European Network of Rehabilitation Centres for Survivors of Torture

Refugee survivors of torture in Europe.

Towards positive public policy and health outcomes

This publication of the European Network of Rehabilitation Centres for Survivors of Torture was compiled by the German Association of Psychosocial Centres for Refugees and Victims of Torture, BAfF.

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Content

Executive Summary

The European Network of Rehabilitation Centres for Survivors of Torture ('European network') has collective professional and multidisciplinary experience in the field of providing rehabilitation to torture survivors in Europe. It is a non-financed and largely a self-sustaining professional network of health, social care and legal professionals, from over 120 centres in Europe. The European Network.

This report is based on a two-day conference and annual meeting of the European Network of Rehabilitation Centres for Survivors of Torture, held in Bucharest, November 2017. The overarching theme was 'public health and positive public policy to ensure positive health outcomes for asylum seekers, refugees and torture survivors'.

Refugee torture survivors in Europe

In recent years, the unprecedented movements of people fleeing war, civil conflict and persecution to seek refuge in Europe has presented significant challenges to states in terms of managing borders; ensuring appropriate protection; ensuring relevant health and social care services for those in need; raising awareness within the public, whilst also managing hostility towards asylum seekers and the backlash from segments of the host population.

The question remains:

What should states and health and social care service providers do to address the needs of those torture survivors amidst the asylum seekers?

States have a responsibility for the protection, welfare and rehabilitation of torture survivors whose needs, strengths and presentations are often complex and vary, requiring specialist multidisciplinary care and rehabilitation. In its General Comment no. 3 on the implementation of Article 14 by the States parties, the United Nations Committee against Torture affirms that the provision of means for as full rehabilitation as possible should be *holistic and include medical and psychological care as well as legal and social services.*

Rehabilitation for torture survivors in Europe

Each country has its own unique social, economic, political, cultural and historical context; and rehabilitation and health service provision will depend on a number of factors. These factors include the current public and legal policies in each country, relevant to torture survivors (including asylum seekers and refugees), as well as the infrastructure and provision for public health and social care as well as for education, vocational support etc. The majority of current rehabilitation services for torture survivors in Europe are provided by independent NGOs. According to the European Network, in Europe there are more than 120 NGO-run rehabilitation centres, though many are for refugees or others affected by war-related traumas, and not specifically designed for torture survivors. Some services in Europe are supported by government funds, or mainstreamed and integrated within State services and therefore fully State-funded. Most have struggled against the changing and often increasingly harsh political and economic climate, often grasping at survival as funding has become increasingly scarce. This has raised questions about the need to frame rehabilitation for torture survivors as a public health concern – as a responsibility of the State, to provide for all torture survivors.

Why take a public health approach?

The provision of rehabilitation is important from a public health perspective, for a number of reasons. For example, rehabilitation helps

a. Ensure the health and well-being of survivors can have positive effects for the survivor's family members and family life.

b. Improve social functioning whereby adult survivors can fulfil their family, social and work roles, and survivors who are minors can be supported in their functioning within education and in their overall development and functioning.

c. Minimise the negative and potentially longer-term impacts of torture and across generations, thereby contributing to more resilient communities.

d. Survivors in becoming productive members of society, and facilitate social inclusion and integration.

e. Improve understanding and practice of human rights standards among health professionals and health service providers, including in civil society.

There are a number of benefits of pursuing a public health approach for torture survivors, including that torture survivors and their needs would be seen as a public health responsibility and a priority; States may then ensure protected budget lines for specialist care for the health needs of torture survivors; specialist medical and other healthcare and facilities can be made available to torture survivors; funding for specialist services does not fall solely to non-governmental organisations and services (State-run and NGOs) can be better coordinated with appropriate protocols and agreements for cooperation.

However, there are also a number of risks and disadvantages of pursuing a public health approach to address the needs of torture survivors. For example, the human rights obligation for torture survivors to receive specialist, holistic and multidisciplinary rehabilitation, as a form of reparation, is obscured; a reductive and narrow approach to rehabilitation is adopted, which focuses only on health needs, thereby neglecting the full range of needs and the social, welfare, security, interpersonal, educational, legal, vocational support service needs which together constitute 'rehabilitation'; and specialist knowledge, skills and services for torture survivors within NGOs are neglected, or at worst, eradicated. However, there is broad consensus within the field currently is that to neglect a public health perspective is to be negligent towards survivors, who in time may have no access to services if existing services, predominantly offered by NGOs, diminish in numbers and size as funding sources steadily shrink.

Adopting a two-pronged approach would require States to take responsibility to provide health services for torture survivors as a form of health protection and prevention of the deterioration of complex health concerns of survivors; and for States to commit to addressing the wider determinants of health concerns of torture survivors-which would include the health impacts of the absence or lack of adequate housing, welfare, food and safety for survivors; the health impacts of stigma, marginalisation, social exclusion and discrimination; and the health impacts of economic and sexual exploitation and physical or sexual harm to which survivors may be subjected to within Europe.

What needs to change?

In Europe, based on our collective experience over three decades, there are important lessons we have identified together. These lessons point to specific changes and action needed by policy-makers, changes which the European Network holds as crucial to ensuring a humane, ethical and professional response to the needs of torture survivors in Europe.

The European Network believes that it is important to:

1. Ensure policies and effective, ethical and culturally- and gender-appropriate mechanisms to identify torture survivors and vulnerable refugees as early as possible, by those appropriately qualified to do so.
2. Ensure all frontline health professionals are adequately trained to identify torture survivors and vulnerable refugees, and to provide appropriate care and support.
3. Ensure professional training programmes for health professionals and other relevant professional groups that includes training on holistic rehabilitation and relevant competencies to conduct appropriate health assessments and to provide appropriate, non-discriminatory care for torture survivors and vulnerable refugees.
4. Ensure appropriate, non-discriminatory state health and social care services for all torture survivors and vulnerable refugees, accessible on the basis of need and their rights to health and rehabilitation.
5. Ensure effective regulation, accountability and professional support mechanisms to protect torture survivors and vulnerable refugees from receiving sub-standard and potentially harmful and unsafe health services as well as psychosocial care by inadequately qualified and trained personnel in civil society organisations.
6. Ensure public policy and a programme of activities to address the social determinants (in the receiving country) for poor health of torture survivors and vulnerable refugees.
7. Strengthen the existing infrastructure within civil society to consolidate practice, integration and rehabilitation services for refugees and torture survivors.
8. Raise awareness and understanding of all relevant stakeholders, political representatives and health professionals on torture, rehabilitation and health care of torture survivors and their families.
9. Ensure public policy, mechanisms and a programme of activities to prevent exploitation (economic and sexual) and harm, poverty and discrimination (including institutional, interpersonal, physical, and verbal racism).
10. End impunity for crimes of torture in Europe, and address its impact on torture survivors.
11. Ensure public policies (e.g. anti-terrorism policies) do not unfairly target and discriminate against torture survivors and vulnerable refugees.
12. Ensure adequate State financing for the provision of professional and coordinated general and specialist health and social care, legal, educational and other support for the rehabilitation and participation and integration of all torture survivors and vulnerable refugees.

1. Introduction

The European Network has met annually for 17 years in different locations across Europe, each year focusing on current concerns and developments and on our collective professional and multidisciplinary experience in the field of providing rehabilitation to torture survivors in Europe. It is a non-financed and largely a self-sustaining professional network of health, social care and legal professionals, offering a space and forum for debating and sharing our professional experiences in relation to current issues. These debates and discussions, over the years, have helped us to raise the awareness of other professionals, different state institutions and governments – based on our practical experience of hearing the stories of survivors of torture every day. We know that survivors are unable to access relevant and appropriate support, care and rehabilitation – this is the gap we try to fill and to which we persistently draw attention. Our centres have immense and widely-recognised experience. We are seen as health professionals, but we are also seen – and this is very important to us – as human rights activists. We have been trusted with the stories told by survivors of torture and so it falls to us to help preserve these collective memories of violations of human rights and to make them accessible to current and future generations.

1. 1. Background to the report

This report is based on a two-day conference and annual meeting of the European Network of Rehabilitation Centres for Survivors of Torture, held in Bucharest, October 2017. The annual conference comprised presentations, debates, workshops and small group seminars on specific themes, with the overarching theme being 'public health and positive public policy to ensure positive health outcomes for asylum seekers, refugees and torture survivors'.

The report draws on some of those discussions and highlights key considerations and lessons learnt, based on the collective experience of a range of health, social care and legal professionals working in different centres in Europe, specializing in providing such care to asylum seekers and refugees.[1]

1 For more information on the work of the European Rehabilitation Centres in Europe, see Elise Bittenbinder (Ed.) (2012): Beyond statistics. Sharing, learning and developing good practice in the care of victims of torture, and Elise Bittenbinder (Ed.) (2010): Good Practice in the Care of Victims of Torture.

1. 2. Why 'global health' means appropriate health and social care for all torture survivors

There have always been refugees in Europe but in 2015 the context has changed significantly. It has been described frequently as the "greatest refugee crisis since World War II", a crisis which has shone a light on many of the challenges we have faced for decades, with additional and new challenges.

The European Network of Rehabilitation Centres for Survivors of Torture stands for what we call 'global health for all survivors of torture'. In other words, we believe that every survivor of torture, including asylum seekers and refugees, should have access to appropriate health and social care as part of specialist rehabilitation. For us, as specialists working with torture survivors and other vulnerable refugees, one of the first requirements is that victims of torture and other serious human rights abuses should be identified amongst all the refugees who come to our countries. Yet, there still is no coherent system for the identification of torture survivors which functions effectively and in a way that torture survivors are able to access our specialist or other generic state health services early and promptly as possible. Civil society organisations like our centres in Europe cannot provide these services on their own – each country's regular state health and social services will need to take responsibility and provide relevant services and care, which means they will have to learn and adapt to ensure they are able to provide the necessary services. Yet, currently, there is a big gap between what is required and what is offered by the general state health care providers. For survivors of torture, it is often a lottery: it depends on where they have landed and from whom they receive their services (if at all) as to whether they will have access to appropriate rehabilitation.

Refugee survivors of torture also need protection from the risk of being torn out of their new fragile place of safety and being removed, returned to a 'home' which is no longer a home to them, or to a third country with which they have no relationship or any social support networks. Meanwhile, our rehabilitation centres in Europe are providing services while surviving on a day to day basis, starved of funds and state support. The refugee crisis is no longer a crisis; it is an enduring and now permanent part of our world and daily work. European governments have failed to systematically and adequately provide for the care and rehabilitation of torture survivors.

Increasingly, politicians are demanding that migrants, including refugees, integrate into their host societies. Yet, governments fail to protect them from the exclusion they experience, both from public services, including parts of the health system, and from society – the prevalence of xenophobia, Islamophobia and racism has increased in many European countries and worse, it is increasingly normalised.

Despite ongoing challenges, depleted resources and working in the context of hostile immigration policies across Europe, the European Network centres have achieved much, separately and together, not least by putting the issue of care, support and rehabilitation for torture survivors on the map. Our collective achievements include developing ways to assess and document human rights abuses such as torture and presenting this evidence in court proceedings, writing professional guidance and manuals based on our experience in this field, developing and delivering training programmes for health, social care and legal practitioners; and a multitude of ways to enable the rehabilitation of torture survivors.

Our hopes for the future include achieving a better understanding of the challenges survivors and those working with them face; better synthesis of the lessons we learnt from the past; and more establishment of guidelines for practitioners, based on our experience, which can be disseminated and implemented across Europe. We want to find ways of better protecting torture survivors – from future harm and torture, from xenophobia and racism, social exclusion, exploitation and from the harmful impacts of inadequate state funding for the services they need. Ultimately, we recognise that our efforts towards stronger cooperation and collaboration between our centres and with state health services need more support, resources and genuine commitment by states.

As human rights activists, we know that our professional activities must include advocacy for the rights of torture survivors and other vulnerable refugees in our societies. Additionally, we must help to protect our own societies from drifting into a culture of indifference and inhumanity towards the 'other' for we also have a responsibility towards our own societies, to strengthen the tradition of humanity and respect for all human beings.

2. Understanding the service needs of refugee torture survivors

This section outlines the current obligations and challenges to ensuring an appropriate response by states to address the needs of torture survivors in Europe currently.

2. 1. Refugee torture survivors

In recent years, the unprecedented movements of people fleeing war, civil conflict and persecution to seek refuge in Europe has presented significant challenges to states in terms of managing borders; ensuring appropriate protection; ensuring relevant health and social care services for those in need; raising awareness within the public, whilst also managing hostility towards asylum seekers and the backlash from segments of the host population. In these pressured circumstances there have been many competing discourses, including the discourse of the *responsibility* and obligation to provide protection; the discourse of the *burden* of managing or controlling illegal/economic migrants; and the discourse of migrants as terrorists etc.

Fuelled by a lack of a coordinated response in Europe and the absence of reliable statistics, the dominant discourses which continue to prevail (those of controlling borders and immigration and controlling terrorism) have inevitably overshadowed discussions on what should states do to ensure the health and legal protection of asylum seekers. In particular, the question remains: *what should states, health and social care service providers do to address the needs of those torture survivors amidst the asylum seekers?*

2. 2. Why should states, health and social care service providers address the needs of torture survivors?

States have a responsibility for the protection, welfare and rehabilitation of torture survivors. However, encouraging States to respond with commitment and efforts towards this responsibility is often met with a number of related and legitimate questions, such as how many torture survivors are there, what do they need and what does rehabilitation entail.

How many survivors of torture are there amongst the newly-arrived asylum seekers?

Unfortunately, it is almost impossible to estimate this number. Firstly, States do not collect this information or have a system for estimating this number. Secondly, there are many obstacles to collecting accurate and reliable statistics on numbers of torture survivors because this would require systematic, valid and effective mechanisms to screen torture survivors wherever they may present (e.g. refuges, health centres, non-governmental organisations etc.). Thirdly, there would need to be effective, culturally and gender-appropriate methods, as well as the availability of staff competent and trained to conduct appropriate health assessments, in order to identify torture survivors and to document torture and ill-treatment. Fourthly, the systems would need to ensure that torture survivors amidst the asylum-seeking population feel sufficiently safe and are not likely to be subjected to stigma or other negative repercussions if they do disclose torture or other ill-treatment.

To date, there is no precedence of good and effective practice on these questions. Estimates of the number of torture survivors tend to rely on figures based on survivors who are seen at specialist rehabilitation, counselling or social welfare services. Not all staff in these services would be trained and competent to ensure effective identification of torture survivors, and few services, apart from specialist torture rehabilitation services have mechanisms to systematically collect such information – and even then this would only be for those people who present to and can access these services. Thus, the statistics are partial and highly likely to be a significant underestimation.

That said, the International Rehabilitation Council for Torture Victims (IRCT) estimated that in 2010, prior to the recent refugee movements into Europe, around 400,000 torture survivors live in the European Union alone[2], with similar earlier estimates in the USA[3]. General estimates across services suggest that between 30-60% of those asylum seekers who present to health services are likely to be torture survivors.

What do torture survivors need?

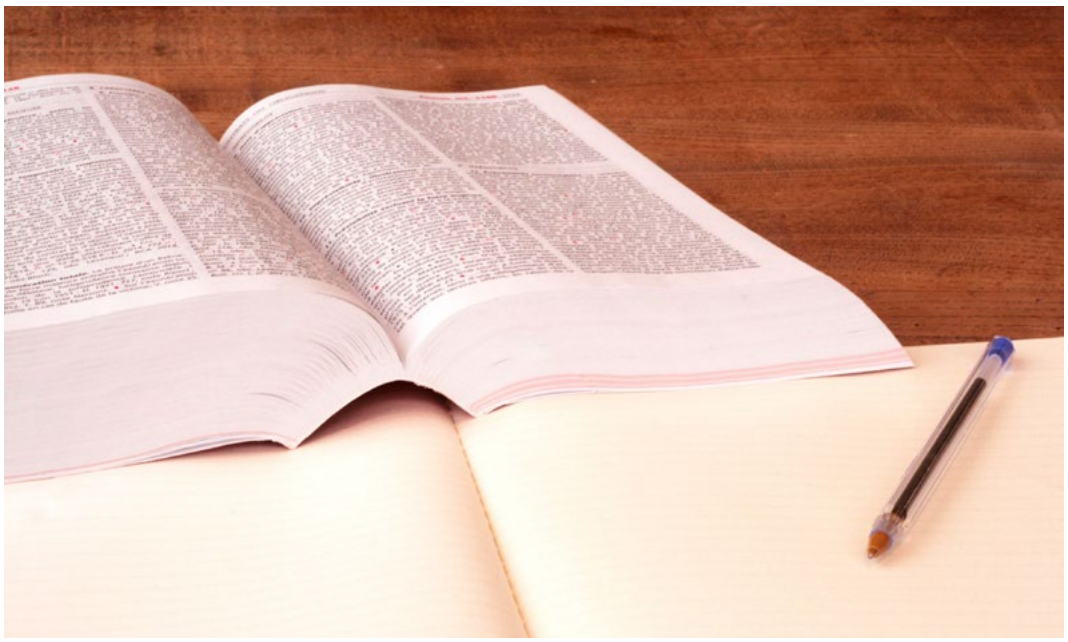
Torture survivors are diverse in their experiences of torture and other ill-treatment and in their social, cultural and political contexts and personal backgrounds. Further, torture is not any one specific act, and can be physical and/or psychological, including sexual. It is defined as:

"The term '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."

Article 1 of the UN Convention against Torture and Cruel, Inhuman or Degrading Treatment or Punishment

2 International Rehabilitation Council for Torture victims (2007): 26 June - International Day against Torture. The fight against torture: a key priority for the EU. Available at: www.europa.eu/rapid/press-release_MEMO-07-254_en.pdf. These figures do not account for recent Syrian refugees.

3 Jaranson J.M. (1995). Government-sanctioned torture: status of the rehabilitation movement. Transcultural Psychiatric Research Review, 32, 253–86; and CVT http://www.cvt.org/where-we-work/united-states.



Torture survivors may also face stigma, social isolation, social exclusion, discrimination and racist verbal abuse and violence as asylum seekers and refugees. *(CQF-avocat, CC0 | pixabay.com)*

The impact of torture can be profound, long-term and severe, and significantly, not always visible. This creates many challenges for those health professionals (medical and psychological) and lay persons (including community support workers, border control personnel etc.) in identifying those who may have suffered torture and in assessing the health and social care needs of torture survivors.

The impact of torture includes physical injury, disability, illness, chronic pain, difficulties in psychological health, in interpersonal, couple and family relationships and in social functioning in everyday life, education or vocational pursuits. Additionally, torture survivors have needs which relate to their safety, basic welfare (adequate food, housing, clothing etc.) and protection against further harm, whether from within the host society or from being returned to the place where they were subjected to torture and risk facing further torture or other harm. Torture survivors may also face stigma, judgement, social isolation, social exclusion, discrimination and racist verbal abuse and violence as asylum seekers and refugees. Some may resort to substance misuse as a way of coping with their difficulties, which can create further health complications and needs.

What are the legal obligations of States relevant to ensuring an appropriate health response for torture survivors?

Given the breadth of health, social, educational and vocational support needs torture survivors can have, services need to ensure that the focus is not exclusively on one aspect of health (e.g. physical health or mental health) or on health at the exclusion of other needs for social care, welfare support, educational support etc. In its General Comment no. 3 on the implementation of Article 14 by the States parties, the United Nations Committee against Torture affirms that the provision of means for as full rehabilitation as possible should be *holistic and include medical and psychological care as well as legal and social services*. The Committee specifies that States parties shall ensure that effective rehabilitation services and programmes are set-up in the State, that access to such rehabilitation should not depend on the victims pursuing legal remedies, and that the right applies to all victims without discrimination and regardless of the victim's status.[4]

4 CAT, General Comment N°3 (2012), paras. 15 and 32.

Box 1.

State health response for torture survivors: Relevant legal provisions

Relevant legal provisions	Key sources
The right to rehabilitation as reparation for torture	• Article 14, UN Convention Against Torture (UNCAT) [5] • General Comment 3 on Article 14, UNCAT[6] • UN Human Rights Resolution on rehabilitation for torture survivors[7]
The right to the highest attainable physical and mental health	• Article 12, UN International Covenant on Economic, Social and Cultural Rights • Article 25, UN Convention on the Rights of Persons with Disabilities
The right to 'habilitation and rehabilitation' for persons with disabilities	• Article 26, UN Convention on the Rights of Persons with Disabilities
The right to an effective remedy and reparation	• Articles 3 and 13, European Convention of Human Rights • Article 4, the Council of Europe Convention on the Compensation of Victims of Violent Crime • Articles 4 and 47, EU Charter of Fundamental Rights • Council of Europe, Commissioner for Human Rights, Human Rights Comment, 7 June 2016[8]

In terms of health specifically, there are a number of legal obligations relevant to the health needs of torture survivors (see Box 1). However, it is important to note that torture survivors' needs extend beyond health and social care, and as such rehabilitation is defined and understood in practice as being a combination of services which may need to be provided simultaneously or at different stages according to each survivor's needs and situation. For States, it is important to establish inter-departmental coordination (e.g. across government, such as departments of education, social services, health etc.) to ensure rehabilitation for torture survivors.

What are public health reasons for providing rehabilitation to torture survivors?

There are a number of reasons why the provision of rehabilitation, which comprises comprehensive and holistic care and support for torture survivors, is important from a public health perspective. Rehabilitation helps:

- Ensure the health and well-being of survivors, which can have positive effects for the survivor's family members. For example, survivors can benefit from positive family relationships, including supportive parenting (minimising the risk of harm or threats of harm to children or other family members).

5 The United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT) enshrines the right to rehabilitation, as a form of reparation, in Article 14: *"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 dependents shall be entitled to compensation […]."*

6 UNCAT, General Comment 3, Implementation of Article 14 by the States parties, CAT/C/GC/3, 19 November 2012.

7 UN Human Rights Council resolution on Torture and other cruel, inhuman or degrading treatment or punishment: rehabilitation of torture victims, A/HRC/22/L.11/Rev.1, 19 March 2013.

8 http://www.coe.int/da/web/commissioner/-/torture-survivors-have-the-right-to-redress-and-rehabilitation

- Improve well-being of survivors, which can also support improved social functioning whereby adult survivors can fulfil their family, social and work roles, and survivors who are minors can be supported in their functioning within education and in their overall development and functioning.
- Improve well-being of survivors, which can help to minimise the negative and potentially longer-term impacts of torture and across generations, thereby contributing to more resilient communities.
- Support survivors in becoming productive members of society, and facilitate social inclusion and integration.
- Support an ongoing process of improvement in the awareness, understanding and practice of human rights standards among health professionals and health service providers, including in civil society.

The negative consequences of the absence or delay of appropriate and effective multidisciplinary rehabilitation services include:

- increased chronicity of torture-related health problems;
- resulting additional strain on health and social care services with increasing costs;
- the increased likelihood that survivors present to services only in crisis when health problems become very serious, severe, chronic and intractable; and
- increase the risk of serious health and protection concerns (e.g. suicide, self-harm, violence to others, child-protection issues) – which can lead to further serious complications, harm or death.
- increase the risk of discrimination if not appropriately recognised.

2. 3. How can states ensure appropriate health and social care response to torture survivors?

States have a legal obligation to ensure the means to as full rehabilitation as possible for torture survivors and these services may be provided by States or by non-governmental and non-state organisations. A summary of what is required to address the needs of torture survivors is presented in Box 2.

Appropriate monitoring and evaluation of state practice in relation to ensuring the *"means to as full rehabilitation as possible for torture survivors"*[9] is essential to ensure accountability. However, one of the main difficulties of assessing the effective implementation of rehabilitation is the lack of clear indicators, which has been an obstacle to date in ensuring States are accountable and that service providers are able to adequately report on the services they provide[10].

Each country has its own unique social, economic, political, cultural and historical context; and service provision will depend on a number of factors. These factors include the current public and legal policies in each country, relevant to torture survivors (including asylum seekers and refugees), as well as the infrastructure and provision for public health and social care as well as for education, vocational support etc.

Funding invariably influences the way in which governments deliver rehabilitation. Whilst traditionally, rehabilitation services have been predominantly provided by NGOs not States, General Comment 3 of the United Nations Convention Against Torture is clear that "the obligation in Article 14 to provide for the means for as full rehabilitation as possible can be fulfilled through

9 UNCAT, article 14.

10 The International Centre for Health and Human Rights, UK has recently completed its work on developing indicators for the right to rehabilitation, which can be adjusted to each country context (forthcoming publications).

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)".[11]

There are increasingly limited sources of external funding for rehabilitation of torture survivors. One source of external funding, specifically for torture survivors is the UN Voluntary Fund for the Support for Victims of Torture[12]. However, external funding is never adequate to ensure comprehensive and appropriate services nationally in each country; nor is it intended to replace government allocation of adequate resources for rehabilitation for torture survivors.

The majority of current rehabilitation services for torture survivors in Europe are provided by independent NGOs. According to the European Network, in Europe there are more than 120 NGO-run rehabilitation centres, though many are for refugees or others affected by war-related traumas, and not specifically designed for torture survivors. Some services in Europe are supported by government funds, or main-streamed and integrated within State services and therefore fully State-funded.

Box 2.

Rehabilitation for torture survivors[13]

- **Available, readily accessible, adequate, appropriate rehabilitation**
- **Holistic approach, with range of interdisciplinary and specialist services**
- **for torture survivors**
- **Provided on the basis of a needs assessment and evaluation by qualified, independent health professionals**
- **More than initial care in the aftermath of torture**
- **Non-discriminatory and culture- and gender-sensitive**
- **Available in relevant languages of victims**
- **Victim-centred: tailored to address the victim's needs, preferences for rehabilitation service and their culture, personality, history and background**
- **Provided in a way that guarantees the safety and personal integrity of the victims and their families**
- **Provided without a requirement for the victim to pursue judicial remedies; and without reprisals or intimidation.**

11 UNCAT, General Comment N°3 (2012), para. 15.

12 *http://www.ohchr.org/EN/Issues/Torture/UNVFT/Pages/WhattheFunddoes.aspx*

13 See General Comment N°3 (2012) on Article 14 of UNCAT.

3. Health and social care services for torture survivors in Europe

The nature, range and coverage of health and social care services across Europe vary tremendously, each system and country context also giving rise to many dilemmas and challenges for policy-makers and service providers. The question of how, amidst those diverse systems, torture survivors and other vulnerable refugees can access relevant services, remains.

In this section, common challenges in providing rehabilitation services for torture survivors are outlined; followed by an examination of five countries and their practices currently, in relation to torture survivors and other vulnerable refugees.

3. 1. Current challenges in providing rehabilitation services for torture survivors

There are numerous challenges to ensuring that torture survivors in Europe, including those amongst asylum-seeking and refugee populations, can access and receive appropriate, adequate and effective rehabilitation. Some of the key challenges include:

- Establishing ethical, effective and culturally- and gender-appropriate and valid ways to identify promptly torture survivors amidst the asylum seekers and refugee population, including
- those who are particularly vulnerable and those with special needs.
- Establishing appropriate models and methods of services which are culturally appropriate and valid; which address the wide and full range of needs of torture survivors (e.g. not just focussing on psychological trauma); and which lead to positive outcomes. There remain numerous conceptual, methodological and ethical shortcomings of existing research[14] and there is a need for further, more rigorous, culturally-valid and ethical research.
- The lack of security and basic welfare provision for torture survivors and their families – which in turn can hinder their ability to access or to engage in rehabilitations services, where available.
- Ongoing impunity, for crimes of torture or other harm by the State. This is particularly relevant in European countries where there remain torture survivors who were subjected to torture within Europe.
- Ongoing risks of exploitation (e.g. economic, sexual) and harm, poverty, discrimination and marginalisation within society.
- The absence or lack of nationally sufficient numbers of qualified staff (e.g. doctors, psychologists, social workers, interpreters) who are also trained and specialised in working with torture survivors.
- Inadequate State financing and structures and related protocols for the provision of professional and coordinated health and social care, legal, educational and other support.

Challenges, some common to many European countries and some specifically related to each, Denmark, Germany, Poland, Turkey and Spain, are summarised below.

There is a lack of security, basic welfare and coordinated health and social care for torture survivors, refugees and asylum seekers. *(Wokandapix, CC0 | pixabay.com)*

14 For a fuller discussion see: Jaranson J.M., and Quiroga J. (2011) Evaluating the services of torture rehabilitation programmes: History and recommendations. Torture, 21, no. 2, 98–140; Montgomery E. and Patel N. (2011) Torture rehabilitation: reflections on treatment outcome studies. Torture, 21, no. 2, 141-5; Patel, N., Williams, AC de C. and Kellezi, B. (2016) Reviewing outcomes of psychological interventions with torture survivors: Conceptual, methodological and ethical issues. Torture, vol.26, no.1, 2-16.

3. 2. Denmark

In 2017, Denmark registered the lowest number of asylum applications in nine years. The number of asylum applications lodged dropped from 21,316 in 2015 to 3,479 in 2017. Simultaneously, the percentage of people who were granted asylum dropped from 85 percent to 36 percent.[15] The majority of asylum applicants come from Syria, Eritrea, Afghanistan and Iran.[16]

Labour market integration is seen as a key component in the integration process of asylum seekers and recognized refugees. While asylum applications are processed, asylum seekers are assigned practical tasks in the asylum centres, including minor repair work, cleaning and cooking in addition to mandatory attendance at education and language training courses provided. Asylum seekers can access the labour market and work outside the asylum centre after six months, if it is decided that the asylum case will be further processed.

Aside from Danish language classes, education covers subjects that equip asylum seekers with skills which can facilitate integration into the labour market in Denmark or the country of origin. Once granted asylum, municipalities assume responsibility for integration activities, including language and orientation courses, civic education and job placement. By law the regular integration period lasts for a maximum of three years and activities amount to 37 hours per week. Once a refugee is employed or has entered formal education, attendance is no longer mandatory.[17]

Access to health care

Denmark has a universal and tax-financed health care system which can be utilized depending on residence status. According to The Danish Health Act[18], all persons present in the country, including foreign citizens staying temporarily in Denmark, are entitled to acute and urgent treatment free of charge. In addition, all persons officially residing in the country receive a social security number and health insurance card which are used to register each contact of an individual with the health care system. Recognized refugees are granted full access to health services. Asylum seekers are issued a temporary social security number that entitles them to emergency care as well as primary health care provided by health personnel at the asylum centre. Each asylum centre is equipped with a small medical office where health consultations are offered by appointment. Non-emergency care is restricted and asylum seekers have to apply to the Danish Immigration Service for the costs to be covered. A limited number of appointments with specialists and primary consultations with a psychologist or psychiatrist can be arranged without permission

15 Danish Parliament (2010): Danish Health Care Act (Sundhedsloven), available at: https://www.mindbank.info/item/1194

16 Danish Immigration Service (2018): Statistics and key figures regarding population, asylum, family reunification and immigration.

17 European Commission (2016): Labour market integration of asylum seekers and refugees / Denmark.

18 The Health Act (Sundhedsloven), § 80

from the Danish Immigration Service.

Undocumented migrants have the right to emergency care but are not entitled to primary or specialist care. Even though emergency care is provided in theory, informal barriers, such as the fear of being reported to the authorities, inhibit accessibility.[19] In order to help to fill this gap, the Red Cross has set up a well-frequented clinic that provides health care to paperless immigrants free of charge. The clinic is the first and only one of its kind in Denmark and has two departments, one in Copenhagen and one in Aarhus. Patients do not need to prove identification upon registration, health personnel do not report them to the authorities nor do the police interfere with the clinic's activities.[20]

Health screening and early access to treatment

In Denmark, refugees suffering from trauma have the right to specialized treatment. Even though rehabilitation centres can be found nationwide, demand exceeds the capacity of the centres and patients have to wait up to a year to receive treatment.[21]

There is no consistent system of health assessment and early identification. Examinations vary among municipalities and "health assessment is, if at all, often not more than an interview by a nurse," says Morten Sodemann, Professor of Global and Migrant Health at the University of Southern Denmark. A few years ago, a general health assessment for newly-arrived asylum seekers was introduced by health authorities. According to Professor Sodemann the assessment was carried out only by about half of Denmark's municipalities and was withdrawn after only two years. The municipalities no longer have the obligation to offer health screening to newly arrived asylum seekers, except in the case of quota refugees. Instead it is the responsibility of social workers to assess whether there is a need for health screening.

Due to the lack of an identification system, signs of torture and ill-treatment are often not identified until a much later stage.[22] According to the Danish Institute Against Torture, DIGNITY, it takes in Denmark up to 10–15 years for a need of trauma treatment to be recognized and thus get adequate access to treatment.[23] The lack of health education for refugees has been named as another factor delaying diagnosis, as newly-arrived asylum seekers often access the wrong places when in need of treatment.[24] Moreover, Sodemann comments that "it is vastly underestimated how we train our professionals. It is very clear that professionals have very few tools to deal with the different kinds of problems that refugees are facing." With the exception of some compulsory courses on the Istanbul Protocol for medical students specializing in forensic medicine and a few lectures on the topic for public health students, there is no systematic training of health professionals in identifying signs of torture and ill-treatment. The University of Southern Denmark and some rehabilitations centres, such as OASIS and DIGNITY, offer specialized training and professional supervision to health professionals, training them in the identification of torture victims.[25]

One positive element in the Danish context is the cooperation between the centres and the agencies within the public sector as a whole, including the health and social sector. David Oehlenschläger, Head of the National Rehabilitation Unit at Dignity says "it is difficult to address the very different problems of victims of torture as they are difficult to address in one centre. Working inside the public sector, it is easier to link up with other services." Moving services into a pub-

Morten Sodemann is Professor of Global and Migrant Health at the University of Southern Denmark. *(© Emilian Savescu)*

19 Jensen et al. (2011): Providing medical care for undocumented migrants in Denmark: what are the challenges for health professionals? .

20 Nino (2016): Health Clinics for Undocumented Migrants in Denmark.

21 DIGNITY (2017): Fra asylum til rehabilitering hos DIGNITY: De 5 anbefalinger,

22 Alternative Report to the list of issues (CAT/C/DNK/Q/6-7) dated 19 January 2010 to be considered by the UN Committee against Torture during the examination of the 6th and 7th periodic report of Denmark. 54th Session, November 2015.

23 DIGNITY (2017)

24 Scholten et al. (2017): Policy Innovation in Refugee integration? A comparative analysis of innovative policy strategies towards refugee integration in Europe. Erasmus University of Rotterdam.

25 Alternative Report to the list of issues (CAT/C/DNK/Q/6-7).

lic sector, he says, opens different political channels for influencing policy-making.

There are specialized migrant health clinics within the public health care system in several regions. In addition, there are four treatment centres and several private clinics specializing in the treatment of torture survivors within the public health care system, some of which actually only treat war veterans. In southern Denmark, hospitals have 'ethnic minority patient coordinators' and trained migrant hospital teams. However, according to Sodemann, there are still huge variations in both length and follow-up of the treatment in the centres.

3. 3. Germany

In 2016 Germany ranked among the main host countries for refugees worldwide[26] and remains the main receiving country for asylum seekers in Europe.[27] The number of asylum applications peaked in 2016 and significantly dropped in the following year – from 745,000 in 2016 to 222,000 in 2017.[28] Most asylum seekers come from Syria, followed by Iraq, Afghanistan, Eritrea, Iran and Turkey.

With the exception of unaccompanied minors, there is no procedure in place to systematically identify vulnerable persons in the asylum procedure. Asylum applicants have to undergo basic medical examination shortly after registration to screen for communicable diseases. However, this examination does not include a screening for potential vulnerabilities. Projects for identifying and supporting vulnerable groups have received funds from the Asylum, Migration and Integration Fund and pilot schemes to identify vulnerable persons have been introduced in some states.[29]

Access to health care

Healthcare for refugees is regulated by the Asylum Seekers Benefits Act (AsylbLG). The type of care provided depends on the legal status of a person and for how long he or she has continuously stayed in Germany. The provision of health care to asylum seekers who have stayed in Germany for less than 15 months and persons without legal residence status is restricted to medical

26 UNHCR (2017): Global Trends. Forced Displacement in 2016.

27 BAMF (2018): Asylgeschäftsbericht für den Monat April 2018.

28 BAMF (2018): Aktuelle Zahlen zu Asyl. Ausgabe: April 2018.

29 Asylum Information Database (2016): Country Report: Germany.

care in case of acute illness and persistent pain.[30] This includes the provision of medicines and bandages and other benefits necessary for recovery. In addition, all services for pregnancy and childbirth as well as recommended vaccinations are provided. Further benefits indispensable to secure an individual's health, such as glasses, can also be claimed under AsylbLG.[31]

The provision of services differs across the states in Germany. While some states issue electronic health cards to asylum seekers which enable them to see a doctor without permission from the authorities, most require asylum seekers in need of treatment to apply personally for a medical voucher at the social welfare office.[32] Depending on the municipality, either a general healthcare voucher is issued every three months which can be used repeatedly during this period, or the voucher has to be reviewed and reissued by the welfare office with each treatment required. The need for treatment is assessed by health staff in the reception centres and later by administrative staff of the welfare offices. Cases have been reported where necessary medical assistance was delayed or even denied, due to the lack of medical expertise of the case workers. In addition, since the benefits provided are not defined by AsylbLG, they have been subject of repeated controversy. Frequently this has resulted in refusal of benefits by the social welfare authorities during needs assessment.[33]

As all public bodies with the exception of hospitals have the duty to report people without legal residence status to the immigration office[34], health services remain inaccessible for undocumented migrants. Necessary basic treatment can only be accessed in special open-access surgeries. These volunteer-based and donation-funded services provide basic health care for undocumented migrants free of charge. In case of medical emergency, treatment can be claimed without the need for a health voucher. Both health as well as administrative personnel at the hospitals are bound by patient confidentiality.[35]

After 15 months of the asylum procedure, asylum seekers are entitled to health care under the same conditions that apply to German citizens who receive social benefits. The cost of treatment is covered by the social welfare office and settled via electronic health insurance cards. However, Anna Stammnitz, social counsellor and project coordinator of the mentoring program at XENION, says that even though accessibility improves after 15 months, it is still not fully granted: "When refugees receive their residence permit, they enter the health insurance system and it should make everything easier. But in practice we can see that it is very hard, because of the very different ways of financing of treatment for refugees, especially psychotherapy and interpreters."

Psychosocial Care Centres in Germany

To date, specialized services for the complex needs of refugees are scarce in public health system and frequently accessibility is inhibited by structural as well as language barriers. In the past 40 years, a strong network of civil society organizations has developed specializing in psychosocial care of traumatized refugees and victims of torture. There are currently 37 specialized centres organized under one umbrella organization, the German Association of Psychosocial Centres for Refugees and Victims of Torture (BAfF e.V.). The centres offer a complex range of services based on the needs of the clients. The range of services include diagnostics, psychosocial counselling, crisis intervention as well as legal and social counselling.

Anna Stammnitz says "as the German health care system is not shaped and willing to open for the needs of refugees and victims of torture, we have filled the gap in navigating and providing legal

Anna Stammnitz is social worker at Xenion – a psychosocial treatment centre for politically persecuted in Berlin. *(© BAfF e.V.)*

30 Section 4 Asylum Seekers' Benefits Act

31 Section 6 Asylum Seekers' Benefits Act

32 BAfF e.V. (2016): Versorgungsbericht – Zur psychosozialen Versorgung von Flüchtlingen und Folteropfern in Deutschland. 3. aktualisierte Auflage. Bundesweite Arbeitsgemeinschaft der psychosozialen Zentren für Flüchtlinge und Folteropfer.

33 Ibid.

34 § 87, German Residence Act

35 BAG Gesundheit und Illegalität (2017): Gesundheitsversorgung für Menschen ohne Papiere. Aktuelle Herausforderungen und Lösungsansätze.

Dorothee Bruch is social worker at Xenion - a psychosocial treatment centre for politically persecuted in Berlin. *(© Emilian Savescu)*

counselling, psychiatric, psychological and social support". However, since the number of places in the treatment centres is limited, access to therapy is not always guaranteed. The centres treat about 14,000 people per year, varying from 100 up to 1,900 clients per centre each year.[36] Stammnitz explains that "the demand for treatment and support for refugees and victims of torture is definitely much higher than what the centres can cover. There are long waiting lists in all of the centres."

The process of claiming payment for psychotherapy from the social authorities under AsylbLG is usually arduous and lengthy while the prospect of approval is poor. In many places applications for therapy are declined categorically, some centres have not once had a successful application. A recent report by BAfF e.V. shows that the rejection rate has more than doubled in the past two years. Hence fewer than half the treatment centres even try to claim reimbursement of costs for psychotherapy which are therefore commonly covered through donations or other funds. As large distances between asylum seekers' places of residence and treatment centres inhibit the utilization of the services, some treatment centres claim payment of travel costs instead. However, reimbursement of travel costs is not guaranteed and applications are declined in about half of the cases.

The presence of an interpreter in the therapy setting is essential in many cases, nonetheless, the health care system is "still not willing – and we have been fighting for more than twenty years – to pay translators and interpreters," comments Dorothee Bruch, social worker and legal adviser at the psychotherapeutic treatment centre XENION. As a result, the use of interpreting services in psychosocial care is not common in Germany.[37] If welfare authorities approve the reimbursement of psychotherapy for asylum seekers who receive benefits under AsylbLG in the first 15 months, often costs for interpreting services are reimbursed as well. Once covered by statutory health insurance after 15 months, refugees are no longer eligible for interpreting services – the rejection rate is 100 percent.[38]

Non-governmental specialized psychosocial care and rehabilitation centres for this population are indispensable to fill the gaps of the public health services in Germany. Even though the federal government has increased the financial support to the centres in recent years, most of the centres still lack a stable and sufficient funding base to guarantee appropriate and sustainable rehabilitation care for vulnerable refugees and torture victims.

36 BAfF e.V. (2016): Versorgungsbericht – Zur psychosozialen Versorgung von Flüchtlingen und Folteropfern in Deutschland.

37 Kluge et al. (2012). Health services and the treatment of immigrants: Data on service use, interpreting services and immigrant staff members in services across Europe, European Psychiatry, 27(2), p. 61.

38 BAfF e.V. (2016). Versorgungsbericht – Zur psychosozialen Versorgung von Flüchtlingen und Folteropfern in Deutschland.

3. 4. Poland

In 2017, 5,053 asylum applications were lodged in Poland with a rejection rate of 81 percent. The vast majority of asylum applicants come from Russia's North Caucasus republic Chechnya, Ukraine, Tajikistan and Armenia. While the rejection rate for applicants from Post-Soviet states amounts to 98 percent, the rejection rate for applicants from the Middle East is significantly lower. However, even though only 3 percent of applications from Syria and 16 percent of applications from Iraq were rejected, only 44 and 40 applications were submitted from the two countries respectively.[39]

Reports from numerous national and international NGOs point to the systematic violation of the procedure of accepting asylum applications by Polish border guards. Few refugees get the chance to submit their claim for asylum; the vast majority of asylum requests is ignored and the applicants are forcibly pushed back to Belarus on the grounds that they have no visa.[40] The number of persons arriving at the border without an entry permit vastly exceeds the number of asylum applications which are processed. For example, at the Terespol border crossing 8,250 refugees claimed asylum in 2015, while 24,980 applications were rejected due to the lack of travel documents.[41]

Early identification and detention of vulnerable persons

According to the law on granting protection to foreigners, the Office for Foreigners is obliged to identify vulnerable asylum seekers.[42] However, problems with the identification of vulnerable persons have been reported both during the asylum procedure and during detention. In general, assessments are conducted, but have been criticized as ineffective as well as inconsistent with Polish law and international standards.[43] The Office for Foreigners reports that identification of vulnerable persons takes place during regular psychological counselling at the reception centres. However, in reality, identification is usually carried out at the border when the asylum claim is submitted.[44] In addition to self-identification questions regarding medical conditions, disability and pregnancy in the asylum application forms, border guards assess whether an applicant may be a victim of trafficking or a person subject to torture.

Maria Książak is a psychologist and a founder of the International Humanitarian Initiative Foundation (IHIF) as well as coordinator of the Polish Centre for Torture Survivors. She and other IHIF psychologists sometimes accompany traumatised asylum seekers during asylum applications or asylum interviews. She describes both the set-

39 Helsinki Foundation for Human Rights (2018): Country Report: Poland. 2017 update – February 2018.

40 Human Rights Watch (2017): Poland: Asylum Seekers Blocked at Border; Helsinki Foundation for Human Rights (2016): A road to nowhere.

41 Association for Legal Intervention (2016): At the Border. Analysis, Reports, Evaluations No.2/2016.

42 Art. 68.1 of the Law on granting protection to foreigners, as amended in November 2015.

43 Commissioner for Human Rights (2017): Report of the Polish Commissioner for Human Rights on the Activities of the National Mechanism for the Prevention of Torture in 2016.

44 Helsinki Foundation for Human Rights (2018): Country Report: Poland. 2017 update – February 2018.

ting of the asylum application initial interview and the questions asked by border guards as intimidating and says that "it is not surprising that persons who have been subject to torture will not speak about the experience of torture when questioned this way. Their privacy is not respected and they are expected to speak in crowded rooms with people going in and out about the violence, sexual violence or torture they experienced. However, if they should later during following interview report something more on torture or violence experienced or say something in a different way, they are identified as liars and not as torture survivors." She says "Poland has never respected the right of rehabilitation for victims of torture. Torture has never been properly defined as a crime in criminal law in Poland, neither identified as such. As of today care for torture survivors is stopped right at the first level, which is the lack of their identification."

IHIF is involved in the early identification of torture survivors and provides the government with documents and photographs of bodies which have suffered torture. Nevertheless, according to Książak these persons are frequently detained or deported to their country of origin where they had been tortured. The victims of torture who apply for asylum in Poland are in consequence frequently detained or deported to their country of origin where they had been tortured. Even if they have photographs of their tortured bodies that is not enough for their non-refoulement from Poland. Książak explains "in Poland recently even the role of the psychologist in torture assessment is questioned as supposedly this can only be done only by some official, which is a belief contrary to Istanbul Protocol or other international manuals."

Maria Książak is the founder of the International Humanitarian Initiative Foundation (IHIF) and coordinator of the Polish Centre for Torture Survivors.
(© Emilian Savescu)

Polish law prohibits the detention of victims of violence.[45] However, the frequent placement of victims of torture and violence in closed centres indicates that the mechanism for identifying vulnerable persons is ineffective. Upon admission, detainees are not asked about medical documentation they may have obtained previously in another EU country and there is no system in place to identify vulnerable persons to ensure their immediate treatment. Detainees have access to regular health care by law and medical staff is present in all centres. A report by the Polish Commissioner for Human Rights[46] asserts, ironically, that psychologists working in detention centres are generally not trained in the identification of torture victims and, despite exceedingly limited working hours, providing care to them is only one of their numerous tasks. Moreover, psychological evaluation may not be initiated by the applicant themselves and may only be provided at the written request of the doctor examining the applicant.

Access to health care

Under Polish law, Polish citizens and foreigners are guaranteed the right to health care.[47] Recognized refugees and beneficiaries of subsidiary protection may join the health insurance system, which entitles them to the same services as Poles. Healthcare granted to asylum seekers is equal in scope, but is offered only by service providers contracted by the Office for Foreigners. Basic health care and diagnostics are provided in reception centres and is commonly restricted to emergency care. The ratio of asylum seekers to nurses and doctors at the reception centres is such that capacities of medical personnel is highly limited.[48] If treatment is required that cannot be provided by the medical office in the reception centres, asylum seekers may be transferred to medical specialists outside the centres. As care providers must be contracted by the Office for Foreigners, asylum seekers cannot be referred to the closest medical unit since contracted providers may be situated far away from the reception centres.

Despite the right to equal access, numerous factors impede accessibility of services for refugees. Language, particularly in the case of Arabic or

45 Article 406(1)(2) Law on Foreigners.

46 Commissioner for Human Rights (2017): Report of the Polish Commissioner for Human Rights on the Activities of the National Mechanism for the Prevention of Torture in 2016.

47 Article 68. of the Constitution of the Republic of Poland of 1997.

48 Helsinki Foundation for Human Rights (2018): Country Report: Poland. 2017 update – February 2018.

French speaking refugees, is one of the major factors inhibiting accessibility of services. If refugees do not speak Polish, services can usually only be provided in English or Russian. Costs for interpretation are not reimbursed by Polish authorities. Alongside language, the lack of inter-cultural competence among health staff has been pointed out by experts, resulting from a general scarcity of courses on inter-cultural diagnostics and communication.[49]

In theory, health care for asylum seekers includes specialized treatment for persons suffering from mental health problems. At least one psychologist is employed at each reception centre, offering basic consultations and, if considered necessary, asylum seekers can be referred to a psychiatric hospital. The scope of this assistance and the number of contracted psychologists have been criticized as insufficient to ensure proper treatment in practice. Neither is regular therapy offered, nor do asylum seekers have a choice of psychologist.[50] In addition to the mental health services provided by the state, at present there are only three specialized NGOs that provide psychosocial care for asylum seekers. The operational capacity of the organizations, which are only project-funded, is highly restricted and not sufficient to fill the gaps in the system. Both open camps and detention centres are spread across the country and are often situated outside of cities. Maria Książak emphasizes that NGOs providing medical or psychological care and legal counselling are usually located far away from asylum seekers closed in detention centres, "so most have no access to their assistance."

3. 5. Turkey

According to the periodic report of the UN Committee against Torture[51], there are many and serious human rights violations in Turkey. To understand torture and ill-treatment in its historical context, Turkey's recent past is highly relevant. In the 1980s and 1990s, Turkish security forces evacuated more than 378,000 Kurds and destroyed more than 3,000 villages in the context of counter-terrorism operations in the south-eastern part of the country. During this period, forced displacement, enforced disappearances, ill-treatment of detainees, sudden deaths in custody and extra-judicial killings were frequent.[52] In addition to violent acts carried out by state officials, Turkey has also a strong record of gender-based violence such as domestic violence against women and 'honour killings' within families. The Gezi Park protests in 2013 emerged from a fundamental and wide opposition to authoritarian and repressive policies as well as to the breach of the rule

49 Legal dialogue (2017): Right to healthcare and access to medical services for asylum seekers and beneficiaries of international protection.

50 Helsinki Foundation for Human Rights (2018): Country Report: Poland. 2017 update – February 2018.

51 UN Committee Against Torture (CAT), CAT/C/TUR/CO/4, General, 2 June (2016): Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Concluding observations on the fourth periodic reports of Turkey.

52 Helsinki Federation of Human Rights (2006). Turkey A Minority Police of Systematic Negation. Forced Displacement, p.22.

The panel discussion on "Competing challenges in times of crisis: Re-habilitation for refugees and survivors of torture in Europe". *(© Emilian Savescu)*

of law[53]. There was excessive use of force against demonstrators during the Gezi Park protests, but, even after the protests were over, abuse of human right defenders, journalists and medical doctors who provide assistance to victims of torture continued. The Human Rights Foundation of Turkey (HRFT) describes in a report how ill-treatment and torture became widespread.[54]

In 2016, Turkey imposed a State of Emergency as a response to an attempted coup, which in turn resulted in an atmosphere of conflict, permanent curfews, forced displacement and arbitrary police violence which is still ongoing. The climate of political chaos and insecurity has been fuelled by a series of terrorist bomb attacks which cost civilian lives and further fuelled fear, hatred and dissolution in society. Freedom of expression and demonstration have been limited by law and in practice, and strong media censorship has been effectively imposed through the arrest of journalists, huge fines on newspapers and forced closure of media outlets. Censorship extends beyond traditional media to include internet and social media platforms.[55] In addition, the arbitrary interpretation of existing and new laws has restricted the practice of academics and other intellectuals.[56] Health professionals, volunteers and civilians who expressed their support for victims of torture became a target, demonstrating that the space for expressions of solidarity is steadily shrinking. Curfews linked to security operations have made it difficult for people to access health services and buy food – indeed, health professionals who provided first aid during curfews linked with security operations have been killed, among them members of the HRFT, including one of its founders, Tahir Elci.

Recent developments in the Middle East

The recent developments in the Middle East and their influence on Turkey's south-eastern border have fuelled an environment of social fear and chaos. Oppressive security policies have been used as a strategy in the name of achieving social peace and welfare. Turkey has a long history of widespread and systematic torture, which, after initial improvements, has been intensified under the rule of the Justice and Development Party (AKP) to silence opposition voices. The record of severe human right violations is a long and painful one for Turkish society, but especially for the Kurdish communities. Following the coup of 15 July 2016 a State of Emergency was declared under which alleged opposition figures have been investigated, prosecuted and dismissed from public service, leading to a climate of fear and self-censorship in private and professional spheres.[57]

Like Lebanon and Jordan, Turkey has demonstrated remarkable resilience in absorbing huge numbers of Syrians over the past six years, in Turkey's case more than 3.5 million. Whilst incoming migrants from war zones have played into the country's complex demographics and

53 Sibel Atasayi (2013). #DirenGeziParki – Eine Stadt im Widerstand, Stadtentwicklung: Zündstoff für Proteste, adhoc international (2013, 6).

54 For further information: Uçar, Korkmaz, Dilbirliği & Efe (2015). Human Rights Foundation of Turkey, Treatment and Rehabilitation Centres Report 2015, Human Rights Foundation of Turkey Publications 108.

55 Yaman Akdeniz and Kerem Altiparmak (2016). Turkey: Freedom of Expression in Jeopardy. Violations of the rights of authors, publishers and academics under the state of emergency. English Pen. Violations against Publishers and Writers, p. 21.

56 Supra note 54; Violations against academics, p.39.

57 Supra note 54; Violations against academics, p.39.

political polarization[58], Turkey still hosts the world's largest number of refugees for the third consecutive year according to UNHCR (2017)[59]. By far the largest number of refugees comes from Syria (2,880,325), with smaller numbers coming from Iraq (131,440), Afghanistan (120,529), Iran (31,848) and other countries such as Somalia (some 3,526).[60] In a country that is already struggling with socio-economic strains and political tensions along ethnic, sectarian or ideological lines, reports of host community hostility towards newcomers are not uncommon.[61] One of the main challenges for social integration is that accommodation in camps is guaranteed for only 9% of migrants and refugees. The remaining 91% live in urban and semi-urban areas under precarious conditions.[62] Almost 70% of the refugees are women and children, raising concerns given the shortages in housing, nutrition, hygiene and education. The provision of basic needs to refugees living in urban areas, many of them living on the streets, resembles emergency conditions, with UNHCR having to distribute hygiene articles, blankets and heaters.

At the European level the relocation and resettlement of refugees from Turkey has scarcely taken place due to lack of solidarity and commitment to responsibility-sharing among EU member states. In 2016, the EU prioritized bilateral agreements with countries such as Turkey to further push its policy of externalizing EU borders. This controversial agreement is a clear breach of the right to asylum and has driven thousands of refugees and migrants to risk their lives on even more dangerous and sometimes fatal journeys. Unsurprisingly, trafficking networks have not been dismantled and irregular crossings in the Aegean sea have not diminished. Under the agreement Turkey agreed to take back Syrian or other nationals from Greece regardless of their asylum status. In exchange the EU would resettle the same number of Syrians from Turkey who met asylum qualifications – the so-called '1 for 1' formula – although this agreement is not working in practice.

In April 2014, the first Turkish asylum law set the main pillar of the national asylum system: the Law on Foreigners and International Protection which provides refugees and migrants with temporary protection and basic services including medical care and education.[63] Nevertheless, there are numerous cases reported of expulsion, deportation and violation of the non-refoulement principle of hundreds of Syrian and Afghan asylum seekers who have been returned to their countries of origin, effectively to war zones. According to the United Nations, 247,000 Syrians were forced back across the border between December 15 in 2017 and January 15 in 2018.[64] Turkey is obliged to help those who seek refuge and protection at its borders and the fact that Turkish borders are now closed to all but critical medical cases violates the right to asylum.

Access to health care

Refugees in Turkey are confronted with several hurdles before they can access health care services, such as language barriers and shortages of clinics and ambulances in remote and rural areas. The state health system is overstretched and unable to deliver health services appropriately. In emergencies, individuals are sent to a mobile clinic and/or to one of the 40 out-patient departments which are directly linked to the Ministry of Health. The training of staff members at the Ministry of Health on international protection and health care services for refugees remains a challenge for NGOs and IOs.

Given the ongoing systematised human right violations currently and historically in Turkey, the establishment of rehabilitation and psychosocial services for victims of torture in Turkey dates

Levent Abbasoğlu is a psychologist at the Foundation for Society and Legal Studies in Turkey (TOHAV), which has many psychosocial treatment centres throughout the country. ***(© Emilian Savescu)***

58 International Crisis Group (2016). Turkey's Refugee Crisis: The Politics of Permanence, Europe Report N°241,

59 UNHCR Turkey (2017). Factsheet, January 2017. https://data2.unhcr.org/en/documents/download/53946

60 Supra note 58.

61 International Crisis Group (2018). Turkey's Syrian Refugees: Defusing Metropolitan Tensions, Europe Report N°248, available at: https://www.crisisgroup.org/europe-central-asia/western-europemediterranean/turkey/turkey-s-refugee-crisis-politics-permanence.

62 Supra note 58.

63 http://www.goc.gov.tr/files/files/eng_minikanun_5_son.pdf

64 https://www.hrw.org/news/2018/02/03/turkey/syria-border-guards-shoot-block-fleeing-syrians

back to 1990 when the HRFT was established, with the aim of providing physical and psychological treatment and rehabilitation services to individuals subjected to torture and other cruel, inhuman, or degrading treatment and punishment as well as to document human rights violations. There is no provision under domestic law for the rehabilitation of victims of torture and other forms of ill-treatment. In its four treatment and rehabilitation centres located in Ankara, Diyarbakir, Istanbul and Izmir, HRFT provides multidisciplinary services to refugees and survivors of torture. In Turkey, the rehabilitation centres closely work with local bar associations across the country to document torture and fight impunity for victims of torture which is summarized under its documentation centre.[65]

The rehabilitation centre in Suruc (a city 100km away from the Syrian-Kurdish city of Kobane) was opened in April 2017 to address the great need for psychosocial support in the south-eastern regions of Turkey[66]. This centre provides psychosocial support, medical and psychotherapeutic treatment to more than 1000 refugees and migrants, most of them women and children.

Many NGOs such as HRFT are subject to punitive indirect action from the government. For example, supporters of the anti-government Gezi Protests in 2013 were obliged to pay huge fines by the Social Security Authority.[67] During the conference in Bucharest, Levent Abbasoğlu, a health professional from the Foundation for Society and Legal Studies (TOHAV), stated that their continuing struggle to prevent torture, provide treatment and rehabilitation services for survivors of torture and refugees as well as to ensure the legal accountability of perpetrators – all these will remain goals for civil society actors in Turkey, for which they will need solidarity, advocacy and visibility on the part of the international community.

3. 6. Spain

There is a steady rise in the number of people who lose their lives while trying to cross the Moroccan-Spanish border. In addition, according to the UNHCR[68], Spain lacks the resources and capacity to protect the rising number of refugees and migrants reaching it by sea. Since it is still impossible to come by safe and legal avenues, many refugees are forced to risk their lives crossing the Mediterranean in fragile vessels. The United Nations High Commissioner for Refugees, Filippo Grandi, has said that the Spanish government needs to ensure more and new legal pathways of entry to Spain as well as increasing resettlement programs.[69]

65 For further information: http://en.tihv.org.tr/dokumantasyon-merkezi-index/

66 http://www.tohav.org/multeci-danisma-merkezi-e-bulten-sayi-4

67 For detailed information, see also: https://tihv.org.tr/turkiye-insan-haklari-vakfinin-iskence-gorenlerin-tedavi-sureclerine-iliskin-calismalarinin-engellenmesine-yonelik-basin-aciklamasi/

68 https://www.theguardian.com/world/2017/aug/17/spain-refugees-migrants-unhcr-warning

69 http://www.unhcr.org/afr/admin/hcspeeches/594163424/statement-madrid-conference-refugee-reception-integration.html – June 2017.

Illegal push-backs or forced returns at EU borders represent a flagrant violation of fundamental human rights and refugee laws. In the Spanish enclaves of Ceuta and Melilla on the northern coast of Africa, refugees and migrants are repeatedly subjected to brutal violence from border guards. Anyone attempting to enter these Spanish cities – and therefore reach EU territory – are immediately deported to Morocco without any examination of their right to asylum. During this process, injuries and even deaths are common. Stripped of their rights, it is almost impossible for victims to take advantage of any form of legal redress. According to reports of ECCHR, even children and minors are not safe from Spain's unlawful push-backs.[70] They are simply handed over to Moroccan border guards along with the adults in the group, and there is no due process and no regard to their special need for protection as minors.

These illegal push-backs – so called "hot returns" – are obstacles to the right of asylum and represent an illegal practice. José Hormigo Ramos, a lawyer of a Madrid-based psychosocial centre for refugees SiR[a] explains, "if someone is caught between the different walls, the Spanish police can simply give back to the Moroccan police the people who have been brave enough, strong enough and lucky enough to cross the wall. So these hot returns for sure are a violation of human rights and international protection, because they are not even able to reach the centre to apply for international protection."

In October 2017, the European Court of Human Rights ruled that the long-standing practice of the push-back of migrants at the external borders of the European Union (EU) with Morocco is unlawful. To be more concrete, it is a violation of Article 4 Protocol 4 (prohibition of collective expulsions) and Article 13 (right to an effective remedy) of the European Convention on Human Rights.[71]

Current services for refugees and torture survivors

According to figures from Eurostat, Spain received a total of 15,570 first time asylum applicants in 2016, which barely accounts for 4.7% of the total registrations in the European Union.[72]

The 14th annual report[73] of the Spanish Commission for Refugee Aid (CEAR in Spanish) reports that the government only granted refugee status to 220 people and subsidiary protection to 800, while denying any kind of protection to 68.5% of applicants. Spain has taken in only 105 of the 9,323 people it agreed to receive via the relocation planned in the agreements of June and September 2015. The report states that most refugees come from Syria (5,724) and Ukraine (3,420) and that Melilla received the largest number of first-time applications (6,368, equalling almost 42.8% of the total amount). The Spanish government has faced continuous pressure from its own citizens to take in more asylum seekers[74], as many families have offered to receive refugees in their homes and cities such as Madrid or Valencia have allocated millions of Euros to help refugees. In 2017, the number of first-time applications rose to 30,445 in Spain which is a rose of 96% compared to the previous year in 2016.[75] The majority of the applications were from Venezuela (34%), Syria (14%) and Colombia (8%).

Once migrants are on Spanish territory, they face many obstacles in applying for asylum. The official description of the Refugee Reception Program states that all basic needs of migrants are covered by professional social, health, psychological, labour and legal assistance for the first 6 to 9 months with migrants receiving independent homes in a 6-11 months period.[76] However, this is far from reality.[77]

José Hormigo Ramos is a lawyer at SiR[a], a psychosocial treatment centre in Madrid. ***(© Emilian Savescu)***

70 https://www.ecchr.eu/en/case/no-rights-for-unaccompanied-minors-at-the-spanish-moroccan-border/

71 https://www.ecchr.eu/fileadmin/Pressemitteilungen_englisch/PR_Melilla_ECtHR_ECCHR_20171003.pdf – October 2017.

72 Eurostat newsrelease (2018). Asylum in the EU Member States. 47/2018.

73 https://www.cear.es/wp-content/uploads/2013/05/Executive-Summary-2016-Report-CEAR.pdf

74 https://www.thelocal.es/20150909/citizens-pressure-spanish-government-to-act-on-refugees

75 Supra note 82.

76 http://www.asylumineurope.org/reports/country/spain/conditions-reception-facilities; https://www.resettlement.eu/resource/80-refugees-resettled-spain-under-new-asylum-law

77 See report by Human Rights Watch https://www.hrw.org/news/2017/07/31/spain-migrants-held-poor-conditions – July 2017.

The presentation of various health professionals from psychosocial treatment centres for torture survivors, refugees and asylum seekers across Europe: Spain, Germany, Poland, Denmark and Turkey.
(© Emilian Savescu)

It has been made almost impossible for civil society organisations to enter the so called refugee reception centres to judge living conditions, needs and facilities. Migrants are held for days in "dark, cage-like cells" in police stations and almost certainly will then automatically be placed in longer-term immigration detention facilities pending deportation that may never happen[78]. According to government sources[79], there is a range of collective centres under the authority of the Spanish Ministry of Labour and Social Security which provide refugees with accommodation such as the Refugee Reception Centres (Centros de acogida de refugiados, CAR) and the Migrant Temporary Stay Centres (Centros de estancia temporal para inmigrantes, CETI)[80]. The social integration program for migrants and resettled refugees should be developed and implemented in the municipalities of the autonomous regions in which the Refugee Reception Centres are placed. However, reports by NGOs portray another reality[81]; José Hormigo Ramos describes these so-called reception centres for migrants and asylum seekers as "under-total-custody systems which are the only kind of administrative arrest possible in the Spanish system" and they exist "only for undocumented people who have come into Spanish territory". Human rights organizations such as Amnesty International address the Spanish government of its duty to guarantee adequate reception conditions for asylum-seekers, as they fail to meet the European reception directive.[82]

In summary, incoming migrants still face multiple obstacles to accessing their right to asylum for which information and legal aid is crucial. Being held in Detention Centres for Foreigners (*Jueces de Control de Estancia,* CIE), this becomes even more important as their access largely depends on the centre in which they are detained. Only CIEs in Madrid, Barcelona and Valencia provide legal aid as part of their service, and in these centres the number of application for asylum has risen in recent years.[83] There is also a shortage of health and social service provision, which is extremely poor for asylum seekers and most vulnerable immigrant communities.[84] According to Medicos del Mundo, 75.5% of all migrants residing in Spain face severe obstacles in accessing health care and social services due to administrative problems like registration (22.8%), lack of knowledge and access to information on asylum and health care system (21.7%) and language barriers (15%).[85]

Experts are advocating urgent improvements in the management of asylum, international protection and refugee settlement policies, which is the exclusive competence of the State (Article 13.4 of the Spanish Constitution). Otherwise they claim that 70% of applicants for international protection will fail to enter the system and that Spain will continue to disregard its commitment to the EU by refusing to receive refugees from camps in Italy and Greece.[86]

78 https://www.hrw.org/news/2017/07/31/spain-migrants-held-poor-conditions

79 Aida Asylum Information Database: http://www.asylumineurope.org/reports/country/spain/short-overview-asylum-procedure

80 Aida Asylum Information Database: http://www.asylumineurope.org/reports/country/spain/types-accommodation

81 For further information: https://www.defensordelpueblo.es/wp-content/uploads/2016/07/Asilo_en_Espa%C3%B1a_2016.pdf

82 Amnesty International (2005). Spain – the Southern Border. The state turns its back on the human rights of refugees and migrants.

83 https://www.cear.es/wp-content/uploads/2013/05/Executive-Summary-2016-Report-CEAR.pdf

84 Pablo Bris and Felix Bendito (2017). Lessons Learned from the Failed Spanish Refugee System: For the Recovery of Sustainable Public Policies. Sustainability (9), 1446.

85 https://www.medicosdelmundo.org/que-hacemos/espana/inmigracion

86 Supra note 79.

4. Diverse perspectives: Addressing the needs of refugees and torture survivors

Over the last three decades, a number of perennial obstacles to ensuring that torture survivors, whether asylum seekers, refugees or nationals, receive adequate and specialist rehabilitation, has led to differing perspectives. These divergent approaches, on the face of it, share one common goal – to support those most in need. However, the country contexts as well as national policies vary and the perspectives of health professionals are diverse in their emphasis and engagement with the political, human rights and humanitarian goals. The following explicates some of these perspectives and the implications.

4. 1. Public health as a strategy for addressing the needs of refugee torture survivors

In Europe, for decades, torture survivors have come to the attention of health and other professionals, including torture survivors who are nationals or seeking asylum, safety and sanctuary from persecution and further harm. For decades, public health and social care services have neglected torture survivors, blind or intentionally ignoring their particular needs as well as the ob-

ligation to ensure appropriate services for them. Not surprisingly, non-governmental organisations sprung up across Europe, offering various forms of rehabilitation and with different approaches. These services have struggled against the changing and often increasingly harsh political and economic climate, often grasping at survival as funding has become increasingly scarce.

A number of questions have resurfaced in the field, from time to time, but with increasing urgency. For example:

- Should States take responsibility for fully funding or partly funding rehabilitation services for refugee torture survivors?
- Should rehabilitation services be integrated into public health and social care services?
- To what extent can capacity building of colleagues within public services ensure that survivors receive the appropriate and necessary rehabilitative care?
- Should non-governmental service providers work together, within or alongside public health and social care services – and how?

Inevitably, responses to each of these questions carry risks – as well as raising further questions, such as how can we ensure that public health services can provide quality, specialist and sustainable services for torture survivors? How can survivors be assured of safety and protection against further harm? How can survivors access State services when they may have no funds or recourse to public funds?

To better understand some of the arguments put forward to address these questions, it is important to understand what a public health approach actually means and what it would entail, if applied to the rehabilitation of torture survivors.

What is a public health approach?

The key premises of public health include:

- **Taking collective responsibility** for health protection and health prevention.
- **Addressing the wider determinants** and associate economic determinants of health concerns
- **Ensuring an effective partnership model** with all those providing health or health care within State boundaries.
- **State responsibility:** asking 'what is the State going to do to help ensure the protection and prevention of health concerns?'

What are the benefits of taking a public health approach to ensuring the needs of torture survivors are met?

There are a number of benefits of pursuing an public health approach for torture survivors. For example:

- Torture survivors and their needs would be seen as a public health responsibility and a priority
- States may then ensure protected budget lines for specialist care for the health needs of torture survivors
- Specialist medical and other healthcare and facilities can be made available to torture survivors
- Funding for specialist services does not fall solely to non-governmental organisations
- Services (State-run and NGOs) can be better coordinated with appropriate protocols and agreements for cooperation.

What are the risks and disadvantages of taking a public health approach to ensuring the needs of torture survivors are met?

There are also a number of risks and disadvantages of pursuing a public health approach to address the needs of torture survivors:

- The human rights obligation for torture survivors to receive specialist, holistic and multidisciplinary rehabilitation, as a form of reparation, is obscured
- A reductive and narrow approach to rehabilitation is adopted, which focuses only on health needs, thereby neglecting the full range of needs and the social, welfare, security, interpersonal, educational, legal, vocational support service needs which together constitute 'rehabilitation'
- Rehabilitation for torture survivors is seen as no different to providing adequate healthcare to everyone (under the right to health) and that this can be subject to progressive realisation – for States to address within their means, over time, rather than immediately or promptly, as required under the right to rehabilitation for torture survivors
- Specialist knowledge, skills and services for torture survivors within NGOs are neglected, or at worst, eradicated.

Could there be a both/and position adopted?

The broad consensus within the field currently is that to neglect a public health perspective is to be negligent towards survivors, who in time may have no access to services if existing services, predominantly offered by NGOs, diminish in numbers and size as funding sources steadily shrink. Yet, the risks to adopting a public health approach are also significant and need to be addressed.

It may be possible to adopt a both/and position whereby there is a two-pronged strategy which engages the State as well as ensures that specialist, multidisciplinary NGO services continue to complement and work alongside State services.

Adopting a two-pronged approach would require:

- States to take responsibility to provide health services for torture survivors as a form of health protection and prevention of the deterioration of complex health concerns of survivors
- States to commit to addressing the wider determinants of health concerns of torture survivors- which would include the health impacts of the absence or lack of adequate housing, welfare, food and safety for survivors; the health impacts of stigma, marginalisation, social exclusion and discrimination; the health impacts of economic and sexual exploitation and physical or sexual harm to which survivors may be subjected to within Europe
- States to engage in effective partnerships with NGOs, other governmental departments (social care, welfare, justice, education etc.) and other agencies to ensure comprehensive and appropriate healthcare and other services for survivors
- NGO service providers to continue to raise awareness and build capacity within public, State services to ensure the complex needs and rights of torture survivors are properly understood
- State and NGO service providers to together engage in prevention strategies to minimise and to address the health needs of torture survivors, including public awareness-raising; and highlight to the government and service providers the negative health impacts of neglecting other rehabilitation needs of torture survivors.

How can survivors of torture access State services when they may have no funds or recourse to public funds has been a key question of the conference. *(TeroVesalainen, CC0 | pixabay.com)*

4. 2. International development and mental health and psychosocial support

One pertinent and controversial question is to what extent can (or should) European countries help address the needs of refugees and displaced persons before they may seek refuge in Europe. The humanitarian agenda underpinning international development is important to emphasize, though this can never be disentangled from the political complexities influencing government policies on international development.

One example of an extensive and innovative international development programme to support those who are forcibly displaced is the work of the German Federal Ministry of Economic Cooperation and Development.

The following summarises the keynote presentation by Marianna Knirsch, the senior planning officer responsible for forced displacement at the ministry, at the conference of the European Network of Rehabilitation Centres for Survivors of Torture in Bucharest, 2017.

Marianna Knirsch: Keynote on 'International development and mental health and psychosocial support'

- Government development assistance does not deal with the refugees who make it to Europe, but it has a role in trying to help those displaced who flee either to safer locations inside their own countries or across borders to neighbouring countries.
- German Development Cooperation – in particular, its transitional development assistance (TDA) – has long been supporting and working with refugees, IDPs and host communities in developing countries. Given the increasing numbers of forcibly displaced people worldwide, the ministry has been steadily increasing the funds spent in this area. Their focus is on both the victims of forced displacement as well as the host communities that receive them. They strive to work with both groups in order to facilitate social cohesion and integration.
- The focus is on three core issues:
  - Providing support for the victims of forced displacement and the communities which host them in basic services like health or education, through income generation such as large cash-for-work initiatives providing short-term jobs, through help with the reconstruction of infrastructure and investment in education and professional training.
  - Providing support for those who would like to return to their country of origin when violent conflict has ceased, by promoting job opportunities, rebuilding physical infrastructure and livelihoods as well as supporting social cohesion and peace-building.
  - Challenging the root causes of displacement, by working on issues such as inequality, distributional conflicts, marginalization of particular groups, environmental problems, etc.
- The diverse profiles and networks of the actors with whom German government bodies cooperate mean that they often have more direct access to civil society.
- The basic principles of development cooperation differ from those of humanitarian aid. Humanitarian aid strives to secure the survival of people affected by crisis. But, even after immediate needs have been met, displaced people need continued support to become self-reliant again. Development cooperation focuses more on building local structures, expanding capacities and ensuring sustainability.
- Given the magnitude of displacement crises at the moment and the fact they tend to last longer and longer, the German Development Cooperation increasingly addresses those needs in the longer term – dealing with the traumatic effects of violence, war and displacement is one of them, leading to an increase role for mental health and psychosocial support.
- Although a coherent and systematic approach that addresses the whole health system to provide needed support would be ideal, the context in which the work often is not. In crisis settings like situations of large-scale forced displacement, local systems often already have difficulties providing services to the local population. At the same time, emergency structures are set up by aid organizations that serve displaced people, but are not integrated in the local system. The German Development Cooperation builds up capacities of the local health system and enables it to serve both local and

displaced populations sustainably.

- They support local government structures because they have the best chance of becoming sustainable, but because the German Development Cooperation also believes that public/State structures are the best option for providing a public good like health care for a maximum number. Working with local systems is seen as the most promising way to realize human rights, such as the rights to education, health and security.
- Mental Health and PsychoSocial Support (MHPSS) have been an essential part of the work of the German Development Cooperation for a long time.
- The scope of the current crisis of forced displacement worldwide and the heavy psychological distress that goes with it has resulted in an increased focus on MHPSS. That means not only more funding but also establishing standards in MHPSS and promoting its integration into all sectors.
- For example, the German Development Cooperation supports the establishment of an academic course on trauma therapy at the newly founded institute for psychotherapy at the University of Dohuk in northern Iraq. In cooperation with the German universities of Tübingen and Villingen-Schwenningen, local staff already working on MHPSS will get the opportunity to train as trauma therapists to provide support where it is needed most.
- A recent development is the building of a network of local and German institutions which cooperate in the area of psychosocial support. It brings actors in the Middle East together in order for them to bundle their resources, exchange views on good practices and do-no-harm issues, and learn from each other's experiences. The network includes several German organizations with long experience in working with people who come from a background of loss and violence, such as Medica Mondiale, medico international, the Charité clinic in Berlin and the BAfF.
- The aim is to discuss and develop guidelines as well as quality criteria for MHPSS work with Syrian and Iraqi refugees and IDPs in the Middle East and in Germany, as well as providing orientation for German Development Cooperation in the Middle East. The guidelines stress that mental health approaches and psychosocial approaches complement each other. Those who need highly specialized services also require community-based services – they are not mutually exclusive. Indeed many of the services are neither basic nor specialized but mostly both – and they may be something completely different, such as help in strengthening connections with family and community.
- There are two reasons why mental health and psychosocial support are important for the German Development Cooperation: our rights-based approach and our orientation towards results.
- A rights-based approach means that people affected by violent conflict and crises have the right to health and well-being, including mental health and psychosocial well-being. If the aim is to empower people to restore control over their lives, to be self-reliant again, there is also a need to support them after traumatic experiences that can leave people feeling helpless, powerless, fearful, depressed, angry and ashamed. For affected communities, this can often mean less social coherence, mistrust and increased levels of violence.
- It is therefore crucial to mainstream MHPSS in other development sectors to ensure that activities are carried out in a participatory, safe, dignified and socially-appropriate manner. Activities to ensure food security, rebuild livelihoods or promote income-generation are a lot more likely to succeed if they take into account that the people might be affected in ways that hinder development.
- Staff of development organizations working in contexts of conflict and displacement can also be affected by traumatic experiences and psychological distress. They too need support: space for reflection and reduction of stress.
- Psychosocial well-being and mental health are a lot more difficult to measure than for example the number of children who are going to school again, but the German Development Cooperation is accountable for the effectiveness of their programmes, although they are only at the beginning of properly measuring the impact of MHPSS

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activities in Development Cooperation.

- The development of the common orientation framework mentioned above is an important step forward in the German Development Cooperation to address the importance of MHPSS. It counters the fear of some actors who are wary about addressing trauma in a volatile and dynamic environment: if you rip off the band-aid without giving the wound the necessary time to heal, aren't you doing more harm than good?

4. 3. The European Union and health policy

Since 1986[87] there have been numerous conferences on health promotion and public health policy, projects designed to strengthen community action and the preparedness of the public health sector and public health capacity to better address migration-related issues as well as engaging in cross-national political dialogue and migrant health in European Regions[88]. One might then expect that the EU would have a significant input and competence in public health policy at the European level. Furthermore, given the recent migrations resulting from humanitarian crises, one might expect the EU to consider physical and psychosocial health issues in terms of citizens' rights. Yet, there are few avenues to bring public health issues – and more specifically, mental health and psychosocial issues – to the table at the European level.

The following summarises the keynote presentation by Ortwin Schulte, formerly Coordinator for refugee health issues at the German Ministry of Health and since 2017, the Head of the Health Policy Unit in the German permanent representation to the European Union in Brussels. The presentation was made at the conference of the European Network of Rehabilitation Centres for Survivors of Torture, 2017.

The keynote speaker Ortwin Schulte has helped us to better understand the role of the European Union in health policy and in health system development which further explored the core themes of the conference.
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87 The **Ottawa Charter for Health Promotion** is the agreement signed at the First International Conference on Health Promotion, organized by the World Health Organisation (WHO) in 1986 in Ottawa. The Ottawa Charter called on international organizations, national governments and local communities to advocate the promotion of health in all appropriate forums by setting up of strategies and programmes for health promotion in line with health equity, which implies that there are no differences in access to health care between populations based on race, ethnicity, sexual orientation or socioeconomic status.

88 See also www.euro.who.int

Ortwin Schulte: Keynote on 'The role of the European Union in health policy and in health system development'

- EU competencies on health policy are very limited, since the founding members saw it as one of the areas in which they wanted to retain full competence at the national level.
- There are only a few areas where competence has been transferred to the European level. One of those is the quality and safety of pharmaceuticals and medical devices – harmonization only applies to quality and safety: all other aspects, such as pricing and reimbursement by public health systems are under the authority of the member states.
- For 15 years there has also been European regulation on minimum quality and safety of organs and blood. Member States may require higher standards if they wish, and they determine rules for the prioritization of the resources when there are shortages in supply, as there are in most cases. There is a foundation called Eurotransplant which arranges cross-border availability of organs, run by eight European States, but it is not a EU institution.
- Public health prevention programmes, such as programmes against communicable diseases and narcotic drugs are also member State competences.
- Otherwise, the organization and development of the health system is a national task and cannot be regulated by Brussels. The health systems in the EU are very different. There are fully tax-financed State-driven systems, as in the UK and Scandinavia, and there are self-administered systems, such as in Germany, where the federal ministry of health devolves health on the one hand to the social insurance system, funded by employers and employees and on the other hand to the self-administration of medical doctors, psychotherapists, hospitals and health insurance providers.
- Thus, health policy is very different from other political areas like agriculture and environment, where nearly one hundred percent is decided at EU level. One political consequence is that the overall EU budget for health is very small. The action program for health provides 55 million Euros each year, 11 cents per citizen.
- However, the EU budget for health research is higher than that, although it is not administered under health policy, but under research policy. And mutual recognition of educational qualifications means that medical qualifications are recognized across the EU. There is also an open dialogue forum on future social and health systems, but 'open' means it is not legally binding, so it has limitations.
- Other fields have a direct influence on health, without being health policy. The largest budget lines are the regional and agricultural funds which have recently adapted agricultural policy to move away from subsidizing agricultural products and to transfer resources into infrastructure development for the rural areas including health care, but this amounts to a very small proportion of these large budgets.
- The 'Euro crisis' also had health consequences: among the obligations of States in return for their financial bail-out were health-related measures, especially in the case of Greece, where health system reform was intended to ensure financial stability. It is yet to be decided whether these emergency measures will be turned into a long-term mechanism of influencing health policy.
- However, there are ways of influencing policy by raising attention to particular issues, like, for example, trauma treatment for survivors of torture. Medical associations also try to influence at the European stage for their own specific interests.
- The most appropriate instrument is the EU presidency. Each State in the EU in turn holds the presidency for six months and has the right to determine the agenda of the European Council. The role of the EU presidency is to determine priorities and to develop political programs, holding conferences, speeding up legislative procedures and initiating political dialogues – not acting in the national interest, but in the interest of all the 28 EU member states. The presidency also represents all the member states in international negotiations, and the presidency

Ortwin Schulte is Head of Unit Health Policy at the Permanent Representation of Germany to the European Union in Brussels.
(© Ortwin Schulte)

provides the chair for all the 1000 council committees existing in Brussels. Germany will hold the presidency in the second half of 2020 and, although it is very cautious about transferring competences in the health field to the European Union, it could be an opportunity to open up the joint development of public health policies.

- Eighteen to twenty months before a country takes over the presidency, it collects various options and decides which priorities to set. The decision can have quite a personal note from the EU presidency because the minister can choose freely between topics, but proposals from administration are also considered.
- The EU stage can be used to start an EU process, but it can also be used to start something on the national level. In some cases it is possible to use the attention generated in Brussels to initiate developments at the level of domestic health policy.
- For example, when in 2016 the Netherlands had the presidency, they tabled an item on pharmaceutical cost containment and the question of affordability of innovative pharmaceuticals and developed a working document as an orientation for follow-up policies. In 2004, the Spanish presidency invented the so-called Barcelona Process, which gave a new format for dialogue between all the States with a Mediterranean coast, including those of North Africa. The presidency normally receives some financial resources for two or three years to help commence the process.
- Germany's last presidency in 2007 engaged in a process 'Together Against HIV AIDS', which was a personal decision of the former health minister Ulla Schmidt, who wanted to have a higher priority for cooperation on AIDS, especially with regard to the post-Soviet States, and it started the very close cooperation we have until today with Moldova and their Ministry of Health.
- The last presidency to have mental health as a priority issue was Finland in 2006 and many presidencies will be quite cautious when it comes to mental health as a presidency topic, partly as a result of sensitivities related to the abuse of psychiatry in Eastern European in the past and partly also because there is an assumption that mental health tends to be expensive.
- There are four criteria if in proposing a topic:
  - It's very important to have the personal commitment of the Minister of Health.
  - Secondly, if the topic is embedded in the existing EU processes, it is possible to state that 'we want to get this regulation through' and that would be a tangible result that resources can be concentrated on. It is more ambitious if there is a topic which is only one of national competence, but the State wishes to bring it to the attention of the European decision-makers.
  - The third question is whether the topic is integrated in the national government

The trio-presidency for 2019 will be Romania, Finland and Croatia. At the end of 2020, it will be Germany, Portugal and Slovenia.
(denzel, CC0 | pixabay.com)

program. For example, e-health was brought forward during the Estonian presidency as part of an overall government digital agenda executed in each ministry.

2 The fourth question relates to the trio presidencies under which three consecutive presidencies are brought together to help ensure continuity.

- If an external EU topic is chosen it is also possible to invite third countries to an informal council of the health ministers, which takes place once in each presidency. In 2007, for instance, Germany's health ministers' council had 43 delegations because all the Eastern European states were invited.
- Ministers are tempted to start new processes rather than to continue existing processes. As mental health issues are almost certainly in the non-harmonized area, it would mean that any process will be built on dialogue and for understandable reasons it will have less tangible results than, for example, there is a legislative proposal.
- In line with its usual role of demanding more EU competence and greater budgets, the European Parliament wants to create a European parliamentary discussion level on health policy and, this can be helpful in planning for a presidency.
- The trio-presidency is an instrument to enhance working continuity. It brings together a fixed group of three member states. Currently, the three are Estonia, the next presidency Bulgaria, and then Austria. At the start of 2019, it will be the first Romanian presidency, followed by Finland and then Croatia. And at the end of 2020, we will have the Germany-Portugal-Slovenia trio-presidency.
- Germany is very cautious in transferring any competence or any budget to the European level on health. Portugal has a completely different view, and such contradictions in one trio-presidency can be useful. Slovenia shares some Portuguese views and some German views and the combination in the best cases can be an advantage for the trio-presidency.
- Medical or health-focused civil society can ask EU presidencies to put certain topics on the agenda, usually 18 to 24 months ahead. First the minister will communicate priorities and if your issue has not been put as first priority issue by the minister, it is possible to have the so-called associative program of the presidency. The presidency has an official program, but it also has an associated program, which has the right to use the logo of the presidency for certain conferences and activities.
- In conclusion, psychosocial care for victims of trauma, violence and torture is a very complex and difficult issue in Germany, but in other states the issue is even more difficult and health systems often react quite slowly. The role and work of civil society organisations such as those members of the European Network is hence very important.

4. 4. Mass refugee movement and providing rehabilitation of torture survivors

In Europe we have faced many challenges in addressing the needs of large numbers of newly-arrived asylum seekers, particularly given recent mass refugee movements, yet, in countries with more forcibly displaced persons and with far less national resources, infrastructure and political stability, there have been significant efforts to address the needs of refugees and torture survivors amongst them.

There are particular challenges to consider, such as how to identify those amongst the newly-arrived asylum seekers and refugees who are torture survivor; how to address the needs of children and adults within families; how to ensure the timely and appropriate care and support[89]; how to ensure there are mechanisms to refer torture survivors to specialist rehabilitation services; how to ensure that care provide is not just emergency assistance[90] and support, but longer term where needed; how to ensure safety of services and that service provided are ethical and provided by those competent and qualified to do so.

89 There exist comprehensive guidelines on the provision of care in emergency settings, notably: UNHCR (2013) Operational Guidance on Mental health and Psychosocial support programming for refugee operations. Geneva: UNHCR; Inter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. These guidelines however, are limited to mental health and psychosocial care, and do not address the need or provision of longer term, comprehensive rehabilitation services (not only as an emergency response) for torture survivors.

90 See CAT, General Comment N°3 (2012), para. 37.

An example of a comprehensive approach to addressing the needs of torture survivors arriving amongst mass movements of forcibly displaced person, is the work of Restart Centre for the Rehabilitation of Victims of Torture and Violence, an NGO in Lebanon.

The following summarises the key points made in a keynote presentation at a conference of the European Network of Rehabilitation Centres for Survivors of Torture, in Bucharest, 2017, by Suzanne Jabbour, a clinical psychologist and Director of the Restart centre, Lebanon.

Suzanne Jabbour: Keynote on 'Mass refugee movement in the Middle East and rehabilitation for refugees and victims of torture: Lessons learned in Lebanon'

- The refugee crisis is not a crisis of numbers. It is a crisis of moral and human responsibility. When listening to and observing discussions in Europe, there is a lot of talk of numbers – large numbers of asylum seekers, yet is there a refugee crisis in Europe or is it a crisis of 'we don't want to receive refugees?'
- **Middle East context:** In the Middle East region, there is a different scale and approach to these issues. The number of refugees officially registered until May 2015 with UNHCR in Lebanon is 1,001,051 in Lebanon. After May 2015 the Lebanese government asked the UNHCR to suspend official registration of refugees and the UN has continued to register refugees unofficially, but these figures are not included here. Globally, there are 5 million+ registered refugees, around 3 million in Turkey, around 1 million registered and around 1.5 million officially unregistered in Lebanon, and in Jordan 654, 877 registered, in Iraq 246, 592 registered and in Egypt, 126,027 registered. In the Middle East, there are 6 million refugees registered – the size of Lebanon's population.
- **Lebanon as an example:** One in five people in Lebanon currently is a Syrian refugee. One in three people is an immigrant. The current population of Lebanon is over 6 million. The Lebanese Population is around 4 million. There are around 31,000 recently arrived Palestinian refugees from Syria and an additional 1 million registered refugees from Syria; 20,000 Iraqi refugees registered with UNHCR; and 350,000 Palestinian refugees already living in Lebanon. Lebanon is a country of 10,452 km2 and it is the smallest recognized country in the entire mainland on the Asian continent.
- **Societal impact:** Lebanon is already an unstable and vulnerable state. The influx of Syrian refugees has had many negative impacts – with increasing refugees, changing demographics, unstable and poor economy, poor infrastructure, overstretched and under-resourced public services. In the public health care system, there is a lack of qualified staff, equipment and medication, overcrowding, extensive waiting times etc. whilst demands for services have risen dramatically.
- **Political and security impact:** This is very complex given the complex politics in the Middle East region, political discourses which have created fear and tension between the host community and the refugee population; decreasing national stability and mounting security concerns, which include acts of violent extremism carried out by the newly-arrived refugees and rising Syrian refugee population in places of detention. Currently, Syrian refugees comprise 35-40% of the total prison population of Lebanon.

Suzanne Jabbour is the Director of the RESTART Centre in Lebanon and is also an international expert on human rights and in monitoring places of detention.
(© Emilian Savescu)

- **Impact on Syrian displaced persons:** The refugees also suffer many problems in Lebanon, including family separation, social problems within families and their social networks, destruction of community structures and resources, psychological problems. Around 40,000 Syrian refugees in Lebanon are noted as suffering from a range of severe psychiatric disorders. There are only two official psychiatric hospitals in the country. There are also additional problems they face in terms of poverty and lack of protection, particularly for children. Children are used as child soldiers, in prostitution, early marriage and until recently when Syrian children are allowed to be registered, a high percentage of Syrian children were out of school and used for labour, particularly when adults were unable to or had irregular work and means to support their families. There are 124,000 Syrian or non-Lebanese children in public schools and still 250,000 Syrian children are out of school. According to the UNPD Rapid Poverty Assessment in Lebanon 2016, 28.5% of the Lebanese population were estimated to be poor, living on less than four dollars per day. About 300,000 individuals were considered as extremely poor, living on less than 2.4 dollars per day and unable to meet their most basic needs.
- **Syrian crisis response plan Lebanon:** There is an absence of a national government strategy on how Lebanon should respond to the recent mass influx of refugees, described in Lebanon as the 'Syrian crisis'. There are many informal refugee camps, as no official refugee camps exist, except for UNRWA refugee camps for Palestinians.
- There is a national response plan led by the UNHCR, implemented by national and international NGOs as partners for the UNHCR.
- **Restart Centre for the rehabilitation of victims of torture and violence has its own Refugee Response Plan:** Restart Centre's work involves rehabilitation to help restore the psychosocial, the medical and the physical well-being of survivors of torture and trauma and their families; educating professionals and the public about torture and its consequences; strengthening the legal and policy frameworks on effective criminalization and abolition of torture on the nationally and regional level; preventing and responding to gender-based violence etc.
- In 20 years, Restart has supported around 7,600 people. Their model operates at three levels: protection, prevention and rehabilitation. Rehabilitation for torture survivors from the refugee crisis and movements of large numbers into Lebanon in recent years has involved many activities. Restart provides specialist support for physical and mental health, community-based mental health services to reach more and to ensure early identification of victims of torture; training of nurses in primary health care centres and other health professionals in public hospitals to screen and to identify torture survivors, capacity-building for staff of UNHCR dealing with refugees; training other NGOs, law enforcement personnel and educators of children. Restart Centre also has an extensive caregivers-program for staff care, for staff in Restart and for UNHCR staff working in emergency settings.
- **Challenges related to acts of torture and ill-treatment:** As in Europe, there is a lack of specific national programs. In the Middle East and in Lebanon, there are areas

Suzanne Jabbour says "The refugee crisis is not a crisis of numbers. It is a crisis of moral and human responsibility." *(Sammmie, CC0 | pixabay.com)*

where there is a total absence of services for torture survivors; many non-specialized NGOs and international NGOs working with victims of torture with no specialist knowledge or skills; no early identification; lack of monitoring and evaluation for the quality of the services; shortage in funding, especially for the victims of torture; short-term planning need to be long-term planning for treatment for victims of torture; NGOs which are not trained to work in emergency settings, especially with survivors of torture; limited number of health professionals and mental health professionals trained to work with torture survivors; staff burnout; limited access to the documentation of torture and therefore lack of records of who needs help, or who may benefit from rehabilitation when the emergency situation and war ends; public acceptance of torture; lack of national independence mechanism; poor access to justice; right to redress and security concern for both health professionals, mental health professionals and the victims; constant risk of detention for refugees, because of their illegal-status; persons deprived of their liberty and some torture survivors involved in terrorism.

- **What are the lessons learnt by Restart Centre in Lebanon?**
  Rehabilitation should be provided in a holistic and comprehensive approach; encompassing two other components: protection and prevention; support a coordinated response nationally; do not work in isolation; be sensitive to cultural differences; do not neglect the refugee communities' specific cultures; tailor assessment tools to the local context; do not use assessment tools not validated for the local context; recognize that torture survivors are affected by emergencies in different ways; do not assume that every torture survivor is traumatized, or that people who appear resilient need no support; pay attention to gender differences; do not assume that torture affects men and women the same way or affects men only; build the capacity of new personnel from the local and affected community e.g. Syrian volunteers to be co-facilitators in our activities; do not use recruiting practices that severely weaken existing local structures; show empathy, be clear about your services, and state your limitations – you cannot do everything; do not give unrealistic promises and unrealistic high expectations to survivors; develop community-owned, managed and run programs – do not use a charity model; build local capacities and strengthen the resources already present in affected groups; do not provide stand-alone services; do not develop or implement rehabilitation programs for survivors without engaging them; be aware of the needs of secondary victims; pay attention to legal responsibly issues in the case of survivors who are in conflict with the law; do not ignore the legal challenges; pay attention to data protection; do not ignore the principles of consent and confidentiality; pay attention to ethical considerations; do no harm; be flexible; pay attention to the survivors' particular fears; do not assume that any volunteers or mental health professionals can work with torture survivors without training and supervision; include documentation of torture in your programs to protect the victim's right to redress.

In the Middle East, there are 6 million refugees registered: 3 million in Turkey, around 1 million registered and 1,5 million officially unregistered in Lebanon, and 654,877 in Jordan and 246,592 in Iraq.
(StartupStockPhotos, CC0 | pixabay.com)

5. What needs to change?

Notwithstanding the significant political, economic, social and professional challenges which face governments and health and social care service providers in relation to asylum seekers, refugees and torture survivors in Europe, there are important lessons based on our collective experience over three decades. These lessons point to specific changes and action needed by policy-makers, changes which the European Network holds as crucial to ensuring a humane, ethical and professional response to the needs of torture survivors in Europe.

The European Network has met annually for 17 years in different locations across Europe as a non-financed and largely self-sustaining platform of health professionals. They see themselves as health professionals and also as human right activists.
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The European Network believes that it is important to:

1. **Ensure policies and effective, ethical and culturally- and gender-appropriate mechanisms to identify torture survivors and vulnerable refugees as early as possible, by those appropriately qualified to do so.**
2. **Ensure all front-line health professionals are adequately trained to identify torture survivors and vulnerable refugees, and to provide appropriate care and support.**
3. **Ensure professional training programmes for health professionals and other relevant professional groups that includes training on holistic rehabilitation and relevant competencies to conduct appropriate health assessments and to provide appropriate, non-discriminatory care for torture survivors and vulnerable refugees.**
4. **Ensure appropriate, non-discriminatory state health and social care services for all torture survivors and vulnerable refugees, accessible on the basis of need and their rights to health and rehabilitation.**
5. **Ensure effective regulation, accountability and professional support mechanisms to protect torture survivors and vulnerable refugees from receiving sub-standard and potentially harmful and unsafe health services as well as psychosocial care by inadequately qualified and trained personnel in civil society organisations.**
6. **Ensure public policy and a programme of activities to address the social determinants (in the receiving country) for poor health of torture survivors and vulnerable refugees.**
7. **Strengthen the existing infrastructure within civil society to consolidate practice, integration and rehabilitation services for refugees and torture survivors.**
8. **Raise awareness and understanding of all relevant stakeholders, political representatives and health professionals on torture, rehabilitation and health care of torture survivors and their families.**
9. **Ensure public policy, mechanisms and a programme of activities to prevent exploitation (economic and sexual) and harm, poverty and discrimination (including institutional, interpersonal, physical, and verbal racism).**
10. **End impunity for crimes of torture in Europe, and address its impact on torture survivors.**
11. **Ensure public policies (e.g. anti-terrorism policies) do not unfairly target and discriminate against torture survivors and vulnerable refugees.**
12. **Ensure adequate State financing for the provision of professional and coordinated general and specialist health and social care, legal, educational and other support for the rehabilitation and participation and integration of all torture survivors and vulnerable refugees.**

About the authors

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Prof Nimisha Patel is a Consultant Clinical Psychologist and Founder and Executive Director of the International Centre for Health and Human Rights, a UK-based NGO and Professor of Clinical Psychology on the Professional Doctorate in Clinical Psychology at the University of East London. Her specialist areas of academic, clinical, research and policy interests are in human rights, racism, torture and gender-based violence. She has worked in various human rights NGOs, the NHS and internationally in many countries, including as a consultant to several United Nations bodies and other international human rights and humanitarian organisations.

Elise Bittenbinder

Elise Bittenbinder is the founder and director of BAfF e.V. – the German association of psychosocial and treatment centres for Refugees and Victims of Torture based in Berlin, deputy director and psychotherapist at XENION, Psychosocial centre for Politically Persecuted, Berlin. She is founder and chairperson of the European Network of Rehabilitation Centres for Survivors of Torture. By training, Elise is couple and family therapist, child psychotherapist (KJP) and supervisor (DGSv). Besides her extensive years of expertise working with survivors of torture and human rights violations she works as trainer, senior consultant and supervisor in projects in the Middle East.

Sibel Atasayi

Sibel Atasayi has gained extensive experience in mediation and national dialogue processes in post-conflict countries through working for the United Nations Development Programme (UNDP), the Common Space Initiative (CSI) in Lebanon and for the Berghof Foundation in Berlin and Turkey. Since 2015, she works as a psychotherapist with migrants, refugees and survivors of torture. Currently, she works for BAfF e.V. and for its member organization Xenion e.V. – Psychotherapeutic counselling and treatment centre for traumatized refugees and survivors of torture as well as for the German umbrella organization for Cognitive and Behavioral Therapy (CBT) in Berlin.

Lotta De Carlo

Lotta De Carlo studied global nutrition and health at the Metropolitan University College in Copenhagen, specialising in public health nutrition. During the last semester of her studies she completed a six months internship with BAfF e.V. and wrote her thesis on interpreting services in psychosocial care for refugees and victims of torture. Since she has been working for several NGOs in the field of health, human rights and environmental policy. Currently she is working at the Research Academy at Leipzig University.

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About the European Network

The European Network of Rehabilitation Centres for Survivors of Torture has wide and deep multidisciplinary professional experience of providing rehabilitation to torture survivors in Europe. The organisation is a self-sustaining professional network of health, social care and legal professionals who hold an annual Europe-wide conference which offers a forum for debating and sharing professional experiences in relation to current issues.

The participants to the Network meetings come from more than 120 centres from all over Europe and they bring with them immense and widely-recognised experience.

As professionals who also see themselves as human rights activists we – the members of the Network – see ourselves as having a responsibility towards the survivors of torture who put their trust in us by telling us their stories. We become their "ear witnesses" and we commit ourselves to work to preserve these individual and collective memories of human rights violations, so that they may be available to decision-makers and others in current and future generations.

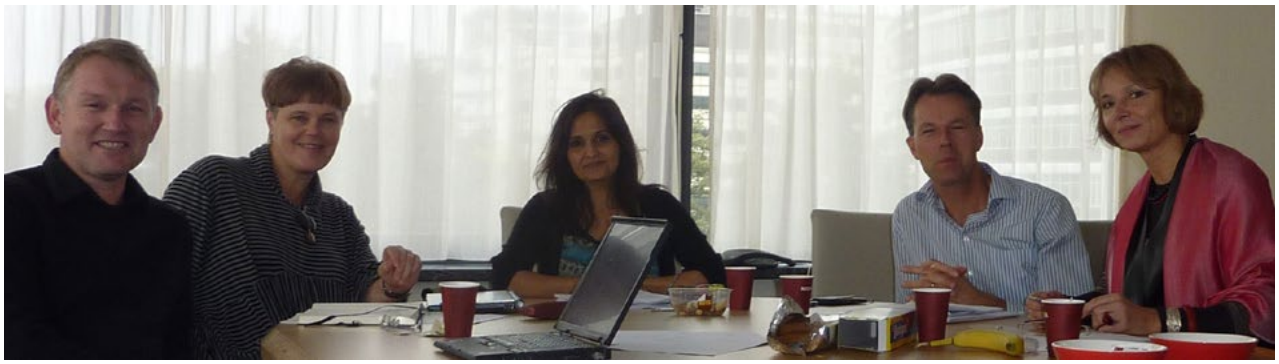
As a self-sustaining professional network we welcome input and contributions from colleagues.

For the Steering Committee 2017,

Elise Bittenbinder, Nimisha Patel, Camelia Doru and David Rhys Jones

For more information on who is currently involved in the European Network, see the list of the members of the European Network of Rehabilitation Centres for Survivors of Torture *(www.european-network.org/european-network/network-participants/)*.

For more information, visit the website of the European Network (*www.european-network.org*) or contact us: *info@baff-zentren.org*



29. Oct. 2010, Diemen/Amsterdam: The Steering Committee preparing the European Network Meeting 2011 in Amsterdam: Ole Haagensen, Elise Bittenbinder, Nimisha Patel, Jan Schaart and Camelia Doru (left to right). © EURONET

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