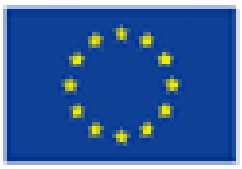
Medical Rehabilitation Center
for Torture Victims, Athens



European Commission
European Refugee Fund

« Identifying survivors of torture»

A guide for training asylum authorities' staff and health professionals working with asylum seekers and refugees

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Ioanna Babassika

INTRODUCTION

The present manual is the result of the common effort of the following rehabilitation centres:

1. Medical Rehabilitation Center for Torture Victims (MRCT), Greece
2. Behandlungszentrum fur Foltropfer e. V., BZFO, Germany
3. Consiglio Italiano per i Rifugiati – onlus CIR-VI.TO., Italy
4. Cordelia Foundation for the Rehabilitation of Torture Victims, Hungary
5. Swedish Red Cross, Sweden
6. Verein ZEBRA – Interkulturelles Beratungs – un Therapiezentrum, Austria

and of the International Rehabilitation Council for Torture Victims (IRCT), Denmark. The above partners participated by sending some material they have been using in their practice.

Coordination and drafting was performed by the legal counsellor and founding member (1989) of the Medical Rehabilitation Centre for Torture Victims, Ioanna Babassika, member of the Appeals Board on Asylum Requests since 1999 (representing Bar Association of Athens), former member of the Committee for the Prevention of Torture-CPT, 2000-2004, member of the Special Committee for the Protection of Rights of Mental Health Patients since 1999.

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We are grateful for the possibility to produce this manual because the need for it was felt already for a long time in the every-day practice and experience of each one of the centres in the various countries. This text is inspired from and incorporating a number of specific texts used so far by the centres, who have been for a number of years training state officials in the field of asylum. However, it is not possible to comprise the very extensive bibliography existing in this field. The ambition of the participants was to produce a structured text, in order to help asylum authorities, medical services dealing with asylum seekers, lawyers, as well as rehabilitation centres to better organise the necessary training in order to carry out adequately their work. The rehabilitation centres have already a vast experience in this field and we hope that further practice will in the future enrich subsequent editions. In other words, and as modern technology allows for it, we would like to initiate a process which will be open-ended for further enrichment rather than a text curved in stone.

Europe has over the centuries been a continent receiving persecuted people from all over the world. However, for more than 25 years now, Europe has been receiving an increasing influx of refugees, not only from regions close to its borders, but also from far away countries in every continent. The human rights situation in many areas around the world is one of the most compelling reasons for people to leave their homes and to seek shelter and protection in safe havens. Nowadays, they manage by legal or illegal means to reach Europe that should not be forgotten, stands as an area of democracy, justice and protection of human rights in the mind of people living under constant threat of gross violations of their human dignity. It is natural, therefore, that the above contrast raises expectations that their dignity will at last be respected and that they will find protection following their persecution and suffering.

Reality, however, is different. The systems of reception and granting asylum in the various European countries still have many differences in structure, quality, sufficiency of staff, training, which results in un-equal treatment of similar categories of refugees. Looking at the statistics concerning the rate of recognition in the various European countries and analysing them, we can easily come to the conclusion that the asylum systems, despite the efforts undertaken by the various European countries to harmonise a number of components, are far from giving equal chances for recognition and protection, irrespective of the country that is the receiving country.

If the facts lead us to the above conclusion concerning refugees in general, the situation is even more difficult when it comes to refugees who have been subjected to torture or ill-treatment as part of their persecution.

By various sources, including experts of UNHCR, it is estimated that victims of torture and organized violence among the refugee population could reach a very high percentage (various studies, using different criteria, reach percentages from 5 to more than 35%; an average estimated by the rehabilitation centres reaches 20%)[1]. This shows that we are not dealing with a marginal issue, but with a problem at the very heart of the asylum systems, connected also with public health issues, social care issues, etc.

These insufficiencies were felt many years ago, already in the 80's, by health and legal professionals who, in various countries, had taken initiatives to help refugees, first of all by helping them to ensure their legal protection. In the course of

[1] 'Torture and its Consequences', edited by Metin Basoglu, Cambridge University Press, p. 87

their work, in the frame of non-governmental organizations providing legal assistance and health care to refugees, it became apparent that there was lack of knowledge and understanding of the issues relating to torture among the state officials who are in charge of reception and procedures.

Despite the differences from country to country, the common denominator has been that the responsible officials and services, in every country dealing with asylum issues, lack basic knowledge and understanding of torture and its consequences. This led the specialized professionals who, in fact, work in a structured way in rehabilitation centres for torture victims, to develop training material adapted to the needs of these groups of state employees and to start using them, where it was possible, in seminars and information meetings with staff of the asylum services.

This activity again did not have equal development in all European Countries because of various factors: positive or not attitude of national authorities, technical and logistical issues, etc.

However, the efforts undertaken on the level of the European Union to harmonize asylum practices throughout the Union have already created a new landscape. The knowledge acquired over the years, especially by the work of rehabilitation centres, shared with UNHCR, lawyers, refugee protection organizations, medical and social care NGOs, created the necessary understanding on the part of the States that torture victims should ideally be detected as early as possible in the asylum procedures in order to, on the one hand, take this fact into consideration for the protection of the applicant and the provision of specialized care, but also because it is the true interest of the States to take every necessary step to ensure respect of their international obligations by not risking violation of article 3 of the Convention Against Torture of the UN (CAT), as well as violation of article 3 of the European Convention of Human Rights (ECHR), (in this respect there is a very extensive jurisprudence of the European Human Rights Court, as well as of the CAT Committee).

In this respect, the present state of harmonization of asylum law and practices has reached already, as far torture victims are concerned, a high level of protection obligations of the European states. The **Directive 2003/9 of 27 January 2003** on laying down minimum standards for the reception of asylum seekers in the EU Member States, as well as the **2004/83 Directive of 29 April 2004** on minimum standards for the qualification and status of third country nationals or stateless persons

as refugees or as person who otherwise need international protection and the content of the protection granted and the **Council Directive 2005/85/EC of 1 December 2005** on minimum standards on procedures in Member States for granting and withdrawing refugee status deal explicitly with the recognition and special care that has to be given to torture victims (see the legal chapter for brief analysis).

The European states are states with a long tradition of the rule of law and of humanitarian and democratic principles. They have therefore every reason to ensure that these fundamental principles, constituting the basis of their existence, are to be respected in all cases towards all individuals that are on their soil.

UNHCR, on the other hand, being the competent UN Agency in immediate contact with the issue, started many years ago to try to structure particular efforts in order to provide specialized guidelines for victims of torture, as it does for other particular groups of refugees who have special needs for protection and assistance (such as unaccompanied minors, etc.). Already in 1993, UNHCR convened a group of experts (many of them working for rehabilitation centres), the work of which produced draft guidelines for the «evaluation and care of victims of trauma and violence». This work has continued and in December 1998, UNHCR organized an expert workshop in Athens on the issue: «Human Rights and Refugees-Non State Agents», where among other recommendations to states it was recommended[2]:

- «to create national procedures for identifying those who are protected by ECHR art. 3, CAT art. 3 and ICCPR[3] art. 7 – in particular fact finding»;
- «to train officials at all levels in international human rights law, and to ensure their awareness of the views and comments adopted by the treaty bodies. All officials should be familiar with the approach adopted by the CAT Committee which considers that discrepancies in statements made by victims of torture are not uncommon as long as the inconsistencies do not raise doubts about the general veracity of the application»;

At this point it is important to define what is the international crime of torture and, therefore, why the victims of this crime are protected by international law, as well as by domestic law.

According to the UN Convention against Torture (CAT), the definition given is the following: ***Article 1****: '1. the term 'torture' means act by which severe pain or*

[2] *'Expert Workshop on Human Rights and Refugees: Non State Agent's*, Athens, 18-20 December 1998
[3] International Covenant for Civil and Political Rights

suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions'.

Further, **Article 3** provides that: '*1. No State Party shall expel, return ('refouler') or extradite a person to another State where there are substantial grounds for believing that he would be in danger of being subjected to torture'.*

Furthermore, in **Article 14**, the Convention provides for redress as a right of the victim, as well as '*adequate compensation, including the means for as full rehabilitation as possible*'. Although it is obvious that this obligation falls upon, primarily, the state responsible for the crime of torture, it is also obvious that, as far as refugees and asylum-seekers are concerned, the protection of the international community, as it is represented by the receiving states, in respect of the Refugee Convention, is a substitute of the national responsibility. In other words, since the refugee no longer can or wishes to avail the protection of his/her country of origin, but asks, instead, for international protection, in this specific case also it is the international community that will have to recognise and rehabilitate the victim of torture, as torture has been part of the persecution suffered.

A pertinent analysis of the crime of torture has been done by Herbert C. Kelman in the International Review of the Red Cross, Vol. 87, No 857, March 2005, in his article 'The policy context of torture: a social-psychological analysis', where he states: «Despite the fact that torture is a crime under the UN Convention against Torture, adopted by the General Assembly in 1984, and other relevant international frameworks, and it is similarly defined in the national legal codes of many of the UN's member States, it is a practice that is widespread throughout the world. Some instances of torture constitute 'ordinary' crimes, i.e., crimes committed in violation of the expectations and instructions of authority. Torture would be an ordinary crime in this sense if it were carried out by individual officials at their own initiative and in disregard of the policies and orders which they function. Similarly, officials could be

charged with torture as an ordinary crime if they used means of pressure in excess of what was legally permitted.

The essential phenomenon of torture, however, is that it is not an ordinary crime, but a crime of obedience: a crime that takes place, not in opposition to the authorities, but under explicit instructions from the authorities to engage in acts of torture, or in an environment in which such acts are implicitly sponsored, expected or at least tolerated by the authorities. Lee Hamilton and I have defined a crime of obedience as 'an act performed in response to orders from authority that is considered illegal or immoral by the larger community'. Torture is clearly considered illegal and immoral by the larger community; it is prohibited by international declarations and conventions that have been unanimously adopted by member states of the United Nations. Yet it is the authorities of these very states that order, encourage or tolerate systematic policies or sporadic acts of torture.

When does an ordinary crime become a crime of obedience? It is often the case – in acts of torture as much as in other gross violations of human rights – that the perpetrators engage in the action willingly, enthusiastically and with varying degrees of innovation. But 'the fact that a criminal action serves various personal motives or is carried out with a high degree of initiative and personal involvement does not necessarily remove it form the category of crimes of obedience', as long as the action is supported by the authority structure: as long as the perpetrators believe and have good reason to believe that the action is authorized, expected, at least tolerated, and probably approved by the authorities – that it conforms with official policy and reflects what their supervisors want them to do.

Recognizing torture as a crime of obedience immediately directs our attention to the other side of coin: to the crimes of authority that invariably accompany crimes of obedience. For every subordinate who performs acts of torture under official orders or with the encouragement or toleration of the authorities, there is a superior – or typically an entire hierarchy of superiors – who issue the orders and who formulate the policies, create the atmosphere and establish the framework within which officials at intermediate levels of hierarchy translate general policy directives into specific acts of torture.

The fact that crimes of obedience take place within a hierarchical structure makes it especially difficult to pinpoint responsibility for them. The question, however, is not 'who is responsible?' – the actual perpetrator or the authority – but

'who is responsible for what?'. When the question is framed that way, it becomes clear that both ought to be held responsible.

The torturers themselves are properly held responsible for the actions they perform and the harm they cause, even if they are acting unde superior orders. Since the adoption of the Nuremberg Principles after World War II, which have been incorporated into the military codes of all Western States, superior orders cannot be use as an absolute defence for criminal actions on the part of subordinates. The UN Convention against Torture specifically applies this principle to torturers when it states that: 'an order from a superior officer or a public authority may not be invoked as a justification of torture'. Subordinates have the obligation to evaluate the legality of orders and to disobey those orders that they know or should have known to be illegal.

Superiors, for their part, have the obligation to consider the consequences of the policies they set and to oversee the ways in which those policies are translated into specific orders and actions as they move down the ladder. The authorities' obligation of oversight makes the defence of ignorance of or lack of control over the actions of subordinates generally unacceptable, since they are expected to know and to control what their subordinates are doing. Of course, more often than not, torture does not result from negligence at the top, but from deliberate policy – or perhaps deliberate inattention at the top to the way in which policy is carried out below».

The above analysis gives clearly the relation of power, obedience, responsibility, chain of command and hierarchy that may lead to committing this heinous crime.

On the other hand, it is necessary to understand what the survivors have been through and their state of mind in the period of their life following torture. It becomes even more difficult when exile, poverty, uncertainty for the future is added to the effects of torture, all in conditions of detention.

The task of asylum authorities to distinguish among asylum seekers those who, apart from other kinds of persecution, have suffered torture, becomes very difficult. Questions such as the following are frequently raised:

- Is this person telling the truth?
- Why his account of events has some discrepancies? Is this person credible?
- Why this person refuses to answer certain questions regarding his arrest or imprisonment or gives vague answers?

- Why this lady refuses to speak?

The above questions are just a small sample of issues arising during the asylum process and all the interviewing officers have encountered such experiences. The staff of asylum services, apart from specific knowledge concerning countries of origin, human rights violations in each one of them, legal systems, etc., need specific training and information concerning torture and its effects.

The purpose of this Manual is to provide the necessary knowledge in order to help asylum authorities to distinguish **possible torture victims** among larger numbers of asylum seekers in order to **refer them** to specialized experts for diagnosis and confirmation and further specialized treatment services, as provided for by the harmonised European Union rules.

Such knowledge and training will also help the asylum system itself to become more efficient and fair. We need to know that, for a torture victim, the asylum process can be in itself a traumatic experience. In this connection, many examples have been collected by the rehabilitation centres.

Another reason for more knowledge and better preparation of the asylum authorities on this issue is the protection of asylum officers themselves from vicarious traumatization. Again, over the years, the rehabilitation centres have made a collective experience – similar in every country – consisting mainly in a reaction of interviewing officers not to touch this very sensitive issue during the interview, since they feel insecure as to how to handle the matter. To close our eyes and ears before evil, in order to avoid as much as possible any contact with it, is a natural human reaction, but in the frame of the asylum procedure, whereby the life and the future of a person is at stake, there should be a proper way to face all these 'difficult' questions and answers. Several rehabilitation centres have already been working for years in supporting the staff of asylum authorities in order to carry out properly their tasks.

In the various chapters that follow all relevant issues will be analysed. This Manual, apart from members of asylum authorities, is also addressed to lawyers, to medical staff and, more generally, to health professionals who work inside or in relation with reception centres. Since they are, at a first stage, conducting medical examinations for screening or other purposes (for public health protection or other reasons), they have possibilities to detect signs of torture and to refer to the specialists for further diagnosis and confirmation.

In essence, efficient protection and care for those who have suffered the most atrocious human rights violations is nothing else but fulfilment of one of the main targets of the European Union: to be an area of Justice, Security and Freedom. We should add at this point that this is in the experience of the rehabilitation centres the main demand of the victims of torture. **They do not seek vengeance; they merely want ,Justice to be done**. Recognition by the asylum country of their ordeal is the necessary first step in the healing process.

GENERAL PART

CHAPTER 1

LEGAL SOURCES

The effect of torture in societies

Torture is intended to terrorize the population represented by the individual (Genefke, 1994) and, in countries subjected to repression and torture on a very large scale, whole communities may be affected. Torture may have a dramatic effect on the social and political life of a country or region. The political action of the opposition is paralysed and the price of being a political activist is very high, with harassment, arbitrary detention, torture, and possibly death. Societies may remain highly polarized, suspicious, and angry, which requires a process of reconciliation for national healing. Social reparation needs several sequential steps: truth, justice, and pardon. Social reconciliation requires that society acknowledges what has happened. Truth is the mechanism because it is the end of the social denial and silence. Truth commissions have been created in several countries to investigate the atrocities of past regimes, such as in Argentina, Chile, Uruguay, Brazil, and South Africa. Justice is the logical next step after the truth in known. Pardon comes after justice, if society accepts it (Jaranson et al., 2001)[4]

Victims seeking protection elsewhere

This second category of torture victims is the one viewed by this manual.

The legal protection of torture victims seeking refuge and asylum in another country is based not only on the Geneva Convention of 1951 regarding refugees, but on a variety of International Conventions which need in all cases to be taken into account, in order to understand the European Union Directives which used all this important pre-existing body of legal provisions and obligations as source and basis.

1.1. International Humanitarian Law

A short historical note

By chronological order the rules contained in this body of provisions are the first to appear in modern times (19th century). The special interest in analysing these provisions is that War is one of the main generators of Torture.

The four Geneva Conventions of 1949, completed by the Additional Protocols of 1977, constitute the basis of modern Humanitarian Law. Furthermore, the

[4] 'Politically-motivated torture and its survivors', by Jose Quiroga, MD and James M. Jaranson, MD, MA, MPH, Torture Journal, Volume 15, No 2-3-, 2005, p. 30

International Criminal Court, established in 1998, has imposed some new elements. Among them the notion of 'War Crime' is now fully analysed and explained in detail, as one of the international crimes.

In the course of the 90's there seemed to be some progress: on the one hand, the principle of non-involvement in the internal affairs of a State, until then not contested, was put under discussion and scrutiny (the practical example is the military operations in Kossovo, 1999) and, on the other hand, the creation of International Criminal Courts or Tribunals, with all their imperfections, seemed to begin amending the major weakness of the Humanitarian Law System, namely the absence of a system of sanctions and penalties.

Only a few years later, there is again a feeling of regression, mainly due to ideas advanced after September 2001, namely that the struggle against terrorism may justify some exceptional measures in detaining, interrogating, etc. This brings the debate again to the basics: does the aim or the end justify the means? It is precisely on the idea that no end whatsoever can justify any means that the construction of International Humanitarian Law was based.

It was not pacifism that had inspired these ideas. Starting from the premise that banning the war was not realistic, International Humanitarian Law tried in a pragmatic way to limit the suffering created by the war to the strictly necessary by the military operations. In this way, the rules developed had mainly two directions: on the one hand, to put limits to methods and means used by military forces and, on the other hand, rules relevant to the protection of non-combatants (civil populations and, even more so, particular vulnerable groups).

Another important element to keep in mind is that the rules of International Humanitarian Law, although not ratified by all the countries in the world, by their recognition in 1980 by the United Nations as part of International Customary Law, are binding to all the countries in the world without exception.

Prohibition of torture

As far as **torture** is concerned, International Humanitarian Law contains an absolute prohibition during conflicts and considers torture as war crime. This interdiction is part of the fundamental norms of human rights as well, where **no exception is permitted**, even during war. The basic rule is contained in the Universal Declaration of Human Rights of 1948. In its article 5 is stated that '**no one shall be subjected to torture or to cruel, inhuman or degrading treatment or**

punishment'. The Convention against Torture of 1984 comes to add: '**no exceptional circumstances may be invoked as justification of torture**'.

According to the Geneva Conventions and Additional Protocols, states have the obligation to provide information and training on Humanitarian Law, in particular to their military staff, and to incorporate it in their Criminal Law. They are obliged to bring war criminals before Justice, whatever their nationality, or to extradite to another state for the same purpose. Practice teaches us until now that such actions of states constitute rather the exception than the rule.

However, there is a movement against Impunity, led by non-governmental organizations, which influence public opinion that created a certain development. The creation of the International Criminal Court was supported in a very important way by this movement in order precisely to bring into the centre of discussion the norms of International Humanitarian Law, despite reactions and behaviours of powerful states.

Coming to the rules themselves, we need to remember that in the Geneva Conventions the list of 'war crimes' is contained in the article 3 of each one of them and in the Statute of the International Criminal Court the definition of what is 'war crime' is given by article 8. In both cases, the absolute prohibition of **torture and any other form of degrading and humiliating treatment** comes right after the prohibition of intentional homicide. It is crystal clear that the protection of Human Life and the protection of Human Dignity are on the top of the basic values to be protected at all times and at all places.

1.2. International Human Rights Law

International Human Rights Law saw a rapid development after the 2nd World War, due to the measure of the atrocities that took place in the first half on the 20th century. Humanity, in shock, decided to take measures to prevent such crimes to happen again. In this spirit, when the United Nations took substance, one of the first texts to be decided by all parties was the **Universal Declaration of Human Rights of 1948.** In it, the basic rule of prohibition of torture is contained in article 5: '**no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment**'.

The Universal Declaration set out the aim and the moral content to be followed in the future. However, since, as a Declaration, is not of a strictly legally

binding force, subsequent legal texts with binding powers (Conventions) were drafted and agreed between the states – members of United Nations.

At first, the **International Covenant on Civil and Political Rights of 1966**, in its article 7, contains the following rule: '**no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation**'.

We observe that medical or scientific experiments are included, since the 2nd World War left horrible memories in that respect.

Despite all the above efforts, torture continued to exist or even to expand and an international discussion was initiated by non-governmental organizations and a number of personalities, which took new impetus after the mid-70's, in the light of information revealed following the fall of dictatorships in Greece, Spain and Portugal, as well as information on events following the coups d' etat in Chile, Argentina and other countries.

At the same time, systematic work on **documenting torture from a medical point of view in order to use it as evidence** has started. This is an important component of the rehabilitation process since, apart from care for the somatic and psychological sequeale, the victims need to know that evidence is documented and that wrong doing against them is recognised by the society and that there are chances that justice will be done. This very important issue of legal and moral recognition of the crime and its destructive effects on the integrity and dignity of the survivor is essential to help re-organize his/her life.

The rehabilitation centres for torture survivors started opening around, the same time when it became apparent that torture in order to be eliminated had to be attacked from all sides (legal, medical, social).

From all this movement derived the adoption of a specialized International Convention; the **Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment of 1984.** In its **article 3** it states that**: 'no State Party shall expel, return ('refouler') or extradite a person to another State where there are substantial grounds for believing that he would be in danger of being subjected to torture'.**

For the first time, there was an international instrument, detailed enough, to contain, apart from definitions and general interdictions, specific rules binding the

states to act (for instance to rehabilitate) or to abstain from action in a number of particular issues. Furthermore, State Authorities are obliged to provide training to the relevant personnel (such as Police, military, prison staff, etc.) that may be described as high risk personnel. States are also obliged to introduce in their domestic legal system, namely in Penal Law, the punishment of torture and ill-treatment as a specific crime, punished with heavier sentences in comparison to similar harm that may arise between private persons[5].

In the field of International Human Rights Law there are numerous other texts referring also to the prohibition of torture. Special mention should be made to:

The **International Convention on the Rights of the Child**

Reference to the protection of children from torture or any other form of physical or mental violence etc. is made in articles 19, 23 (disabled children), 24 (enjoyment of the highest standard of health care and, especially, in article 37, explicitly dedicated to prohibition of torture and article 39 (**obligation of states to rehabilitate**)[6].

It was to be expected that special care would be manifested by all relevant international bodies. We could mention, in an indicative manner, beginning with reports such as:

a) on children in armed conflict:

- 'Conference on the Rights of the Children in Armed Conflict', final report, Amsterdam, 20-21 June 1994
- 'Impact of Armed Conflict on Children', report of Graca Machel, United Nations, New York, 1996

These initiatives (following the recent experiences in Africa – Ethiopia, Eritrea, Mozambique and elsewhere) were followed by work resulting to specific guidelines.

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[5] In this connection, a characteristic example should be mentioned; in 1984 the then Greek Minister of Justice, Pr. G. A. Mangakis (a torture victim during the dictatorship himself) introduced a Bill to the Parliament in order to amend the Penal Code and at the same time to fulfil the obligations deriving from the Convention against Torture (even before its signature and ratification). The Law itself reflects in all its provisions both the letter and the spirit of what this crime is and of the way the perpetrators should be punished. A most important issue, however, is that this amendment of the Penal Code is placed not in the chapter of crimes against life and personal integrity but in the chapter of crimes against the democratic regime (such as high treason). As Pr. Mangakis states in the Introductory Report of this Law:

'This solution is advisable for the following reasons:

a) it is made very clear that the crime of torture does not only offend individuals-they are protected by other provisions of the criminal code anyway-but mainly the foundations of State itself, which, understanding itself as a democratic one, is deeply offended by the distortion of its power, with inhumanities violating human dignity.

b) It corresponds faithfully to the spirit of the Constitution, which defines in Article 1 of the part 'forms of regime' the democratic character and the structure of our State and in Article 2 as essence of this form of government the respect and protection of human dignity'.

[6] See Annex 1, article 39 of the International Convention on the Rights of the Child

b) on children in various kinds of risky conditions, such as refugees, asylum-seekers, separated from families, victims of abuse, trafficking, etc.

The central idea of protection of such children has been acknowledged by the International Community **to be the obligation of states to seek the best interest of the child**. UNHCR has been instrumental in this effort and for many years has been working on specific practical measures and instructions on this issue. These efforts after more of a decade of work have finally resulted into a very important document: **The 'UNHCR Guidelines on Determining the Best Interests of the Child', Geneva, May 2008.** In page 66, in the paragraph entitled 'seeking the views of experts', the guidelines provide for the following: '*in some cases, it may be useful or necessary to seek expert medical and psycho-social views, particularly in assessing children who have experienced traumatic events, and those with mental or physical disabilities. Such expertise may help determine whether the child's ability to provide information is affected, for instance, by trauma. Investigations must not, under any circumstances, violate the child's physical or mental integrity. In the absence of local expertise, access to the services of experts located in the capitals or elsewhere may be arranged*'.

Although the states are trying to provide special protection and care to children, in many countries, even in the European Union, there is still a lot of ground to cover in order to reach satisfactory implementation of UNHCR's instructions, as proven by recent studies conducted in some countries.

Several texts in the form of Codes, Declarations, Guidelines, etc., concerning issues such as prison rules (internal prison regulations, standards), rules on transfer of prisoners, on deportations, etc. are relevant to the issue of torture. Please see annex 2 for the list of those international documents.

In the sphere of peripheral Conventions relevant to the issue of torture, in the European context, the key Convention is the **European Convention on Human Rights**, adopted by the Council of Europe in 1950. In its article 3 it is stated: '**No one shall be subjected to torture or to inhuman or degrading treatment or punishment'**. The field of application of this rule is now extended to the 46 member states of the Council of Europe, but the persons covered include anybody, national or foreigner, who, for whatever reason, resides in any member state of the Council of Europe, irrespective of status. It becomes apparent that by this provision, when it comes to foreigners, it is forbidden to extradite or deport or return in any way person

or persons into a country where they would be at risk of torture (annex 1 European Convention on Human Rights).

This provision offers a wider protection to torture victims, if compared to the principle of non- refoulement (article 33) of the **Geneva Convention of 1951 (Refugee Convention)** because it can cover cases of victims of war and other events causing populations to move, which do not necessarily fall under the protection of the Refugee Convention.

In this way, we see that International Human Rights Law, as it is phrased in both provisions: article 3 of the CAT Convention and article 3 of the European Human Rights Convention is a safety net going beyond the Refugee Convention to protect torture victims.

In case of risk of violation of these two provisions **legal remedies** are available which are more and more used by lawyers and legal counsellors:

- in the case of the United Nations Convention against Torture complaints can be filed with the Committee against Torture (CAT), which examines the facts of the particular case within the frame concerning the human rights record of the country where return is going to take place. Such complaints have suspensive effect.
- in the case of the European Human Rights Convention, the Human Rights Court is competent and there exists a vast jurisdiction on the issue. Filing a case with the Court has also suspensive effect.

Another very important recent international text is **the Rome Statute of the International Criminal Court,** (in fact, the Statute is an International Convention expressing the agreement of the signatory states establishing the Court and describing its jurisdiction).

In its articles 7 and 8 torture falls within the jurisdiction of this Court, since once again, torture is defined as an international crime[7].

1.3. International Refugee Law

In the refugee definition of the Geneva Convention of 1951 the concept of persecution or justified fear of persecution is the central element or criterion in order to constitute the notion of the refugee.

[7] See Annex 1

It is useful, in this relation, to refer to relevant paragraphs of the UNHCR manual regarding the Procedures and Criteria for Determining Refugee Status under the 1951 Convention and the 1967 Protocol relating to the status of refugees, already known to asylum authorities as the authentic interpretation of the Geneva Convention, which constitutes the main guidelines for its implementation:

'The phrase 'well-founded fear of being persecuted' is the key phrase of the definition…..

To the element of fear-a state of mind and a subjective condition-is added the qualification 'well-founded'. This implies that it is not only the frame of mind of the person concerned that determines his refugee status, but that this frame of mind must be supported by an objective situation. The term 'well-founded fear' therefore contains a subjective and an objective element, and in determining whether well-founded fear exists, both elements must be taken into consideration.

……..

……

An evaluation of the subjective element is inseparable from an assessment of the personality of the applicant, since psychological reactions of different individuals may not be the same in identical conditions. One person may have strong political or religious convictions, the disregard of which would make his life intolerable; another may have no such strong convictions. One person may make an impulsive decision to escape; another may carefully plan his departure.

Due to the importance that the definition attaches to the subjective element, am assessment of credibility is indispensable where the case is not sufficiently clear from the facts on record. It will be necessary to take into account the personal and family background of the applicant, his membership of a particular racial, religious, national, social or political group, his own interpretation of his situation, and his personal experience – in other words, everything that may serve to indicate that the predominant motive for his application is fear. Fear must be reasonable. Exaggerated fear, however, may be well-founded if, in all the circumstances of the case, such a state of mind can be regarded as justified.

……..

……..

While refugee status must normally be determined on an individual basis, situations have also arisen in which entire groups have been displaced under

circumstances indicating that members of the group could be considered individually as refugees. In such situations the need to provide assistance is often extremely urgent and it may not be possible for purely practical reasons to carry out an individual determination of refugee status for each member of the group. Resource has therefore been had to so-called 'group determination' of refugee status, whereby each member of the group is regarded prima facie (i.e. in the absence of evidence to the contrary) as a refugee.

Apart from the situations of the type referred to in the preceding paragraph, an applicant for refugee status must normally show good reason why he individually fears persecution. It may be assumed that a person has well-founded fear of being persecuted if he has already been the victim of persecution for one of the reasons enumerated in the 1951 Convention. However, the word 'fear' refers not only to person who have actually been persecuted, but also to those who wish to avoid a situation entailing the risk of persecution.

……

……..

There is no universally accepted definition of 'persecution', and various attempts to formulate such a definition have met with little success. From article 33 of the 1951 Convention, it may be inferred that a threat to life or freedom on account of race, religion, nationality, political opinion or membership of a particular social group is always persecution. Other serious violations of human rights-for the same reasons-would also constitute persecution'.[8]

……..

……

There is a huge amount of material related to training on the Geneva Convention. The module No2 of UNHCR on Refugee Status Determination (edition September, 2005) is of particular relevance. Especially look at the chapters 2.2.2, 'Well-founded fear', p. 29 and 2.2.3., 'Persecution', p.31.

It should be noted at this point that torture can be, and usually is, a cumulative threat: on the one hand, repeated ill-treatment with threats for more or worse and, on the other hand, also, a threat of life. Therefore, torture can be easily understood as

[8] In cases of massive displacement of populations seeking protection, particular attention must be paid to distinguish traumatized persons and offer special care and protection. This is why UNHCR stresses this issue.

included in the concept of persecution. Deriving from that, evidence of torture is already a very strong element for consideration together with the other elements of the refugee definition and it can be extremely important for the asylum authorities in order to decide to provide protection to the applicant.

It is very interesting to observe the policy followed by UNHCR over the years as regards asylum-seekers who are victims of torture. Since it is not easy, or even necessary, to change article 1A of the Geneva Convention, while, on the other hand, it was more and more understood that an important part of the refugee population are indeed torture victims, guidelines were developed including torture victims into the vulnerable groups, in need of special care and protection[9].

This work was triggered by the needs created by the war in former Yugoslavia and a number of important international experts worked to issue *specific recommendations centered around the need of training all those concerned in cases of refugee recognition and protection.*

This was the beginning of a process within UNHCR to set out the principles and the methods of work with victims of torture within the refugee population, by inviting experts to work on the issue. Among these experts were health professionals working for rehabilitation centres.

This work continued and in an international meeting that UNHCR organised in Athens (December, 1998) where the main focus was on human rights violations, persecution and non-state agents, the issue of victims of torture became one of the central ones in the recommendations addressed to Governments:

' Governments are recommended:

- *to create national procedures for identifying those who are protected by ECHR art.3, CAT art.3 and ICCPR art.7 - - in particular fact finding*
- *to train officials at all levels in international human rights law, and to ensure their awareness of the views and comments adopted by the treaty bodies. All officials should be familiar with the approach adopted by the CAT Committee which considers that discrepancies in statements made by the victims of torture are not uncommon as long*

[9] UNHCR 'Guidelines on Evaluation and Care of Victims of Trauma and Violence', Geneva, December 1993 was the beginning of this important process.

as the inconsistencies do not raise doubts about the general veracity of the application

- *to use as far as possible medical and other relevant expert evidence from professionals specially trained in the field of torture and other traumatic experiences'*[10].

Recently, UNHCR reiterated its instructions to states concerning protection of both refugees and asylum-seekers from torture in case of extradition with a '**Guidance Note on Extradition and International Refugee Protection**', Geneva, April 2008, where it is stated:

'*The protection of article 33(1) applies to any person who is a refugee under the terms of 1951 Convention, that is, anyone who meets the requirements of the refugee definition contained in article 1A(2) of the 1951 Convention (the 'inclusion criteria') and does not come within the scope of one of its exclusion provisions. The principle of non-refoulement as provided for in article 33(1) of the 1951 Convention also applies to persons who meet the eligibility criteria set out in article 1 of the 1951 Convention but have not had their refugee status formally recognized. This is of particular relevance to asylum-seekers. As they may be refugees, asylum-seekers should not be returned or expelled pending a final determination of their status.*

The principle of non-refoulement applies not only with regard to a refugee's country of origin, but also any other country where he or she has reason to fear persecution related to one or more of the grounds set out in article 1A(2) of the 1951 Convention, or from where he or she could be sent to a country where there is a risk of persecution linked to a Convention ground.

……

The requested State's non-refoulement obligations under international human rights law establish a mandatory bar to extradition where the surrender of the wanted person would result in exposing him or her to a risk of torture or other serious human rights violations.

Article 3 of the 1984 Convention Against Torture or Other Cruel, Inhuman or Degrading Treatment or Punishment expressly provides that '[n]o State Party shall expel, return ('refouler') or extradite a person to another State where there are substantial grounds for believing that he would be in danger of being subjected to

[10] UNHCR *Expert Workshop on Human Rights and Refugees: Non State Agents, Athens, 18-20 December 1998.*

torture'. As an inherent part of the prohibition of torture under customary international law, which was attained the rank of jus cogens, the prohibition of refoulement to a danger of such treatment is binding on all States, including those which have not yet become party to the relevant treaties.

The prohibition of arbitrary deprivation of life and of torture and other cruel, inhuman or degrading treatment or punishment under article 6 and 7, respectively, of the 1966 International Covenant on Civil and Political Rights, as interpreted by the Human Rights Committee, also encompasses a prohibition of refoulement to a risk of such treatment. The prohibition under international human rights law of refoulement to a real risk of 'irreparable harm' extends to all persons who may be within a State's territory or subject to its jurisdiction. This includes refugees and asylum-seekers. It also applies with regards to the country to which removal is to be effected or any other country to which the person may subsequently be removed. It is non-derogable and not subject to exceptions.

…… The European Court of Human Rights has held in consistent jurisprudence that a non-refoulement obligation is inherent in the obligation not to subject any person to torture or to inhuman or degrading treatment or punishment under article 3 of the 1950 European Convention for the Protection of Human Rights and Fundamental Freedom (ECHR), and that this obligation is engaged whenever there is a real risk of exposure to such treatment as a result of forcible removal, including extradition[11]*'.*

In short, UNHCR continued to draw the attention of all governments on the issue, especially of the EU governments, which, during the last decade, work on the emergence of an EU common asylum and migration policy, as further analysed in the following chapter.

[11] The leading jurisprudence of the European Human Rights Court is explicit and firm. See the following Court decisions: *Soering v. United Kngdom, 1989, Cruz Varas v. Sweden, 1991, Vilvarajah et al. v. United Kingdom, 1991, Chahal v. United Kingdom, 1996, Ahmed v. Austria, 1996, TI v. United Kingdom, 2000, Saadi v. Italy, 2008.* The European Court of Human Rights reaffirmed its earlier jurisprudence according to which the prohibition of torture and of inhuman or degrading treatment or punishment in Article 3 of ECHR, including the *non-refoulement* obligation inherent in it, is absolute and applies irrespective of the conduct of the individual concerned, however undesirable or dangerous, and the nature of the offence allegedly committed by him or her. The Court also reiterated its earlier finding that it is not possible to weight the risk of ill-treatment against the reasons put forward for the expulsion in order to determine whether the responsibility of a State engaged under Article 3 ECHR.

1.4. European Union Law

A short historical note

Members States have a long tradition of working together on an intergovernmental level on Justice and Home Affairs, ranging from combating crime and terrorism to migration and asylum. **The Amsterdam Treaty** put these issues firmly on the European Union's agenda, making them not any longer a purely intergovernmental affair. In addition to a chapter on the free movement of persons, a new chapter of the EC Treaty deals with visas, asylum, immigration and other policies related to the free movement of persons. As part of the establishment of an area of freedom, security and justice, the Treaty sets out a programme with a five years' deadline for the adoption of a common asylum and migration policy. Europe's commitment to human rights is reiterated as a basis for the further integration and enlargement of the European Union. *(see Annex 1)*

The 1999 Tampere European Council took a number of decisions providing a political mandate and programme for action. A high-level working group on asylum and immigration was set up and a 'Scoreboard' was introduced which had to review progress, twice a year, made in the implementation of the programme of action. A new Directorate General Justice and Home Affairs was created and headed by a Commissioner. In the years following the entry into force of the Treaty of Amsterdam a great number of legislative initiatives were taken, the large majority of them initiated by the European Commission. Individual Member States also regularly used their right to take legislative initiatives. This chapter gives an overview of the most important legislative measures proposed and adopted in the field of our interest.

1.4.a.Minimum Reception Conditions

In 2001, the European Commission tabled a proposal for a Council Directive laying down minimum standards on the reception of asylum-seekers by Member States. The proposal required states to ensure a dignified standard of living to all asylum-seekers, paying specific attention to the situation of applicants with special needs or in detention. The text was formally adopted and came into force in 2003. The Directive is designed to meet two important objectives of the common asylum system: to guarantee a dignified standard of living for people coming within the scope of the Directive and to limit the movements of asylum applicants (to prevent the so-called 'asylum shopping'). The Directive is in particular concerned with issues of information, documentation, freedom of movement, but also with healthcare,

accommodation, schooling of minors, and access to the labour market and vocational training. Special rules are set for persons with special needs, minors, unaccompanied children **and victims of torture**. The relevant chapter C of the Directive explicitly provides for these categories of persons in a detailed way in articles 17, 18, 19 and 20, which, more particularly, provides for the obligation of state authorities to transfer victims of torture, rape or other serious acts of violence to specialized services for the necessary support and treatment. It is also important to notice that this transfer should precede the asylum determination interview. In this way, it becomes obvious how important it is to have confirmation by specialists of the allegations about torture, rape, etc. for consideration in the asylum procedure. So far, all over the world the only specialized services existing for identification and treatment of torture victims are the rehabilitation centres.

1.4.b.Qualification Directive

The relevant directive (2004/83/EC of the Council of April 29, 2004 – EL 304/30-9-2004) providing for minimum standards to be established by Member States in granting and withdrawing refugee status procedures, adopted after a long period of negotiations evolving around a number of issues, includes a number of very important provisions relevant to torture victims.

In article 9, the Directive gives a frame in order to define which acts against an asylum seeker can be considered as acts of persecution in order to consider granting refugee protection. In this context, acts of persecution can especially be acts of somatic or psychological violence, including acts of sexual violence. In this way, the Directive wants to include torture, ill-treatment, etc. when considering an asylum application.

In the field of subsidiary protection, again, the Directive is its article 15 gives the frame of the meaning *serious damage* in order to include in a protective regime persons at risk. Serious damage can de either death penalty or execution or torture or inhuman or degrading treatment or punishment of the applicant in the country of origin or serious personal threat against the life or the personal integrity of a non-combatant due to indiscriminate violence in case of war or internal conflict. .

As to the contents of the international protection, the Directive includes in this chapter both recognised refugees and people protected under subsidiary protection. In article 20, § 3, it is provided that the special condition of vulnerable people is taken into consideration; torture victims are included among

other categories of vulnerable groups. It further provides for a case by case evaluation in order to identify these special needs. There is a very important issue here: while it is rather easy to identify unaccompanied minors, elderly with health problems, pregnant women or single mothers, etc., it is difficult to detect and identify torture victims or rape victims within a larger group of persons.

Therefore, asylum authorities in order to fulfil their obligations deriving from the Directive need particular training, on the one hand, and co-operation with specialists, such as the rehabilitation centres, on the other hand.

1.4.c. Asylum determination procedures

The Council Directive 2005/85/EC of 1 December 2005 on minimum standards on procedures in Member States for granting and withdrawing refugee status, hereinafter 'Procedures Directive'

The Directive should come into force in all Member States in December 2007, therefore it is early to say whether there was any detailed assessment about its implementation.

There are certain points that need special attention as far as torture victims are concerned. First of all, member states can apply this procedure also for cases needing subsidiary protection. Therefore, torture victims who may fall under either asylum regime or subsidiary protection regime are concerned.

Secondly, in the considerations 17[12] and 21 of the Directive torture victims are taken into account.

Thirdly, in the articles relevant to the personal interview, in the article 12, § 3 is relevant to torture victims. Article 13, § 3 is also relevant.

The risk of torture or ill-treatment is also taken into consideration in the provision concerning the safe third country of asylum and the safe third country issue. It should not be omitted that the annex 2 of the Directive which sets out the criteria for determining whether a country is safe or not includes all the International Conventions relevant to protection from torture[13].

It will be necessary to re-visit the subject of this Directive after the first review following its implementation in order to draw the relevant conclusions. In any case, of

[12] '*A key consideration for the well-foundedness of an asylum application is the safety of the applicant in his/her country of origin. Where a third country can be regarded as a safe country of origin, Member States should be able to designate it as safe and presume its safety for a particular applicant , unless he/she presents serious counter-indications*'

[13] European Convention for the Protection of Human Rights and Fundamental Freedom, International Covenant for Civil and Political Rights, Convention against Torture.

particular for victims of torture, rape or other forms of organised violence are the procedures existing in almost all European countries providing for very fast processing of the asylum application (**accelerated asylum procedures**). Many criticisms have focused on this issue because of its great risk of sending back to countries where they may face torture or ill-treatment applicants who did not have sufficient chances to expose the facts and obtain protection. Even the Parliamentary Assembly of the Council of Europe issued Resolution 1471 (2005) pinpointing the specific danger *(see relevant paragraphs of Resolution in Annex 3)*

1.4.e. Monitoring of the implementation of European Law and Policy

a. The European Commission, following its usual practice, in order to assess the effectiveness of measures taken in this field, mandated in 2006 the Odysseus Academic Network (which, in many cases, acts as a consultant to the Commission for policy issues) to conduct a study on the implementation of the Directive 2003/9 of 27 January 2003 on laying down minimum standards for the reception of asylum seekers in the EU Member States (**Reception Directive**). (*See in Annex 4 a number of relevant findings and recommendations of this study).*

Among the most important deficiencies of the system established by this Directive, the study stresses the lack of a system of proper identification of vulnerable persons, and more particularly, of torture victims that cannot be identified at first sight, as for instance is possible for pregnant women, single mothers, unaccompanied minors, etc.. Suitable procedures for an initial medical screening with mental health component should be discussed and, as a first step, the study proposes to exchange best practices.

Another question is of particular importance in the study: unless there is an effective procedure of identification of torture victims, the mandatory character of the relevant provision of the Directive shall remain a dead letter.

It further suggests to train health professionals with the help of tools, such as the Istanbul Protocol of the UN and the manual 'Examining Asylum Seekers' elaborated by the Physicians for Human Rights.[14]

b. Study of UNHCR on the **Qualification Directive**. This study describes deficiencies that need to be amended in the system of the Qualification Directive[15].

[14] Documents, including the above, are the outcome of long years of experience and knowledge of the work of rehabilitation centres around the world, used as standard methods by the rehabilitation centres for identification purposes, in order to proceed to treatment.

In relation to this Directive, it is relevant to analyse in particular, as far as torture victims are concerned, the chapter on Subsidiary Protection. These provisions represent the first super national legislation on European level regarding subsidiary protection and create obligation for the state to grant this status to those who qualify. However, although the Directive in Law has expanded the scope of international protection, in practice, due to procedural flaws and to a narrow interpretation of the Directive, subsidiary protection is not granted to a significant number of those who have a right to it. One such problem arises concerning the interpretation of the term 'individual threat', since it appears to be incompatible with the case law of the European Court of Human Rights. (*See in Annex 5 this issue more in detail).*

1.5.*European Refugee Fund*

The European Union, recognizing the importance of the multi-level work of refugee protection and assistance, inside and outside its borders, has created a financial instrument under the title European Refugee Fund (ERF), which supports activities in the specific field, including state level projects, but also NGO run actions. The positive influence of ERF in improving the system is already visible.

1.6. Council of Europe

General comment

It should not be forgotten that all the issues discussed so far in this chapter cannot be seen outside the frame of the relevant Resolutions (decisions of the **Council of Europe**). Legislation adopted by the Council of Europe is consisting of provisions interpreting and implementing the European Convention of Human Rights, one of the basic sources of law, for European Union Law also.

Therefore, it is very necessary to keep in mind when considering the whole body of provisions of the Directives the following:

1.6.a. The Council of Europe's position on Removal to Country of Origin[16]

Various bodies of the Council of Europe have repeatedly made it clear that the prohibition on the return of individuals to countries where they are at risk of torture or other inhuman or degrading treatment or punishment is absolute. These statements

[15] 2004/83 Directive of 29 April 2004 on minimum standards for the qualification and status of third country nationals or stateless persons as refugees or as person who otherwise need international protection and the content of the protection granted.

[16] For detailed analysis, see ELENA Cessation and Exclusion Clauses, National Security and Non-Refoulement, 22-14 February 2008, Athens-Greece, article of mrs Nuala Mole, page 375, excerpts of which are presented here.

taken together form a consensus, which is now being challenged, that makes clear that a state- party to the ECHR may not remove an individual, regardless of the threat they pose, once it has been established that their refoulement will lead to a real risk of that individual being tortured.

The obligation of the Member States of the Council of Europe under article 3 of the Convention is not only to abstain from prohibited treatment themselves, but also to be instrumental in not exposing individuals to such treatment. This is what can happen when individuals are sent to a state where they face a risk of being ill-treated. Where this is a real risk, the Council of Europe has repeatedly made it clear Governments are prohibited from carrying out the expulsion.

1.6.b.View of the Committee of Ministers

The Committee of Ministers of the Council of Europe has agreed on several occasions that individuals may not be lawfully returned by States to nations where they may be threatened with torture or other prohibited treatment. Measures adopted by the Committee of Ministers are an expression of the collective consensus of the Member State governments.

The Committee of Ministers of the Council of Europe adopted unanimously on 2002 'Guidelines on human rights and the fight against terrorism'[17].

In Guideline XII on 'Asylum, return ('refoulement') and expulsion', the Committee agreed that:

'*2. It is the duty of a State that has received a request for asylum to ensure that the possible return ('refoulement') of the applicant to his/her country of origin or to another country will not expose him/her to the death penalty, to torture or to inhuman or degrading treatment or punishment. The same applies to expulsion*'.

The Committee goes on in Guideline XIII on 'Extradition' to insist that:

'*3. Extradition may not be granted when there is serious reason to believe that: (i) the person whose extradition has been requested will be subjected to torture or to inhuman or degrading treatment or punishment*'.

The Guidelines do not permit or suggest any exception to the prohibition or return. These Guidelines were adopted expressly in the context of the fight against terrorism and they are couched in the same absolute terms as the jurisprudence of the Court.

[17] 'Guidelines on human rights and the fight against terrorism', adopted by the Committee of Ministers at the 804th meeting of the Ministers' Deputies, 11 July 2002.

In 2005, the Committee of Ministers spoke again when they adopted 'Twenty guidelines of forced return'[18]. These guidelines were adopted at the behest of the Parliamentary Assembly which was concerned about the 'present climate of hostility towards refugees, asylum seekers and immigrants', which, if it continues, would threaten ' the Council of Europe's fundamental values'.[19] The Committee agreed it should 'draw up a code of good conduct for expulsion procedures'.

In the second guideline, the Committee made it clear that a State can only forcibly remove after it has been shown the return will not be exposed to a 'real risk of being executed, or exposed to torture or inhuman or degrading treatment or punishment'. Again, the Committee of Ministers did not state any exception to the prohibition on forced return that risks exposure to ill-treatment.

In these guidelines, the Ministers of the Member States of the Council of Europe have restated their position that return is forbidden if it would lead to a real risk of prohibited treatment. Yet in spite of this recent affirmation by the States intervening in this case, they seem to be seeking to move the Court away from the position they so recently expressly articulated.

The Committee of Ministers have consistently agreed the prohibition on return to face ill-treatment is not-derogable. These pronouncements have spanned the last several years and in all of it there is not one exception listed for when a person can be lawfully expelled to face treatment prohibited under article 3 of the Convention on Human Rights. The Ministers have embraced the previous case-law of the Court that article 3 of the ECHR and many other international instruments are violated by a State forcibly expelling an individual to a nation where they confront a real possibility that they will be tortured or threatened in other ways that are cruel, inhuman, or degrading.

1.6.c.Resolutions of the Parliamentary Assembly

The Parliamentrary Assembly of the Council of Europe is the voice of the democratically elected representatives of the 46 Member States of the Council of Europe. The Assembly has adopted several resolutions which contain a clear commitment to forbid all return of individuals to States where they risk treatment contrary to article 3 of the ECHR.

Among these, is Resolution 1471 which, like the 'Twenty Guidelines of the Committee of Ministers', was adopted in 2005. the Resolution is titled 'Accelerated

[18] Document CM(2005)40, adopted 4 May 2005.
[19] Parliamentary Assembly Recommendation 1547 (2002), paragraph 8.

asylum procedure in Council of Europe member states' and it was adopted in the context of the Member States designing their processing of asylum claims.[20]

The Parliamentary Assembly adopted this Resolution in response to the heavy criticism made from many quarters of the proposed European Union Council Directive on minimum standards for accelerated asylum procedures. One of the criticisms the Assembly thought important to note was the fear that the proposed Council Directive 'will lead to refoulement'.

In Resolution 1471, the Parliamentary Assembly termed the prohibition on return to face torture 'the corner-stone of international refugee protection' and mandated that Member States ensure any asylum procedures they adopt protects against *non-refoulement* of individuals without exception.

The Assembly stated its position even more explicitly in 2002 in Resolution 1271.[21] This Resolution adopted by the Parliamentary Assembly resolves that Member States 'should under no circumstances extradite persons who risk being subjected to ill-treatment in violation of article 3 of the European Convention on Human Rights'. Little doubt is left that the Parliamentary Assembly was referring to the settled interpretation of article 3 which makes clear that the prohibition on return to face inhuman treatment is absolute.

The title of the Resolution should be noted – 'Combating terrorism and respect for human rights'. The Assembly is affirming that, in the context of the war on terrorism, the ban on return to face torture is still non-derogable under the ECHR.

1.6.d. Reports of the Committee for the Prevention of Torture (CPT)

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment ('CPT') produces a report every year on their activities and issues related to their activities. In their most recent report, they expressed the similarity between their views and those of the Committee of Ministers in its 'Twenty Guidelines on Forced Return' as discussed above in paragraphs 18-21.[22]

The CPT also stated that while 'Present times continue to be marked by the fight against terrorism', that:

[20] Parliamentary Assembly Resolution 1471 (2005).
[21] Parliamentary Assembly Resolution 1271 (2002).
[22] Committee for the Prevention of Torture, 15th General Report, 22 September 2005, page 15.

'*the universal recognition of the prohibition of torture and inhuman or degrading treatment…occurred in the immediate aftermath of a world war…And it was a time of continuing uncertainty and danger. Is there anything so different … today? In fact, it is precisely at a time of emergency that the prohibition of torture and inhuman or degrading treatment is particularly relevant … the prohibition … is one of those few human rights which admits of no derogations. Talk of 'striking the right balance' is misguided when such human rights are at stake*'.

1.6.e. Comments of the Secretary General of the Council of Europe

In 2005, Mr. Terry Davis, the Secretary General of the Council of Europe, re-affirmed that the ECHR[23]: '*includes an absolute ban or transferring any person to another jurisdiction if there are substantial grounds to believe that the person would face a real risk of being subjected to such ill-treatment. This is the 'settled case-law' of the European Court of Human Rights and a commonly agreed position of the Governments of the Council of Europe, contained in 2002 'Guidelines on human rights and the fight against terrorism', which were unanimously approved in the wake of the terrorist attacks in the United States. It is wrong to suggest that this unequivocal legal and political position has changed as a result of recent terrorist threats. There cannot be any question of 'striking the right balance' when absolute rights are at stake*'.

These words of the Secretary General send a very clear message that within the Council of Europe, the prohibition on return to torture and ill-treatment is non-derogable. Though the Government intervenors may be pushing for 'striking the right balance', to do so would go against the position of the Secretary General and, in his words, against the 'settled case-law' of the Court.

The absolute right to not be tortured under article 3 is violated when a State sends someone to a nation where they will face treatment that is banned by article 3 – and, as Mr. David says, 'it is wrong to suggest that this … has changed as a result of recent terrorist threats'.

Further, the CPT provides specific instructions and guidance to the Immigration and Asylum authorities of the Members States of the Council of Europe as regards the treatment of foreign nationals, detained under aliens legislation [24]

[23] Statement of the Secretary General in Strasbourg, 11 October 2005 [Annex A].
[24] The CPT standards, revised edition of 2006, p.39. See Annex 6.

CHAPTER 2

Evidence of Torture and Documentation

2.1. General guidelines

The aim of this chapter is not to provide training to health professionals dealing with **documenting** torture allegations, but rather to provide accurate information to state officials and lawyers about the general framework of the medical work and the particular methods used by health professionals to investigate allegations of torture and to liaise the findings, physical and/or psychological, to the events that took place when the torture victims suffered the alleged crimes. Therefore, the very extensive medical work as it is analysed in the Istanbul Protocol and other texts based on it, is not relevant to non-health professionals. However, health professionals performing their duties in reception centres or in detention centres or in hospitals, where detainees may be transferred, need this more general information in order to detect a probable torture victim and to collaborate with the specialists for further evaluation and treatment.

The present shortened analysis aims to provide both state officials and lawyers, as well as health professionals with enough knowledge, based on the Istanbul Protocol, helping them to be alerted before a possible torture case in order to refer and to collaborate with the specialists.

The particular aims and goals of investigating torture, including medical documentation, is based on the fact that in International Law, but also in National Law (at least in all the European Union countries), **torture is a crime**. International Law, not only prohibits the use of torture, but also imposes to the states to conduct thorough investigation of any allegation of torture and to bring the perpetrators before the Justice system. A number of particular goals are achieved in that way:

- raising awareness
- fighting impunity
- redress for the survivor, including compensation, restitution and rehabilitation
- reforming the system, which will mean changes in legislation, practices, education and training of State personnel, etc.

2.2. Character of team work in rehabilitation centres[25]

A basic element of the work performed in rehabilitation centres is the multidisciplinary approach. Although a health professional would, in theory, be able to document torture sequelae alone, in practice he needs to have thorough knowledge about the country of origin of the victim, including especially torture methods and the particular variations used by the Security personnel of the country in question. There are many particular characteristics having to do with traditions, culture, habits, etc., which differentiate even the same methods. These issues are studied and known by a small circle of experts. **This knowledge is also used by the rehabilitation centre professionals in order to control the veracity of the victim's allegations.**

The specialized health professional knows as well what exactly symptoms are experienced by a torture victim in the various stages of the period following the torture event. These stages and symptoms are very characteristic and no person can fully describe them without having been through the experience.[26]

Therefore, the collaboration of a human rights expert, of a specialized lawyer, who can thoroughly understand the legal system of the country of origin and of the health professional, is, ideally, the team working on the documentation of torture. In this way, it is possible to relate the cause with the outcome, that is to say the particular method of torture used to the sequelae. This is precisely why rehabilitation centres are in a position to document torture and to link the method used with the scars, etc., produced, which is not possible, as it has been observed repeatedly, even for experienced forensic doctors, who, although perfectly able to describe scars, wounds, etc., lack the knowledge about countries of origin and torture methods used, which would help to correlate and link the two ends of the equation.

It should never been forgotten that the first concern of the health professional is the immediate health and well being of the torture survivor, in other words his/her therapeutic role in treating the patient. In case the same health professional is asked to play a forensic role, in establishing possible causes and origins of somatic and psychological sequelae, there are concerns that this dual role may cause a bias in the reporting. Therefore, in the rehabilitation centres attention is given to this particular

[25] The purpose of this description is to make evident that the process of identifying and documenting torture is a very complex one that is not possible to take place in any structure such as reception centres, etc. The primary aim for the asylum authorities is, having all this knowledge, to detect possible torture victims and to refer for further processing to the rehabilitation centres.

[26] Professionals working in the frame of the rehabilitation centres for torture victims are trained following the Istanbul Protocol and other international instruments.

issue in order to ensure that the process of documenting torture is not preventing to provide the necessary care to the torture survivor, including especially the following:

- short term treatment and long term rehabilitation
- psychological assessment and long term therapy
- detailed recording of any physical signs of injuries and psychological symptoms and long term treatment of both.

In working with torture victims it should also be kept in mind that certain methods of torture used may not leave physical signs and it must be emphasized that the absence of physical or psychological findings can never be considered as evidence that torture did not occur. Therefore, in case a **medical certificate,** issued by a rehabilitation centre, states that it has not been possible to document physical or psychological sequelae, does not mean that it is a negative certificate. It merely means what it says, in other words that sequelae have not been found, but the allegations of the victim may very well be true.

Role of the lawyer

Collecting facts and evidence in order to establish the facts is a primary role of the lawyer, including all available details of times and places of the victim's alleged torture, as well as, if possible, elements of identification of the torturers.

Following the above, the lawyer will be the link between the victim and the Judicial or Administrative system that the torture victim has to face, advising on the many procedural aspects. The lawyer's role may begin while the torture survivor is still in custody (usual practice concerning asylum seekers) and may continue until redress has been achieved. In his/her work the lawyer will include statements of the individual (victim), of possible witnesses, as well as medical evidence obtained with the help of the health professional.

Role of the human rights expert

This role has a multiple nature: on the one hand, the human rights expert gathers, in view of a specific case of torture survivor, all the information existing in regard to the country of origin and its human rights record (especially in torture methods, judicial system, Penal Law, prison system, etc.) and on the other hand advocacy, dissemination of the information through the proper channels, the final aim being prevention.

The human rights expert is in a position to help the two other professionals in a very important way; in understanding and evaluating the information available about the country in question, in order to place the individual case in the right context.

In some cases the role of the lawyer and the role of the human rights expert could be held by the same individual.

2.3.Medical Documentation

Medical documentation is valuable and plays a very important role into all the general aims of investigating torture allegations. Producing a detailed extensive record of signs and symptoms of torture is the basis for further producing a comprehensive report. It provides also detailed understanding of the case, so that the person can be referred to specialists (for instance, to a rehabilitation centre) for the appropriate treatment. It will be also the basis for producing a medico-legal report for use by a Judicial or Administrative Authority. In the case, for instance, of asylum seekers, medical evidence can be used as part of the evidence showing what happens in the country of origin and how the applicant's case fits into this more general picture. It can also serve to document patterns of torture in the various countries for use by Courts, NGO's, Intergovernmental Bodies, etc.

Medical evidence is often used together with other types and forms of evidence, such as the individuals' statements, possible witnesses' statements, other forms of third party evidence (experts' testimony), objective evidence on the subject of patterns of torture in the circumstances of the particular country, time, etc. (which usually includes reports of international bodies and NGO's), as well as any other additional element that can help to support and substantiate the case (press articles, etc.).

Medical evidence is also used in a more general way when visiting places of detention in order to support allegations of conditions and treatment amounting to torture or ill-treatment. In this case, medical documentation does not lead necessarily to the production of a medico-legal report on specific cases, but is used to show the abuses and to support preventive action (most characteristic example is the work of the European Committee for the Prevention of Torture, known by the initials CPT).

When using medical evidence it should always be kept in mind that it is usually forming part of the supporting material in the individual case, which adds strong support to the testimony of the victim. In many cases, though, medical evidence cannot be conclusive by itself, because many methods of torture leave few

traces. Even more so, many methods of torture leave even fewer traces in the long term (this should be kept in mind especially when it comes to cases of asylum seekers, as there is usually a long distance in time between the torture events and examination by an asylum authority). There is also the difficulty in some cases to distinguish signs of torture (scars, etc.) from accidental or other causes of these signs with a high degree of certainty. What the medical evidence can do is to demonstrate that injuries, scars or other clinical findings described ***are consistent with*** the method of torture described. This includes physical and psychological sequelae. [27]

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[27] An example demonstrating what has been analysed above is given by a case before the European Court of Justice

Case of Selmouni v France

(Application No.25803/94

Judgment

Strasbourg

28 July 1999

The European Court of Human Rights, in reaching its conclusion, cited the medical findings in an earlier judgement of the Versailles Court of Appeal. The reliance on medical findings demonstrates the significance of thorough medical documentation as a tool in establishing allegation of ill-treatment.

'As to the medical findings

The accusations made by the civil parties are supported by unequivocal medical findings. In the first place, as regards Selmouni, the expert Professor Garnier noted in his report of 5 May 1998 that all the doctors who had examined him while he was in police custody had found lesions of traumatic origin on the left arm, in the left orbital region, on the scalp and on the back. On 29 November 1991 further lesions were seen on the lower limbs. He added that during his examination on 7 December 1991 he had again found lesions that had been described earlier and that he found others on the buttocks and on the right ankle.

The extent of the injuries on Selmouni's person increased as the uninterrupted police custody continued.

The bruising on the left eyelid, the thin linear scar one centimetre long continuing the line of the left eyebrow, the left and right sub-orbital haematomas found on 29 November 1991 by Dr Edery, and then described on 2 December 1991 by Dr Nicot as being «round the eyes», <u>are consistent with</u> the punching mentioned by Selmouni.

The various haematomas found on the thorax, the left and right sides and the abdomen <u>are consistent with</u> the punching and kicking in his statement of 7 December 1991.

The pain in the scalp and the headaches mentioned by Drs Aoustin and Edery are likewise of a kind to support Selmouni's statements, according to which his hair was pulled and he was repeatedly tapped on the head with an instrument which could have been a baseball bat.

The haematomas found on his buttocks and the thighs could only have come from blows by a blunt instrument. Similarly, the lesions apparent on the legs, ankles and feet <u>are consistent with</u> the blows or crushing that Selmouni complained of.

It follows from the foregoing that the objective injuries, as recorded in successive examinations, match the blows described by Selmouni.'

2.4. Evidence

The importance of precise and accurate evidence does not need to be explained. During the process of thorough investigation and documentation of torture, as done in the rehabilitation centres, certain principles and patterns are used, which are too complicated and detailed for the initial stage of work, such as it can be done in reception or detention centres by asylum services staff and health professionals with general duties.

However, it is of primary importance, given the element of time, to keep in view certain important parameters which will facilitate further work. At this point, it should also be stressed that since proper identification and investigation procedures take a lot of time, it is of paramount importance to place possible torture victims outside accelerated procedures.

For the initial stage of identification[28] and investigation it is very useful to take notes on the following:

- **identity of the victim;** full name, gender, age, occupation and address should be included and additionally, photograph, description of appearance, any relevant documents (ID card, driver's licence, diplomas, medical files, etc.)
- **identity of the perpetrators;** in some cases it is possible to identify a particular individual or individuals. However, usually such information is not known, but in order to show the link between the perpetrators and the State, to establish State's responsibility, it will be enough to have relevant information, such as: if they are members of the Army or the Police or Security Service, description of uniforms, signs of rank and possibly names. Also, description of vehicles, weapons and any other characteristic able to identify the perpetrators.
- **description of arrest or apprehension;** under this come details such as: time, date, place, manner of arrest or apprehension, use of violence or restraints
- **description of the location of torture or ill-treatment event**; this location could be a prison, a police detention area, a military camp, a detention centre for foreigners or any other place, even an outdoor place. Additional information would include description of the room, such as size, furniture or

[28] These paragraphs are of practical importance both for asylum authorities and health professionals working in reception centres or general hospitals.

equipment, hygiene conditions, lighting, presence of others, access to medical care, to legal aid, etc.

- **description of torture or ill-treatment**; the account of what happened will include exactly what and how frequently it occurred, what were the immediate effects and what at a later stage, whether there was presence of anyone else in the room, including other detainees or Security personnel or others, what instruments were used, whether medical attention was given and the exact parameters of this (requested, denied, before, during and after torture).
- **witnesses**; details about those present during the torture or ill-treatment, including their identity and role (for example other detainees present) are extremely useful. This includes persons who saw the torture victim immediately after the torture or ill-treatment (for instance cellmates or medical staff of the prison or detention centre)

As in all cases documenting human rights violations it is of paramount importance to collect accurate, precise and detailed information for reasons of reliability. This has to do with various factors:

- source of information; it is important to have direct information from the victim. Second or third hand information about the event of torture is likely to be less reliable.
- Contradictions; inconsistencies and contradictions that are minor should not influence the overall account of the events. Major contradictions should motivate to seek further clarifications without rejecting at first sight the information given. It should be noted here that up to a certain extent gaps can br explained on psychological or physical reasons.
- Documentation supporting the account of torture; the more existing documents that could support the allegation of torture the better, if possible. However, absence of such documents does not mean that torture did not take place.
- Patterns; the extent to which there are more allegations of torture, following a certain pattern as to the methods used, as regards the same country, situation, etc., is supportive to the specific case..

2.5. Medical Reports

The process of identification and thorough investigation of torture, as far asylum seekers are concerned, may begin at a reception or detention centre[29], but will most probably end with a medical report drawn up by specialists in a rehabilitation centre. It is necessary, therefore, for asylum authorities to understand the form and the contents of such reports and this is why we need to stress the following:

At the end of an examination of a torture allegation (which may take a period of time over which various tests, interviews, examinations, etc. take place) and at the request of the victim, a medical report may be drawn up, according to the following general lines:

a. The account of the events as described by the victim. This account contains events before and during arrest and conditions of detention, events concerning torture, descriptions of symptoms and signs at the time of torture and posterior health condition in general.
b. Physical and psychological findings in detail.
c. Professional opinion of the causes of these findings and, finally,
d. Conclusion about whether these specific findings can be attributed to the symptoms and signs described as a result of torture or ill-treatment.

It should not be forgotten that organizations such as the rehabilitation centres are multidimensional in their function in the society, in the sense that they do on the one hand work on health issues but, on the other hand, they document gross human rights violations. The exchange of specialised information among the rehabilitation centres helps to **establish methods and patterns of torture** in the countries of origin of asylum seekers. This second aspect of the rehabilitation centres' work leads to their involvement in the protection of the individual who has been proven to be a torture victim. In the specific situation of asylum seekers, this protection means not to send back to a country persons who are at risk of being subjected to torture (as it has been dictated by art. 3 of the U.N. Convention Against torture- CAT and of the art. 3 of the European Convention for Human Rights). This is why several rehabilitation centres when drafting a medical report consider necessary to add a special mention to the obligation of states to respect the above rules.

[29] See previous paragraph 2.4.on evidence

CHAPTER 3

Professional Codes of Conduct and Medical Ethics

3.1.Introduction

In many professions there exist codes of professional conduct setting a frame of obligations relevant to the nature of the profession. Most of these codes have been adopted by international bodies, such as the Council of Europe, UN Bodies and other international organizations, in a way creating, on the national level, the obligation to conform to these provisions. Such is the example of the UN Code of Conduct for Law Enforcement Officials and the Council of Europe relevant Code of Conduct, relevant to Police Ethics, codes of conduct concerning prison officers, prosecutors, etc. Some of these codes include also an obligation of secrecy (for example lawyers).

In the same way, the term «medical ethics» is the term describing the general moral frame binding health professionals as to how to perform their duties. All particular specialities in the health professions have these moral obligations, including medical doctors, nurses, psychologists, clinical assistants, social assistants, social workers, etc. Many of the rules and the principles of medical ethics have been formally adopted as professional codes of conduct. These codes, adopted by the highest Boards or Councils on international level, representing the Institutional and moral Authority in each one of the health professions (such as the World Medical Association), have then been adopted and recognized by the United Nations as official texts carrying world authority. As such, these texts are guidelines to be followed by all nations and countries when adopting relevant legislation (such as national Deontology Codes), as well as for all Courts, national and international, when considering specific cases under their jurisdiction[30]. *(Please find the list of the relevant texts in annex 2, Part 3).*

Following the principle that medical ethics must guide health professionals in all aspects of their work, when we examine the more particular case of how to investigate and how to document violations of human rights, such as torture and ill-treatment, we have before us some specific ethical considerations which the health professional has to know and follow.

[30] Understanding this chapter is useful not only for the health professionals, but also for asylum authorities. It will lead to a better understanding of positions taken by health professionals in various circumstances related to the whole issue of asylum procedures, health issues and identification of torture victims.

These specific fields are: the duty to the patient, clinical independence and the way to produce medical reports.

Related to this issue are some particular situations encountered by health professionals, which raise particular ethical considerations. An example of this is the medical examination of a person who is brought to a hospital or a clinic in custody of Police or other Security Force and another issue is dual obligations of health professionals working in prisons or detention centres.

Knowledge of these issues is necessary not only for the health professionals, but also for asylum authorities, police staff, detention centre officers, prison officers, etc. in order to understand where is the *red line* where conflicts can arise and what solutions should be given.[31]

3.2 Duty to the patient

Health professionals have the duty to provide treatment to all patients based on medical criteria only. This means that any kind of discrimination, as well as any kind of outside influence, is violating this primordial duty establishing the relation between doctor and patient (not only medical doctor, but all health professionals).

This principle constitutes the health professionals' primary duty. According to the Tokyo Declaration «the doctor's fundamental role is to alleviate the distress of his or her fellow men, and no motive, whether personal, collective or political, shall prevail against this higher purpose».

And in other words, the World Medical Association in its Declaration on the Rights of the Patient states "whenever legislation, government action or any other administration or institution denies patients these rights, physicians should pursue appropriate means to assure or to restore them".

In fact, many UN documents are relevant to the specific ethical obligations of doctors and other health professionals, for example:

- Principles of Medical Ethics relevant to the role of health personnel, particularly physicians, in the protection of prisoners and detainees against torture and other cruel, inhuman or degrading treatment or punishment
- Body of Principles for the protection of all persons under any form of detention or imprisonment
- Standard Minimum Rules for the treatment of prisoners

[31] As an example, issues frequently raised are: medical examinations of handcuffed detainees and in the presence of police or security forces.

- Manual on the Effective Investigation and Documentation of torture and other cruel, inhuman or degrading treatment or punishment (Istanbul Protocol)

The above documents point out in a strong way that it is a gross violation of medical ethics to participate in torture or other ill-treatment or condone it in any way. Participation can be active or passive.

Furthermore, medical services must be provided without discrimination and the ethical obligations of health professionals, as to how to perform their duties in the best interests of their patients, are given in detail.

3.3. Prohibition for health professionals of involvement in torture

When investigating the various parameters of torture cases, it is standard practice to inquire about possible participation, active or passive, or even mere presence of health professionals. For instance, deprivation of medication for non-medical reasons in detention conditions is considered as ill-treatment.

In a number of international standards the question of direct involvement, active or passive, and the obligations of health professionals in relation to torture and ill-treatment are addressed. The World Medical Association in 1975 has adopted the Tokyo Declaration entitled «GUIDELINES FOR MEDICAL DOCTORS CONCERNING TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT IN RELATION TO DETENTION AND IMPRISONMENT». This Declaration contains the rule of absolute prohibition on any form of participation, active or passive, of a doctor in torture or ill-treatment. The text states:

«*The doctor shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offence of which the victim of such procedure is suspected, accused or guilty, and whatever the victim's belief or motives, and in all situations, including armed conflict or civil strife.*

The doctor shall not provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment.
The doctor shall not be present during any procedure during which torture or other forms of cruel, inhuman or degrading treatment are used or threatened».

These principles apply not only to medical doctors, but to all health care professionals. For instance, nurses' obligations have been described in the position statement on Nurses' Role in the Care of Prisoners and Detainees, which has been adopted by the International Council of Nurses. In that text the obligation of the nurse to restore the health and alleviate the suffering of the patient, including prisoners or detainees, and to protect them from ill-treatment is described with particular emphasis. In a similar way, the World Psychiatric Association has issued specific guidelines, which prohibit any participation of Psychiatrists in torture. The text is entitled «Declaration of Madrid» of 1996.

The meaning of «participation» in torture refers either to action at the time of the abuse or at a later stage or by omission to act.

For example, ***active participation*** of a health professional would be to evaluate, mandated by the Authority, whether or not a person is in a position to withstand torture or ill-treatment, or to be present during the scene of interrogation under torture, in the role of supervisor, in the role of participant or in the role of resuscitating the person under interrogation, so that ill-treatment can continue. Other examples could be to put medical knowledge in general to the service of the torturers or particular medical information for the person under torture.

Of particular importance in this relation is, especially nowadays, medical advise, information and guidance given to torturers for use, concerning torture methods not leaving physical traces, such as scars, etc., in order to avoid recognition and documentation by specialists. The knowledge of physicians concerning the human body can lead to this illegal, unethical and distorted use of knowledge that has been acquired for the benefit of human beings. Examples of such methods we encountered in the recent years more and more are the «submarino», shaking, sensory deprivation (like the Guantanamo prisoners), «cultural» torture (nakedness, use of dogs-like in Abu Graib).

Passive participation or ***participation by omission*** could be, for example, the act of not providing medical treatment, in order to aggravate the condition and the pain of a torture victim, as well as issues having to do with reporting or not cases of ill-treatment or torture or falsifying reports in such cases.

3.4. Possible conflicts

Following the above reasoning about active or passive participation of health professionals, one should stress particular cases and situations where a health

professional may face problems of conflict between the principles of professional ethics that he/she is bound to respect in all cases and all situations and different orders by his/her employer, for instance in the case of a prison doctor or a detention camp doctor or a police doctor. As a health professional he/she has to provide indiscriminately his/her services to the patient, whoever this patient may be and to provide treatment, alleviate suffering and fully document the findings in case there has been torture or ill-treatment. On the other hand, he/she could be asked to examine a person before interrogation, in order to make certain that this person will be able to be submitted to «tough» methods, or to revive or treat a person under interrogation in order to continue, etc.

In all such cases the health professional must respect the rules of medical ethics and remember that the primary duty is to the patient, he must refuse to participate in torture or to tolerate it, he must do everything in his/her power to end torture or ill-treatment and to document physical and/or psychological sequelae.

Furthermore, health professionals should always keep in mind that, apart from being bound by medical ethics, are also bound by the rules of International Law, according to which torture is a crime against humanity and in several cases can lead to criminal responsibility for participation to torture. **Obeying orders of superiors does not provide defence in all such cases.**

There are two particular issues that should be mentioned in relation to the above; one is the role a health professional may play in an environment of deprivation of liberty (prison, detention centre, etc.) when, **for reasons of prevention**, he/she is invited to examine an arrested person at the beginning and at the end of the period of detention. This is a requirement and a recommendation which can be a very important guarantee to prevent abuse during interrogation, provided it is used as a measure for this purpose. The relevant standards of the European Committee for the Prevention of Torture (CPT) are explicit on this issue and in several national legislations in European countries this is provided for as a standard procedure in order to prevent ill-treatment.

The other particular issue, which has to be mentioned, is the role of the forensic doctors. Their role is to report their findings to the Courts. Therefore, the obligation of confidentiality of medical information between doctor and patient is from the very beginning compromised. Therefore, forensic doctors should not conduct examinations and tests without, first, explaining the nature of their work and

getting specific consent. In case a person refuses to consent, this must be recorded and respected and for further action there must be provision by the legal system, such as asking a Court to issue an order for any further forensic examination.

Another related issue is the extent to which a forensic report is permitted to go. The contents of the forensic report should include only the relevant to the purpose of the forensic examination medical information and also include clearly any evidence of torture or ill-treatment in their findings.

3.5. Equal treatment

It has to be stressed that the code of medical ethics and the medical professional rules provide for equal treatment and care to prisoners and detainees as to the general population in the community, without discrimination and with equal quality, equal for instance to the National Health System level. This applies to all health professionals whether in prisons, detention centres or other places of deprivation of liberty or to those working in National Health Systems where detainees may be referred to. Again the CPT standards make crystal clear this issue.

3.6. Medical examinations-Special issues

1. A very common issue that may arise in the every day routine of places of deprivation of liberty (prison, police and other detention areas, etc.) is the medical examination of detainees in the presence of Security Forces. The reasons for such medical examinations may be, for instance, complaint of illness, referral for medical treatment, complaint of ill-treatment or the initial medical examination at the beginning of detention, which is the norm in a number of countries.

The ethical rules concerning the work of health professionals do not differentiate in anything the conduct of health personnel in such circumstances compared with the rules applying in general.

The practical consequences are:

- ***informed consent*;** as when the health professional is to conduct any examination resulting in an assessment and treatment, prior informed consent must be given by the patient, in this case the detainee, who has to be informed in advance about any examination, treatment or procedure, as well as the explanation of who will have access to the findings and how these findings may be used.
- ***Confidentiality;*** medical ethics impose that consultation and information given should be confidential between doctor and patient. In the case of

detainees the Security Forces (prison guards or police officers or military personnel) will often insist to be present during the consultation, usually with the excuse that this is for the safety and protection of the health professionals. However, since the duty of health professionals is to observe the ethical rules in all circumstances, it is to be observed that there is rarely a real security risk, which would necessitate the presence of Security Personnel in the consultation room and even then care should be taken that hearing the exchange between doctor and patient should not be possible. If risk of escape is the argument of the security personnel, consultations could be conducted in a room with only one entrance and barred windows.

- ***Use of restraints****;* another common issue is the insistence of security staff of maintaining handcuffs or other means of restraint during medical consultations. This practice is also contrary to medical ethics and to international standards and should be unacceptable by health professionals. Restraints are contrary to the inherent dignity of all human beings and have adverse effects to the relation between doctor and patient, influencing in this way the proper medical work in a negative manner. Possible exceptions should be extremely rare and only in cases where there is a temporary need, upon medical assessment and orders and until the patient is calm enough to proceed to the medical work (in this respect, please look at CPT standards).
- ***Use of blindfolds****;* this is absolutely unacceptable under any circumstances and it has been found, in various circumstances, to be by itself a form of ill-treatment. In an environment of health care it is absolutely unacceptable to prevent visual contact between doctor and patient in order to establish the right therapeutic relationship. Furthermore, such a practice will expose the health professionals to accusations of participating or tolerating ill-treatment.
- ***Abusive medical treatment****;* health professionals may, in the course of their duties, face pressure to provide treatment or medication that is not aimed to the amelioration of the health (physical or mental) of the patient, but aimed to help the authorities, for instance in the interrogation of the detainee. This is, of course, strictly prohibited and it is liable to draw penal consequences against the health professional for participation to torture or ill-treatment. It should be also mentioned at this point that such cases may occur not only in

detention facilities, but also in other institutions such as Psychiatric Hospitals, Geriatric Institutions, etc., where deprivation of liberty is the norm.

- ***Confidentiality and consent;*** the general principle of medical ethics is that patients should receive explanations and full understanding of any medical act and consent to it. This general rule is of particular importance when the patients are torture victims who have been through a period of not having any control over their body, even their lives. Therefore, it is extremely important that medical examinations and treatment do not create in them feelings of being powerless, as they were during their ordeal. Another extremely important aspect of this is the full understanding that the medico-legal documents and reports to be established following examinations, tests, etc., are liable to become public domain and to be used either for criminal proceedings or, as in the case of asylum procedures, to support their claims of persecution. They should be made to understand fully the consequences of this and to give express consent to such use. This is the reason why the practice in the rehabilitation centres is standardised: the medico-legal report is handed only to the torture survivor, leaving him or her to decide whether to use it or not before any authority. This practice is an expression of fundamental ideas developed over the years into the modern medical ethics, in other words that the competent adult patient is the best judge of his or her own interest and that the health professional has to have this principle as his or her number one consideration. In this connection, issues provided for in the four Geneva Conventions and their Protocols are related and issues related to the management of hunger strikes are also relevant. Please, see CPT standards .
- ***Security issues;*** while on a universal level there exist security concerns both for the torture victim revealing the crime suffered, but also for the health professional who is documenting the evidence relevant to the above crime, it is unthinkable that such concerns should ever arise in Europe, a space of freedom, justice, security and rule of law, because in this case it would be an explosion destroying the very foundations of Democracy.
- ***Involvement of other health professionals in torture and seeking information and support;*** even in the European countries where such cases, hopefully, constitute rather the exception than the rule, there may be circumstances where a health professional has strong reasons or even evidence

to suspect that a colleague may be involved directly or indirectly in cases of ill-treatment. A careful reading of the CPT's Country reports is revealing of relevant examples, whereby a health professional for instance is administering sedatives not as a medical act but in order to collaborate in a deportation or cases of deprivation of medication in a detention facility as a punitive measure, not dictated by medical therapeutic reasons. Such acts have been qualified by CPT as amounting to ill-treatment.

Depending on the particular circumstances, the health professional who suspects or has evidence of such acts can seek advise and support a) by other colleagues, b) by the professional organization, association, etc. to which he/she belongs, or even c) by an external body national or international.

CHAPTER 4

PHYSICAL EVIDENCE OF TORTURE

4.1. Introductory guidelines

The testimony of the survivors of torture is the necessary component in documenting torture. Following that and to the extend that physical evidence of torture can be traced, constitutes an important confirmation. However, absence of such physical evidence should not be interpreted that torture did not take place, because in many cases torture does not leave permanent signs or scars. For a better understanding of this issue, there follows a brief description of different findings, which constitute physical evidence of torture, related to the different systems and parts of the human body.

Health professionals working in reception centres for asylum seekers or in general hospitals need to know that, on order to identify possible torture victims, when they are performing the first clinical examinations, they need to examine the whole body and not to limit themselves to the area pointed out by the torture victim, who may not remember that he has scars in the back or other signs and concentrate only to some symptoms felt at the time of the examination. In the same spirit, a neurological examination might also be necessary because the peripheral nervous system may present damages expressed by motor difficulties or lack of ability to sense in parts of the body.

These examinations must be done in the presence of a third person of the same sex as the torture survivor, in case the health professional is of the opposite sex, usually a nurse, etc., or an interpreter, unless there is objection by the individual.

The possibility for the presence of a close relative of friend should be offered for reasons of support. On the other hand, in such a case it should be kept in mind that there are certain things that the individual will not be willing to reveal in front of the relative or friend. It is understandable that sexual torture or other methods that are particularly humiliating are not easy to be discussed in the presence of third people and many times not even to the health professional. In the rehabilitation centre's experience over the years, it is common knowledge that it may take a long time, which allows establishing confidence in order to proceed to such revelations.

In any case the final decision about the presence of others belongs to the individual examined.

Another important factor during these examinations is to take measures showing care for the individuals' modesty keeping in mind always geographical origins, cultural origins, etc.

Although the following chapters on physical and psychological signs of torture are mainly the concern of health professionals (based on the Istanbul Protocol), it is also useful for non-medical professionals, that is members of the asylum authorities who first come into contact with asylum seekers, to be provided with knowledge which will alert them about possible torture survivors, in order to refer them immediately to the specialists for evaluation, in respect of the relevant provisions of the Reception Directive and of the Procedures Directive.

4.2. Torture effects on the different systems of the human body

In the following paragraphs a very brief description is given on each one of the different parts of the human body, with the exception of the skin for evident reasons as explained below.

4.2.a. Torture sequelae on the skin

Many times interviewing officers can observe scars or lesions, etc., on the skin (not covered by clothes) of the applicant before them. This gives the opportunity, in case they observe skin problems similar to the ones described here-after, to put questions as to the cause of these scars and give the applicant the opportunity to explain. They might, also, encounter a reaction by the applicant which should also alert them to suspect that this person might be a torture survivor (see further on the chapter 5 on psychological sequelae).

Therefore, the skin is a very important system of the human body helping to reveal and evaluate torture. It is in other words what many specialists say, that a common characteristic of tortured people is that their skin becomes the mirror of their suffering. Skin is a register where the signs of recent or older torture are perceived. Usually a great part of the torture sequelae in the skin disappears within a short period after torture has been inflicted. However:

- Linear or irregular scars after blunt violence appear in some cases as permanent changes in the skin.
- Burns apparently often give rise to the following permanent sequeale in the skin: Cicatrices with central atrophy and a hypertrophic peripheral zone apparent after exposure to a cigarette or to an electrode.

- Also, many skin diseases as are psoriasis, eczema, orticaria and alopecia may be provoked after the infliction of a physical and psychological trauma.

Most of the time one finds it difficult to correlate these clinic symptoms with precedent torture, but the infliction of torture is verified by the account of the survivor. In addition, the evidence of torture found in the skin is highly important in the cases that a certificate is needed for the application of a survivor to become accepted as a refugee in the reception country.

Typical sequeale that can be observed on the skin following ill-treatment and/or torture are:

- Bruises
- Abrasions
- Incisions
- Lacerations
- Burns and scalds

The time factor is very important since in some of the above sequelae the skin may heal completely after a longer while and even hair may grow again.

Therefore, it is useful to be aware of the **time factor** for some of the above sequelae.

Other factors that need to be taken into account are the age, the sex, the health condition of the individual examined, as well as the tissue characteristics and the severity of the lesion. Further analysis of the above typical sequelae follows.

- Bruises/contusions; bruises are appearing on the skin after beating when small blood vessels under the skin bleed without breach of the full thickness the skin. If the skin and the subcutaneous tissues are thin, bruises appear very quickly and usually have the shape of the torture instrument used, as for instance in case a whip has been used, there are parallel linear bruises, or in case a glob or a wooden stick or punches and kicks are used diffuse bruising can be produced. When the bruise is deep, it may not appear immediately, but after a short period of a few days. This is why it is necessary to have a second examination after a short while. Bruises change colour day by day following deconstruction of haemoglobin. In this way, the bruise is red at the beginning and then becomes successively dark blue, green and then yellow. It is not easy, at all cases, to relate the blow or beating to the bruise, because there are cases where the bruise may appear at a distance from the point where

pressure has been put. An example of this is the case of blows on the head where we can have bruises under the eyes. Therefore**, there are many complex cases where evaluation by the specialists is necessary**.

- Abrasions; abrasions are created on the surface of the skin either by blow with a blunt object or by fall on a rough surface, in which case breaches of the full thickness of the skin are produced. Parts of the surface of the skin are damaged many times during the beating and more serious damage is produced when under the skin there is bone. After two or three days from the abrasion, due to the fluid produced (containing blood serum) follows the creation of crust. If the injury is not covered by crust, it remains open and the superinfection is easy, on the one hand, as well as in case of deep tissue damage, the creation of a scar follows. When the damage is superficial, it may be followed by skin of a darker or lighter colour, according to the original skin colour of the individual. Violent dragging on the ground, dragging of nails on the skin and injuries produce linear abrasions which if deep enough, may leave scars. These elements can be evaluated in case the victims ask for specialized documentation about what happened.
- Incisions; incisions may be caused by sharp objects, such as broken bottles, razors, blades, which if violently dragged on the skin, may cause deep wounds by cutting the skin in a well demarcated manner.
- Lacerations; lacerations are produced by violent dragging of the skin on a rough surface and it looks characteristically as if «the skin is in tears». Separation of the skin may not be perfect or complete, but there may be tissue bridges with healthy skin.
- Burns and scalds: burns and scalds are produced by high temperatures of dry or liquid material. Dry material is material that can be heated up to very high temperatures, such as metallic objects, cigarettes, etc. which, when in contact with the skin, produce perfectly characteristic macroscopical and histological findings which can be evaluated and certified by specialists.

  According to the degree of burns the following traumatic alterations follow:

  - surface burns (1st degree) probably will not leave permanent damage on the skin, apart from a temporary reddening

  - when the burn is deeper (2nd degree), it contains blisters and creates damage of tissue.

- when the burn is going to the whole depth of the skin (3rd degree) and is extended to a big part of the surface of the skin, it may be lethal.

There are special kinds of burns which leave scars absolutely revealing for the instrument or object used, such as:

- burns from pressure of burning cigarette. These scars tend to be circular, atrophic, surrounded by hypertrophic, peripheral halo. In case of tissue tests, there have been findings of calcification.

- scalds caused by boiling water or liquid chemicals. The signs produced usually show the liquid material's direction on the skin.

All the above described damages of the skin are usually appearing immediately following torture. The damages that are lasting and can be evaluated by the specialized physician (based on knowledge of the Istanbul Protocol) are mainly scars, hyperchromic spots, achromic spots following ill-treatment or traumatization of the skin. Taking the history in a detailed way and the description of the torture suffered is prior to the evaluation of the findings.

- complex lesions: attention must be given to the fact that many times there are different types of wounds in the same area of lesions. An example can be that wounds by broken glass may show both incisions and lacerations.

The main long-term findings of torture are **scars**. According to the depth of the lesion the skin is healing in two ways:

- In case of surface damage, healing is taking place on the outer surface of the skin (primary intention).
- In case the damage is going deeper in the skin, possibly accompanied or not with loss of tissues, healing takes place from the bottom of the lesion (by secondary intention).

Scars produced by primary intention usually are hyperchromic or achromic.

Scars produced by secondary intention are irregular, anomalous, for instance deeper or hypertrophic, that is to say lower or higher that the rest of the surface of the skin.

Individuals whose skin has the characteristic to over-produce keloid tissue, keloid scars are produced.

Scars can give many times information confirming or disputing the presentation of facts. There are scars confirming abhorring detention conditions, scars that are infected and acquire characteristic dimensions. In case scars are caused by

infant diseases or by operations or by rituals specific to the tribe of the person, disprove references to torture.

The specialized doctor is in a position to make the proper diagnosis and to conclude whether torture has taken place.

4.2.b. Head (face and neck)

Head injuries are most common sequelae of torture. There are cases that permanent damage is caused. We need to know that in case of repeated even minor trauma ("shaking'', blows, asphyxiation, etc.), could also be causes for post traumatic epilepsis and other problems. Severe headaches, scissors, loss of consciousness, disorientation are phenomena that need to alert attention/.

Scars and lesions on the face and neck can be particularly stressful for torture survivors because they are a constant reminder of the torture event.

Fracture of bones or damage of the ear drum, damage in the teeth or other problems of the mouth or in the eyes can be after proper evaluation by the specialists, evidence of torture.

4.2.c. Upper and lower limbs.

Various signs may be evidence of torture, such as wounds, abrasions, reddening of the skin round the wrists, extracted or crashed figures and nails, scars, etc.. especially, around the Mediterranean and in the Middle East, torture survivors may have been subjected to phalanga, known to the specialists for the sequelae that in many cases leaves.

4.2.d. Chest, back and abdomen

Following the method of torture used (for instance, whipping or beating with sticks), the specialists can distinguish specific sequelae.

Other signs, such as pains, problems in the back, fractures, etc., need to be evaluated to find what causes them.

4.2.e. Fractures

Beatings and falls can lead to fractures of bones. If fractures heal well, there will be no way of knowing whether the injury was caused by torture or by accidental causes. However, the fact that an injury can be demonstrated may be corroboration of the individual's account. Mal-united fractures are highly supportive of a history of torture with no immediate medical treatment.

4.2.f. Joint damage

Many forms of torture involve damaging joints. Suspension is a common form of torture, in which the individual is suspended by the arms or wrists. In one variant, 'Palestinian suspension' (also referred to as 'Palestinian hanging'), the arms are behind the back, increasing the strain on the shoulder joints and often stretching the nerves running into the arms.

Other forms of joint damage are specific to particular parts of the world.

4.2.g. Nerve damage

Many forms of torture can cause nerve damage, including stretching injuries associated with joint damage and physical damage from fractures and incisions. The speed of resolution of nerve damage is relatively predictable, so it may be possible for an expert to determine the approximate time of the original injury from a series of examinations over several months.

'Palestinian suspension' can lead to neuropathy of the brachial plexus. 'Winging' of the scapula must be looked for. Survivors will sometimes describe having suffered weakness of the muscles around the shoulder associated with the loss of certain movements which have recovered progressively over a period of months. If he or she did not have access to information about the clinical processes involved, this description can be very supportive of allegations of torture.

Peripheral nerve lesions of the hands and feet may also be detected following the prolonged application of restraints (wires, ropes, handcuffs, etc.) to the wrists or ankles.

4.2.h. Electrical injuries

Electric shocks have been used commonly by torturers for many years because they cause exquisite pain but rarely leave identifiable physical signs.

Electrical torture uses the property of the electrical current to cause pain. As the current travels it causes contractions to the muscles involved and severe pain. These contractions can cause dislocation of joints and, if the chest muscles are involved, difficulties in breathing. If the current passes through the heart, arrhythmias (irregular heartbeat) can develop, leading to sudden death.

Torturers apply electricity to the most vulnerable and intimate parts of the body. Genitals and breasts are often targeted and the victim is threatened on his or her reproductive capacity. The mouth also is very sensitive and often targeted.

Areas of reddening may persist for weeks. Also, occasionally the electrodes can leave small burns.

4.3.Sexual assault

Sexual assault is probably common worldwide as a form of torture, but less widely discussed. Perpetrators generally claim that torture is necessary to gain information, but sexual abuse suggests a motivation more to debase, humiliate and intimidate, not only the victim, but often the family and even the wider community. Survivors of sexual assault are often unwilling to disclose the abuse openly. In many cultures victims are blamed, even though they were powerless at the time of the incident. This makes it even less likely that they will testify against their torturers.

Medical examinations by trained specialists will, under the proper conditions, probably reveal the details of what happened. It must be kept in mind, though, that many victims of sexual assault may never reveal their ordeal since most sensitive parts of their personality are humiliated and debased.

A very important role is played by factors such as culture, tradition, religion, social environment, etc.

Another extremely important element is gender. The reactions of women or men can be very different and the background (culture, ethnic, religious, etc.) should always be taken into consideration.

The element of time is also extremely important in the sense that the usual behaviour of a victim of sexual torture is to complain to health professionals about other symptoms and only after a rather prolonged period to reveal the truth and ask for help and psychological support. Unless there are physical symptoms that need immediate health care, such as bleeding, etc., it is highly improbable that a survivor, in a detention place, during the very first period of arrival in the host country, will even mention sexual torture.

Health professionals should be aware of the above and conduct any necessary medical examinations in a manner to avoid further humiliation or even risk causing revival of the torture seen.

4.4.Laboratory tests and other specialised examinations

In the process of investigating allegations of torture the specialised health professionals may often need to collaborate findings of the clinical examination by laboratory tests, such as X-rays, scanning and other specialised tests.

All these additional examinations have to be conducted under the instructions of the specialist, to be specifically targeted and to look for results confirming clinical images.

The way such tests should be conducted is also a matter of special care for the specialists because all the principles of medical ethics are to be respected once more.

4.5.Medical photography

A very helpful tool on order to document torture is photography used by the specialists. Again, here, rules of medical ethics regarding informed consent and data protection or permission to use this evidence apply and the technical details of how to photograph, to store and to interpret are of use by the specialists

CHAPTER 5

PSYCHOLOGICAL ASSESSMENT

5.1. Introduction

Torture always leaves psychological sequelae. In many cases, when examining torture survivors, the psychological component of the assessment will be the most significant part. The reason is that, in many cases, intentionally or not, the perpetrators have not left long term visible physical signs, scars, etc. This is particularly relevant to asylum seekers since, usually, the lapse of time between the torture event and the examinations that produce findings is very long. We should also consider cases of psychological damage as an unintended consequence of creating fear through physical abuse. Also, some of the psychological distress is caused by such issues as loss of control, losing the ability to trust, and a belief in the world as a just place, as well as feelings of guilt when others have been tortured as well.

It is useful to fully understand the stress generated by exile more in general before dealing with torture victims among asylum seekers in particular.

5.2.The traumatic process under stress factors in exile[32]

Refugees living in Europe have often suffered from severe and repeated man-made traumatic situations in the course of political persecution, detention and torture. Sometimes the trauma also included the circumstances of their fight. Depending on the country of origin, about 40% of refugees are suffering from PTSD by the time of their arrival in the country of exile. An even higher percentage has gone through potentially traumatizing situations. These individuals are at risk of developing trauma sequelae later on, if preventive measures are not granted in the country of exile.

Having been uprooted and having lost their material and social basis of living, close and beloved persons, social support, their home country and their cultural and political context, refugees are weakened in their capacity to cope with the traumatic impact to which they have been submitted. In addition to severe trauma, refugees pass through a situation of loss and ongoing stress.

Getting to European countries means to the survivors that they can finally feel safe from persecution. The anxiety due to external factors is reduced and the hope for a better future may alleviate depressive moods and pain.

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[32] '*Treatment of torture survivors-influences of the exile situation on the course of the traumatic process and therapeutic possibilities'*, Mechthild Wenk-Ansohn, M.D., Journal Torture, Volume 17, No2, 2007

But on the other hand – especially if the refugees are not granted asylum right after their first interview with the immigration authorities – they will soon suffer from an exile situation with a variety of adverse factors such as:

- Ongoing uncertainty (insecure residence status: asylum seekers, temporary permission to stay)
- Lack of prospects for the future
- Inactivity, interdiction to work/study, dependency on social aid
- Subjection to degrading and incomprehensible bureaucratic acts
- Housing in mass accommodations often far away from cities and exile communities
- Restriction to leave their residence areas
- Isolation within the society and difficulties with communication
- Sometimes violence with xenophobic context
- Lack of access to adequate medical/psychological care

A study made by the Berlin Centre for the Treatment of Torture Victims (bzfo) showed that about 90% of the patients treated annually by them do not have a secure residence status at the time of intake and sometimes for many years to follow. This means the treatment will be under a situation of ongoing stress and uncertainty. Being forced into a passive role is one of the important factors that hinder refugees in developing coping strategies after a trauma; it weights heavily on their self esteem and reinforces states of depression.

Migration always means a process of changes and adaption. Sludzki described the process of relocation as one in which the emotional needs of individuals increase markedly, while their support social network is severely disrupted. As a result, relocations are strongly associated with increased psychosomatic and interpersonal distress.

As Hans Keilson found out in his study of holocaust child survivors, the period after the traumatic incidents is crucial for the development of the traumatic process. His concept of sequential traumatization, which distinguishes three consecutive phases of stress, is still fundamental to understanding the traumatic process that is induced by traumatic experiences but influenced by many external and internal factors.

Refugees are very likely to experience an extremely stressful and depressing situation ('ongoing stress') in the important third phase of their traumatic process. The ongoing exposure to situations that are adverse to a process of trauma compensation goes along with a high tendency of chronicity of posttraumatic stress disorders. The more severe the traumatization is and the longer the traumatic process under conditions of ongoing stress continues, the higher the tendency to develop complex posttraumatic disorders with persistent or periodic PTSD symptomatology accompanied by increasing comorbidity such as:

- Alterations in the regulation of affect and impulses
- Disorders of attention and consciousness
- Depression
- Somatization
- Anxiety
- Alterations in systems of meaning, enduring personality changes
- Changes concerning the interpersonal area
- Worsening of pre-existing mental and social disorders

Laban, Gernaat, Komproe, Schreuders and De Jong recently published a study of the impact of long asylum procedures on the prevalence of psychiatric disorders of asylum seekers. The overall prevalence of psychiatric disorders increased from 42% to 66.2% when the (Iraqi) refugees had lived more than two years as asylum seekers in the Netherlands.

A posttraumatic stress disorder, even if the symptoms are already in remission, can be reactualized (updated) by renewed stress and stimuli which are connected with the trauma. If the victim is confronted with a severe or long lasting stressful situation or a new loss of safety and coping possibilities or with reactualizing stimuli in a situation that is experienced as uncontrollable, there is a risk for a so called retraumatization with acute crisis and eventually persistent exacerbation of the trauma related psychopathology. Unfortunately, the life of a refugee bears a relatively high level of risk for retraumatization. We especially see such heavy decompensations when traumatized refugees are threatened with deportation to their countries of origin.

1st phase	2nd phase	3rd phase
Repression	Persecution/flight	Exile

Discrimination War Anxiety Isolation	Torture, prison Lifethreat/agony, loss Traumatic events Anxiety	Uprooting (new culture asylum situation) Uncertainty Anxiety Dissociation Chronicity of posttraumatic syndromes

Other influences: personal and social meaning of the trauma, consequences/losses age, sex, pre-traumatic resources of the personality, active modus, social support.

5.3. From the outside, nothing is visible[33]

'They do the most horrible and disgusting things, it is awkward even to talk about it. It still disgusts me; I tremble and feel mental torture very day when I think about it. To be able to endure these thoughts I have to take sleeping pills and pain-killers in order to become 'unconscious' for some hours each night, or else I cannot sleep due to the suffering, anxiety and nightmare. Even if it's some years ago since all this happened it feels as it was last week. Never before have I told anyone exactly what happened in prison'.

Fractures that have not healed properly, burn damage to the skin, scarred soles on the feet, fingernails and toenails that have been pulled out, are common and visible signs of physical torture. Due to this fact, the torturers have developed new methods of torture that do not leave any visible signs of injury. Refugees, who consult doctors for help, often describe general symptoms, such as headaches, stomach pains or heart conditions, but these are also three common physical complaints from persons who have been subjected to serious assault. A victim of torture or war trauma also meets a series of mental health problems such as anxiety, insomnia, nightmares, difficulties in memorising, irritability and depression. The symptoms can momentarily be relieved with medication, but for long term relief special therapeutic treatment is required.

Some, but far from all, also suffer from a serious mental disorder: post-traumatic stress disorder (PTSD). When this disorder occurs as an after-effect of war, oppression, torture and enforced exile, more extensive treatment than the usual methods for treating stress related conditions is needed. It is frequently a matter of

[33] Swedish Red Cross, 'Returning to life', p. 8,9.

having the strength to work through deeply existential questions and having the courage to talk about feelings of guilt and shame.

Many people who seek asylum or are refugees have been imprisoned and subjected to torture, rape or other degrading treatment. For a variety of reasons many of them lack the ability to speak about the incident. That is why some people have passed through various departments in the health care system and have received inadequate treatment resulting in increased supplies of medicine.

5.4. Issues of particular importance for the asylum procedure [34], [35]

Torture may cause severe consequences and burden the victim with serious health problems and disability, without leaving any physical evidence. Psychological symptoms may be the only evidence of torture or ill-treatment. Therefore, asylum authorities should be able to assess whether a person authorities shows psychological trauma symptoms and whether this evidence is in accordance with any allegations of ill-treatment. A second reason to focus on psychological trauma symptoms is that it may indicate serious and common medical problems. In addition, it may indicate treatable diseases, so it would be important to assess whether adequate treatment is available.

Traumatised subjects are often passive, shy and non-assertive[36]. They find it painful to describe their trauma and may therefore, understandably, refrain from a detailed description. A former detainee who has been subjected to violence may not volunteer this information. This is especially the case if he/she has developed post-traumatic stress disorder (PTSD), which actually causes him to be silent about the specifics of the trauma, not merely because of a conscious decision, but rather because of a psychological or neuropsychological process, evidenced by neuro-anatomical changes seen in these patients, as a result of the trauma.

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[34] Our acknowledgements to Dr. Petur Hauksson Psychiatrist, member of the CPT, who has contributed a big part of this chapter. The article is entitled ‘, Psychological Evidence of Torture; How to conduct an interview with a detainee to document metal health consequences of torture or ill-treatment’. The text containing specific guidance as to the interview is of particular relevance, because of long practical experience of interviewing in ‘closed or restrained environments’. It should not be forgotten that at least the first interviews of asylum determination process are usually conducted in a reception facility or even in a detention centre.

[35] Detailed analysis, destined especially to health professionals, is given by the publication ‘Care Full; Medico-Legal Reports and the Istanbul Protocol in Asylum Procedures’, edited by Rene Bruin, Marcelle Reneman and Evert Bloemen, Utrecht, Amsterdam, 2006.

[36] There are cases, depending on personality and circumstances, that traumatised people may react differently.

What usually makes an experience traumatic is a sense of horror, utter helplessness, serious injury or the threat of physical injury or death. Different categories of trauma cause similar psychological symptoms. Therefore, the study of trauma in general is helpful for the understanding of psychological consequences of torture. The use of strict diagnostic criteria allows precise treatment, prescription and prognostic prediction. However, care should be taken not to turn natural response to severe stress into a medical disorder. A majority of trauma victims show a natural decline in 'symptoms' or even complete recovery. It should be born in mind that being a torture victim is not a psychopathological condition.

The detailed criteria for the PTSD diagnosis will not be recounted here, but an attempt will be made to show how a knowledgeable interviewer might determine whether psychological consequences of trauma are present.

5.4.a. Limitations

Because of the nature of trauma symptoms, it cannot be expected that the whole history of the traumatic event, or all the symptoms will be elicited in one interview. The memories are per definition fragmented, important details are impossible to recollect and the strong feelings connected to the memories can cause pain and re-traumatisation. When only one interview is possible, it is important to realise these limitations. One should not try to pressure a traumatised person to describe details of the trauma if he/she does not seem up to it, or seems to be in pain.

If the interviewed person on the other hand, goes into a long and detailed monologue on the trauma, the interviewer has the obligation to limit the flow of narration, because such flooding can also cause deterioration. The interviewed person might be relating the events for the fist time, and may not be aware of the possible psychological consequences. This deterioration may not be evident until later and may last for several days. It should be asked whether this is the first time the details of the trauma are recounted, and if that is the case and the details are extensive, then the person should be warned that there might be some discomfort after the interview and that such discomfort is normal.

5.4.b. Retraumatization

'*We know that many refugees and asylum seekers are themselves torture victims-the way in which they are being treated promotes severe re-traumatisation and violates all international principles of the rights of refugees. The closing of*

borders and the long-term detention of such people places their right to rehabilitation at stake'[37].

The main risk factor causing a higher incidence of PTSD after trauma is a prior trauma. The risk is irrespective of the type of trauma. For example, the risk of a physical accident causing PTSD symptoms is higher if there is a history of abuse in childhood. This means that those that have been subjected to torture previously are at high risk of developing symptoms and disability as a result of the trauma of detention, especially if it is carried out in a forceful manner.

Re-traumatising a previously traumatised detainee, i.e. a refugee that has previously subjected to or witnessed violence and subsequently subjected to detention, possibly with use of physical force, causes a repetition of the formerly experienced violence.

5.4.c. Incidence

Post-traumatic stress disorder is a common disease, with a lifetime prevalence of around 9% in specific populations. Over a third of rape or assault victims report lifetime PTSD and prospective studies show that 47% of sexual assault and 22% of nonsexual assault victims meet criteria for PTSD 3 months post-assault. Almost half of concentration camp survivors have long standing PTSD, and in some studies the prevalence is even higher.

A study of refugees in the Netherlands[38] showed that in spite of a high rate of torture events, refugees often contributed their psychological distress to the post-migration situation. Therefore, the authors concluded that paying attention only to health complaints and to past violent experiences, was too limited an approach in responding to the needs of refugees. They pointed out that the stress disorder was not 'post-', but rather ongoing. Also, relatively few refugees are diagnosed with PTSD, in spite of torture events, perhaps because some of them diagnostic criteria, such as avoidance behaviour, do not apply to detained persons.

On the other hand, one of the few studies of trauma among prisoners demonstrated that 81% of female prisoners currently suffered from a post-traumatic

[37] Jens Modvig, IRCT Secretary-General, quoted in the IRCT Annual Report 2001, p.28

[38] Hondius AJK et al. (2000). Health Problems Among Latin-American and Middle-Eastern Refugees in the Netherlands: Relations With Violence Exposure and ongoing Sociopsychological Strain. Journal of Traumatic Stress, 13, 619-634.

stress disorder[39]. The traumatic events experienced included rape or sexual assault by 71%, childhood sexual abuse by 55% and physical assault by 32%. Symptoms often preceded the history of criminal behaviour. Many of their crimes related to the need to support their drug abuse, which often represented an attempt to self-medicate their traumatic symptoms. Thus, victims became perpetrators, and were consequently re-victimised. Re-victimisation is a common predicament of trauma victims.

Studies have found childhood maltreatment to be more strongly associated with depression and substance dependence among women than among men. Also, the severity of substance misuse and problems associated with it are stronger predictors of female rates of criminal activity than male rates. The authors suggested a female empowerment treatment model to help women attain control over their lives[40].

One study of former political prisoners showed that 64% suffered chronic depression and anxiety, somatic complaints and increased arousal[41].

The younger the age at which the trauma occurs, and the longer its duration, the more likely people are to have long-term problems with the regulation of anger, anxiety and sexual impulse. The lack or loss of self-regulation is a far-reaching effect of trauma[42]. The intensity of effect responses to stressors leads to withdrawal and numbness, punctuated by intermittent responses to traumatic reminders.

5.4.d. The interview

Disclosure of a traumatic event may require the establishment of trust and confidence between patient and physician[43]. To obtain a fairly complete description of the trauma, it is often necessary to establish a secure relationship at the outset. This can of course be difficult in the setting of a detention or reception centre, but should not be ruled out. The doctor could raise concern that the patient's medical problems might be related to trauma. Routine questioning about traumatic events is

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[39] Reaside, C.W.J. (1994). Post traumatic Stress Disorder in a Female Prison Population, RANZCP Dissertation. Cited in McFarlane, A. Attitudes to Victims: Issues for Medicine, the Law and Society. Australian Institute of Criminology Symposium 1994. www.aic.gov/publications/proceedings/27

[40] McClelland, D.S., Farabee, D., and Crouch, B.M. Early Victimisation, Drug Use, and Criminality. A Comparison of Male and Female Prisoners (1997. Criminal Justice Behavior, 24: 455-76.

[41] Bauer, M. et al. (1993). Long-term mental sequelae of political imprisonment in East Germany. Journal of Nervous and Mental Disease. 181 (4): 257-62.

[42] Van der Kolk, B.A. The Complexity of Adaptation to Trauma. Self Regulation, Stimulus Discrimination, and Characterological Development. In: Van der Kolk, B.A., McFarlane, Weisaeth, L. (Editors). Traumatic Stress. The Overwhelming Experience on Mind, Body, and Society. New York: The Guilford Press 1996. (pp. 182-213).

[43] Davidson, J.R.T. (2001). Recognition and Treatment of Posttraumatic Stree Disorder. Journal of the American Medical Association, 286, 584-588.

recommended, and it is important to ask specific, non-leading questions to elicit the history of trauma.

The task of eliciting information on traumatic experience can itself cause psychological strain for the interviewer, a risk that should not be taken lightly, because of the possible consequences.

5.4.e. What to observe and what to ask for[44]

The difficulties experienced after trauma are categorised into three clusters of symptoms: re-experiencing, avoidance and hyper-arousal. Vivid images, sounds or other sensations reminiscent of the trauma can interrupt or dominate the victim's thought. They can feel like the event is happening again. Flashbacks can present while awake or appear as nightmares, and when severe, they can be difficult to distinguish from hallucinations. The victim can re-experience the trauma in various ways. Intrusive thoughts are common, especially just after the trauma. Recurring memories of the event can be difficult to shake. These experiences are often accompanied by fear, tension or anxiety, in the form of heart palpitation, rapid breathing or excessive sweating. Understandably, the survivor tries to avoid thoughts and places that remind of the trauma incident. Sometimes this avoidance is not completely voluntary. Memories can be difficult to recall, and often parts of the event cannot be recalled. This blackout can be distressing for the victim, as can the chaotic bits of recollections of the event. Emotional numbness is common, but not until a few weeks after the trauma. Interest in significant activities can be markedly diminished. The victim feels detached or distant from others, fells alone or alienated. There is a sense of foreshortened future, which leads to a lack of preparedness and consideration of future possibilities. Sleep is disturbed and there are other symptoms of arousal, such as irritability and outbursts of anger. A common complaint after a few months is difficulty concentrating and memory feels diminished. The victims becomes vigilant and on guard for signs of danger (which, however, may be necessary), and has an exaggerated startle response.[45] [46]

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[44] The following paragraphs are addressed more particularly to health professionals working with asylum seekers either in reception or detention centre or in general hospital. Asylum authorities staff could ask the first question and refer to health professionals for assistance.

[45] Istanbul Protocol. Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. New York and Geneva: United Nations 2001.

[46] Goldfeld, A.E., Mollica, R.F., Pesavento, B.H., and Faraone, S.V. (1988) The Physical and Psychological Sequelae of Torture. JAMA 259: 2725-9.

When the three different types of trauma symptoms are present and are severe, Post-Traumatic Stress Disorder (PTSD) is diagnosed. PTSD is a debilitating and chronic disease. It can result from a sudden risk of death or a threat to ones own or others' health or integrity[47]. The disorder can lead to impairment and there is a high rate of suicide attempts. PTSD is often associated with depression, anxiety, alcohol and sun stance abuse, and somatic disease. A high number of medical complaints should raise suspicion of trauma.

Questions that can be asked

- Have you experienced trauma or been subjected to physical violence that has caused you to fear for your life or safety?
- Do you have thoughts about the event that keep returning? Do you feel you are in control of these thoughts? How do you feel when you have these thoughts and memories? Do these memories upset you? Do they cause fear or physical discomfort?
- How is your sleep? Have you had recurring dreams or nightmares about the event?
- Do you find that you try to avoid thoughts, memories, places or things that can remind you of the event, because it causes discomfort or bad memories?
- Can you remember all or most parts of the event? How is your memory and concentration now?
- Does anything interest you or amuse you? Do you feel numb? Do you startle easily and are you careful not o be caught of guard? Do you easily get angry or irritated now? How were you before the event?

[47] Diagnostic and Statistical Manual, 4th edition (DSM-IV).

5.5.Post Traumatic Stress Disorder (PTSD)[48]

The term is present almost in every chapter of this publication. Most importantly medical certificates certifying torture victims very often make reference to it as being a torture sequelae. Therefore, and for better understanding by the asylum authorities of this particular issue, it is useful to read the following short analysis:

Torture affects the psychological level of an individual[49]

Also on a psychological level victims are extremely injured and may suffer for years from the effects of torture. The impacts of torture and political violence on a psychological level are termed trauma. The medical technical expression is Posttraumatic Stress Disorder (PTSD).

The Symptoms of Posttraumatic Stress Disorder are:

a. Re-experience the trauma

A victim of torture may have flashbacks or intrusive memories, in which the traumatic event is happening all over again, even while the person is awake and conscious; or the victim has recurrent nightmares.

b. Avoidance and emotional numbing

Avoidance of any thought, conversation, activity, place or person that arouse a recollection of the traumatic experience, for example the contact with state authorities, like policemen or military. Sometimes avoidance may lead to a complete denial of the trauma

c. Emotional constriction and social withdrawal

d. Hyper-arousal: difficulties in falling or staying asleep, concentration difficulties, outbursts of anger, generalized anxiety, shortness of breath, sweating, dry mouth;

e. Symptoms of depression: loss of energy, feeling of worthlessness and excessive guilt, thoughts of death, suicide attempts

f. *Dissociation*: a victim may feel split in two and feel as if observing him or herself from a distance; feeling detached from oneself, feeling of being not really here; impulse control problems, self-destructive and suicidal behavior

g. *Substance abuse*: alcohol and drug abuse often develop secondarily in torture victims as a way of obliterating traumatic experiences and reduce symptoms like sleep disturbances

Up to now I have reported on the individual effects of torture but it is absolutely necessary to highlight the effects of torture on an entire society. Torture is systematic and deliberate, torture is directed not only at the individual but also at the social and political structure of a society. On a broader level the reason for torture is to intimidate, to spread fear and to ensure conformity in a society. Violation of

[48] In the International Classification of Diseases the World Health Organisation (WHO) gives detailed description of what is meant by the relevant terms, *see Annex 7.*

[49] *'The impacts of torture and other forms of political organized violence',* Edith Glanzer, Managing Director, ZEBRA, Austria

fundamental human rights cannot be viewed exclusively from the perspective of isolated abuses. Their implications are extensive and lead to an atmosphere of chronic fear. In this sense torture is a political, social, ethical, psycho-social and mental health problem for a society.

Torture can best be described as a total violation of human dignity and affects all levels of beings. Due to this fact it is absolutely essential to work against torture and its impacts on different levels. That means:

On a medical level:

- adequate medical treatment for victims of torture
- training for medical staff

On a mental level:

- provide psychotherapy for victims

On a legal level:

- legal counselling for refugees
- persecution and punishment of the perpetrators
- compensation for the victims

On a social level:

- Support of the victims and their families to save their li
- velihood

On a political level:

- a refugee policy which respects human rights and the dignity of refugees and victims of torture
- public proscription of torture
- awareness raising
- training for police and other state authorities
- preventive measures

5.6 Retraumatization and Asylum Procedure

5.6.a. Retraumatization

Case studies show that traumatized refugees, who are survivors of serious human rights violations, suffer from persisting **impunity** in their home countries.

Ongoing impunity - the inability to overcome the legal protection of the perpetrators assured by impunity laws, incomplete truthfinding, missing integral reparation and a lack of the necessary acknowledgement by society - represents an important obstacle for the recovery of survivors of serious human rights violations.

There are reports describing that a high percentage of survivors show an elevated mental vulnerability caused by impunity. Mental health problems resulting from traumatic experiences can persist or be reactivated by certain events. In particular, family members of the forcibly disappeared suffer from an incomplete mourning due to the uncertain fate of their beloved ones. The ongoing search for the forcibly disappeared under an atmosphere of impunity puts family members under high risk of *retraumatization*. Studies from other continents also prove that impunity severely affects mental health.

Due to the global character of impunity there can be only little evidence about a positive impact of justice on mental health. Nevertheless, a few examples, in particular from Latin America, show that the combined implementation of memory, truth and justice can have a healing impact on those who suffer from trauma. They demonstrate that the fight against impunity is not only a legitimate moral struggle for human rights, but also a basic need for the sustainable recovery of survivors.

On first sight and in the most common use of term, *impunity* means the absence of legal justice, the protection of the perpetrators, mostly assured by impunity laws or other mechanisms to avoid their prosecution.

But impunity includes more than this. It describes a social phenomeon characterizing and affecting society as a whole. Impunity keeps alive the atmosphere of repression throughout society. By denying survivor's access to the truth, impunity continues the historical interpretation of the repressors and denies the necessary acknowledgement and reparation for victims and survivors.[50]

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[50] '*Justice heals: the impact of impunity and the fight against it on the recovery of severe human rights violations' survivors'*, Knut Rauchfuss, MD & Bianca Schmolze, BA, BSc, Journal Torture, Volume 18, No 1, 2008

The fight against impunity includes political measures to reveal the truth about the pat, to construct a collective memory, to bring the perpetrators to court to derive integral reparation to survivors, and structural reforms to prevent society from suffering the same kind of atrocities again.

5.6.b.Particular issues related to the asylum procedure.

Taking into account the above, it becomes evident that asylum seekers on the one hand have become distrustful to state authorities, courts, control mechanisms and they no longer believe that any authority can do them justice. In addition to this, the usual environment where they should manifest themselves as torture victims, so that the identification process can begin, is an environment of deprivation or of restriction of liberty, run by uniformed personnel, etc. On the other hand, because of this environment (uniforms, locked areas, etc.), revival of traumatic experiences might appear and they may present an unusual behaviour. Their family members also, having probably experienced a violent arrest scene or even worse, may also be affected by similar symptoms.

Therefore, asylum authorities should always keep in mind that incomprehensible behaviour by asylum seekers could probably be attributed to retraumatization. This is one more reason to collaborate closely with specialists.

5.7.Facing Vicarious Traumatization

In some European countries, a number of rehabilitation centres have, over the years, acquired a vast experience in working inside reception facilities for asylum seekers and to cooperate with asylum authorities. Valuable lessons have come from these experiences, not only concerning the identification and care of asylum seekers who are torture victims, but also how to take special care of the staff working in this environment in order to prevent the so-called 'burn-out' syndrome.

'In 1998, the Cordelia Foundation[51] recognized the need to address the issue of care and empathy on the part of the staff and administrators working in the refugee camps. As an NGO providing psychological support for these refugees, we realised that the staff had not received even the minimum training teaching them how to cope with the psychosocial problems facing the asylum seekers, how to handle with the so-

[51] '*Care for caregivers – self care strategies and other methods for work, care and casehandling*', Lilla Hardi – Cordelia Foundation for the Rehabilitation of Torture Victims, Hungary, Journal Torture, Volume 17, No 2, 2007

called ‘difficult cases’ and conflicts. Our positive psychological attitude towards the asylum seekers met a hostile response from some of the shelters’ staff.

The great fluctuation of the staff members at the reception centres also drew the attention of the Immigration Office, and it ‘ordered’ its employees to participate in our sessions. Two of us – one in the medical director and a psychiatrist, the other is a non verbal therapist – began to support the social workers and the nurses.

With the help of the Hungarian UNHCR Office, we began providing regular psychologically oriented training sessions to the staff.

Step-by step- we moved forward, and some years later, the staff realised that the work with refugees could be seriously traumatic. At the same time, they recognised the need for regular psychological support and self care strategies to protect them from *vicarious traumatization* and from burn-out.

Hungarian experiences – focus points

- Psychological mindedness
- Training
- Vicarious traumatization

Psychological mindedness	**Vicarious traumatization**	**The burn-out syndrome**
- Vulnerability - Traumatization -primary - secondary - Empathy - Compassion fatigue	- is originating from the ‘intrusive nature of trauma’ that invades the listener as well	- is a psychological phenomenon of caregivers/ helpers changing their relationships towards clients, colleagues and family. A person can burn out if s/he used to or had the capacity to ‘burn’ before!
Training *Participants* -decision makers/ immigration officers - border guards - social workers - nurses - members of other NGO’s involved in Refugee issues *Topics* - trauma and torture	*Symptoms* - anxiety - depression - helplessness - flashbacks - alienation from ‘normal’ life - dissociative episodes - paranoid thoughts - cynicism, pessimism - extended helper’s role - overidentification with the aggressor	*Solution strategies* *Active* - changing stress situation - influencing certain stressors - positive attidute *Passive* - denial of certain elements of stress - playing down the elements of the stress - leaving the stressful

issues
- basic health care issues
- psychological definitions
- care and cure
- vicarious traumatization
- burnout

- feelings of guilt
- hypervigilance
- social dysfunction
- mistrust
- existential panic

situation

Direct
- speak about the stress!
- insight, understanding
- other activities

Indirect
- drinking (alcohol abuse)
- escaping into disease
- breakdown

Supervision

It is not 'super' and not a 'vision'

The 'rule of the N-s' (never, nowhere, nobody)

Its aim is
- to elaborate a self image through introspection
- to analyse the work in a self-reflective manner
- to discuss work and self-image in a group situation

Each session is divided into a verbal and a non-verbal part

Verbal part
Focusing on psychological processes concurrent (individual) psychotherapeutic

Non-verbal part
Relaxation and contact exercises

Conclusions-where we stand now

The use of regular care for caregivers
- changing attitude towards applicants
- sensitisation towards human and psychological problems
- psychoeducation
- better understanding of clients
- *more constant working teams*
- prevention form vicarious trauma-tization and burn-out

Employee turnover at reception centres has decreased.

The rate of recognised refugees used to be very low in Hungary in the part. It was one percent per year. Lately it has increased to nine percent as the result of trainings, supervision and the impact of medico-legal reports about the victims/survivors of torture.

Recently, in the summer of 2006, thirty Somalian refugees arrived in Hungary. After the first hearing the eligibility officers were intimidated by the 'torture stories' of each of these applicants and they requested extra supervision sessions to discuss the trauma they had suffered during the hearings. The entire Immigration and Naturalization Office was deeply moved. They arranged for special care for this Group of torture survivors requesting the help of Cordelia Foundation in providing services to the Somalian refugees. Each of them has received refugee status.

A final note – some advice for the prevention of vicarious trauma and burn-out

- Make your reactions conscious in the stress situation!
- Examine your ability to adapt and your coping mechanisms!
- Prioritise your aims!
- Divide your energies!
- Separate your private life and work!
- Evaluate the situation and your ego-forces!
- Positive attitude: humour and delight.

5.8.Adapted form of treatment

The Directives provide for proper treatment to torture victims identified during the asylum procedure (pursuant also to article 14 of the International Convention Against Torture). **The first measure to be taken is to no longer keep them under detention and to refer them to specialists**. Here follows a short enumeration of elements to be taken into account.

Basic measures and necessary elements of health care[52]

If we want to support torture survivors to overcome the traumatic impact that has shattered their lives, we have to try to minimize the risk factors for the worsening of the traumatic process on one hand and to increase protective factors on the other hand.

The initial treatment of torture survivors in exile is focused on secondary prevention in order to increase health promoting factors. What helps to overcome the traumatic impact and find a way into a worthwhile life after trauma and uprooting are basic measures in areas such as:

- Security
- Housing
- Access to legal advice
- Access to health care (with interpreters!)
- Access to social support
- Supporting autonomy wherever possible

[52] '*Treatment of torture survivors-influences of the exile situation on the course of the traumatic process and therapeutic possibilities'*, Mechthild Wenk-Ansohn, M.D., Journal Torture, Volume 17, No2, 2007

- Adequate physical conditions
- Language skills, access to education
- Occupation, acknowledgement
- Social contact, integrative activities
- Developing future prospects (the survivors and their families)

Health care and the access to psychological care are important, but they are not the only concern in the process of rehabilitation of torture victims. There are many other factors playing an important role in the outcome of treatment for the traumatized refugees – some of them we can influence, others not.

Following the EU Council Directive laying down the minimum standards for the reception and asylum seekers, adequate material conditions and the 'necessary treatment of damages' should be granted to person who have been subjected to torture rape or other serious acts of violence. Taking into account the experience of the treatment centres for torture survivors and refugees, the access to, and the realization of, a 'necessary treatment of damages' consists of various steps.

Upon arrival in the exile country all refugees need basic medical care and access to psychological diagnostics if it wanted and necessary. Traumatized refugees need appropriate living conditions and psychosocial support and the possibility to take part in so-called low threshold offers. Some of the refugees need psychotherapy over a long period of time or at various times of the process after the traumatizing experiences.

5.9. Social Assistance during the process of identification of torture victims[53]

In general, social assistance forms a part of what is usually called psycho-social intervention.

In the particular situation of reception centres for asylum seekers the social worker(s) is a basic member of the team facilitating in a very significant way the work of asylum authorities, health professionals, etc., in appeasing tensions, finding practical solution, liasing with the outside world (relatives, lawyers) and, in general, helping the different sides to communicate. This is all the more important for torture

[53] The complex work of social assistance to torture victims, as it is done by rehabilitation centres in the process of treatment is useful to be described for better understanding of both asylum authorities and health professionals. See *Annex 8* for a concise description.

victims because of the very difficult psychological and somatic problems they may have.

The professional experience of social workers in interviewing ‘difficult cases’ (people with serious illnesses, mental patients, children) can prove to be especially valuable in the context of reception or detention centre. They may be the first to identify possible signs of torture.

CHAPTER 6
INTERPRETATION

Working with asylum seekers entails, in most cases, he use of interpreters. To use interpreters, particularly from the same cultural and linguistic background to the examined victim of torture, is very helpful in order to better understand other than purely linguistic issues, namely culture and tradition.

However, interpreters need to be trained in order to work with victims of torture. Professional interpreters have their own code of ethics. However, it is very rare that asylum authorities can afford to use them in the context of asylum determination procedures. Usually, non-professional interpreters are hired. The same stands for reception centres and similar facilities where interpreters or 'cultural mediators' are people from the same nationalities as the asylum seekers, who already have a status in the country of asylum. It becomes self- evident that for torture survivors the issue of securing confidentiality is even more crucial than for all other asylum seekers. This is the reason why, in many cases, as it has been registered by rehabilitation centres afterwards, torture victims are not willing to reveal their horrible experiences at this initial stage of the procedure. The fact of having an interpreter of the same nationality in many cases does not inspire confidence that information will not be leaked to other compatriots, even embassies, etc. This is an element needing particular attention by the asylum authorities in order to take measures to secure strict confidentiality.

Other important factors in interpretation are:

- *Gender*. Usually, it is preferable that the interpreter be of the same gender as the interviewed person. For instance, it is easier for women to relate their torture experience to female interpreters.
- *Age*. Age can also play an important role, considering especially sexual or other humiliating methods of torture, which would be easier to relate to an older person (kind of fatherly or motherly figure) than to a young one.

For the above reasons, it has probably been noticed already by the asylum authorities in several countries that rehabilitation centres are not using the same interpreters as the ones working for the police or any other state authority. This could create confusion to the torture survivor, as well as mistrust and jeopardise all the effort for treatment.

The utmost attention should be paid also to the psychological effects that work with torture victims can have on the interpreters themselves.

As it stands for therapists, it must be reminded also that having to work with people who have gone through horrible events could also be traumatic for the interpreters. Therefore, care should be taken into paying attention to this issue by training them and supporting them (debriefing, etc.) during their service.

The above make abundantly clear that interpreters used by the authorities in the course of asylum procedures, as well as in stressful environments, such as detention centres, are liable to suffer **burn-out** without proper training and support.

CHAPTER 7

Children and Torture[54]

The statistical data reveal that a very important percentage of asylum seekers in the European Union are children. One category is the group of unaccompanied minors. Another group are the children who have arrived with their parent or parents or caregivers to the reception country. In both cases, the particular needs and situations concerning children have to be addressed and cared for, and the receiving country is responsible to provide protection and care. This is based, first of all, to the UN Convention on the Rights of the Child, independently if concurring protection obligations, existing in other International Conventions, such as the Geneva Convention of 1951 on Refugees, or National provisions that all European Constitutions and Domestic Laws have stipulated and have to respect.

Among these groups of children, mentioned above, there is a number having suffered torture directly or indirectly (for instance, by witnessing torture performed on parents). Specialized clinicians and therapists dealing with child abuse and experienced in evaluating torture sequelae, should be involved in such cases in order to evaluate the particular findings, but also to avoid traumatization or re-traumatization.

However, it is useful to mention a number of points which will hopefully contribute to a better understanding, for the non-specialists, of the issue:

- first of all, the age of the child and its level of development is crucial for the method or methods the specialist will use to investigate torture or abuse
- it is widely known that many times, again depending on the age, children are using non-verbal ways to communicate or to express themselves
- it is important, during the whole process of examination and evaluation, to have the caring presence of a parent or other caretaker, trusted by the child
- it is important to know that for certain examinations, special measures might have to be taken (such as anaesthesia), in order to avoid experiencing the examination as torture once again. This stands particularly for genital or anal examination.

[54] There is a very vast international bibliography on the issue. However, the practical need to concentrate on the specific context puts its own limitations.

- It is to be remembered that symptoms such as hyperarousal, restlessness, sleep disturbance, irritability, avoidance, withdrawal, refusal to speak and others may very well be torture sequelae
- We need as well to know that symptoms of Post Traumatic Stress Disorder (PTSD) may also appear in children. The symptoms may be similar to those observed on adult victims, but the child has other ways to express it, by his/her behaviour rather than by verbal expression.

The **family** plays a very important role in the dynamics related to the child's behaviour following direct or indirect torture. There are cases that roles are exchanged and the child becomes the protector of the tortured parent, in this way trying to behave as a responsible adult individual, while the development stage does not allow it. Again, there is need to help the entire family in order to change these dynamics and to have the family members assuming their natural role and responsibilities[55].

It should not be forgotten that the International Convention on the Rights of the Child obliges states to act for the protection of children using the best interest of the child as the main criterion. For refugee-children and, even more, traumatised children in exile it becomes even more crucial for the authorities to act under specific instructions, to use specially trained staff and to collaborate to the highest possible extent with specialised NGO's.

See in *Annex 1* relevant articles of the International Convention on the Rights of the Child.

[55] This is one of the reasons that in rehabilitation centres particular care is given to the members of the family other than the primary torture victim, who are considered as **secondary** victims, entitled to the same care and attention and psychosocial support.

Special Part

Chapter 8

THE ISTANBUL PROTOCOL: INTERNATIONAL GUIDELINES FOR THE INVESTIGATION AND DOCUMENTATION OF TORTURE

8.1. Introductory remarks

The Istanbul Protocol is the first set of international guidelines for the investigation and documentation of torture.

The Protocol provides comprehensive, practical guidelines for the assessment of persons who allege torture and ill treatment, for investigating cases of alleged torture, and for reporting the findings to the relevant authorities. The Protocol was developed over three years with the involvement of more than 40 organizations and international bodies, including the IRCT.

Annexed to the Protocol are Principles for the effective investigation and documentation of torture, and other cruel, inhuman or degrading treatment or punishment. These Principles summarize the most salient features of the Protocol and represent minimum standards for States in order to ensure the effective documentation of torture.

The Protocol was submitted to the UN High Commissioner for Human Rights on 9 August 1999. The Istanbul Principles have subsequently received support in resolutions of the Human Rights Commission and the General Assembly, and the Protocol has been published by the Office of the High Commissioner for Human Rights in its Professional Training Series.

8.2. International recognition of the Istanbul Protocol

The Istanbul Protocol was submitted to the UN High Commissioner for Human Rights on the 9th of August 1999. Both the UN General Assembly and the then UN Commission on Human Rights (since 2006, the UN Human Rights Council) have strongly encouraged states to reflect upon the Principles in the Protocol as a useful tool to combat torture in their resolutions 55/89 on the 4th of December 2000, following the recommendation of the United Nations Special Rapporteur on Torture during the fifty-sixth session, on the 2nd of February 2000.

The UN Special Rapporteur on Torture stressed in his General Recommendations of 2003 the importance of the Istanbul Principles in the context of establishing independent national authorities for investigation; promptness and independence of investigations; independence of forensic medical services by governmental investigatory bodies and obtaining forensic evidence.

On the 23rd of April 2003, the UN Commission on Human Rights, in its resolution on human rights and forensic science, drew the attention of governments to these principles as a useful tool in combating torture. Likewise, reference was made to

the Istanbul Protocol in the resolution on the competence of national investigative authorities in preventing torture.

In addition to recognition by the UN system, the Istanbul Protocol has also been adopted by several regional bodies.

The African Commission on Human and Peoples' Rights deliberated on the importance of the Istanbul Protocol during its 32nd ordinary session in October 2002 and concluded that investigations of all allegations of torture or ill-treatment, shall be conducted promptly, impartially and effectively, and be guided by the Istanbul Principles.

The European Union has referred to the Istanbul Protocol in its *Guidelines to EU Policy towards Third Countries on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* adopted by the General Affairs Council in 2001. The EU guidelines mention that states should *"conduct prompt, impartial and effective investigations of all allegations of torture in accordance with the Istanbul Rules annexed to CHR resolution 2000/43"* and should *"establish and operate effective domestic procedures for responding to and investigating complaints and reports of torture and ill-treatment in accordance with the Istanbul Rules."*

Other institutions and organisations have reiterated the UN and other bodies' recommendations in their reports, statements, and comments (including the Advisory Council of Jurists and the Asia Pacific Forum of National Human Rights Institutions). These references can roughly be summarised into three categories:

- References that cite the Istanbul Protocol as a useful tool in the efforts to combat torture and strongly encourage governments to reflect upon the principles contained in the Protocol;
- References that stress that all investigations and documentation of torture allegations should be conducted promptly, impartially and effectively, and be guided by the Istanbul Principles;
- References that say that states should establish and operate effective domestic procedures for the investigation and documentation of torture allegations in accordance with the Istanbul Protocol.

The purpose of this part is not to train physicians as to the proper use of the Istanbul Protocol, but rather to help both asylum authorities and health professionals working with asylum seekers to understand and appreciate the complexities of the process followed by the Istanbul Protocol.[56]

Asylum authorities' staff members as well as health professionals who work in reception centres, detention facilities or general hospitals are working in an environment which, objectively, does not allow them to follow the principles and

[56] Recent publications intended for specialised training are: 1) '*Examining Asylum Seekers; A health professional's guide to medical and psychological evaluations of torture'*, Physicians for Human Rights, August, 2001. 2) '*Medical Investigation and Documentation of Torture; a handbook for health professionals'*, by Michael Peel and Noam Lubell with Jonathan Beynon, University of Essex, September, 2005. 3) '*Care Full; medico-legal reports and the Istanbul Protocol in asylum procedures',* edited by Rene Bruin, Marcelle Reneman, Evert Bloemen, 2006.

guidelines of the Istanbul Protocol. The complexity of this process needs time, coordination, globality, concetration, different environment (not a usually crowded and restrained one). These pre-conditions are non-existant, at least during the first stages of the asylum procedure. On the other hand, it is necessary for the health professional mentioned already to understand the basic principles and functioning of this process, so that they could detect possible cases of torture victims in order to refer and collaborate with the specialists. For asylum auhtorities as well, it is necessary to understand this process in order to:

- detect as early as possible in the asylum procedure probable torture victims for referral and confirmation
- understand the medical reports issued by the specialists following thorough examination based on the Istanbul Protocol
- perform their duties in a manner that constitues a qualitative step forward for the efficiency and the fairness of the asylum system
- finally, to contribute in the frame of their own work to the international obligations of their country to protect torture victims, one of the main targets of the global fight against torture.

8.3. Assessment

On the basis of the above, two internationally renowned specialists published a desk study reviewing the relevant literature.[57] Hereinafter excerpts particularly related to the understanding of the Istanbul Protocol process are following:

8.3.a.Medical assessment

Interviewing in general medical settings

Many survivors initially seek help from a general medical clinic, whether in the home country, in the refugee camp, or in countries of resettlement. Often, however, the doctor may recognize the depression in a patient, yet not recognize the patient as a survivor of torture. The primary care practitioner needs to know whether the patient belongs to a population at risk for torture or extreme trauma, e.g., refugees, asylum seekers, or those involved in radical political activity in their own countries. Presumably innocuous situations, such as a visit to the doctor, may precipitate re-experiencing symptoms in a torture survivor. Survivors may be reluctant to talk about their lives. Sometimes they have physical evidence of trauma or, more likely, may have somatic symptoms with no known physical cause. Many times torture survivors are fearful of being touched or examined. Merely sitting in a waiting room might remind the torture survivor of periods of enforced waiting. A doctor wearing a white coat may have been responsible for assisting torturers. Dental work may trigger

[57] 'Politically-motivated torture and its survivors', by Jose Quiroga, MD and James M. Jaranson, MD, MA, MPH, Torture Journal, Volume 15, No 2-3-, 2005, p. 30

recollections of dental extractions during torture. Reasons to refer to more specialized services, if they are available, include a need for expertise in physical and psychological trauma, sensitivity to cross-cultural issues, special knowledge of the multiplicity of needs of refugees or other survivors, and the availability of interpreters who van bridge the language barriers.

8.3.b. Physical assessment

Torture survivors need a comprehensive medical assessment to investigate all these potential problems. The assessment should include:

- Trauma history
- Medical history
- Family history
- Review of systems
- Review of the vaccination history
- Nutritional assessment

With the exception of trauma history and nutritional assessment, these areas are part of a comprehensive medical evaluation conducted during routine medical care. Trauma history is a new problem for primary practitioners but is a central issue in the care of refugees. Sometimes the trauma history has to wait until a trusting relationship has been established (Mollica, 2001b). In some torture rehabilitation programs the trauma history is taken by the physician and psychologist together in order to avoid repetition.

Physical exam should include:

- Complete physical examination
- Vision and hearing screening if indicated
- PPD in all and chest x-rays if the test is positive
- Vaccination as needed
- Stool ova/parasite if client has gastrointestinal symptoms
- HIV, RPR, Hepatitis B antigen, and a gynaecological examination, preferably with a female physician in all cases where women have been raped
- Forensic evaluation if the torture survivor presents torture sequelae

- Treatment of all medical conditions, acute or chronic, related or not related to torture and referring the client to other medical facilities if the program cannot provide the necessary medical care.

The laboratory tests most frequently requested for the care of torture survivors and refugees are:

- Urinalysis, chemical and microscopic
- CBC
- Chem. 12
- Liver function test
- Lipid profile
- Pregnancy test
- HIV
- RPR
- Hepatitis panel
- H. pylori
- Stool ova/parasite
- Stool occult blood
- PSA for men over 50 years old
- All other tests or procedures if they are indicated

At the end of the medical work, the medical problems can be separated into those related to torture and those not related to the trauma. From the medical point of view, all medical problems need to be detected and treated from a humanitarian perspective.

8.3.c.Psychiatric/psychological assessment

Assessment approaches and techniques can be used in research studies, in screening of high risk populations such as refuges for possible referral by public health, immigration, or educational personnel, or as the first part of the intervention strategy in treatment. However, many survivors live in countries where health professionals and specialised services may be in short supply or where access to the health care system is limited. Friends, family, teachers, lawyers, community or religious leaders,

and traditional healers may be their own perceived source of help (Jaranson et al., 2001).

(This obviously does not stand for European countries).

Interviewing by mental health professionals

The most problematic aspect of diagnosis is the interview process itself, which can stimulate memory of traumatic events and reactivate posttraumatic stress symptoms to the point where, for the first time, the survivor exhibits the full spectrum of PTSD. Consequently, in the interview process, the survivor should be allowed to tell his or her story at a pace that is comfortable. Interviewers who are too aggressive may cause re-traumatization or re-experiencing of the symptoms. The interview should be interactive in the manner in which the interviewer supports probes and questions the patient. The interviewer needs to monitor the patient's non-verbal communication and expressed language, observing whether the questions are too sensitive or painful and whether the patient wants to explain or clarify. When survivors are reticent to tell their stories or seem less upset than expected following horrible torture experiences, interviewers might become cynic; or disbelieve the survivor's story (Jaranson, 1995). Mainstream professional staff often do not know how to ask the difficult questions or wish to know the answers. The bond that develops between the therapist and the patient begins during the initial interview and therapy can begin at that time with a good explanation of the reason and/origin of the symptoms. Certain aspects of the evaluation process must be emphasized when assisting survivors of extreme interpersonal trauma. Professionals must be well-acquainted with key-elements of the survivor's world, since lack of this knowledge will almost certainly lead to significant arrors in assessment and evaluation. The establishment of rapport between the specialist and the survivor is crucial, based partly on the fact that the survivor is an active participant. Assessment and diagnosis, as well as any subsequent intervention, must cultivate the trust of the survivor, who must feel safe. If these conditions are not met, the survivor is unlikely to continue with intervention or may terminate intervention prematurely (Jaranson et al., 2001).

8.3.d. Assessment challenges for the professional

From the professional's perspective, the task of assessing patients who have been victims of severe interpersonal trauma is extremely complicated. At least partly because of difficulties at the initial assessment, it has been shown that systematic re-

evaluation of established patients may increase case findings (Kinzie et al., 1990). Jaranson et al. (2001) have identified the following difficulties even in trauma sensitive programs: 1) Survivors may have multiple concurrent psychiatric disorders or longer term personality changes; 2) Symptoms of PTSD, particularly the intrusive symptoms, wax and wane over time and may not be present at the time of interview; 3) Symptoms of avoidance, numbing, and amnesia may prevent the patient from remembering information about the trauma and other symptoms; 4) The information may be so disturbing that the interviewer reacts, preventing objective data gathering; 5) The interviewer may correctly feel that the patient is decompensating and that the clinical situation precludes pursuing relevant information (Kinzie and Jaranson, 2001); 6) Survivors may expect rapid improvement in symptoms and leave treatment early unless this happens.

8.3.e. Assessment principles

In the most well equipped settings, the best assessment is done as part of a treatment program and by professionals who can treat the patient both biologically and psychologically immediately after the evaluation. The assessment should include a thorough mental status examination, physical examination, and laboratory tests, in addition to details the survivor is willing to share about the trauma experience. In addition, historical data preceding and following the trauma need to be gathered. Not only the survivor's symptoms but also the level of function before and after the trauma experience is important. Pre-existing psychiatric and physical conditions, personality maladjustment, and prior trauma experience (as victim or perpetrator) need to be assessed. Active psychiatric disorders or other more mundane psycho-social trauma increase vulnerability (Kinzie et al., 1990). Also of importance is the history of head trauma, with or without loss of consciousness, at any time in the survivor's past. In particular for refugees and asylum seekers, post migration factors need to be explored. Treatment plans, accompanied by responsibility for carrying out these plans over time, must be formulated at the initial interview (Jaranson et al., 2001).

8.3.f. Cultural issues in assessment

Cultural differences are found in the willingness and need for detailed recall and recollection of the torture experience. Indochinese tend to minimize the problems

and are reluctant to talk about the events. South American refugees seem to be more eager and perhaps even helped by the experience of going though the trauma in detail (Morris and Sivole, 1992; Jaranson et al., 20001).

Cultural understanding is essential in choosing the methodology of the assessment. A standard Western psychiatric interview can be toxic (Mollica and Son, 1989). An assessment of the individual's larger life experiences, personal values, current life situation, family situation, and external social support are of equal importance to the medical assessment.

8.3.g. Questionnaires and rating scales

Use of structured interviews and diagnostic instruments as part of instruments as part of the assessment process can have several advantages, such as systematically recording symptoms in a way that elicits more than would be spontaneously volunteered by survivors. Some can be self-administered or administered by even briefly trained non-professionals, to give reasonably accurate diagnoses, and to provide information fro research purposes. Many of these are now in versions that have been translated and validated for increasing numbers of cultural groups and new measures are being developed specifically for assessing refugees and torture survivors. These tools are also useful for repeat assessments for comparison purposes. A complete review of these is beyond the scope of this text.

8.3.h. Accuracy of memory recall

Accurate recall of the experience of torture is critically important in documenting support for asylum claims, as well as in assessment and rehabilitation. A review of these issues is beyond the scope of this desk study, but will be briefly discussed here. The strength of the traumatic memory relates to the degree to which particular neuromodulatory systems are activated. Some of the acute neurobiological responses to trauma may facilitate the encoding of the traumatic memories. The memories of traumatic experiences remain indelible for many decades and are easily reawakened by all sorts of stimuli and stressors (Charney, 1993). These traumatic experiences are encoded by the brain in the amygdala, which connects and integrates information of the five senses, the cortical sensory systems, and the emotional reactions from the thalamus and hypothalamus (Southwick, 1994; Charney, 1993).

Issues of memory recall are important for accurate assessment, diagnosis, treatment, and research of torture survivors. Traumatic stress may cause amnesia or events or distortion of the memories. Later, a survivor may remember details initially repressed, either through psychotherapy or under other circumstances. For example, some survivors of childhood sexual assault only retrieve and deal with the memories once they have developed a stronger ego and a stable support system. Herlihy et al. (2002) investigated the consistency of autobiographical memory of 27 Kosovan and 12 Bosnian asylum seekers in England, finding that discrepancies were common but that the inconsistencies did not necessarily indicate poor credibility.

In recent years, concern about the validity of memories of childhood trauma has led to considerable discussion which has relevance for torture survivors. The debate centers around whether it is common for adults to forget, then later remember traumatic experiences which happened to them in childhood. According to Roth and Friedman (1997), evidence suggests that these memories can be 'recovered' after periods in which they were forgotten.

On the other hand, evidence has also shown that inaccurate memories can be 'strongly believed and convincingly described' (Roth and Freidman, 1997, p.8). in laboratory research, subjects can be persuaded to believe that they experienced events which they did not. Findings suggest that situation and personality characteristics may increase suggestibility and, consequently, some people may report false or inaccurate memories of trauma.

Layton and Krikorian (2002) have proposed anew theory of the neurobiology which mediates memory in PTSD. The comprehensive model argues that the amygdala is where consolidation of the traumatic experience occurs, but that the amygdala also inhibits the hippocampus at high levels of emotional arousal, causing a reduction in conscious memory for events surrounding the trauma. Southwick et al. (2002) have suggested that enhanced memory for arousing events is associated with an increase in norepinephrine when memory is consolidated.

8.3. i. Forensic evaluations

Several authors have written articles communicating their experiences on medical, psychological, or forensic assessment of torture survivors requesting medical or psychological care or an evaluation for political asylum (Oemichen, 1990;

Pounder, 1999; Thomsen, 2000; Jacobs et al., 2001, Part 1; Jacobs et al., 2001, Part II).

Physical evidence is often more readily accepted by the legal systems in many countries than is psychological evidence. The dual role of documentation and treatment becomes potentially problematic because the goal of acquiring safe legal status may be a more powerful motive than receiving other necessary treatment services. A conflict may exist between provision of treatment and providing support for social security disability, asylum, or workers compensation applications. On the other hand, since there are relatively few skilled professionals available, these roles are difficult to separate.

These dilemmas are discussed in depth in recent issues of the Torture Journal and further elaborated below.

Jacobs (2000) argues for the central role psychological evidence must have in documenting torture, since many sequelae of torture cannot be directly addressed by physical evidence. Jacobs conceptualises resistance to properly recognizing psychological evidence as a psycho-political constriction of psychic space for both examiners and survivors. Certain basic assumptions, psycho-political in nature, may negatively affect evaluators' attempts to effectively document torture, including the over evaluation of physical evidence, acceptance of the burden of proof , the medicalization of mental health into symptoms, syndromes, and diagnoses, and the perpetuation of mind-body dualism. Although the mainly subjective nature of psychological evidence cannot claim the objective validity of physical evidence, psychological evidence can nonetheless claim legitimacy. Even when physical evidence is primary, the survivor's psychological impairment can interfere with accurate narrative, and assessment can clarify these impairments for the legal system and, hopefully, for benefit of the survivor.

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Although objectivity, independence, and neutrality are required in forensic work, excessive removal and critical approaches by the evaluator can compromise the vulnerability of torture survivors. Jacobs cites Haenel's (2001, Part II, p. 42) description of the idea as 'the greatest possible empathy combined with the greatest possible distance'. As an evaluator, the job is to focus on the facts rather that on the psychic reality of the survivor, while the reverse is often true in therapy. The evaluator must offer an opinion about the probability of whether torture occurred and

might occur again. The court wants the expert to provide evidence to corroborate the claim based on detailed history, to assess the claimant's credibility, to describe the psychological problems, and to discuss the 'nexus' issue, on whether torture rather than other factors caused the problems. Specifics about the structure of taking the forensic history incorporates many of the sensitive approaches discussed elsewhere in interviewing torture survivors, but highlights include using a non-adversarial approach, establishing a sense of safety, and understanding the reluctance to disclose sensitive, but crucial, information. Often the interview begins with psychosocial and family history predating the trauma and persecution history, explaining this approach to the survivor before beginning the interview. The assessment of possible malingering and deception depends upon the assessment described above. Credibility is subject to the consistency of the history, the consistency of symptoms, behavioural observations, and validity indicators in psychological assessment procedures. If an application is not granted, it is important to find out the reason for denying the claim.

Jacobs et al, (2001, Part II) continues in the second section to discuss data gathering from behavioural observations, mental status exams, structured interviews and questionnaires, and psychological test results. The observations should not be limited to psychological distress but to the way in which the narrative is told. When selecting questions for the evaluation of the mental status, education level of the survivor and linguistic barriers must be considered. Questionnaires and interviews are limited by cross-cultural factors, and must be used with caution. Selecting those available in the survivor's language, including those widely translated such as the HTQ and HSCL 25. PTSD scales, mood and anxiety disorders modules of the SCID, and depression scales such as the Beck have high face validity. For greater in-depth testing, Jacobs recommends the MMPI-2 which is widely used, translated, and validated, and the TSI, which is shorter and includes validity scales.

In conclusion, the examiner must determine whether the history was detailed and consistent, that the findings suggested trauma, and that there was no evidence of malingering or deception. Finally, the examiner must answer where and where not causes other than torture could have caused the psychological symptoms. Since torture survivors usually suffer additional trauma and distress, the examiner should identify these events as contributors in order to assure the courts of the completeness and independence of the examination. If properly explained, this will support torture as the primary cause.

Herlihy, Scragg, and Turner (2002) investigated the consistency of autobiographical memory of refugees in the United Kingdom. All participants in the study had been granted political asylum under the United High Commission for Refugee program to avoid the secondary gain factor in people seeking political asylum. Discrepancies between the two accounts were found for all participants. Discrepancies increased with length of time between interviews and in refugees showing symptoms of PTSD. More discrepancies occurred in details peripheral to the account that in details that were central to the account (Herlihy, Scragg, and Turner, 2002).

Haenel (2001, I and II) uses case examples to elaborate the principles and procedures described by Jacobs and colleagues. Examples of programs which include forensic evaluations are recently described at the Medical Foundation of London (Peel et al., 2001; Peel et al., 2000) and at the Human Rights Clinic in the Bronx, New York, by Shenson and Silver (1997). Heisler et al. (2003) have surveyed forensic physicians in Mexico, finding not only that torture and ill treatment of detainees is problematic, but that additional training, protocols, and procedures are required to improve the documentation'.

8.4. Conclusions

From all the above description the complexity of the issue becomes evident. It is also apparent that at the initial stage of the effort to detect probable torture victims during asylum procedures, special care should be taken in order:

- to avoid retraumatization while interviewing
- to prevent vicarious traumatiazation of interviewers

Therefore, although asylum authorities' staff, as well as health professionals are knowledgeable in **interviewing techniques**, some specific points should be stressed to be taken in consideration when interviewing probable torture victims:

- **information is certainly important, but the well-being of the person being interviewed in more important**
- **listening is more important than asking questions**
- **to the asylum applicant, it may be more important to talk about family than to talk about torture. This should be duly considered, and time should be allowed for more discussion of personal matters**

- **torture, particularly sexual torture, is a very intimate subject, and may not come up before a follow-up visit – or even later. Individuals should not be 'forced' to talk about any form of torture if they feel uncomfortable about it**
- **whenever possible, one should utilize open-ended questions (e.g. 'Can you tell me what happened?'; 'Tell me more about that') and allow the individual to tell his/her story with as few interruptions as possible. This may result in a more accurate and detailed disclosure of information than moving too quickly to a rapid-fire form of questioning, which may, in fact, mimic interrogation. Further details can be elicited with appropriate follow up questions.**

Basic Useful Websites

www.un.org
United Nations

www.unhchr.ch
Office of the United Nations High Commissioner for Human Rights (OHCHR)

www1.umn.edu/humanrts/Africa/commission
African Commission on Human and People's Rights

www.oas.org
Organisation of American States

www.,cidh.oas.org
Inter-American Commission on Human Rights

www.coe.int
Council of Europe

www.cpt.coe.int
European Committee for the Prevention of Torture

www.europa.eu.int
European Union (EU)

www.osce.org
Organisation for Security and Co-operation in Europe (OSCE)

www.irct.org
International Rehabilitation Council for Torture Victims

Glossary of Specialised Terms[58]

Medical terms

- **Auditory hallucinations**: The experience of external sounds where there are no external stimuli
- **Axilla**: Armpit
- **Brachial ple**xus: The nerves running from the spine into the arm
- **Callus**: An area of thickening of bone at the place of healing
- **Cerebral oedema**: Swelling of the brain
- **Cognitive impairment**: Partial impairment of memory, thinking, perception or mood
- **Depigmentation**: Complete loss of pigment from a patch of skin
- **Haematuria**: Blood in the urine
- **Hyperpigmentation**: Increase of pigmentation of a patch of a skin
- **Hypopigmentation**: Partial loss of pigment from a patch of skin
- **Intrusive memories**: Involuntary, unpleasant and recurrent memories of an incident
- **Laceration**: A wound in which the skin is torn by blunt force
- **Medical History**: An individual's personal account of a health problem
- **Medico-legal**: Relating to that branch of medicine that assists the courts
- **Neuropathy:** Nerve damage
- **Oedematous**: Swollen
- **Pathognomonic**: A pathological finding that has only one cause
- **Perianal**: Around the anus
- **Petechiae:** Clusters of very small bruises
- **Psychosomatic symptoms**: Appartently physical symptoms that have a psychological cause
- **Retinal haemorrhage**: Bleeding into the back of the eye
- **Sequelae**: The consequences of a medical problem
- **Striae distensae**: Stretch marks on the skin

[58] This glossary is reproduced with the kind permission of Professor Sir Nigel Rodley KBE, Chair, Human Rights Centre, University of Essex. It was published in a handbook for health professionals, entitled: 'Medical Investigation and Documentation of Torture', written by Michael Peel and Noam Lubell with Jonathan Beynon.

- **Subdural bleeding**: Bleeding between certain layers of fibrous tissue covering the brain
- **Tonic-clonic fits**: The common form of epileptic convulsions
- **Urethral meatus**: The aperture at the end of the penis through which urine is voided
- **Vectors of Disease**: Agents that can transmit infections

Legal Terms

- **Arrest**: The act of apprehending a person for the alleged commission of an offense or by the action of an authority
- **Asylum**: Asylum is sought by individuals who do not wish to return to a country, usually their own, where they are at risk. If granted, they would be allowed to remain in a country which is not their own. This may be temporary or permanent.
- **Convention:** see Treaty
- **Corroboration**: Evidence which supports or confirms the truth of an allegation
- **Crimes against humanity**: Serious acts, such as torture, committed as part of a widespread or systematic attack against a civilian population, whether or not they are committed in the course of an armed conflict
- **Declaration:** A particularly formal resolution, usually of the United Nations General Assembly, which is not as such legally-binding, but sets out standards which states undertake to respect
- **Deportation**: Expulsion from a country
- **Derogate**: To temporarily suspend or limit
- **Detention:** Depriving a person of personal liberty except as a result of conviction for an offence
- **Domestic law or legal system**: National law or legal system; law or legal system which is specific to a particular country
- **Enforcement (of obligations):** Making the obligations effective; ensuring that they are respected
- **Impunity:** Being able to avoid punishment for illegal or undesirable behaviour

- **Incommunicado detention**: Being held by the authorities without being allowed any contact with the outside world
- **Instrument**: A general term to refer to international law documents, whether legally binding or not
- **Inter-governmental body**: A body or organization composed of the governmental representatives of more than one country
- **Judicial**: Relating to administration of justice or the courts of law
- **Legally-binding**: If something is legally-binding on a state, this means that the state is obliged to act in accordance with it, and there may be legal consequences if it does not so
- **Monitoring**: Seeking and receiving information for the purpose of reporting on a subject or situation
- **Non-state actors**: Private persons or groups acting independently of the authorities
- **Perpetrator**: The person who has carried out an act
- **Ratification**: The process through which a state agrees to be bound by a treaty
- **Reparation**: Measures to repair damage caused, e.g. compensation
- **State Party (to a treaty):** State which has agreed to be bound to a treaty
- **Treaty:** International law document which set out legally-binding obligations for states
- **Violation (of obligations):** Failure by a state to respect its obligations under international law
- **War crimes**: Serious violations of the rules of war, for which the perpetrator can be held criminally responsible

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ANNEXES

ANNEX 1

1. GENEVA Conventions of 1949 and Additional Protocols of 1977

- First Geneva Convention *"for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field"* (first adopted in 1864, last revision in 1949)
- Second Geneva Convention *"for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea"* (first adopted in 1906)
- Third Geneva Convention *"relative to the Treatment of Prisoners of War"* (first adopted in 1929, last revision in 1949)
- Fourth Geneva Convention *"relative to the Protection of Civilian Persons in Time of War"* (first adopted in 1949, based on parts of the 1907 Hague Convention IV)

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Article 3:

‘ In the case of armed conflict not of an international character occurring in the territory of one of the High Contracting Parties, each party to the conflict shall be bound to apply, as a minimum, the following provisions:

1. Persons taking no active part in the hostilities, including members of armed forces who have laid down their arms and those placed hors de combat by sickness, wounds, detention, or any other cause, shall in all circumstances be treated humanely, without any adverse distinction founded on race, colour, religion or faith, sex, birth or wealth, or any other similar criteria.

To this end the following acts are and shall remain prohibited at any time and in any place whatsoever with respect to the above-mentioned persons:

(a) Violence to life and person, in particular murder of all kinds, mutilation, cruel treatment and torture;

(b) Taking of hostages;

(c) Outrages upon personal dignity, in particular, humiliating and degrading treatment;

(d) The passing of sentences and the carrying out of executions without previous judgment pronounced by a regularly constituted court affording all the judicial guarantees which are recognized as indispensable by civilized peoples.

2. The wounded and sick shall be collected and cared for.

An impartial humanitarian body, such as the International Committee of the Red Cross, may offer its services to the Parties to the conflict.

The Parties to the conflict should further endeavour to bring into force, by means of special agreements, all or part of the other provisions of the present Convention.

The application of the preceding provisions shall not affect the legal status of the Parties to the conflict.'.

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In addition, there are three additional amendment protocols to the Geneva Conventions:

- Protocol I (1977): Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of International Armed Conflicts. As of 12 January 2007 it had been ratified by 167 countries.
- Protocol II (1977): Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of Non-International Armed Conflicts. As of 12 January 2007 it had been ratified by 163 countries.
- Protocol III (2005): Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Adoption of an Additional Distinctive Emblem. As of June 2007 it had been ratified by 17 countries and signed but not yet ratified by an additional 68 countries.

All four conventions were last revised and ratified in 1949, based on previous revisions and partly on some of the 1907 Hague Conventions; the whole set is referred to as the "Geneva Conventions of 1949" or simply the "Geneva Conventions". Later conferences have added provisions prohibiting certain methods of warfare and addressing issues of civil wars. Nearly all 200 countries of the world are "signatory" nations, in that they have ratified these conventions.

2. Universal Declaration of Human Rights

Article 5
No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

3. Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1984

Part 1

Article 1

1. For the purposes of this Convention, the term "torture" means act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.
2. This article is without prejudice to any international or national legislation which does or may contain provisions of wider application.

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Article 3

1. No State Party shall expel, return ("refouler") or extradite a person to another State where there are substantial grounds for believing that he would be in danger of being subjected to torture.
2. For the purpose of determining whether there are such grounds, the competent authorities shall take into account all relevant considerations including, where applicable, the existence in the State concerned of a consistent pattern of gross, flagrant or mass violations of human rights.

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Article 14

1. Each State Party shall ensure in its legal system that the victim of an act of torture obtains redress and has an enforceable right to fair and adequate compensation, including the means for as full rehabilitation as possible. In the event of the death of the victims as a result of an act of torture, his dependants shall be entitled to compensation.
2. Nothing in this article shall affect any right of the victim or other persons to compensation which may exist under national law.

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4. ROME STATUTE OF THE INTERNATIONAL CRIMINAL COURT

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Article 7

Crimes against humanity

1. For the purpose of this Statute, "crime against humanity" means any of the following acts when committed as part of a widespread or systematic attack directed against any civilian population, with knowledge of the attack:

(a) Murder;

(b) Extermination;

(c) Enslavement;

(d) Deportation or forcible transfer of population;

(e) Imprisonment or other severe deprivation of physical liberty in violation of fundamental rules of international law;

(f) Torture;

(g) Rape, sexual slavery, enforced prostitution, forced pregnancy, enforced sterilization, or any other form of sexual violence of comparable gravity;

(h) Persecution against any identifiable group or collectivity on political, racial, national, ethnic, cultural, religious, gender as defined in paragraph 3, or other grounds that are universally recognized as impermissible under international law, in connection with any act referred to in this paragraph or any crime within the jurisdiction of the Court;

(i) Enforced disappearance of persons;

(j) The crime of apartheid;

(k) Other inhumane acts of a similar character intentionally causing great suffering, or serious injury to body or to mental or physical health.

2. For the purpose of paragraph 1:

(a) "Attack directed against any civilian population" means a course of conduct involving the multiple commission of acts referred to in paragraph 1 against any civilian population, pursuant to or in furtherance of a State or organizational policy to commit such attack;

(b) "Extermination" includes the intentional infliction of conditions of life, inter alia the deprivation of access to food and medicine, calculated to bring about the destruction of part of a population;

(c) "Enslavement" means the exercise of any or all of the powers attaching to the right of ownership over a person and includes the exercise of such power in the course of trafficking in persons, in particular women and children;

(d) "Deportation or forcible transfer of population" means forced displacement of the persons concerned by expulsion or other coercive acts from the area in which they are lawfully present, without grounds permitted under international law;

(e) "Torture" means the intentional infliction of severe pain or suffering, whether physical or mental, upon a person in the custody or under the control of the accused; except that torture shall not include pain or suffering arising only from, inherent in or incidental to, lawful sanctions;

(f) "Forced pregnancy" means the unlawful confinement of a woman forcibly made pregnant, with the intent of affecting the ethnic composition of any population or carrying out other grave violations of international law. This definition shall not in any way be interpreted as affecting national laws relating to pregnancy;

(g) "Persecution" means the intentional and severe deprivation of fundamental rights contrary to international law by reason of the identity of the group or collectivity;

(h) "The crime of apartheid" means inhumane acts of a character similar to those referred to in paragraph 1, committed in the context of an institutionalized regime of systematic oppression and domination by one racial group over any other racial group or groups and committed with the intention of maintaining that regime;

(i) "Enforced disappearance of persons" means the arrest, detention or abduction of persons by, or with the authorization, support or acquiescence of, a State or a political organization, followed by a refusal to acknowledge that deprivation of freedom or to give information on the fate or whereabouts of those persons, with the intention of removing them from the protection of the law for a prolonged period of time.

3. For the purpose of this Statute, it is understood that the term "gender" refers to the two sexes, male and female, within the context of society. The term "gender" does not indicate any meaning different from the above.

Article 8

War crimes

1. The Court shall have jurisdiction in respect of war crimes in particular when committed as part of a plan or policy or as part of a large-scale commission of such crimes.

2. For the purpose of this Statute, "war crimes" means:

(a) Grave breaches of the Geneva Conventions of 12 August 1949, namely, any of the following acts against persons or property protected under the provisions of the relevant Geneva Convention:

(i) Wilful killing;

(ii) Torture or inhuman treatment, including biological experiments;

(iii) Wilfully causing great suffering, or serious injury to body or health;

(iv) Extensive destruction and appropriation of property, not justified by military necessity and carried out unlawfully and wantonly;

(v) Compelling a prisoner of war or other protected person to serve in the forces of a hostile Power;

(vi) Wilfully depriving a prisoner of war or other protected person of the rights of fair and regular trial;

(vii) Unlawful deportation or transfer or unlawful confinement;

(viii) Taking of hostages.

(b) Other serious violations of the laws and customs applicable in international armed conflict, within the established framework of international law, namely, any of the following acts:

(i) Intentionally directing attacks against the civilian population as such or against individual civilians not taking direct part in hostilities;

(ii) Intentionally directing attacks against civilian objects, that is, objects which are not military objectives;

(iii) Intentionally directing attacks against personnel, installations, material, units or vehicles involved in a humanitarian assistance or peacekeeping mission in accordance with the Charter of the United Nations, as long as they are entitled to the protection given to civilians or civilian objects under the international law of armed conflict;

(iv) Intentionally launching an attack in the knowledge that such attack will cause incidental loss of life or injury to civilians or damage to civilian objects or widespread, long-term and severe damage to the natural environment which would be clearly excessive in relation to the concrete and direct overall military advantage anticipated;

(v) Attacking or bombarding, by whatever means, towns, villages, dwellings or buildings which are undefended and which are not military objectives;

(vi) Killing or wounding a combatant who, having laid down his arms or having no longer means of defence, has surrendered at discretion;

(vii) Making improper use of a flag of truce, of the flag or of the military insignia and uniform of the enemy or of the United Nations, as well as of the distinctive emblems of the Geneva Conventions, resulting in death or serious personal injury;

(viii) The transfer, directly or indirectly, by the Occupying Power of parts of its own civilian population into the territory it occupies, or the deportation or transfer of all or parts of the population of the occupied territory within or outside this territory;

(ix) Intentionally directing attacks against buildings dedicated to religion, education, art, science or charitable purposes, historic monuments, hospitals and places where the sick and wounded are collected, provided they are not military objectives;

(x) Subjecting persons who are in the power of an adverse party to physical mutilation or to medical or scientific experiments of any kind which are neither justified by the medical, dental or hospital treatment of the person concerned nor carried out in his or her interest, and which cause death to or seriously endanger the health of such person or persons;

(xi) Killing or wounding treacherously individuals belonging to the hostile nation or army;

(xii) Declaring that no quarter will be given;

(xiii) Destroying or seizing the enemy's property unless such destruction or seizure be imperatively demanded by the necessities of war;

(xiv) Declaring abolished, suspended or inadmissible in a court of law the rights and actions of the nationals of the hostile party;

(xv) Compelling the nationals of the hostile party to take part in the operations of war directed against their own country, even if they were in the belligerent's service before the commencement of the war;

(xvi) Pillaging a town or place, even when taken by assault;

(xvii) Employing poison or poisoned weapons;

(xviii) Employing asphyxiating, poisonous or other gases, and all analogous liquids, materials or devices;

(xix) Employing bullets which expand or flatten easily in the human body, such as bullets with a hard envelope which does not entirely cover the core or is pierced with incisions;

(xx) Employing weapons, projectiles and material and methods of warfare which are of a nature to cause superfluous injury or unnecessary suffering or which are

inherently indiscriminate in violation of the international law of armed conflict, provided that such weapons, projectiles and material and methods of warfare are the subject of a comprehensive prohibition and are included in an annex to this Statute, by an amendment in accordance with the relevant provisions set forth in articles 121 and 123;

(xxi) Committing outrages upon personal dignity, in particular humiliating and degrading treatment;

(xxii) Committing rape, sexual slavery, enforced prostitution, forced pregnancy, as defined in article 7, paragraph 2 (f), enforced sterilization, or any other form of sexual violence also constituting a grave breach of the Geneva Conventions;

(xxiii) Utilizing the presence of a civilian or other protected person to render certain points, areas or military forces immune from military operations;

(xxiv) Intentionally directing attacks against buildings, material, medical units and transport, and personnel using the distinctive emblems of the Geneva Conventions in conformity with international law;

(xxv) Intentionally using starvation of civilians as a method of warfare by depriving them of objects indispensable to their survival, including wilfully impeding relief supplies as provided for under the Geneva Conventions;

(xxvi) Conscripting or enlisting children under the age of fifteen years into the national armed forces or using them to participate actively in hostilities.

(c) In the case of an armed conflict not of an international character, serious violations of article 3 common to the four Geneva Conventions of 12 August 1949, namely, any of the following acts committed against persons taking no active part in the hostilities, including members of armed forces who have laid down their arms and those placed hors de combat by sickness, wounds, detention or any other cause:

(i) Violence to life and person, in particular murder of all kinds, mutilation, cruel treatment and torture;

(ii) Committing outrages upon personal dignity, in particular humiliating and degrading treatment;

(iii) Taking of hostages;

(iv) The passing of sentences and the carrying out of executions without previous judgement pronounced by a regularly constituted court, affording all judicial guarantees which are generally recognized as indispensable.

(d) Paragraph 2 (c) applies to armed conflicts not of an international character and thus does not apply to situations of internal disturbances and tensions, such as riots, isolated and sporadic acts of violence or other acts of a similar nature.

(e) Other serious violations of the laws and customs applicable in armed conflicts not of an international character, within the established framework of international law, namely, any of the following acts:

(i) Intentionally directing attacks against the civilian population as such or against individual civilians not taking direct part in hostilities;

(ii) Intentionally directing attacks against buildings, material, medical units and transport, and personnel using the distinctive emblems of the Geneva Conventions in conformity with international law;

(iii) Intentionally directing attacks against personnel, installations, material, units or vehicles involved in a humanitarian assistance or peacekeeping mission in accordance with the Charter of the United Nations, as long as they are entitled to the protection given to civilians or civilian objects under the international law of armed conflict;

(iv) Intentionally directing attacks against buildings dedicated to religion, education, art, science or charitable purposes, historic monuments, hospitals and places where the sick and wounded are collected, provided they are not military objectives;

(v) Pillaging a town or place, even when taken by assault;

(vi) Committing rape, sexual slavery, enforced prostitution, forced pregnancy, as defined in article 7, paragraph 2 (f), enforced sterilization, and any other form of sexual violence also constituting a serious violation of article 3 common to the four Geneva Conventions;

(vii) Conscripting or enlisting children under the age of fifteen years into armed forces or groups or using them to participate actively in hostilities;

(viii) Ordering the displacement of the civilian population for reasons related to the conflict, unless the security of the civilians involved or imperative military reasons so demand;

(ix) Killing or wounding treacherously a combatant adversary;

(x) Declaring that no quarter will be given;

(xi) Subjecting persons who are in the power of another party to the conflict to physical mutilation or to medical or scientific experiments of any kind which are neither justified by the medical, dental or hospital treatment of the person concerned nor carried out in his or her interest, and which cause death to or seriously endanger the health of such person or persons;

(xii) Destroying or seizing the property of an adversary unless such destruction or seizure be imperatively demanded by the necessities of the conflict;

(f) Paragraph 2 (e) applies to armed conflicts not of an international character and thus does not apply to situations of internal disturbances and tensions, such as riots, isolated and sporadic acts of violence or other acts of a similar nature. It applies to armed conflicts that take place in the territory of a State when there is protracted armed conflict between governmental authorities and organized armed groups or between such groups.

3. Nothing in paragraph 2 (c) and (e) shall affect the responsibility of a Government to maintain or re-establish law and order in the State or to defend the unity and territorial integrity of the State, by all legitimate means.
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5. International Covenant on Civil and Political Rights

Article 7
No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.

6. International Convention on the Rights of the Child

The whole text of the Convention is relevant to children asylum seekers. More directly linked to children having suffered torture are the following articles:

Article 2, § 2
‘ *States Parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions, or beliefs of the child’s parents, legal guardians, or family members’.*

Article 3, §1
‘*In all actions concerning children, whether undertaken by public or private welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration’.*

Article 19
1. ‘ States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child’.
2. ‘Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of

prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement'.

Article 37

'States Parties shall ensure that:

(a) No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment. Neither capital punishment nor life imprisonment without possibility of release shall be imposed for offences committed by persons below eighteen years of age;

(b) No child shall be deprived of his or her liberty unlawfully or arbitrarily. The arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time;

(c) Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age. In particular, every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so and shall have the right to maintain contact with his or her family through correspondence and visits, save in exceptional circumstances;

(d) Every child deprived of his or her liberty shall have the right to prompt access to legal and other appropriate assistance, as well as the right to challenge the legality of the deprivation of his or her liberty before a court or other competent, independent and impartial authority, and to a prompt decision on any such action'.

Article 39

'States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or other form of Cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child'.

7. The European Convention on Human Rights

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Article 3

'No one shall be subjected to torture or to inhuman or degrading treatment or punishment'.

…….

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Done at Rome this 4th day of November, 1950, in English and French, both text being equally authentic, in a single copy which shall remain deposited in the archives of the Council of Europe. The Secretary-General shall transmit certified copies to each of the signatories.

8. Convention relating to the Status of Refugees

Adopted on 28 July 1951 by the United Nations Conference of Plenipotentiaries on the Status of Refugees and Stateless Persons convened under General Assembly resolution 429 (V) of 14 December 1950

entry into force 22 April 1954, in accordance with article 43

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Article 33. Prohibition of expulsion or return ("refoulement")

‘ 1. No Contracting State shall expel or return ("refouler") a refugee in any manner whatsoever to the frontiers of territories where his life or freedom would be threatened on account of his race, religion, nationality, membership of a particular social group or political opinion.

2. The benefit of the present provision may not, however, be claimed by a refugee whom there are reasonable grounds for regarding as a danger to the security of the country in which he is, or who, having been convicted by a final judgement of a particularly serious crime, constitutes a danger to the community of that country’.

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8. Amsterdam Treaty of October 1997

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15. The following title shall be inserted in Part Three:

‘Title IIIa

VISAS, ASYLUM, IMMIGRATION AND OTHER POLICIES RELATED TO FREE MOVEMENT OF PERSONS

Article 73i

In order to establish progressively an area of freedom, security and justice, the Council shall adopt:

(a) within a period of five years after the entry into force of the Treaty of Amsterdam, measures aimed at ensuring the free movement of persons in accordance with Article 7a, in conjunction with directly related flanking measures with respect to external border controls, asylum and immigration, in accordance with the provisions of Article 73j(2) and (3) and Article 73k(1)(a) and (2)(a), and measures to prevent and combat crime in accordance with the provisions of Article K.3(e) of the Treaty on European Union;

(b) other measures in the fields of asylum, immigration and safeguarding the rights of nationals of third countries, in accordance with the provisions of Article 73k;

(c) measures in the field of judicial cooperation in civil matters as provided for in Article 73m;

(d) appropriate measures to encourage and strengthen administrative cooperation, as provided for in Article 73n;

(e) measures in the field of police and judicial cooperation in criminal matters aimed at a high level of security by preventing and combating crime within the Union in accordance with the provisions of the Treaty on European Union.

Article 73j

The Council, acting in accordance with the procedure referred to in Article 73o, shall, within a period of five years after the entry into force of the Treaty of Amsterdam, adopt:

(1) measures with a view to ensuring, in compliance with Article 7a, the absence of any controls on persons, be they citizens of the Union or nationals of third countries, when crossing internal borders;

(2) measures on the crossing of the external borders of the Member States which shall establish:

(a) standards and procedures to be followed by Member States in carrying out checks on persons at such borders;

(b) rules on visas for intended stays of no more than three months, including:

(i) the list of third countries whose nationals must be in possession of visas when crossing the external borders and those whose nationals are exempt from that requirement;

(ii) the procedures and conditions for issuing visas by Member States;

(iii) a uniform format for visas;

(iv) rules on a uniform visa;

(3) measures setting out the conditions under which nationals of third countries shall have the freedom to travel within the territory of the Member States during a period of no more than three months.

Article 73k

The Council, acting in accordance with the procedure referred to in Article 73o, shall, within a period of five years after the entry into force of the Treaty of Amsterdam, adopt:

(1) measures on asylum, in accordance with the Geneva Convention of 28 July 1951 and the Protocol of 31 January 1967 relating to the status of refugees and other relevant treaties, within the following areas:

(a) criteria and mechanisms for determining which Member State is responsible for considering an application for asylum submitted by a national of a third country in one of the Member States,

(b) minimum standards on the reception of asylum seekers in Member States,

(c) minimum standards with respect to the qualification of nationals of third countries as refugees,

(d) minimum standards on procedures in Member States for granting or withdrawing refugee status;

(2) measures on refugees and displaced persons within the following areas:

(a) minimum standards for giving temporary protection to displaced persons from third countries who cannot return to their country of origin and for persons who otherwise need international protection,

(b) promoting a balance of effort between Member States in receiving and bearing the consequences of receiving refugees and displaced persons;

(3) measures on immigration policy within the following areas:

(a) conditions of entry and residence, and standards on procedures for the issue by Member States of long term visas and residence permits, including those for the purpose of family reunion,

(b) illegal immigration and illegal residence, including repatriation of illegal residents;

(4) measures defining the rights and conditions under which nationals of third countries who are legally resident in a Member State may reside in other Member States.

Measures adopted by the Council pursuant to points 3 and 4 shall not prevent any Member State from maintaining or introducing in the areas concerned national provisions which are compatible with this Treaty and with international agreements.

Measures to be adopted pursuant to points 2(b), 3(a) and 4 shall not be subject to the five year period referred to above..

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ANNEX 2

International Insrtuments and Mechanisms for the Fight against Torture

Part 1: Legal Instruments on Torture

A. Universal texts concerning torture

a. UN Conventions:

- The United Nations Charter (1945)
- International Covenant on Civil and Political Rights- ICCPR, Article 7
- Optional Protocol to the International Covenant on Civil and Political Rights (1966)
- UN Human Rights Committee General Comment 20 concerning Article 7 of the ICCPR (1992)
- UN Human Rights Committee General Comment 21 concerning Article 10 of the ICCPR (1992)
- International Covenant on Economic, Social and Cultural Rights (1966)
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984, entered into force 26 June 1987)
- UN Committee against Torture General Comment No 1 on the implementation of article 3 of the Convention in the context of article 22 (1997)
- Convention on the Rights of the Child (198, entered into force 2 September 1990)
- International Convention on the Elimination of All Forms of Racial Discrimination (1965, entered into force 4 January 1969)
- Convention on the Elimination of All Forms of Discrimination against Women (1979, entered into force 3 September 1981)
- UN Committee on the Elimination of Discrimination against Women General Recommendation No 19 concerning Violence against Women (1992)
- Optional Protocol to the Convention on the Elimination of Discrimination against Women (1999, entered into force 22 December 2000)
- Convention on the Prevention and Punishment of the Crime of Genocide (1948, entered into force 12 January 1951)
- International Convention on the Suppression and Punishment of the Crime of Apartheid (1973, entered into force 18 July 1976)

b. Non-binding texts adopted by the UN

- Universal Declaration of Human Rights (1948)

- Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1975)
- Vienna Declaration and Programme of Action (1993)
- Declaration on the Elimination of Violence against Women (1993)
- Declaration on the Protection of Women and Children in Emergency and Armed Conflict (1974)
- United Nations Standard Minimum Rules for the Administration of Juvenile Justice (1985)
- United Nations Rules for the Protection of Juveniles Deprived of their Liberty (1990)
- Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment (1988)
- Basic Principles for the Treatment of Prisoners (1990)
- Standard Minimum Rules for the Treatment of Prisoners (1957 & 1977)
- Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1982)
- Code of Conduct for Law Enforcement Officials (1979)
- Basic Principles on the Use of Force and Firearms by Law Enforcement Officials (1990)
- Guidelines on the Role of Prosecutors (1990)
- Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power (1985)
- Declaration on the Human Rights of Individuals who are not Nationals of the Country in which They Live (1985)
- Declaration on the Protection of all Persons from Enforced Disappearance (1992)
- United Nations Declaration on the Elimination of All Forms of Racial Discrimination (1963)
- Declaration on the Right and Responsibility of Individuals, Groups and Organs of Society to Promote and Protect Universally Recognized Human Rights and Fundamental Freedoms (1998)

B. Prohibition of Torture in Humanitarian Law

- Common Article 3 of the Geneva Conventions
- Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field (1949, entered into force 21 October 1950)
- Geneva Convention for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea (1949, entered into force 21 October 1950)
- Geneva Convention relative to the Treatment of Prisoners of War (1949, entered into force 21 October 1950)
- Geneva Convention relative to the Protection of Civilian Persons in Time of War (1949, entered into force 21 October 1950)
- Protocol I Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of International Armed Conflicts (1977, entered into force 7 December 1979)
- Protocol II Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of Non-International Armed Conflicts (1977, entered into force 7 December 1979)

C. Prohibition of Torture in the International Criminal Court and the Ad Hoc Tribunals

- Statute of the International Criminal Tribunal for the Former Yogoslavia (1993)
- Statute of the International Criminal Tribunal for Rwanda (1994)
- Rome Statute of the International Criminal Court (1998, entered into force July 1st, 2002)

D. Regional Texts Concerning Torture

a. Texts adopted by the Organization of African Unity

- African Charter on Human and Peoples' Rights (1981)
- African Charter on the Rights and Welfare of the Child (1990)

b. Texts adopted by the Organisation of American States

- America Convention on Human Rights (1969)
- Inter-American Convention to Prevent and Punish Torture (1985)

Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (1994)

- Inter-American Convention on the Forced Disappearance of Persons (1994)

c. Texts adopted by **the Council of Europe**

- European Convention for the Protection of Human Rights and Fundamental Freedoms (1950, entered into force 3 September 1953), **Article 3**
- European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, CPT (1987, entered into force 1 February 1989)
- European Convention on the Compensation of Victims of Violent Crimes (1983, entered into force 1 January 1988)
- Resolution 690 (1979) on the Declaration on the Police

- Recommendation No. R (87) 3 of the Committee of Ministers to Member States on the European Prison Rules (1987)
- Recommendation No R (98) 7 of the Committee of Ministers to Member States concerning the Ethical and Organisational Aspects of Health Care in Prison (1998)
- Recommendation No R (99) 3 of the Committee of Ministers to Member States on the Harmonisation of Medico-Legal Autopsy Rules (1999)

d. Texts adopted by **the OSCE/CSCE**

- Concluding document of the Third Follow-up Meeting, Vienna (1989)
- Document of the Copenhagen Meeting of the Conference on the Human Dimension of the OSCE (1990)
- Document of the Moscow Meeting of the Conference on the Human Dimension of the OSCE (1991)
- Charter for European Security (1999)

e.Texts adopted by **the European Union**

- Charter of the Fundamental Rights of the European Union, Nice (2000), **Article 4**
- Guidelines to EU policy towards third country on torture and other cruel, inhuman or degrading treatment or punishment (2001)

f.Middle East

- The Cairo Declaration on Human Rights in Islam (1990)
- Arab Charter on Human Rights (1994)

Part 2: International Torture Reporting Mechanisms and Complaint Procedures

UN Mechanisms

- UN Committee against Torture
- UN Human Rights Committee
- UN Committee on the Rights of the Child
- UN Committee on the Elimination of Discrimination against Women
- UN Commission on Human Rights
- UN Special Rapporteur on the Question of Torture
- UN Special Rapporteur on Violence against Women, its Causes and Consequences
- UN Special Representative on Human Rights Defenders

African Mechanisms

- African Commission on Human and people's Rights
- Special Rapporteur on Prisons and Conditions of Detention in Africa

American Mechanisms

- Inter-American Commission on Human Rights
- Inter-American Court on Human Rights

European Mechanisms

- European Court of Human Rights
- European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)

Part 3: Health Professional Standards on Torture

The World Medical Association

- Declaration of Geneva (1948)
- World Medical Association Declaration – Guidelines for Medical Doctors Concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment (Tokyo,1975)
- World Medical Association Declaration Concerning Support for Medical Doctors Refusing to Participate in, or to Condone, the Use of Torture or Other Forms of Cruel, Inhuman or Degrading Treatment (Hamburg, 1997)

The International Council of Nurses

- The Nurse's Role in the Care of Detainees and Prisoners (1975)
- Nurses and Human Rights (1983)
- Torture, Death Penalty and Participation by Nurses in Executions (1989)

(All three replaced by unique text in 1998)

The World Confederation for Physical Therapy

- Guidelines Concerning Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment (1995)

The World Psychiatric Association

- Madrid Declaration on Ethical Standards for Psychiatric Practice (1996)

Standing Committee of Doctors of the European Communities

- Statement of Madrid (1989)

International Council of Prison Medical Services

- The Oath of Athens (1979)

International Federation of Gynaecology and Obstetrics

- Resolution on Violence against Women (Copenhagen, 1997)

International Union of Psychological Science

- Statement by the International Union of Psychological Science (1976)

Part 4: Other Relevant Texts

- Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
- The Prishtina Declaration on National Psychosocial Rehabilitation, Peaceful Co-existence and Prevention of Torture (Kosovo, 2000)
- Amnesty International 12-Point Program for the Prevention of Torture by Agents of the State (1983, revised in 2000)
- Recommendations of the Special Rapporteur on Torture for the Prevention and Eradication of Torture (2001)

Annex 3

Resolution 1471 (2005)[1]

Accelerated asylum procedures in Council of Europe member states

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7. The particularly problematic aspects of accelerated procedures are fourfold. They include the application of the notion of the safe country of origin, the application of the principle of a safe third country, including the concept of "super safe third country", procedures adopted at the border for dealing with asylum seekers and the right of appeal with suspensive effect. These four areas raise a certain number of concerns, notably the danger of *refoulement*, the particular situation of vulnerable groups – such as children or victims of torture or sexual violence or trafficking – and the denial of access to basic procedural safeguards, such as the right to legal advice and representation, the right to a personal interview and the right to an interpreter.

……

8.3.2.vi. the exclusion of vulnerable persons, including separated children and persons suffering from trauma as a result of torture or other ill-treatment, including sexual and gender-based violence, from the application of the safe third country concept;

……

8.11. as regards exemptions from accelerated procedures: to ensure that certain categories of persons be excluded from accelerated procedures due to their vulnerability and the complexity of their cases, namely separated children/unaccompanied minors, victims of torture and sexual violence and trafficking, and also cases raising issues under the exclusion clauses of the 1951 Refugee Convention;

……

8.14. as regards the decision-making process, to ensure that all officials dealing with asylum seekers receive relevant training and access to sources of information and research in order to carry out their work in a gender- and age-sensitive manner and with due consideration to the particular situation of victims of torture and ill-treatment, including victims of sexual or other forms of gender-based violence;

……

1. *Assembly debate* on 7 October 2005 (32nd Sitting) (see Doc. 10655, report of the Committee on Migration, Refugees and Population, rapporteur: Mr Agramunt). *Text adopted by the Assembly* on 7 October 2005 (32nd Sitting).

Annex 4

Findings of the study on the Reception Directive[59]

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The study contains an assessment of the situation and pinpoints problematic areas in the proper treatment of vulnerable groups and most specifically of torture victims. It is very useful to set forth a few relevant paragraphs of this study, showing clearly the deficiencies that need to be faced:

a. the biggest problem regarding the personal scope of the application of the directive certainly concerns asylum-seekers with special needs: there is a deficiency of medical and other assistance for these persons in 14 Member States

The study also recommends legislative amendments of the provision of the Directive:

- identification of asylum seekers with special needs, which should be considered as a top priority because of its crucial importance and the weakness of article 17, par. 2 of the Directive, through a clear allocation of responsibilities between the different actors entering into contact with asylum seekers on that precise point or through the definition of a specific procedure for the identification of asylum seekers with special needs.

(To our knowledge the European Commission is still working on amendments to the Reception Directive)

The study goes on analysing the special needs of particular categories of vulnerable asylum seekers and the questions and answers of the study speak for themselves:

Question 30A of the study: **Which of the different categories of persons with special needs considered in the Directive are taken into account in the national legislation (see article 17, §1 which is a mandatory provision): disabled people, elderly people, pregnant women, single parents with minor children, persons who have been tortured, raped or victims of serious physical or psychological violence? Include in your answer all other categories envisaged in national law.**

[59] Odysseus Academic Network; Comparative Overview of the Implementation of the Directive 2003/9 of 27 January 2003 laying down minimum standards for the reception of asylum seekers in the EU Member states'.

Belgium, Cyprus, Spain, Italy, Greece, Luxembourg, Portugal, Slovenia and the United Kingdom explicitly cater for the different categories of persons listed in article 17 §1 of the Directive which, as a result, has influenced the national law of these Member States.
On the other hand, certain Member States do not cater for the situation of a group or of several groups of vulnerable persons in their legislation (Austria where the situation may vary from one Land to another, France, Hungary, Lithuania, Malta, Poland). The Czech Republic lists certain categories of vulnerable persons, referring moreover to "other persons according to individual cases", similarly Slovenia adds "persons requiring special needs". Other Member States do not cater for any of the categories listed in the Directive and address asylum seekers with special needs as a whole. Germany points out that additional benefits may be granted if these are necessary to ensure the health or existence of the asylum seeker. In the Netherlands, vulnerable persons with special needs have the right to specific support or counsel. In Sweden, the categories of persons with special needs are not expressly listed in the legislation on reception conditions, but are covered in a more general manner in other legal provisions such as the "Social Services Act" and guidelines from the State authority in charge. Finally, some Member States also consider other categories of persons other than those covered by the Directive: Belgium hosts victims of human trafficking in specialised centres; Finland pays particular attention to families. Finally, the technique used by Member States for addressing asylum seekers hardly matters when the categories of persons are listed by the Directive only as examples. The only thing which matters from a legal point of view is that persons with special needs see that these needs are being effectively taken into account "in the national legislation", as is required by article 17, §1 of the Directive. This is surely not the case of Latvia which does not cater for any category of vulnerable asylum seekers, the same applies to Estonia which only refers to minors, probably because they are the object of specific provisions in the Directive. The problem with these two Member States may, however, be purely legal on account of the extremely small number of asylum seekers that they receive.

NO TRANSPOSITION AT ALL Latvia, Estonia, Hungary, Slovakia

Question 30B of the study: **How is their specific situation taken into account (see articles 13, §2, second indent, 16 §4 second sentence and 17 which are mandatory provisions)?**

The reader is asked to note that the specific measures granted to unaccompanied male and female minors are dealt with in the answer to question 31. The specific measures taken in favour of persons with special needs concern mainly two spheres.
First of all housing about which one can provide the following information:
• In Belgium, the place of registration is chosen according to the needs of the beneficiary depending on availability. Thereafter, the practice is to grant a transfer according to the personal situation of the asylum seeker;
• In Spain, vulnerable asylum seekers have priority for access to reception centres for refugees;
• In Finland, special attention is given to granting adequate housing to pregnant women and disabled persons;
• In Hungary, women on their own and single parents with minor children are accommodated in a protected environment;

• In Latvia, the only reception centre is equipped for persons using a wheelchair;
• In Malta, families with children and pregnant women who cannot be detained are accommodated in special houses;
• In the Netherlands, there are housing facilities with equipment adapted for disabled persons and single rooms for pregnant women;
• In the Czech Republic, vulnerable asylum seekers are housed in the protected zones of centres that are more secured than others. Families, women and children have separate accommodation.
• In Slovenia, applicants with special needs are accommodated in a specific wing of the House of Asylum and specific activities are taken over by NGOs;
• In Sweden, there are apartments which are especially equipped for disabled persons.

Furthermore, the question of health care will be tackled hereunder as an answer to question 30D because the Directive accords this question a specific importance through specific mandatory provisions (infra).
It has been pointed out that in Germany, practice is sometimes directed by courts and tribunals. Thus, for example, the administrative tribunal of Munich decided that a child suffering from several illnesses had the right to be admitted into an integrated kindergarten in order to meet his specific needs; the administrative tribunal of Gera meanwhile considered that the implantation of a prosthesis is not necessary, even if the asylum seeker's hip is irrevocably damaged, as long as there is the possibility of a painkiller treatment which enables him to live without pain. It has been pointed out that no measure was taken in Cyprus for the granting of a specific aid because of the small number of cases that presented themselves. In spite of its possibly limited character, this situation constitutes nonetheless, on the part of this Member State, a failure to put the directive into action.

PROBLEM Austria, Cyprus, Italy, Lithuania

Question 30C of the study: **How and when are the special needs of the concerned persons supposed to be legally identified (see article 17 § 2 which is a mandatory provision and clarify how it has been interpreted by transposition)?**

Article 17 §2 of the Directive is of great importance, as the assessment of persons with special needs determines the granting of the specific reception conditions to which they have a right under articles 18 and 20 of the Directive. It is to be noted that this question may also have a bearing on the proofs which, particularly for persons who are victims of torture or of other forms of violence, may be provided within the context of their application for asylum.

Certain Member States have provided for a specific procedure at the time of the medical screening of asylum seekers (Cyprus, Lithuania, the Netherlands, Poland but it seems that this system does not function well in practice), at the time of the lodging of the asylum claim (Spain, Portugal), at the time of the first hearing in the context of the asylum procedure (Lithuania, Czech Republic), at the time of arrival on the territory or at the border (Poland), or at the time of an interview with a social assistant in the centre (Finland). Estonia, France and Hungary have provided for specific procedures only for unaccompanied minors.

Ten Member States, with some among them receiving asylum seekers in great numbers and among whom there must be persons with special needs, have unfortunately not provided for any specific procedure to identify asylum seekers with special needs (United Kingdom, Germany, Austria, Belgium, Luxembourg, Greece, Italy, Latvia, Slovakia, Slovenia). The identification of the special needs of the persons concerned therefore depends -when they are detected- on their being taken into account by the authorities who examine the application for asylum, the social workers, the NGOs and the police, unless the asylum seeker concerned or a family member accompanying him draws attention to the case. Moreover, the United Kingdom has added a specific rule in its implementing legislation which explicitly states that: "Nothing in this regulation obliges the Secretary of State to carry out or arrange for the carrying out of an individual evaluation of a vulnerable person's situation to determine whether he has special needs"! Such a system is questionable, as it allows for some uncertainty regarding the identification of the persons with special needs, if clear regulations and precise instructions are not given in this regard to the persons who come into contact with the asylum seekers, which does not seem to be the case in the concerned Member States.

In Malta, where the identification of the concerned persons is absolutely crucial as the recognition of their special needs will release them from detention applied in principle to all asylum seekers, the procedure is more or less formalised but could be improved despite the progresses recently accomplished which seem to be real despite persistent controversies about the length of their detention for the purpose of the evaluation of their situation.

Unfortunately, article 17 of the Directive is questionable in that it does not explicitly require, from a legal point of view, a specific procedure to be put in place in order to identify those asylum seekers with special needs. This led the experts to consider that the correct mention in the table of transposition is "no need to transpose". As, in reality, the system clearly rests on an identification of these persons, it is a matter on which progress needs to be made in certain Member States. Progress towards a system of identification could be achieved either by obliging Member States to draw up a specific procedure for the identification of special needs (the medical screening, which most of the Member States impose on asylum seekers as shown by the answer to question 27 A, seems to be a suitable opportunity to carry out this identification) or at least, by providing clear and precise regulations, obliging the authorities and persons entering into contact with the asylum seekers to refer those who seem to have special needs to the competent department which can allow them to benefit from adequate reception conditions. A first step forward could be made through the exchange of best practices among Member States (possible "providers" and "benefiting" Members States could be listed on the basis of the indications given above), but legal certainty on such a crucial point for persons with special needs requires an amendment of the Directive during the second stage of the building of a Common European Asylum system.

Question 30D of the study: **Is the necessary medical and other assistance provided to persons with special needs as requested by article 15, §2 which is a mandatory provision and in particular to victims of torture and violence as requested by article 20 which is a mandatory provision?**

First of all, two Member States (Cyprus and France except for minors who benefit from a special medical support) do not take into account special needs. The legislation of Slovakia not precise enough while the one of Malta is incomplete even if the way persons with special needs are treated once they have been identified and released of detention is satisfactory.
In many Member States, the necessary treatment is given in or by rehabilitation centres financed entirely (Finland, Hungary) or partially (United Kingdom, Germany, Italy, Greece, Austria) by NGOs or non-State funds, sometimes on the basis of contract signed with the public authorities (for instance in Belgium).

Furthermore, the analysis of the practices of Member States by the Odysseus academic Network, which in this regard has benefited from a complementary report drafted by the International Rehabilitation Council for Torture Victims, reveals many deficiencies – the list hereunder is not at all exhaustive:
• In Germany, sufficient treatment is not always given.
• In Austria, long waiting lists and the fact that translation and transport costs are not covered is a problem regarding real access to the necessary support;
• In Italy, specific aid is only provided for if the director of the reception centre has a formal agreement with the local authorities. This type of agreement however is not mandatory;
• In Poland, NGOs note that the psychological help given is insufficient.
• In the United Kingdom, regulations integrate the specific medical needs of the asylum seekers, but these needs are neither well evaluated nor addressed in practice.
• In Slovenia, specific medical help is only given by an NGO.

Only a few rare good practices could be identified. In Italy, 19 specific centres have, since 2006, been reserved for vulnerable asylum seekers; their workings have yet to be assessed. In Sweden, an institutionalised system exists by which the authorities and the hospitals direct potential torture victims to the Red Cross who manage specific rehabilitation centres.

This question which presents a problem in 13 Member States should be the object of the particular attention of the European Commission in order to avoid that the provisions of the Directive which, it should be stressed, have been drawn up in such a way as to make them mandatory, do not remain a dead letter. Regarding cases of torture, the manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment know as the “Istanbul Protocol” as well as the Health professional’s guide to medical and psychological evaluations of torture (document entitled “Examining Asylum seekers” elaborated by Physicians for Human Rights) could be used as a starting point. Besides monitoring the implementation of the Directive by Member States, in order to register progress in the matter, national initiatives could be encouraged through financing by the European Refugee Fund.

NO TRANSPOSITION Latvia, Hungary, France, Malta
PROBLEM Austria, Cyprus, Greece regarding article 15§2, Italy, United Kingdom, Slovenia, Slovakia, Lithuania, Germany, Estonia regarding article 15§2

Annex 5

Findings of the study of UNHCR on the Qualification Directive

In November 2007, UNHCR published a study entitled '**Asylum in the European Union – A study of the implementation of the Qualification Directive'**. It concerns the 2004/83 Directive of 29 April 2004 on minimum standards for the qualification and status of third country nationals or stateless persons as refugees or as person who otherwise need international protection and the content of the protection granted.

It is useful to mention some relevant comments of UNHCR, included in the study:

……..

- In general terms, the provisions on **subsidiary protection** have been welcomed. They represent the first supranational legislation in Europe defining qualification for subsidiary protection, and create an obligation to grant this status to those who qualify. In law, the Directive thus has expanded the scope of international protection. However, the research found that, in practice, subsidiary protection is not granted to significant numbers of persons who appear to be in need of international protection. This is due both to the impact of procedural flaws and to a narrow interpretation of the terms of Directive itself.
- The provisions on subsidiary protection remain unavailable for the overwhelming majority of asylum applicants in Greece due to procedural flaws, which result in the fact that most applications are not assessed with regard to qualification for subsidiary protection. This could constitute a breach of article 18 of the Qualification Directive.
- The potential of article 15 (c) to provide protection to those who fear serious harm to life or person is undermined by a highly restrictive interpretation of the term 'individual threat' in line with Recital 26 of the Directive. This has resulted in authorities requiring that the applicant be at a greater risk of harm than the rest of the population, or sections of it, in his or her country of origin. The research has shown that the impact of this interpretation of 'individual threat' is to deny subsidiary protection to persons who risk serious harm or return to their country of origin on the basis that they face the same risk as, for

example, other members of their clan or other residents of their town. As such, this interpretation of Recital 26 renders the protection offered by the Qualification Directive illusory for many persons and appears to be incompatible with case-law of the European Court of Human Rights.

- The research revealed that the potential of the Qualification Directive to deliver subsidiary protection is further limited by the approach taken by Germany to the assessment of risk. Where the risk of death or other serious harm affects the population generally, Ministry of Interior guidelines require that the risk to life or person must be 'inevitable'. Requiring 'near certainty' of death or severest injury is not in line with the requirement of 'real risk' set by the Qualification Directive or with human rights standards.
- The term 'internal armed conflict' is a source of divergent interpretation across Member States and within national jurisdictions. There is no agreed definition of 'internal armed conflict' in international law, and decisions screened in France, Germany and Sweden highlighted divergences in interpretation and application. As a result, at the time of the research, the situation in parts of Iraq was assessed as an 'internal armed conflict' in France, but not in Sweden where it was described as a 'severe conflict'. Whilst the Swedish authorities considered the conflict in Chechnya as an 'internal armed conflict', the Slovak authorities did not. Moreover, the Swedish authorities did not consider that the situation in Somalia amounted to an 'internal armed conflict' although the German authorities did. This term is clearly a source of interpretational differences. However, it is not clear what added value this term brings to a legal provision of subsidiary protection, as persons who face a real risk of serious harm due to indiscriminate violence and widespread human rights violations are in need of international protection regardless whether the context is classified as an internal armed conflict or not. This is reflected in the Temporary Protection Directive and other regional legislation in Latin America and Africa. The application of this term in the Qualification Directive in at least some Member States would appear to deny subsidiary protection to persons facing a real risk of serious harm in their country of origin.
- It has been difficult to draw conclusions on the application of article 15 (b), which resembles article 3 of the European Convention on Human Rights on

torture, inhuman and degrading treatment and punishment. This is due to the fact that where it was applied, decisions contained little pertinent legal analysis. It is also due to the fact that it was often not applied in some Member States. This could be an indication of insufficient doctrinal guidance on the detection between 'inhuman and degrading treatment' and 'serious threat to life or person' contained in article 15 (c). It was hoped that a review of decisions would provide some clarity on which serious threats do not fall within 'inhuman and degrading treatment' but do constitute a 'serious threat to life or person'. However, the review of decisions did not provide this clarity. It may be deduced from the decisions analysed that either decision makers do not necessarily exclude articles 15 (a) and (b) before considering article 15 (c), i.e. the grounds are not considered a hierarchy, and/or some authorities apply a restrictive interpretation of article 15 (b), as the review found treatment such as slavery, forced blood donation to captors, and death threats were considered in relation to article 15 (c) rather than article 15 (b).

Annex 6

CPT standards, Rev. 2006

‘ *……The staff of centres for immigration detainees have a particularly onerous task. Firstly, there will inevitably be communication difficulties caused by language barriers. Secondly, many detained persons will find the fact that they have been deprived of their liberty when they are not suspected of any criminal offence difficult to accept. Thirdly, there is a risk of tension between detainees of different nationalities or ethnic groups. Consequently, the CPT places a premium upon the supervisory staff in such centres being carefully selected and receiving appropriate training. As well as possessing well-developed qualities in the field of interpersonal communication, the staff concerned should be familiarised with the different cultures of the detained and at least some of them should have relevant language skills.* ***Further, they should be taught to recognise possible symptoms of stress reactions displayed by detained persons (whether post-traumatic or induced by socio-cultural changes) and to take appropriate action’***.

…….

‘All detention facilities for immigration detainees should provide access to medical care. ***Particular attention should be paid to the physical and psychological state of asylum seekers, some of whom may have been tortured or otherwise ill-treated in the countries from which they have come’.***

……

‘The prohibition of torture and inhuman or degrading treatment or punishment englobes the obligation no to send a person to a country where there are substantial grounds for believing that he would run a real risk of being subjected to torture or ill-treatment. Whether Parties to the Convention are fulfilling this obligation is obviously a matter of considerable interest to the CPT. What is the precise role that the Committee should seek to play in relation to that question?

Any communications addressed to the CPT in Strasbourg by persons alleging that they are to be sent to a country where they run a risk of being subjected to torture or ill-treatment are immediately brought to the attention of the European Court of Human Rights. The Court is better placed than the CPT to examine such allegations and, if appropriate, take preventing action.

If an immigration detainee (or any other person deprived of his liberty) interviewed in the course of a visit alleges that he is to be sent to a country where he runs a risk of being subjected to torture or ill-treatment, the CPT's visiting delegation will verify that this assertion has been brought to the attention of the relevant national authorities and is being given due consideration. Depending on the circumstances, the delegation might request to be kept informed of the detainee's position and/or inform the detainee of the possibility of raising the issue with the European Court of Human Rights (and, in the latter case, verify that he is in a position to submit a petition to the Court).

However, in view of the CPT's essentially preventive function, the Committee is inclined to focus its attention on the question whether the decision-making process as a whole offers suitable guarantees against persons being sent to countries where they run a risk of torture or ill-treatment. In this connection, the CPT will wish to explore whether the applicable procedure offers the persons concerned a real opportunity to present their cases, and whether officials entrusted with handling such cases have been provided with appropriate training and have access to objective and independent information about the human rights situation in other countries. Further, in view of the potential gravity of the interests at stake, the Committee considers that a decision involving the removal of a person from a State's territory should be appealable before another body of an independent nature prior to its implementation'.

……

…….

The CPT standards are in effect a set of practical guidelines for the authorities, based totally on the European Convention of Human Rights and the Jurisprudence of the Strasbourg Court, therefore of particular importance in every day operations.

Annex 7

WHO International Classification of Diseases, 10th Edition (ICD 10)

Reaction to severe stress, and adjustment disorders

This category differs from others in that it includes disorders identifiable on the basis of not only symptoms and course but also the existence of one or other of two causative influences: an exceptionally stressful life event producing an acute stress reaction, or a significant life change leading to continued unpleasant circumstances that result in an adjustment disorder. Although less severe psychosocial stress ('life events') may precipitate the onset or contribute to the presentation of a wide range of disorders classifies elsewhere in this chapter, its etiological importance is not always clear and in each case will be found to depend on individual, often idiosyncratic, vulnerability, i.e. the life events are neither necessary nor sufficient to explain the occurrence and form of the disorder. In contrast, the disorders brought together here are thought to arise always as a direct consequence of acute severe stress or continued trauma. The stressful events on the continuing unpleasant circumstances are the primary and overriding causal factor and the disorder would not have occurred without their impact. The disorders in this section can thus be regarded as maladaptive responses to severe or continued stress, in that they interfere with successful coping mechanisms and therefore lead to problem of social functioning.

F43.0 Acute stress disorder reaction

A transient disorder that develops in an individual without any other apparent mental disorder in response to the exceptional physical and mental stress and that usually subsides within hours or days. Individual vulnerability and coping capacity play a role in the occurrence and severity of acute stress reactions. The symptoms show a typically mixed and changing picture and include an initial stage of 'daze' with some constriction of the field of consciousness and narrowing of attention, inability to comprehend stimuli, and disorientation. This state may be followed either by further withdrawal from the surrounding situation (to the extent of a dissociative stupor – F44.2), or by agitation and over-activity (flight reaction or fugue). Autonomic signs of panic anxiety (tachycardia, sweating, flushing) are commonly present. The symptoms usually appear within minutes of the impact of the stressful stimulus or event, and disappear within two or three days (often within hours). Partial or

complete amnesia (F44.0) for the episode may be present. If the symptoms persist, a change in diagnosis should be considered.

Acute:

- crisis reaction
- reaction to stress

Combat fatigue

Crisis state

Psychic shock

F43.1 Post-traumatic stress disorder

Arises as a delayed or protracted response to a stressful event or situation (of either brief or long duration) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone. Predisposing factors, such as personality traits (e.g. compulsive, aesthetic) or previous history of neuritis illness, may lower the threshold for the development of the syndrome or aggravate its course, but they are neither necessary nor sufficient to explain its occurrence. Typical features include episodes of repeated reliving of the trauma in intrusive memories ('flashbacks'), dreams or nightmares, occurring against the persisting background of a sense of 'numbness' and emotional blunting, detachment from other people, unresponsiveness to surroundings, anhedonia, and avoidance of activities and situations reminiscent of the trauma. There is usually a state of autonomic hyperarousal with hypervigilance, an enhanced startle reaction, and insomnia. Anxiety and depression are commonly associated with the above symptoms and signs, and suicidal ideation is not infrequent. The onset follows the trauma with a latency period that may range from a few weeks to months. The course is fluctuating but recovery can be expected in the majority of the cases. In a small proportion of cases the condition may follow a chronic course over many years, with eventual transition to an enduring personality change (F62.0)

Annex 8

Social Assistance as part of the rehabilitation process

In the experience of the rehabilitation centres, the work of social workers or social assistants is an integral part of the overall process. Social workers are members of the therapeutic team and their role in what is widely known as psychosocial support, generally recognised as indispensable in helping asylum seekers to adapt to a new reality, is even more crucial when we deal with torture victims. The earlier this intervention can take place, the better for the torture survivor and family, for the authorities and for the society. In this way, we consider that starting this work already from the first days of arrival is of a major importance for a better and quicker adaptation to the rules of a reception or detention facility and for alleviating tension. Social workers are also, by their professional training, able to conduct interviews in order to help identify possible torture victims, following a different way than the official asylum interview.

A short description of the content of social workers' work with torture victims, as well as the guidelines they follow in the performance of their duties is considered very useful as background knowledge for state officials in asylum services as well as other health professionals in order to see the complexity of work with torture survivors and to contribute to their general understanding. Very often this process is very time consuming and difficult. Refugees who have been subjected to torture have been through an immense ordeal in their country of origin, but they face a new one in the country of asylum. Many of their basic needs are not satisfied and they need immediate solutions. Their past experiences push them to become introvert and «immobilized» instead of taking initiatives and very often they are only capable of expressing complaints. They need support, encouragement, direction, counselling and re-organization of their own forces and powers. The professionals called to play this role are individuals who see clearly in their minds the problems faced by this group of population, as well as the ways to solve them.

Before «judging» the applicant (asylum seeker-torture victim), we try to understand in the best possible way that he/she has been living in totally different societies and suddenly they find themselves (without making that choice) in a new and foreign country that essentially cannot provide them with what they were hoping and dreaming. They quit the effort of trying, due to despair and lack of trust to the

authorities and services dealing with them or visited by them. The staff of organizations and services dealing with this group of population need to make constant efforts to have very good and continuous cooperation and to try to complement each other avoiding duplication of efforts which creates confusion, loss of time for all concerned and waste of resources and waist of valuable resources.

Certain **guidelines** concerning social work and assistance for torture victims follow:

- **Attitude** towards torture survivors must inspire trust and respect. The effort is to behave at all times in a friendly and calm manner and to coordinate **together** with the torture survivor all activities for his/her rehabilitation and social integration. By this coordination, tensions can be avoided and real needs can better understood.
- Ways and means to cover **basic needs** for the recipient of services and his/her family have to be found.
- Arrangements must be made to provide **interpreters** whenever this is needed (to accompany to hospitals, medical tests, mental health services, public offices authorities, etc.).
- **Collaboration** with volunteers, the local community and various NGO's and associations to find material help, for instance for clothing, furniture, food, etc. must be organised.
- Organizing **contact** of the newly arrived with persons of their own nationality or ethnicity that are already in the country for some time.
- Recommending them to associations and centres teaching the language of the reception country. The most basic tool of the refugee in a new country and new reality seems to be the knowledge of the **new language**. This knowledge is going to help him/her in finding work, in all kinds of everyday needs and in a faster integration into the society.

When working in the community social workers spend considerable time with torture survivors and their families discussing all kinds of issues, accompanying them to other services or organizations, helping them to bring a household together and to acquire knowledge about the new realities. Good knowledge of resources in the community, helpful in the process of rehabilitation of torture victims, is a basic element for the professional social worker.

Another element to be taken into consideration is that torture victims sometimes cannot accept rules and limits. They function in their own rhythms, for instance they do not respect appointments, they do not mobilize themselves to find jobs, to learn the language, to participate in team work or to educational activities, as well as for very important issues, such as medical treatment and psychological support. All that, of course, constitutes secondary sequelae of torture and there is need of time, effort and persistence to begin seeing results. As the time goes, the refugee-torture victim will start to trust the social worker and a relation will begin to build up between them, their meeting become more frequent and the requests more concrete: health problems, problems concerning the family and the children or legal issues.

The social worker **listens** and tries to implicate the refugee's actual participation into the process of rehabilitation. Very often health symptoms (such as headaches, nervousness, insomnia, difficulty to concentrate) are due to psychosocial factors. The professional tries to offer relief with various ways and means, but when the symptoms insist, referral to health professionals is necessary.

Another important working method for the social worker is to visit the residence of the refugee and his family, because, by looking at the conditions the family lives in, the professional can estimate the needs and coordinate actions.

Contribution of volunteers is necessary, since the state mechanisms cannot fully support this vulnerable group of population, if at all. It is to be noted that asylum seekers in some countries, who are not yet having a temporary residence status, have no access to the National Health System and this can have a long duration.

Annex 9 (Annex 1 of the Istanbul Protocol)

Text will be produced in the printed version

Annex 10 (annex 4 of the Istanbul Protocol)

Text will be produced in the printed version