Doctors Against Torture: One Team's Report, March 9 – May 3, 2020

Following the Prime Minister's Degree of March 9, 2020, which ordered lockdown for the entire country, our Center was temporarily closed and "active cases" were immediately divided up among three work teams. Twenty cases were assigned to our team. The first step was to identify a tutor for each case. It would be the tutors' job to follow each specific situation reported by subjects, and communicate those situations to the rest of the team, highlighting critical situations and special needs. This way, tutors proved to be a big help when it came to planning individual interventions. Over time, we expanded our files of useful information, with a special focus on subjects' current living situations (temporary housing, shelters and refugee centers, or autonomous housing) and work status. The workload among the teams was not, however, rigidly structured, and whenever necessary, further support would be called upon to bolster the efforts of individual tutors.

The next step was to contact all subjects in order to communicate news of the center's closing and our commitment to continuing our services through the use of the technology at our disposal, i.e., WhatsApp messaging, telephone and video calls. In this phase we provided subjects with information on the rules to follow during lockdown and, at the same time, we also gathered information on individual situations. We found that having previously started a WhatsApp group for staff proved very useful, where members could continue to share news that we received from subjects. Through initial discussions among staff, it was decided that a central role would be assigned to Social Workers, for a number of reasons: Social Workers already knew subjects who were participating regularly with them in meetings held at the Center; Social Workers were privy to a broader view of each case, with access to data from various areas of our intervention, and were already aware of subjects' specific needs on different levels; Social Workers are not medical doctors, and as such may facilitate subjects' approach to our service, making it more accessible.

In the days that followed, we also assigned Social Workers the role of "moderator" during interventions that replaced person-to-person meetings with subjects. As moderators, Social Workers provided introductions to discussions, explaining new forms of intervention and goals of intervention. Social Workers also laid the framework for governing team members' turns for input, thus helping to avoid overlapping or lengthy input, while facilitating their relationships with subjects.

While we considered the evolving situation, the group was joined by a mediator, whose presence proved very useful. The mediator became the main contact for three of our subjects, and helped resolve problems that had come about due to foreign language obstacles. The mediator also provided a new perspective for our discussions, which was more in line with subjects' actual needs.

Operations

After the initial phase, which we termed "informative", we began more direct contact with subjects, where we acquired information regarding their physical and mental health status, and learned what their most urgent needs were. In cases of economic hardship (lack of access to food and credit for telephones), the social assistance sector intervened both autonomously and through the activation of local services and volunteer groups. In conditions of isolation, providing access to credit for telephones proved to be the most useful assistance. Many subjects were also provided with online tools for learning Italian. From a psychological perspective, subjects exhibited various reactions linked to the uncertainty of the situation,

and to the lack of information and protective gear available at reception centers. Most frequently, subjects reported general anxiety, somatic conversion disorders and insomnia. In such cases, intervention by psychologists proved crucial. From a psychiatric perspective, sleep disorders were drivers of anxiety and most likely led to reliving past trauma. Subjects who had not experienced insomnia for quite some time and whose mental health situations had been relatively stable also reported insomnia. In terms of pharmacology, short-acting benzodiazepines were initially prescribed; in collaboration with specialists in internal medicine, we phased those out almost completely and replaced them with neuropathic pain medication, taking advantage of the sedative effect.

Two cases were particularly challenging:

– The first regarded one of our own subjects. When the first cases of Covid-19 turned up at the reception center where the subject was staying, and everyone staying there was placed under quarantine, the subject, despite voluntarily undergoing testing Covid-19 multiple times and testing negative, developed alarming signs of anxiety. Given the situation, it was impossible to maintain necessary interpersonal distancing,[1] which meant the virus was likely to spread among the quarantined persons at the reception center, at which point, the subject in question requested transfer to another center that might offer greater protection. Since no transfer was possible, the subject, through us, was able to contact the lawyer that had been following the subject's case, who filed the subject's request with the local Prefecture. Multiple phone calls were made, involving the subject, the subject's lawyer, and the staff at Doctors Against Torture. Various attempts were made to contact the reception center (which provided temporary housing for 4 DAT subjects) by telephone and email, but unfortunately no reply was ever received. The only source of news here was from our subjects.

– The second case regarded a subject hosted at a structure run by the region. The subject was a young male whose trust we'd only recently gained. At the start of lockdown, diffused thoracic pain sparked general anxiety. After calling and emailing the structure numerous times, we arranged for a doctor's visit for the subject in question; the doctor then contacted us, and together we formulated and prescribed pharmacotherapy. The doctor's visit alone had a calming effect on the subject. From then on, the subject was monitored on a more or less daily basis, and could be contacted via online video calls. In this case as well, the lack of cooperation on the part of the structure that housed the subject led to an amplification of the subject's anxiety. This is but the umpteenth example that shows how crucial the relationship between structures and subjects is, especially in generalized emergency situations.

In the next phase, beginning April 9, 2020, we launched our online "video visits". We adhered to the pre-lockdown schedule, i.e., Wednesday afternoons and Thursday mornings. The visits were preceded by briefings on Skype, during which staff members exchanged news and updates on the subjects we'd be meeting with. For the visits themselves, we were forced to use WhatsApp video calls, despite the limitations involved:

[1] There's an interesting debate in progress regarding the term "social distancing". Many people consider it not only inappropriate, but downright dangerous, for governments to impose a loosening of social bonds and stigmatize them as a potential risk factor. The danger is accentuated in categories such as migrants, who in many respects are already "invisible" and face enormous difficulties when it comes to social integration. Though the term "social distancing" has become ingrained, and the practice has been widely adopted, a "neutral" alternative would be the term "physical distancing".

- Since this platform allows a maximum of 4 participants per call, if the mediator was required, it meant one of the three team members could not participate. In such cases, the Social Worker would always remain among the participants (for the reasons explained above), while the psychologist and psychiatrist would alternate, depending on their pre-lockdown relationship with a given subject and the subject's current needs. Often, the team member excluded from the call would contact the subject after the group visit.
- The quality of WhatsApp video calls is not as good as that offered by other platforms, but those platforms were not available on the telephones used by our subjects. This underscores the problem of "digital poverty",[2] which we'll no doubt have to deal with in the future as well.

In April 2020 we were able to hold video calls with 12 of our 20 subjects. Apart from the considerations above regarding two particularly challenging cases, most subjects appeared to have handled the restrictions imposed by lockdown fairly well. The fact that we remained in contact with them through video calls provided further confirmation of our commitment to them. Despite the situation and the limits of the technology at our disposal, our subjects reacted positively to the video visits, which contributed to strengthening our bonds with subjects.

The use of video calls brings to the fore the following consideration, albeit marginal: the degree to which the medium disrupts the private sphere and constitutes an invasion of privacy. When participating in video calls, we "enter" a subject's private space, just as they "enter" our homes, i.e, the location we usually call from. We thought it best to use shots of our heads against "impersonal" backgrounds in order to maintain the most "professional" appearance, or one that resembled the appearance we give while consulting with subjects in person, in an office setting. However, this was not a major consideration for our subjects. In some cases, subjects participated in video calls from their rooms, in the presence of roommates or friends. This situation did not always depend on a lack of available space or the objective difficulties involved in isolating oneself. This led us to consider the degree to which our conception of privacy is culturally biased, and how obsession with privacy might be a trademark of western societies. Our subjects' message seemed clear – that they took our calls from what they considered their private spaces, and that they had no more privacy available to them – and perhaps in all their lives had never had any more privacy than this.

Another problem that became more obvious during lockdown was related to access to healthcare treatment. If that access was already limited, lockdown made things worse. Due to legal obstacles, many of our subjects do not have the same access to general practitioners that legal residents in Italy and Italian citizens have. Since reception centers are generally understaffed, they are often in no position to provide medical assistance to persons housed there. During lockdown, we were able to collaborate with a local pharmacy to ensure that subjects quickly got the pharmaceuticals they required. In the near future it would be opportune to dedicate our efforts to making sure subjects have access to general practitioners. We should work to engage individual doctors locally – the idea was floated prior to the Covid-19 pandemic, though nothing ever came of it.

[2] As seen especially during lockdown, "digital poverty" exacerbates inequality. Access to quality internet connections in today's world has become imperative, yet because of economic disparity, the digital divide persists, meaning that many people are excluded from this basic staple of modern life, i.e., quality access to internet. In a country lagging behind in broadband connectivity, solutions must be found to augment internet access.

To conclude, a consideration regarding the Italian press, whose treatment of the “migrant issue” seems to both shape and reflect certain collective attitudes concerning immigrants. The Italian press pays little or no attention to the problems faced by semi- or non-citizens living in phases of forced confinement, i.e., the fact that most of these individuals are experiencing extreme poverty and overcrowding. At the same time, the Italian press is quick to laud government intervention without mentioning that it is usually too little, too late, and cases of heavy-handed treatment of refugees by the police, without decrying the deplorable conditions that many immigrants must cope with on a daily basis, without championing their cause. For too long, the Italian press has portrayed the “migrant issue” as a question of national security, creating a climate of mistrust and ostracism.