irct BACKGROUND PAPER

TORTURE VICTIMS IN EUROPE

Eva was 15 when she first arrived in the UK with her family. She was fleeing Albania where some members of her family, including Eva, had been tortured. Eva herself was raped. "I'm really pleased to be over here but I still don't feel fully happy. It's better to be here though and by studying I know I'll achieve something. I still find it difficult to form close relationships. Maybe I'm too scared... so I keep myself to myself, but it's lonely. College has helped me and learning English was the best thing I've done. How I think now is so different to how I used to think. Now I'm able to communicate and I feel good about myself and who I am. I'm not ashamed to be a single Muslim woman with a baby."*
**Fake name*

A VULNERABLE AND DISCRIMINATED GROUP

Torture victims within the EU[1] are found among vulnerable and marginalised populations including undocumented migrants, asylum seekers, refugees and also Member State nationals (either victims of former oppressive regimes or refugees who have been naturalised).

The UNHCR generally considers that, on average, between 20 and 30% of asylum seekers and refugees are torture victims. Thus, of the 2.9 million asylum seekers who arrived in the 27 Member States from 2000 to 2010, **at least 580 000 are potential torture victims**. Moreover, within Europe, it is estimated that around 1.5 million people were **victims of torture, repression, deportation, detention, arbitrary or politically motivated arrest** under totalitarian regimes between 1945 and 1989.

Despite their diversity in terms of social and legal status, victims of torture make up a **specific group** embodying all major characteristics of **vulnerability**, as will be further explained.

Survivors respond to, and recover from, torture in a variety of ways. The consequences of torture are both physical and psychological: cognition impairment,

[1] The definition of torture is clearly stated in article 1(1) of the United Nations Convention Against Torture, whereby the term "torture" refers to "any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions".

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anxiety, memory flaws, fear of representatives of authority, acute stress disorder, nightmares and sleeping disorders among others. Furthermore, long-lasting suffering from mental health disorders such as depression and posttraumatic stress disorder are also commonplace.[2]

However, torture impacts on families and communities, not just those who have been tortured. For example, torture victims often develop behavioural disorders, the consequences of which impact upon those close to them, i.e. family members. The aim of rehabilitation services is to enable individual victims, their families and their communities to resume as full a life as possible and to restore their dignity.

Additionally, in Europe, torture victims are often from ethnic minority and immigrant groups who are highly vulnerable to multiple discrimination (firstly on the basis of their ethnic or national backgrounds and, secondly, on the basis of gender and/or age).[3]

As a result of all these conditions, they suffer from social exclusion and poverty which negatively impact their health through the following ways:

- low/no possibility to exercise their rights,
- low access to basic health care,
- low/no access to specific rehabilitation services,
- poor socio-economic conditions, such as:
  - low/no access to decent housing,
  - low/no access to quality education,
  - difficulty accessing public services,
  - difficulty accessing the labour market / lack of financial resources.

The exclusion and marginalisation of torture victims exposes them to further harm, reflected in social phenomena such as domestic violence, sexual exploitation, human trafficking, or alcohol/drug dependencies. Often they do not have the ability (lack of self confidence, lack of self-esteem, submission to the authority), the knowledge (of their rights, of the structures to address) nor the social network needed to resist such risks.

A PUBLIC HEALTH CONCERN...

The abovementioned physical and psychological impacts of torture clearly constitute a **public health concern**, requiring serious consideration primarily out of regard for the **victims** but secondarily also for their **families** and **society** in general. This was recognised by the European Parliament (EP) in its study entitled "An Update to the Implementation of the EU Guidelines on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment".[4]

As studies have demonstrated, the effects of torture are rarely limited to the victims. In fact, they are often followed by a serious negative ripple effect towards their families, their communities and even wider society. Therefore, it requires swift

[2] Steel, Z. et al. Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: a systematic review and meta-analysis. *JAMA: the Journal of the American Medical Association* 302, 537-49 (2009).
[3] EU MIDIS Data in Focus report: Multiple discrimination, February 2011.
[4] EXPO/B/DROI/2008/77, PE407.013, September 2009.

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and effective holistic assistance (medical, psychological, physicotherapeutical, social, practical and legal) for both **reparative** and **preventive** purposes.

To deliver treatment that fulfils the complex needs of torture survivors, the methodologies used should be evidence-based. As their needs are diverse due to the consequences of torture, the best results have been reported by multidisciplinary treatment teams where there is a close interaction of different health professionals.[5] [6]

Rehabilitation is conceptualized as an outcome, referring to the restauration of the victims' functional ability and sense of self. Aimed at empowering victims to resume as fulll a life as possible, rehabilitation focuses on the fulfillment of the objectives identified by the individual, thus furthering autonomy and choice. The achievement of independency and auto-sufficiency is crucial for victims' (re)integration into society, while enabling them to pursue their interests and goals without having to rely on the permanent support of social services. Hence, rehabilitation constitutes an initial tool for the provision of support with clear long-term gains.

The positive impact of rehabilitation is often far-reaching. Torture is a political act and rehabilitation centres play a key role in promoting democracy, co-existence, and respect for human rights as their mere existence is a systemic demonstration of the implementation of the rule of law.

… AND AN INEQUALITY ISSUE, IN VIOLATION OF FUNDAMENTAL RIGHTS!

The **right to health** has been endorsed as a fundamental human right by various international instruments ratified by EU Member States.[7]
Moreover, the right to health care is contained in Article 35 of the Charter of Fundamental Rights of the EU, which became legally binding after the entry into force of the Lisbon Treaty. This means that, apart from the respect owed by Union institutions to such right whenever they take action, the right to health care also applies to Member States when implementing Union law.

The right to health is interpreted as including timely and appropriate **access to healthcare** as well as other essential conditions for health.[8]
Although the right to health is subject to progressive realisation, States are bound to specific obligations of immediate effect, such as the **guarantee of non-discrimination** and **equal access** to any existing health services, particularly taking into account vulnerable or marginalised groups.[9]

[5] Keller, A. et al. Traumatic experiences and psychological distress in an urban refugee population seeking treatment services. *The Journal of nervous and mental disease* 194, 188-94 (2006).
[6] Watters, C. Emerging paradigms in the mental health care of refugees. *Social Science & Medicine* 52, 1709-1718(2001).
[7] To name a few examples: the International Covenant on Economic, Social and Cultural Rights, Article 12; the European Social Charter, Article 11, and the Convention on the Rights of the Child, Article 24.
[8] *See* Committee on Economic, Social and Cultural Rights, Right to the Highest Attainable Standard of Health: General Comment 14, UN Doc. E/CN.12/2000/4 (2000), paras. 4 and 11.
[9] *Ibidem,* paras. 12, 18, 19, 30, 34 and 43.

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Regretably, the issue in the European context is often one of **inequality in the accessibility of health care** between the general population and vulnerable groups. For instance, studies regarding access to health care by asylum seekers and undocumented migrants (who, as explained above, include torture victims among them) have shown that, frequently, concerns about migration take precedence over human rights considerations. This is reflected in the fact that Member States have put in place diverse conditions for accessing health entitlements.[10] Such circumstance runs counter to the EC's White Paper "Together for Health – A Strategic Approach for the EU, 2008-2013",[11] and its approach based on shared values such as **universality, equity and solidarity**.

As emphasised by the EC Communication "Solidarity in Health: Reducing Health Inequalities in the EU",[12] **addressing health inequalities** in areas such as **mental health** constitutes one of the **priorities** of the EU Health Strategy.
Strikingly, the EC asserts that for "some groups, the issue of **health inequality** including reduced access to adequate health care, **can be qualified as one which involves their fundamental rights**".

FUNDING IN EUROPE FOR REHABILITATION SERVICES

For over15 years, the European Union (EU) has been the main donor supporting the rehabilitation of torture victims within Europe. The EU has shown willingness to step in to support torture victims in accessing care through funding rehabilitation centres at a time when most Member States have been reluctant to do so.

However, the EU has renewed its decision[13] to phase-out the funding of European-based rehabilitation centres on the grounds that the budget line dedicated to it was located within EIDHR - an external action instrument. While the strategy paper asserts that Member States "should" assume greater financial responsibility, the Reception Directive (2003/9/EC) states it as an obligation in Article 15.2 on Health care. The Qualification Directive (2004/83/EC) tackles as well the special health needs of vulnerable groups such as torture victims in its Article 29 (now Article 30 under the Qualification directive recast proposal), along with the General Rules provision contained in Article 20(3).

[10] HUMA REPORT: "Are undocumented migrants and asylum seekers entitled to health care in the EU : comparative overview of 16 EU countries », November 2010 & PICUM "Access to health care for undocumented migrants in Europe", 2007.
[11] COM(2007) 630 final, 23 October 2007.
[12] COM(2009) 567, 20 October 2009.
[13] European Instrument for Democracy and Human Rights (EIDHR) strategy paper 2011-2013. The EIDHR strategy paper 2007-2010 had prescribed, as one of its objectives, "[s]upporting actions on human rights and democracy issues in areas covered by EU Guidelines, including … on torture, and on children and armed conflict". Recognizing that torture and other forms of ill-treatment were pervasive and that torture victims were spread around the globe, no specific geographical focus or limitations on eligibility for funding were foreseen under Objective 3, Therefore, activities undertaken by civil society organisations based in the EU could be eligible. However, EIDHR funding for rehabilitation and support activities in the EU was intended to act as a "catalyst to develop a greater financial commitment by Member States and candidate countries, in accordance with the provisions of the CAT and relevant EC legislation". *See* EIDHR strategy paper 2007-2010, available in: http://ec.europa.eu/europeaid/what/human-rights/documents/eidhr_strategy_paper_2007-2010_en.pdf.

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Nevertheless, as underlined by a study undertaken by the Odysseus Academic Network[14], few Member States support torture rehabilitation needs in their own country, with many offering little or no support at all.

The European Refugee Fund (ERF), which could present an alternative source of funding, also has significant disadvantages: as funding is handled by Member States, each of them can define their own priorities, ignoring the rehabilitation of torture victims; as it is project based, it cannot finance core funding and long term activities needed for the rehabilitative therapy; administratively mismanaged, there are considerable delays in the release of payments. In extreme cases, these delays have resulted in centres having to cease all activities.

As a result, European based rehabilitation centres for victims of torture will soon find themselves without access to sustainable funding, **to the ultimate cost of torture victims themselves**, who will be unable to access appropriate care.

On the EP DROI Committee meeting held on the 25th January 2011, Chair Heidi Hautala tabled a question on this situation. The European Commission (EC) was specifically queried about its views on ensuring future access to sustainable funding by European rehabilitation centres for torture victims.

Manfred Nowak, the highly respected former UN Special Rapporteur on Torture, asserted that it is of the utmost importance to search for alternatives to the EIDHR. While acknowledging that European Governments are often not willing to provide adequate funds to torture rehabilitation - despite their obligations -, Nowak saw the issue as one of **joint responsibility** for both the EU and its Member States.

CONCLUSION

The establishment of a specific policy would be a component of a desirable EU strategy, wider in scope, and allowing a coherent, holistic, sustainable and coordinated approach to torture victims' special needs.

Indeed, just as any broken arm needs a cast, the right to rehabilitation should be independent of the legal status of the victims as it should address the diversity of origin and status of torture victims in Europe.

Therefore, in order to offer all torture victims access to specialised holistic care, it is desirable that a comprehensive policy, ensuring a high level of human health, focusing on the issues of mental health and inequality in access to health care in the EU and fighting the discrimination suffered by torture victims should be defined in order to enable the implementation of positive and inclusive conditions for torture victims to receive appropriate care from sustainable rehabilitation centres in the European Union.

20 October 2011

[14] Odysseus Academic Network, Comparative overview of the implementation of the "reception directive" 2003/9 of 27 January 2003, October 2006, at:http://ec.europa.eu/justice_home/doc_centre/asylum/studies/docs/odysseus_synthesis_report_2007_en.pdf

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