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Situation of asylum seekers and beneficiaries of protection with mental health problems in

Italy

Report and recommendations of the Swiss Refugee Council

Bern, February 2022

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1 Introduction

The application of the Dublin III Regulation[1] or of a Readmission Agreement[2] leads to a person's transfer back to a state that was mostly left voluntarily. The transfer back to that country is, therefore, rarely voluntary. It often includes the enforcement by arrest, detention and coercion. This causes in itself a risk for people's mental health. Since a relevant part of asylum seeking persons already suffers from psychological traumas[3], enforced return can lead to a significant deterioration of mental health.

Additionally, transfers back to the country of first entrance, first asylum application or even to the country that first provided protection imply long procedures and instability. Fixed routines and strong social networks as well as stable and continuing treatment are a known prerequisite for a successful recovery of a person's mental health and to overcome or at least deal with psychological illness or trauma. The risk of re-traumatisation by using force to carry out a transfer itself cannot be ignored.[4]

The Swiss Refugee Council has been monitoring developments in Dublin member states for several years, and regularly publishes reports on the countries of main interest and relevance according to current developments. A recurring theme is the question of treatment for persons with mental illness after transfer to a Dublin State or, in the case of persons with protection status in that state, to a safe third country.

Italy has always been one of the most important Dublin partners for Switzerland,[5] and litigation concerning removals to it is, by now, quite extensive. The judgment of the European Court of Human Rights (ECtHR) *Tarakhel v. Switzerland*, of November 2014, has been the

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1 Regulation (EU) No 604/2013 of the European Parliament and of the Council of 26 June 2013 establishing the criteria and mechanisms for determining the Member State responsible for examining an application for international protection lodged in one of the Member States by a third-country national or a stateless person

2 The list of Readmission Agreements currently in force between Switzerland and third countries (as well as countries of origin) can be found here: www.sem.admin.ch/sem/en/home/international-rueckkehr/ch-migrationsaussenpolitik/abkommen/rueckuebernahme.html.

3 Fazel, M., Wheeler, J. and Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: A systematic review. The Lancet, 365(9467): «Refugees resettled in western countries could be about ten times more likely to have post-traumatic stress disorder than age-matched general populations in those countries. Worldwide, tens of thousands of refugees and former refugees resettled in western countries probably have post-traumatic stress disorder»; Mueller, J., Schmidt, M., Staeheli, A., Maier, T. (2010). Mental health of failed asylum seekers as compared with pending and temporarily accepted asylum seekers. Oxford University Press: European Journal of Public Health, Vol. 21, No. 2, 184 – 189: «Given the great vulnerability of these individuals, long and unsettling asylum processes as practiced in Western host countries seem problematic, as does the withdrawal of health and social welfare benefits. Finally, high rates of psychopathology amongst FAS indicate that refugee and humanitarian decision-making procedures may be failing to identify those most in need of protection.».

4 See the Swiss Refugee Council Report on the Situation of asylum seekers and beneficiaries of protection with mental health problems in Croatia, p. 4 ss.

5 According to the statistics published by the State Secretariat for Migration (SEM), in 2021 alone the number of Dublin procedures with Italy amounted to 926. Of these, 864 were 'procedures out', i.e. concerning removals from Switzerland to Italy. Up until the end of November 2021, 271 transfers were effectively carried out. Leaving aside 2020 which, for reasons related to the global SARS-COVID 19 pandemic, is a *sui generis* year, it is certainly interesting to note that, in 2019, the amount of Dublin procedures with Italy was even higher, reaching a peak of 1570 cases, with 1432 'procedures out'. Transfers effectively carried out were 610 in total.

judgement of reference ever since.[6] In it, the ECtHR ruled that serious doubts existed as to the capacities of the Italian reception and accommodation system. The possibility that a significant number of asylum seekers removed to that country may be left without accommodation or accommodated in overcrowded facilities without any privacy, or even in insalubrious or violent conditions, could not be discarded. Therefore, if the transfer involved particularly vulnerable individuals (as was the case in point, concerning a family with various minor children), it was incumbent to the Swiss authorities to obtain assurances from their Italian counterparts that upon their arrival in Italy the applicants will be received in adequate facilities. Other international bodies have also stated that Swiss authorities should take special care when removing particularly vulnerable individuals to Italy.[7]

Swiss practice has, formally, complied with the instructions coming from the ECtHR. In one reference ruling of 2019,[8] the Federal Administrative Court (FAC, the highest instance in asylum and immigration matters in Switzerland) expanded the duty to collect individual guarantees of adequate care and accommodation to seriously ill people. The practice still stands.

The Swiss Refugee Council has been monitoring the Italian accommodation and reception system for more than ten years, and has always advised against removals to Italy, especially when these concerned vulnerable persons.[9] The Swiss Refugee Council believes that a closer examination is needed on a case-by-case basis as to whether refugee protection and human rights obligations are being complied with, and that this is especially important in cases of vulnerable persons. This report therefore addresses the important topic of possibilities and problems of access and treatment for mentally ill persons in Italy.

To gather information, reports were taken into account and organisations in Italy provided information and inputs, first according to a questionnaire via e-mail. At a later stage, online meetings were conducted to clarify open questions and verify the information collected.

The report first sets out the legal background, including the relevant EU law and the provisions regarding health care in Italian law. After a short overview of the rules concerning accommodation, it dives into the regulations regarding mental health care for asylum seekers and status holders in Italy. The report closes with conclusions on the information gathered as well as recommendations.

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6 ECtHR, judgement of 4 November 2014, *Tarakhel v. Switzeland*, application no. 29217/12.

7 UN Committee Against Torture CAT, CAT/C/65/D/758/2016, *Adam Harun v. Switzerland*, 24 January 2019. In this judgement, concerning the return of an Ethiopian refugee from Switzerland back to Italy, the Committee concluded that the FAC assumed that the applicant would generally be safe in Italy, instead of examining his particular vulnerability as an asylum seeker and victim of torture. The return was found to violate Article 3 of the CAT and Switzerland was instructed to abstain from the enforcement of the return decision. See also : CAT/C/64/D/742/2016, *A.N. v. Switzerland*, 21 September 2018 and CAT/C65/D/811/2017.

8 FAC, E-962/2019, 17 December 2019.

9 See Swiss Refugee Council and borderline-Europe, Reception conditions in Italy – Latest developments, Bern/Palermo, June 2021, p. 16 and Swiss Refugee Council, Reception conditions in Italy, Bern, January 2020, p. 111.

2 Legal basis

2.1 International and European legal framework

The Geneva Convention

Article 33 of the Convention relating to the Status of Refugees (Refugee Convention)[10], signed in Geneva on 28 July 1951 and entitled 'Prohibition of expulsion or return ("*refoulement*")' provides, in paragraph 1: «No Contracting State shall expel or return ("*refouler*") a refugee in any manner whatsoever to the frontiers of territories where his life or freedom would be threatened on account of his race, religion, nationality, membership of a particular social group or political opinion.»

Prohibition of torture and inhuman or degrading treatment or punishment

Article 3 ECHR[11] provides that no one shall be subjected to torture or to inhuman or degrading treatment or punishment. The same wording can be found in Article 4 of the EU Charter of Fundamental Rights[12]. Referring to this Article, the Court of Justice of the European Union (CJEU) stated in a judgement[13] concerning mental health that it is not enough to merely consider the consequences of physically transporting the person concerned from one Member State to another, but that **all the significant and permanent consequences which might arise from the transfer must be taken into consideration**. Even without assuming systemic flaws in the responsible Member State, the transfer of an asylum seeking person with a particularly serious mental illness could result in a real risk of a significant and permanent deterioration in the state of health of the person concerned. In this case, the transfer would constitute inhuman and degrading treatment according to the CJEU.

Return Directive (RD)[14]

According to the RD, Member States have to ensure that asylum seekers receive the necessary health care including, at the very least, emergency care and fast treatment of illness (Articles 17/19 RD). Furthermore, according to the RD, Member States have to provide asylum seekers with information on any established benefits and organisations that might be able to help with access to health care (Article 5 (1) RD).

[10] The 1951 Refugee Convention, Geneva, 1951, SR 0.142.30.
[11] Convention for the Protection of Human Rights and Fundamental Freedoms, Rome 1950, SR 0.101.
[12] Charter of Fundamental Rights of the European Union, 2012/C 326/02, Brussels, 2012.
[13] CJEU, judgment of 16 February 2017, *C.K. and others*, C-578/16 PPU, para. 76.
[14] Directive 2008/115/EC of the European Parliament and of the Council of 16 December 2008 on common standards and procedures in Member States for returning illegally staying third-country nationals.

Qualification Directive (QD)[15]

The QD provides that recognised refugees and beneficiaries of subsidiary protection are eligible for the same access to health care as nationals, including the treatment of mental disorders (Article 30 (1) and (2)).

The QD stipulates that as soon as possible after international protection status has been granted, beneficiaries must be provided with access to information, in a language that they understand or can be reasonably expected to understand, on their rights and obligations relating to their status (Article 22 QD). Furthermore, according to Article 17 (4) RCD, Member States may only require applicants to cover the cost of medical treatment if they have sufficient resources.

Procedures Directive (PD)[16]

Article 24 (1) of the PD requires Member States to assess within a reasonable period after the application is made whether an applicant is in need of special procedural guarantees.

Reception Conditions Directive (RCD)[17]

According to the RCD, vulnerable persons have special reception needs and must be accommodated accordingly. In order for that to happen, vulnerable persons must be properly identified at the earliest possible stage of their asylum application (Article 22 RCD).

Dublin III Regulation

While the receiving State must provide adequate reception conditions, the sending State must provide all the information needed in order to allow the receiving State to fulfill this obligation.

Article 31 in Section VI of the Regulation is therefore dedicated to the '**Exchange of relevant information before a transfer is carried out**'. Such provision states that the Member State carrying out the transfer of an applicant shall communicate to the Member State responsible relevant information within a reasonable period of time before a transfer is carried out, in order to ensure that its competent authorities in accordance with national law have sufficient time to take the necessary measures. This implicates of course that measures according to the provided information should be put in place.

Further, the second part of Article 31 Dublin III Regulation states that it is essential to transmit information on immediate special needs, in particular any immediate measures which the Member State responsible is required to take in order to ensure that the special needs

[15] Directive 2011/95/EU of the European Parliament and of the Council of 13 December 2011 on standards for the qualification of third-country nationals or stateless persons as beneficiaries of international protection, for a uniform status for refugees or for persons eligible for subsidiary protection, and for the content of the protection granted (recast).

[16] Directive 2013/32/EU of the European Parliament and of the Council of 26 June 2013 on common procedures for granting and withdrawing international protection.

[17] Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013 laying down standards for the reception of applicants for international protection (recast).

of the person to be transferred are adequately addressed, including any immediate health care that may be required. Therefore, Article 32 Dublin III Regulation on the '**Exchange of health data before a transfer is carried out**', provides in paragraph 1: «For the sole purpose of the provision of medical care or treatment, in particular concerning [...] persons who have been subject to torture, rape or other serious forms of psychological, physical and sexual violence, the transferring Member State shall, in so far as it is available to the competent authority in accordance with national law, transmit to the Member State responsible information on any special needs of the person to be transferred, which in specific cases may include information on that person's physical or mental health. That information shall be transferred in a common health certificate with the necessary documents attached. The Member State responsible shall ensure that those special needs are adequately addressed, including in particular any essential medical care that may be required.»

2.2 Italian national law

Note: The structure of the Italian asylum system, with its relevant legal framework and practical implementation, is laid out in detail in the Swiss Refugee Council report on Reception Conditions in Italy, published in 2020 and its update, published in 2021. The reports are an important preliminary reading for those who want to have a complete overview of the Italian situation regarding asylum seekers, Dublin returnees and status holders. Reference will be made to such reports whenever appropriate, to avoid repetition.

2.2.1 The Lamorgese Law

Important legal changes took place in the Italian asylum system, following the passing by the new Minister of the Interior Luciana Lamorgese of the Law **173/2020 of 18 December 2020**,[18] which partially abrogated the former Legal Decree 113/2018 (also known as the Salvini decree). Most importantly, while the Salvini Decree confined all applicants to 'first line' reception centres such as CAS and CARA, the Lamorgese law extends the access and fruition of the 'second line' reception system SAI (*Sistema di Accoglienza e Integrazione*, formerly known as SPRAR, then SIPROIMI)[19] again to asylum seekers and therefore also to Dublin returnees.[20]

[18] Legge 18 dicembre 2020, n 173.

[19] SAI is a publicly funded network of local authorities and NGOs which accommodates unaccompanied children, beneficiaries of international protection and, in case of available places, asylum seekers and people who have obtained some other residence permits for specific reasons.

[20] According to the provisions of the new Lamorgese Law (Article 11, Paragraph 3), accommodation within the CAS is «limitata al tempo strettamente necessario al trasferimento del richiedente». Furthermore, according to the Naga Report Piú fuori che dentro, 2021, p. 26: «Un'altra importante modifica riguarda il trasferimento prioritario di **richiedenti asilo con vulnerabilità** dai Centri governativi ordinari e straordinari presso le strutture del SAI».

2.2.2 Other relevant legal provisions

According to **Article 32 of the Italian Constitution**,[21] access to healthcare is a fundamental right of the individual and in the interest of the community. This constitutional norm also applies to foreigners – whether they are staying in Italy regularly or irregularly.

According to the Legislative Decree no 251/2007[22], **beneficiaries of international protection** are entitled **to equal treatment** with Italian citizens in the area of health care and social security.

Under the **Consolidated Act on Immigration (*Testo Unico Immigrazione – TUI*)**[23], all asylum seekers and beneficiaries of international protection are to be enrolled in the National Health Service (*Servizio Sanitario Nazionale – SSN*), where they are entitled to equal treatment and equality of rights and obligations with Italian citizens. Paragraph 7 of Article 34 specifies that foreigners **must be registered with the local health board** (*Azienda Sanitaria Locale – ASL*) of the municipality in which they declare to have a domicile. The right to access to healthcare is acquired at the moment of the registration of the asylum request and remains applicable in the process of the renewal of the permit of stay.[24] Furthermore, the right to access the healthcare system extends automatically to each regularly resident family member under the applicant's care in Italy and is also immediately recognised for newborn babies of parents registered with the SSN.[25]

The Consolidated Act on Immigration also spells out that «**irregular migrants**» are entitled to treatment in public health care facilities for **emergency** and **essential** treatments because of illness or accident, as well as to preventive medical treatment programs aimed at safeguarding individual and collective health.[26]

Guidelines for the planning of assistance and rehabilitation, as well as for treatment of psychological disorders of refugees and beneficiaries of international protection were published in 2017, and they also apply to asylum seekers.[27] The Guidelines are comprehensive, and they highlight the importance of early detection of vulnerable cases, as well as the need for a multidisciplinary approach to them, in order to ensure better outcomes. According to ASGI, though, the organisation of a network collaboration as required by the Guidelines has not yet started in all the health care institutions across the national territory and, since 2017, the Guidelines **have not been effectively implemented**.[28]

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21 Costituzione della Repubblica italiana, updated to October 2021.
22 Legislative Decree 251/2007, Article 27.
23 Legislative Decree 286/1998, Article 34.
24 Presidential Decree (PD) 394/1999, Article 42.
25 Article 34, Paragraph 1 and 2, TUI.
26 Article 35, TUI.
27 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, 22 March 2017.
28 ECRE/AIDA, Country Report on Italy, 2020 Update, p. 187.

As far as **mental healthcare** is concerned, it may be relevant to remind that the Italian mental healthcare system was completely reformed in 1978.[29] The new law laid down that patients with mental disorders should be treated the same way as patients with other health problems. As a result, **psychiatric hospitals were closed down** and mental health conditions are now to be treated in psychiatric wards located in general hospitals. Investments in public healthcare have stalled over the years, and this has had a bad effect on the availability of mental healthcare in the public healthcare system.[30] Access to mental healthcare in Italy is thus limited for Italian citizens as well as for asylum seekers and protection status holders.[31]

On the long and burdensome procedure to follow in order to register with the National Health Service (SSN) we refer to the Swiss Refugee Council report on Reception Conditions in Italy.[32] While the Lamorgese Law has finally gotten rid of the provision that, in the Salvini decree, prevented asylum seekers from obtaining a civil registration (*iscrizione anagrafica*) at their municipality[33], the hurdles and difficulties linked to the language barrier, the long waiting lists, and the regional differences remain the same.

29 Law 180/1978, Accertamenti e trattamenti sanitari volontari e obbligatori.

30 See for instance, B. Armocida, et al, The Italian health system and the COVID-19 challenge, 2020: «the National Healthcare Service is close to collapse—the results of years of fragmentation and decades of finance cuts, privatisation, and deprivation of human and technical resources. The National Healthcare Service is regionally based, with local authorities responsible for the organisation and delivery of health services, leaving the Italian Government with a weak strategic leadership. Over the period 2010–19, the National Healthcare Service suffered financial cuts of more than €37 billion, a progressive privatisation of health-care services. Public health expenditure as a proportion of gross domestic product was 6·6% for the years 2018–20 and is forecast to fall to 6·4% in 2022».

31 See the Swiss Refugee Council, Reception conditions in Italy, January 2020, p. 82 ss. The Report analyses data from the WHO, according to which «Italy lags far behind other G7 countries [...] with regard to human resources and available places in mental healthcare and has the lowest proportion of government expenditure on mental health».

32 Swiss Refugee Council, Reception conditions in Italy, January 2020, p. 73 ss: «the documents [the applicants] need to register with the national health service are a) a valid residence permit of proof that prolongation/issuance has been requested; b) a certification of residence or, in the absence thereof, a declaration of actual residence, as stated on the residence permit; c) a tax identification number [...] these prerequisites [are] problematic for people who were not in the possession of a residence permit. This affected mostly asylum seekers whose applications were not yet formally registered (*verbalizzazione*) at the Questura, or people transferred back to Italy with a Dublin decision who have to reopen their proceedings. These prerequisites also posed unsurmountable obstacles to beneficiaries of international protection who had become homeless and for that reason have difficulties prolonging their residence permit and/or showing proof of residence. Furthermore, the unknown administrative processes and language barriers also contributed to a large share of status holders not being registred with the SSN».

33 Law 173/2020 (Lamorgese), art 3, para 2, let a). The Italian Constitutional Court had already stated, in judgement 186/2020, that the provision of the Salvini Decree preventing asylum seekers from obtaining their civil registration was discriminatory and therefore unlawful.

Some important findings regarding health care from the 2020 report[34] on Reception Conditions in Italy:

Until the registration of the asylum application in Italy, this means the *fotosegnalamento* (identification and registration of the asylum application) as well as the *verbalizzazione* (formal registration of the application) are concluded, asylum seekers are only entitled to emergency health care. This is due to the fact, that they do not have a tax number nor a residence permit before. The waiting time to finish the registration can last monts.

For homeless persons there is the problem regarding their impossibility to provide an address (*residenza*), which excludes them from the registration with the national health services, as so called fictional residences are not accepted uniformly through the national territory

Even those persons benefitting from the SSN need to contribute to the cost of their treatment (so called ticket). The only exception applies to asylum seekers that have been in Italy for up to two months, because they are not allowed to work anyways. Even after the first two months, though, most asylum seekers do not have acces to the labor market and, yet, exemptions to the rule are not applied uniformly through the national territory. This is clearly problematic.

Additionally, as in many sectors, a language barrier is often preventing proper treatment, as asylum seekers have to contact their general practicioner where they are registred at the local ASL. Those doctor are not supported with translators or mediators.

There are long waiting lists for referral to a specialist doctor or a medical intervention. The treatment of any health problem that is not labelled as priority can take longer than a year.

3 Accommodation

A person's housing situation has a major impact on their health and the success of medical and especially psychological treatment. Health, social and legal problems are interrelated. People requiring treatment must be given a place in a house or accommodation centre; otherwise, it is impossible to guarantee meaningful and targeted treatment.[35] Life on the street is detrimental to a person's health. It is impossible to provide suitable treatment for mental illness under these circumstances. In other words, treatment must be adapted to the person's living situation.

[34] Swiss Refugee Council, Reception conditions in Italy, January 2020, p. 73 ss: «the documents [the applicants] need to register with the national health service are a) a valid residence permit of proof that prolongation/issuance has been requested; b) a certification of residence or, in the absence thereof, a declaration of actual residence, as stated on the residence permit; c) a tax identification number [...] these prerequisites [are] problematic for people who were not in the possession of a residence permit. This affected mostly asylum seekers whose applications were not yet formally registered (*verbalizzazione*) at the Questura, or people transferred back to Italy with a Dublin decision who have to reopen their proceedings. These prerequisites also posed unsurmountable obstacles to beneficiaries of international protection who had become homeless and for that reason have difficulties prolonging their residence permit and/or showing proof of residence. Furthermore, the unknown administrative processes and language barriers also contributed to a large share of status holders not being registred with the SSN».

[35] Regarding this connection we refer to Swiss Refugee Council, Reception conditions in Italy, January 2020, chapter 8.7.

The Italian legislation[36] establishes that the applicant has the right to obtain accommodation as soon as the will to seek international protection is manifested. The systemic practice of granting admission to the asylum reception system only *after* the formalisation of the application (the completion of the C3 form) is thus highly problematic, in the view of legal observers.[37] **This practice has the effect of often leaving asylum seekers (including Dublin returnees) without accommodation (and therefore without appropriate medical treatment) for weeks or months**. With the pandemic, waiting times have lengthened, at least in cities, because people have found it difficult to get an appointment at the Questura.[38]

The Swiss Refugee Council report of 2020 addresses in detail the procedure that asylum seekers (as well as Dublin returnees) need to follow in order to access the Italian reception system, and we thus refer the readers to it for further information.[39]

3.1 Dublin returnees

3.1.1 Airport

Persons who are transferred by plane to Italy usually arrive at Malpensa airport (Milan) or Fiumicino airport (Rome).

At **Malpensa airport**, according to an agreement with the Prefecture of Varese, a psychologist can be called by the agency that manages the counter inside the airport to assist the most vulnerable cases upon arrival. However, this service has never been activated in the knowledge of our informants.[40] There's no update on the current situation at **Fiumicino** airport. According to the latest information available, an NGO named Synergasia was tasked with the reception of arrivals at the airport for the 2019/2020 and 2020/2021 period.[41] Yet,

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36 Legislative Decree 142/2015, Article 1 (Decreto Accoglienza).

37 ECRE/AIDA, Country Report on Italy, 2020 Update, p. 41«With the completion of the C3, the formal stage of applying for international protection is concluded. The "fotosegnalamento" and the lodging of the international protection application do not always take place at the same time, especially in big cities, due to the high number of asylum application and to the shortage of police staff. In practice, the formal registration might take place weeks after the date the asylum seeker made the asylum application. This delay created and still creates difficulties for asylum seekers who, in the meantime, might not have access to the reception system and the national health system; with the exception of emergency health care».

38 Centro Astalli, information by email, 24 June 2021.According to information provided by NAGA in January 2022, in Milan and its metropolitan area waiting times have remained quite long throughout 2021 and the first part of 2022 even though, on paper, there should be available spots both in the local CAS and SAI. No official explanation has been offered for such long periods of wait so far.

39 Swiss Refugee Council, Reception Conditions in Italy, January 2020, p. 24 ss.

40 Italian legal caseworker, information by email, 13 June 2021.

41 On the tasks and role of this NGO, see Swiss Refugee Council, Reception conditions in Italy, January 2020, p. 32 ss: «according to Synergasia, the NGO has a room at its premises at the airport where people transferred from other countries under the Dublin III Regulation can stay for one night, sometimes for two or three. These include asylum seekers transferred to Italy, after they have declared their intention to remain in Italy for the duration of their asylum procedure. If the returned asylum seekers – due to the lack of translation or for any other reason – do not express their wish to receive protection in Italy, they are not referred to Synergasia by the border police [...] Synergasia does not offer any legal counselling. No information on their services at the airport can be found on the internet. People whose right to reception has been withdrawn cannot be supported by the NGO at the airport. Synergasia did not share statistics regarding their work at Fiumicino with OSAR [...] The medical support at Fiumicino Airport is limited to the first aid centre which is responsible for all airport

the mandate expires end of January 2022, and it is not publicly available yet which organisation will take over.

As far as Dublin returnees are concerned, according to the information collected by the Swiss Refugee Council, only few vulnerable cases had been reported by the Dublin unit of the sending country prior to transfer. Furthermore, their arrival was never reported to SAI in advance and no referral to a specific SAI project for vulnerable people is made upon arrival at the airport.[42]

Even if the arrival of a vulnerable case was flagged, psychological support is not transfer-oriented, but only foreseen in case of critical issues identified by an operator. Thus, in general, such support is only given after the person has been issued with a tax code and a health card, and has been referred to a psychologist. As stated above, these procedures are quite lengthy, therefore some months can pass before someone receives the appropriate support.

It must also be reminded that it is unfortunately quite easy for asylum seekers and **Dublin returnees** arriving to the country to **fall through the cracks of the reception system**.[43] In such cases, of course, their access to appropriate medical healthcare is practically non-existent, apart from very acute cases that will be treated via compulsory health treatment.

MSF (*Doctors without Borders – Medici senza Frontiere*) quantifies in around 10'000 the number of individuals, be they asylum seekers, Dublin returnees and recipients of international protection, that are excluded from any kind of medical and psychological care.

3.1.2 First line reception (CAS, CARA)

There are currently 5'000 CAS in the country, with 80'000 available places, 50'000 of which were allocated until August 2021.[44] Reception in CAS is organised on a prefectural basis. According to the information available, in CAS the presence of a psychologist is generally not foreseen,[45] even though that might vary, depending on the management of the single CAS (small ones, or the ones that are managed by cooperatives generally offer a better service than the big ones, run by profit-oriented organisations).[46]

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medical cases. According to the Polizia di Stato, there are sometimes problems with vulnerable people whose health problems were not reported in advance by the sending country. Some cases even have to be sent back.»

42 Italian legal caseworker, information by email, 13 June 2021, confirms the findings of the Swiss Refugee Council in the reports of the Dublin Returnee Monitoring Project (DRMP).

43 «Although current legislation provides for access to the reception system at the moment of manifestation of the will to requesting asylum, in practice - for migrants who apply independently autonomously to the police headquarters - reception is postponed until the formalisation of the application by filling in form C3. Given the long time needed for verbalisation, applicants are forced to weeks of waiting without any form of assistance. This is the case for instance in those police stations in the vicinity of large first reception large-scale reception centres», MSF, Fuori Campo, 2018 Report, p. 3 (translation by the Swiss Refugee Council). See also the Swiss Refugee Council, Reception Conditions in Italy, p. 24 ss.

44 Naga Report Piú fuori che dentro, 2021, p. 32.

45 Centro Astalli, information by email, 24 June 2021 and Italian legal caseworker, information by email, 13 June 2021. See also the report from NAGA, Senza |(s)campo, 2019, p. 17.

46 On the different management of the CAS, see also the Swiss Refugee Council Reception conditions in Italy: «As one of the consequences of the new Capitolato, smaller centres have been shut down as they cannot be

A new Decree jointly passed by the Ministry of the Interior and the Ministry of Public Health in July 2021 specifies the types of services that must now be provided by the Centres. In addition to material reception, health care, and linguistic-cultural mediation, it also lists social and psychological assistance, the provision of Italian language courses, and legal guidance services.[47]

If the person is accepted in a CAS and the team there realises that there's a vulnerability, there are **three possible venues** to explore. The team could ask for the person to be inserted in a SAI project for vulnerable people, but, as we'll discuss below, this does not seem to be a very frequent option. As a **second** option, the person's psychological support could be taken in charge by a third-sector organisation specialised in the field, and working in the CAS. As a **third** option, such assistance will have to be requested to the national public health system. In this latter case, the person will have to obtain a tax code and a health card before lodging a request to be referred to a psychologist. In the case of services provided by third sector organisations, access depends on the availability of their resources and often occurs through network approach, with referrals from the individual professional figures with whom the person comes into contact. This most of the time occurs through the legal assistance service.

It must be remembered that **reception measures** can oftentimes be **revoked**, which is a very serious risk especially for Dublin returnees.[48] In this case, persons do not have access to state funded accommodation anymore and thus they do not have a residence which is a prerequisite to register with the local health authority.[49]

3.1.3 Second line reception (SAI)

As discussed above, the Lamorgese Law has now extended the possibility of accessing SAI to asylum seekers and Dublin returnees. Given the fact that SAI are generally better equipped to provide appropriate services and care,[50] this amendment could potentially have

financed anymore. Instead, large collective centres are being opened which are more likely able to operate with the very low financial contribution from the state», p. 40. See also the ECRE/AIDA, Country Report on Italy, 2020 Update, p. 107 ss. For more information, see also ch. 5.1.

47 Decreto Ministero dell'Interno 22 luglio 2021, Fissazione degli standard igienico-sanitari, abitativi e di sicurezza dei centri di accoglienza per I migranti.

48 «Directive 2013/33/EU provides for the possibility of withdrawal of reception for asylum seekers. In Italy the measure is adopted without proportionality, especially for the guests of the CAS, especially to sanction the violation of the management regulations of the centres, violations ranging from unjustified removal from the structure, to violent behavior, up to minor disciplinary offences. The consequence is that the presence within the informal settlements of asylum seekers whose reception has been withdrawn before the conclusion of the asylum procedure, and who are therefore deprived of any form of assistance, is becoming increasingly significant». MSF, Fuori Campo, 2018 Report, p 4 (translation by the Swiss Refugee Council).

49 For more information on this problem see Swiss Refugee Council, Reception Conditions in Italy, January 2020, p. 42 ss. and p. 52 ss.

50 SAI system is formed by small reception structures where assistance and integration services are provided. SAI projects are run by local authorities and together with civil society actors such as NGOs. The accommodation centres ensure interpretation and linguistic-cultural mediations services, legal counselling, teaching of the Italian language, health assistance, socio-psychological support in particular to vulnerable persons, training and re-training, support at providing employment, counselling on the services available at local level to

great impact on the reception conditions of asylum seekers, as well as of Dublin returnees.[51] Yet, such improvement remained, for now, **only on paper**, because the amount of places available in 'second line' reception centres is still very limited and does not cover the needs.

In September 2021 the system had a total of **32'456 places**. Of these places, 24'981 are «normal» places (*ordinari*), 6'692 are for unaccompanied minors and only **783** (2.4 %) for persons with psychological or physical health problems (*disagio mentale o disabilità*).[52] It is important to remind that, even though numbers have been increased, recently, they are still subject to oscillations and changes (including reductions) according to the funding that is made available per year.[53]

In addition to the difficulties posed by the limited number of places, the other major difficulty in accessing the SAI lies in the way in which **eligibility is sorted**. The system is based on the choice of a local authority to host a SAI on its territory. The basic voluntariness implies that, for asylum seekers and beneficiaries of protection who are entitled to access it, the place is not guaranteed. The Central Service, located in Rome, sorts the requests coming from the various Prefectures which are in charge of the reception of asylum seekers in the CAS, **but there is no waiting list for SAI places**.[54] If an application for placement in a SAI is approved but there is no appropriate place in a project available, the responsible Prefecture will have to apply again a month later, or even several times, until there is a place available for this person. During this waiting time, no accommodation is provided to the person.

On the basis of the above, it is thus safe to assume that Dublin returnees, also vulnerable ones, will very likely be directed to 'first line' reception centres, or to live on the streets.[55]

3.2 Persons with protection status

Persons with protection status have the right to be accommodated in second line reception SAI for six months after their status was granted. The placement in a SAI centre mainly occurs in cases of vulnerability but is not mandatory nor systematic.[56]

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allow integration locally, information on (assisted) voluntary return programs, as well as information on recreational, sport and cultural activities. For more information, see ECRE/AIDA, Country Report on Italy, 2020 Update, p. 180 ss.

51 Upon arrival in Italy, Dublin returnees are not treated any different than other asylum seekers in Italy.

52 Numbers available at: www.retesai.it/.

53 This oscillation is clear if we but consider the numbers for 2020 and 2019. According to the data reported in the Ministry of the Interior "SIPROIMI/SAI 2020 Report", in 2020 the SAI system was composed at national level of 794 projects, for a total of 31,324 places, 6.8% less than in 2019. Of these projects only 5.5% (44 projects) are for people suffering from mental and/or physical disabilities. This makes for a striking reduction (-6.4%) compared to 2019. The situation, as said, is better for 2021, but still below the 2019 levels.

54 Naga Report, Piú fuori che dentro, 2021, p. 40.

55 Swiss Refugee Council and borderline-europe, Reception conditions in Italy – Latest developments, Bern/Palermo, June 2021, p. 4-5. See also the ECRE/AIDA, Country Report on Italy, 2020 Update, p. 180: «Despite the reform, the SAI system is still conceived and indicated as primarily intended for beneficiaries of international protection and unaccompanied foreign minors. Other foreign nationals can only access SAI in case of available places [...] they do not have enough places to meet the reception needs of all those who are entitled to it». See, for a recent example, the case of a Nigerian family followed by Naga in the autumn of 2020, as presented in their Report, Piú fuori che dentro, 2021, p. 68.

56 A Buon Diritto, information by email, 19 July 2021.

Provided that a place is available (there are many more places in first line reception then in SAI which leads to a bottleneck effect, see above), psychological support is available to the beneficiaries of the SAI Reception and Integration system. The National Fund for Asylum Policies and Services (*Fondo nazionale per le politiche e i servizi dell'asilo*) provides board and lodging for applicants and holders of international protection and activities related to the achievement of personal autonomy (including Italian language and vocational training courses and also psychological support and legal orientation). **There are SAI centres dedicated to people with psychological problems but as described above, these have very few places, 2,4% of the whole system. The city of Rome for example only provides 6 of these specialised places, the city of Milan 8**.[57] Due to the very limited availability of places for people with mental health problems and the need for an adequate referral to be placed there, in practice only few persons and mainly status holders are able to access such projects.[58]

Recently, persons with protection status have also suffered from significant delays in finding accommodation because of the difficulties in getting an appointment at the *Ufficio Immigrazione*.[59]

3.3 Accommodation of persons in urgent need of psychological treatment

In very serious cases of psychological illness, even the specialised places of SAI are not accessible. These centres are not geared to treating people with severe mental health problems. In these cases, hospitalisation is often the only option.

Hospitalisation in psychiatric hospital wards (SPDC) is only foreseen in the acute phases of the patients' pathologies.

The CSM (Mental health centres) have suffered from serious cuts over the years, and they are often understaffed and overburdened.[60] Furthermore, in order for the patient to enjoy the proposed treatments free of charge, the person must be enrolled in the National Health Service which, as discussed above, is not an easy task for asylum seekers and beneficiaries of international protection. Thus, asylum seekers, protection status holders and other migrants

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57 Centro Astalli, information by email, 24 June 2021. According to the Ministry of the Interior "SIPROIMI/SAI 2020 Report", the Region that allows more places for mentally ill persons is by far Sicily (193), followed by Puglia (159) and Calabria (87).

58 Italian legal caseworker, information by email, 13 June 2021.

59 Centro Astalli, information by email, 24 June 2021.

60 The last available report of the Ministry of Health was published in 2021, but accounts for the situation in 2019: Rapporto salute mentale. Analisi dei dati del Sistema Informativo per la Salute Mentale (SISM). Anno 2019. According to the observers, such Report lays bare the crisis of the mental health sector in Italy: «Continua la dieta per i servizi di Salute Mentale: calano le strutture e la dotazione di posti letto (-1,6% rispetto all'anno precedente) ma il personale dopo il brusco calo del 2018 torna sui livelli del 2017 con 28.811 unità nel 2019. Sempre in discesa il numero degli utenti che hanno usufruito del servizio (nel 2019 sono 826.465 contro gli 837.027 del 2018) ma crescono parallelamente gli accessi in Pronto soccorso che nel 2019 sono stati 648.408 contro i 617.326 del 2018. Sono questi alcuni dati del Rapporto 2019 sulla Salute Mentale appena pubblicato dal Ministero della Salute.». See also note 30 in this Report.

who have spent time on the psychiatric ward of a hospital are often released without providing them with further in- or out-patient trajectories. They end up on the streets, depending on the non-state-run healthcare services provided by organisations with limited capacities.[61]

4 Identification

Legislative Decree 25/2008 lists some groups of asylum seekers who are considered vulnerable.[62] These include minors (both accompanied and unaccompanied), victims of torture, victims of trafficking, victims of female genital mutilation (FGM) and persons with (mental or physical) health problems. Yet, the Italian law **does not include any specific provision for the identification of vulnerable persons**, nor for the assessment of their special needs. This leads to many – especially not visible – vulnerablilities to remain undetected and therefore untreated.[63]

In the absence of formal identification mechanisms, the **role of civil society organisations** is central to the recognition of vulnerabilities. Yet, the lack of legislative provisions to coordinate and prioritise the operators' activities may still result in vulnerable asylum seekers not being recognised and supported. In addition, the restriction of the role of NGOs in the accommodation of asylum seekers following the legal changes of the past years reduces the chances of NGOs identifying vulnerabilities.[64]

5 Treatment

Most asylum seekers and protection status holders suffer from different forms of trauma and depression. MSF noted that 89% of travelers reported having had traumatic experiences prior to and during their journey to Italy, ranging from witnessing violence and death to sexual assault. Once at their destination, the Migration Policy Institute found that many migrants experience loneliness, boredom, fear of deportation, and worries about the future, as well as mental health conditions as asylum processing drags on.[65] The refugees/asylum seekers/Dublin returnees arriving in Italy are unfortunately not an exception.[66]

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61 For more information on this problem see Swiss Refugee Council, Reception Conditions in Italy, January 2020, p. 84 ss.

62 Legislative Decree 25/2008 «Implementation of Directive 2005/85/EC on minimum standards on procedures in Member States for granting and withdrawing refugee status», Article h-bis) «persone vulnerabili»: minori; minori non accompagnati; disabili, anziani, donne in stato di gravidanza, genitori singoli con figli minori, vittime della tratta di esseri umani, persone affette da gravi malattie o da disturbi mentali; persone per le quali è accertato che hanno subito torture, stupri o altre forme gravi di violenza psicologica, fisica o sessuale, vittime di mutilazioni genitali».

63 Statement from borderline-europe, 24 January 2022.

64 Swiss Refugee Council Reception conditions in Italy: «The new Capitolato omits psychological support [...] no services for vulnerable people are provided, thus leaving the protection of these people to purely voluntary contributions», p. 40.

65 Migration Policy Institute, Life After Trauma: The Mental-Health Needs of Asylum Seekers in Europe, 30 January 2018.

66 Naga, Piú fuori che dentro, 2021: «Complessivamente viene segnalata da tutti la presenza di disagi psicologici dovuti alla situazione generale di vita e a traumi, legati specialmente al "viaggio" per giungere in Europa. Spesso la presenza di tali disagi condiziona anche l'apprendimento della lingua italiana e l'inserimento nella vita sociale » See also the Report from the Ministry of the Interior on the SAI system: «Emerge una presenza rilevante di beneficiari in condizioni di vulnerabilitá. La quota più significativa si riferisce alle vittime di tortura

5.1 Dublin Returnees

As discussed, access to SAI and its services is not very likely for Dublin Returnees, they mostly end up in first line reception.[67]

The services that can be provided in CAS, which are the main form of first line reception centres, are detailed in the new provisions for public procurement tenders (*Capitolato*), published in February 2021. While it is true that the new *Capitolato* reintroduces in CAS some services that had been eliminated by the Salvini decree, notably the social and psychological assistance, it is unfortunate to see that the resources available remain extremely limited. More specifically, for small centres (up to 50 places) a psychologist is foreseen only for 6 hours per week, while a cultural mediator (essentially, an interpreter) is available for up to 10 hours per week. For bigger centres (up to 300 places), psychologists should be available for 24 hours per week, same as mediators.[68] Asylum seekers placed in the reception centres functioning under the new Capitolato might have access to a **social worker only for 15 minutes**, on average, **per month**. **Medics can also only spend 15 minutes per asylum seeker per month.**

There are **some NGOs** that provide programs to fill the gap left by the State for the support of people with psychological or psychiatric needs, but these alternative programs, as meritorious as they can be, **cannot meet the ever-growing demand for their services.[69] There is no guarantee that Dublin Returnees will have access to treatment.[70]**

In case of transfer from first to second line reception, there is a risk that the information on a persons needs is not transferred to the relevant actors, which may lead to the fact, that a person originally identitified as vulnerable remains undetected and untreated in second line reception.[71]

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e/o violenze (pari al 5,8% del totale degli accolti), seguono le vittime di tratta (4,8%) e i beneficiari con problemi di disagio mentale (3,1%)», p. 57.

67 Naga Report Piú fuori che dentro, 2021, p. 51: «I richiedenti asilo che non riescono ad accedere a un SAI entrano gioco forza in un CAS. I Centri di accoglienza straordinaria, che il ministro Lamorgese vorrebbe abolire, rimangono ancora aperti e attivi, soprattutto quelli di grandi dimensioni (dai 100 accolti in su). »

68 According to the Naga Report Piú fuori che dentro, 2021: «Tuttavia, nonostante l'aumento di ore in carico ad alcune figure professionali e servizi, il capitolato rimane insufficiente a confronto con quello del 2018 (26). Infatti, se paragoniamo la dotazione del personale prevista da questo capitolato del 2021 con quella del bando di dicembre 2016, vediamo che il monte ore rimane nettamente inferiore. Ai tempi per esempio, nelle strutture fino a 50 posti erano previsti 3 operatori diurni, 18 ore settimanali di sostegno psicologico, 12 di assistenza sociale, 36 di mediazione linguistica e 24 di informazione normativa. Queste andavano aumentando nelle strutture più grandi», p. 27.

69 Examples: for Rome and its metropolitan area, SaMiFo; for Milan and its metropolitan area, the Etno-psichiatria dept of the Ospedale Niguarda.

70 Statement from borderline-europe, 24 January 2022.

71 Naga Report Piú fuori che dentro, 2021, p. 46: «[Gli operatori] hanno evidenziato il fatto che spesso nel passaggio da CAS a SAI non viene segnalata la problematica psichica e questo rappresenta poi una difficoltà di gestione non indifferente.»

5.2 Persons with protection status

If a person with international protection status has not benefited from the reception in SAI (ex SIPROIMI, ex SPRAR) before and manages to be received in a SAI, the presence of a psychologist is foreseen, and otherwise the SAI project should have the funds to finance a psychological assistance.[72] According to very recent information, though, not all SAI have the necessary funds and resources. As far as the Lombardy region is concerned, only a few implementing organisations have taken steps to employ or provide themselves with a permanent consultant or a psychologist, but by personal choice and with funds outside the mandate. Furthermore, apparently, in more than one case, the operators themselves have to turn down very fragile cases because of the difficulty in managing them, also due to an often limited staff and the absence of specialised professionals. An additional problem is the fact that often, in the transition from CAS to SAI, the psychological problem is **not reported** and this represents a significant management difficulty and makes the assignment to an adequate place impossible. This is all the more troubling given the fact that Lombardy is, by far, the richest Italian Region, so it seems fair to assume that elsewhere in the country resources may be even sparser.[73]

Beneficiaries of protection can also, on their own initiative and if appropriately oriented, turn to the SSN.[74] However, in order to do so they need to be in possession of a tax code (*codice fiscale*) and health card (*tessera sanitaria*).[75]

5.3 Availability of translation services

According to the information collected by the Swiss Refugee Council, the presence of cultural mediators and interpreters is foreseen in CAS, but for very limited hours. SAI accommodations can generally rely on better budgets, which may result in a better quality of mediation and translation services. There is, however, no systematic presence of mediators in public services.[76] According to the AIDA Report on Italy, the language barrier is one of the most relevant obstacles to access health services, because the vast majority of medical operators only speak Italian.[77] Hospitals may set up cooperation agreements with associations providing translation services, but such agreements generally only cover *ad-hoc* interventions, and they cannot cover longer therapies.[78] Local, private projects such as SaMiFO, or Terrenuove Cooperative do ensure the presence of mediators, who are considered an integral part of the care and recovery process.

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72 Italian legal caseworker, information by email, 13 June 2021.
73 Naga Report Piú fuori che dentro, 2021, p 45-46. Interestingly enough, most of the SAI are located in the southern part of the country: Sicilia, Puglia, Calabria, make up, alone, for half of the available places.
74 A Buon Diritto, information by email, 19 July 2021.
75 Centro Astalli, information by email, 24 June 2021.
76 Centro Astalli, , information by email, 24 June 2021.
77 ECRE/AIDA, Country Report on Italy, 2020 Update, p. 128.
78 Naga, information by email, 31 July 2021.

6 Conclusions

Persons returned to Italy under the Dublin Regulation are most likely to be placed – provided that their right to reception conditions has not been revoked – **in first line reception centres**. In those centres, the time frame to see a social worker and medics is limited to 15 minutes per person per month.

Although asylum seekers as well as beneficiaries of international protection would in theory have access to the better equipped second line reception system SAI, the **specialised places** for persons with psychological (or physical) health problems are by far not enough to cover the demand. In additional, although foreseen on paper, not all centres in the SAI system provide access to psychological treatment. There is no long-term solution for persons with severe psychological illness.

As there is a lack of effective **identification mechanisms**, identification of vulnerabilities and the detection of special needs in case of non-visible issues like psychological health problems are left to specialised NGOs, who do not have the ressources to cover all needs and who are dependent on fluctuating finances.

Another problem seems to be the **transfer of information**. Even if assumed the sending country is informing the Italian authorities about special needs in terms of psychological treatment, this information is not transmitted to the relevant actor who is directing the person concerned to some accommodation. Further, in the transition from first to second line reception, this information is again not always forwarded. In view of the lack regarding the identification of vulnerabilities, this may lead to needs not even detected.

The most relevant obstacle is **language** as medical operators often only speak Italian. Although some translation is foreseen in first and second line reception, they are not able to cover all the languages. The time frame a translator is available does not cover the access to the public health care system and is often limited to the time frame available to see a medic in the centre.

7 Recommendations

1. The Swiss Refugee Council **advises in general against the transfer of persons with serious mental health problems.** Regardless of the services provided in the other Dublin or safe third country, a Dublin/safe third country procedure and a possible transfer do not only take time but also cause unnecessary stress for the persons concerned. While this is the case for all persons, those with already existing serious psychological illness suffer a risk of further deterioration of their mental health.

2. In the specific case of **Italy**, there is a general lack of identification of vulnerabilities and need of psychological or psychiatric treatment, a lack of stable long term treatment and a lack of interpreters. Therefore the Swiss Refugee Council **advises against the transfer of persons in need of long term psychological or psychiatric treatment to Italy**.

3. If it is likely that the state of health of the asylum seeker concerned is not expected to improve in the short term, or that the suspension of the procedure for a long period would risk worsening the condition of the person concerned, the requesting Member State should choose to conduct its own examination of that person's application by making use of the '**discretionary clause**' in Article 17(1) of Regulation No 604/2013, or refrain from transferring a person with protection status under a bilateral readmission agreement.

4. If a transfer is to be conducted nevertheless, the Swiss Refugee Council advises the state authorities to make sure with individual confirmations and guarantees that the **Italian authorities are aware of the specific need of the person** and take the necessary precautions. This is particularly crucial to avoid that the person concerned may depend on a flawed system to be identified in the first place, risking not getting access to the necessary treatment.

5. **The best interest of persons with mental health problems** should be a primary consideration when it comes to asylum procedures and transfers under the Dublin III Regulation or bilateral readmission agreements. According to expert organisations, health needs of asylum seekers represent invisible emergencies that can easily be treated before they escalate into irreversible complications. Access to early treatment is not only beneficial for the person concerned but also cost-efficient in the long-term as it reduces demand for emergency care by providing cheaper and more effective primary care. Early treatment is also important for tackling and protecting against the deterioration of mental health due to pre-existing traumas. Therefore, all possible measures must be taken to guarantee timely access to the necessary psychological or psychiatric treatment as well as adequate reception conditions, be that in the country where the person is currently in the asylum procedure or in the responsible Dublin/safe third country.

8 Annex

8.1 Contacts

A buon diritto, Rome
Associazione studi giuridici sulla migrazione Asgi
borderline-europe, Palermo
Associazione Naga, Milan
Centro Astalli, Rome

8.2 Literature

- AIDA Country Report: Italy, 2020 update, written by ASGI
- Medici senza frontiere (Doctors without borders), Fuori campo, 2016
- Medici senza frontiere (Doctors without borders), Fuori campo, 2018 update
- Ministero dell'Interno, Atlante Siproimi/SAI, 2020
- Naga, Piú fuori che dentro, 2021
- Swiss Refugee Council, Reception conditions in Italy 2020
- Swiss Refugee Council, Reception conditions in Italy, 2021 Update
- Swiss Refugee Council, DRMP Reports 2017 2018

8.3 Note of thanks

We would like to dedicate a special thanks to the following organisations for their tireless commitment and passion, as well as to the great generosity they showed in answering our questions: **A buon Diritto; ASGI; borderline-europe, Centro Astalli and Naga.**

Without their expertise and knowledge, this desk-researched report would not have been possible. And without their work, the situation regarding the psychological health support for asylum seekers and beneficiaries of international protection would be much worse.

Another special thanks goes to the German **Stiftung Pro Asyl** for supporting and financing the project generously.

8.4 Abbreviations

AIDA	Asylum Information Database
ASGI	Associazione studi giuridici sulla migrazione
CJEU	Court of Justice of the European Union
CPT	European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
EASO	European Asylum Support Office
ECHR	European Convention on Human Rights
ECRE	European Council on Refugees and Exiles
ECtHR	European Court of Human Rights
ELENA	European Legal Network on Asylum
EU	European Union
FAC	Federal Administrative Court (Switzerland)
IOM	International Organisation for Migration
PD	Procedures Directive[79]
RD	Return Directive[80]
RCD	Reception Conditions Directive
SEM	State Secretariat for Migration (Switzerland)
TUI	Testo Unico Immigrazione
UNHCR	United Nations High Commissioner for Refugees
QD	Qualification Directive[81]

OSAR/SRC publications on various Dublin countries are available at www.refugeecouncil.ch/publications/dublin-state-situation-reports.

The OSAR/SRC newsletter (in German and French) provides information about the latest publications. Subscribe to it here: www.refugeecouncil.ch/subscribe-to-the-newsletter.

[79] Directive 2013/32/EU of the European Parliament and of the Council of 26 June 2013 on common procedures for granting and withdrawing international protection (recast).

[80] Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013 laying down standards for the reception of applicants for international protection (recast).

[81] Directive 2011/95/EU of the European Parliament and of the Council of 13 December 2011 on standards for the qualification of third-country nationals or stateless people as beneficiaries of international protection, for a uniform status for refugees or for people eligible for subsidiary protection, and for the content of the protection granted (recast).