



Rehabilitation of Torture Survivors

Resource Kit for Service Providers



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The International Rehabilitation Council for Torture Victims (IRCT) is an independent, international health-based human rights organisation, which promotes and supports the rehabilitation of torture victims, promotes access to justice and works for the prevention of torture worldwide. The vision of the IRCT is a world without torture.

For more information please visit www.irct.org

Preface



As health professionals and human rights defenders, the IRCT Members have stated their commitment to 'a world without torture', – a world where no one, regardless of their background or societal status, will endure suffering, violence or harm in any guise.

This shared message is useful and necessary for our fight against torture. So is a shared means of promoting this message and knowing exactly how we can, together, provide the survivors of torture with the best care possible within our local contexts.

The fight for human rights remains an everyday occurrence. IRCT has worked and will continue to work tirelessly to bring together expertise and rehabilitate torture victims in over 140 member centres. This guide has the purpose of gathering their knowledge so that it can be shared.

This resource kit exists so that centres and staff across the globe can quickly reference and find vital information. It will therefore be a living instrument that will evolve with our members and their knowledge.

Victor H. Madrigal-Borloz
Secretary General

Acknowledgements

This resource kit represents the collective effort of a number of contributors, researchers and experts. It is the first edition of a resource we will continue to build in the future to ensure a flow of knowledge with those working for the prevention of torture and the rehabilitation of its survivors.

The contribution of the IRCT partners in this three-year project - generously funded by the EU - included: CRAT and TCC in Cameroon; ACTV Uganda; SACH Pakistan; MAG Philippines; Survivors Associated (SA) Sri Lanka; EATIP Argentina; CAPS Peru; CCTI Mexico; Restart and KRC in Lebanon; and TRC in Palestine. The resources do not specifically reflect the programs of any one partner center, but have been supplemented with a selection of materials produced by the IRCT. Others who significantly contributed their expertise in holistic rehabilitation to this edition of the kit included Dr Nimisha Patel, Alice Verghese and Leanne MacMillan. It was very ably edited by Sweta Bonnet and Ashley Scrace.

For more information email irct@irct.org and watch our website for further updates.

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1. INTRODUCTION

1.1 Who is this resource kit for?

The resource kit is produced by the IRCT, the umbrella organisation for more than 140 independent international torture rehabilitation centres promoting and supporting torture rehabilitation and working for the prevention of torture worldwide. This resource kit is produced as part of a three year project entitled "***Developing the Capacity of IRCT Member Centres to Deliver Holistic Torture Rehabilitation Services through South-South and South-North Peer Supervision and Support***", funded by the European Commission from 2010–2012.

We hope this kit will be of use to a wide range of professionals working with torture survivors in contexts around the world. It captures the results of exchanges and workshops held to address a range of rehabilitation issues under this project and we hope it provides a user-friendly overview of the main concepts and practices in torture rehabilitation. It is based on work with the project partners from several countries and across various types of practice contexts including Cameroon, Uganda, Pakistan, the Philippines, Sri Lanka, Argentina, Peru, Mexico, Lebanon and Palestine. The examples, case studies and findings in the kit are largely gained from direct work with clients. However, this kit does not specifically reflect the clinical/rehabilitation programmes of any one partner centre and for that reason, we hope that service providers will find a menu of approaches that relate to their context.

The information included represents a "getting started" and "where to go for more information" guide. We present options for providers along a continuum of services they might choose to provide, from implementing a survivor service component in their ongoing practice to developing a full-service torture rehabilitation program. Some of the main elements to consider when thinking about rehabilitation and related support services to survivors of torture include the need for specialized assessment and care, with a focus on programs that will help survivors to heal, and rebuild lives of self-reliance and hope for themselves and their families.

Not all torture survivors require a full-service rehabilitation program. Some may seek specific services such as counselling, medical services, legal assistance, help with family reunification, or in finding housing and/or employment. Some survivors may not be sure about what they need or the services possible to enable their recovery process to begin. While torture rehabilitation programs and services may not meet the needs of all torture survivors, they can benefit from referrals to the appropriate service providers and/or individuals that can help in the local community.

1.2 How to use this resource kit

The purpose of this resource is to share the information developed under this project and to lay a basic foundation for others to contribute to our ethos of sharing knowledge.

This resource kit is designed to link the reader to key information on the web so that it is as current as possible. Links have been grouped by topic and a brief introduction to the topic area is provided alongside the links. This is the most efficient way of updating this resource, as the online version of this resource kit will benefit from new links and entries as materials become available. In the online version of this kit simply click the highlighted words and phrases to open the online material in your web browser. If you have materials you would like to share then please email them to irct@irct.org and we will happily get back to you.

We hope this resource kit will guide your efforts to fulfil torture rehabilitation obligations, to enhance learning amongst the IRCT network and to provide the basis for:

- Further development of the sector to enhance learning amongst centres
- To inform establishment of new centres
- To inform rehabilitation services within mainstream health services
- To inform administrative reparation programmes, and
- To contribute to building up the broader ecosystem of quality treatment services for victims of torture.

We urge you to continue these efforts and to keep us informed of your initiatives and developments - including successful practices, protocols, templates and systems that you would like to share with others - and any case studies or innovations you have found useful in the provision of services.

2. KEY CONCEPTS

2.1 Definition of torture

The most widely accepted internationally agreed definition of torture is set out in Article 1 of the *United Nations Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (UN CAT)*:

"...'torture' means any 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."

See <http://www.irct.org/what-is-torture/defining-torture.aspx> for the complete text of the UN CAT.

This definition contains three cumulative elements:

- The intentional infliction of severe mental or physical suffering,
- by a public official, who is directly or indirectly involved,
- for a specific purpose.

This definition raises the question of how to classify and respond to acts failing to meet all three criteria. For instance, what about an act that is not inflicted intentionally but occurs because of negligence? What if an act does not occur for a specific purpose? What if an act inflicts pain or suffering which is not considered severe? In these situations the prohibition of other forms of cruel, inhuman or degrading treatment or punishment may apply. As with torture, this prohibition is also absolute and non-derogable.

(For further reference see: <http://www2.ohchr.org/english/law/cat.htm>)

The prohibition of torture and cruel, inhuman or degrading treatment or punishment is absolute to ensure harm can never be justified under any circumstances whatsoever. Customary international law - which applies to all States, including those that have not ratified relevant human rights or international humanitarian law treaties - considers the prohibition of torture to be a peremptory norm, or *jus cogens*. In other words, no exception or derogation to the prohibition is permitted in any circumstance, even a state of war, the threat of war, internal political instability or public emergency. Necessity, self-defence and other defences are not accepted in any case of torture, no matter how extreme or grave the circumstance. Relevant international treaties unanimously exclude the freedom from torture and ill-treatment from derogation and restriction clauses.

2.2 Rehabilitation and state obligations

Article 14 of the UN CAT states:

"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 victim 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."

For many years there was no attention paid specifically to the meaning of the right to rehabilitation aspect of Article 14. Finally, in 2012, the Committee against Torture issued General Comment No. 3 on the implementation of Article 14 of the Convention against Torture. Some of the paragraphs directly relevant to torture rehabilitation service providers are presented below, though it is advisable to read the General Comment in its entirety. This is a very important development in relation to how we understand what the right to rehabilitation includes and will be the backbone of the claims we make of States in relation to ensuring that resources are dedicated to the rehabilitation of survivors.

"1. This general comment explains and clarifies to States parties the content and scope of the obligations under article 14 of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Each State party is required to "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.**" The Committee considers that article 14 is applicable to all victims of torture and acts of cruel, inhuman or degrading treatment or punishment (hereafter "ill-treatment") without discrimination of any kind, in line with the Committee's General Comment No. 2."

"2. The Committee considers that the term 'redress' in article 14 encompasses the concepts of 'effective remedy' and 'reparation'. The comprehensive reparative concept therefore entails restitution, compensation, **rehabilitation**, satisfaction and guarantees of non-repetition and refers to the full scope of measures required to redress violations under the Convention."

"11. The Committee affirms that **the provision of means for as full rehabilitation as possible** for anyone who has suffered harm as a result of a violation of the Convention should **be holistic and include medical and psychological care as well as legal and social services.** Rehabilitation, for the purposes of this general comment, refers to the restoration of function or the acquisition of new skills required as a result of the changed circumstances of a victim in the aftermath of torture or ill-treatment. It seeks to enable the maximum possible self-sufficiency and function for the individual concerned, and may involve adjustments to the person's physical and social environment. Rehabilitation for victims should aim to restore, as far as possible, their independence, physical, mental, social and vocational ability; and full inclusion and participation in society."

"12. The Committee emphasizes that the **obligation of States parties to provide the means** for 'as full rehabilitation as possible' refers to the need to restore and repair the harm suffered by a victim whose life situation, including dignity, health and self-sufficiency may never be fully recovered as a result of the pervasive effect of torture. The obligation does not relate to the available resources of States parties and may not be postponed."

"13. In order to fulfil its obligations to provide a victim of torture or ill-treatment with the means for as full rehabilitation as possible, **each State party should adopt a long-term, integrated approach and ensure that specialist services for victims of torture or ill-treatment are available, appropriate and readily accessible.**

These should include: a procedure for the assessment and evaluation of individuals' therapeutic and other needs, based on, inter alia, the Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (The Istanbul Protocol); and may include a wide range of inter-disciplinary measures, such as medical, physical and psychological rehabilitative services; re-integrative and social services; community and family-oriented assistance and services; vocational training; education etc. A holistic approach to rehabilitation which also takes into consideration the strength and resilience of the victim is of utmost importance. Furthermore, victims may be at risk of re-traumatisation and have a valid fear of acts which remind them of the torture or ill-treatment they have endured. Consequently, a high priority should be placed on the need to create a context of confidence and trust in which assistance can be provided. Confidential services should be provided as required."

"14. The requirement in the Convention to provide these forms of rehabilitative services does **not extinguish the need to provide medical and psychosocial services for victims in the direct aftermath of torture**, nor does such initial care represent the fulfilment of the obligation to provide the means for as full rehabilitation as possible."

"15. **States parties shall ensure that effective rehabilitation services and programmes are established in the State**, taking into account a victim's culture, personality, history and background and are accessible to all victims without discrimination and regardless of a victim's identity or status within a marginalized or vulnerable group, as illustrated in paragraph 32, including asylum seekers and refugees. States parties' legislation should establish concrete mechanisms and programmes for providing rehabilitation to victims of torture or ill-treatment. Torture victims should be provided access to rehabilitation programmes as soon as possible following an assessment by qualified independent medical professionals."

Access to rehabilitation programmes should not depend on the victim pursuing judicial remedies. The obligation in article 14 to provide for the means for as full rehabilitation as possible can be fulfilled through the direct provision of rehabilitative services by the State, or through the funding of private medical, legal and other facilities, including those administered by non-governmental organizations (NGOs), in which case the State shall ensure that no reprisals or intimidation are directed at them. The victim's participation in the selection of the service provider is essential. Services should be available in relevant languages. States parties are encouraged to establish systems for assessing the effective implementation of rehabilitation programmes and services, including by using appropriate indicators and benchmarks."

General Comment No.3 addressing the implementation of Article 14 is available at:
<http://www2.ohchr.org/english/bodies/cat/comments.htm>

Suggested reading

IRCT Conference Report (2013): The Right to Rehabilitation for Torture Victims. Copenhagen: IRCT.

<http://www.irct.org/media-and-resources/irct-news/show-news.aspx?Action=1&NewsId=3838&M=NewsV2&PID=13767>

Sandoval, C. and McGregor, L. (eds.) (2011) Rehabilitating Victims in Processes of Transition: The Law and Practice of Rehabilitation as a Form of Reparation. From REDRESS (2009) *Rehabilitation as a form of reparation under international law*. London: REDRESS.

<http://www.redress.org/reports/The%20right%20to%20rehabilitation.pdf>

Smith, E., Patel, N. and MacMillan, L. (2010) A remedy for torture survivors in international law: Interpreting rehabilitation. Discussion Paper. London: Medical Foundation for the Care of Victims of Torture.

<http://www.freedomfromtorture.org/sites/default/files/documents/MF%20Rehabilitation%202010%20Final.pdf>

IRCT: What is rehabilitation?

<http://www.irct.org/what-is-torture/rehabilitation.aspx>

Role of rehabilitation centres for torture victims - interim report of the Special Rapporteur for Torture, 65th session to the UN General Assembly

<http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N10/480/49/PDF/N1048049.pdf?OpenElement>

(pp. 13 -18)

Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment on forms of abuse in health care settings which breach the prohibition against torture and cruel, inhuman or degrading treatment and punishment and on states obligations to control, regulate and prevent these practices. A/HRC/22/53

http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf

Center for Victims of Torture (CVT):

For extensive resources on torture and other cruel, inhuman or degrading treatment please visit the resources section of the CVT website

<http://www.cvt.org/resources>

2.3 Torture prevention and state obligations

It is well recognised that States have a duty to prevent torture and there are a number of international, regional and national organisations that focus on ensuring that the administration of justice operates in a way that will lower, if not eliminate, the potential for torture. When working directly with survivors of torture, the service provider will want to be aware of the duty of a State to prevent torture and to ensure they support those survivors who may choose to seek justice given the violation of a most basic human right.

There is ample good authority of this duty and the Office of the High Commissioner for Human Rights says that States have a duty to prevent torture and that this includes taking positive measures:

"Considering the particular importance placed on the prohibition of torture, the traditional obligations of States to respect, to protect and to fulfil human rights is complemented by a further obligation to prevent torture and other forms of ill-treatment.

"States are required to take positive measures to prevent its occurrence. In the case of torture, the requirement that States expeditiously institute national implementing measures is an integral part of the international obligation to prohibit this practice."

For further reference see:

http://www.ohchr.org/Documents/Countries/NHRI/Torture_Prevention_Guide.pdf

The approach of the Subcommittee on Prevention of Torture to the concept of prevention of torture and other cruel, inhuman or degrading treatment or punishment under the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment is the following:

"Prevention is a multifaceted and interdisciplinary endeavour... there is more to the prevention of torture and ill-treatment than compliance with legal commitments. In this sense, the prevention of torture and ill-treatment embraces – or should embrace – as many as possible of those things which in a given situation can **contribute towards the lessening of the likelihood or risk of torture or ill-treatment occurring**. Such an approach requires not only that there be compliance with relevant international obligations and standards in both form and substance but that attention also be paid to the whole range of other factors relevant to the experience and treatment of persons deprived of their liberty and which by their very nature will be context specific."

For further reference see 'Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment'; Twelfth session; Geneva, 15-19, November 2010.

<http://www2.ohchr.org/english/bodies/cat/opcat/ConceptPrevention.htm>
http://bim.lbg.ac.at/files/sites/bim/Atlas%20of%20Torture_Brochure_0.pdf

For some organisations it is important to distinguish between two different forms of torture prevention. This distinction is based on when the intervention occurs and the approach that is employed.

Direct prevention (mitigation) aims to prevent torture by reducing the risk factors and eliminating possible causes. This intervention happens before torture takes place and aims to address the root causes that can lead to torture and ill-treatment through training, education and regular monitoring of places of detention. Direct prevention is forward-looking and, over the long term, aims to create an environment where torture is not likely to occur.

Indirect prevention (deterrence) takes place once cases of torture or ill-treatment have already occurred and is focused on avoiding the repetition of such acts. Through investigation and documentation of past cases, denunciation, litigation, prosecution and sanction of the perpetrators, as well as reparation for victims, indirect prevention aims to convince potential torturers that the "costs" of torturing are greater than any possible "benefits".

Suggested reading

Making Torture Prevention in the Philippines a Reality

(Power point presentation, 5mb) *Medical Action Group, Philippines*

www.ict.org/Admin/Public/DWSDownload.aspx?File=%2fFiles%2fFiler%2fPresentations+for+resource+kit%2fMaking+Torture+Prevention+in+the+Philippines+A+Reality.ppt

Influencing Policy in the Philippines

(Power point presentation, 412Kb) *Medical Action Group, Philippines*

www.ict.org/Admin/Public/DWSDownload.aspx?File=%2fFiles%2fFiler%2fPresentations+for+resource+kit%2fMAG+Philippines+Policy+Influence.pptx

3. HOLISTIC REHABILITATION: Service provision and practice

The development of rehabilitation services for torture survivors has been shaped by developments in medicine, psychology and in related health and social care fields. This experience has been emboldened on the basis of rehabilitation responses across a wide range of contexts including with survivors of torture from genocides, repressive regimes, armed conflict and concentration camps. Experience working with the specific and diverse needs of torture survivors in differing country contexts, combined with professional theoretical preferences, informed different conceptualisations of rehabilitation, and different approaches to rehabilitation service delivery, the IRCT advocates that rehabilitation should be:

- Holistic
- Available, appropriate, accessible
- Provided in a way that guarantees the safety and personal integrity of the victims, their family and their caretakers
- Provided at the earliest possible point in time after the torture event
- Provided without a requirement for the victim to pursue judicial remedies, but solely based on recommendations by a qualified health professional
- Provided in close consultation with the victim and tailored to meet the specific needs of each individual victim
- Adequately funded by national governments.

For further reference see: <http://www.irct.org/what-is-torture/rehabilitation.aspx>

3.1 Reaching out to your community and community awareness-building

An important component of rehabilitation services is working with communities affected by torture in addition to the individuals who were tortured. The types and levels of interventions may vary according to local context, need and safety. The interventions may range from awareness-raising events - in collaboration with communities, schools, community leaders etc. - to interventions aimed at facilitating support and resources within the community, through to facilitating healing by the use of story-telling, testimony and narrative approaches to explore collective memories using art, drama, literature, film and music.

Working with local communities

- ✓ **Understand who your local communities** are, their context (e.g. economic, political, cultural, religious) and their needs
- ✓ **Identify communities you wish to engage** in awareness-building – where there is already knowledge, experience of and commitment to combatting torture and ill treatment
- ✓ Identify communities and **groups within those communities** you wish to target
- ✓ **Build relationships with communities** you wish to engage and to target – this takes time, effort and creativity
- ✓ Try to bring together and **work with individuals who may be important allies** in awareness-raising, and who have some influence in the communities you wish to work with

- ✓ **Be careful to not privilege those in explicit leadership positions** (e.g. male religious leaders), whilst excluding marginalised, but important voices when collaborating with community leaders (e.g. women)
- ✓ **Build a strategy for engaging communities** and raising awareness – in collaboration with the communities and on the basis of participation
- ✓ **Actively include community members** in awareness-raising activities and events (attending to issues of safety and security for those individuals, their families and for staff)
- ✓ **Support local communities** in developing sustainable efforts to raise awareness (e.g. working with schools, training frontline health/social care/welfare workers)

Suggested reading

Binta, B. & Pearson, L. (2004) Rebuilding Communities: Training trauma survivors to help communities heal after atrocities.

New Tactics Project of the Center for Victims of Torture.

<https://www.newtactics.org/sites/default/files/resources/Rebuilding-Communities-EN.pdf>

Dinesh, S. (2004) Access to Justice: Creating local level, citizen action mediation bodies to ensure human rights.

New Tactics Project of the Center for Victims of Torture

<https://www.newtactics.org/sites/default/files/resources/Access-Justice-EN.pdf>

Influencing Policy in the Philippines

(Power point presentation, 412Kb) *Medical Action Group, Philippines*

www.irct.org/Admin/Public/DWSDownload.aspx?File=%2fFiles%2fFiler%2fPresentations+for+resource+kit%2fMAG+Philippines+Policy+Influence.pptx

Working with Partnerships and Exchanges

(Power point presentation, 2.5mb) *ACTV, Uganda*

www.irct.org/Admin/Public/DWSDownload.aspx?File=%2fFiles%2fFiler%2fPresentations+for+resource+kit%2fWorking+in+Partnerships+and+Exchanges+ACTV+Uganda.ppt

Working with local communities. Some examples:

Transcultural Psychosocial Organisation Cambodia Programs

<http://tpocambodia.org/index.php?id=33>

Mpande, E., Higson-Smith, C., Chimatria, J.R. *et al* (2013) Community intervention during ongoing political violence: What is possible? What works?

From: *Peace and Conflict: Journal of Peace Psychology, Vol 19(2), May 2013, 196-208.*

<http://psycnet.apa.org/index.cfm?fa=buy.optionToBuy&id=2013-16201-004>

Simmelink, J. & Shannon, P. (2012) Evaluating the Mental Health Training Needs of Community-based Organizations Serving Refugees.

From: *Advances in social work*

<http://advancesinsocialwork.iupui.edu/index.php/advancesinsocialwork/article/view/1963/2459>

3.2 Key components of holistic rehabilitation services

The components of rehabilitation services vary according to context, needs and resource availability. Holistic rehabilitation involves providing a range of services to meet the needs of torture survivors and their families, as well as engaging in activities towards the prevention of torture and in capacity-building.

Key components of holistic rehabilitation services:

It is good practice to ensure that services and activities include:

- ✓ **Assessment/examination for documentation of torture** and its impact
- ✓ **Assessment/examination for treatment**
- ✓ **Interventions** (medical/physical, psychological, social, welfare, housing, legal)
- ✓ **Advocacy** (for individuals, families)
- ✓ **Prevention activities** (awareness-raising, advocacy to influence policy, litigation, using national mechanisms, UN complaints mechanisms, regional or other international procedures)
- ✓ **Capacity building** (e.g. of care-givers, legal representatives)

Suggested reading

Regional seminar presentation on SACH, Pakistan
(Power point presentation, 9.1mb) *SACH, Pakistan*
<http://tinyurl.com/oyev7v8>

Working with Victims of Sexual Torture
(Power point presentation, 590Kb) *SAVE Congo Cameroon*
<http://tinyurl.com/oahfbep>

Designing and funding projects
(Power point presentation, 3.3mb) *PRAWA Nigeria*
<http://tinyurl.com/ok27pkz>

Measures for Personal Safety
(Power point presentation, 172Kb) *INREDH, Ecuador*
<http://tinyurl.com/orv658f>

Developing the Capacity of non-State Torture Rehabilitation Services in Burundi, the Democratic Republic of Congo and Rwanda
(Power point presentation, 172Kb) *IRCT*
<http://tinyurl.com/nsydbw8>

3.3 Staff and skills required

The range and number of staff for rehabilitation services vary according to context, needs of survivors and local population, availability of appropriately qualified and experienced staff, and resources.

Skills necessary for rehabilitation services:

- ✓ It is good practice to ensure that the staff and skills required for each service/centre are **based on a thorough needs assessment**.
- ✓ It may be that what is needed is unrealistic to obtain, and in this situation, it is good practice to ensure that **strategic priorities for each service** centre inform which skill-sets are to be prioritised.
- ✓ There are a range of skills which are found to be essential to establishing and delivering rehabilitation services for torture survivors. It is good practice when prioritising which skills are most important to **consider what would enable optimal functioning and effectiveness of the centre service** at any given point in time. At different stages of a centre's development, the priority for these skills will change, and a periodic organisational review is advisable. Skills necessary to establish, develop and deliver rehabilitation services for torture survivors include:
 - Management and strategic leadership skills
 - Operational systems development skills
 - Information and Communication Technology skills
 - Assessment (medical, psychological, psychiatric, social/welfare, legal) skills
 - Intervention skills (medical, psychological, psychiatric, social/welfare, legal)
 - Documentation and report-writing skills (medical and psychological)
 - Advocacy skills (legal policy)
 - Training and capacity-building skills
 - Communication and dissemination for awareness-raising skills
 - Monitoring, evaluation and research skills
- ✓ Where appropriately-qualified and skilled staff is not available, it is good practice to consider essential skills required (as above) and to **develop or secure appropriate training** to enhance the professional development and competency of existing staff to reach required standards.
- ✓ **To avoid providing only short-term or incoherent training**, since the systematic development of knowledge and skills is hindered, leading to gaps and inconsistencies in practice and standards. Also the absence of strategic training is likely to severely compromise the quality and sustainability of rehabilitation services provided by staff.

Suggested reading:

Keeping Safe When Preventing Torture (Power point presentation, 822Kb)
MATESO, Kenya
<http://tinyurl.com/qgslp9n>

Focus on Forensic Examination (in Spanish. Power point presentation, 3mb)

EATIP, Argentina

<http://tinyurl.com/qgy88xp>

Regional seminar presentation on SACH, Pakistan
(Power point presentation, 9.1mb) *SACH, Pakistan*

<http://tinyurl.com/oyev7v8>

Measures for Personal Safety

(Power point presentation, 172Kb) *INREDH, Ecuador*

<http://tinyurl.com/orv658f>

3.4 The steps in providing rehabilitation

There are a number of basic features of a rehabilitation service and most importantly these must respond to the human rights, health care and community contexts you work in. However, responding to the operational possibilities and limits of your context is important to ensure a basic framework is in place for appropriate rehabilitation responses are adequate and safe for both the service users and providers. In this section we have included the basic structure and features of a rehabilitation service that you are encouraged to establish, either as part of a community response or - if resources and efficiencies allow - within the confines of your rehabilitation service.

3.4.1 Referral criteria and client registration

Each rehabilitation centre or service will be designed to be appropriate to the local context. Some services are provided on a one-stop basis – the person who is referred is assessed and supported in the same centre/service. Other centres or services will be structured to provide different levels of screening and assessment, based on information available for each client/family.

For example, some services will accept and register a client based on a referral letter from another professional, an agency or - in the case of a self-referral - by the client themselves. Other services will conduct an initial assessment (sometimes called an intake assessment) and register the client's details to discuss in a team or with colleagues to determine if the client fits the service referral criteria.

Deciding referral (service) criteria

In deciding who is a client and who is not, **it is important to establish referral criteria** which rehabilitation centres/services may need to consider - in other words criteria to help a centre/service to decide if the person who is referred/self-referred to the service can be offered any services. In developing referral criteria it is good practice to consider:

- ✓ **What is the definition of torture survivors used by the service** (to include perpetrators, or particular survivors only etc.)?
Who will decide whether the individual and/or their family members fit the definitions you decide upon in your centre/service? Will this be one staff member/manager who makes this decision or will it be a team decision? If it is a

- team decision, who will this include?
- ✓ **How will you define and prioritise client needs** (health, social, welfare, legal etc.?)
 - ✓ Once you have decided which individuals fit your service definition of 'torture survivor and their family members', **how will you prioritise who you will offer a service to** (e.g. those with urgent health needs or risks, those who are at risk of self-harm, harm against others, suicide, neglect, young people in need of protection, those at risk of homelessness, those in detention, removal/deportation etc.).
 - ✓ **Will you see all those who fit your service/centre criteria?** If demand outstrips your service resources, will you have a waiting list? How will you operate a waiting list and monitor changing circumstances of those on your waiting list and changing prioritisation?
 - ✓ If you decide not all individuals who fit your service criteria (all or some criteria) can be offered a service, **how will you decide who you will turn away**, and to where? In making such organisational decisions it is good practice to consider:
 - The remit and organisational priorities of the service/centre
 - Availability of resources and skills and appropriately qualified staff
 - Availability of alternative, appropriate services (State, NGO etc.) where some survivors or their families could receive a service

In deciding what aspects of client details are registered, each service will have its own system. In some services there may be an initial referral form with key details which the service/centre needs to register the individual and to make an initial decision about whether to see the person or not. Some services may decide on key information they need to register at an initial assessment (using what is sometimes called an 'intake assessment form'). Some services may have a further full, holistic assessment registration form. Each service/centre will make organisational decisions as to what is the best system and what the key information the centre/service needs. Client information commonly registered by rehabilitation centres/services is presented below:

Types of information to include for client registration

The different types of information to include for client registration, and to help decide if the client fits the service priorities could include:

- ✓ Client's service identification number
- ✓ Client name, date of birth, gender, address
- ✓ Country of origin
- ✓ Ethnicity, religious background, first language
- ✓ Nationality
- ✓ Legal status (citizen, refugee, asylum seeker, IDP, unknown)
- ✓ Relationship status (married/civil partnership, widowed, divorced, separated, living together, unknown)
- ✓ Education level (primary, lower secondary education, upper secondary education, post-secondary, non-tertiary education, tertiary/higher education)
- ✓ Occupation
- ✓ Current employment status (unemployed, part-time, full-time, unknown).
- ✓ If unemployed: reason
- ✓ Monthly income (in local currency)
- ✓ Type of housing/accommodation
- ✓ Housing condition (poor, moderate, good, excellent)
- ✓ Number of people living in the house
- ✓ Number of minors living in the same house

- ✓ Family and circumstances (who, how many, where, relationships, legal status?)
- ✓ External agencies/professionals (e.g. school, legal representative, family doctor)

Examples of inclusion criteria (or referral criteria) in order to assess whether or not a person is a beneficiary vary. Some services use questions relating to the UN CAT or WMA definition of torture, for example:

- ✓ Who was the perpetrator? (a state official; non state actor)
- ✓ Nature of torture/ill-treatment? Is what the perpetrator did considered as torture or CIDT according to UNCAT? Nature of torture/ill-treatment?
- ✓ Where did the torture happen? (on the street, in place of detention, prison, unknown)
- ✓ When did the torture happen? (date(s) or unknown)
- ✓ Reason for torture – was it related to discrimination?
- ✓ Was the person detained in country of asylum? Where, how long, and what happened?

Further information for client registration could include:

- ✓ Health problems (physical/medical, psychological)
- ✓ Social welfare problems (e.g. food, adequate housing/shelter, clothing)
- ✓ Legal problems, legal situation (e.g. seeking reparation)
- ✓ Risk assessment (risk of self-harm, self-neglect, violence to others, risk from others, child protection concerns, domestic violence, other protection concerns for young people)
- ✓ Date referred
- ✓ Who referred the client?
- ✓ Reason for referral
- ✓ Name of assessor/key worker/responsible staff member
- ✓ Date of first contact with client
- ✓ Date of last contact (if treatment/care ending was unplanned e.g. client dropped out, deported, detained)
- ✓ End of treatment/rehabilitation date

3.4.2 Referral processes and sign-posting

Those who approach a rehabilitation centre may have diverse and complex needs, not all of which will be within the remit of the centre, or within the capabilities of the centre. Rehabilitation centres, which often work with highly constrained funding, staff resources and with high volumes of work can rarely provide all the services and full range of specialist health, social care services that may (or may not) be available in national State health and social care systems. However, there is an ethical duty of care to each person/family to ensure that there is appropriate follow-up for those in need of services which the centre may not be able to provide.

Ensuring effective referral processes

It is good practice for a rehabilitation centre to:

- ✓ Ensure that the **ethical duty of care** to each individual and/or family of a survivor is acknowledged and respected by all staff
- ✓ Ensure that there is a **system for conducting comprehensive and appropriate assessments** of each individual client and/or family, and for

recording and reviewing the outcome of those assessments so there can be a plan for the care, support or treatment for them

- ✓ **Ensure there is an organisational policy** with clear procedures as to what to do for clients whose needs cannot be met by the centre or, when there are risks which have been identified as potentially threatening, the safety and well-being/health of the client/family or others
- ✓ Ensure that the person assessing the torture survivor and/or their family has a **follow-up plan to ensure that the health needs or concerns can be addressed**. This may mean that there will need to be a plan to attend to protection issues (e.g. in terms of risk of deteriorating health, risk of self-harm, risk of forced return/refoulement) that have emerged during the course of the assessment.
- ✓ Ensure that the **follow-up plans** have a clear indication which staff member will carry out the next action and the urgency of that action.
- ✓ Ensure that **clients (individuals and families) are consulted**, as far as possible, and informed of the follow-up plan. It is important to gain consent, wherever possible, from clients before follow-on referrals to other services, professionals, organisations or agencies are made disclosing personal and sensitive information about the client/family
- ✓ Ensure that a referral is made to another colleague, specialist professional or specialist or other agency or institution, **where needs cannot be met** by the centre staff themselves
- ✓ Ensure there is a clear **organisational system for recording referrals** made to other agencies, specialists or services for clients seen by the organisation, and for keeping those records secure
- ✓ Ensure there is an organisational system and **procedures for monitoring clients who are waiting to be seen** by whomever they have been referred onto (particularly where there is a risk of deterioration in health, risk of harm, child protection risks etc.)

Please see 'Working with Partnerships and Exchanges' (Power point presentation, 2.5mb) from ACTV Uganda for an overview.
<http://tinyurl.com/qgahk8j>

3.4.3 Assessment and documentation

The assessment and documentation of torture is central to deciding how best to meet the needs of the torture survivor. Assessment is also a prerequisite to the formal documentation of torture. Assessment can include writing detailed clinical notes, formal medical, psychiatric or psychological reports, as well as writing country-based or theme-based reports using findings from medical and psychological reports (where consent is given).

The documentation of torture is an essential aspect of the prevention of torture and can contribute to the protection of torture survivors from *refoulement* (the forced return of *refugees* who have a right to be protected as a UN Convention refugee). Documentation also contributes to litigation where the torture survivor is seeking justice and reparations, and awareness-raising and advocacy activities aimed at combating torture and promoting justice and reparations for torture survivors and their families.

The formal standards for the documentation of torture can be found in the Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (also known as the Istanbul Protocol).

Rehabilitation services vary considerably in their position on whether documentation of torture is a component of rehabilitation services or whether care-providers can be, or should be, engaged in the documentation of torture. The availability of qualified health professionals competent in the documentation of torture may also dictate whether documentation is offered as a component of rehabilitation services. The unique context of each service often dictates whether documentation is offered as a service.

Suggested reading

Istanbul Protocol Manual on the Effective Investigation and Documentation of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (2004). Professional Training series no.8/Rev.1. Office of the United Nations High Commissioner of Human Rights.

UN: Geneva and New York

<http://www.ohchr.org/Documents/Publications/training8Rev1en.pdf>

IRCT (2009) Medical physical examination of alleged torture victims. A practical guide to the Istanbul Protocol – for medical doctors.

IRCT: Copenhagen

<http://www.irct.org/media-and-resources/library/other-irct-key-publications.aspx>

IRCT (2009) Psychological evaluation of torture allegations. A practical guide to the Istanbul Protocol – for psychologists.

IRCT: Copenhagen

<http://www.irct.org/media-and-resources/library/other-irct-key-publications.aspx>

IRCT (2009) Action against torture. A practical guide to the Istanbul Protocol – for lawyers.

IRCT: Copenhagen

<http://www.irct.org/media-and-resources/library/other-irct-key-publications.aspx>

IRCT resources on documentation of torture:

- <http://www.irct.org/investigation---documentation/medical-documentation.aspx>
- <http://www.irct.org/investigation---documentation/the-istanbul-protocol.aspx>
- <http://www.irct.org/investigation---documentation/the-istanbul-protocol/content.aspx>
- <http://www.irct.org/investigation---documentation/the-istanbul-protocol/medical-screening-format.aspx>
- <http://www.irct.org/Files/Filer/publications/Operational-Manual-EN-10.02.12.pdf>
- <http://www.irct.org/Files/Filer/publications/FEAT-2013.pdf>

Torture Journal on Rehabilitation of torture victims and prevention of torture.

Thematic issue: Combating torture with medical evidence. Vol.20, no.3., 2010

<http://www.irct.org/media-and-resources/library/torture-journal/archive/volume-20--no.-3--2010.aspx>

Torture Journal on Rehabilitation of torture victims and prevention of torture.

Forensic evidence against torture (supplementum). Vol.22, supplementum 1, 2012

<http://www.irct.org/media-and-resources/library/torture-journal/archive/volume-22--supplementum-1--2012.aspx>

Patel, N. & Granville-Chapman, C. (2010) Health Assessments with Survivors of Torture: Good Practice Clinical Guidelines. Medical Foundation with the Department of Health (UK): London.

Example of methodology employed in writing Medico-Legal Reports in UK:
<http://www.freedomfromtorture.org/sites/default/files/documents/methodology%20mlr.pdf>

Example of guidance on examining torture survivors and preparing Medico-Legal Reports: Forest, D. (2012) (second edition). Guidelines on the examination of survivors of torture.

<http://www.freedomfromtorture.org/sites/default/files/documents/Forrest%2C%20guidelines%2C2002.pdf>

Country example of torture prevention, documentation and prosecution in the Philippines
http://www.irct.org/Files/Filer/TortureJournal/22_S1_2012/Human-rights-human-wrongs-S1-2012.pdf

Partnerships: Formulation and Maintenance
(Power point presentation, 102Kb) *PRAWA, Nigeria*
<http://tinyurl.com/qffxkcs>

3.4.4 Record-keeping in rehabilitation centres

Records can include all information about any individual, family or agency with whom the organisation works. Records specific to torture survivors and their families, gained in the course of health and/or legal assessments within an organisation, are sensitive records with personal information. This information is normally protected by national legislation which differs from country to country (e.g. data protection legislation, accessing health records legislation), and by ethical standards of professional bodies govern how professionals collect and record sensitive, confidential personal information. This information may be related to health, experiences of torture and other human rights violations, family circumstances, family members, political activities, welfare and housing context.

Records may be used for a variety of purposes: clinical practice, legal support and advice, advocacy, medico-legal reports/documentation, research, publicity, fundraising among others.

Record-keeping

It is good practice to:

- ✓ **Be aware of the national legislation** which impacts on the practice of collecting, recording, accessing and disclosing sensitive, personal information about individuals and families.
- ✓ **Ensure there is an organisational policy on how and where to record sensitive information**, how to protect it, procedures to follow when there has been a breach of ethics and/or organisational policy and procedures to safeguard the welfare of individuals and their families where such breaches have occurred.
- ✓ Ensure all staff engaged in collecting information from torture survivors and their families are **adequately informed of the organisational policy** on record-keeping, trained in good ethical practice, and provided with opportunities for supervision from senior practitioners (clinical, legal etc.) to consider ethical dilemmas.

- ✓ **Have a clear organisational system** for recording client-related information (paper and/or electronic)
- ✓ **Have a robust organisational system for accessing** (or restricting access to) client-related information (paper/electronic)
- ✓ **Have clear practice guidelines in the organisation** on what can be disclosed to whom under which circumstances and when
- ✓ Have clear practice **guidelines in the organisation on how to use client-related information**, within ethical and legal boundaries, for the purposes of publicity, research, advocacy and fundraising, or any purpose other than for direct rehabilitation activities for the torture survivor and their family.

Suggested reading

IRCT (2013) Policy on the collection of stories, images/video and audio, 'Personal information'

<http://www.irct.org/Files/Filer/publications/IRCT%20policy%20on%20the%20collection%20of%20stories%20images%20and%20audio%20-%20personal%20information.pdf>

3.5 Holistic rehabilitation through interdisciplinary responses

The rehabilitation response to each person, their family or community will depend on the range of needs, strengths, resources and the social, cultural and material context for survivors. In practice rehabilitation services are best delivered with an interdisciplinary approach, where a range of therapies and activities are offered, sometimes sequentially or simultaneously, depending on need, availability and context.

Interdisciplinary rehabilitation services

These services can include:

- ✓ Psychological individual counselling and therapies
- ✓ Family support, counselling, therapy
- ✓ Group work (offering therapy, support, activities, self-help etc.)
- ✓ Medical services (assessment/examination, meeting urgent medical needs, referring on to specialist medical services where necessary)
- ✓ Physical and complementary therapies
- ✓ Psychosocial approaches/crisis responses
- ✓ Horticultural approaches
- ✓ Community-based interventions
- ✓ School-based interventions
- ✓ Documentation of torture
- ✓ Legal services
- ✓ Social welfare services (food, shelter, clothing, education, employment etc.)
- ✓ Livelihoods approaches (productive capacity and skills-building)

Suggested reading

Torture Journal on Rehabilitation of Torture Victims and Prevention of Torture (2011). Thematic issue: Best, promising and emerging practices: A compendium for providers working with survivors of torture. Vol. 21, no. 1., 2011.

http://www.irct.org/Files/Filer/TortureJournal/21_01_2011/Best_promising_Torture1-2011.pdf

Critchley, C. (2008) Horticultural Therapy with Survivors of Torture
Medical Foundation for the Care of Victims of Torture

http://www.freedomfromtorture.org/sites/default/files/documents/horticultural_therapy.pdf

Transcultural Psychosocial Organisation Cambodia, Programs

<http://tpocambodia.org/index.php?id=33>

Blackwell, D. (2005) Counselling and psychotherapy with refugees.
Jessica Kingsley: London.

Elsass, P. (1997). Treating Victims of Torture and Violence. Theoretical, Cross-Cultural and Clinical Implications.

New York: New York University Press.

Marsella, A., Bornemann, T., Ekblad, S. & Orley, J. (Eds.) (1994) Amidst Peril and pain:

The Mental Health and Well-being of the World's refugees.

American Psychological Association: Washington.

Van der Veer, G. (1998) (2nd edition). Counselling and Therapy with Refugees.
Wiley: Chichester.

Wilson, J.P. & Droždek, B. (2004) Broken spirits. The treatment of traumatized asylum seekers, refugees, war and torture victims.

Brunner-Routledge: New York, Hove.

3.5.1 Legal services

Torture survivors will have many needs that relate to the provision of legal services. These can include the most practical of concerns such as gaining protection as a refugee who has fled their country due to torture, to respond to their detention or pending court proceedings, to access justice so torture perpetrators can be held to account, or to get compensation for their torture. By either directly supporting or ensuring an appropriate referral resource, responding to the legal needs of torture survivors is key to rehabilitation.

Legal services for torture survivors: Case studies

Argentina

One of the most re-traumatising experiences for a survivor can be to seek justice through a legal mechanism. Most survivors cannot afford to seek justice or do not have access to justice, so it has become important to support not only their psycho-

social needs but their fiscal needs to pursue justice and hold perpetrators to account. An interesting and important response to supporting survivors is that by NSA project partner EATIP (El Equipo Argentino de Trabajo e Investigación Psicosocial) in Argentina, who provide support in the form of travel expenses, legal aid and psychological counselling to contribute to access to justice and redress for torture survivors witnessing in trials for crimes against humanity during the Argentine dictatorship.

Through EATIP, a lawyer has worked on the preparation of briefings, court filings and attendance at hearings in close contact with the witnesses in order to facilitate and optimize their participation in the trials. The NSA has also contributed to the payment of necessary travel expenses for witnesses to attend and testify. Psychiatric medication has been purchased and is being provided for free to the victims of torture who need it. EATIP currently has a valuable cooperation with the Association of Former Detained Disappeared (AEDD) on the current cases of crimes against humanity, both in terms of rehabilitation and intervention.

Mexico

CCTI (Colectivo Contra la Tortura y la Impunidad) has helped incarcerated torture survivors with their legal cases in order to achieve psychosocial and economic reintegration of the survivors and work towards ensuring their freedom. The support covers mainly travel expenses and legal aid, including forensic documentation following the Istanbul Protocol guidelines. The activity involves the legal defence in two very important and precedent-setting cases – the case in Ciudad Juárez, and that in Tlaxcala. Both of these cases involve five torture survivors who were tortured in order to make them confess to crimes. CCTI has established links in particular with four other organisations to widen the support for these extremely difficult cases. For legal assistance they have allied with Centro Paso del Norte and Centre in Guadalajara and established alliances with human rights organisations such as el Centro de Derechos Humanos Fray Bartolomé de las Casas, Frayba (Chiapas) and Código (Oaxaca).

CCTI was able to send teams of one doctor and one psychologist to the prisons (Maximum Security Prison of Tepic and Medium Security Prison “Villa Aldama” en Veracruz) where the survivors are held in order to carry out the first medical and psychological evaluations necessary for the medical reports. The examinations were made according to the standard of the Istanbul Protocol. After the examinations in Ciudad Juárez, a complaint was filed to the National Human Rights Commission and the National Preventative Mechanism stating the lack of medical and psychological attention for two of the detained survivors who had received a high degree of maltreatment. In the Tlaxcala case, CCTI filed *amicus curiae* (known as a friend of the Court briefing) – where CCTI voiced their views on the case and put across their knowledge of the subject to aid the legal process. However, the Attorney General of Justice has delayed the process with the argument that the people responsible from the public ministry were reading the records of the case. As a result, CCTI is still awaiting the court’s decision on the appeal to define the next steps in the psycho-support legal strategy.

Suggested reading:

R. A. 9851: A Breakthrough Law for International Humanitarian Law Enforcement in the Philippines, Balay Rehabilitation Center, March 2010

<http://www.balayph.net/publications/65-r-a-9851-a-breakthrough-law-for-international-humanitarian-law-enforcement-in-the-philippines.html>

Capacity Development Methods
(Power point presentation, 208Kb) *IRCT*
<http://tinyurl.com/pas4pwo>

Partnerships: Formulation and Maintenance
(Power point presentation, 102Kb) *PRAWA, Nigeria*
<http://tinyurl.com/qffxkcs>

3.5.2 Social and welfare interventions

Social welfare interventions for torture survivors can include the provision of - or advocacy efforts to ensure the provision of - food, shelter, transportation to attend medical, legal and other appointments relating to support to gain employment. It can also include advice and support to secure welfare entitlements (State benefits), support to provide access to education, access to language courses, and more.

Social welfare interventions vary across country contexts since each country also has its own state systems and legal parameters on the entitlement of torture survivors. In countries where torture survivors have sought asylum, systems may differ depending on the legal status of the torture survivor, and depending on what stage they are at in the asylum determination process. In some countries agencies such as the national Red Cross or other NGOs may be the primary providers of social welfare interventions.

Social welfare interventions

It is good practice to:

- ✓ **Assess routinely the social welfare needs** of torture survivors in your centre/service.
- ✓ **Ensure that social welfare interventions are individually tailored** as far as possible.
- ✓ Be aware of the **range and extent of social welfare needs of torture survivors** in your centre/service – collate data periodically to identify patterns or particularly vulnerable groups.
- ✓ Create **mechanisms in your centre/service to use such data** to advocate on behalf of torture survivors, including those whom are particularly vulnerable (e.g. to homelessness, to risk of harm or exploitation by others and so on).
- ✓ Ensure your social welfare services are **delivered by someone appropriately qualified** and experienced in understanding the social welfare system and the country's legislative framework, as well as being knowledgeable about other services available to torture survivors.
- ✓ **Ensure your social welfare interventions are culturally appropriate** and sensitive to the diverse needs, resources and complexities of torture survivors' social support networks (e.g. mistrust and suspicion, stigma towards torture, gender-based violence and mental health problems within communities and families which may make these networks inaccessible for meaningful welfare, housing or other support for the survivor).

Suggested reading:

Partnerships: Formulation and Maintenance
(Power point presentation, 102Kb) *PRAWA, Nigeria*
<http://tinyurl.com/qffxkcs>

Regional seminar presentation on SACH, Pakistan
(Power point presentation, 9.1mb) *SACH, Pakistan*
<http://tinyurl.com/oyev7v8>

3.5.3 Building livelihoods, rebuilding lives

Livelihoods development support can be seen as a part of the rehabilitation process, as well as being a recognised and integral component of development approaches. The NSA project piloted livelihood initiatives in 11 partner centres with varying results, however with two commonly shared expected outcomes:

- (a) To deliver practical skills or fiscal support that enables a survivor to earn an income to support themselves and their families and;
- (b) Through engaging with survivors of torture in the context of livelihood development activities, to facilitate psycho-social benefits (improved work function through the strengthening of their productive skills) that directly relate to their rehabilitation.

The livelihood activities of this project have mostly taken the form of direct training in a specific craft or skill (tailoring, masonry, hairdressing) that enabled or improved the livelihood of torture survivors and, as a result, their family.

As torture survivors have different skills, some activities will need to focus more on entrepreneurship or small business management skills. Of fundamental importance is that the training matches the needs of the torture survivors and that a needs assessment is carried out. Some rehabilitation service providers work with specific target groups, such as current or previous prison detainees or female torture survivors.

In many contexts livelihoods work may be best achieved by drawing on external expertise and resources of other international organizations or government agencies. Examples of links made by partners in this project included with the ministries of social affairs, employment, labour, technical education skills development, justice and jail management. These links will heighten sustainability and at the same time ensure that the support to survivors is maintained by those with the clinical expertise to ensure the psycho-social outcomes aimed for. Creating new linkages with experienced livelihood organisations increases capacity in this field by bringing improvements to the methodologies used in their socio-economic support activities.

The result of linkages formed with public authorities - as a result of these livelihood initiatives - is that they are sensitized towards the importance of preventing torture, providing support to the victims and creating change in practice and policy.

At the individual level, rehabilitation service providers have reported positive outcomes, such as a decrease in depression levels of their clients. Many clients began to work from

home using their newly-acquired skills and in one project, more than 50% of those trained were employed.

Building livelihoods as a rehabilitative process: some examples

CAPS in Peru

Internal armed conflict in Peru from 1980 to 2000 was the most devastating and lengthy period of violence in the history of the country. The persons who were unjustly imprisoned and later released (by acquittal or pardon) have suffered from stigmatisation, rejection and social exclusion from their communities. This also made it impossible for them to start to work again, impacting on the economic and social situation for their families, including hindering their children from accessing further education. One of the main problems experienced by clients seen by CAPS is the lack of work and education opportunities, and the resulting poverty. This in turn leads to low self-esteem, frustration and despair at not being able to study (due to their limited financial resources), to work, or to pursue vocational ambitions.

Aims of livelihoods development interventions

- To enable torture survivors to develop their capacities, abilities and skills in order to increase opportunities for improving their income.
- To train, strengthen and promote the enterprising culture of businesses and microenterprises.
- To make the necessary agreements with centres working in the field of enterprise administration in order to achieve the aforementioned goal.
- To promote activities which contribute to capacity building and skills training of the clients, either through cooperation or direct referrals to relevant organisations or programs.

Livelihoods development activities included:

- Identification of international organizations focussing on developing livelihoods in Peru, with potential relevance for CAPS, and establishing links with these organisations
- Establishing a plan to enhance the productive capacities of a group of 15 survivors; 7 in 2011 and 8 in 2012
- Identification by the Social Work department in CAPS of a list of survivors who have a small business (grocery store, selling homemade cleaning products etc.) and who had a modest income.
- Establishing a plan that these persons are trained according to the type of business that they have, informed about the benefits of formalization and that they are helped in this process to be put in contact with institutions that finance micro-businesses.
- Identification of and contact with organizations providing training on entrepreneurship.
- Provision by these organisations of workshops and courses, developed in consultation with CAPS.
- Establishing guidelines for participation in the training.
- Assessment of each participant's initial knowledge and data on their chosen enterprise and field visits to each business.
- Delivery of training, group exchanges of knowledge and experience in establishing and developing their businesses.
- Advice, consultation and support to each participant in developing their business.
- Sharing their knowledge on livelihoods with other service providers through exchanges and seminars on their experience in socio-economic development for torture survivors and their families.

Recommendations following the interventions

- To continue support for the participants/entrepreneurs by CAPs
- To continue monthly consultancy/support to the participants.
- To develop free training courses in key areas of marketing, costs, finances and business formalization.
- For each participant to share acquired knowledge and business experience by going to other districts and provinces to train individuals and institutions.
- To create a virtual community among the entrepreneurs to enable mutual support system.

Survivors Associated, Sri Lanka

Livelihood approaches as a component of rehabilitation

Survivors Associated has undertaken livelihood activities, using external trainers. These activities include:

- Skills training for youth in former war-torn areas utilising skilled trainers from the area (e.g. in masonry).
- Provision of masonry tools after training.
- Entrepreneurship Development for training to female heads of households.
- Revolving credit loans to support groups for micro entrepreneurship
- Trained Survivors Associated Business Counsellors in place for problem-solving and support

MAG, Philippines

Livelihood development approaches included:

- Focus-group discussion and survey among political detainees in detention on livelihood and income generating projects of relevance to them.
- Conducting surveys of the socio-economic profile of political detainees across the Philippines in order to identify the most suitable activities for generating income and supporting the detainees in future ambitions
- Drawing on expertise of other organizations or government agencies (e.g. prison or detention centres) to obtain training on topics such as Technical Education and Skills Development Authority (TESDA) or Technology and Livelihood Resource Centre (TLRC), and/or NGOs.
- Engaging help from Ozamis City School of Arts and Trade in coordination with officials on the provision of capacity building for the beneficiaries on sewing and cutting of cloth.
- Establishing a plan for training in income-generating activities such as sewing clothes and rugs, securing sewing machines.
- Training of sample of individuals in prisons across Philippines.
- Provision of fabric and different clothing templates to support individuals to use their skills to when they leave prison to provide for their family and pay for medical treatment.

Suggested reading:

Working with Victims of Rape and Sexual Torture in Zimbabwe
(Power point presentation, 261Kb) *SOSA Project, Zimbabwe*
<http://tinyurl.com/nlv7dot>

4. WORKING WITH SPECIFIC CATEGORIES OF SURVIVORS

Victims of torture are often targeted because of their identities such as their gender, race, ethnic group, religion, culture, age, political beliefs and sexual orientation. They are also tortured in ways that relate to their identity – for example, rape is used as a “corrective” measure for those who are gay or lesbians, religious symbols or icons are used as part of torture to mock the religious beliefs of those tortured due to their religion, women and men are raped as an act that is deeply shaming to them. These survivors require specific, tailored responses that address their related experiences of torture and appropriate rehabilitation responses given their identity.

We continue to develop and capture our expertise in this area of work and will update this resource kit as more materials and information becomes available that we will share.

4.1 Working with women survivors

Women and girls are frequently targeted for torture as part of a deliberate tactic of war where the form of harm (i.e. sexual torture, rape and forcible impregnation) is intended to inflict harm on the woman, her family and her community. Violence against women is commonplace in conflict, in its aftermath, and torture of women during times of conflict and in detention is part of a continuum of violence against women in many communities.

Impunity for these crimes is common as women are doubly disadvantaged in seeking justice given that they often have little, if any, access to justice due to a lack of education, poverty and their marginalized position in society.

Many of the member centres of IRCT have programs to respond to the specific needs of women victims of torture. These centres make a key contribution in their communities by offering programs that women survivors of torture need based on the medical, psychological, legal, social, economic and cultural issues that women victims face. The shame and stigma associated with rape and sexual torture can be powerful barriers to women disclosing their torture. This presents challenges to the care provider in adequately assessing women so that they can meaningfully access rehabilitation services suited to their particular needs.

In many instances women live in the very communities where the perpetrators remain and face seemingly insurmountable challenges in relation to living with the legacy of their torture within family and community contexts, where they are not able to or cannot safely disclose their torture. It is very important for organisations offering rehabilitation services to women that they are attuned to these challenges and that they offer the range and depth of services needed by these women, whether that be through individual interventions or appropriately structured group work approaches.

In a report by the Medical Foundation for the Care of Victims of Torture called “*Justice Denied*” (which you can find in the suggested reading, below) the case histories of 100 women survivors of torture from 24 countries were examined. The clinical records of these women were built over a period of time and the likelihood of disclosure was heightened given that these women were in the relative security of being outside their country of origin and being protected as refugees in the UK.

The study found that 80% of these women had been raped and that many were raped and sexually assaulted numerous times and by multiple perpetrators. Other findings were that age was no barrier with young girls and elderly women being targeted.

The rehabilitation service provider needs to respond to a complex set of outcomes of the torture of women in addition to the social and cultural context that they are in. Among the range of outcomes are depression, sleeplessness, nightmares, flashbacks, fistula and other types of damage to their reproductive organs as found in cases where women are raped, and raped with implements. Many women will have also contracted HIV and other sexually transmitted diseases and the clinical responses to this may mean the development of effective outreach programs to providers specializing in meeting the health and psycho-social needs of those with HIV.

One of the key findings of the Justice Denied report that will inform many rehabilitation service providers is:

“ (r)esort to healthcare in the immediate aftermath of torture was surprisingly low given the brutality of the violence inflicted. Treatment was often sought informally or in secret to avoid public or community knowledge of sexual violation. Where women formally sought professional care from medical staff, it was often for the treatment of physical injuries ... many women seeking medical assistance failed to report rape...”. (page 3)

It is clear that there are powerful barriers to women in seeking effective rehabilitation due to the nature of the torture and of their marginalized role in so many societies. A major challenge for service providers in this context is to find ways to make rehabilitation services accessible in the fullest sense of the word. That is, services must be attuned to the needs and circumstances of women and respond to their needs with extensive account of their individual community and family contexts.

Against this backdrop are the persistent gender inequalities in many communities that mean there are other systemic biases. The challenge for rehabilitation service providers is to provide appropriate services that specifically address women survivors particular needs, knowing that disclosure will not be possible without the right conditions and that some of these conditions are externally imposed and not within the control of the service provider. Rehabilitation services need to develop care pathways that are suited to this situation. Finally, women should be active participants in determining the context and content of any rehabilitation services.

Included in this section are examples of programs that are in place in some of the rehabilitation service providers that are part of this project. For further information on appropriate rehabilitation responses and establishing rehabilitation services that are suited to women victims of torture, contact Leanne MacMillan at lm@irct.org.

Suggested reading

Amnesty International and REDRESS (2011) Gender and Torture: Conference report
<http://www.redress.org/downloads/publications/GenderandTortureConferenceReport-191011.pdf>

MacMillan, Leanne Ed., Smith, Ellie and Boyles, Jude.
Justice Denied: the experiences of 100 torture surviving women of seeking justice and rehabilitation. Medical Foundation for the Care of Victims of Torture (2009)
<http://www.torturecare.org.uk>

TPO Nepal, CARE Nepal and CARE, Austria. Psychosocial issues of Women Affected by

Conflict in Churia Region of Nepal.

www.tponepal.org

Improving access to justice for female survivors under the Khmer Rouge

<http://tpocambodia.org/index.php?id=134>

Working with Victims of Rape and Sexual Torture in Zimbabwe

(Power point presentation, 261Kb) *SOSA Project, Zimbabwe*

<http://tinyurl.com/nlv7dot>

Access to Justice for Women, TPO Cambodia:

<http://tpocambodia.org/index.php?id=166>

Working with Victims of Sexual Torture

(Power point presentation, 590Kb) *SAVE Congo Cameroon*

<http://tinyurl.com/oahfbep>

Victims of Sexual Violence

(in French. Power point presentation, 3mb)

CAPREC, Senegal

<http://tinyurl.com/nwppb7p>

Livelihoods Support Project for Female Victims of Sexual Violence and Torture (Power point presentation, 1mb) *ACTV, Uganda*

<http://tinyurl.com/ozogc5h>

Approaches to Prevent Torture

(Power point presentation, 824Kb) *CRTS, Bangladesh*

<http://tinyurl.com/pfntoze>

4.2 Working with children and young people

Rehabilitation services for torture survivors often provide services for children and young people. Young people may be unaccompanied (where services include healthcare, social care, education support, advocacy, or legal support) or they may be seen with their families, as individuals or in groups of other minors. They may have directly experienced torture and/or ill-treatment, or witnessed parents or other family members or others being tortured, or be in families where family members and/or parents were tortured or they may have been child soldiers. Some services provide services specific to different groups of minors (e.g. unaccompanied minors), others provide more general support, individual therapy, group activities/therapy and other therapeutic services for children in the context of family work. Some services offer school-based interventions or prevention activities. The cultural, social and political context, including the availability and nature of State services, in each country setting may dictate how services for children and young people are organised and the nature of services offered.

Services for children and young people

It is good practice to:

- ✓ Promote in all rehabilitation and prevention activities the founding principles and the rights of the child as set out in the Convention on the Rights of the Child (CRC):

- All children have the same right to develop their potential regardless of their race, gender, language, opinion, colour, origin, disability or any other characteristic.
 - The best interests of the child should be the primary consideration in all actions and decisions affecting children – to protect children where there may be competing rights or interests.
 - Access to basic services and equity of opportunity to achieve their full development should be ensured to each child.
 - Views of the child should be given regard and respected, their opinions and participation in decision-making are central to achieving their rights as children.
- ✓ Develop a child-centred approach in rehabilitation services to promote the best interests of the child, recognising that to enable each child to reach their full developmental potential requires that health, social care and educational interventions focus on the needs of children.
 - ✓ Value the experience of the child and their voice, throughout the assessment, documentation and rehabilitation process.
 - ✓ Ensure a commitment to and establishment of appropriate systems and practices to promote interdisciplinary and inter-agency collaboration and working to promote the well-being of the child
 - ✓ Promote a holistic understanding of the child, recognising their psychological, physical, social, welfare and safety and educational needs, as well as recognition of their creativity, strengths, resources and resilience in facing challenges and adversity.
 - ✓ Promote a contextual understanding of the child, recognising that children do not exist in a vacuum: the family, social, cultural, political, religious, economic and material contexts of the child shape their health, their emotional and educational development and their overall well-being and capacity to fulfil their potential. Assessment and rehabilitation interventions should thus always consider and attend to the context (as far as possible) and the specific situation of the child/minor.
 - ✓ Ensure that rehabilitation services are appropriate to the age and developmental stage of the child/minor.
 - ✓ Ensure that services are culturally appropriate.
 - ✓ Provide a range of services and activities for minors and their families, as appropriate to their needs. These can include creative activities or formal therapies, using art, drama, theatre, dance, music, play, sport as well as verbal therapies.
 - ✓ Ensure that services are accessible, including by providing interpreters wherever necessary.
 - ✓ Ensure that rehabilitation services include a prevention focus and are integrated with prevention activities. These can include school-based interventions to raise awareness of the impact of torture, ill-treatment and armed conflict on children, interventions to support teachers in working with children who have experienced torture or ill-treatment, interventions to promote awareness of the needs of unaccompanied minors or other children who have experienced torture, ill-treatment and exile, interventions or activities to build self-esteem, promote social integration, learning (language support, non-verbal teaching methods to improve trust, well-being, social and behaviour skills, learning), vocational guidance etc. These interventions can include after-school activities, sports, cultural events, befriending/buddy projects to support minors, promote social network-building, to promote peer friendships, social integration, confidence, social and language skills and well-being. Other activities could include livelihood skills training, summer camps, holiday camps and host/guest parents projects to host minors for short periods to decrease isolation (for example, of unaccompanied minors), build social networks and facilitate social

integration.

- ✓ Attending to the risks children may face is also important to the rehabilitation of children. These risks include: risks to child safety, risks of armed conflict, risks of corporal punishment, risks of poverty.

Suggested reading

Torture Journal (2009) on Rehabilitation of torture victims and prevention of torture. Thematic issue: Torture in children

http://www.irct.org/Files/Filer/TortureJournal/19_02_2009/Torture_in_children.pdf

<http://www.irct.org/libraryold/torture-journal/back-issues/volume-19--no.-2--2009.aspx>

Working with children and young people: some examples

Examples of torture of children and rehabilitation and prevention responses can be found in:

Balay Rehabilitation Center (2006) Children as Zones of Peace 1

<http://www.balayph.net/features-and-articles/13-children-as-zones-of-peace-1.html>

Balay Rehabilitation Center (2006) Child's Rights Programming in Community-Based Disaster Management

<http://www.balayph.net/features-and-articles/10-childs-rights-programming-in-community-based-disaster-management.html>

4.3 Working with families

Torture affects families of survivors and in some families more than one member will have experienced torture. Families can also be a source of support and an important resource for survivors. However, families and their ways of interacting and managing the effect of torture can also hinder the family and those family members who have been tortured from moving forward. Sometimes, where a guardian or parent has been tortured, this may affect parenting and raise concerns about violence towards children and other child protection issues. As such, any assessment or intervention with a torture survivor (children and adults) should always consider the significance of their family to them (whether they are absent, separated, deceased or present) and each family's specific context and needs.

Working with families

It is good practice to:

- ✓ Always consider the family when working with minors or adults: who are they, where are they (separated, disappeared, deceased, living with the torture survivor etc.), relationships, who has experienced torture, family history and

family context

- ✓ Explore how the family is coping
- ✓ Consider the needs of children when working with families – recognising that children’s reactions depend on their age, developmental stage, gender, culture, family relationships and many other factors
- ✓ Be aware of family taboos, stigma (e.g. towards mental health problems, torture, rape) and the impact on the torture survivor(s) in the family
- ✓ Identify specific needs of the family and particular family members (e.g. health, disability, economic needs, welfare needs, social care needs, legal needs, everyday living issues)
- ✓ Identify resources the family has in terms of other social support networks (e.g. their own community, religious group/leader, elders, neighbours)
- ✓ Consider and ‘think family’ in all assessments, all interventions and in team case discussions
- ✓ Develop organisational systems and procedures (including in recording client information) to ensure that all stages of assessment and interventions, the family as a whole, and the family’s needs and context are kept in mind
- ✓ Where possible, ensure the rehabilitation service/centre has appropriately qualified professionals who can work with families, or has access to clinical supervisors who have experience working with families
- ✓ Consult families in developing services to best meet common needs
- ✓ Engage families in developing a range of support and social integration activities (e.g. outings, sports days, cultural events).

Suggested reading

Reichelt, S. & Sveaass, N. (1994). Therapy with refugee families: what is a “good” conversation? *Family Process*, 33, 247 – 262

Woodcock, J. (1995). Healing rituals with families in exile. *Journal of Family Therapy*, 17, 397-409.

4.4 Survivors on the move: Refugees, asylum seekers, internally displaced people and migrants

People flee and seek refuge in other countries or in other parts of their own countries because they are in fear of torture or have been tortured. One of the reasons why people are offered protection as UN Convention refugees is because of the legacy of torture or fear of torture if they return to the country they fled.

Also, many people are tortured and ill-treated while on the move, whether as refugees, asylum seekers, the internally displaced or as migrants. Leaving behind a home, family, community and country can make a person extremely vulnerable, including to situations where torture is rife such as in immigration detention, refugee camps or other places where those migrating or seeking safe haven are detained while authorities determine their fate.

When people are on the move it is very important for those providing a rehabilitation service to understand their particular circumstances and to ensure that they assess for a history of torture in the country fled or while on the move as migrants or the displaced.

In a recent publication by the IRCT there is a full discussion of the vagaries of being on the move:

www.irct.org/Admin/Public/DWSDownload.aspx?File=%2fFiles%2fFiler%2fpublications%2fMLRweb.pdf

Also, the PROTECT project - a joint initiative of a number of organisations - was developed to assist those working with asylum seekers and refugees to assess their history of torture as part of supporting individuals in their rehabilitation and in many instances of securing a legal status. See <http://www.irct.org/our-work/our-projects/protect-able.aspx>

5. THE FIGHT AGAINST TORTURE: Prevention of torture, accountability, and the rehabilitation of survivors

5.1 Survivor activism

In a number of contexts survivors want to speak out and tell their story of torture and the challenges of rehabilitation. The motivation for sharing their story can include seeking justice, holding perpetrators to account, preventing torture and, for some survivors, it is a key part of their rehabilitation to break the silence about what happened to them and the effect that it has had on them, their family and communities.

A number of rehabilitation services offer group work programs that include supporting torture survivors to communicate beyond the rehabilitation service provider to a broader community. Examples of these approaches include therapy programs structured around writing, drama and art that are shared with the public at events or through publications. These approaches have proven very effective in raising awareness about torture and its consequences.

In some cases, survivor activism projects or programs are developed and aimed at human rights bodies, governmental and policy targets that can have an influence on the prevention of torture and the rehabilitation of its survivors. This has proven to be a powerful approach as in many contexts; those we seek to influence in our sector to prevent torture and to respond to the needs of its survivors have never met a survivor. It can be a real motivator when those who can create the change we seek have the experience of responding to the well placed message of a torture survivor making informed demands.

Key to engaging in these types of approaches in a rehabilitation service context is proper clinical support as telling of one's story of torture and its ruinous effect can raise powerful emotions that a survivor may need support in handling. Equally important, is the skills building to ensure that the survivor acquires knowledge, competencies and confidence to share their story in a public setting. For example, in survivor activism approaches there is a skills build that includes training in human rights, effective story writing, communicating through various media such as television, radio and public speaking, lobbying and advocacy skills for political targets and communicating with youth groups and through social media.

It is important that the skills needed to engage in these sorts of approaches are gained by survivors and in many instances, survivors had a very public life prior to their torture and will feel very confident in appearing publicly to recount their story of torture and most importantly, how to prevent it and to respond to its consequences as a community.

An important element of this approach to providing a rehabilitation response that includes survivor activism is that it has to be survivor led, carried out in a way that it is safe for the survivor, and informed by an understanding of the implications of sharing a story about oneself in a public manner. The service provider needs to ensure that the nature of public disclosure is understood and in particular the implications of social media and the permanent nature of sharing information on the internet. Appropriate steps to ensure safety and confidentiality should be taken with due account for the participatory rights of survivors and the rehabilitative effect of empowering them by opening up spaces for their voices to be heard.

Finally, for those survivors who do decide that as part of their rehabilitation they will engage in these approaches, it is important that they are able to see the results of what they have contributed and the influence they have achieved by sharing with them the outcomes of their intervention. In this regard, the service provider would want to be accountable for how they use the survivor's stories – whether shared directly by the survivor themselves – or as part of a book, art show or event and most importantly if these stories are used to raise funds.

There are a number of rehabilitation service providers with structured group work programs that are public facing in writing, art, drama, and activism but as this is a developing area of work there is a need to share more of our approaches and to develop best practice. For further information on capacity building in this area or to contribute your approach that we can share via the web please contact Leanne MacMillan at lm@irct.org.

Suggested reading:

Holistic Rehabilitation and Findings of the IRCT NSA Project (Power point presentation, 100Kb)

IRCT, Brussels

<http://tinyurl.com/puywtcj>

Restart: Review of Holistic Rehabilitation and IRCT NSA Project and Developments (Power point presentation, 374kb)

Restart, Lebanon

<http://tinyurl.com/qbj7f6x>

5.2 Communicating torture survivors' stories to raise awareness

There are some risks in collecting the stories of survivors of torture, the most significant perhaps is that of re-traumatisation as a survivor recalls painful memories. Other risks include having ones torture legacy shared and the stigma that can come with this. However these risks can be significantly reduced in the interest of the many benefits of bringing to light the torture that people have survived and their need for rehabilitation. If the story gathering process is implemented sensitively with regard for confidentiality, informed consent and security - the stories and experiences gathered from survivors of torture not only allow the survivor a platform to share their experience, but can play a wider part in tackling torture across the globe. In many instances, survivors have stated that sharing their story has been beneficial to them.

Some of the benefits of collecting and disseminating stories are as follows:

- To show the positive impact rehabilitation has on a person, their community and their life through their personal story which encapsulates their journey through torture to rehabilitation.
- To provide evidence to other NGOs, governments and a multitude of political, social and economic forums that the work carried out by centres across the globe is meaningful, important and beneficial.
- Other members, upon reading survivor stories from elsewhere, may gain ideas for their services or wish to collaborate with the practices of

rehabilitation elsewhere, thereby ensuring a united approach to providing rehabilitation and preventing torture.

- To show the public and the media the realities of torture so that we can, together, fight torture on a global scale.
- To allow the survivors of torture to speak, to tell the world about their story so that they feel released, as if they have made a difference, or even both of the previous reasons.

Collecting and communicating the story of torture survivors for awareness-raising

It is good practice to:

- ✓ **Ensure informed consent** – making the process of obtaining the story, communicating it, how the information will be used, where it will be disseminated, likely audience, possible consequences, including anticipated risks – transparent in discussion with the survivor at all times.
- ✓ **Use interpreters** and/or translated information for the survivor to be able to make an informed choice if confusion should arise.
- ✓ **Ensure the survivor knows they can withdraw consent at any stage** of the process, up to and including publishing of their story.
- ✓ Ensure particular **consideration is given to sensitive information** and that there is a clear, robust organisational policy on deciding how to identify, manage and withhold, where necessary, sensitive material to ensure protection of the survivor, their family and/or staff.
- ✓ Ensure that survivors of torture understand that **anonymity is an option**.
- ✓ Ensure that for children their **parent/guardian can provide informed consent** on their behalf.
- ✓ Ensure all information obtained from the torture survivor and personally **identifiable information (audio, visual, written) is securely held** (refer to organisational confidentiality policy and procedures).
- ✓ Ensure there is **due consideration and appreciation shown to the survivor**, throughout and after the process of providing and communicating their story.
- ✓ Ensure **there is a policy and clear procedures in the organisation/centre** for collecting and using survivor stories in raising awareness, addressing the above points.

Suggested reading

IRCT (2013) Policy on the collection of stories, images/video and audio, 'Personal information'

<http://www.irct.org/Files/Filer/publications/IRCT%20policy%20on%20the%20collection%20of%20stories%20images%20and%20audio%20-%20personal%20information.pdf>

Giffard, C. (2008) The torture reporting handbook

University of Essex

[http://www.essex.ac.uk/Torturehandbook/handbook\(english\).pdf](http://www.essex.ac.uk/Torturehandbook/handbook(english).pdf)

Varouhakis, M. (2008) Interviewing victims of torture: A handbook and guide for journalists

Michigan State University

http://www.victims.jrn.msu.edu/INTERVIEWING_VICTIMS_OF_TORTURE_.pdf

Regional seminar presentation on SACH, Pakistan
(Power point presentation, 9.1mb) *SACH, Pakistan*

<http://tinyurl.com/oyev7v8>

Influencing Policy in the Philippines

(Power point presentation, 412Kb) *Medical Action Group, Philippines*

www.irct.org/Admin/Public/DWSDownload.aspx?File=%2fFiles%2fFiler%2fPresentations+for+resource+kit%2fMAG+Philippines+Policy+Influence.pptx

5.3 Advocacy based on the health based entry point of rehabilitation

A key component of the work of the partners in this global project was in the area of advocacy – from the local to global level. This work was highly motivated on the basis that rehabilitation service providers hold a unique and powerful set of information and can be compelling advocates for change. Please refer to the rehabilitation centre power points linked below for examples of advocacy work of centres directed at international actors, the State, the police and to raise general awareness within communities about how to prevent torture and to ensure that victims were rehabilitated.

It is important to recall that advocacy is but one tool to create the change that we all seek to end torture and rehabilitate its victims. Other tools regularly used include reaching out with community based approaches, campaigning and communications to influence change. In this regard, whether a rehabilitation service provider will engage in advocacy will be very context and resource specific. Working in partnerships to improve outcomes and to build solidarity are other common approaches taken by rehabilitation service providers to reach out within the health, human rights and development sector.

In the work of the IRCT there are dedicated resources for carrying out a range of advocacy initiatives based on our evidence, either in individual cases, thematically or that is country specific. Depending on where the change we need can be delivered, we will use our information and expertise to influence a range of actors at the local level including those engaged in health, human rights, the administration of justice, policing and those running institutions where people are deprived of their liberty, such as jails, detention centres, prisons, where we know that the risk of torture runs high.

At the regional or international level we will target various international mechanisms and in particular those relevant to torture survivors such as the Committee against Torture, the Human Rights Council and related committees and the Committee on Economic Social and Cultural Rights. There are also opportunities we have yet to pursue under the UN relating to women, children and migrants.

In this section we provide you with guidance on how to advance advocacy work and there are useful links to other areas of ongoing work.

Advocacy using international mechanisms

Good practice includes:

- **Drawing on lessons learned** from other organisations that have used the international treaty body and thematic mechanism to good effect.
- Establish a broader coalition amongst NGOs, or **at least joint** meetings to be conducted in the country of origin for familiarisation of the issues.
- **A strategy should be devised** amongst the NGO group on the themes and issues to be raised. Even if joint reports are not feasible, nor desirable, agreement must be reached on prioritisation and framing of each issue. It is too late to leave this activity to a few days before or at the NGO/pre-session.
- References on issues or themes raised must be **made in direct reference to the State report**, wherever possible.
- **Providing statistics** on the numbers of victims concerned and other relevant statistics in presenting robust arguments, since reporting on the rights demands concrete information on the scope of the problem.
- **Providing an introduction to the broader** context in which the report takes place (e.g. post-conflict situation in Peru), including data on the numbers of people tortured and in need of rehabilitation.
- **Preparing arguments which identify key issues** in relation to specific rights, as well as attempting to link to other rights in a comprehensive and meaningful way to facilitate the questioning of the country delegations.
- Establishing and maintaining good contact with the treaty bodies and thematic mechanism secretariats to **ensure positive and pragmatic support** in pushing the aims of reporting on torture rehabilitation.
- **Being aware that the NGO pre-session takes place two days before** the initiation of the country-session where procedures are clarified. NGOs need to spend significant amount of time in Geneva, which raises the costs of participating substantially.

Advocacy on right to health and rehabilitation of torture survivors: Case study in Peru

An NSA initiative in Peru involved using information on rehabilitation of torture survivors and their experiences to develop advocacy to monitor the State in relation to obligations under the Convention of Economic, Social and Cultural Rights. The initiative resulted in mixed outcomes, summarised below.

In March 2012 the IRCT submitted an alternative report to the Committee on Economic, Social and Cultural Rights (CESCR) in cooperation with a NSA project partner and member centre, Centro de Atención Psicosocial, Peru (CAPS). The advocacy intervention can be found at:

http://www2.ohchr.org/english/bodies/cescr/docs/ngos/CAPS-IRCT_Peru48.pdf

The report was an attempt to demonstrate how torture and ill-treatment constitutes a violation of the right to health, as well as of other economic, social and cultural rights. The initiative was the first attempt of its kind to access a UN treaty body other than CAT on behalf of torture victims. Specifically, the report addresses paragraph 23 of the list of issues prior to reporting on Peru, which states:

“Please provide information on steps taken to improve access to and quality of health services, especially in rural and remote areas, including addressing economic, cultural and social barriers to such access.”

Advocacy interventions included:

- Submission of a written report to demonstrate how economic, social and cultural barriers for torture survivors' access to health care services in Peru
- A formal presentation at the NGO forums pre-session in connection with CESCRs review of Peru in Geneva in May 2012. On behalf of CAPS, IRCT presented highlights of the joint alternative report submitted to CESCR. There were not many Peruvian NGOs at the pre-session and the majority represented were organisations focusing on reproductive health. Thus, this topic dominated the 20 minutes that were allocated to NGO presentations. Apart from reproductive health, the topics covered by other NGOs were right to food and indigenous people's rights.

The reaction from the Committee to IRCT's presentation was initially quite critical. Their reactions were exacerbated by the fact that the cluster of NGOs reporting on reproductive health, instead of presenting a collective report, took most of the time to present individually on the same theme. This limited the number and breadth of issues that were raised. One of the committee members further stated that "torture had nothing to do with CESCR". Nevertheless, IRCT got an opportunity to comment and explain further which led to some interest in the topic.

A more elaborate presentation was made by the IRCT, with a reference to the State report in particular, challenging the claim that an estimated number of 70.000 victims were treated through mental health care teams sent out in the regions.

For further information see:

<http://worldwithouttorture.org/2012/05/29/torture-is-a-violation-of-the-right-to-health/>

Suggested Reading

IRCT (2011) Practical guide for NGOs using the Universal Review Process

<http://www.irct.org/Files/Filer/publications/UPR-Guide.pdf>

Joint Cambodian NGO Report (Oct. 2010): Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in the Kingdom of Cambodia

http://tpocambodia.org/fileadmin/templates/pdf/Research_and_Reports/Joint%20Cambodian%20NGO%20CAT%20Report%2006-10-10_English.pdf

5.4 Prevention activities: Challenging torture

The prevention of torture is multifaceted and prevention efforts can be aimed at primary, secondary and tertiary levels. Inevitably, prevention activities have to be context-relevant, and can be specific to the local or country context or span regional and international efforts.

Prevention includes measures to reduce or hinder acts of torture such as activities aimed at reducing risk factors, promoting effective legal and protective frameworks, monitoring compliance with national and international human rights obligations, combating impunity, training, and education. Broadly speaking, prevention activities can also include advocacy, awareness-raising and capacity-building, with many activities serving

more than one prevention aim. Some of the common issues and challenges experienced by rehabilitation centres/services and examples of good practice are summarised below.

Common issues and challenges in prevention activities

Good practice in prevention of torture

Failure in ratification of relevant international instruments in national laws and implementation domestically

- ✓ Use existing systems in the government in terms of developing and implementing a torture prevention strategy (e.g. a national human rights institution or commission). Establish a good working relationship with and lobbying the government to influence policy in torture prevention (e.g. ratify OPCAT, implementation of an effective National Prevention Mechanism, development of a national human rights action plan).
- ✓ Establish a good working relationship with and lobby the government to comply with the international human rights instruments and obligations to eliminate torture.
- ✓ Use public interest litigation for influencing policy changes.
- ✓ Use a range of methods: legislative forums, policy workshops, advocacy meetings, public hearings, prison monitoring, education.
- ✓ Use available mechanisms strategically at the UN/international/ regional mechanisms to get policy gains at national level.
- ✓ Use systematic medical/psychological documentation of torture in lobbying.

Impunity

- ✓ Use national laws, individual cases and legal procedures to influence policy changes.
- ✓ Lobby government to address impunity.
- ✓ Engage broader civil society to cooperate on anti-torture work.

Engaging government (who, which structures, how) and lack of independence of national human rights commissions (government appointees)

- ✓ Familiarize your organisation with the government structures and bodies to target for prevention activities and engage with other stakeholders committed to prevention.
- ✓ Refer cases to the national Human Rights Commission to alert them, raise their awareness and involve them.
- ✓ Recognize and plan for a sustained approach given that human rights institutions have broad agenda and a long term approach is needed.

Insensitivity and lack of knowledge regarding absolute prohibition of torture (CAT)

- ✓ Awareness-raising for public is key to building understanding of the need to prevent torture and rehabilitate its victims.

obligation)

- ✓ Training for police and other law enforcement agencies is fundamental to creating the context for change.
- ✓ Training for frontline health and social care professionals to understand torture and to identify its victims so that they can readily assist them.

- ✓ Involve and use media by:
 - Mapping target audience;
 - Identifying best form of media – print, radio, TV, electronic and social media tools such as Facebook and Twitter;
 - Strategic use of media - one hour current affairs programme may have less impact than a brief targeted news report on television, with careful use of images for high impact, using debates and discussions;
 - Developing strategy to use local and national media.

MOVE UP PLSE Raising awareness of torture, its prohibition, impact and consequences.

Challenge of raising awareness of prison management and staff, police and police investigation officers, health staff, judiciary, senior government, ombudsmen, military/security forces, journalists, academics and public.

- ✓ Identify vulnerable groups and relevant bodies to target for prevention activities (e.g. government child welfare body/Committee and Juvenile Justice Board).
- ✓ Provide targeted training on definition of torture and legal framework, impact of trauma and torture, non-torture interrogation techniques, basic support for victims, accessing rehabilitation.
- ✓ Build relationships with relevant government officials, offering free training, being persuasive not overly confrontational e.g. highlight weaknesses in policing rather than denouncing police force.
- ✓ Work in collaboration with stakeholders committed to prevention to raise awareness.
- ✓ Work with communities and families, building support and awareness (e.g. by using leaflets on torture and its impact on survivors and their families, oral history and truth-telling initiatives; public ceremonies and hearings).
- ✓ Strengthen local governance structures by raising awareness of youth development centres, local council for protection of women and children etc.

Lack of resources/incentives for doctors to engage in assessing and documenting torture

- ✓ Lobby government to support health professionals in independent documentation of torture.
- ✓ Ensure all doctors in mainstream health services trained in identification and documentation of torture.
- ✓ Raise awareness of clinical staff to how medical

documentation can be used to prevent torture by identifying torture patterns and perpetrators, to pursue legal action and to engage in advocacy to ensure protection of vulnerable populations and groups at risk.

Documentation of torture not a shared value within service/centre, and therefore not used effectively in prevention of torture

- ✓ Establish system within centres to monitor documentation of torture.
- ✓ Create systems/mechanisms to report on torture practices.
- ✓ Raise awareness of torture (within bounds of confidentiality) with staff, students/interns, across organisations and within regions.

Prosecutors not accepting evidence of trained medico legal professionals

- ✓ Awareness-raising for prosecutors.
- ✓ Enhance skills-sharing and technical cooperation between regional and global centres/services to train and influence prosecutors.
- ✓ Litigate this matter where strategic and seek a ruling of the court on the status of this evidence and experts.

Influencing policy using clinical documentation of torture

- ✓ Ensure systems within centre/organisation for ethical and safe use of clinical documentation of torture for advocacy.
- ✓ Establish an advocacy officer post or leadership within rehabilitation centres.
- ✓ Train clinicians in human rights and in influencing policy

Inadequate or no support for prevention activities

- ✓ Engage community leaders in developing prevention activities for the local communities.
- ✓ Involve community leaders in making approaches to government officials.
- ✓ Collaborate with other centres, learning from each other and supporting each other in developing prevention activities and where appropriate, adopting successful, 'tried and tested' prevention activities within the region.
- ✓ Collaborate with stakeholders and service-providers.

Accessing prisons to monitor torture or cruel, inhuman or degrading treatment or punishment

- ✓ Engagement with prison management.
- ✓ Providing capacity building to prison management.

Human rights defenders at risk

- ✓ Ensure protection of victims/witnesses and their families through appropriate legal mechanisms.

Suggested reading

IRCT: Prevention

<http://www.irct.org/what-is-torture/prevention.aspx>

Association for the Prevention of Torture

<http://www.apr.ch/en>

European Committee for the Prevention of Torture

<http://www.cpt.coe.int/en/about.htm>

World Medical Association: the role of physicians in the prevention of torture

<http://www.wma.net/en/20activities/20humanrights/40torture/>

Optional Protocol to Convention Against Torture (OPCAT): Subcommittee on the prevention of torture

<http://www2.ohchr.org/english/bodies/cat/opcat/index.htm>

OCHR (2010): Preventing torture: An operational guide for national human rights organisations. OCHR, APT and APF

http://www.ohchr.org/Documents/Countries/NHRI/Torture_Prevention_Guide.pdf

OSCE: Preventing torture: A handbook for OSCE field staff

<http://www.osce.org/odihr/42871>

5.5 Using clinical data for human rights outcomes

By its very nature the rehabilitation service provider works in an interdisciplinary manner given the complex nature of torture and the rehabilitation needs of survivors. As part of this work the service provider records information that is unique to both the clinical and justice imperatives of a rehabilitation service. Most professionals engaged in this area of work, have both a clinical as well as a human rights objective in mind as it is well acknowledged across the professions that to be tortured is a violation of a fundamental human right and that the justice is an integral part of rehabilitation.

Part of the challenge for the rehabilitation sector is to gather data and find ways to share it so that it can be used for both clinical and human rights purposes. In clinical terms record keeping and data collection includes ensuring appropriate records are kept as part of best practices for clinical settings, to hold in confidence what is sensitive, respect ethical considerations about using client data, data protection and use of confidential information, and to ensure continuity of practice for the survivor given that there may be a number of interventions by a range of professionals in relation to one survivor and their holistic rehabilitation care plan. At another level, the data collected is gathered and analysed as practice-based evidence that will improve our clinical rehabilitation responses at the sector-wide, individual organization and individual survivor level.

Equally important in the interest of working in human rights respecting ways, is to use our data to contribute to the global effort to prevent torture, end impunity and ensure adequate and appropriate rehabilitation is provided to survivors.

There is an abundance of information on clinical record keeping, monitoring and evaluation and evidencing our work in the area of torture rehabilitation. However, in the

area of using our data for human rights outcomes, there is very little guidance in this area and a training program specifically addressing this approach was carried out under this project. (For further information, please contact Leanne MacMillan at lm@irct.org).

There are a number of human rights outcomes we can gain from the appropriate use of the clinical data we hold and a range of tools we can use from sharing individual stories as part of a communications push to raise awareness to reports with recommendations that become the basis for a sustained campaign to create change. For example, data can be used to provide evidence for an individual survivor to seek justice; we can draw on trends and patterns we see across clients in our rehabilitation practice to identify and pursue perpetrators; we can identify places where torture is more likely to occur; we can identify torture victims targeted due to their identify such as women and children, political, religious, ethnic and cultural groups. In the past few years emphasis has been placed on using clinical data for the purposes of holding States to account through research reports submitted to international treaty bodies and thematic mechanisms with some success (see the IRCT website for current information on country and thematic reports at UN and regional mechanisms).

A new challenge for rehabilitation service providers and the sector itself is to gather the data and evidence to support our demands of States to deliver on their duty to establish and support torture rehabilitation services according to the requirements of international law. A three-year long project will be launched in early 2014 that will bring together a number of partners providing rehabilitation services to build their skills in data collection and dissemination. Watch the IRCT website for details as that emerges and guidance on how to do this work.

Using clinical data for human rights outcomes

It is good practice to:

- ✓ **Assess the risks and opportunities of sharing client data** or stories externally in your context and beyond including any risks that might be created for the individual survivor, the service provider and the rehabilitation center.
- ✓ **Evaluate the ethical implications of using clinical data** and develop appropriate standards and protocols for using this information that is system-wide and includes considerations by all those professional groups within an holistic rehabilitation service setting (many organizations set up a research ethics committee).
- ✓ **Develop a policy and practice of informed client consent** for the use of clinical data, protocols for ensuring confidentiality and data protection. Update the client consent regularly and ensure that it is time bounded.
- ✓ **Develop an understanding and practice of appropriate data collection, management, research and reporting standards** with an emphasis on best practices, accuracy and impartiality.
- ✓ **Determine what information you hold** and how it might best be used such as for a campaign, for advocacy, lobbying or policy making purposes.
- ✓ **Establish a research strategy or plan** of action to ensure that effective use is made of data held in clinical records and that all efforts are made to limit use of these records with a view to efficient and effective use.

6. CARING FOR CAREGIVERS

Caring for yourself in working with torture survivors is one of the most important considerations you must take, yet it is often one of the most overlooked. This could be due to a lack of institution support for the well-being of staff, workloads, time

management, lack of skills, or simply from feeling despondent due to an accumulation of negative experiences endured when seeking to support survivors. In some circumstances, the press of those survivors needing assistance who are on long waiting lists can be overwhelming and the response of many is to just keep working to try and assist as many survivors as possible. For others, working with survivors creates in them a need to be heroic, ignoring ones' own health and wellbeing.

In any case, provisions should be in place to provide effective self-care and to assist others in assuring their wellbeing. This is the responsibility of the entire organisation and only with everyone playing a part can a safe, secure, blossoming working environment be maintained. Leadership of both management and governance bodies is crucial in this area and appropriate resources should be dedicated to this area of work with appropriate policies and prevention strategies.

Most importantly, ALL staff working in this environment needs to be supported in carrying it out effectively by being supported. Clinical staff has some tools such as supervision or intervision to support them in this environment. It is equally important that the person who types up clinical or legal records, or those dealing with media stories who are presented with some very disturbing information are also provided with care.

6.1 Supervision and professional development

Professional practice in rehabilitation centres for torture survivors can be highly stressful, both in the content of the work as well as the range and volume of demands on staff, which are often related to the often precarious, complex, insecure circumstances, poor conditions of living and hardships survivors may face. Essential to professional practice in rehabilitation centres is an organisational system to address staff needs.

Addressing supervision and professional development of staff

It is good practice to:

- ✓ Establish a clear organisational policy to **ensure that the professional supervision and development needs of staff can be addressed.**
- ✓ Ensure that **quality professional supervision of staff**, particularly for those engaged in direct client work, is secured and periodically monitored for its regularity, and its adequacy reviewed with the staff member, by line managers.
- ✓ Ensure that **staff members have a range of mechanisms available to them** for professional support. These can include peer supervision and support groups, case discussion seminars, team days etc.
- ✓ Ensure that **staff members have opportunities for professional development** to ensure good practice, enhance motivation and support staff needs. Professional development opportunities include attending training events, conferences, seminars, meetings with external agencies etc.
- ✓ **Ensure that managers are also able to access appropriate professional support**, supervision and opportunities to enhance their learning, knowledge of the work of the centre and to optimise their management practice, including their competency in identifying the professional and support needs and supporting staff they manage.

Staff care: Case study

The theme of the Latin American NSA regional seminar in Mexico 2012 was "Holistic Health and Human Rights. Psycho-social risks and risks of Human Rights Defenders". In this context security measures, human rights defenders and care for care-givers were discussed. Centres shared their knowledge and experience in applying a care-for-care givers perspective in their work.

Common risks identified by centres included two broad areas. One area includes risk of work-related stress (which can be related to volume and nature of work and the organisational processes by which "what happens to victims happens to us").

The latter can refer to the psychological dynamics of organisations where aspects of clients' experiences (e.g. fear, suspiciousness, isolation, aggression) are experienced by staff and manifest in the social system of the organisation (e.g. in tense staff relations, behaviour which is secretive, punitive, blaming, extreme mistrust of others etc.). The second area of risk involved threats towards and security of staff and their families. Various recommendations were made to address such risks (included below).

6.2 Staff care and self-care

The impact of working in highly stressful environments with torture survivors and their families can be far-reaching, regardless of the experience and seniority of the staff member. Potentially all staff in torture rehabilitation centres may be at risk of experiencing work-related stress. The effects have sometimes been referred to as burn-out, vicarious trauma, or secondary traumatic stress. Additional risks to staff members and their families may also arise as result of working with torture survivors and human rights defenders.

Addressing the risk of work-related stress

To minimise and address the risk of work-related stress and work stress-related health problems, it is good practice to:

- ✓ Ensure there are appropriate **health and safety policies** in your organisation.
- ✓ Ensure **staff is familiar with the health and safety policy**.
- ✓ Ensure **management are alert to work-related stress or threats to staff**.
- ✓ **Staff and managers should be alert to symptoms** of work-related stress as early as possible.
- ✓ **Encourage staff to take regular** breaks during the day, utilise their annual leave provision and minimise any out-of-hours work.
- ✓ **Support and encourage staff to engage in relaxation activities**, exercise/sports, creative activity, meditation, yoga, good nutrition and appropriate rest and sleep.
- ✓ **Ensure regular meetings with each staff member** to review any work-related/personal factors hindering work progress and work satisfaction, and well-being.
- ✓ **Ensure fair conditions for work** including adequate holiday/annual leave entitlements, to make sure that staff well-being is addressed.
- ✓ Create a work environment and organisational culture where **staff feel valued and supported**, for example, by ensuring there are regular opportunities for sharing news, lunch, perhaps celebrating birthdays of colleagues, staff excursions/activities etc.

- ✓ Create an organisational **culture where staff can express what they need to** enable them to manage the stresses of their work, and where creative solutions can be explored.

Addressing work-related stress: Bolivia case study

Recently ITEI (Institute of Therapy and Research about Sequelae of Torture and State Violence) had an internal crisis in the organisation due to a traumatic incidence in the country where there had been a massacre in a community. As a result, all staff dealt with people presenting as severely traumatised as well as confronting the number of persons who had died. This work took place within a very compressed period of time.

After the incident and their work in response, the staff at ITEI suffered in many ways, including feeling de-motivated and experiencing trauma symptoms. The staff asked that in order to overcome this experience and their stress, it would be helpful to have someone come and “clean” the organisation from the bad spirits and emotions, through the use of cultural rituals.

The management at ITEI was not at all sure that this would make a difference, but since it was a wish from staff, they implemented it in the hope that it could help and in order to demonstrate that they valued the well-being of staff and took their concerns very seriously. In addition, ITEI had exchanges with staff from EATIP in Argentina in the after-math of the crisis. The exchange between the two organisations was found to be very useful for ITEI in order to help staff to reflect on and manage their responses and experiences with colleagues external to the organisation, thereby enabling them to continue with their work.

Source: Translated Excerpts of IRCT Regional Meeting in Mexico, IRCT Mission Report, December 2012

Addressing the risk of threats or harm to staff and their families

To minimise and address the risk of threats or harm to staff and their families, it is good practice for centres to:

- ✓ **Develop a prevention approach** to prevent the risk of harm to staff and their families
- ✓ Develop a **protocol on security of staff and their families**, firstly identifying threats, vulnerability and capacity for your Centre/service
- ✓ Ensure **contact with international presence locally and internationally**, such as with the EU or UN bodies.

Suggested reading

Pross, C. (2011) Manual for Good Practice and Management in Trauma Centres, Structural Aspects of Work Related Stress - Care for Caregivers

<http://www.irct.org/Files/Filer/publications/ManualGoodPract-EN.pdf>

Caring for Caregivers (Power point presentation, 1mb)

TCC, Cameroon

<http://tinyurl.com/nl7sxkh>