



Dossier prepared by the association Diritti alla Follia

FRAGILE RIGHTS

ITALY 2026

*Psychiatry, courts and restrictions on personal freedom,
self-determination and individual rights*

Associazione Diritti alla Follia

English translation

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1 Introduction

1.1 Who is Diritti alla Follia

Diritti alla Follia is an association founded in 2018 to promote the rights of users, former users and survivors of psychiatry. Its work rests on a fundamental principle: no right to health can be imposed against a person's will.

The association works nationally to promote reform of the laws and practices that allow coercion and the substitution of another person's decisions for an individual's own will, with particular attention to compulsory medical treatment (Trattamento Sanitario Obbligatorio, TSO), support administration (amministrazione di sostegno, a court-appointed arrangement for assistance and, where authorised, representation), curatorship and guardianship, security measures for persons lacking criminal responsibility, and institutionalisation.

In this field it promotes respect for self-determination, informed consent and the person's will through advocacy, public initiatives, reform proposals, dialogue with institutions and oversight bodies, and the collection of reports and testimonies.

This dossier forms part of that work.

The dossier

Over the years, hundreds of people have contacted Diritti alla Follia to describe what they were experiencing, request information, seek guidance on dealing with circumstances directly affecting them, or ask for assistance. Their communications concerned widely differing experiences: psychiatric admissions and treatment, very often under TSO; support administration; security measures; medication; court proceedings; family and financial matters; and other situations in which people encountered difficulties exercising their rights in connection with their own or a relative's status as a “psychiatric patient”.

Only a very small proportion of those who contacted us subsequently accepted our invitation to provide testimony for this dossier. The collection therefore does not quantitatively represent the communications received by the association, nor does it claim to offer a statistical picture of the phenomenon. Rather, it is the outcome of a process of spontaneous selection: among the very many people who wrote to us, only some found the opportunity, willingness or strength to recount their experience.

This is significant for another reason too. Publicly recounting an experience of coercion or loss of autonomy, even anonymously, is not easy. Many people who contact us remain within the systems they describe, “depend” on services, institutions or judicial decisions, or fear that speaking out could affect their situation. Others, after years of traumatic experiences, lack the strength to reconstruct what happened. The relatively small number of testimonies collected compared with the number of communications received should therefore not be interpreted as evidence that the reported experiences are infrequent, but rather as an indication of the difficulties many people face in describing them and making them visible.

The testimonies in this dossier thus represent a necessarily incomplete selection of the “stories” that reached our association. For that reason, they are presented as individual testimonies rather than statistical data or, on their own, proof that each phenomenon described is widespread. Their value lies in their ability to reveal, through concrete and varied stories, dynamics and problems recurring across multiple communications that deserve public and institutional attention.

In particular, in recent months, as the association's social media following has grown, so too has the number of reports, testimonies and requests for help from people subject to compulsory medical treatment, support administration, psychiatric admission, security measures, especially supervised liberty, therapeutic communities, residential facilities and prolonged processes of psychiatrisation.

The testimonies collected here come from different settings and people with different experiences, yet display recurring and convergent features: restrictions on personal freedom implemented through formally lawful legal and medical instruments, but applied in distorted or disproportionate ways or without adequate safeguards.

Communications have arrived from all over Italy. Young and older people, relatives, beneficiaries of support administration, people subjected to TSO, former patients of hospital psychiatric diagnosis and treatment units (SPDC), people discharged from residences for the execution of security measures (REMS) or released from non-custodial security measures, and citizens frightened by judicial or medical procedures they perceive as oppressive all write to us.

Many describe admissions in coercive circumstances, often preceded by reports from relatives, police interventions or emergency department attendance in situations of vulnerability, conflict, bereavement, financial difficulty or emotional suffering. Numerous testimonies convey a sense of not having been listened to, not having received adequate explanations, having signed documents without understanding their content, or having experienced formally “voluntary” admissions that in practice became processes they were not free to leave.

Several accounts report the administration of psychotropic drugs by force or, in any event, without genuine consent, particularly intense sedation and adverse effects including loss of mental clarity, tremor, cognitive slowing, weight gain, apathy and movement difficulties, as well as medication dependence and the resulting progressive loss of personal autonomy. Some people report trying for years to explain to staff how particular drugs worsened their emotional or physical condition, without being believed or the situation being remedied.

Many testimonies include physical restraint, threats of TSO used to exert pressure, constant fear of compulsory admission and reluctance to approach health services even for physical health problems, because of the risk of being channelled back into psychiatric care.

A recurring theme is the harm associated with the application of support administration. Numerous people describe the measure as a progressive loss of control over their lives, money, relationships and personal decisions, rather than temporary assistance. Several accounts mention:

- difficulty or inability to oppose the appointment of a support administrator;
- management of assets without meaningful involvement of the beneficiary;
- placement in residential nursing and care facilities (RSA) or other institutions against the person's will;
- restrictions on communication with relatives or friends;
- inability to access one's own money directly;
- fear of further legal restrictions.

Some testimonies also describe family conflicts, inheritance disputes, property litigation or financial vulnerability intertwined with intervention by psychiatric or social services.

Some people describe situations in which family assets, inheritances or property ownership appear to play a decisive role in the appointment of a support administrator. Others report being deprived of the use of their own money or living on very small amounts despite receiving pensions or owning assets.

Particularly alarming is the recurrence of accounts of long periods of institutionalisation: people transferred from SPDC units to therapeutic communities, residential facilities or RSA facilities without a genuine plan for emancipation, with a progressive loss of personal freedom and self-determination.

Several accounts concern people subjected to security measures. Reports describe difficulties relating to their duration and implementation, monitoring and requirements, and the possibility of building a pathway back to an independent life. Some describe lengthy trajectories through SPDC units, therapeutic communities, REMS facilities and judicial supervision. Fear of stigma, anxiety about new restrictions and difficulty rebuilding an independent life outside psychiatric and judicial systems emerge.

The testimonies also reveal a strong sense of isolation. Many people say they do not know whom to turn to, cannot find lawyers willing to address these issues, feel discredited from the outset because of a psychiatric diagnosis, and perceive a fundamental inability to defend themselves.

A substantial proportion of emails concern difficulty obtaining legal protection. Many write that they cannot find lawyers willing to bring proceedings against doctors, healthcare workers, support administrators or social services. Some express profound distrust of the judicial system, reporting a feeling that lawyers, services, courts and institutions operate as a closed system.

Some communications come from relatives.

Mothers, fathers, children, brothers and sisters recount seeing their loved ones change radically following admissions or prolonged medication. Some describe people who had been independent and socially integrated becoming progressively dependent on institutions, sedated or deprived of initiative.

Other relatives report being completely excluded from decision-making, receiving no information and having contact with hospitalised or institutionalised loved ones restricted.

Many emails are written in a state of intense emotional distress. Some are orderly and detailed; others are fragmented, confused or interrupted by anger, fear or despair. Almost all,

however, share one element: the feeling of having been deprived of the opportunity to be heard as a person.

A substantial proportion of communications concern compulsory medical treatment.

Numerous people describe sudden admissions following family conflicts, bereavement, emotional crises, requests for help from social services or emergency department attendance for initially non-psychiatric problems. Some report being taken to SPDC units by police and healthcare personnel without understanding what was happening. Others recount signing documents without real awareness, or discovering only later that their admission had been converted to “voluntary”.

Many testimonies describe fear of physical restraint. In some cases there are direct references to beds with restraint straps already prepared, immobilisation, deep sedation and confusion so severe that entire periods have disappeared from memory.

Loss of mental clarity due to psychotropic medication is frequently mentioned. Some report tremor, cognitive slowing, loss of energy, drooling, restlessness, movement difficulties, marked weight gain or loss, insomnia or apathy. Many say they were not believed when trying to explain that medication was worsening their condition.

Other accounts describe years of depot medication imposed through an implicit or explicit threat of TSO if refused.

Several messages come from people who maintain that they received incorrect or superficial diagnoses. Some report being labelled schizophrenic, delusional or bipolar following emotional distress, family conflict, substance use, bereavement or periods of social isolation.

On several occasions, the association was contacted by people asking for:

- names of lawyers;
- expert consultations;
- “non-coercive” psychiatrists;
- support in discontinuing psychotropic medication;
- help terminating support administration;
- guidance on opposing TSO or hospital admission;
- guidance and information on challenging security measures, including supervised liberty and placement in REMS.

Many people write after years of silence. Some describe experiences from decades earlier. Others write while still in residential facilities, therapeutic communities, RSA facilities or under psychiatric supervision.

Some emails also contain material that is difficult to verify, confused reconstructions or strongly held personal beliefs.

Many contributors to this dossier did not request legal assistance or individual intervention. Often they wrote simply to leave a record, recount what happened and break an isolation characterised by opaque procedures, institutional silence and practical obstacles to making their voices heard. Some had no access to records concerning them; others could not

effectively defend themselves; others saw measures intended to be temporary or supportive become enduring constraints that replaced their own will.

In reworking the stories, we chose to:

- anonymise names, places and identifying references;
- preserve the substance of the testimonies as far as possible;
- turn fragmented or confused texts into readable narratives without changing their meaning.

The association has consistently made clear that it does not undertake individual case management or provide direct clinical or legal advice. We have always explained the limits of our role: Diritti alla Follia does not provide legal representation, intervene in individual proceedings or replace lawyers, judges or services. Our work is civic, cultural and political. Precisely for that reason, the gradual accumulation of these testimonies has made clear that these are systemic problems deserving documentation and the attention of the competent institutions, rather than isolated cases.

Although it does not undertake individual case management or provide structured legal advice, the association has sought to create a collective space for listening and speaking out, continually clarifying its function: to help make visible practices and experiences too often ignored, rather than replace professionals or services.

During our exchanges, numerous people were told that the association undertakes:

- public campaigns exposing psychiatric coercion;
- awareness-raising on human rights in psychiatry;
- initiatives against abuses in support administration;
- criticism of psychiatric security measures;
- opposition to institutionalisation;
- legislative and cultural reform proposals;
- collection of testimonies for thematic dossiers.

A brief clarification: in this dossier we deliberately chose simple, non-technical language to convey the experiences faithfully and make them understandable outside specialist settings. These stories concern real lives first and foremost, rather than abstract procedures.

The dossier is intended for national, European and international human rights institutions. The anonymised testimonies will be sent to the relevant bodies, including:

- authorities safeguarding the rights of persons deprived of their liberty;
- the authority safeguarding the rights of persons with disabilities;
- the UN Committee on the Rights of Persons with Disabilities;
- the European Committee for the Prevention of Torture (CPT);
- the UN Subcommittee on Prevention of Torture (SPT);
- the European Court of Human Rights;
- the European Union Agency for Fundamental Rights (FRA);
- the relevant United Nations bodies;
- associations, academic bodies and institutions interested in the subject.

The purpose of submitting this material is to bring systemic practices restricting rights to these institutions' attention so that they can be assessed together rather than as isolated incidents, and lead to inspections, formal recommendations and official positions.

The dossier does not seek to replace judicial action or prejudge its outcomes. It aims to offer an overall picture, grounded in real experiences, of how instruments designed to “protect” individuals can, without adequate limits and oversight, become restrictions on personal freedom incompatible with fundamental human rights.

Despite individual differences, the communications received present a coherent overall picture: many people perceive the psychiatric, judicial and health and social care systems as experiences of control, dependence and reduced personal autonomy, rather than spaces of care or support.

This collection stems from the wish to preserve these voices as human testimonies that profoundly question the relationship between mental health, freedom, consent, dignity and fundamental rights, rather than as absolute truths or generalisations.

This dossier arises from the need to make these experiences visible and contribute to public and institutional debate on the limitations of the current psychiatric and health and social care system, continuing coercive practices, and the need for models genuinely grounded in self-determination, informed consent, non-coercive support and respect for human dignity.

On this basis, Diritti alla Follia would welcome the opportunity to begin, or in some cases continue and deepen, relationships with recipients of this dossier interested in examining old and new “individual cases”, drawing on our monitoring work and establishing forms of ongoing collaboration.

Beyond the rhetoric of the “country of Franco Basaglia” and the “closure of asylums”, Italy emerges as a republic that still has a long way to go to guarantee every individual, including those experiencing psychosocial distress, whether real or merely labelled as such, the possibility of living freely and with respect for the laws protecting that freedom.

The prevailing culture, both in society and politics generally and particularly in the judiciary, psychiatry, social care and among the various professionals involved in the procedures we describe, bears the clear imprint of habitual unchecked power, oppression, unwillingness to listen, prejudice and hypocrisy. These failings are as evident as they are ignored, and thus concealed, by a journalistic community that forms part of the “problem” of institutional violence described here.

The short history of Diritti alla Follia, which represents Italy in the European network ENUSP, comprising “users, former users and survivors of psychiatry”, already documents the persistent institutional refusal, now also “unlawful”, as we explain in the conclusions, to engage in genuine dialogue with “mad people”, individually or collectively. Such dialogue is complex and painful, as all dialogue that truly matters must be. At most, institutions resort to the expedient of staging false exchanges with those who are resigned or can be tamed, gathered here and there into the equivalent, within so-called “mental health” policy, of the infamous “yellow unions”.

2 Compulsory medical treatment TSO

TSO as actually experienced

Compulsory medical treatment is one of the most far-reaching restrictions on personal freedom provided for in Italian law. The law specifies its conditions and procedures precisely because treatment is administered against the person's will and restricts their freedom. The testimonies collected nevertheless reveal a sometimes substantial gap between the statutory safeguards, which after almost fifty years of application were found constitutionally deficient in their procedural protection of the person concerned and therefore supplemented by the Constitutional Court in 2025, as discussed below, and how people actually experience TSO, that is, how it is applied.

The experiences described differ widely. In some cases, people report TSO following reports by relatives, more or less connected to conflicts, which those concerned regard as untrue or inadequately checked. In others it is described as a response to crises, behaviour considered problematic or conditions the people themselves did not consider sufficient to justify coercive intervention. Some testimonies also describe interventions in which force appeared immediate, without, according to their accounts, any genuine attempt to understand, engage in dialogue or identify alternatives.

A recurring issue is the boundary, not always perceived as clear, between voluntary admission and compulsory treatment. Some people report being taken “voluntarily” to hospital under the threat of coercive consequences if they refused, or signing for voluntary admission while experiencing the choice as effectively compulsory. Others say they discovered only later that they had been subjected to TSO, or found themselves confined for an uncertain period without clearly understanding the legal status of their admission.

The testimonies also describe mechanical restraint, sedation and medication against the person's will. In some accounts, restraint reportedly lasted very long periods and was experienced as physically and psychologically traumatic. In others, sedation is described as so intense that it impaired memory and the very ability to understand what was happening.

Another recurring element concerns the relationship between coercion and medication. Some people report repeatedly expressing disagreement with medication, reporting adverse effects or asking for alternatives without feeling heard. Some describe depot medication or intensive drug regimens accompanied by the perception that adverse reactions were subsequently interpreted as further manifestations of illness, creating a cycle in which deterioration attributed to treatment became, in the person's understanding, confirmation of the need to continue that treatment.

In any event, TSO appears as a crucial component in the broader pattern of perpetual pharmacological coercion, serving to condition the individual over time. Seven days of TSO, repeated for less compliant patients, become the “gateway” to decades of compulsory treatment, lived in acquiescence to medication which, if refused, will bring the renewed traumatic experience of hospital admission. In essence, this is the “chemical asylum”: capable

of moving within the individual the walls only apparently demolished by Law 180 of 1978, perpetuating social exclusion and denying personal freedom.

Some testimonies also place TSO within wider family or social circumstances. They describe cases in which family conflict, violence, relationship difficulties or isolation seem to have remained in the background while services focused primarily on the psychiatric condition attributed to the person. One testimony, for example, reports repeated TSO based on family reports the person considers distorted, without adequate examination of the domestic violence she reported.

Other experiences highlight the risk of TSO being perceived as a response to behaviour considered difficult to manage socially or institutionally. A legal professional's testimony describes situations in which non-violent people considered inconvenient or difficult to manage were allegedly subjected to TSO in circumstances where, in his account, healthcare powers were misused to address public-order issues or conceal other conduct.

Finally, a cross-cutting issue is the practical ability to exercise one's rights during treatment. People describe difficulty obtaining information, communicating with relatives and trusted persons, understanding documents concerning their admission and speaking to a lawyer. In some cases, sedation or restraint reportedly made communication and understanding even harder.

A particularly significant development occurred on this point in 2025. In judgment No. 76 of 30 May 2025, the Constitutional Court declared Article 35 of Law No. 833 of 1978 unconstitutional insofar as it failed to require that the mayor's order be communicated to the person concerned, that the guardianship judge hear the person directly before judicial confirmation, and that the confirmation order subsequently be served on the person or their legal representative, if any. The Court linked these safeguards to protection of personal liberty, the right of defence and adversarial proceedings, emphasising the importance of the judge hearing the person directly.

The judgment is particularly significant in light of the experiences collected in this dossier, because it addresses precisely some recurring problems: not being formally aware of being subjected to TSO, not knowing the reasons for the order, not being heard directly by the judge, or lacking a real opportunity to participate in proceedings concerning one's personal freedom. The Court also clarified that communication of the order and the hearing cannot be considered unnecessary even when the person is experiencing mental disturbance, precisely because the opportunity to understand and participate in proceedings is an essential component of effective safeguards.

In 2026, defence safeguards in proceedings to confirm TSO returned to constitutional adjudication and received another important response. In judgment No. 157 of 2 October 2026, the Constitutional Court declared Article 35 of Law No. 833 of 1978 unconstitutional insofar as it failed to require proceedings confirming inpatient TSO and any extension to include the safeguards of legal representation. The decision arose from a question referred by the Florence Court in an order of 29 December 2025 and further develops judgment No. 76 of 2025.

The Court ruled that, when the mayor's TSO order is communicated, the person must be informed of the right to appoint a lawyer of their choice; if none is appointed, they must be assisted by a court-appointed lawyer designated by the guardianship judge. The lawyer must be notified promptly and may attend the person's hearing before the guardianship judge for confirmation; the confirmation order must also be served on the lawyer. Similar safeguards apply to proceedings concerning any extension of treatment.

The Court based its reasoning on TSO's nature as coercive medical treatment affecting personal liberty, particularly physical freedom. After recalling that judgment No. 76 of 2025 had already introduced safeguards concerning communication of the mayor's order, the person's hearing and service of the confirmation order into Article 35, it clarified that the right of defence has another dimension: professional legal assistance.

According to the Court, merely allowing a person to appoint a lawyer of their choice would not effectively guarantee the right of defence, because precisely those people whose circumstances make it hardest to understand the notice or contact a lawyer might be unable to exercise that option. Hence the need for mandatory legal representation through a court-appointed lawyer where no chosen lawyer has been appointed.

Judgment No. 157 of 2026 thus marks a further stage in the development of constitutional safeguards applicable to TSO. Whereas the 2025 judgment recognised the need to inform and hear the person in confirmation proceedings, the new decision recognises the need to ensure legal representation in those same proceedings. The Court further specifies that similar safeguards must apply when treatment is extended.

The testimonies in this section therefore sit within a constitutional framework that saw a significant strengthening of procedural safeguards for people subjected to TSO between 2025 and 2026. Following judgment No. 76 of 2025, which recognised the need to ensure awareness of proceedings, an opportunity to be heard by the guardianship judge and service of the confirmation order, judgment No. 157 of 2026 established the need for legal representation in proceedings confirming and potentially extending TSO.

On one hand, these testimonies describe experiences in which people say they were not informed, heard or practically enabled to exercise their rights. On the other, they are presented in a context where the Constitutional Court has progressively identified increasingly precise safeguards for people subjected to the measure, including through two successive judgments on Article 35 of Law No. 833 of 1978.

2.0.0.1 A safeguard already proposed by Diritti alla Follia

Mandatory legal representation in confirmation proceedings is not a new issue for Diritti alla Follia. The association's popular initiative bill reforming TSO already provided for service of the mayor's order on the person concerned, with notice that legal representation was mandatory and free, and for appointment of a court-appointed lawyer where no chosen lawyer had been appointed.

The same proposal also provided safeguards for hearing the person concerned, including through their lawyer. The Constitutional Court referred to these provisions in judgment No. 157 of 2026 when setting out the positions presented in the proceedings.

The Court's decision therefore addresses an issue the association had already identified as necessary to make the right of defence effective for people subjected to TSO.

The following stories do not constitute a statistical reconstruction of TSO in Italy and cannot, on their own, establish how frequent the individual situations described are. They nevertheless collect experiences in which recurring issues concern personal liberty, consent, information, listening to the person, restraint, sedation, medication and the practical possibility of challenging a measure directly affecting freedom and self-determination.

Through these concrete experiences, the dossier seeks to examine not only the formal conditions for TSO, but also the actual circumstances in which those rights are exercised when a person is confined against their will in a psychiatric ward.

2.1 I asked for help. Then they started deciding for me

I am writing this testimony to describe what I experienced between 2016 and 2025 through psychiatric admissions, forced medication and coercive measures that I believe violated my fundamental rights.

My clinical history began in 2013, at fifteen, with the onset of an eating disorder, anorexia nervosa, and major depressive disorder following failure at school and earlier bullying.

In November 2016, I independently approached a nutrition centre for help with anorexia. I was prescribed antidepressants and anxiolytics. After an episode of self-harm, I was admitted voluntarily to an SPDC unit for the first time.

During that admission, antipsychotics, Abilify, were introduced despite what I considered a lack of clinical indications consistent with the diagnosis of anorexia and psychomotor agitation. Doses progressively increased during subsequent admissions. In December 2016 and the following months, I was diagnosed with “bipolar disorder” without, in my perception, adequate clinical evidence.

Between January and May 2017 I was admitted to a residential community. Medication included antidepressants, benzodiazepines, antiepileptics and numerous antipsychotics: Haldol, Clopixol, Entumin, Seroquel, Abilify, Tegretol, Topamax, Rivotril, Gabapentin, fluoxetine, Tavor, En, Xanax and Flunox. In nine months, from November 2016 to September 2017, I underwent intensive polypharmacy that worsened my physical and mental condition.

I developed serious adverse effects: weight gain of around 18-20 kg from a starting weight of 37 kg; akathisia; extrapyramidal disturbances with dystonia and myoclonus in my left arm; motor tics; restless legs syndrome; deep sedation; cognitive slowing; difficulty concentrating and studying; and urinary dysfunction requiring catheterisation. In the context of anorexia, the weight gain was profoundly traumatic for me.

In June 2017, during a TSO admission, I experienced a sexual incident without explicit consent while sedated and chemically restrained. In the following months I experienced further situations I consider abusive, including in healthcare, such as attempted catheterisation by a non-healthcare person while I was semi-conscious following an overdose of psychotropic medication.

In July 2017, I attempted suicide by overdosing on medication. I was admitted to intensive care and then again to SPDC. I requested psychological support but received only one meeting with a trainee. I was offered a choice between a residential community and a clinic as a voluntary patient, under the threat of legal incapacitation if I refused.

After further admissions and treatment, in 2018 I voluntarily discontinued treatment and contact with the mental health centre (CSM) because of its insistence on medication.

In July 2021, years later, I developed auditory hallucinations and delusions of reference, which I attribute to rebound psychosis following medication withdrawal and excessive dopamine receptor blockade. I was reported for stalking.

In 2022 I was subjected to a precautionary judicial measure and psychiatric admission. In 2023, during an initially voluntary admission, I tried to reduce medication myself to protect myself; my admission was converted to TSO. I received Abilify injections and subsequently Moditen, depot fluphenazine. After attempts at self-harm I was mechanically restrained, tied to the bed.

With the introduction of Moditen, I developed severe effects: intense akathisia, inability to remain seated, a need to walk constantly, marked sedation, rapid weight gain, persistent left-sided extrapyramidal disturbances, slowed speech and cognitive impairment. To counter restlessness, I received up to 100-150 drops of benzodiazepines, En, without real benefit. The extrapyramidal effects persisted for months after the last injection in October 2023; the metabolic effects lasted until 2025.

During these periods I experienced changes in impulsivity, disinhibition in relationships, use of dating apps I had never previously used, and behaviours I do not recognise as usual for me. I experienced profound distress concerning my identity and relationships. I engaged in self-harm and desperately asked to be returned to prison to escape the treatment.

I currently report residual muscle spasms, left-hand tremor, transient hallucinations manageable without medication, persistent sexual arousal disorder (PSAD), increased body fat and cognitive changes, with preserved ability to understand and exercise volition but functional limitations.

I believe I experienced:

- medical treatment imposed through threats or coercion;
- formally voluntary admissions experienced as compulsory;
- medication inconsistent with the initial diagnosis of eating disorder and depression;
- disregard for informed consent under Law 219/2017;
- permanent physical and psychological iatrogenic harm;
- mechanical restraint and forced sedation;
- denial of adequate psychotherapeutic alternatives.

I declare that the above corresponds to my experience and recollection of events. I reserve the right to supplement it with further documentation.

I write so that what I experienced is not reduced to a “difficult treatment journey”, but is also assessed in terms of fundamental rights, personal dignity and consent to treatment.

2.2 When violence becomes a diagnosis

I underwent my first compulsory medical treatment as an adult without the statutory requirements being respected. In particular, the order was based on a single medical assessment and untrue family reports describing me as aggressive and dangerous.

These reports came from relatives who had subjected me to physical and psychological violence since childhood. Services never considered these circumstances, either before or after the TSO orders.

In subsequent years I underwent further compulsory treatment, always based on the same distorted portrayals, without any investigation into the actual family dynamics or domestic violence in which I lived. Later, that violence was also examined in judicial proceedings that recognised the validity of my position. However, precarious finances, social isolation and employment difficulties forced me to withdraw my complaints.

The mental health service responsible for my care consistently minimised or ignored the violence, effectively legitimising my relatives' behaviour. Arrangements had previously been made to support the family as well, but these commitments were never honoured.

Over time my care became almost exclusively compulsory medication, with periodic administration of long-acting drugs and anxiolytics, without genuine informed consent or therapeutic alternatives. Following these treatments I developed severe medication dependence and serious sleep disturbances.

At the same time, I experienced financial and psychological violence: during particularly vulnerable periods I was left without money, clear information about decisions affecting me or adequate legal support. Again, services failed to intervene to protect me.

I wish to clarify that, despite all this, no judicial authority has ever declared me incapable; I have never been subject to full or partial legal incapacitation, nor had criminal proceedings pending against me or civil or administrative restrictions. I am, and have always been, fully capable of understanding and exercising volition.

This testimony seeks to show how repeated TSO based on unverified reports and without genuine procedural safeguards can become an instrument of control and silencing rather than care, particularly when the person is isolated and lacks outside protection.

2.3 “You are not under TSO.” “Then why can I not leave?”

I have to struggle to find a starting point from which to recover memories of my first TSO and those that followed, in a process I now consider more than twenty years of psychiatrisation.

The first episode was in 2006, shortly after my father's death. I was going through an emotionally intense period. One day, in the family kitchen, in a fit of anger I kicked a cupboard hard, breaking its upper glass. I then left the house, still very agitated. When I returned about half an hour later, municipal police officers were speaking with my mother. I presume she had called them, perhaps at the suggestion of my older sister, with whom I had previously had family disputes and who had already called me “schizophrenic”.

The officers surrounded me. When I tried to move away, one said, “Don't even try!” They then lifted me bodily and carried me towards an ambulance that had arrived outside. I was taken to SPDC, where I remained for more than three weeks. I was diagnosed with bipolar disorder.

At the time I was a far-left political activist and had read extensively about the history of anti-psychiatry and the laws governing compulsory treatment. I knew TSO was time-limited and subject to specific renewal procedures. After about two weeks I met the SPDC medical director, also responsible for the hospital psychiatric service and mental health centre. I asked when I would be discharged, since the TSO period had expired and presumably had been renewed. His answer surprised me: he said I was not under TSO.

This left me deeply puzzled. A few days earlier, a nurse had stopped me in the ward television room and told me to sign some documents. No clear explanation of their content had been given.

For me, that episode remains emblematic of something I repeatedly encountered later: admissions that, at least in my perception, become stays of uncertain duration in which it is not always clear whether a person is held compulsorily or formally voluntarily.

During subsequent detentions in SPDC over many years, I experienced other episodes I regard as marked by abuse, mistreatment, humiliation and domineering conduct by staff or healthcare workers.

My testimony comes from the wish for experiences like mine to be heard and considered. I hope it prompts reflection on practices and procedures that, when misapplied, risk undermining the self-determination of people receiving psychiatric treatment and weakening statutory safeguards.

2.4 “If you do not come with us...”: fourteen days of restraint and a TSO discovered afterwards

In 2022, a few months after losing both parents, I was in deep emotional distress. Alongside bereavement, I had to deal with inheritance procedures and imminent appointment to a permanent teaching position at a state academy of fine arts, where I still teach.

Between November and December, social services began making regular visits to my home.

Every visit ended with a threat to call the police if I did not open the door next time.

During one of these weekly visits my general practitioner also attended. In his presence I opened up more, but he left in the lift with the social services staff despite my request to stop these unwanted visits.

On 20 December 2022, two community psychiatrists, a nurse and a social worker came to my home. They said I should accompany them to the emergency department for routine clinical checks. When I refused, one psychiatrist said that if I did not go willingly, they would do what they did not want to do. I interpreted this as a threat of TSO and decided to go.

At the emergency department I was immediately immobilised and sedated, losing consciousness. In the following days I underwent continuous mechanical restraint and medication of which I retain fragmented memories.

All this is duly recorded in the hospital medical notes.

The clinical records show that during restraint a hypertensive crisis led to an initial head and brain CT scan, revealing a meningioma and an area of cerebral ischaemia.

A second CT a few days later revealed areas of cerebral injury.

Meanwhile, a urinary catheter was inserted because acute bladder distension had developed, resulting in substantial blood in the urine.

Mechanical restraint was applied for fourteen consecutive days in the extremely painful “cross” position, with my arms raised.

I still remember the threatening, violent faces of nurses who, after very brief releases, restrained me again despite my protests and pleas.

The notes indicate that mechanical restraint stopped only after intervention by a doctor I knew.

I remained catheterised, with visible bruising around wrists and ankles.

The overall admission lasted more than forty days.

Only afterwards, on consulting my medical notes, did I learn I had been subjected to TSO. After discharge I attended my local mental health centre, where an antidepressant and an antipsychotic were prescribed for about three years. I repeatedly reported adverse effects and symptoms I believed related to the medication.

In 2026, I consulted a neurologist to investigate the cerebral ischaemia identified during admission and assess possible neurological consequences. At the same time a private psychiatrist discontinued my antipsychotic. Since then I report a clear improvement in my overall condition.

I also began psychotherapy with a private psychologist, which is making me increasingly aware of the injustice I suffered.

I still consider that admission and its aftermath among the most traumatic events of my life. I offer this testimony so that similar experiences become known, discussed and subjected to effective public scrutiny, and no one has to live through them without being able to make their voice heard.

2.5 The empty home after TSO

I am a mother of two children.

For years I tried to protect our family from a difficult separation, an unresolved conflict with their father and tension that grew like a silent, ever-present fear. I lived, worked and raised my children devotedly, but beneath the surface there remained a constant sense of threat.

An incident of violence in front of the children profoundly affected all of us. I filed a complaint, seeking protection that would give them safety and stability. Instead, judicial proceedings began, bringing social services involvement and a progressive transfer of control over our family life.

Conflict with their father intensified. Every action became grounds for accusations, suspicion and reports. Despite the other parent's prolonged absences and aggressive behaviour, sole custody was never granted. Eventually custody was entrusted to a public body, although the children remained living with me.

A few days later, something happened that changed my life forever.

I had long been anxious and afraid. That morning I perceived lights and marks on the walls of my home that frightened me deeply. I panicked and called emergency services.

I cannot know whether what I saw was real or an altered perception. But I know with certainty what happened next.

Healthcare workers and police arrived. No one tried to understand what was happening to me, entered the house to check or genuinely tried to talk to me. I was immediately treated as disturbed, dangerous and unable to understand.

My children were taken away without explanation and placed in an emergency vehicle while I desperately tried to reach them. As I tried to see them, I was pinned to the ground. I felt several injections, then lost consciousness.

I woke in a hospital psychiatric ward, my hands and feet tied to the bed. I did not know where my children were. I was heavily sedated.

Over the following days I remained confused under extremely heavy medication. Only later did I discover that I had been admitted through compulsory treatment disguised as voluntary admission, with consent signed without awareness because of sedation. Staff reassured my relatives that I “needed rest and treatment”, and that was enough for no one to question what was happening.

When I returned home, it was empty.

The children's room was untouched: toys, books and small possessions exactly where they had left them. But they were gone.

It is hard to explain losing your children this way. Not through a decision reached after a clear, transparent process, but following coercive medical intervention triggered by fear, to say the least.

Since then, my life has become a struggle to show I am not “ill” in the sense attributed to me, reduce and finally discontinue imposed high-dose medication, and recover personal and working autonomy. I still cannot return to being a mother.

I was told that refusing medication would mean losing my children forever. I continued taking a long-acting psychotropic drug, an antipsychotic, for more than a year despite disagreeing with the unclear diagnosis assigned to me, without any prior history, somewhere between post-traumatic stress disorder and schizophrenia. I then returned to my pre-motherhood life and work, moving somewhere more natural than the metropolis and finding painting an excellent form of psychological self-therapy.

What happened to me shows how fragile the boundary between protection and abuse is when instruments such as TSO are used without immediate legal protection for the “patient”, listening, verification or respect for the person and their emotional ties.

Forced admission, sedation and separation from my children are wounds that do not heal easily. They conflict with my innate sense of justice as someone with personal and civic awareness, and appear in dreams with the force of unresolved emotion.

That is why I decided to tell my story entirely anonymously, so that what happened to me cannot happen to others.

2.6 A body asking for help: a psychiatric response

My testimony concerns a journey marked by psychiatric institutionalisation, possible medical errors and difficulties exercising rights for those unable to conform to prevailing social norms. I have a recognised disability rating of 90%, with visual and psychiatric disabilities, and also fibromyalgia. Throughout my life I have received several psychiatric diagnoses and attended both public services and private professionals.

After taking multiple medications prescribed by the public service, in February 2024 I developed optic neuritis and was left with a small slit in my left eye, corrected with glasses to 4/10 vision, so I am condemned to blurred vision for life.

When my vision became blurred I went to the emergency department, but instead of being examined by ophthalmologists or neurologists I was made to speak with a psychiatrist, who attributed it to a temporary medication side effect.

My personal history also includes highly conflictual family dynamics. For many years my family supported me financially, while often describing me as incapable or dependent. Recently that support has almost completely stopped. I now live on a very low disability pension, supplemented by occasional help and charity.

Over the years I have had several difficult relationships with mental health services. Some physical conditions, such as fibromyalgia, were questioned or attributed to psychological factors. Some medical documents contain information I do not recognise as matching my history.

Following difficulties also involving a family inheritance dispute, I underwent compulsory medical assessment, leading to psychiatric admission. I remained for several weeks. I experienced the ward as detention: my phone was taken away, I was often isolated and was offered medication I disagreed with.

After discharge I was required to maintain contact with community services. During that period the family and judicial situation became more complicated. An application for support administration was also made, which I experienced as a threat to my autonomy.

These events had a profound emotional impact. During a severe crisis I attempted suicide by medication overdose. After hospital admission I faced the usual ultimatum: accept voluntary psychiatric admission or undergo TSO. I therefore accepted admission.

Subsequently I underwent various medico-legal assessments and expert consultations in the judicial proceedings concerning support administration. Ultimately the measure was not imposed.

Looking back, I consider myself very fortunate to have avoided a formal restriction of legal capacity. Nevertheless, my experience shows how easily someone experiencing existential distress and lacking strong financial or family resources can face decisions profoundly affecting their autonomy and life.

2.7 A “voluntary” patient who could not say no

I first encountered the mental health centre at eighteen, on my mother's initiative rather than my own request. Our relationship was then highly conflictual. I was deeply distressed by the family environment, constant tension and lack of listening. This affected my education, eventually leading me to leave the secondary school where I had been doing well.

What I was experiencing was adolescent and relationship distress, yet from the first interview it was immediately interpreted as psychiatric illness. Almost exclusively on my mother's account, without genuinely hearing mine, I received progressively more serious diagnoses and medication was imposed as the only possible response. Psychological support or a space to work through family conflict was never offered.

I soon understood the coercive nature of that setting and tried every way to avoid medication, which caused severe, disabling adverse effects. During a particularly heated family argument my mother contacted a centre worker, who ordered that I be brought there immediately. When I refused, they announced they would collect me at home. Several workers arrived soon afterwards, spoke only to my mother and within minutes decided on psychiatric admission.

I resisted with all my strength and begged not to be taken away, but was told the alternative was TSO with police involvement. I was thus taken to SPDC under “voluntary” admission despite explicit, desperate opposition. I remained five days, forced to take medication under supervision and constantly distressed. It was deeply traumatic.

At home I tried to put it behind me, but two years later it happened again almost identically. Following family tensions I was summoned to the centre and another admission ordered without allowing me to express my view. Only my mother's hesitant intervention prevented admission, but I was forced to take medication immediately under threat of TSO. I had to swallow it in front of the psychiatrist under humiliating supervision.

The trauma then returned intensely. For months I lived terrified of being taken away again and losing all control over my body and life. These experiences profoundly affected my identity, self-esteem and sense of safety. I felt branded by a diagnosis that would precede me everywhere, deprived of credibility and dignity.

Only later, after my relationship with my mother changed, did I escape the centre's circuit. I sought justice through a complaint supported by an independent psychiatric report confirming no illness and the inappropriateness of the interventions. Nevertheless, the case was dismissed. Staff assessments were treated as beyond challenge, while my voice was considered biased and distorted.

This showed me how the judicial and psychiatric systems tend to protect each other, making it almost impossible to challenge coercive practices seriously affecting personal freedom. I tell this story so it does not remain isolated and invisible, but helps expose a structural problem continuing to cause profound and lasting harm.

2.8 The “voluntary” admission I cannot remember

I am a mental health service user offering testimony about my experiences over the years.

In 2007 I underwent my first psychiatric admission. Afterwards, using personal strategies, I maintained some balance and avoided further admissions for a long time. However, in August 2025, following my mother's death, another admission was imposed. Again it was formally defined as “voluntary”.

From the outset I realised what was happening: while an intravenous injection was being administered, I reacted instinctively and injured a vein trying to escape. I was then taken to a room with restraint straps on the bed, which frightened me deeply because of what that environment meant to me.

The admission lasted over a month. My memories are fragmented: much of that period seems erased, a genuine “black hole”. I remember only confused episodes and hallucinations that I attribute to medication, since I had never experienced anything like them before.

After discharge I came under the mental health centre's management. I now depend on instructions from services and relatives, who accompany me for medication administration. I also face profound uncertainty about personal and family matters without clear information.

This experience profoundly affected my memory, autonomy and sense of self, leaving me dependent and disoriented to this day.

2.9 When saying no becomes a symptom

I entered the psychiatric system young, during a personal crisis. For over a decade thereafter my life was marked by repeated admissions and continuous medication, often without my viewpoint being genuinely heard.

From the beginning I tried to tell doctors that prescribed drugs did not improve my condition and seemed instead to worsen it, increasing distress, guilt and agitation. Despite repeated reports, these were ignored. Even obvious adverse effects, such as irritability and intense anger, were interpreted as symptoms of my supposed illness rather than possible treatment consequences.

Over the years my emotional, physical and psychological state worsened. Admissions continued without real improvement. I experienced a system that did not question treatment effectiveness but followed an established course with no room for discussion.

Eventually I clearly stated that I wanted to stop medication and asked for alternatives to be assessed. In response I was forced onto long-acting depot treatment with the very drugs I had repeatedly called ineffective or harmful. This intensified my helplessness.

Sedated and suffering, I sometimes reacted with anger and frustration. These reactions too confirmed the initial diagnosis, without considering context or medication. Over time a closed cycle formed: the worse I felt, the more treatment intensified; the worse treatment made me feel, the more this was interpreted as proof of my condition.

Only after many years and numerous difficulties, including formal obstacles, did something begin changing when I met a new doctor willing at least partly to hear my experience. Yet I am still told I need medication regardless, as if this were inevitable and beyond discussion.

Recently I have struggled to reduce treatment and observed a reduction in some symptoms long attributed solely to my condition. This strengthens my conviction that my viewpoint should have been heard much earlier.

I recognise having experienced difficult periods and problematic behaviour, but believe the care I received was inadequate and sometimes worsened my situation.

My experience convinces me that profound change is needed: more listening, attention to treatment effects, genuine choice and alternative pathways. Distress cannot be addressed solely through medication, particularly when the person continues expressing suffering and disagreement.

I share this testimony in the hope of contributing to broader reflection and change that prevents others undergoing similar experiences.

2.10 I was no longer myself, I was my diagnosis

I first received a psychiatric diagnosis at twenty-five after an episode of mental distress. From then on I was trapped in stigma. I was no longer seen as a young woman with dreams, but as “the one with a mental disorder”.

The stigma came not only from those around me, but also from public mental health services. I do not feel I ever received concrete help understanding or resolving my distress. Whenever I expressed suffering, the response was psychiatric admission. In my view, these decisions reflected a need to “keep things under control” rather than a genuine care plan.

I felt my identity progressively trampled on, every intervention justified by the need to contain distress. Yet in the situations leading to TSO, no alternative support was offered and my need to be heard and understood was not recognised. I was a young woman suffering and struggling to recover a sense of self.

I believe addressing mental disorder means examining what a person can express and mobilise to counterbalance vulnerability. This is possible only if they can express themselves, participate actively in decisions and be recognised as a subject rather than an object of intervention. The mental health system I encountered seemed instead primarily based on suppressing distress rather than valuing expression and self-determination.

2.11 84 hours of restraint

I seek here to reconstruct events that, some years ago, led to psychiatric admission under TSO and mechanical restraint for several consecutive days.

My account is based on available medical documentation and subjective recollection. Without medical or legal expertise, I limit myself to raising questions and identifying problems, also in light of constitutional and professional ethical principles protecting individuals.

Before these events I was experiencing severe psychological distress linked to traumatic relationship events and prolonged psychological pressure and violence. My emotional wellbeing progressively deteriorated, without any recent history of continuous psychiatric care.

A psychiatric diagnosis made in adolescence has always seemed questionable to me, being based on brief assessments during development. In subsequent years I lived substantially independently and functioned well.

Some years ago I attended the emergency department after a self-endangering act without a developed suicidal intention, as demonstrated by my own request for help.

Nevertheless, in the following hours I was de facto detained without a formal compulsory assessment or treatment order, without clear information about decisions and without being able fully to exercise my rights.

TSO was subsequently ordered. During admission I underwent five-point mechanical restraint for 84 consecutive hours.

The documentation shows a recurring justification of presumed risk of psychomotor agitation and aggression towards myself or others, despite no documented physical violence.

During restraint I had no meaningful dialogue with doctors, could not freely communicate with relatives and experienced it as deeply traumatic and humiliating.

2.12 TSO for an “inconvenient” person

I have practised law for many years, predominantly criminal law. Various cases led me to examine TSO, its legal conditions and practical implementation.

On several occasions I have observed TSO being used less to meet genuine urgent healthcare needs than to manage situations considered “inconvenient” for public order. When someone behaves unconventionally but non-violently and becomes socially “troublesome”, inadequate responses can lead to inappropriate use of TSO as a quick solution.

I particularly recall a young man with a history of psychological suffering living in a small town. In such settings mental distress is often stigmatised and barely tolerated by the community and local institutions. Police knew him for exaggerated behaviour, such as shouting in public or protesting loudly in offices, but he had never been violent towards people.

One day he was summoned to a police station. He attended voluntarily and calmly, as several witnesses confirmed. Following an argument with an officer inside, he was physically assaulted. Injured and frightened, he cried and asked for help, phoning his mother.

When the situation risked becoming known outside, a doctor was called to order TSO. Emergency personnel administered a powerful sedative and immobilised him. He later escaped and returned home a few hours afterwards entirely calm, demonstrating the absence of a condition justifying coercive treatment.

None of the statutory conditions for TSO existed: no urgent treatment need, informed refusal of treatment or impossibility of alternatives. His agitation was an understandable response to assault, not a clinical symptom. Yet his psychological distress was used to conceal unlawful conduct.

The subsequent criminal proceedings also revealed untruthful official communications portraying the victim as the aggressor and retrospectively justifying TSO. Strikingly, no charge of unlawful coercion connected to the illegitimate medical coercion was brought, demonstrating limited institutional attention to misuse of this instrument.

I have also witnessed many TSO interventions in public places or homes seriously violating dignity: people immobilised, handcuffed or sedated before others, without genuine dialogue or attempts to obtain informed consent. Doctors often fail to perform the mediating role required by law, and force follows rapidly.

Many experience TSO as traumatic and humiliating. Police intervention without genuine necessity gravely infringes human dignity, openly contradicting statutory principles.

I have also found frequent obstacles for those seeking legal protection: limited document access, difficulty meeting lawyers and healthcare staff resentment towards lawyers informing patients of their rights. Sometimes sedation makes even a conversation impossible.

These experiences convinced me that TSO requires profound reconsideration and effective safeguards, including legal representation, to prevent an exceptional instrument becoming routine control, repression and concealment of abuse.

3 Support administration

In democratic legal systems, protective legal arrangements originate to support people experiencing temporary or permanent difficulty or reduced autonomy, depriving them as little as possible of self-determination. But when protection replaces the person's will instead of supporting them, without proportionality, sufficient safeguards or effective involvement, it risks becoming “civil detention”: profound restrictions on freedom and decisions about one's own life.

In 2004, the support administration system introduced by Law No. 6 of 9 January 2004 came fully into force, with the stated aim of providing more flexible, less intrusive protection than traditional full legal incapacitation.

The testimonies nevertheless show how, in many cases, this institution can become an instrument subordinating the person to others' decisions, affecting fundamental aspects of life:

- remaining at home or placement in a facility;
- management of assets and finances;
- family, emotional and friendship relationships;
- health and treatment decisions;
- undertaking particular legal acts and asserting one's interests.

This section documents situations where, without effective oversight or genuine exchanges between the person and the guardianship judge, support administration was experienced as progressive dispossession of decision-making power rather than assistance.

Several recurring problems emerge.

3.0.0.1 Relatively easy access to the procedure

Appointment can be requested by, among others, beneficiaries themselves, relatives and social and health services, without necessarily requiring a lawyer.

Designed to make the institution accessible to those genuinely needing it, this can become problematic when proceedings begin from indirect reports, family conflicts or insufficiently thorough assessments.

3.0.0.2 Broad and indeterminate circumstances leading to appointment

Testimonies frequently refer to conditions described generically as “vulnerability”, “difficulty”, “suggestibility”, “weakness” or “inability to attend to one's interests”.

The issue is determining when these genuinely require legal support and when they become general judgments about a person's ability to live according to their own choices.

3.0.0.3 Difficulty obtaining independent assessments

Several cases show difficulties obtaining truly independent assessment of condition and self-determination, especially when initial assessments come from services or people already involved in care.

This is particularly significant when capacity assessments justify substantial restrictions on autonomy.

3.0.0.4 Potential conflicts of interest and professional administrators

Many external support administrators are professionals, including lawyers, who may receive remuneration or allowances under legislation and guardianship judges' orders.

The testimonies question the concentration of numerous appointments in one professional's hands and highlight the need to ensure that the person's interests always remain paramount.

3.0.0.5 Broad powers and insufficient checks

Depending on the appointment order, administrators may receive powers profoundly affecting a person's life.

Exercised without adequate involvement of the person, support risks becoming substituted decision-making.

3.0.0.6 Risk of judicial conflict against those seeking to help

Some testimonies describe relatives, loved ones or friends supporting beneficiaries coming into conflict with administrators or services.

Certain accounts report judicial action or allegations against those trying to assist.

The issue is ensuring that conflict between involved parties does not automatically discredit supporters or further restrict relationships.

In the circumstances described, support administration risks appearing as an extensive control system rather than help, affecting very different people: those with experiences of psychiatrisation, isolated older people, those with limited economic or social autonomy, those involved in family conflicts or property disputes, and those whose behaviour is considered problematic or non-conforming.

Paradoxically, the person under administration is called the “beneficiary”. Yet some testimonies show this person feeling they benefit least, progressively losing decision-making opportunities.

This section thus documents how a protective institution can, without adequate limits, safeguards and oversight, substantially restrict fundamental rights: freedom and self-determination, management of property, family life and relationships, housing, informed consent and refusal of treatment within statutory limits.

These need not be individual mistakes or isolated conduct. The problems may be systemic, requiring reconsideration, clearer limits, adequate safeguards and independent oversight.

Above all, something simple, just and revolutionary is needed: listening to the person. Law 6/2004 itself states its purpose as “protecting persons wholly or partly lacking autonomy, with the least possible restriction of their capacity to act”.

This risks remaining a fine but empty collection of words when people are progressively deprived of practical autonomy instead of supported in exercising it.

Before presenting testimonies received by Diritti alla Follia, we outline some emblematic cases already brought to our attention, highlighting principal problems.

3.1 Emblematic cases of abuse through support administration

3.1.1 Case A The institutionalised young woman

A young Italian woman raised in an unstable family without reliable emotional support develops relationship difficulties in adolescence and independently seeks community help. A mild personality disorder is diagnosed, compatible with full ability to understand and exercise volition.

She stops some psychotropic drugs because their adverse effects are incompatible with daily life. This refusal becomes decisive in initiating judicial proceedings appointing a support administrator, despite her clear, documented refusal.

In the following months she is placed in a group home without independent expert assessment or consent. She loses freedom to communicate outside, see whom she wishes and make decisions about her life.

Over the years she repeatedly tries to escape, walking kilometres to leave. Each time police help locate and return her.

Her formal attempts to terminate administration are rejected without genuine assessment of self-determination. Her statements are progressively devalued and reinterpreted as incapacity.

After more than ten years of forced residence in facilities under continuous psychotropic medication, she dies following massive ingestion of medication.

3.1.2 Case B The isolated older homeowner

An older widower without children lives independently in his own home, manages expenses, gardens, drives and maintains ordinary social relationships.

Following a neighbours' report, proceedings appoint an external support administrator. No psychiatric expert assessment appears to have preceded appointment.

The order refers generically to “cognitive deterioration”, but a subsequent independent medical assessment finds him lucid, oriented and capable of judgment.

Nevertheless, his finances and daily life remain controlled by the administrator: he receives only a small portion of his pension and cannot freely use money or decide on treatment or major purchases.

He is progressively transformed from an independent citizen into a dependent person without genuine clinical justification.

3.1.3 Case C The financially independent woman

An adult woman without psychiatric illness, owning a home and savings, is reported by a relative with whom she has a conflictual relationship. The report cites “non-conformity”: living alone, having no family, giving gifts or loans to acquaintances and keeping pets.

Without any medical expert assessment, the court appoints an external administrator. Credit cards, cheques, cash and spending powers are soon taken away.

The administrator receives high remuneration for ordinary daily financial management while she loses control of her assets.

To free herself, she must undertake lengthy, costly litigation.

3.1.4 Case D The older intellectual

An older man known for cultural activities remains fully lucid, writes, attends public events and gives interviews.

He has an affectionate, trusting relationship with a younger person who assists daily. Third parties report to the court that he is “susceptible to exploitation”.

Despite expert assessments confirming capacity, support administration is imposed and his assistant faces criminal investigation.

A legal contradiction emerges: he is considered lucid enough to manage himself, yet incapable of choosing whom to trust and love.

These different cases show recurring features. Reports need not concern concretely established incapacity; they may involve non-conformity, family conflicts or financial interests. Administration may be imposed without sufficiently rigorous independent assessment and progressively cause loss of autonomy, isolation and financial control. Opposition itself may be reinterpreted as further irrationality or incapacity, while termination becomes lengthy and difficult for precisely the person seeking full autonomy.

When this occurs, it can cause serious deprivation of civil rights and assume features described as “social detention”, even without criminal proceedings.

The following testimonies convey some collected experiences. They differ, but recurrent issues concern autonomy, control over personal choices, relationships, housing, assets and treatment.

3.2 The mother, the son and support administration

On 21 July 2020, around 5 p.m., M, a retired teacher, receives notice of a criminal investigation with an order immediately removing him from his elderly mother's home. Unmarried, although long owning his own home, he had always continued living with his parents. His mother's support administrator filed the complaint with backing from two non-resident siblings. M is stunned but complies; two Carabinieri stand before him.

Why did his mother have an administrator? Briefly, this is the story.

17 April 2019: M dismisses the caregiver who had assisted his parents for three years, both until May 2018 and his mother alone after his father's death. After another harsh incident he loses patience and dismisses her. The problem was years old. His sister, who hired her, vehemently disapproves: an unforgivable, damaging, fatal mistake; the elderly woman's survival supposedly depends on this irreplaceable caregiver.

Endless reports about her cold, harsh, even mocking manner, sharp tones, brusqueness, threatening demeanour and impatience achieved nothing. Nor did reports that their mother had long complained, calling her a “beast”, “she-devil”, “witch” and “wretch”, suffering from her presence. Nor that, alone with M, she begged him not to “abandon her in this witch's hands”.

They seek a replacement. After various difficulties, failed trials and disagreements, things settle. Their mother bonds with the new foreign caregiver beginning in June 2019, who is naturally empathetic, discreet and patient. Another, Italian caregiver has worked for almost five years, initially weekends and later nights as independence disappeared. The opposite of the dismissed woman, she is much loved by their mother.

But M's sister harbours resentment: her “perfect” care system has broken, and M is responsible. She insists the former caregiver retain a role periodically supervising the other two, who dislike it. With authority over the bank account, she repeatedly reprimands and pressures the Italian caregiver, who becomes exhausted and hints at resigning. M warns his siblings that unless conflict stops, an external administrator will be necessary.

That happens: in October 2019 a woman lawyer is appointed and immediately establishes a preferential relationship with the non-resident children. At December's end a third caregiver is hired, the administrator stating this is the only way to provide round-the-clock care for someone needing night assistance. Costs rise; substantial contributions from all three children are required. M is told not to interfere in care, particularly the new night caregiver's work: too many cloths are being changed. Things continue this way awhile. His mother sometimes has restless insomnia; naturally M cannot simply sleep peacefully. The administrator calls this “interference”.

At February 2020's end comes a sudden reversal: the administrator returns to one live-in caregiver, with weekend cover. What was impossible months earlier is now possible. M's mother takes life-saving Lasix, a diuretic causing frequent wetting. Nights are difficult: discomfort wakes her and she complains persistently and painfully. Faecal soiling is also frequent. How can one caregiver cover twenty-four hours? The administrator tolerates no

discussion; she commands. Between the lines it becomes clear that the live-in caregiver will be the former one M dismissed, still foremost in his sister's thoughts: the miracle worker. Only M's presence stands in the way. A written request to leave voluntarily arrives on logistical grounds.

M refuses and seeks legal assistance. The administrator turns to a criminal complaint: the offence is family maltreatment. With M removed, the former caregiver is rehired in early September 2020.

Committed for trial for family maltreatment, M chooses ordinary trial proceedings. After three years and eight hearings, amid an evidential void that sometimes leads the prosecutor astonishingly to abandon examination of prosecution witnesses, M is acquitted because the alleged act did not occur, in February 2025. His mother meanwhile died on 1 August 2021. Over a year he saw her only three times in court-authorized, one-hour meetings attended by the administrator's representative.

She died doubting whether the son with whom she had spent her whole life still loved her. M filed a complaint for false criminal accusation against the administrator and relatives involved.

3.3 Even after death: the ban on visits and silence about burial

The ban on visits continues even after death. I do not know where my partner is buried, and his support administrator, a relative, carefully avoids revealing it.

My partner, with whom I had lived since 2009, died in August 2024, confined in an RSA after an ordeal lasting over two years, beginning in May 2022 with forced transfer to two private facilities. All I have left are three voice messages asking for help. Afterwards the administrator confiscated his phone and took him to a private facility, absolutely prohibiting visits or communication without authorisation. For me and lifelong friends, total silence descended.

He entered that first facility, later found to be irregular and run by a convicted offender, walking independently and recognising everyone, with a promise he would stay only for summer. He never returned home, even for a visit. Soon he was in a wheelchair, tied “for his safety”.

In two years and three months I saw him once, for one hour in September 2022 at the administrator's home, exceptionally authorised by the guardianship judge. The entire meeting was filmed on the judge's orders, something not done even to prisoners. He was unrecognisable: dramatically thin, black hair turned white, eyes lost and resigned. Of the facility he said, “hospital, horrible people, pain”. The administrator called it “wonderful” and said he “understood nothing because he had dementia”.

Every application to bring him home was rejected. Yet anyone seriously working with dementia knows that uprooting people, isolating them from loved ones and confining them behind bars accelerates cognitive decline. The guardianship judge never wanted to hear him or me. Having replaced another judge, he did not know him and claimed no time to meet. At a hearing he told me: “If you dare speak or write about this story, I will never let you see him again.”

I, the woman with whom he lived, whose address was his registered residence and whose household register included him, had become a stranger. “He was only a guest; there was never a relationship,” the administrator maintained. I became the number-one enemy because I interfered with his plans. I wanted to care for my partner at home, never institutionalise him. Perhaps, had he remained free, he would not have died in just over two years.

In December 2021 we consulted a lawyer to formalise our cohabiting partnership, without financial implications. We did not know his family was preparing an application for support administration, quickly granted without truly explaining what it meant: complete loss of control over life. The administrator strongly opposed formalising the partnership. We postponed. It proved fatal.

The administrator's lawyer called my attempt to free him from the facility “a criminal scheme”. In a July 2022 video, filmed by the administrator as if he were an object, he still asks to leave, return home and see loved ones. Then he faded away.

There were no assets to protect. I was better off and paid everything. An administrator who said he “enjoyed total control” destroyed two lives: his, ending in an RSA, and mine, spent for years fighting merely for the right to hold his hand.

One final “gem”: when I finally discovered his facility, I went believing I could see him. I was assaulted, beaten and expelled amid shouts of “criminal, we’ll have you imprisoned for life”.

Is any of this normal? What monstrosity has “support” become?

3.4 The business of pain: when protection becomes the kidnapping of family bonds

This is the story of my father, in a vegetative state for nineteen years after a serious accident. It is also the story of how, at a time of extreme vulnerability for our family, support administration was used, in our experience, not as protection but as a mechanism progressively isolating our father and his family.

When my father was fighting for his life after the accident, our family was still in shock. His brother then approached the court to be appointed support administrator. He was subsequently removed and replaced by an external professional, a young lawyer undertaking this role for the first time. We thought the change would bring balance and peace to management of the situation. Over time, instead, we felt decisions continued to be directed by the same people as before. Despite formal removal, our uncle continued influencing decisions about works, spending and our father's life. Beside him we perceived the constant presence of his trusted lawyer, a very well-known practitioner before the Court of Cassation, who in our view exercised influence so strong that it effectively reduced the officially appointed administrator's autonomy. We realised with dismay that a figure who should have been neutral appeared to execute decisions made elsewhere.

After one of the most recent hospital admissions, the guardianship judge suggested permanent placement in a care facility. Despite this indication, the administrator insisted on returning him "home". The place chosen, however, is a basement owned by our grandmother. We consider it unsuitable: damp, with mould and fungi, windows closed by bars and no real escape route. We have always maintained that these conditions were incompletely described in reports to the judge. During our father's years there, caregivers also abandoned him during earthquakes. My father has traumatic brain injury, is paralysed and completely defenceless. He spent about nine years in surroundings we always considered unsuitable for someone in his condition. In our perception, returning to that house allowed works and spending to be managed without outside oversight and kept the situation from prying eyes. Every request for basic medical care, such as dentistry to prevent infection, was interpreted as interference and even called "stalking". Despite the photographs and expert reports we submitted, the judge never carried out a personal inspection.

To understand what happened to our father, we must also look at our grandmother. After one of her sons died by suicide, she was devastated. A Cassation lawyer close to the family presented himself as a trusted supporter. Numerous property transactions soon began: gifts of houses, rapid land sales and ownership transfers. All occurred while our father was vegetative and unable to defend his rights. When we grandchildren sought support administration to protect her, we encountered major obstacles. After these transactions she was moved to an older people's facility about forty kilometres away. Her life there appeared very different from before. A once prosperous woman had no money for small everyday expenses and was sedated. Visits were rigidly controlled. We could not enter her room, meeting only in communal areas under supervision. When I requested medical records to understand her health, the facility called the Carabinieri and treated me as if I were acting unlawfully. The

judge appointed an expert to assess her understanding and volition, but the examination never occurred in the ensuing months before she died. The family never received the medical records.

After her death, succession proceedings began. Our father's administrator did not attend the opening of the will and even waived attendance by the notary appointed by the court in his interests. The inventory was prepared directly by the interested party in the property matter. We knew there was a ten-year limitation period for an action to reduce gifts infringing inheritance entitlements. At expiry a communication was sent to the administrator the day before limitation. According to our reconstruction, no action interrupted the period or protected our father's assets.

Beyond finances, the greatest harm was human. Formally our father lives at home, but actually he is surrounded by staff chosen by the administrator rather than family. In our experience they control our entry and create tension. We have often felt they act as a filter between us and him, preventing a spontaneous, affectionate relationship. Every decision was communicated as already settled, and we never genuinely participated. We were progressively treated as strangers, despite being his children.

When my mother protested about her husband's living conditions and inadequate care, her presence was described as interference. Her pain became hostility and her demands for dignity became disturbance. In our experience, even separation proceedings were initiated between our parents against their will. To us this is a profoundly intrusive intervention in family life and the relationship of spouses who never wished to separate.

Throughout this affair, the greatest loss is human rather than financial. My father is not an administrative file or assets to manage. He is a father, husband and man unable to defend himself. We ask only respect for his dignity and for our family to be part of his life again, without being treated as an obstacle. This testimony reminds us that behind bureaucratic decisions and legal acts are real people, wounded families and truths that cannot be buried either in a basement or in denied medical records.

3.5 Support administration as an instrument of family dispossession

For many years I handled my family's daily and administrative affairs. After my father's death I cared for my mother, who had a recognised disability, undertaking all practical tasks. I also assisted my sister, who had mild cognitive difficulties but was fully able to express her will. Precisely for that reason, years earlier she had granted me a general notarised power of attorney to represent her if her condition worsened.

Over time I also took responsibility for my seriously ill nephew, for whom I was appointed support administrator following a healthcare request. I performed that role for years, submitting regular accounts without any objection.

Matters deteriorated when, at a particularly vulnerable family moment, third parties began inserting themselves into my mother's and sister's affairs. External legal figures suddenly appeared, obtaining delegations and powers of attorney in unclear circumstances amid contradictory medical certificates. Some documents recorded cognitive difficulties; others, issued only days later, declared full understanding and volition, without any thorough independent assessment.

Faced with evident administrative irregularities, uncollected pensions and unusual conduct, I asked the guardianship judge to intervene and appoint me for my mother, respecting her earlier wishes and existing powers. From then on, a long sequence of proceedings progressively excluded me despite being the most involved relative and the persons' designated choice.

My applications, submissions, requests for expert assessments and financial checks remained largely unanswered. Instead, external administrators were appointed, ignoring valid notarised powers and the beneficiaries' expressly recorded wishes. Procedures became opaque: files difficult to access, missing documents and decisions without genuine adversarial participation.

Meanwhile every protective initiative became suspicious. Complaints reporting anomalies became criminal proceedings against me. Repeated criminal-law use had a clearly intimidating effect: defending myself required enormous financial resources, changes of lawyer, years of stress and isolation. Meanwhile the people I should have protected remained under administration, with dramatically reduced autonomy and access to their own money.

After my mother's death serious financial anomalies emerged: missing assets, unavailable sensitive documents and unexplained debts. Nevertheless, my sister's administration continued, leaving her materially and relationally neglected, with monthly sums insufficient relative to actual resources.

This showed me how support administration can become total substitution and exclusion of family relationships that do not align. I learned that criminal law is often used in these settings as a lever to “normalise” opposition to institutional decisions, while judicial oversight is weak or merely formal.

When someone is defined as “vulnerable”, the system tends to speak for them. If money exists, pressure increases. Those resisting risk discrediting, isolation and judicial action. This is not a sum of individual mistakes, but the predictable operation of an arrangement concentrating power, reducing safeguards and making fundamental rights extremely difficult to defend for those in non-contentious proceedings.

3.6 A protective measure becoming isolation: testimony on support administration

This testimony brings significant problems in support administration to attention, arising within a large family and concerning an older person with vulnerability and mild cognitive decline.

She led a simple life and wished to remain home surrounded by her children and grandchildren's affection. Some relatives, believing administration intended protection and support, offered cooperation and identified a potential appointee. However, the beneficiary and relatives attending the hearing were heard only generically; relevant information in the applicant's documents was not communicated. Neither could therefore properly challenge or assess the situation, preventing meaningful discussion and thorough contextual evaluation.

Only later did it emerge that what was presented at the hearing reflected a previously settled plan. Absence of genuine involvement gravely betrayed the beneficiary's and some relatives' trust.

Some relatives could have provided practical support from the start. This became possible only near the end of her life, until shortly before hospitalisation and death. In that phase she could have lived peacefully, respecting wishes and affectionate relationships. Instead, administrators, both family and external, proved harmful, with irreparable consequences for her and some relatives.

Over time the measure progressively became substitutive and coercive. She was excluded from fundamental life decisions. Predominant sedative treatment negatively affected alertness, autonomy and expression of preferences, accelerating weakening of remaining abilities.

Her relational autonomy was severely restricted. Meaningful family contact was discouraged, promoting emotional isolation and difficulty expressing disagreement. This tended to facilitate coercive choices, such as residential transfer against her will, which did not actually occur.

External management was opaque, intermittently present and contradictory in communication. Delayed and omitted daily-care payments forced relatives to intervene directly without formal recognition. The external administrator's appointment also obscured problems and irregular conduct by the predecessor, without effective protection.

In her final moments, relatives were denied health information. Although receiving medical care, she lived her final phase alone, without the affection that could have offered comfort and dignity.

In conclusion, administration deprived her of self-determination, meaningful relationships and dignified life. Structural problems include insufficient oversight, difficulty terminating the measure and a concrete risk of abuse and institutional abandonment. Oversight and protective institutions have a fundamental role in ensuring effective protection for vulnerable people. Without practical exercise of those responsibilities, the measure risks becoming institutional abandonment, with grave consequences for life and dignity.

In this sad affair, everything that should have ensured protection, listening and care progressively disappeared.

3.7 Protection failing through induced debt and human degradation

For eight years I watched my parents' dignity progressively collapse under support administration intended to protect them. Introduced after payment-management difficulties, its stated aim was preventing further debt. In practice it became constant deprivation.

After appointment they received an extremely small weekly allowance, inadequate for two older people and their pets. It barely covered food and ignored bills, medication, maintenance and emergencies. A paradoxical spiral followed: to survive they postponed payments or incurred small debts, then covered by my mother's modest pension. One person's sacrifices compensated for management failures that aggravated rather than solved problems.

Housing meanwhile deteriorated alarmingly. Safe heating was not addressed for years, forcing dangerous, expensive alternatives and escalating electricity bills. Widespread mould, non-compliant installations and malfunctioning sanitation created daily health risks and constant abandonment.

The gravest paradox was that a measure for orderly financial management also caused interruption of essential services. One delayed payment meant utilities disconnected, leaving them without electricity and gas for weeks. Supposed protection exposed them to further hardship and humiliation.

My mother died after years in these conditions. I now ask recognition that protection cannot mean hunger, degradation and lost dignity. A measure intended to help cannot deprive people of minimum means for humane living.

3.8 Ten years of institutionalisation: a mother reports her daughter's loss of rights and autonomy

I am the mother of a young woman who, already at eleven or twelve, showed symptoms of psychosocial distress resulting from events in which we were victims. I devoted my entire life to my daughter in every respect, undertaking long journeys and lengthy stays alone at the best treatment centres, with unimaginable sacrifices, simply to help her. We shared, and still share, an immensely strong affection and the knowledge that we two are a family. This gave her strength and the will to fight and succeed, certain of having beside her someone who not only loved her but cared for her as well as possible, supported and encouraged her, never giving up before adversity. Despite difficulties, her achievements were quite encouraging in several respects. Gradually, however, the initial distress developed into a genuine illness, now severe and, it seems, perhaps irreversible. Many years ago, against my wishes, she was deported and interned in psychiatric residential facilities by our local mental health centre, into whose clutches we had meanwhile fallen. It proved incapable and entirely unwilling to provide community-based psychiatry as legislation requires. For opportunistic reasons and sordid personal interests of its psychiatrists, particularly its director, more demanding cases are sent to extremely restrictive, falsely “rehabilitative” facilities, preferably outside the region, as happened to my daughter. She has been segregated there FOR TEN ENDLESS YEARS, subjected to every kind of abuse, deprived of dignity and every right, ignored and forgotten by all institutions, and treated purely as business by private operators. With public money and institutional approval, these operators created excessively inhuman places of psychiatric detention, sometimes for life, which institutions at every level never trouble to inspect for compliance or quality. In these self-styled psychiatric “rehabilitation” facilities, including hers, perpetrators of extremely serious offences, following OPG closure and insufficient REMS capacity, live alongside people with drug dependence and psychiatric patients who have never offended.

It is impossible here to give even a minimal account of the hell in which my daughter has been forced to survive for TEN YEARS, bombarded with tons of psychotropic drugs and without the slightest contact with the outside world. Above all, this became possible through appointment six years ago of an external administrator whose only interest is “lightening” the so-called beneficiary's bank account and keeping her in that place of every kind of abuse, to the satisfaction of all institutions, foremost the improperly named guardianship judge. Six years ago, despite my daughter's letter requesting her mother, myself, as her natural and logical support administrator, and numerous incontrovertible documents demonstrating my psychological, physical and moral integrity and complete ability to undertake the task, merely continuing years of total dedication to her assistance and care, the judge appointed an external administrator indefinitely with exclusive powers, without ever “hearing” the so-called beneficiary.

The administrator lives more than 200 kilometres from where my daughter is confined. In six years she has glimpsed the so-called beneficiary two or three times, on formal occasions following formal legal applications I submitted. For THREE ENDLESS YEARS she prevented me meeting my only daughter, who, segregated, isolated, exiled and deprived of

everything, even her mother's affection, sank meanwhile into today's severe illness, amid extreme indifference and negligence by all formally responsible for her care and custody. In agreement with facility staff, the administrator openly monitors every word during our rare, extremely brief calls. She has never engaged with the beneficiary to learn her needs and aspirations.

My daughter has also been made physically ill. She had to undergo major surgery removing the entire left ovary and fallopian tube because of a large tumour. Its symptoms and a specialist's clinical instructions were obstinately and irresponsibly disregarded by the administrator, guardianship judge, referring CSM doctors and facility, despite my many urgent applications to all. During the years I could not meet her, I recognised from afar how much my beloved daughter also suffered physically and formally requested examination and necessary investigations. Every request, even the most heartfelt, was ignored and disregarded. Despite grave, undeniable criminal responsibilities for her ordeal and current serious mental and physical health, judge, administrator, CSM and facility escape accountability; they evidently expect to escape it as they arrogantly continue unchecked and uncensored. Although I repeatedly considered reporting them and seeking justice, I have so far refrained because I no longer trust the judiciary. I would risk intensifying the anger, profound frustration and injustice gripping me.

For about two years, offices handling non-contentious proceedings have prohibited electronic-file access even to beneficiaries' closest relatives. This confirms that even parents, the mother in our case, are nobody, nonexistent and erased, while any decision can be made undisturbed and with impunity at the expense of beneficiaries and relatives deeply concerned for loved ones' health and fate. Any lie can be written about those relatives without their being able to defend themselves or even exercise adversarial rights. Meanwhile the administrator takes numerous sums from my daughter's account without oversight by the judge, who protects only the administrator. The judge does not know my daughter, has never wanted to know her and has never met her in over SIX YEARS!

With my own money, many sacrifices and personal privations, I meticulously meet all expenses for my daughter, especially the largest, while the external administrator "pockets" money without the slightest trouble, even in the face of the gravest harm caused. Even banks seem complicit with predatory, dishonest external administrators. Statements no longer arrive at my daughter's registered address, as is also true for other beneficiaries according to various testimonies. Before the external appointment, the bank punctually sent quarterly statements; afterwards they gradually dwindled and disappeared last year, remaining absent today. I have much more to say, but to avoid prolonging this further I conclude without a shadow of doubt: the unfortunate people absurdly handed to unscrupulous external administrators with exclusive, substitutive powers, and their relatives, cease to be persons and become slaves of a state that steals and destroys their dignity, constitutional rights, mental and physical health, and possessions!!!

3.9 Nine months in proceedings: when a support administration application becomes a cage

Everything began in April 2024 after hospital admission, when I received a court summons concerning possible appointment of an administrator on the initiative of someone outside my family.

Proceedings could have ended in about two months; instead the judge prolonged them to nine.

At the first hearing, with all my relatives present and opposed, the judge referred the decision to the public prosecutor.

At the second hearing in June the prosecutor attended, heard me and withdrew, considering the case could close. Nevertheless the judge ordered another psychiatric assessment, finding the withdrawal insufficient.

My lawyer then filed a defence submission demonstrating my full ability to meet ordinary and extraordinary needs, citing relevant case law: Civil Court of Cassation, First Section, order No. 32542 of 4 November 2022; Genoa Court of Appeal, Third Section, decree No. 168 of 24 March 2023; Civil Court of Cassation, First Section, order No. 29981 of 31 December 2020.

At the third hearing, still dissatisfied with the psychiatrist's assessment, the judge ordered a court-appointed expert report (CTU).

To protect myself I also appointed a party-appointed expert (CTP), allowing comparison. I paid both entirely myself.

Both concluded there was no reason to appoint an administrator.

At the 31 January hearing the prosecutor attended again, exclaiming:

“What are you still doing here?!”

The judge then closed proceedings.

For nine months I felt caged, living without enthusiasm, constantly wondering how I would cope and what would happen if the decision went against me.

My relatives also endured continuous tension, considering it profoundly unjust that an outsider could determine another person's protection and future.

3.10 From independent life to an RSA

This testimony is told from the perspective of a sister appointed support administrator with exclusively administrative responsibilities.

The person concerned, an adult woman, had shown behavioural difficulties since adolescence and received psychiatric diagnoses over the years. She lived with her parents for a long time, undergoing numerous brief psychiatric admissions, each followed by return home. Despite difficulties, the family environment always provided a stable point of reference.

In adulthood she was offered placement in a residential facility outside her local area because no places were available locally. It was her first experience of permanently living away from home. There she experienced greater autonomy: participating in activities, developing relationships with other residents and widening social skills, overcoming the isolation experienced within the family. After some years she moved to a facility nearer the family, remaining for a long period with positive outcomes in relationships and daily life.

Nevertheless, the mental health department decided to end the pathway, considering possibilities for further improvement exhausted. A supervised shared-living project for several vulnerable people was proposed, with a single external administrator for all beneficiaries. She initially accepted. Later, without clear explanation, she was excluded and her sister appointed administrator instead.

Following exclusion, she was discharged from the psychiatric facility after years of residence and returned to her parents, now elderly and seriously ill. From then on, social services proposed only an older people's nursing home/RSA, despite her age and a psychiatric condition requiring appropriate therapeutic surroundings.

Fully able to express herself, she clearly and repeatedly refused an older people's RSA. She requested a facility appropriate to her distress, with psychiatric support and opportunities to relate to people her own age. Her family supported this request. Nevertheless, her wishes were systematically ignored.

A lengthy conflict began between the person's and family's wishes on one side and the social worker's and guardianship judge's decisions on the other. The administrator repeatedly reported serious vulnerabilities: previous suicide attempts, major physical illnesses and an extremely high health risk. These were met with indifference.

Over the following months the administrator was repeatedly threatened, verbally and in writing, with removal unless she accepted RSA placement, openly violating the beneficiary's will. Legal protection thus became an instrument of imposition rather than support.

During the Covid-19 pandemic, despite extreme risk and lack of adequate protection, no suspension or reassessment was considered. She was forcibly placed in a nursing home before sixty.

A few months after admission a Covid-19 outbreak developed, linked to serious failings in safety-protocol management for which judicial proceedings were reportedly initiated. She

became infected and died in isolation, without loved ones beside her and without meeting the nephew who would be born shortly afterwards.

In subsequent years, her sister unsuccessfully sought further examination of the reasons behind decisions so damaging to wellbeing. Documents show RSA transfer shifted costs from public healthcare to the person and family. The suspicion remains, never investigated, that economic considerations prevailed over protection of rights.

This experience profoundly questions the meaning and actual use of legal protective measures. An instrument created to protect became denial of will, self-determination and finally life itself.

3.11 Support administration ordered without hearing the person: eight months of proceedings and an expert report ruling out its necessity

I write as the mother of a young adult for whom a support administrator was urgently appointed.

The case arose from a report by community mental health services which, as I later learned, apparently reached the public prosecutor on the basis of information and statements from family members and third parties involved.

Despite what services claimed, I had made no report against my son. Instead, they had contacted me earlier at an elderly relative's initiative. I attended two interviews in which I simply described some difficulties in the post-pandemic period. I never mentioned dangerous circumstances or wrote or signed any report. I later told them my son had begun voluntary psychological support and I did not consider their intervention necessary. From then on I had no further contact.

Meanwhile my son showed clear improvement. He gradually resumed going out, travelling and social activities. Nothing in the daily life we shared indicated serious deterioration or inability to manage his interests, as services instead described to the prosecutor.

Much later, about two years after that contact, I received an email from a lawyer informing me he had been appointed my son's provisional support administrator under an urgent guardianship judge's order.

The order had not even been served. We received no prior notice and my son had not been heard before the decision. Neither I nor my daughter, who lived with him, had been heard. A hearing had taken place without notifying any of the three of us, not even the person directly concerned!

The order, which I saw only later, used expressions such as “severe social isolation”, “poor self-care” and “severe psychophysical deterioration”. I did not recognise these descriptions and, in my view, they did not match what I experienced beside my son every day.

As a mother, what struck me most was imposing such an intrusive measure without first hearing him. Reading a portrayal so far from the reality I knew gave me a profound sense of helplessness.

It was equally painful to be identified as the “reporting person” for a situation I had never described in the terms appearing in the records, as if my words had become something different from what I actually expressed.

Added to this was the financial burden of legal expenses to bring out the truth and challenge what, in my eyes, was neither pathological nor dangerous, but a personal situation requiring support and listening without substituting my son's will.

Although the order had not yet been formally served, the administrator began requesting my son's personal documents, possible bank-account information and GP details, also insisting on a home visit with healthcare staff.

We appointed a new lawyer. The one initially chosen considered opposition unnecessary, but I then discovered he was himself a support administrator. The new lawyer challenged the order and requested suspension of its effect. Nevertheless, the administrator continued pressing for visits and meetings, even threatening police involvement if access to our home was prevented. All this happened over Christmas.

A hearing subsequently took place at our home. My son spoke calmly and coherently with the judge, describing activities, trips and relationships.

Despite this, a subsequent order required a court-appointed expert assessment, healthcare services involvement and continued provisional administration. My son was described as “severely emaciated” and I was admonished to cooperate. Although confronted with someone different from the person described, the judge evidently struggled to retrace his steps. Perhaps the expert assessment offered a way out of a dead end, but admitting error would have been better than prolonging this painful affair another six months.

The expert assessment is particularly important to reconstructing events because the judge posed very specific questions. The expert was not asked generally to assess my son's condition, but to establish whether a psychopathological state impaired understanding and volition and prevented management of interests, or exposed him to abusive third-party influence.

The expert also had to determine whether my son could independently manage money, assess expenditure, critically choose whom to trust, and care for health and assets. Only if lack of autonomy was found should the expert specify daily acts he could not independently undertake and whether assistance would suffice or substitution by an administrator was necessary.

The conclusion was unequivocal.

After examining records, undertaking the necessary investigations and acquiring and assessing relevant documents, the expert concluded “with a high degree of certainty” that my son had no psychopathological condition impairing understanding and volition, preventing care of his interests or exposing his volitional processes to abusive influence.

The expert further considered him “entirely capable”, in terms of mental ability, of independently managing money, assessing expenditure against needs and available resources, critically choosing whom to trust, and caring for health and assets.

Following this finding, support administration ended.

For us, this was deeply significant. The technical assessment requested by the judge himself excluded precisely the conditions that could justify restricting self-determination and requiring an administrator.

Nevertheless, the experience left profound bitterness and helplessness. My son suddenly found himself in proceedings portraying him as incapable and needing protection, based on

statements by people who did not know him at all: the reporting services had never met him. He had not even been heard beforehand to explain his own situation directly.

I also felt accused of helping trigger a mechanism I had never wanted to initiate, as services claimed in their report to the prosecutor.

I do not question protective instruments for people genuinely needing them. But such an intrusive measure must rest on concrete, current and individual assessment of abilities, with the person's will heard and taken seriously. Applied as in this particular case, protection represented only unjust restriction of constitutionally guaranteed rights and fundamental freedoms. The whole affair deeply traumatised our family, foremost my son: for eight months we were literally at the mercy of an absurd system seemingly unwilling to hear reason and continuing to act disconnected from reality.

The expert conclusion and subsequent termination confirm an important principle: personal difficulties or suffering cannot automatically become inability to self-determine or manage one's interests. Moreover, because these measures are highly invasive, every safeguard must be respected. Applying the law would have sufficed: hearing the person before deciding. Here, a young man's and family's lives were put through a meat grinder with extreme carelessness.

I write so there remains a record not only of our family's difficulties but also of how important it is to verify concretely, through listening and adequate investigation, whether protection is truly necessary, proportionate and justified by current circumstances.

3.12 A collection of support administration cases received by the association

The following report, received by the association, collects and connects several experiences concerning support administration. It is reproduced as testimony and a contribution to documenting reported problems.

This report seeks to bring the reality of Law No. 6/2004's application in Italy to public attention.

Law No. 6 of 2004 was not announced by any television news programme. It began quietly and progressively spread nationally. Jurist Paolo Cendon decisively contributed to its development and promotion, first drafting the support administration project in 1986 and developing it through a long legislative process culminating in 2004. The law was introduced, we were told, to reduce full and partial legal incapacitation and offer people alone and in difficulty support with assets, utilities and taxes after unfortunate events.

In reality things are quite different, but I shall turn to concrete examples.

Marco, around ten years ago, was assisted and taken to hospital after a domestic accident. Because of his fondness for wine, not spirits, in a local setting where his generation widely shared a wine-drinking culture, he was labelled alcoholic and referred to Ser.D addiction services. He was offered an administrator for bill payments during “social recovery”. We are talking about a man who always worked and never had problems of social adjustment. Seeing things presented in this rosy sauce, if you will forgive the expression, Marco enthusiastically accepted, only to discover he could no longer access his substantial pension in any way, could no longer even support a kitten and had no contact with the administrator, who nevertheless received substantial annual remuneration from the “beneficiary's” account.

Today Marco is confined in an RSA, desperately but methodically trying to leave. He takes initiative, has not drunk for years, found an apartment and underwent every Ser.D check. With walking problems caused by previous osteomyelitis, not chronic alcoholism as apparently recorded, he even found a housemate as demanded by those now controlling his life as a conscious adult. They delayed: MONTHS. The apartment fell through. He is over seventy and fully aware of his actions.

Only resignation or despair remain because he does not want to end life this way. He sees NOT ONE CENT of his pension. Everything goes to the facility. He relies on friends' CHARITY for a coffee or cigarette, despite receiving around EUR 1,780 monthly WHICH HE NEVER SEES. Recently the administrator forgot the RED income declaration, so Marco receives less than when managing his affairs alone.

Giulia died last year after her administrator confined her in a facility and put her home up for sale. Widowed and living alone, she was nevertheless protected by TRUSTED friends and relatives. After the unfortunate COVID period she had a serious heart attack and no one could accompany her in the ambulance. On arrival, social services intervened before even the doctors, taking personal effects, keys and naturally her BANK CARD, entering her house and clearing it in every sense, and requesting administration. Once recovered, she was told

everything was in her hands and she could say at a very simple hearing (sic) that she did not need the measure.

Years of pleading, tears and despair passed. Giulia was a former operating-theatre nurse with a beautiful home and excellent pension. She died confined to bed, broken-hearted after her house went up for sale. Relatives and friends tried to intervene with social services but were INTIMIDATED and TURNED AWAY. Certainly she was over seventy, diabetic and had had a heart attack, but she was not alone and had a social life and resources. She died in a bed where she had been confined for years without adequate rehabilitation, spending her final months in a facility while her home was sold.

Elena was overweight and not particularly well integrated socially. She lived with her mother. Placed under administration, she died within months. Her mother is still alive; no one has seen her since, and she too is under administration.

Teresa had an argument with her daughter and a neighbour reported the colourful exchange. Mother and daughter were removed, taken to hospital and separated. The daughter was confined in SPDC, leaving after only three days after requesting and obtaining a conversation with a doctor from whom she concealed no detail. Meanwhile her mother was placed under administration.

The daughter's situation quickly became clear. Her mother, an entirely lucid eighty-eight-year-old, requested a lawyer and immediately opposed. But her bank account was seized and she never saw her pension again before dying broken-hearted at ninety, after eighteen expert assessment sessions and learning they would never leave her alone. Meanwhile her daughter, myself, had secured her return home, shouldered everything and faced police checks as if she had committed crimes. Proceedings continued. The two women, we, were united and determined, but the judge played for time and began saying that at ninety “a person can no longer look after themselves alone”.

I therefore suppose the intention is clear: progressively placing anyone no longer as they were at twenty or thirty under administration.

Laura is a teacher on temporary contracts, left alone after her mother's death and prey to a caregiver's legal warfare. To escape it, she was left without money to pay succession costs. She is overweight, alone, penniless and unable to maintain her home, feels shattered but maintains a social life. Now, following a stranger's “solidarity”, she is confined in psychiatry, under administration and decides nothing about herself.

I should also mention a man hospitalised for a broken leg who found himself under administration as “unable to assess risks”, at only seventy-seven, or two unmarried, elderly, very wealthy sisters persuaded to appoint a trusted administrator. Then that trusted person grew tired and resigned, but they did not become free again, NO: the JUDGE appointed a lawyer. Both died without recovering dignity and freedom.

All these people share one thing: none was without assets; all lost access to their property.

Given a far larger number of cases than one might imagine, and that PEOPLE DO NOT COME OUT ALIVE from this PROTECTIVE MEASURE, one wonders whether this is

another expression of “YOU WILL OWN NOTHING AND BE HAPPY; I WILL LOOK AFTER YOU”. No, thank you.

That is why television news stays silent: we are ALL at risk. An emergency department visit suffices; they do not even warn you. Notices arrive too late in a manner I dare call fraudulent. I consider it important to inform as many people as possible of this deadly danger hanging over everyone.

Meanwhile my doctor's office confirms a steady increase in newly “administered” people.

3.13 M's story

M was twenty when she was removed from her life and confined against her will in a facility called a “group home”. The expression evokes protection and care, but her experience meant something entirely different: isolation, loss of liberty and erasure of personal will.

She had just completed secondary education with a psychology and education focus and wished to attend university. She had plans, aspirations and a life ahead. That life, however, ended long before her physical death: eleven years earlier.

Her story unfolds in southern Italy and exemplifies a mechanism affecting thousands of young people: the combined use of psychiatric diagnoses, support administration and residential placements that effectively become indefinite detention.

M approached community services seeking to be heard about relationship and family difficulties. She was not asking for hospitalisation or deprivation of rights. Rather, she rejected an exclusively pharmacological response to her problems.

That refusal was interpreted as a symptom.

Soon afterwards she received a court notification: support administration proceedings had begun. She clearly opposed them. Before the judge she explained that she lived independently, attended school, had social relationships and did not wish to take psychotropic drugs because they made her dull, confused and unlike herself.

Those words were not enough.

Without a party-appointed expert assessment or independent investigation, an administrator was appointed. The order spoke of “severe behavioural disturbances” and “psychotic manifestations”, a definition not corresponding to clinical reality but paving the way for irreversible decisions.

Within months M was placed in a “group home”. She had just turned twenty.

From then on, transfers between facilities, repeated hospital admissions and unrelenting, often sedative medication followed. She tried to escape, fleeing kilometres on foot. Each time she was found and returned with police assistance.

Official reports spoke of “unauthorised departures”, “agitation” and “poor adherence to the programme”. They never mentioned her constantly, lucidly expressed wish: she did not want to be there.

Outside contacts were limited, obstructed and sometimes denied. Even a simple greeting depended on administrator authorisation. Visits were prevented and telephone calls monitored. Every word M spoke was reinterpreted, rewritten and reversed in staff reports.

Outside testimonies describe a sad, isolated girl forced to take medication against her will. A young woman asking only to be heard.

Over the years she repeatedly sought help. She tried to secure termination of administration or at least replacement of the person deciding for her. She requested independent assessment.

She asked to choose. She rejected medication, reporting how it altered her body and mind. She expressed fear of the environment where she was forced to live.

These requests too were rejected.

Her will, though clearly expressed, carried no weight.

After eleven years between facilities and hospitals, M died at thirty-one following massive ingestion of psychotropic drugs. An extreme act arising amid desperation, segregation and no prospects.

Yet her life had been broken much earlier: the day her right to decide was taken away “for her own good”.

M's story is not an exception. It results from a system which, while professing protection, allows endless institutionalisation based on decisions made for people, against their will, without genuine possibilities of leaving.

It profoundly questions legal protective measures, support administration and residential facilities when they become instruments erasing identity and personal liberty.

M did not ask to be saved. She asked to be heard.

4 Security measures

4.1 Psychiatric security measures: the persistence of the social dangerousness paradigm

The closure of forensic psychiatric hospitals (OPG), initiated by Law No. 81 of 2014, was presented as a historic turning point in overcoming institutions that, for decades, had been among the most dramatic settings for the denial of the rights of offenders subjected to psychiatric security measures. The residences for the execution of security measures (REMS), established to replace the OPGs, were intended to mark the transition from a custodial approach to a model centred on care, the temporary nature of the measure and respect for personal dignity.

More than ten years after the closure of the OPGs, however, it is increasingly clear that moving beyond asylum institutions has not meant moving beyond the legal and cultural paradigm that justified their existence. Social dangerousness, introduced by the Rocco Criminal Code of 1930 and still central to the security measures system, continues to permit restrictions on personal liberty based not on current behaviour but on predictions of future conduct considered potentially dangerous.

The current psychiatric security measures system rests on the interplay of two particularly controversial concepts: assessment of the person's ability to understand and exercise volition at the time of the act, and prognosis concerning future social dangerousness. Although both assessments have extremely serious consequences for personal liberty, they inevitably involve margins of uncertainty and discretion.

Contemporary scientific research has progressively challenged the idea that a psychiatric diagnosis makes it possible to predict a person's future behaviour with sufficient reliability. Diagnostic categories currently in use are primarily descriptive and do not establish a certain causal relationship between a diagnosis and a particular act. Numerous studies have shown that most people with severe psychiatric diagnoses do not engage in violence, and that violence risk is strongly influenced by social, relational, environmental and biographical factors extending far beyond membership of a diagnostic category.

Despite these problems, the security measures system continues to operate through a mechanism radically transforming the person's status: they are simultaneously considered not fully responsible for their actions and, precisely for that reason, subjected to restrictions on liberty potentially longer than the punishment prescribed for the offence.

Within this framework, diminished criminal responsibility deserves particular attention. A person found to have partially impaired understanding and volition receives a reduced custodial sentence on one hand and a security measure based on predicted social dangerousness on the other. Consequently, while a fully responsible offender generally receives only punishment, a person with diminished responsibility may face both the reduced sentence and a security measure. This can mean an overall deprivation of liberty longer than that experienced by an offender without a psychiatric diagnosis. Far from providing a

safeguard, a finding of diminished responsibility thus risks becoming the basis for increased control and prolonged restrictions justified by intrinsically uncertain prognostic assessments.

The risk concerns not only the transformation of these measures into genuine “white life sentences”, indefinite confinement made possible by absent or merely formal review of psychiatric dangerousness, but also the constitutional legitimacy of double punishment: prison first and a security measure afterwards. This sequence reproduces the so-called dual-track system introduced by the Rocco Code and calls into question the equality principles enshrined in Article 3 of the Constitution. This anomaly does not affect only persons with diminished responsibility: fully responsible offenders may also remain subject to further dangerousness-based security measures after serving their sentence, such as assignment to an agricultural colony or workhouse, making the legal response longer and more onerous than the punishment formally imposed. This section nevertheless focuses on psychiatric security measures, where the dangerousness paradigm connects more directly with diagnosis and restrictions on self-determination.

The closure of OPGs has also produced what might be described as a transformation of forms of control rather than their elimination. Asylum detention has been replaced by new restrictions on personal liberty, often less visible but not necessarily less intrusive. Alongside REMS, non-custodial measures are increasingly important, particularly supervised liberty, which may in practice entail residence requirements, forced stays in therapeutic communities, imposed or heavily pressured medication, continuous monitoring and repeated assessments of social dangerousness.

As we have observed in our association's work, the risk is a genuine “fraud of labels”: the names of institutions and measures change, but substantially similar dynamics of control, dependence and restricted self-determination may remain. Internment becomes a “therapeutic programme”, custody becomes “care”, and coercion is redefined as “protection”, while the person continues to experience loss of freedom and the ability to decide about their own life.

The testimonies collected in this dossier reveal another critical aspect: a tendency towards institutional chronicity. People subjected to security measures describe pathways lasting years, sometimes decades, characterised by loss of employment, emotional relationships, financial resources, opportunities to plan the future and, progressively, social identity itself. Staying in residential or community facilities, often with prolonged medication and repeated dangerousness assessments, can become a pathway from which escape appears increasingly difficult.

The following testimonies show another recurring element: people perceive that they have lost not only personal liberty but also the opportunity to be heard, believed and recognised as holders of rights and responsibilities. A finding of lack of criminal responsibility and the consequent attribution of social dangerousness can dispossess a person's subjectivity, progressively denying participation in decisions about their life.

This section does not seek to deny the complexity of situations leading to security measures or underestimate the need to protect the public. Rather, it promotes critical reflection on the current system's compatibility with constitutional principles, the UN Convention on the

Rights of Persons with Disabilities (CRPD), and the latest scientific understanding of mental health, individual responsibility and self-determination.

The testimonies in this dossier do not represent only individual experiences. They expose a system continuing to permit restrictions on liberty grounded in controversial diagnostic categories, intrinsically uncertain forecasts and a concept of social dangerousness whose scientific, legal and ethical legitimacy is now more than ever disputed.

The following pages give voice to people who, despite differing journeys, share the experience of feeling deprived of the opportunity to decide about their life and future.

4.2 When a community becomes a form of detention

Everything began in 2020, when serious conflict arose with neighbours who accused me of alleged harassment. Over time the atmosphere became increasingly tense, culminating in a particularly serious episode in which a neighbour physically attacked me with a car jack inside my home.

The neighbours subsequently filed a complaint against me. A psychiatric expert assessment was ordered in the proceedings which, in my view, relied essentially on their statements and attributed psychiatric illness to me.

After the assault I approached the police to report what had happened. Instead of taking my complaint, they accompanied me to SPDC, where I was admitted and immediately restrained, although I was calm and my leg was swollen and painful from the neighbour's blows with the iron bar. Doctors told me restraint was necessary because I was not a known patient. I remained tied to the bed for three days. My family was allowed into the ward only after twenty days. I spent two months in SPDC altogether, because they had to find the community requested by the prosecutor's consultant.

This consultant came to the police station on the very morning of the argument. The previous week officers had delivered an invitation at home to attend police headquarters alone. They did not tell me this consultant would be waiting to carry out a psychiatric assessment.

Criminal proceedings followed. I felt that attention focused from the outset primarily on the presumed psychiatric disorder, supported by numerous consultations and assessments. My family, particularly my mother and sister, was effectively excluded from the process. The CPS asked the judge for a provisional administrator because it considered them oppositional and obstructive.

In the first community, two violent patients and two staff members assaulted me, and I had to go to the emergency department. I filed a complaint against staff and was sent back to SPDC for another three months awaiting a new community placement.

The second community was worse: complete deprivation of every freedom. We were kept confined inside and forced to sit all day. Some were beaten by staff even in wheelchairs. For a week I had lower back pain but was not allowed to lie on my bed outside designated hours. The rules were prison-like. I never kept my mobile: it was immediately confiscated. Calls to relatives were three per week, on weekdays, ten minutes each, using the community phone under the psychologist's supervision.

After I reported this community too, I was once again returned like a parcel to its sender to SPDC. This time I was parked there for seven and a half months before placement elsewhere. It was certainly a form of punishment.

In 2025, after I had already spent a long time in a therapeutic community, I was found to have committed stalking, threats and bodily injury against the neighbours. At the same time I was declared unable to understand and exercise volition, and socially dangerous.

The security measure of supervised liberty followed. In my case, however, it did not take its ordinarily envisaged form, but required residence in a therapeutic community, a condition continuing for years which I experience as a genuine restriction of personal liberty.

My greatest wish is to return to my family, with whom I maintain deep, affectionate bonds. I am convinced that in a peaceful, welcoming family environment I would have greater opportunities to rebuild my life and responsibly address what happened. I still have many years ahead and believe I deserve the chance to demonstrate that a different pathway is possible.

4.3 Security measures and coercive pathways

The person's security measure was executed in two different facilities over two years.

The first year was spent in a ReGIA, a residence for young adults, from which there was no possibility of leaving. The second was spent in an “open” psychiatric residence, where the person could go out for an internship agreed with the facility.

Towards the end of the second year, the person left without authorisation. Police subsequently located them and they were admitted to SPDC, awaiting information on how the security measure would continue.

During both placements there were several admissions to SPDC and a publicly contracted private clinic, generally following episodes termed “psychomotor agitation”. These arose particularly during discussions about antipsychotic medication, which the person refused for fear of adverse effects previously experienced.

The measure was initially ordered for one year and subsequently extended for another by the sentence-supervision judge.

Its origin was a parental complaint of “family maltreatment”. The complaint described family conflict between ages eighteen and twenty-five involving verbal aggression, threats, demands for money, destruction of objects and occasional physical contact.

The person had already undergone a first TSO at eighteen and entered community services. Further admissions followed, including TSO. During this care, they never became genuinely convinced of medication's usefulness, especially because of mental dulling, lost vitality and concentration difficulties.

After the complaint and another admission, a court-appointed expert diagnosed schizophrenia, finding the person unable to understand and exercise volition at the relevant time and socially dangerous, also because of medication refusal. Earlier diagnoses, however, had differed: psychosis, personality disorder and substance use disorder.

During residential placement the pathway appeared strongly centred on mandatory medication, often imposed against the person's will. Requests to stop or change it because of adverse effects generated staff conflict and further admissions.

In the second year, despite rehabilitation activities, medication-related coercion remained.

Staff subsequently reviewed diagnosis, excluding schizophrenia and diagnosing personality disorder. Nevertheless, treatment refusal was often interpreted as “lack of awareness of illness”. In some documents the judge explicitly imposed a duty to take prescribed medication.

After two years there are no significant improvements in living conditions. On the contrary, the reported experience is injustice, no escape and coercion and destruction, with thoughts of death and profound distrust of psychiatry and institutions.

At the end of the second year, a further extension of the security measure is contemplated.

4.4 Thirty years of psychiatry ending in a security measure

For over thirty years I have lived with the consequences of a psychiatric pathway which, in my view, compromised my health, employment, relationships and personal liberty.

In 1994, on relatives' advice, I voluntarily approached psychiatric services. Some years later I began fluphenazine and subsequently Moditen Depot, treatment continuing for over twenty years. I already had hepatitis C and, in my experience and belief, the medication contributed to worsening liver disease. In 2021 my cirrhosis became macronodular. I consider it particularly serious that despite hepatologists recommending the lowest possible dose and less hepatotoxic drugs, I was prescribed treatment I consider even more damaging to my liver.

Over the years I underwent numerous admissions and TSO orders. I lost five jobs, three in Italy and two abroad. The financial consequences made it impossible to meet legal costs needed to continue action against psychiatric services. I progressively felt deprived of the means to defend my rights and challenge decisions I considered unjust.

In 2020, after drawing services' attention to material critical of the pharmaceutical industry and expressing objections to treatment, I underwent TSO lasting all of June. My distrust then increased further. Over the years I developed intense fear of admission and coercive practices, associating sirens and medical vehicles with the risk of another TSO.

Meanwhile, support administration brought additional difficulties. The administrator did not pay regularly and was often difficult to contact. On several occasions I had no money and faced practical problems I could not resolve. In this growing desperation, I damaged the administrator's office door. I have never physically assaulted anyone, but felt intense anger and frustration after years of conflict with services and progressive loss of autonomy.

In 2022 I underwent prolonged TSO followed by placement in a psychiatric therapeutic rehabilitation community (CTRP). I spent almost three years in a type A facility and have been in a type B CTRP since March 2025. A measure related to social dangerousness assessment remains in force, requiring residence until 2027.

During community placement I received depot medication and now receive Clopixol every twenty-eight days. The physical consequences I attribute to treatment, particularly concerning liver disease, cause constant suffering. I also fear that treatment may further aggravate a condition I already consider severely compromised.

Throughout life I developed personal studies and research I consider important. I believe these interests and convictions were interpreted as pathological manifestations, contributing to a psychiatric diagnosis I have disputed for years.

Today I feel progressively deprived of the opportunity to decide about my life and future. Above all, my testimony arises from a request that others not have to experience anything similar. In my view, too many people suffer extremely serious consequences from imposed treatment and pathways without their voice being genuinely heard.

5 Conclusions

5.1 Structural mechanisms of abuse

Taken together, the cases presented in the different sections of this dossier do not appear to be entirely isolated incidents. Testimonies collected in different areas and settings reveal recurring mechanisms through which instruments originally intended for care, protection or security can in practice restrict autonomy, personal liberty and the person's ability to influence decisions concerning them. The dossier does not claim to establish individual professionals' responsibility or the statistical frequency of particular conduct on testimonies alone. Rather, it highlights recurring patterns deserving verification and action at institutional level too.

5.1.0.1 An excessively low threshold for intervention

One recurring element concerns the circumstances preceding TSO, support administration, admission or a security measure. In several cases, people describe institutional intervention initiated amid family conflict, supposedly non-conforming behaviour, refusal of medical treatment, emotional or relationship difficulties, or situations considered difficult to manage.

The problem is not necessarily the lawfulness of each intervention, which must be assessed against facts and documents in the particular case, but the risk that broad, subjective or insufficiently verified judgments become the starting point for significant restrictions on liberty and autonomy.

When disagreement, difficulty or supposedly problematic behaviour is directly interpreted as proof of incapacity, dangerousness or need for protection, a particularly serious transformation occurs: the very condition that should be heard and understood becomes the reason for restricting the person's rights.

5.1.0.2 Medical knowledge as an instrument of power

A second mechanism concerns the role assigned to psychiatric assessment. Some people describe diagnosis not as one element helping understand their situation, but as an instrument determining in advance the meaning of everything they will subsequently say or do.

Once a diagnostic label is assigned, protest can be interpreted as a symptom, a request for help as manipulation, disagreement with treatment as inability to understand one's interests, and an attempt to challenge a measure as further confirmation of the condition leading to it.

A circular mechanism thus develops: the more a person protests to defend freedom, the more that protest risks being interpreted as proof of inability to exercise it. Specialist knowledge can thereby acquire a function beyond healthcare and become an instrument devaluing the person's words precisely when they try to oppose restrictions on rights.

5.1.0.3 Erasure of the person's will

Another recurring element is the gap between expressed wishes and decisions taken. Formally, the person's will should be central to decisions about life, health and relationships. Instead, testimonies describe people clearly stating what they want while their decisions are replaced by what relatives, professionals, administrators or authorities consider to be in their interests.

As this mechanism consolidates, protection risks becoming substitution. People are no longer enabled to exercise rights with necessary support, but progressively deprived of decision-making while others interpret their will and interests.

The problem therefore extends beyond a single decision contrary to wishes to a model in which the person's will progressively loses value precisely because they are deemed incapable of expressing what they truly want.

5.1.0.4 The system's irreversibility

Finally, many testimonies describe difficulty leaving institutional pathways once initiated. Entering support administration, psychiatric admission, residential placement or security measures can create a situation where every subsequent request for change is assessed within the very system that produced or maintains the measure.

In some accounts, opposition is perceived as further confirmation of the need for control; requests for termination or reduced restrictions become lengthy, complex processes; people struggle to recover full control over decisions, relationships, home or finances.

The system thus risks becoming self-referential: it controls, assesses and judges the very person under its control, making a genuinely independent assessment of necessity and proportionality particularly difficult.

What emerges is therefore not merely possible individual errors, but a need to question the overall operation of instruments that, without sufficiently clear limits, effective safeguards and independent oversight, can produce segregation, social isolation, loss of asset control and restriction of fundamental civil rights.

A zone develops in which people may not be formally detained yet may not feel genuinely free to decide about their lives.

5.2 Issues arising under the ECHR and CRPD

The experiences also raise questions directly concerning international human rights protection. In particular, the situations described may engage safeguards under the European Convention on Human Rights (ECHR) and the UN Convention on the Rights of Persons with Disabilities (CRPD).

We do not suggest that each testimony automatically proves violation of a particular provision. Legal characterisation requires examination of the specific case and documents. Taken together, however, the testimonies highlight areas requiring particular attention regarding Italy's international obligations.

5.2.0.1 Prohibition of torture and inhuman or degrading treatment

Article 3 ECHR provides that no one shall be subjected to torture or inhuman or degrading treatment or punishment. This absolute guarantee is particularly significant where someone is subjected to coercion, deprived of liberty or placed in a facility they cannot freely leave.

In psychiatry the prohibition is especially important in relation to actual treatment and use of coercive means. Mechanical restraint, sedation, forced medication, isolation, admission conditions and other practices must therefore also be assessed against the risk of Article 3 violations, considering particular circumstances, duration, application and safeguards.

The work of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) belongs precisely to this preventive framework. It visits places of deprivation of liberty, including psychiatric and health and social care facilities, to examine actual conditions and recommend prevention of abuse and ill-treatment. Its standards on restraint, involuntary admission, procedural safeguards and treatment conditions are preventive tools supporting effective respect for Article 3.

The testimonies are particularly significant where they describe prolonged restraint, intense sedation, medication against the person's will, isolation, humiliation or other coercion. Here too, establishing a violation naturally requires assessment of each case's specific circumstances. The dossier nevertheless flags situations deserving attention and verification against European standards for preventing torture and inhuman or degrading treatment.

5.2.1 Personal liberty and security

Article 5 ECHR protects the right to liberty and security of person, requiring deprivation of liberty only in cases permitted by the Convention and through a procedure prescribed by law. The person must also be able to obtain prompt judicial review of its lawfulness.

These safeguards are particularly significant for involuntary psychiatric admission and other circumstances where people are effectively unable to leave a facility or independently determine conditions of residence. Formal classification alone is therefore insufficient: actual ability to leave and available means of challenging restrictions must be examined.

Article 14 CRPD gives this a broader dimension, protecting persons with disabilities' liberty and security and providing that disability itself cannot justify deprivation of liberty.

5.2.2 Private and family life and self determination

Article 8 ECHR protects respect for private and family life, home and communications. Measures affecting choice of residence, relationships with relatives and others, organisation of daily life or personal affairs may therefore engage it. Any interference must be lawful and meet the Convention's necessity and proportionality requirements.

Article 19 CRPD strengthens this protection, recognising persons with disabilities' right to independent living and community inclusion, choosing residence and where and with whom to live equally with others. The UN Committee has clarified that institutionalisation, including forced institutionalisation, is incompatible with independent and community living, linking this principle to deinstitutionalisation.

Article 23 CRPD on respect for home and family is also relevant, as are circumstances where healthcare, social or judicial intervention substantially affects family relationships without adequate consideration of the person's will.

5.2.3 Legal capacity and the right to decide

A central issue throughout the dossier is substitution of the person's will by others deemed authorised to decide in their interests.

Article 12 CRPD recognises legal capacity on an equal basis with others and requires states to provide necessary support for its exercise, with adequate safeguards to prevent abuse and ensure respect for rights, will and preferences.

The UN Committee expressly distinguishes substituted decision-making systems from models supporting exercise of legal capacity, identifying as problematic precisely replacement of the person's will with what others consider their “best interests”.

This principle also runs through support administration testimonies, where protection is sometimes described as progressively transforming the relationship between the person and decisions about their life.

5.2.4 Access to justice and procedural safeguards

Article 6 ECHR protects a fair trial before an independent, impartial tribunal, while Article 13 requires an effective remedy protecting Convention rights. These guarantees are particularly significant when measures affect liberty, family life, capacity to act or other fundamental rights.

Article 13 CRPD also concerns access to justice, requiring persons with disabilities to enjoy equal access, including appropriate procedural accommodations.

The testimonies thus raise a question beyond formal availability of a remedy: people must actually be enabled to know the measure concerning them, challenge it, participate in proceedings and obtain an independent assessment.

5.2.4.1 Personal integrity, coercion and treatment

Accounts of mechanical restraint, sedation, forced medication, isolation or other coercion are particularly significant.

Article 15 CRPD protects against torture and cruel, inhuman or degrading treatment or punishment, while Article 17 protects physical and mental integrity. These provisions are especially important in examining coercive practices in psychiatric services and residential facilities.

The CPT likewise pays particular preventive attention to restraint in psychiatric institutions. It emphasises its intrusive nature and abuse potential, requiring use only as a last resort, for the shortest possible time and with adequate safeguards, recording and oversight.

These standards matter particularly for accounts of prolonged restraint, intense sedation, medication against wishes or difficulty understanding and challenging events.

5.2.5 Violence, abuse and institutional responsibility

Article 16 CRPD requires effective protection against exploitation, violence and abuse, including independent monitoring of facilities and services for persons with disabilities.

This is especially relevant to accounts of physical, psychological, sexual or institutional violence, and to ensuring people can report abuse without their condition being used to discredit their words or impede justice.

Protection therefore cannot stop at abstract prohibitions: it requires effective prevention, monitoring, reporting, investigation and redress.

5.2.6 Deinstitutionalisation and the right to community living

Institutionalisation runs through many experiences, even beyond traditional psychiatric hospitals. Repeated admissions, prolonged facility stays, therapeutic communities, residential pathways and measures obstructing independent living can create different forms of institutional dependence.

Article 19 CRPD recognises independent living and community inclusion. The UN Committee's Guidelines on deinstitutionalisation also emphasise institutionalisation's harmful effects, expressly mentioning violence, abuse, ill-treatment and physical, mechanical and chemical restraint within institutions.

Deinstitutionalisation therefore means more than closing a particular facility. It requires actually restoring community living, choice of where and with whom to live, and necessary support without loss of freedom or decision-making capacity.

5.3 The CPT and OPCAT framework

The documented issues are also particularly significant within European prevention of torture and inhuman or degrading treatment. The CPT has developed specific standards for psychiatric institutions and social facilities where people may be deprived of liberty, addressing involuntary admission, restraint, procedural safeguards, complaints and oversight.

The CPT perspective moves attention beyond formal lawfulness to actual deprivation conditions. Once someone is in a facility they cannot freely leave, examination must cover not only grounds for admission but treatment, restriction duration, outside communication, information access, complaints and independent oversight.

The CPT has also called on Italy to strengthen involuntary admission safeguards and recommended that, as a rule, the competent judge hear the person directly. It has further emphasised adequate medical assessments, independent of the detaining facility as far as possible.

This perspective closely connects with the Optional Protocol to the UN Convention against Torture (OPCAT) and national preventive mechanisms, since abuse prevention requires regular, independent monitoring of places of deprivation of liberty.

In this sense, the dossier offers not only individual experiences but material identifying areas potentially requiring further examination, independent verification and institutional intervention.

5.4 National guarantor authorities

The collected experiences are also submitted to national guarantor authorities because of their specific responsibilities protecting persons deprived of liberty and the rights of persons with disabilities.

5.4.1 To the National Guarantor for the Rights of Persons Deprived of their Liberty

The testimonies are submitted in view of this authority's monitoring responsibilities for places and circumstances of deprivation of liberty, including medical, health and social care, and psychiatric settings.

Particularly important are accounts concerning TSO, SPDC, mechanical and chemical restraint, sedation, prolonged psychiatric stays, REMS and security measures, and situations where people report no practical opportunity to challenge residence or exercise rights.

The dossier offers material to assess possible recurring problems in deprivation methods, procedural safeguards, access to information and remedies, force and restraint, and actual conditions for people under these measures.

The gap between formal classification and actual impact on liberty also merits special attention. People report inability to end admission, leave a facility or avoid decisions despite a different formal status.

The dossier is therefore also submitted as a possible basis for further monitoring, examination and verification within the authority's remit.

TSO and restraint problems are particularly significant alongside existing National Guarantor observations calling for stronger TSO monitoring and attention to restraint methods and safeguards for people under liberty restrictions.

5.4.2 To the National Guarantor for the Rights of Persons with Disabilities

This dossier is also submitted in relation to obligations under the UN Convention on the Rights of Persons with Disabilities.

The testimonies reveal circumstances where diagnosis, disability or supposed incapacity becomes grounds to restrict liberty, substitute will, affect choice of where and with whom to live, restrict family and personal relationships, condition healthcare access and cause institutionalisation or prolonged control.

These directly engage equality and non-discrimination, particularly recognition of legal capacity under Article 12 CRPD and support for its exercise, with safeguards respecting rights, will and preferences.

Also relevant are liberty and security under Article 14, prohibition of torture and cruel, inhuman or degrading treatment or punishment under Article 15, protection against exploitation, violence and abuse under Article 16, and physical and mental integrity under Article 17.

Article 19 has particular significance, recognising independent community living and choice of where and with whom to live. The Convention and the UN Committee's subsequent deinstitutionalisation work raise an issue spanning several experiences: healthcare, social or judicial pathways producing prolonged institutionalisation or institutional dependence and obstructing return to independence.

Finally, Article 13 on justice matters especially where people face obstacles challenging a measure, asserting will or obtaining independent assessment.

The dossier therefore submits the gap between these principles and directly affected people's experiences, asking that it also be considered in terms of potential disability-based discrimination and compatibility with the Convention's human rights model.

In particular, it raises a question across many testimonies: whether, and to what extent, diagnosis, disability or supposed incapacity may continue to justify a different threshold of protection for liberty, legal capacity, personal integrity and the right to decide about one's life.

5.5 Making rights effective

The common thread is therefore not merely a particular measure, TSO, support administration, admission, residential placement or security measure, but the person's practical opportunity to remain the holder and active participant in their rights while it is applied.

The central issue is whether people are genuinely heard, their will and preferences considered, information understandable, decisions challengeable, independent oversight accessible, and exit genuinely possible once grounds cease to exist.

The testimonies ask attention precisely to this gap between formally recognised rights and practical exercise.

The dossier therefore submits not only individual episodes but a body of experiences which, taken together, question practices' compatibility with ECHR and CRPD obligations and international standards for preventing torture and inhuman or degrading treatment.

The aim is not to replace competent authorities in determining individual responsibility, but to ask that experiences also be considered structurally: what mechanisms enable progressive loss of autonomy? What safeguards prevent protection becoming control? What instruments enable effective challenge to liberty restrictions? And what independent oversight exists when decision-makers, carers and supervisors belong to the same institutional circuit?

These are the questions entrusted with directly affected people's voices and experiences.

The necessary restoration of legality to the position of psychiatric patients in Italy

By “restoration of legality”, the association means fully bringing the position of persons subjected to psychiatrisation within constitutional safeguards and international human rights obligations. This also means making coercive and liberty-restricting instruments genuinely lawful, starting with TSO, through rules clearly defining grounds, limits, procedures, safeguards and oversight.

Over time, amid media and institutional indifference to these uncomfortable, politically and administratively unpopular subjects, which conflict with entrenched subcultural prejudices silently dictating “guidelines” to social, health and judicial professionals and political representatives, Diritti alla Follia has developed reforms of TSO, support administration, with associated abolition of full and partial legal incapacitation, and security measures for persons lacking criminal responsibility. For TSO and administration it unsuccessfully sought the 50,000 signatures required to submit popular initiative bills.

The proposals seek to align Italian law with the supranational framework described above, as well as a properly interpreted Constitution.

5.5.0.1 TSO

Proposal to amend Articles 33, 34 and 35 of Law No. 833 of 23 December 1978.

“Bringing the procedure and execution of psychiatric TSO into conformity with the Constitution and Italy's international obligations”.

The reform seeks a more structured psychiatric TSO procedure with stronger safeguards, respecting the Constitution and international obligations. It addresses systemic problems by strengthening procedural transparency, safeguards for the person, opportunities to know and challenge the order, and external supervision and oversight.

5.5.0.2 Support administration

Proposal to amend Law No. 6 of 9 January 2004.

“Abolition of full and partial legal incapacitation and reform of support administration”.

The association seeks comprehensive revision, restoring the institution's supportive function rather than substitution or degradation of autonomy. Among other matters, it addresses effective participation in proceedings and expression of will, choice of a trusted person and preservation of independent decision-making even when an administrator is appointed.

5.5.0.3 Security measures for persons lacking criminal responsibility

For these security measures the association proposes moving beyond the current system, opening the way to differentiated, individualised responses to offences committed amid psychosocial distress, without presumed future dangerousness.

Reform should shift the centre of gravity from dangerousness-based deprivation of liberty to individualised pathways respecting fundamental rights, self-determination and will.

For further information, see the page on reform proposals: Reform proposals

Final considerations

The Constitutional Court, awakening after half a century of embarrassing silence, opened a first breach in the TSO safeguards system in 2025, intervening on Article 35 of Law No. 833 of 1978 and recognising its unlawfulness insofar as it failed to ensure adequate information, hearing and awareness of the confirmation order.

In 2026, judgment No. 157 returned to the same provisions, taking a further step: recognising mandatory legal representation in confirmation and extension proceedings, and providing a court-appointed lawyer when no chosen lawyer exists. A person subjected to TSO is thus recognised not merely as the recipient of coercion, but as the holder of an effective right of defence in proceedings affecting liberty.

Although addressing specific aspects, both judgments are particularly significant and encourage continuation and enrichment of the association's comprehensive proposal to restore legality: effectively bringing all continuing coercion and liberty restrictions within constitutional safeguards and international obligations.

The association intends to continue developing its “package” of reforms for citizens' consideration, sometimes resubmitting them, covering TSO, support administration and

security measures for persons lacking criminal responsibility. These reforms should fully realise the “promise of freedom and liberation” carried by the CRPD and ECHR framework.

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