/resources/cms/documents/e276136e864d9a7d1df4042e39e5e32a.pdf
CPR Rome (2024)	Reference to WHO guidelines: training + systematic screening on admission and during detention; strengthening medical/psychosocial communication and liaison with external services.	Report on the Rome Ponte Galeria CPR (2024), p. 2 https://www.garantenazionaleprivatiliberta.it/gnpl/resources/cms/documents/d70476fc637eec0cb294b61973b76757.pdf
Trapani CPR (2024)	It is "urgent" to define strategies and methods of intervention to protect vulnerable individuals; there is a need for periodic screening and the reporting of cases where health conditions are incompatible with detention.	Report on the visit to the CPR in Trapani (2024), p. 9 https://www.garantenazionaleprivatiliberta.it/gnpl/resources/cms/documents/b9c953eab58b78f7e034822e1270b182.pdf
General recommendations (2025)	Finding of absence of protocols for the care of vulnerable groups and the prevention of self-harm/suicidal risk; CPT referral.	GNPL submission and general recommendations (27 August 2025), p. 7 https://www.garantenazionaleprivatiliberta.it/gnpl/resources/cms/documents/20250827_Invio_e_raccomandazioni_generali_Gnpl.pdf
CPR Palazzo San Gervasio (2025)	'No protocols have been established for dealing with vulnerability and suicide risk' and,	Report on the visit to the CPR in Palazzo San Gervasio (12 December 2024), p. 10 https://www.garantenazionaleprivatiliberta.it/gnpl

	in the face of acts of self-harm, the intervention reported consists of increasing the number of sessions with a psychologist and social worker	/resources/cms/documents/20250827_Rapporto_Gnpl_Cpr_Palazzo_San_Gervasio.pdf
CPR Trapani (2025)	Lack of plans for the prevention of self-harm and suicide aimed at identifying indicators of vulnerability and providing care.	Report on the visit to the CPR in Trapani (24 October 2025), p. 6 https://www.garantenazionaleprivatiliberta.it/gnpl/resources/cms/documents/20251024_Rapporto_GNPL.pdf
Opinion on Article 3 of the CPR Regulations	The National Health Service has 'exclusive' competence to assess the medical grounds for the application or continuation of detention.	Opinion on Article 3 of the CPR Regulations (1 February 2023), p. 3 https://www.garantenazionaleprivatiliberta.it/gnpl/resources/cms/documents/04bbc8c727a1472f36299ff909c55688.pdf
Report on forced returns	Medical clearance as a 'certificate of fitness' without details of medical conditions or treatments; risk of TID as a consequence of expulsion.	NPM thematic report on the monitoring of forced returns (1 July 2021–15 September 2022), p. 23 https://www.garantenazionaleprivatiliberta.it/gnpl/resources/cms/documents/9f78e6bf0276f12bb6adbeea72049f7d.pdf

(i) Screening and documentation. NPM findings on the Taranto Hotspot and the Milan CPR show that, in the absence of standardised tools and appropriate settings, the identification of trauma, signs of torture or psychological distress remain outside the actual scope of initial assessments. This critical issue is consistent with the absence, in the specifications, of verifiable requirements regarding 'who' should carry out the *trauma-informed screening*, 'with what tools' and 'under what conditions', and with facilities that, in large centres, render individual interviews a mere formality.

(ii) Risk of self-harm and suicide: protocols versus compliance. Following deaths in CPR (Turin 2021; Rome/Trapani 2024), the NPM highlights the need for structured plans (training, systematic screening, internal and external information flows). The 2025 visits show that the lack of protocols and plans can persist even after recommendations have been made, with direct repercussions on the protection of vulnerable individuals and the prevention of inhuman or degrading treatment.

(iii) Linguistic and cultural mediation as a prerequisite. In a 2023 report, the NPM highlights uncertainty regarding the languages actually covered and the presence of a 'wildcard' interpreter. This finding reinforces the premise of this report: without adequate mediation (continuity, confidentiality, training), health and social services fail to transform observation into identification, nor identification into *referral*.

(iv) Integration into the NHS and independence. The NPM's opinion on Article 3 of the CPR Regulation clarifies that the assessment of the medical grounds for detention is the exclusive responsibility of the NHS; however, the 2019–2020 report highlights that, in practice, cooperation between the Prefecture and the Local Health Authority may remain unimplemented. This discrepancy is also central to the interpretation of the tender specifications: a 'complementary' healthcare system with spending caps and no explicit channels for independent assessment does not, on its own, guarantee effective protection of vulnerable individuals.

(v) Direct link to the tender specifications. In its technical opinion on the Ministerial Decree of 4 March 2024, the NPM highlights a "lack of attention" to the context of deprivation of liberty and points to the absence of requirements for specialisation/training in migration medicine, the identification of vulnerabilities, and the prevention of self-harm and suicide risk (pp. 2–3).

In summary, the NPM's findings do not recount isolated 'incidents', but describe a recurring critical issue: the lack of procedural mechanisms (SOPs, protocols, training, clinically oriented traceability and coordination with the NHS) renders the capacity of CPRs, CTRAs and hotspots to identify and protect vulnerable persons—including victims of torture and inhuman or degrading treatment—structurally fragile. The tender specifications contain only 'abstract obligations' that do not translate into binding and verifiable operational requirements.

ANNEX 2

Analysis of the MOI Service Specification for the award of reception centre management services

The Service Specifications set out the services to be provided and the minimum staffing levels, differentiated by type of facility and capacity range. To assess the actual feasibility of the services, we have converted these staffing levels into a simple and verifiable indicator: the theoretical minutes available per day for each person present, assuming the facility is operating at full capacity. The per-capita calculation has been applied to the 'dimensional extremes' (minimum and maximum capacity ranges for each type)[1] set out in Annex A to the Service Specification. This quantification represents a theoretical upper limit, as it inevitably includes indirect activities (registration, coordination, meetings, emergency management, accompaniment, conflict management, etc.) and guarantees neither *privacy* nor continuity in the individual's relationship with the same practitioner. The actual time available for secure, in-depth and repeated sessions (necessary for the emergence of complex trauma) is therefore certainly lower.

1. (a) CAS centres lack crucial specialist services (psychological support, legal support, etc.);
2. (b) as capacity increases, the time per person allocated to key services plummets to just a few minutes or even seconds a day;
3. (c) in 10-ter centres/Hotspots/CTRA[1], the 'intake' stage – where the identification of vulnerabilities should begin – is structurally understaffed, and in centres under Article 11, paragraph 2bis (CAP) there is a substantial lack of services;
4. (d) in CPRs, despite a higher quantitative level of support, the per-capita time per day allocated to psychologists, social workers and legal advice is incompatible with *trauma-informed* practice.
5. Looking at the 'architecture' of the minimum strategic services for identification and *referral*, the diagram shows an uneven distribution of: (i) social work; (ii) linguistic and cultural mediation; (iii) legal information and guidance; (iv) psychological support; (v) healthcare provision and effective access to the NHS.
6. Legal information and guidance are provided only in centres under Article 10-ter and in CPRs; social work is excluded from temporary CAP facilities, where psychological services are not provided; the same applies to CASs, where, furthermore, nursing care – absent in small centres – is available only in those with higher capacity. On the healthcare front, 'additional' services are also provided within an annual budget limit (€500 per place, with a ceiling not adjusted for turnover), negatively impacting the necessary services when vulnerability emerges in a non-linear manner.
7. In CASs, even in the most favourable scenario (small facilities), the theoretical time allocated per person is already limited, with associated costs that are difficult to sustain. It is no coincidence that phenomena such as repeated tenders and direct awards have emerged over time: the third sector has often withdrawn from tenders for 'networked' CASs, and *for-profit* operators have come to dominate the reception market. It is predominantly organisations (such as those linked to the Church) that can rely on their own resources to provide the services necessary for dignified reception that ensure accommodation in CAS housing units. In 10-bed accommodation units, the social worker has an average of 13.71 minutes per person per day, the doctor 12, and the mediator 6.86. These figures drop to 5.49, 4.80 and 4.11 respectively, with a capacity of 50 places. Furthermore, some healthcare staff in small CASs are classified as 'on call': this classification may further reduce actual clinical time and the ability to conduct in-depth medical histories. For victims of torture, who frequently are unable or unwilling to immediately disclose their experiences, the absence of even minimal psychological support and a protected setting make structural under-reporting likely.

8. In collective centres, the scale effect is even more pronounced: the capacity ranges from 10 places (12 minutes per day per social worker and doctor; 5.14 minutes for mediation) to 900 places, with around one and a half minutes per social worker, less than 30 seconds per doctor and just over a minute for mediation, the same as for a nurse. At these levels, individual intervention becomes structurally residual: 'case management' is reduced to emergencies and administrative tasks, with a high probability that vulnerabilities not immediately apparent will remain unseen until a critical incident occurs, which may, moreover, not be correctly interpreted in the absence of specific expertise.

9. In small '10-ter' centres (25 places), the theoretical time allocations are already extremely limited: social worker 2.06 minutes per person per day; psychologist 4.80; doctor 8.57; nurse 8.57; mediation 6.86; regulatory information/guidance 5.49. In comparable large centres (600 places), these figures drop to around 26 seconds for the social worker, just over a minute for the psychologist, doctor, nurse and mediator, and not even 38 seconds for legal information. This figure is crucial, because the 10-ter/hotspots are one of the main points of initial contact and triage: if screening and guidance take place with per-person, per-day times in the order of a few seconds, the likelihood of identifying torture/trauma and initiating appropriate *referrals* becomes systemically negligible.

10. In CAP facilities, the per-capita daily time allocated to doctors and nurses drops from 8.57 minutes (25 places) to 1.14 minutes (600 places); for mediation, from 6.86 to 1.29 minutes: in the 'most extraordinary' circuit, the minimal framework lacks the psychosocial support necessary to identify complex vulnerabilities. This circuit is emblematic of what occurs at the systemic level: vulnerability is invoked as a principle, but its identification and the taking of the person into care are neither made practicable nor contractually enforceable, resulting in an inability to protect victims of torture and TDI and a real risk of re-traumatisation.

11. In small CPRs (25 places), the social worker accounts for 6.17 minutes/person/day and the psychologist 8.23; the doctor 7.2; the nurse 57.6; regulatory information 3.43. Linguistic and cultural mediation, measured in person-hours (excluding night-time staffing), amounts to 76.8 minutes per person per day. In large CPRs (300 places), the figures plummet: social worker 1.71; psychologist 2.06; doctor 2.60; nurse 4.80; regulatory information 0.69; mediation 22.4 minutes/person/day. Although mediation remains quantitatively higher than other categories, the minutes allocated to key roles for complex trauma, self-harm risk prevention and the initiation of external pathways fall to levels incompatible with individualised assessment.

12. Per-capita, per-day data are not intended to determine an 'optimal' level of services, but to verify whether the contractual minimum is at least compatible with the operational standards necessary to identify and protect vulnerable people. 'Per-capita time' is not an indicator of quality in itself; however, it is a necessary indicator of feasibility. The very notion of 'constant observation' referred to in the tender specifications is hardly compatible with thresholds in the order of 1 minute per day. For victims of torture and TID, identification rarely occurs at the first contact: *disclosure* is often delayed, fragmentary or mediated by non-specific symptoms (insomnia, somatisation, anxiety attacks, reactive aggression, social withdrawal). An effective model requires repeated interviews, continuity, trust, privacy, the ability to work with trained mediators and – where necessary – medico-legal and psychodiagnostics assessments consistent with the Istanbul Protocol.

ANNEX 3

Technical analysis regarding the per capita per diem calculation

[41] I per capita per diem calculations: derived from the staffing tables in the tender specifications (Annex A) and comparison of capacities

1. Tables on strategic services (contractual minimums → minutes per capita): capacity figures

The tables below summarise, for each type, the capacity figures set out in Annex A and referred to in the text, and the corresponding minutes per person per day for the services most directly linked to the identification and management of vulnerability (including torture). The tables are intended to provide an immediate comparison between the 'most favourable' scenario (small facility) and the 'most critical' scenario (maximum capacity facility). The figures are always calculated based on the maximum capacity of the category (at full capacity). Even assuming the most favourable scenario (small facilities, lower overcrowding and greater proximity), the minimum provision of services does not, however, guarantee an effective system for the identification, *referral* and care of complex vulnerabilities – in particular victims of torture and inhuman or degrading treatment (IHD). In the opposite scenario (large facilities), the theoretical time per person drops to levels that make any individualised and repeated work materially impracticable.

Table A.0 – Capacity extremes by type: minutes/person/day (key services)

Type (extreme)	Used capacity (max)	Social worker	Mediation	Regulatory information/guidance	Psychologist	Doctor	Nurse
CAS - Housing units (0-10) – smallest	10	13.71	6.86	—	—	12.00	—
CAS - Housing units (41–50) – largest	50	5.49	4.11	—	—	4.80	—
CAS - Collective centres (0-10) – smallest	10	12.00	5.14	—	—	12.00	—
CAS - Collective Centres (751–900) – largest	900	1.52	1.10	—	—	0.48	1.09
CAP - Art. 11(2-bis) (0–	25	—	6.86	—	—	8.57	8.57

[41] Calculation method. The conversion is: minutes/person/week = (weekly hours × 60) ÷ maximum capacity. Minutes/person/day = minutes/person/week ÷ 7. For 24-hour mediation in the CPRs, person-hours were used, as Annex A defines a 'unit' as a shift period during which staff work together; if multiple units are scheduled within the same time period, the hours are added together (Annex A – Staff Tables, p. 6, note 'UNIT'). For each band, the maximum capacity was used (e.g. band 26–50 → 50), assuming the centre is operating at full capacity. Assuming maximum capacity avoids overestimating minutes per person but does not correct for the further discrepancy between theoretical and actual time due to indirect activities and emergencies.

25) – smallest							
CAP - Art. 11(2-bis) (451–600) – larger	600	—	1.29	—	—	1.14	1.14
CTRA / Hotspot / 10-ter (0-25) – smallest	25	2.06	6.86	5.49	4.80	8.57	8.57
CTRA / Hotspot / 10-ter (301-600) – larger	600	0.43	1.29	0.63	1.14	1.14	1.14
CPR (Art. 14) (0–25) – smallest	25	6.17	115.20	3.43	8.23	7.20	57.60
CPR (Art. 14) (151–300) – larger	300	1.71	32.00	0.69	2.06	2.60	4.80

Note: "—" indicates that the service is not included in Annex A for that type/category.

Table A.0.1 – CAS – Housing units: detailed specifications (small 0–10, large 41–50)

Figure/Service	Hours/week (small)	Min/person/day (small)	Hours/week (large)	Min/person/day (large)
Director	4	3.43	10	1.71
language mediation	8	6.86	24	4.11
doctor	14	12.00	28	4.80
social worker	16	13.71	32	5.49
day care workers** (6/22)	56	48.00	98	16.80
night operators (22/06)	56	48.00	56	9.60

Table A.0.2 – CAS – Collective centres: detailed data (small 0–10, large 751–900)

Figure/Service	Hours/week (small)	Min/person/day (small)	Hours/week (large)	Min/person/day (large)
Administrative	—	—	44	0.42
director	4	3.43	39	0.37
nurse	—	—	114	1.09
language mediation	6	5.14	116	1.10

doctor	14	12.00	50	0.48
social worker	14	12.00	160	1.52
day care workers** (6/22)	56	48.00	840	8.00
night shift workers (22/06)	56	48.00	224	2.13

Table A.0.3 – CTRA/Hotspot/10-ter: detailed figures (small 0–25, large 301–600)

Figure/Service	Hours/week (small)	Min/person/day (small)	Hours/week (large)	Min/person/day (large)
Administrative	6	2.06	30	0.43
director	16	5.49	40	0.57
nurse	25	8.57	80	1.14
Regulatory information and local guidance	16	5.49	44	0.63
storekeeper/store manager	4	1.37	21	0.30
language mediation	20	6.86	90	1.29
doctor	25	8.57	80	1.14
social worker	6	2.06	30	0.43
day care workers** (6/22)	112	38.40	672	9.60
night shift workers (22/06)	56	19.20	280	4.00
psychologist	14	4.80	80	1.14

Table A.0.4 – Art. 11(2-bis): detailed figures (small 0–25, large 451–600)

Figure/Service	Hours/week (small)	Min/person/day (small)	Hours/week (large)	Min/person/day (large)
Director	16	5.49	40	0.57
nurse	25	8.57	80	1.14
language mediation	20	6.86	90	1.29
doctor	25	8.57	80	1.14
day staff** (6/22)	112	38.40	672	9.60
night shift workers (22/06)	56	19.20	280	4.00

Table A.0.5 – CPR (Art. 14): detailed figures (small 0–25, large 151–300)

Figure/Service	Hours/week (small)	Min/person/day (small)	Hours/week (large)	Min/person/day (large)
SOCIAL WORKER	18	6.17	60	1.71
administrative	4	1.37	16	0.46
director	18	6.17	34	0.97
nurses	168	57.60	168	4.80
regulatory information	10	3.43	24	0.69
daytime language mediation (6/22)	224	76.80	784	22.40
language mediation evening course (22/6)	112	38.40	336	9.60
doctor	21	7.20	91	2.60
day staff** (6/22)	224	76.80	1120	32.00
night shift workers (22/06)	56	19.20	504	14.40
psychologist	24	8.23	72	2.06
language mediation (total day and night) – calculated	336	115.20	1120	32.00

2. Tables on strategic services (contractual minimums → minutes per capita) – selection of intermediate bands

The following table presents the calculation for the most commonly used intermediate ('average') capacity bands, to compare the most favourable scenario (small facility) with a typical configuration for medium-to-large facilities. Here too, the calculation assumes the maximum capacity of the band (full capacity). For CPRs, the average shown in the summary is the sum of day and night (24 hours).

Table A.1 – Selected "average" categories: minutes/person/day (key services)

Type (category)	Used capacity (max)	Social worker	Mediation	Regulatory information/guidance	Psychologist	Doctor	Nurse
CAS - Collective centres (41–50)	50	4.46	2.40	—	—	4.80	—
CAS - Community-s (51–75)	75	3.20	1.94	—	—	1.60	1.37
CAS - Collective Centres (76–100)	100	2.74	1.71	—	—	1.37	1.54
CAS - Collective Centres (101–150)	150	2.29	1.49	—	—	1.14	1.37

CAS - Collective Centres (151–300)	300	1.83	1.26	—	—	0.74	1.20
CAP - Art. 11(2-bis) (301–450)	450	—	1.43	—	—	1.35	1.35
CTRA / Hotspot / 10-ter (301–600)	600	0.43	1.29	0.63	1.14	1.14	1.14
CPR (Art. 14) (101–150)	150	2.40	22.40	1.03	2.74	2.80	9.60

Table A.1.1 – CAS – Collective centres: 'medium' category (hours/week → minutes/person/day)

Category (max capacity)	Social worker	Doctor	Nurse	Mediation
41–50 (50)	26h → 4.46	28h → 4.80	—	14h → 2.40
51–75 (75)	28h → 3.20	14h → 1.60	12h → 1.37	17h → 1.94
76–100 (100)	32h → 2.74	16h → 1.37	18h → 1.54	20h → 1.71
101–150 (150)	40 hours → 2.29	20h → 1.14	24h → 1.37	26 hours → 1.49
151–300 (300)	64h → 1.83	26h → 0.74	42h → 1.20	44h → 1.26

Table A.1.2 – Art. 11(2-bis): 'medium' category (301–450; capacity 450)

Service	Hours/week	Min/person/day
doctor	71	1.35
nurse	71	1.35
linguistic and cultural mediation	75	1.43

Table A.1.3 – CTRA / Hotspot / 10-ter: band 301–600 (capacity 600)

Service	Hours/week	Min/person/day
social worker	30	0.43
doctor	80	1.14
nurse	80	1.14
psychologist	80	1.14
linguistic and cultural mediation	90	1.29
Regulatory information and local guidance	44	0.63

Table A.1.4 – CPR (Art. 14): 'medium' category (101–150; capacity 150)

Service	Hours/week	Min/person/day

social worker	42	2.40
doctor	49	2.80
nurse	168	9.60
psychologist	48	2.74
day centre mediation (6/22)	224	12.80
night shift mediation (22/6)	168	9.60
Total mediation (day + night)	392	22.40
regulatory information	18	1.03

3. Comparison between small and medium-to-large facilities: reduction in per-capita time per day

The comparison between the 'small' scenario (facilities operating at minimum capacity) and the 'medium' category shown above reveals a very marked reduction in the theoretical time available for the services most relevant to identifying vulnerabilities, and in particular cases of trauma/torture.

Type/service	**Small (capacity)**	**Medium (capacity)**	**Variation (medium vs small)**
Group CAS – Social worker	12.00 min (10)	4.46 mins (50)	-62.9%
Group CAS – Social worker	12.00 min (10)	1.83 min (300)	-84.8%
Group CAS – Doctor	12.00 min (10)	4.80 min (50)	-60.0%
Group CAS – Doctor	12.00 min (10)	0.74 min (300)	-93.8%
Group CAS – Mediation	5.14 mins (10)	2.40 mins (50)	-53.3%
Group CAS – Mediation	5.14 mins (10)	1.26 min (300)	-75.6%
Art. 11(2-bis) – Doctor	8.57 mins (25)	1.35 min (450)	-84.2%
Article 11(2-bis) – Nurses	8.57 mins (25)	1.35 min (450)	-84.2%
Art. 11(2-bis) – Mediation	6.86 mins (25)	1.43 min (450)	-79.2%
10-ter – Social worker	2.06 min (25)	0.43 min (600)	-79.2%
10-ter – Doctor	8.57 min (25)	1.14 min (600)	-86.7%
10-ter – Nurse	8.57 min (25)	1.14 min (600)	-86.7%
10-ter – Psychologist	4.80 mins (25)	1.14 min (600)	-76.2%
10-ter – Mediation	6.86 min (25)	1.29 min (600)	-81.2%
10-ter – Regulatory information	5.49 mins (25)	0.63 min (600)	-88.5%
CPR – Social worker	6.17 mins (25)	2.40 mins (150)	-61.1%
CPR – Doctor	7.20 mins (25)	2.80 mins (150)	-61.1%
CPR – Nurse	57.60 min (25)	9.60 min (150)	-83.3%
CPR – Psychologist	8.23 mins (25)	2.74 mins (150)	-66.7%

CPR – 24-hour total mediation	115.20 min (25)	22.40 mins (150)	-80.6%
CPR – Regulatory information	3.43 mins (25)	1.03 min (150)	-70.0%

In terms of order of magnitude: when moving from small to 'medium-large' facilities, language mediation decreases by approximately 53–76% in collective CAS centres (depending on whether 50 or 300 places are considered), by approximately 79% in facilities under Article 11(2-bis) (25→450) and by approximately 81% in 10-ter centres (25→600). In the CPR, 24-hour mediation decreases by approximately 81% (25→150). Similarly, the time spent by doctors decreases by approximately 60–94% in collective CAS (10→50/300), by approximately 84% in facilities under Article 11(2-bis) (25→450) and by approximately 87% in 10-ter centres (25→600); in the CPR, it falls by approximately 61% (25→150).