THE PROTECTION OF HEALTH IN ADMINISTRATIVE DETENTION CENTRES

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Introduction

Andrea Oleandri

In 1998, Italy entered an era of administrative detention for foreign nationals; a total restriction of personal liberty imposed not on those proven to have committed a crime, but on individuals in violation of an administrative regulation by way of entering the country without documentation, or remaining without a residence permit.

Over the years, the detention system has undergone changes in management model and duration of detention. However, its oppressive and repressive nature has persisted, along with the consistent violation of fundamental rights. Those violations are not exceptional but rather constitute the norm underpinning the entire structure of administrative detention.

The pre-removal centres (*in Italian, Centres for Repatriation, and hereafter CPRs)* are opaque spaces, shielded from media scrutiny and political accountability, where invisibility becomes the standard condition. These are places where people live under conditions of confinement, often for months, awaiting deportation - which in some cases never materialises. We referred to them as “black holes” in a campaign launched in 2019, as they swallow up people’s lives.

In this context, the right to health - fundamental and universal - is systematically denied, ignored, or reduced to a minimal function of managing distress.

It is precisely this issue of healthcare in detention centres - or more accurately, the violation of the right to health - that the Italian Coalition for Civil Liberties and Rights (CILD), in collaboration with Progetto Diritti and the International Detention Coalition (IDC), sought to highlight during a roundtable discussion in Rome in June 2024.

The testimonies, official data (when available), reports by CILD and other organisations working on this issue, and legal analyses collected all converge in depicting a system that is structurally incapable of protecting those detained within it. Healthcare services in CPRs are entrusted to doctors employed by the same private entities that manage the centres, who often operate under economic imperatives rather than health protection. The National Health Service (SSN) is frequently marginal or entirely absent within CPRs, even as regards the medical fitness-for-detention assessments that regulations assign to the SSN but which, as revealed by investigations and inquiries, are often carried out by staff of the managing entities.

The suffering of people detained in these centres is both physical and psychological. Their mental suffering frequently goes undetected due to a lack of resources or adequate training on the needs of migrants, who often suffer from complex trauma, chronic illnesses, and face linguistic and cultural barriers. At

other times, their suffering is simply ignored: detainees are often treated as threats to order and are heavily sedated with psychotropic medications; frequently administered without proper diagnosis.

But it is not only mental health that is compromised. Numerous reports describe serious difficulties for detainees in accessing even basic medical care, poor hygiene, dilapidated facilities, and the absence of health screenings upon entry or during detention.

Health, however, is not merely the absence of illness. It is a state of physical, mental, and social well-being. Within CPRs, this concept is completely stripped of meaning. Detainees are condemned to total apathy for the entire duration of their detention, with no access to work, education, or recreational activities. Their time in detention is suspended while they await deportation, which in most cases does not occur, leaving them in a state of existential precarity.

Detention itself becomes a pathogenic factor, something that causes suffering and exacerbates pre-existing health conditions. In documented cases, detention has resulted in tragic outcomes, including death.

This is not a condition unique to Italy; it has much broader geographical relevance.

In Italy, in 2024, the Italian Society of Migration Medicine (SIMM), a network called ""Mai più lager – No ai CPR" and the Association for Legal Studies on Immigration (ASGI) issued a call to all healthcare personnel to raise awareness about the conditions and health risks faced by migrants subjected to administrative detention in CPRs.

The roundtable held in June 2024 offered an opportunity to explore these and other issues from an international perspective. This e-book originates from that event and contains several of the interventions presented on that day, interviews with some of the speakers, and emblematic case studies illustrating the consequences of failing to uphold the right to health in CPRs.

Health Protection in CPRs. Assessing medical fitness for detention

Gaetano Mario Pasqualino

This kind of detention[1] is an administrative law measure used to ensure physical control over migrants for the purpose of verifying their right to enter Italy and/or to enable their deportation, as an exercise of the coercive power of the administration aimed at serving a specific public interest

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Putting aside any consideration of the effectiveness of administrative detention - especially in the frequent absence of repatriation agreements with migrants' countries of origin[2] - it is evident that the term "custody" is a case of semantic softening, being in essence equivalent to "detention", i.e. a "measure affecting personal liberty" within the facilities designated for the repatriation of migrants (CPRs) that "cannot be implemented outside the guarantees provided by Article 13 of the Constitution"[3]. Therefore, the health protection of the detained person must be ensured primarily through an assessment of their physical and mental fitness to live in a confined environment - analogous to the provision under Article 11(7) of Law No. 354/1975 (Prison System) - which must be verified exclusively by a doctor from the National Health Service (SSN) or a public hospital.

From the combined provisions of Articles 32, 2 and 3 of the Constitution, it is clear that the right to health has an immediate and direct effect *erga omnes*, as an absolute subjective right that deserves protection against any third-party infringement, and as a social right whose practical implementation is essential to achieve the principle of liberty and dignity guaranteed by the Constitution. The right to health of migrants - understood in a comprehensive, unlimited, and absolute sense - is therefore directly protected by Article 32, and becomes central when evaluating the legitimacy of custody. Such detention must be assessed on an individual basis, particularly given the broad powers of judicial oversight of administrative detention.

This assessment of a person's physical and mental condition and their ability to withstand detention conditions, necessary and preliminary, is further clarified in secondary legislation[4], which requires a prior medical examination regarding any "contagious and infectious diseases dangerous to the community, psychiatric disorders, acute or chronic degenerative pathologies -...- that cannot be adequately treated in confined communities" (Article 3, paragraph 1), and that "a

[1]Regulated by Article 14 of the Consolidated Immigration Act and by Articles 6 and following of Legislative Decree 142/2015.
[2]In the fourth quarter of 2023, 105,585 third-country nationals received a return decision from an EU country, and 28,900 were effectively returned to a third country. Total since the beginning of 2024: 199,620 removal orders issued with 56,080 removals carried out across the Union. In the first half of 2024, Italy issued 13,330 return decisions and expelled 2,035 non-EU nationals.[EUROSTAT data].
[3] Constitutional Court, Judgment No. 105/2001.
[4]Directive of 19 May 2022: Criteria for the Organisation and Management of Pre Removal Centres.

medical certificate must attest the compatibility of the person's health or vulnerability status, pursuant to Article 17(1) of Legislative Decree No. 142 of 18 August 2015".[5]

Although primary legislation does not make explicit reference to this preliminary health verification, this does not exempt the administration - and later the judge responsible for validating the detention - from the obligation to assess whether the person's health condition is compatible with immediate detention in a CPR.

The general nature of a defence lawyer's claim during a detention hearing, concerning a detainee's vulnerability or poor health, does not negate the judiciary's autonomous duty to conduct fact-finding, since the assessment of vulnerability is an essential component of judicial validation.

The detention judge holds the power to assess the lawfulness of the detention process and cannot disregard relevant reports or objections raised by the parties involved. When a person's right to health and life, and their fitness for a restrictive environment, are at stake, the judge must - according to this author - conduct an independent review, at minimum by verifying the existence of the required health certification prescribed by secondary legislation,[6] which must be submitted to the judge by the administration.

Otherwise, the necessary verification of the health status of the person in administrative detention would go unchecked in case of inertia or a failure to raise the issue at the hearing, leading to an unacceptable restriction of the right to health. This is especially critical given the expedited nature of these proceedings and the communication challenges faced by defence lawyers due to geographical distance and language barriers.

The current ambiguity in the application of health protection standards for detainees in CPRs necessitates a primary legal provision making the submission of a certificate of fitness for detention - issued by a doctor from the local health authority (ASP/ASL) or a public hospital - a procedural requirement for validating the detention. The medical file of the detainee should also be submitted, in accordance with Article 3 of the aforementioned Directive.

As regards the certificate, it is essential that it contains a specific statement confirming the absence of physical or mental illnesses or conditions of vulnerability: a simple declaration of "absence of infectious diseases" or the use of

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[5] I.e. Minors, unaccompanied minors, persons with disabilities, elderly individuals, pregnant women, single parents with minor children, victims of human trafficking, persons suffering from serious illnesses or mental disorders, individuals who have been verified as having experienced torture, rape or other serious forms of psychological, physical or sexual violence, including violence related to sexual orientation or gender identity, and victims of genital mutilation.

[6] The assessment of fitness for living in restricted community and the reports from the Centre's socio-health service are handed over to the Police office within the Centre so that they can be included in the file submitted to the Judicial Authority during the validation and extension of detention, and, in the case of asylum seekers, forwarded to the Territorial Commission for the recognition of international protection. (Directive, Article 3, par. 7).

anonymous pre-printed forms is not sufficient. The relevance of the certification's currency has become particularly significant today, given that recent legislative amendments have extended the duration of detention up to 18 months. Even a concise certificate must detail the medical examinations performed and must be issued by a qualified and specialised doctor - otherwise, it is ineffective due to inadequacy.

It is also important to highlight that, in many cases, the detention itself and the administration of neuroleptic drugs have contributed to the deterioration of the physical and mental health of migrants who had arrived in Italy in good health. Particularly telling is the significant expenditure by CPR managing entities on antipsychotic and antiepileptic medications.[7] This reveals how management often limits itself to pharmacological interventions in cases of psychological distress, and resorts to involuntary treatment (TSO) in more severe instances. This approach is a direct consequence of CPRs lacking the facilities and personnel necessary to adequately address the mental health needs of detainees with psychiatric conditions; a situation that has led to documented cases of suicide and attempted suicide[8].

[7] "*Rinchiusi e sedati: l'abuso quotidiano di psicofarmaci nei Cpr italiani*" - https://altreconomia.it/rinchiusi-e-sedati-labuso-quotidiano-di-psicofarmaci-nei-cpr-italiani/.
[8] See the case study section.

CPRs, Administrative Detention and Health Vulnerabilities

Nicola Cocco

The right to health of migrants is frequently violated or disregarded in host countries, particularly in certain externally-imposed conditions. The well-known "healthy migrant effect"[9] paradigm in migration medicine has long been replaced by that of the "exhausted migrant effect": the conditions endured during the migration journey - and, above all, the living conditions in host countries - result in a significantly worse actual and perceived health status compared to the resident population.[10] There are contexts in which the health capital of migrants is further, if not completely, depleted, for instance, in criminal detention and administrative detention of individuals deemed "irregular."[11] The latter refers to deprivation of liberty based on the lack of documentation such as a residence permit, which constitutes an administrative offence, not a criminal one. In such restrictive environments, the ability to manage and safeguard one's own health may be so severely compromised that one may speak of a veritable "detained migrant effect". This is demonstrated by the high prevalence of mental health disorders - particularly anxiety, depression, and post-traumatic stress disorder - among migrants held in administrative detention. These rates are higher than those found in the general population and even among the prison population.[12]

Health-related challenges in administrative detention have been flagged internationally by numerous studies.[13] In particular, the uncertainty inherent in the nature of administrative detention and the risk of deportation or removal has a significant impact on migrants' mental health.[14]

In 2022, the European Regional Office of the World Health Organization (WHO) published a document highlighting the health risks faced by migrants subjected to administrative detention[15]. In Italy, the main facilities used for administrative detention are called "Centri di Permanenza per il Rimpatrio" (CPRs). Healthcare

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[9] Razum, O. (2008). *Migrant Mortality, Healthy Migrant Effect* . In: Kirch, W. (eds) Encyclopedia of Public Health. Springer, Dordrecht. https://doi.org/10.1007/978-1-4020-5614-7_2188.

[10] Neuman, S. *Are immigrants healthier than native residents?*. IZA World of Labor 2014: 108 doi: 10.15185/izawol.108.

[11] Lungu-Byrne, Cassie & Germain, Jenny & Plugge, Emma & Hout, Marie-Claire. (2020). *Contemporary Migrant Health Experience and Unique Health Care Needs in European Prisons and Immigration Detention Settings. International Journal of Forensic Mental Health.* 20. 1-20. 10.1080/14999013.2020.1821129.

[12] Von Werthern M, Robjant K, Chui Z, et al. *The impact of immigration detention on mental health: a systematic review.* BMC Psychiatry. 2018;18(1):382. Published 2018 Dec 6. doi:10.1186/s12888-018-1945-y.

[13] *Van Hout MC, Lungu-Byrne C, Germain J. Migrant health situation when detained in European immigration detention centres: a synthesis of extant qualitative literature. Int J Prison Health. 2020;16(3):221-236. doi:10.1108/IJPH-12-2019-0074.*

[14] Verhülsdonk, Irina & Shahab, Mona & Molendijk, Marc. (2021). *Prevalence of psychiatric disorders among refugees and migrants in immigration detention: systematic review with meta-analysis.* BJPsych Open. 7. 10.1192/bjo.2021.1026.

[15] *WHO Regional Office for Europe. Addressing the health challenges in immigration detention, and alternatives to detention: a country implementation guide.* WHO Regional Office for Europe, Copenhagen 2022, https://apps.who.int/iris/handle/10665/353569 .

provision for migrants detained in these centres is contracted to medical staff hired by private managing entities, without requirements for qualifications or specific training in detention or migration medicine. Numerous reports and investigations by independent bodies[16] - as well as by the *Garante Nazionale dei diritti delle persone private della libertà personale* (Italy's Ombudsperson for the rights of the people deprived of their liberty)[17] - have exposed the degraded and degrading conditions of CPRs, both in terms of hygiene and the physical and mental health of detained migrants. Detainees often suffer from serious health problems, exacerbated by the detention environment and lack of access to quality healthcare standards guaranteed by the National Health Service (SSN). CPRs operate under a regime of abandonment, where detained migrants are often left with no other means of expression than their own bodies, resulting in numerous incidents of self-harm, suicide attempts, and completed suicides. Although official or published data specific to the Italian context are lacking, individual incidents and various situations have been widely documented during monitoring activities by institutional and civil society guarantors. So-called "anti-conservative acts" (i.e. self-destructive behaviours) are a daily occurrence in administrative detention centres. For example, in the United Kingdom, four migrant detention centres recorded 1,743 such incidents requiring intervention or treatment over 2,099 days (data as of November 2023).[18] A "continuum of violence" has often been described in CPRs - violence inflicted on one's own body met with violence by law enforcement and CPR staff, including the violence of inadequate healthcare. These centres often foster normalised cycles of violence and dehumanisation: for example, detainees are typically referred to by their assigned number rather than their name. This further increases the frequency of self-harming and protest behaviours, as a means of "escaping" the grip of detention.[19]

Detention can currently be prolonged for up to 18 months while awaiting deportation - an outcome that is achieved in less than 40% of cases[20] and is implemented traumatically. Repatriation typically occurs at night without prior notice, with police officers storming the CPRs in large numbers, removing the individual with just a few minutes to collect belongings (usually in black plastic bags similar to those used for rubbish), make a phone call, and undergo a medical check intended to certify that the person is "fit to travel". However, this

[16]See in particular reports produced by "Rete mai più lager – No ai CPR" (Delle pene senza delitti. Istantanea del CPR di Milano. Report dell'accesso presso il Centro di Permanenza per il Rimpatrio di Milano, via Corelli n. 28, del Senatore Gregorio De Falco nelle giornate del 5 e 6 giugno 2021, and Delle pene senza delitti. Istantanea del CPR di Milano – Un anno dopo), by ASGI (cfr. https://www.asgi.it/tag/cpr/) and Naga (Al di là di quella porta - Un anno di osservazione dal buco della serratura del Centro di Permanenza per il Rimpatrio di Milano).

[17] See the most recent reports published by the Italian Ombudsperson for the rights of the people deprived of their liberty cfr. *https://www.garantenazionaleprivatiliberta.it/gnpl/pages/it/homepage/dettaglio_contenuto/?contentId=CNG15448&modelId=10019* .

[18]Taylor D. Self-harm incident nearly every day in UK immigration detention, data shows. The Guardian, 27 novembre 2023, https://www.theguardian.com/uk-news/2023/nov/27/self-harm-incident-nearly-every-day-in-uk-immigration-detention-data-shows.

[19]For a comprehensive analysis of cycles of violence, normalization and dehumanization see *Volpato C. Deumanizzazione. Come si legittima la violenza, Laterza – Bari, 2014.*

[20]See *ActionAid. Trattenuti - Una radiografia del sistema detentivo per stranieri, ActionAid Italia, Università di Bari, 2023.*

examination is often superficial and purely procedural.[21] These practices not only call into question the "efficiency" of a system heavily promoted by successive Italian governments over the past decade but also render the deportation process even more violent. Its arbitrary and punitive nature is inflicted directly on the body of the detainee, with no possibility for understanding or intervention - causing clear harm to mental health.[22] This situation is further compounded by the confirmed abuse and misuse of psychotropic medication.[23]

Under current legislation,[24] placement in a CPR requires a health assessment by a doctor affiliated with the SSN ("*valutazione di idoneità alla vita in comunità ristretta*"). In practice, this assessment is nearly always reduced to a generic clearance certifying the absence of infectious diseases, without any real evaluation of the person's overall health. This raises serious concerns. In response, and in line with WHO guidance, SIMM, in collaboration with the "Mai più lager – No ai CPR" network and ASGI, launched a public awareness campaign in early 2024. The campaign calls on all Italian healthcare professionals to recognise the risks and health impacts of administrative detention and, specifically, urges doctors tasked with evaluating fitness for life in CPRs to refrain from issuing such clearances for any migrant. This appeal is supported by extensive evidence and the input of experts and bioethicists, who have substantiated the case for public health, medical ethics, and medico-legal principles. These arguments establish that it is ethically acceptable - if not necessary - for healthcare professionals to refuse to assess anyone as fit for containment in CPRs.[25] In particular, the campaign stresses that beyond the inherently pathogenic conditions of CPRs, the assessment itself raises major ethical violations. These include the impossibility of conducting a proper health evaluation under current police procedures, the absence of informed consent or cultural mediation,[26] and the incompatibility of the physician's role - as protector of individual health - with the function they are required to fulfil. The Medical Ethical Code obliges doctors to safeguard vulnerable individuals, "particularly when they believe that the environment in which the person lives is not adequate to protect their health, dignity, and quality of life."[27] Existing evidence clearly shows that CPRs are hazardous to the health and life of migrants. It is therefore ethically legitimate for doctors to act to prevent anyone from being detained in such settings.

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[21]See Garante nazionale dei diritti delle persone private della libertà personale, *Linee guida sul monitoraggio dei rimpatri forzati – seconda edizione*, 2022, https://www.garantenazionaleprivatiliberta.it/gnpl/resources/cms/documents/23ab168803a17df21168c9ef0c295f90.pdf.

[22]*Harrigan, N.M., Koh, C.Y. & Amirrudin, A. Threat of Deportation as Proximal Social Determinant of Mental Health Amongst Migrant Workers. J Immigrant Minority Health 19, 511–522 (2017).* https://doi.org/10.1007/s10903-016-0532-x.

[23]Rondi L, Figoni L. *Rinchiusi e sedati: l'abuso quotidiano di psicofarmaci nei Cpr italiani.* Altreconomia, 1 aprile 2023, https://altreconomia.it/rinchiusi-e-sedati-labuso-quotidiano-di-psicofarmaci-nei-cpr-italiani/.

[24]Article 3 of Directive of the Ministry of the Interior of 19 May 2022 (*https://www.interno.gov.it/sites/default/files/2022-06/direttiva_ministro_lamorgese_19.5.2022_accessibile.pdf*)

[25]*https://www.asgi.it/allontamento-espulsione/idoneita-alla-vita-nel-cpr-appello-ai-medici-necessaria-la-presa-di-coscienza/*.

[26]Medical Ethical Code, artt. 3, 6, 24.

[27]Medical Ethical Code, art. 32.

The campaign is currently ongoing and has gained national traction. Internationally, it has sparked debate about the role of healthcare workers in advancing an abolitionist approach to administrative detention of migrants.[28]

A recent petition has also been launched, targeted toward all health professionals (doctors, nurses, psychologists, caregivers, etc.), calling for the closure of CPRs, as they are spaces of degradation, suffering, and abandonment. The petition questions the legitimacy of healthcare professionals working in these environments, both in Italy and abroad (e.g. in the centres currently under construction in Albania as part of the agreement with Italy on externalising the detention of "irregular" migrants).[29] This concern is already being borne out in places such as Macomer (Sardinia) and Ponte Galeria (Rome), where SSN psychiatrists operating within CPRs risk not only being unable to provide adequate support to those with mental health conditions but also contributing to the "normalisation" of their detention.[30] These centres reveal a dangerous psychiatric drift, marked by detention, isolation, abandonment, and overmedication. Several CPRs have already reported such conditions: individuals with clear mental health issues left in filth; use of mechanical restraints like handcuffs; and "atraumatic" isolation rooms (entirely empty to prevent self-harm), all without clear psychiatric care pathways - in breach even of the Ministry of the Interior's Directive of 19 May 2022, which lists "psychiatric disorders" as a criterion for exclusion from CPR detention.[31]

In light of the European Parliament's recent approval of the "Pact on Migration and Asylum" - which, among other provisions undermining the right to asylum in Europe, includes extensive use of administrative detention at borders - the urgent need for public and political scrutiny of this legal, informational and humanitarian black hole becomes all the more pressing. This legislative shift calls for critical reflection on the health risks stemming from systemic rights violations, as many activist and humanitarian organisations have already warned.[32]

To recall the lesson of Franco Basaglia: there can be no care where there is no respect for rights. CPRs and administrative detention constitute a true public

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[28] Doctors should not declare anyone fit to be held in immigration detention centres. BMJ. 2024;384:q531. Published 2024 Mar 1. doi:10.1136/bmj.q531, https://www.bmj.com/content/384/bmj.q531.

[29] Cfr. https://www.change.org/p/appello-per-operator-della-salute-contro-i-centri-di-permanenza-per-il-rimpatrio?recruiter=1341459589&recruited_by_id=59ed5f10-2c27-11ef-bf18-1bb7dd89d8b0&utm_source=share_petition&utm_campaign=share_petition&utm_term=share_for_starters_page&utm_medium=copylink&utm_content=cl_sharecopy_490104211_it-IT%3A1.

[30] Notwithstanding Article *3 of the Directive of the Ministry of Interior 19 may 2022, appointing "psychiatric disorders" as one of the criteria for not being fit for life in CPR.*

[31] *Cfr. https://www.facebook.com/NoaiCPR/videos/-loasi-3non-abbiamo-pi%C3%B9-parole-ma-parlano-le-immagini-questa-%C3%A8-la-persona-che-vi-/334240385869108?locale=it_IT*

[32] Cfr. Tiberio L. *Il nuovo Patto europeo per le migrazioni e l'asilo avrà conseguenze umanitarie devastanti*. Valigia Blu, 11 aprile 2024.

health emergency - endangering the rights, health, and lives of migrants, and the integrity of the medical profession and of society as a whole.[33]

[33]Basaglia F, Ongaro F. (a cura di). *Crimini di pace - Ricerche sugli intellettuali e sui tecnici come addetti all'oppressione*. Einaudi – Torino, 1975.

“We rise up simply because we can no longer breathe”. Towards a deconstruction of the concept of health in CPRs

Monica Serrano

Frantz Fanon sits beside us: in his work *The North African Syndrome* (1952), he outlines a lengthy list of objective symptoms - or rather, the discomfort of the Other - the colonised Algerian, observed promptly by the French physician. In his work, Algerians are described as lazy, suspicious, dishonest about their condition and his own intentions, unreliable, inconsistent, hostile, and bound to primitive and inferior values. In the clinical setting, what most concerns the doctor is his inability to locate the illness in a specific and clearly defined part of the body. “It hurts here” says the patient (pointing to his stomach) “and here” (his liver) “not here anymore but over there” (his spleen), “and also here” (his intestines). This indecipherable *diffuse pain* is inevitably interpreted as a sign of some *deviance*, and no clear scientific knowledge can properly identify it. The Other thus remains, under the hands of the white coloniser, incurable, inaccessible, incomprehensible and uncontainable within one of the most extensive experiments of containment, control, and brutal violence in French colonial history.

While monitoring CPRs together alongside the *Garante Nazionale* (National Ombudsperson) between 2022 and 2023 in my role as an external consultant, Fanon’s writing frequently returned to mind. The medical clinics and staff I encountered were immersed in a well-established and deeply rooted culture of scepticism (to borrow Khosravi’s euphemism), in which the alarmingly high number of suicide attempts are quickly dismissed as staged acts: manipulative, instrumental, imitative, fake, and foolish. Such language appears regularly in paper records concerning critical events and in the spoken comments of doctors and nurses. “Once it was a Sunday, and one of them made me come back here just because he staged himself hanging. I’m used to it, but the problem is that when I return, I risk not finding parking” stated one doctor on duty.

Fanon’s words root into this specific *humus* - the racialised and colonial order of power over othered bodies, both colonised and detained. These subjects are trapped in a continuum of violence, crushed into subaltern conditions: the former were natives in 1950s Algeria, the latter are today’s audacious migrants - many from the same region of the world (North Africa- Maghreb). It is this continuum of violence that suffocates, which we refuse to sugarcoat with the lexicon of humanitarianism and social work: in the lived experience of migrant people, persecution and deprivation, uprooting, corruption, abuse and arbitrariness, coercion, detention, commodification (*black man is money*), torture, and exposure to death constitutes the very core of the migratory path. Both there and here. This continuum encompasses not only the journey, but also the arrival and

the conditions of *akkoglienza- welkome* (a term I wish to disturb, much as Mahasweta Devi does with the word *Enkounter - Inkontro* - uttered by Indian military men while in fact torturing the activist Draupadi).

Over two decades of the Italian reception system's history, both policy and practice have increasingly moved toward selection, reduction, containment, and control, aligning with the empty shell of either *integration* or *expulsion*. The most glaring issue remains the ease with which personal liberty is deprived, as though migrant subjectivities were not persons before the law: a "simplified" and brutal legal order weighs down on their bodies, making it standard practice to cage them. In the accounts of foreign individuals, life is lived under constant threat, being at any moment, on the verge of that *lesser* condition then a failed regularization. Stumbling through the labyrinth of progressively deprived rights to reception and legal guidance; suddenly crashing down upon them, destroying their ability to stay here or to go elsewhere. It's the path of a life constantly uprooted, with no real freedom to choose.

Within this scenario, detention and forced repatriation represent *something more*, a form of excess, the final stage of a journey that was worth risking one's life for, and along which death was often a close companion. If one arrives as a survivor, they will return as a criminal. The *something more* of detention in a pre-removal centre is made up of the following alienating elements:

- Reiteration of the order of violence: Military forces, police, and armed *Guardia di Finanza* agents in large numbers closely monitor the few permitted movements of detained people within a space made of cages, locked metal doors, metal gates, cells, broken windows and bars, cold, filth, and an overwhelming emptiness filled with screams and the constant banging of fists and feet against the metal grates.

- Disintegration of the sense of self: the end of expectations, of promises, and of the ties to what was left behind; ties often invisible to us as healthcare providers, yet central to the sense of being here. As doctors in white coats, we overlook the fact that *the body* before us is also *a community*, whether present or absent, visible or invisible, living or dead. Let me out, I have to take care of my sick mother and without my money, she'll die. Let me out, my wife would die if she saw me return like this. Let me talk to my uncle, my brother, my children, I've been gone a month, they must be going mad. Betraying this community causes wounds deeper than any physical injury.

- De-humanisation of the repatriation system: beyond the material conditions of CPRs, internment involves a radical *suspension of time*. If *to exist* is to be in time (Heidegger), then the inability to know when and how it will end, this uncertainty lasting for days or even months is itself a

pathogenic, consuming act embedded within administrative detention. The Latin term *finis*, as Viktor Frankl -survivor of concentration camps- reminds us, has a dual meaning: it refers both to an end as the termination of something, and to an end as the purpose, goal, or meaning of future existence. In CPRs, the suspension of temporality for the detained person - the "not knowing what will become of me, and how my end will be determined by others" - used to last up to three months and now extends up to eighteen: it literally drives people mad. *Chronos* devours *Kairos*. The erasure of one's sense of self, of the world and human connection, this destruction of the *ability to be* and any vision of a future world: in the face of this apocalypse of deprivation, not even the best psychologist in a detention centre can offer real healing. I remember a committed psychologist who had just finished a one-on-one support session with a man described as "depressed and desperate". She encouraged him to imagine possible paths toward work and inclusion once released. Just a few minutes later that same morning, the man was taken from his room for immediate repatriation — his belongings stuffed in a black bag, his wrists bound with cable ties while transferred to the airport.

What remains of the human? An imperfect testimony, a language distorted by "constant currents of the inhuman and the human" (Agamben). Such are the testimonies we collected during our monitoring visits to detention centres (CPRs): stories we now share here, aware that those who are submerged cannot speak.

Yet within the vast machinery of de-subjectivation that is the CPR, something speaks before and beyond words: bodies of detained people. I'm referring not only to the countless acts of self-harm recorded and left to fade in the logbooks of critical incidents, but also to the visible cuts, the bleeding skin, the improvised stitches that mark the bodies of those imprisoned. As if suffering finds, on the surface of the skin, its final field of action. In a state of total deprivation—of self and of world—what remains as a trace of free will is precisely the act of cutting, ingesting, injuring oneself at the risk of death. It is the surgical violence enacted on the body that speaks—the body as the only part of the world still under one's control. It speaks, and it unsettles the detention system.

No longer recognised as a legal subject, the body takes on the risk of freedom, occupying the precarious space between *just enough to* and *not too much to*: I hurt myself just enough to be taken out of here (to the infirmary, to the hospital, in front of other hands that may sign off on my release by declaring me unfit for detention), but not too much - perhaps- to die.

Pain, inflicted upon the body thus inverts -acrobatically, at the risk of life- the very legal condition of the detained person: while the law categorises the person as an irregular migrant to be forcibly deported, the person uses their body to claim the right to care and health *here,* as long as they remain in the hands of the State.

They demand the State's duty to protect their life. The body becomes an extralegal repertoire for claiming rights.

This act often goes misunderstood by interviewed medical staff, concerned with distinguishing between real or fake suicide attempts, instrumental or genuine self-destructive acts, manipulative or authentic gestures of self-harm - an ultimately futile investigation shaped by what, with Khosravi, we called a skeptical logic, which we now deepen as a broader universe of suspicion and hostility - that precedes and accompanies the control mechanisms of the CPR apparatus.

> *The position in which detained people seem to be trapped is a paradoxical one: their behaviour is threatening yet futile; they are cunning yet childish; they scream and complain, oblivious to their privileges* (Nicola Manghi).

This uncomfortable indecipherability and unpredictability of the Other is quickly offset by declarations of the medical staff's benevolence, humanity and rightful authority:

> *These are childish, immature gestures. I can't send them home just because they cut themselves or whatever else, otherwise everyone would do it. I don't accept to be taken for a fool, I'm a good and honest man. I bring them sugared almonds, sweets; they all like me, even when they see me on the street, they greet me. But when they try to make a fool of me, I won't have it, so I don't send them home in those cases* (idem).

As in the statement made by the doctor quoted at the start of my intervention, self-absolution often goes hand in hand with a kind of blindness brought on by habituation: like the on-call CPR doctor who, n the face of a suicide attempt, is more worried about finding a parking spot.

Dehumanisation is systemic. It would be worth developing a phenomenology of it, as briefly sketched here, to avoid becoming desensitised to its practices masked as ordinary routine. Within this system, the verbal and embodied testimonies of detained individuals leave us with a clear message: we want freedom more than life! And we are willing to make death our companion.

I conclude with a message written on a wall by Ousman Sylla, a young man who took his own life in the Ponte Galeria CPR on 4 February 2024. His words cast a piercing gaze on the workings of administrative detention as well as on the reception system, both now shaped by the hopeless and securitarian course of Italian and European migration policy:

> *"If one day I die, I would like my body to be brought back to Africa, my mother would be glad (...). Italian soldiers understand nothing but money. I miss my Africa and I miss my mother too. There is no need to cry for me, peace be upon my soul, and may I rest in peace."*

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The Right to Health and Alternatives to Detention

Nataliya Novakova

The right to health is a fundamental right for all people regardless of their citizenship, including for refugees and migrants. This right is enshrined in the cornerstone documents of international human rights law. The Universal Declaration of Human Rights states that everyone has the right to a standard of living adequate to ensure the health and well-being of him or herself and their family. The International Covenant on Economic, Social and Cultural Rights recognises the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Health and well-being for all at all ages is coined as a Sustainable Development Goal (SDG 3).

In practice, however, we often observe that states do not make sufficient efforts to ensure the right to health of people on the move. A lack of adequate access to health for migrants can be rooted in different factors. It can be related to the peculiarities of the welfare system, limiting healthcare for those not covered by insurance to the bare minimum of life-saving emergency services. It can also be related to the fear of persecution: in some countries, medical personnel are obliged to report undocumented migrants to law enforcement bodies if they encounter such patients. Cumulatively, these factors lead to a shocking observation made by the WHO in Europe: the longer asylum seekers, irregular migrants, victims of trafficking, and others in vulnerable situations live in the host country, the greater the risk of them contracting noncommunicable diseases. These population groups are also disproportionately affected by many communicable diseases compared to host populations in Europe. International migrants, including refugees, make up approximately 11% of the population residing in Europe.[34]

Access to healthcare is even more problematic for migrants in detention. Considering current policy moves toward increased securitisation and the push for asylum applications to be processed at the border, we should expect an increase in immigration detention in Europe in upcoming years. In this context it is important to be conscious of what such policies mean for the right to health of people on the move.

Currently in Europe there are three types of immigration detention centre ownership: government, government–local, and privatised. The quality of service among them varies, but there is a general agreement that government-owned

[34] Addressing the health challenges in immigration detention, and alternatives to detention - https://idcoalition.org/wp-content/uploads/2024/01/Addressing-the-Health-Challenges-in-Immigration-Detention-ATD.pdf

immigration detention centres have a higher level of trust among migrants and the quality of services there is more consistent.

Across most of the detention centres, irrespective of their form of ownership, the most common problems related to the right to health are related to the fact that in most cases detained people have access only to emergency medical support. The working hours of in-house doctors are extremely limited and access to external medical facilities is limited. There is a lack of specialised care and/or access to secondary and tertiary health-care services.

The following types of healthcare implications are most widespread in immigration detention:

- Communicable diseases
- Trauma and injuries
- Mental health issues
- Women's health issues

When migrants are placed in detention their pre-existing health conditions are often ignored. Vulnerability screening is often missing or is limited to physical checks. A recent Amnesty International report, following visits to CPRs in Italy, confirms that medical assessments and fitness tests do not often accurately reflect the actual health conditions of migrants in detention. Amnesty International documented three cases of acute mental illness and one of physical health issues (inability to move) among migrants in detention. In all cases the migrants were deemed suitable for detention by the competent health authority[35]. The National Associated Press Agency of Italy recently published the investigation "The Mental Asylum of Migrants", highlighting alarming issues related to violations of health rights of detained individuals. Among these is the case of a woman with acute mental health issues held in solitary confinement in Ponte Galeria for 9 months. It took a visit from members of parliament to put an end to her plight. Together with the lawyers they filed an urgent appeal to ECtHR, which ruled on July 3, 2024, ordering Italy to release the detainee.[36] Research conducted by the WHO states that 66% of migrants entered immigration detention with at least one pre-existing mental or physical health condition that required ongoing treatment. Moreover, female irregular migrants were found to

[35] Amnesty International, Liberty and Dignity: Amnesty International's Observations on the Administrative Detention of Migrant and Asylum-Seeking People in Italy, 2024, https://www.amnesty.org/en/documents/eur30/8244/2024/en

[36] ANSA, *Il manicomio dei migranti,* 2024 - *https://www.ansa.it/sito/notizie/magazine/2024/07/09/il-manicomio-dei-migranti_da695b9c-64e4-467c-ad1f-f06664b44f2f.html?utm_source=whatsapp&utm_medium=channel&utm_campaign=social&fbclid=IwY2xjawEv93ZleHRuA2FlbQIxMAABHYHP6LUaILl5tfDQVgrzImOrRqkhAb2ZF0af43vpQuwG79yLIE3nnce5YA_aem_93-N3j6GNjD6J0CfNgURqQ*

be more likely to develop a psychiatric disorder in immigration detention compared to men, even when most of the sample were men (84%).[37]

In this context, the movement towards privatisation of immigration detention centres poses additional threats to migrants' health. The cases of Spain and Italy, where detention centres are administered by private companies, show that the quality of medical services falls and oversight and accountability vanish. The overall logic of cost effectiveness and the dual loyalties of the doctors, and their dependence on the private employer, become additional barriers to ensuring the right to health. In Spain, official investigations have proved a connection between the death of migrant Samba Martine and poor provision of healthcare services in the detention centre managed by the private company SERMEDES S.L.[38] CILD's report on Italian detention facilities shows significant evidence of multiple cases where, even after a suitability check conducted by private doctors, migrants were admitted to detention facilities with serious medical conditions (including cancer), or significant mental health issues, which later led to suicides in detention. Monitoring visits to detention centres on multiple occasions found discrepancies between service provision times declared by the facility/medical staff and the reality of virtual inaccessibility of medical services, including for emergency healthcare and psychological services. Moreover, 90% of the lawyers interviewed in the course of research stated that there were no certificates of suitability in the file of the judicial authority concerning their clients, even if they are a prerequisite for confirming or extending detention.[39]

There is also a worrying trend, particularly prominent in Spain, towards deporting migrants when they or CSOs acting on their behalf, try to draw attention to violations of their rights in detention. For instance, in June 2023, 36 inmates detained at the CIE of Valencia were deported after they went on hunger strike to denounce the bad conditions of the facility and the inhumane treatment by the police. In November 2023 a 68-year-old man detained at the CIE of Valencia was deported to Bolivia despite his serious health condition, which were aggravated by the lack of medical assistance while in detention. In June 2023 a migrant detained at the CIE of Valencia was deported to Paraguay, allegedly for having reported to the competent Judge that he was subjected to beatings and threats by the police while in detention.[40] Given this trend, there is a need for the legal community to strategise and learn from other frontline countries how to better ensure respect of the right to protection, in the event of removal, expulsion or extradition, as enshrined in the EU Charter.

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[37] Addressing the health challenges in immigration detention, and alternatives to detention - https://idcoalition.org/wp-content/uploads/2024/01/Addressing-the-Health-Challenges-in-Immigration-Detention-ATD.pdf

[38] Conditions in detention facilities - Asylum Information Database | European Council on Refugees and Exiles -https://asylumineurope.org/reports/country/spain/detention-asylum-seekers/detention-conditions/conditions-detention-facilities/

[39] M. Marzano, "Black Holes": Detention Without Charge and Violations of Human Rights in Italian Detention Centres, 21 January 2022 - https://atdnetwork.org/wp-content/uploads/2019/03/ReportCPR_En_2vers-1.pdf

[40] Conditions in detention facilities - Asylum Information Database | European Council on Refugees and Exiles - https://asylumineurope.org/reports/country/spain/detention-asylum-seekers/detention-conditions/conditaions-detention-facilities/

By contrast, alternatives to detention (ATDs) present a good opportunity for providing stronger protection of the right to health for the people on the move. ATD are not only required by international law and guidelines but are also essential to ensuring the dignity and respectful treatment of all individuals. ATDs are often considered to be policies or programmes that provide migrants who otherwise would have been detained with the opportunity to instead reside within the community to complete migration procedures (sometimes with restrictions applied,, to ensure compliance). The evidence suggests the following positive outcomes of ATDs for the health of the people on the move:

- The prevalence and severity of poor mental health is greater among migrants in detention compared with similar migrant populations living in community settings.

- Asylum seekers in detention reported more depression, anxiety and avoidance (related to PTSD) than asylum seekers living in community settings.

- Female migrant sex workers who were detained reported high rates of depression (79%), significantly higher than a similar sample of female migrant sex workers living in the community (33%).

- Suicide rates for asylum seekers in immigration detention were much higher than the average found in the local population (112 and 9 per 100.000, respectively)

Evaluation of ATDs in Europe showed improvements in migrants' mental health in 96% of cases.[41]

The benefits of ATDs to migrant health are obvious. Therefore, IDC and its partners in Europe and globally are advocating that the states should seek the opportunities for introducing ATDs, which is the only mechanism providing sufficient protection of the human rights of the people in the move including the right to health.

[41] Addressing the health challenges in immigration detention, and alternatives to detention - *https://idcoalition.org/wp-content/uploads/2024/01/Addressing-the-Health-Challenges-in-Immigration-Detention-ATD.pdf*

Interview with Natasha Tsangarides

Arianna Egle Ventre and Irene Proietto

Can you briefly introduce yourself? Who are you and what is Freedom from Torture?
I am the Associate Director of Advocacy at Freedom from Torture. Freedom from Torture is a UK-based organisation and one of the largest torture rehabilitation centres in Europe. We provide legal and welfare support as well as a range of medical and psychotherapeutic services for survivors of torture. In addition, we engage in a modest amount of advocacy and campaigning work.

How was your organisation founded?
Freedom from Torture was established in 1985 and was originally a spin-off from Amnesty International, specifically from Amnesty's medical group, which sought to bring a medical focus into a human rights organisation. As such, we represent a blend of medicine and human rights, advocating for survivors of torture, most of whom are asylum seekers.

Medical perspectives can sometimes be instrumentalised to support repressive or criminalising systems. How does the medical focus within your organisation interact with the defence of human rights?
Our organisation is deeply committed to protecting survivors of torture, and we pursue this through both a medical and a human rights lens. Of course, in other settings, I can imagine that medical frameworks may be used against people, but for our purposes - protecting human rights - we rely on clinical expertise and the daily experiences our doctors gain from working with patients.

How do you facilitate interaction between people with different experiences, backgrounds, and knowledge within Freedom from Torture?
Interestingly, I don't see this as a problem. I think when there is shared agreement on the organisation's overarching goals, a kind of instinctive complementarity emerges. Of course, there may occasionally be tensions - for instance, between medical priorities and legal or advocacy approaches - but I believe it's about listening to each other, learning from one another, respecting each discipline, and understanding what strategy is best suited for the situation at hand.

Let me give you an example. One key focus for us is involving survivors of torture in every aspect of our work - not only in advocacy, but also in designing clinical services and in organisational priorities and strategies. There were challenges in the past with incorporating a new group of experts into decision-making processes, but we've made progress. Our most recent organisational strategy was co-designed and co-delivered by survivors of torture.

Do you think the involvement of medical professionals in your organisation contributes to broader awareness within the health sector?

Absolutely. Medical professionals are incredibly effective messengers. They can reach and influence audiences far more easily than activists or advocates. That's why we place a strong emphasis on having doctors and clinicians speak on our behalf. Our clinicians also publish in medical journals, speak to the media, and engage with umbrella bodies like the Royal College of Psychiatrists. We also work with many volunteer doctors who draft medico-legal reports for survivors of torture represented by lawyers.

Your organisation includes people with diverse experiences and perspectives. Do you think this contributes to changing the dominant narrative around detention and migration?

Narrative work is a central part of our theory of change and how we aim to advance refugee and survivor rights. On one hand, we use narrative to highlight the clinical and medical impact of detention - on staff and on survivors. On the other hand, we aim to shift the typical government discourse by promoting a more hopeful, forward-looking narrative, presenting policy alternatives through our own messaging.

What messaging did you use in your anti-detention campaign?

Our detention influencing work focused on shifting attention away from control and criminality and toward the harm caused and the inefficiency of detention. It does not achieve its stated aims, and it is costly.

I also think it's important to distinguish between public and private messaging. For example, in public, you might avoid emphasising cost to prevent reinforcing negative associations between migration and expense. However, in private discussions, the cost argument can be effective.

How has the detention landscape in the UK changed since 2018, and how have you adapted your campaign?

The number of people in detention has nearly halved over the last decade. That change came about for many different reasons and involved a wide range of actors - government, NGOs, medical professionals, and others. Campaigns don't operate in isolation; they exist within an ecosystem. It's about finding points of alignment, building alternative narratives and policies, and achieving the consensus needed for change.

What is the dominant narrative on migration and detention in the UK, and how has it evolved?

The narrative has focused heavily on control and the need to "get rid" of people, portraying them all as criminals. Our response was to point out that the system was costly, ineffective, and under scrutiny. Another turning point came when the public became more aware. A BBC investigative journalist went undercover and produced a one-hour programme that aired on national television. It was shocking. It showed the reality many of us already knew, but it exposed it to the public, and that changed things. All the NGOs had already spoken out, medical professionals had raised concerns, and MPs were involved. But public attention shifted the dial. The British public, like the Italian or any other, doesn't want to see that level of abuse. When people see it and understand it, they respond. That's why we must think beyond the usual suspects in closed rooms.

What are the next steps in fighting detention and rights violations?

We need to involve people with lived experience - asylum seekers, those who've been detained. It's vital to build alliances not only with medical professionals, but also with formerly detained men, women, children, and others. It's also about narrative change: educating, informing, and mobilising the public.

How can we build international alliances?

Events like this one are very helpful. We need to bring together sector experts, learn from each other, share good practices and challenges. I think today was a great example, and I hope it's the beginning of more collaboration.

Your advocacy and campaigns work highlights how detention retraumatised survivors. But administrative detention — at least in

Italy — is often justified by distinguishing between those who "deserve" protection and those from "safe countries" who supposedly do not. Past trauma is, in a way, instrumentalised to justify the trauma imposed within detention facilities. How do we counter this logic, which exploits past trauma to legitimise new trauma?
Well, first, I don't know the Italian context, but I'd bet there are torture survivors in those detention centres. So the key is educating the general public. I don't know exactly who is detained in Italy, but in the UK, most are asylum seekers - and most asylum seekers have endured traumatic journeys. Leaving one's home is itself a trauma.

I believe one of the slides mentioned that around two-thirds of people in administrative detention suffer from physical or mental health consequences. This is a population that is inherently vulnerable because they've been forced to flee. That's the narrative I would stick to. Detention causes harm-period. And on top of that, these are vulnerable people who've done nothing wrong and are detained for administrative convenience. That's what needs to be explained to the public - in clear, accessible terms. The criminalisation narrative must be broken.

How do your projects and campaigns connect with each other?
We're a small advocacy team, so detention isn't our only priority. But detention intersects with many aspects of our work, because our clients are vulnerable to being detained at any time. That means our legal, welfare, and medico-legal services could all become involved and all of that has an impact. It affects their mental health, which involves our clinicians. Often, if a client is detained, they're released quickly because they're connected to an organisation like ours.

In any case, we engage with detention through many avenues. For example, we've been very active in campaigning against the Rwanda plan. By doing so, we've had an impact on those vulnerable to be detained under the Rwanda plan.

Interview with Carolina Gottardo

Arianna Egle Ventre and Irene Proietto

Could you briefly introduce yourself and the International Detention Coalition (IDC)?

My name is Carolina Gottardo and I am the Executive Director of the International Detention Coalition. The IDC is a global network of individuals and organisations across more than 75 countries. Our core mission is to advocate against the use of migration detention and to promote community-based alternatives. We operate across all continents: Africa, Asia-Pacific, the Americas, the MENA region (Middle East and North Africa), and Europe. Among our members we include organisations engaged in advocacy, research, service provision, and campaign work, particularly on contentious or detention issues.

Given that the IDC operates in many countries, you have a broad perspective on global trends in immigration detention. What are the current global tendencies in this area?

Yes, we have a clear sense of global developments, and unfortunately, migration detention has increased in recent years. To be precise, the use of detention has grown over the past few decades. Immigration detention is a relatively recent phenomenon historically, but it has expanded across most world regions. The only exception is South America. In that region, countries are managing very large numbers of migrants - for example, millions of people arriving from Venezuela - yet detention remains very limited, and children are not detained at all. Even for adults, detention is used minimally. So South America is the only region where the use of immigration detention has not increased.

By contrast, the United States detains the highest number of migrants globally. Europe is also moving in a negative direction, particularly with the recent adoption of the new Pact on Migration and Asylum, which is expected to lead to an increase in detention across the continent. In fact, the detention of migrant children has already increased - regardless of their age. The situation is similarly concerning in other regions, such as Central America, especially at the Mexican border, where Mexico is now heavily using detention. In the MENA region, the impact of European externalisation policies - such as those involving Libya and North Africa - is evident. There is also growing attention on detention in Sub-Saharan Africa and in Southeast Asia, particularly in India.

What are the main reasons behind this global increase in immigration detention?

The rise in detention is largely driven by the increasing criminalisation of migration. We are witnessing hardline policies, including border externalisation, pushbacks, deportations, and detention. Even acts of solidarity are being criminalised, targeting those who support migrants in various ways. Migration has become a highly politicised issue. In many countries, migration is exploited for electoral gain: migrants, refugees, and people on the move are used as political scapegoats. Many of these criminalising policies have been shown to be ineffective. The problem is that migration policy is no longer evidence-based; it is politically driven. And when populism prevails, so does the criminalisation of migration - with devastating social consequences.

Could you elaborate further on the current situation in Europe?

As mentioned, the trends in Europe are worrying. Many European countries already detain migrants, but with the adoption of the new Pact on Migration and Asylum, the situation has worsened. Changes to the screening and asylum procedures suggest that the EU's external borders may become a continuous chain of detention centres. While it is not yet fully clear how the Pact will operate in practice, we see it as an open door for expanding detention space in Europe. We are particularly disappointed by provisions allowing the detention of migrant children, regardless of their age. Although some countries opposed these measures, others pushed for them - and they prevailed. The combination of national-level dynamics in certain member states and this broader EU trend points to a deeply concerning direction. There is a clear shift towards right-wing populism, with migration issues increasingly under threat and politicised.

What are the alternatives to immigration detention?

There should be multiple models to challenge detention. Civil society plays a key role here. At IDC, we promote alternatives to detention through advocacy and strategic litigation. Our preferred model supports individuals to remain in the community with no restrictions on their freedom of movement, supported by case management assistance. We see this as a viable and humane option that states should seriously consider. Instead of placing people in detention, their cases can be resolved while they are fully included in the community - this is the approach we strongly advocate for.

I believe we also need to broaden our engagement. In civil society, we often speak to the converted, to those who already agree with us. But looking at the rise of populist parties and anti-migration rhetoric in Europe, it's clear that not everyone shares our views. We must offer a range of solutions and engage with people we don't usually engage with. For example, as discussed in today's meeting,

partnering with the healthcare sector is promising - this is not a group typically involved in migration advocacy. We should also engage with Members of the European Parliament, even those from parties we may not align with, to identify potential areas of support.

At the same time, building relationships with local authorities is crucial, especially when they are not aligned with national governments. It's also strategic to form broader coalitions - not only with migration-focused organisations, but across diverse sectors. Talking only among ourselves is a waste of time; it's too easy a fight.

In Italy, the medical sector plays a key role in determining whether someone is "fit for detention." Is healthcare similarly important at the international level?

Yes, and in today's presentation I shared the example of Australia. There, an alliance between civil society and doctors succeeded in ending child detention on Nauru Island, offshore from Australia. Civil society had been campaigning and denouncing human rights violations for years, but it was this partnership with medical professionals that finally led to success. Healthcare professionals applied pressure on the government, forcing change. Without them, the situation likely would not have changed.

This is a powerful example of how collaboration with the medical sector can influence immigration detention policy. On an international level, medical professionals can have significant influence - although this varies depending on the national context and the degree of autonomy they have. Governments are increasingly tired of civil society, viewing us as adversaries. That's a major problem. Civil society must interact with governments regardless of political orientation. Hostility on both sides leads nowhere - we need to find ways to connect.

Healthcare adds a new layer to the discourse. Medical professionals bring a different kind of expertise and can highlight the long-term, devastating impacts of detention - not just on individuals, but on their families and communities. Their involvement lends credibility and expands our base of support. That's what happened in Australia: with healthcare professionals on board, the issue resonated with a broader electorate. Their informed, evidence-based voice is distinct from government messaging and essential to alliance-building.

At IDC, we collaborate closely with the World Health Organization (WHO) on this issue. Health and detention are a priority for them. Two years ago, at our request, WHO produced a toolkit on the impacts of administrative detention and the importance of alternatives. This is a truly global effort, and our collaboration with WHO is one example of that.

Who do you consider to be the key actors for promoting alternatives to detention?

Certainly, medical professionals are crucial, but so are others—starting with members of parliament. Local authorities also play a critical role, especially when their priorities differ from those of national governments. Local actors are the ones who witness the real-life consequences of harmful migration policies on a daily basis. They tend to be more open to migration issues. Of course, we must be cautious not to overgeneralise - each context is different.

At IDC, we've achieved significant change by engaging the right government departments at the right time. For example, when dialogue with immigration departments proved fruitless, we turned to other ministries - child protection, women's affairs, foreign affairs, or health - and found openings. Through constructive engagement, we've identified internal champions who support our advocacy goals.

The Italian context is certainly challenging right now due to the political orientation of the government. But that doesn't mean there are no allies within the system. Bureaucrats and politicians are not the same. Bureaucrats may be required to implement government policy, but some may still be sympathetic to our cause. It's important to maintain those relationships - they could be key allies.

Lawyers are also important actors, especially in pursuing strategic litigation. Courts, too, can play a critical role. Sometimes a carefully chosen legal case can move things forward. The media is another challenging but potentially powerful partner. Migration coverage often follows problematic narratives, so finding journalists willing to tell the right stories - stories that do not demonise migrants - isn't always easy. Governments tend to feed the media with negative messaging, which is widely picked up. That's why finding trustworthy media partners is essential.

Could you share examples where you've influenced policy at national or international levels?

In Mexico, we worked with local partners to pressure the government to legislate a ban on the detention of children, which was previously widespread. After years of advocacy, we succeeded. In Thailand, we helped secure a memorandum of understanding that led to the release of 500 families from immigration detention.

At the global level, IDC was instrumental in shaping Objective 13 of the Global Compact for Migration, which addresses immigration detention. We helped develop the language in that provision, advocating for alternatives and an end to child detention. We've also secured a number of high-level commitments from governments to take concrete steps towards community-based alternatives. So IDC has had significant impact - but this change didn't happen overnight. It took

years of advocacy - local, national, and global - across multiple strategies and political contexts. Understanding the landscape and adapting our approach has been key.

As I mentioned earlier, coalition-building is essential. A unified civil society that reaches across sectors and finds effective channels into government - while remaining open to adversarial strategies like litigation when necessary - is our best route to success. It's the combination of the right tactics, at the right time and place, that brings about real change.

You mentioned alliances with the media. Yet quality journalism relies on access to data and documentation. Do you think there is global transparency around immigration detention?
No, not at all. Immigration detention is one of the most opaque areas of contemporary policy. We don't even know how many people are detained worldwide - there are estimates, but no definitive numbers. This lack of transparency is a direct consequence of how governments manage detention.

One of the main problems is that immigration detention is subject to fewer safeguards than criminal detention. Time limits are often unclear or non-existent. In the Asia-Pacific region, and in countries like the UK and Australia, people can be detained indefinitely - with no fixed end date. That means detention without due process. At least in criminal justice there are procedures, protections. In immigration detention, the lack of due process creates prolonged limbo. This is why we believe immigration detention is one of the most serious human rights violations of our time. It is shocking that crossing a border irregularly can result in such a situation, with virtually no safeguards.

In Italy, the privatisation of detention centres is a major obstacle to transparency. Is this a uniquely Italian issue, or part of a global trend?
There are two deeply concerning global trends. One is the privatisation of immigration detention. This is extensive in countries like the United States, the UK, Australia, and elsewhere in Europe. It's a serious issue because it involves the privatisation of containment on multiple levels - not only the companies running the detention centres, but also those providing healthcare, food, and other services.

Research shows that many healthcare providers in these settings prioritise profit over quality care. Good healthcare is not profitable. Similarly, food quality in detention is often poor-again, due to cost-cutting. Profit motives work directly against basic standards of dignity and care.

The second trend, which we see growing globally, is digitalisation. I'm referring to digital forms of detention - what we might call "digital prisons." These include electronic tagging, ankle or wrist monitors, and other surveillance tools that track individuals' every move. In the US, these programmes have expanded dramatically and are becoming more widespread. So yes - privatisation and digitalisation are alarming trends.

How do these trends affect physical and mental health?

There is extensive research showing that the effects of immigration detention are devastating - for people of all ages. One of the most powerful quotes I've heard from a former detainee is: *"I left detention, but detention never left me."* That speaks volumes. Detention leaves a lasting imprint on the mind, on daily life, on physical and mental health.

These impacts extend beyond the individual - to families and entire communities. The same applies to electronic tagging and surveillance. People lose their freedom, but they also acquire stigma. Going out in public becomes a source of fear, as individuals feel criminalised and isolated. They're treated as though they've done something wrong - humiliated and cut off.

The best approach is to keep people in the community, with freedom of movement, and to manage their cases through civil society organisations. This approach has proven to be far more effective - but unfortunately, current policy is moving in the opposite direction.

The concept of vulnerability is often applied arbitrarily. How is it addressed globally, and how should it be handled?

At IDC, together with UNHCR, we developed a screening tool for vulnerability assessment for exactly this reason. We were concerned that many people were not being properly screened, even though some individuals should never be detained under any circumstances.

In an ideal world, no one would be subject to immigration detention. But within the current system, we should at least be able to identify and exclude those who are most vulnerable. That's why we developed this tool. Unfortunately, its implementation remains weak.

If you look at Europe and the new Pact, for example, many people undergoing screening will already be held in closed centres - even during the assessment itself -and may remain there even if their cases are rejected. This means that the system as it stands cannot function in a way that truly safeguards individuals, let alone recognises specific vulnerabilities. An effective system should include

rigorous vulnerability screening to exclude those who should never be detained, as their presence in detention dramatically exacerbates their vulnerability.

So far we've focused on negative developments. Could you share some positive examples of alternatives to detention or good practices?
Yes, I have several. The most compelling comes from South America. Colombia, for instance, received over 1.5 to 2 million Venezuelan migrants. Instead of detaining or expelling them, the government granted them temporary protection status, allowing them ten years to regularise. That's a massive legalisation programme. Other countries in the region, such as Ecuador and Uruguay, include the "right to migrate" in their constitutions—an extraordinary principle.

Most South American countries do not rely on detention. They don't approach migration through the lens of criminalisation and control. It's simply a different mindset. In Europe, Portugal is an interesting example. The country focuses on regularisation and supporting people in accessing documentation, rather than detention. Ireland has progressive measures on child detention. Belgium and Germany have also made commitments to ending child detention under the International Migration Review Forum. So yes, there are positive developments, though none are as transformative as in South America. Still, Europe has examples worth following—Portugal being a particularly encouraging case.

Case study

Irene Proietto and Arianna Egle Ventre

Ousmane Sylla

Ousmane Sylla, a young man from Guinea, at only twenty years old took his own life on the 4 February 2024, inside the CPR of Ponte Galeria. At the time of writing, related criminal proceedings are still ongoing. As evidenced by the young man's last message, written with a cigarette butt on the walls of the large room in the centre, his suicide was caused by the numerous institutional violences he experienced from the moment of his arrival in Italy, culminating in the atrocious experience of administrative detention.

Ousmane arrived in Lampedusa on 29th July 2023. In August, he was welcomed into a facility for unaccompanied minor migrants (MSNA) in Cassino.[42] There, he reported having suffered violence and mistreatment and on October 6, he asked for help during a session of the City Council, showing signs of scratches and bruises on his body. However, following this episode, it emerged that he was of legal age and on October 13, the Prefecture of Frosinone issued an expulsion decree against him. He was transferred to the CPR of Trapani-Milo.

Ousmane Sylla was detained in Trapani for over three months despite the absence of bilateral repatriation agreements between Italy and Guinea. During his stay at the CPR, the young man was in a state of psychological vulnerability, which led the centre's psychologist to request his immediate transfer to a more suitable facility to support him.[43] However, the Trapani *questura* (police headquarters) denied this request, stating that «the foreigner was equipped with adequate health certification attesting his fitness for life in a restricted community». Additionally, Ousmane was subjected to heavy administration of neuroleptics and psychotropic drugs.[44]

The overcrowding in Trapani CPR - while he was detained - further worsened the already terrible detention conditions. Detained people also complained about being unable to exercise their right to defense, a situation that can prolong detention -sometimes without legal basis- up to 18 months.[45]

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[42]The "Revenge" family home in Sant'Angelo in Theodice (a hamlet of Cassino), opened a few months before Ousmane Sylla's arrival and later closed due to administrative irregularities. Paravani, La storia di Ousmane Sylla, morto di accoglienza: "Spacchiamogli la testa a sta gente" (The story of Ousmane Sylla, died of reception: "Let's smash these people's heads") Fanpage, March 8, 2024.

[43]Ibid.

[44] CILD, Chiusi in gabbia: viaggio nell'inferno del CPR di Ponte Galeria (novembre 2024) p.94.

[45]On the night of 23 January, a riot broke out inside the Trapani Milo Repatriation Detention Centre (CPR): at the time of the protest, the facility, with a maximum capacity of 40 places, was holding approximately 140 detainees. Melting Pot, Rivolta al CPR di Milo-Trapani: la struttura resa inagibile al 90% , 30th January 2024.

In January 2024, protests against these rights violations rendered part of the Trapani-Milo facility unusable, and Ousmane was transferred to the Ponte Galeria CPR in Rome. There, besides having his detention reconfirmed, according to the young man's legal team, his psychiatric medication "Akineton" was abruptly discontinued. According to the medication leaflet, sudden suspension of Akineton can lead to altered and psychotic states.[46] One week after his arrival, during the night between the 3rd and 4th of February, Ousmane took his own life by hanging himself in a room in the male section. Other detained people attempted to resuscitate him, but since no alarm bells were present, help arrived too late.[47]

C.F. [48]

C.F. was held for nine months in the women's section of the Ponte Galeria detention centre in Rome, despite being clearly unfit for detention. Three requests for an extension of custody made by the police headquarters were each upheld by the justice of peace.

In October 2023, C.F. entered the CPR with a medical certificate issued by the Catania local health authority (ASL), declaring them fit for life in a closed community. However, the certificate merely confirmed the absence of infectious diseases. It was therefore entirely illegitimate under current regulations, as no psychological assessment of C.F.'s fitness for detention had been carried out.

Even the police staff and healthcare personnel at the facility agreed that detention was not appropriate for C.F., as reflected in the internal psychologist's reports - albeit sporadic. In the report of a visit dated the 30th of April, the psychologist wrote that C.F. "is not suited to remain in the CPR, a condition that further destabilizes them emotionally and has a negative impact on their psychological fragility." The psychologist also added that C.F. "would need to be placed in specialised facilities where they could receive psychiatric care and access a rehabilitation programme."

It was only many months later, in May 2024, that C.F. was examined by a psychiatrist from the Rome 3 local health authority (ASL Roma 3). Despite agreeing with the psychologist's assessment of the critical condition, the psychiatrist did not comment on C.F.'s (lack of) suitability for life in a closed community.

The end of C.F.'s detention came as a result of a parliamentary inspection visit by the delegation led by MP Rachele Scarpa, in which CILD also participated, and the

[46]DIRE, E. Pretto, Migrante morto in un Cpr a Roma, i legali: "Ci opporremo all'archiviazione"(Migrant dies in a CPR in Rome, lawyers: "We will oppose the dismissal), 26th September 2024.
[47]Internazionale, A. Camilli, Una morte annunciata nel centro di detenzione di Ponte Galeria(A death foretold in the Ponte Galeria detention center), 6th of February 2024.
[48]Most of the information is based on the CILD report "Chiusi in gabbia, viaggio nell'inferno di Ponte Galeria" *(Locked in a Cage: Journey into the Hell of Ponte Galeria)*, November 2024, and on the report from the inspection visit carried out by the delegation led by MP Scarpa, with the participation of CILD, on 18 June 2024.

subsequent appeal submitted to the European Court of Human Rights (ECtHR) by several lawyers and members of parliament. The judges in Strasbourg condemned the asylum-like logic that led to C.F. being held in isolation for nine months -from October 2023 to July 2024- through successive extensions. They ordered the Italian government to provide appropriate care, reaffirming that the detention of a person with mental health issues in a CPR is a violation of the prohibition against torture and inhuman or degrading treatment.

C.F.'s story reveals a long chain of responsibility. Involved are the public health authorities who deemed a person unfit for detention as "fit"; the police authority (*questura*) that requested the extension of detention three times; and the judicial authority that validated and extended those measures. But significant responsibility also lies with the managing body and the prefectural authority, which kept a highly vulnerable person in isolation for nine months.

The case of C.F. is a stark warning sign of the complete absence of a system capable of providing care and protection for individuals both during and after detention, even in cases of vulnerability. Instead of issuing a certificate of unfitness for detention and ensuring access to appropriate treatment pathways, strategies of isolation, containment, or the use of psychiatric medication are implemented, revealing the asylum-like drift of the CPR system.

Moussa Balde

Moussa Balde, a young man of 23 years old from Guinea, took his own life inside Turin's CPR during the night between the 22nd and 23rd May of 2021.

The young man arrived in Italy in 2017 to seek international protection. He was initially welcomed at the CAS (Reception Centre) in Imperia, where, during his stay, he learned Italian and obtained his lower secondary school certificate.

Frustrated by the wait for his summons to the Territorial Commission, in 2019 he attempted to travel to France. However, he was turned back and, having lost his place of residence, missed his appointment for the interview, leaving him without a residence permit.[49]

On the 9th of May 2021, in Ventimiglia, Moussa was violently attacked outside a supermarket. He was hospitalised in Bordighera, but once discharged, due to his irregular status, he was transferred to the Turin CPR (Pre-removal Centre).[50] At Turin CPR on Corso Brunelleschi, Moussa was immediately placed in an isolation room: a cell referred to as the "*ospedaletto*" (small hospital) a container intended

[49]CILD, Buchi neri. La detenzione senza reato nei CPR (Black Holes. Detention Without Crime in CPRs) October 2021, p.265.
[50]Internazionale, A. Camilli, Il suicidio di Moussa Balde svela le anomalie dei centri di detenzione (The suicide of Moussa Balde reveals the anomalies of detention centres), 31st of May 2021.

for individuals with infectious diseases,[51] but improperly used for punitive purposes or reasons of "security".[52] This practice of isolation in administrative detention has been repeatedly condemned by the *Garante Nazionale* (National Ombudsperson) as completely unlawful and lacking any legal basis.[53] There, Moussa took his own life just days after entering the CPR. Moussa's suicide in the CPR of Turin is not an isolated case: back in 2019, after five months of unlawful isolation, Hossain Faisal, a 32-year-old Bangladeshi citizen, also took his own life.

As in the case of Hossain, several factors raise doubts about Moussa Balde's "fitness for life in a closed community", given the young man's fragile psychological state. Regarding the responsibilities for his death, on 29th of October 2024, the investigating judge (GIP) accepted the request for a trial for manslaughter against the delegated director of the managing body "Gepsa" and the facility's doctor, while the chief inspector of the police reached a plea deal and was sentenced to one year of imprisonment.[54]

Oussama Darkaoui

Oussama Darkaoui was 22 years old when he came to Italy from Morocco. He died on 5 August 2024 at the Palazzo San Gervasio CPR in the province of Potenza, engulfed by the depersonalisation process enforced by all CPRs. Although it took several days after his death to accurately identify his name and origin, reconstructing the circumstances of his death is even more complex.[55]

The investigation is still ongoing, led by Prosecutor Curcio, who from the outset has not ruled out any criminal offences. Following the initial investigations, he stated that "the CPR does not meet the health and safety standards that would be expected in a civilised state".[56]

According to statements from Oussama's family's lawyer, Arturo Covella, the young man was deemed fit for detention due to the absence of physical illnesses or psychiatric disorders. However, just a few weeks after his entry into the CPR, he reportedly began receiving pharmaceutical treatments.

Life inside the facility had a radical impact on the young man's health. Despite this, his fitness for detention was never reassessed, even when, on three separate

[51]CILD, Buchi neri, (Black Holes) p.62.
[52]ASGI, Il libro nero del CPR di Torino (The black book of Turin CPR), (2021) p.7.
[53]Garante Nazionale (National Obusmanperson) for the Rights of Persons Deprived of Liberty. (2021, September 8), "Rapporto sulla visita effettuata nel Centro di Permanenza per i Rimpatri (CPR) di Torino il 14 giugno 2021" (Report on the visit to the Turin Pre-Removal Centre (CPR) on 14th of June 2021), pp. 13-14. In the 2021 report, the then Garante Nazionale specifies that "the isolation practices carried out in the Ospedaletto, for reasons unrelated to healthcare needs, therefore occur in a condition of complete informality, without guarantees to protect the detained person, and for extended and indefinite periods of time."
[54]Domani, Due rinvii a giudizio per la morte di Moussa Balde nel Cpr di Torino nel 2021 (Two Indictments for the Death of Moussa Balde at the Turin CPR in 2021), 29th of October 2024.
[55] CILD, Nei CPR si continua a morire (People continue to die inside CPRs), 5th of September 2024.
[56]Ansa, Giovane morto in un Cpr, il Procuratore: "non è escluso l'omicidio" (Young Man Dies in a CPR, Prosecutor: "Murder Not Excluded"), 6th of August 2024.

occasions, Oussama was taken to the emergency room apparently for self-harming incidents. Oussama's medical records show that he had already visited the Melfi hospital three times. During one of these visits, he was examined by a psychiatrist, who noted behavioural anomalies and personality disorders. Yet, his return to the CPR was never questioned. Psychiatric medications, including powerful ones, seemed to be the solution to Oussama's cries for help. Although the exact circumstances of the days leading up to his death remain unclear, according to lawyer Covella, Oussama was taken to the emergency room shortly before his death in an unconscious state due to a drug overdose.[57]

[57] TGR Basilicata, Morte al Cpr, Oussama era entrato in ospedale incosciente (Death at the CPR, Oussama Was Admitted to the Hospital Unconscious), 3rd of October 2024.

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