

**European Network of Rehabilitation  
Centres for Survivors of Torture**

**Annual meeting/conference  
Barcelona: 6th - 8th May 2009**

**Proceedings**

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## **Introduction**

The European Network of Rehabilitation Centres for Survivors of Torture ('the Network'), formally established in 2003, is a network of centres/ programmes across Europe (area covered by the Council of Europe), for the provision of healthcare and support to survivors of torture. Annually, the Network meets to share information and experiences, to consider current challenges and opportunities, to continue work in progress in Working Groups and in Discussion Groups, to network and share thinking and experience on particular themes (e.g. prevention of torture, research etc.) .

## **Aims of the European Network**

The aims of the European Network, as laid out in its Terms of Reference, are presented below:

1. To enable the sharing of information on clinical work, assessment and documentation, research, good practice and innovations in the field, as well as on fundraising both for the Network as a whole and individual centres.
2. To stimulate a range of activities related to the field of rehabilitation and treatment for survivors of torture and other grave human rights violations<sup>1</sup>, hereafter referred to as 'survivors of torture'.
3. To provide support to members' centres and participants of the Network, working with torture survivors or in areas related to this field.
4. To promote common standards, where appropriate in various aspects of work conducted by member centres and participants.
5. To enable the sharing of information on the implementation and impact of domestic and European policies, in relation to survivors of torture and other gross human rights violations.
6. To inform and develop advocacy efforts and contribute to the prevention of torture, based on the direct, professional experience of clinical work with survivors of torture seen within the centres and other settings.
7. To collaborate with other international institutions focussing on torture and with shared objectives.

This document presents the proceedings of the European Network's meeting/conference in Barcelona, on the theme of 'Health and Human Rights Research in the field of Torture'. Any reference to or use of any aspect or contents of this document should be appropriately cited and referenced.

## **Why focus on research as a theme for the European network conference/meeting in Barcelona?**

With increasing pressures on centres to engage in a wide range of services as well as prevention activities one area of strategic importance often neglected is the area of research. The relatively

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<sup>1</sup> At the Network's meeting/conference in Antalya, 2007, it was agreed that the term 'other grave human rights violations' required further discussion to reach a shared understanding.

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limited emphasis on research activities is due to many factors, partly funding, partly centres having to function on extremely limited resources in the face of competing priorities and partly lack of research expertise and resources, amongst other factors.

However, as organisations working with torture survivors, we hold significant information about the torture endured by people around the globe and the governments who perpetrate this most serious of human rights violations. Collectively, we also have significant clinical and advocacy knowledge and experience with respect to torture. It is this access to knowledge, experience and torture survivors that can be used to conduct relevant research which could serve many strategic aims shared by those working with torture survivors. Many of these aims are also the focus of the European Network, as noted above. Research of relevance to those centres working with torture survivors includes research which aids the development of quality clinical services, and high quality documentation which can also facilitate effective reporting, campaigning and advocacy and reparation for torture survivors.

It was hoped that the European Network conference/ meeting in Barcelona could be an opportunity for us to consider the range of perspectives and experiences within the Network related to research relevant to the aims of the Network. It was hoped that such discussions could facilitate inter-agency and inter-centre collaboration, which could benefit clinical services, advocacy and other prevention and fundraising activities across centres.

The key objectives for the conference/meeting with regards to discussions on research were:

1. To explore different approaches to and types of research in the context of torture.
2. To explore how research may benefit the work within and between centres – such that research is seen less as a necessary evil, and more as an opportunity to meet our strategic aims in combating torture and in ensuring high standards of care and services for torture survivors.

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Barcelona, 6<sup>th</sup> – 8<sup>th</sup> May 2009**

**Programme**

<b>Wednesday, 6 May 2009</b>	
9.15 - 9.30	<p>Welcome by Inès Desparture, EXIL</p> <p>Welcome by Chairperson of Network, Elise Bittenbinder</p> <p>Introduction to Network Working Groups and leaders (details of working groups themselves to be on website, participants to pick working groups prior to arrival)</p>
9.30 - 10.00	<p>Opening address (Exil -TBC) (time to include questions/comments)</p>
10.00 - 11.30	<p>Session 1: Plenary</p> <p>Chairperson &amp; Introduction: Nimisha Patel (Medical Foundation) (5mins)</p> <p>Presentations: examples of research</p> <ol style="list-style-type: none"> <li>1. Research on Consequences of Russian Intervention in Georgia: <b>Mariam Jishkariani</b> (Empathy, Georgia) (20 mins)</li>   <li>2. Good Practice in Torturecare: A model of self-evaluation <b>Uta Wedam</b> (Zebra, Austria) and <b>Ester Schoonbeek</b> (Equator Foundation, The Netherlands)(35 mins) <i>cancelled</i></li>   <li>3. Danish ICF project <b>Ulrik Jorgensen</b> (Oasis, Denmark) (20 mins)</li> </ol>
11.30 – 12.00	Break
12.00 – 14.00	<p>Session 2: Plenary continued:</p> <p><b>Small group discussions (60 minutes)</b></p> <ol style="list-style-type: none"> <li>1. Named facilitators (working group leaders/ interested others)</li> <li>2. Specific questions to guide discussion in each group (same questions for each group)</li> <li>3. Note-takers during small group discussions (from working groups, but not the working group leaders – who can facilitate each small group discussion)</li> </ol> <p><b>'Walk and talk' plenary: questions and discussion (60 mins)</b></p> <p>Display flip chart, with key points raised by each small group, with someone from that small group standing beside their group flipchart poster, to address questions. This to be alongside formal poster presentations on current/completed research activities (as per recent call for posters), also with someone standing beside them to answer questions.</p>

14.00 – 15.30	Lunch
15.30 – 17.30	<p>Session 3: Panel discussion</p> <p>Chairperson: Jan Ole Haagenen</p> <p><b>Presentations</b></p> <ol style="list-style-type: none"> <li>1. Human rights research: overview <b>Leanne Macmillan</b> (Medical Foundation, UK)(20 mins)</li> <li>2. Clinical research: overview <b>Peter Brigham</b> (CETTS, Denmark)(20 mins)</li> <li>3. Integrating health and human rights research: Challenges and opportunities. <b>Nimisha Patel</b> (Medical Foundation, UK) (20 mins)</li> </ol> <p>Questions and discussion (30 mins)</p>
17.45 – 19.00	Optional / Time for networking
<b>Thursday, 7 May 2009</b>	
09.15 - 11.30	Session 4: Network Working Groups/ Network Clinical discussion groups (No. 1: total 2 hours)
11.30 - 12.15	Coffee Break
12.15 - 13.45	Session 5: Network Working Groups/ Network Clinical discussion groups (No. 2: total 90 mins)
14.00 - 15.30	Lunch
15.30 - 19.00	<p>Session 6: Network Working Groups/ Network Clinical discussion groups (No. 3: total 3 hours plus break)</p> <p><i>Break (17.30-18.00) optional but no facilities for coffee</i></p>
20.30 -	Dinner
<b>Friday, 8 May 2009</b>	
9.30 - 10.30	Session 7: Network Working Groups/ Network Clinical discussion groups (No. 4: total 1 hour)
10.30 - 11.30	Plenary: Brief reports from Working Groups and Clinical Discussion Group
11.30 - 12.00	Coffee Break
12.00 - 13.45	<p>Closing plenary session</p> <p>Chairperson: Elise Bittenbinder</p> <p>Exil speaker (Exil to confirm) (25 mins)</p> <p>Reseda: presentation on French-speaking Network (15 mins) (Exil to confirm)</p> <p>A.O.B., evaluation + planning next conference (30 mins)</p>
14.00	Departure

## Day 1 - Wednesday, 6 May 2009

9.15 - 12.00	<b>Welcome. Opening address.</b>
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The meeting started with a welcome by **Inès Desparture** on behalf of EXIL Barcelona, the hosting organization for the meeting. Ines gave a brief introduction to EXIL and its major activities in Spain. She also provided organizational information concerning logistics and technical issues with regard to the conference.

The floor was then given to **Elise Bittenbinder**, Chairperson of the European Network, who thanked EXIL, Barcelona and the Medical Foundation, London for the perfect organization of the meeting. Elise made some reflections on the history of the European Network, its objectives and major issues the Network has and continues to work with. She mentioned that the European Network has – after an initiating meeting in Bad Boll, Germany in 2002 -had its regular annual meetings since 2003 that were held by its member organizations in various cities across Europe. In 2003 in Blankenberge, Belgium and Cambridge, UK, 2004 in Sinaia/Bucharest, Romania, 2005 in Geneva, Switzerland, 2006 in Paris, France and 2007 in Ankara, Turkey. The last meeting was convened in Dublin in 2008.

Elise mentioned that the main topics of the conference in Barcelona will be led and presented by **Nimisha Patel** from the Medical Foundation, London. She also said a couple of words on how the topic was selected. At the last meeting in Dublin, the Network focused on the prevention of torture. Nimisha had convinced the participants to follow on and explore the theme of research in the field of human rights as the topic for the next meeting. She outlined all the possibilities that lay in research and the decision was then taken to focus on this topic in Barcelona, 2009. Elise expressed her hope that the Network members could find a common way how to incorporate research in their centre activities.

Elise also reminded participants about the work undertaken on the Terms of Reference that were already discussed and adopted last year in principle, subject to minor amendments. Those amendments had now been made, and the revised Terms of Reference were circulated to all participants by email and Elise reminded participants to provide specific comments for any further amendments by Friday May 8th at the latest.

After the opening address and introduction the floor was given to **Sabine Puig**, an invited speaker from Amnesty International, Spain. She made a brief presentation about the activities of Amnesty International in Spain with the focus on major area of their work and issues of interest. Specifically, she focused on ill-treatment in Spain and related legal and political issues in the local context. The main points of her presentation were the following:

- Major issues of concern regarding ill-treatment and its types
- Practice of the prevention of torture in the police stations and shortages in the prevention.
- Main factors that contribute to effective impunity for ill-treatment by law enforcement officials in Spain.
- Issues of concern related to victims' rights (e.g. excessive delays in the proceedings).

*(For more details, see her power point presentation in the compilation of ppt. files).*

The presentation was followed by the discussion with questions to the presenter and comments. The importance of the topic was stressed, and participants shared their views on the problem of ill-treatment from the perspective of their countries. For instance, in France the issues of torture have become possible to discuss only recently. In many other Eastern post-Soviet dictatorships, e.g. Romania, torture is still not so commonly reported, something it was thought necessary for a country to face its past.

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In Spain, the past is now discussed (e.g. what happened during the dictatorship), but it is a very difficult topic. The Special Rapporteur on Torture, Manfred Nowak, who reported on the systematic ill-treatment in Spain, lost his position. There are a number of NGOs (Network of 40 members "Platform against torture in Spain", which includes EXIL) who are working effectively in raising and publicising these issues.

Among other things, Sabine commented how Amnesty International learns about cases of torture, and what forms of ill-treatment are common in Spain. She also stressed that the local authorities have been pretty progressive with establishing criminal responsibility for ill-treatment. However, the issue of torture is still not taken seriously by the Spanish government.

Another issue that was raised in the discussion was research and how the data that the centres possess could be used for this purpose.

10.00 - 11.30	<b>Session 1: Plenary. Chairperson &amp; Introduction. Presentations: example of research</b>
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Chairperson: Nimisha Patel, Medical Foundation for the Care of Victims of Torture, UK

#### **Presentation by Nimisha Patel (Medical Foundation UK)**

**"Research: An (un)necessary evil, or an exciting opportunity? Welcome & Introduction"**

Nimisha gave an introduction to the purposes of Day 1, on the theme of research and its outline:

##### *Purposes of Day 1:*

- research,
- identifying the areas of good practice,
- dissemination of the publications,
- outcomes of research.

##### *Outline for Day 1:*

Day 1 consists of 3 sessions.

Session 1 - Presentations followed by the discussion.

Session 2 - Small group discussions about the issues related to research. Each group had to decide on the issues they wanted to present in the larger group. Participants could also present their own research (either completed or ongoing).

Session 3 - Presentations followed by the discussion.

Nimisha also made an outline for Day 2 that mainly consisted of discussions in small working groups. She mentioned that there will be two parallel clinical discussions – one in English and one in French to ensure wide participation.

*(For more details on the introduction and the aims of the meeting, see her power point presentation in the compilation of ppt. files in the zip. file).*

**Presentation by Maryam Jishkariani (The Psycho-Rehabilitation Centre for Victims of Torture "EMPATHY" Georgia)**

**"Consequences of Russian Brutal Military Attacks in Georgia"**

**Abstract**

*(Full version is available in the compilation of ppt. files in the zip. file)*

Author: M. Jishkariani;

Co-authors: G. Berulava; K. Gelashvili; M. Kechkhuashvili; N. Naneishvili; K. Mikadze; T. Bokuchava.

**Aim:** In August 7, 2008 Russian military forces attacked Georgia. The brutal actions: bombing by cluster bombs of civilian population, among them medical personnel, civilian targets, including medical facilities, were used by the Russian forces. Living blocks in Gori and villages were destroyed and burnt; more than 150 000 civilians became forcibly migrants, exact number of wounded and dead persons is unclear up today. Many of civilians were captured, tortured, became sexual abuse and ill – treatment survivors.

**Objectives:** The Crisis Intervention programme for brief recovery of trauma outcomes and needs assessment were started by the RCT/EMPATHY.

**Methods:** Multi-profile medical file (including clinical/structural interview on the following items: medical, mental/psychological, social and legal) was elaborated for the investigation. The Harvard Trauma Questionnaire (Mollica et al, 1992) and PTSD (Watson et al 1994) were used for the examination as well. The programme is implementing in the collective living centres of IDPs, as well as in the Hospitals. Brief trauma recovery programme (1) includes: Exposure therapy, anxiety management and psycho – educational techniques, as well as social therapy and management of the urgent medical problems. Statistical data was collected and analyzed, observation and analysis is continuing up today. The preliminary data has been observed after 7 – 10 days of the main life stress events.

**Results:** For nowadays total number of beneficiaries that was observed and supported is 330 persons. Among them men were 115 persons, women 192 persons, children 23 persons. Average age of adults up to 64 years  $E(A) = 45$ ; Over 65 were 66 persons. Average age of children  $E(A) = 9, 85$ . All they were victims of mass bombing and brutal violence. Observation reveals high level of traumatic stress experience in all cases according to the HTQ Part I (Life Stress Events) Index  $KI E = 4.13$ ; and average index  $K2 E = 2, 61$  (evaluation of PTSD symptoms); That means that all these persons have experienced severe traumas and have symptoms of PTSD. According to the PTSD Rating Score (Watson et al, 1994), average index of PTSD  $E = 87.40$ ; that means that all this persons have severe acute PTSD symptoms. 186 of 330 persons (About 56 %) have physical consequences of mass violence as well. Investigated 7 child among them have several severe injuries, one of them was severely burnt. All they declared that have moral, material, social and legal damage and applied to the RCT/EMPATHY for rehabilitation and restoration of their legal rights. According to the ICD – 10 following diagnosis were observed: among total number = 330 persons: Acute stress reaction: 33 persons ( $F = 0.10$ ); PTSD 271 p. ( $F = 0, 82$ ); 2 persons with Dissociate – Conversion Disorder ( $F0, 006$ ), among them 1 p. with Stupor Reaction with mutism (dumbness); PTSD with depression 6 p. ( $F = 0,02$ ); 3 p. – exacerbation of psychosis ( $F = 0, 009$ ).

**Conclusion:** Observation was done among traumatized victims of severe violation of International Humanitarian law from the ethnic cleansing region of Georgia (so called "South Osetia"), practically immediately after the trauma experience (During 2 moth). In all cases of listed above life stress events have severe consequences that reveals in acute stress disorder and PTSD symptoms (2). The most common symptoms were revealed as follows: recurrent images, thoughts, dreams, episodes of flashbacks, symptoms of depersonalization and derealization, as well as dissociative

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amnesia and stupor were revealed too. These symptoms were followed by vital feelings of feebleness, humiliation, and fear of extinction and deep depression senses. In addition, we propose to address following studies: whether or not PTSD or other stress related disorders fully met the consequences of violation of vital fundamental rights of Human being.

**References:** 1) Edna B. Foa, David S. Riggs, Brief Recovery Programme (BRP) for Trauma Survivors, University of Pensilvania, 2001. 2) Matthew J. Friedman, Terence M. Keane, Patricia A. Resick, Handbook of PTSD, New York, London, the Guilford Press, 2007.

During the presentation, there were several concrete cases of inhabitants from Gori and Oni in South Ossetia presented, who suffered from Russian air jet attacks and ill-treatment by Russian soldiers.

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**Discussion – Highlights of questions and comments**

From the scientific point of view, conducting such studies, in such difficult circumstances, is a very complicated and vast undertaking, often with very few resources. Such studies are, indeed, very important for documenting and reporting the violations and abuses committed. Nevertheless, doing such research is very difficult in terms of methodology. How do you select the people? Based on which criteria do you decide that these people are in need of your help and which people are not? The importance of such practical studies should be acknowledged, and their implications for the research methodology and research outcomes should be explored – even though they may not be easily surmountable.

**Presentation by Ulrik Jørgensen (Oasis, Denmark)**

**“International Classification on Functioning Disability and Health (ICF) applied on traumatised refugees – A Danish Pilot Project”**

**Abstract**

*(Full version is available in the compilation of ppt. files in the zip. file)*

This research is a joint project of seven Danish Rehabilitation Centres.

In the recognition that traumatised refugees for the most part are chronically traumatised suffering from cumulative human inflicted extreme stress, it seems that the focus on symptoms and symptom reduction alone is not the most valid way to measure improvements in the health condition of traumatised refugees. The few studies being made on this group on symptom reduction after rehabilitation intervention are not very promising. At the same time centres reports that many clients have been helped to a better level of functioning despite the continuation of their symptoms.

As a consequence seven Danish rehabilitation centres for traumatised refugees have initiated collaboration on a joined pilot project implementing WHO's International Classification on Functioning Disability and Health (ICF).

ICF was recognized by WHO in 2001 as a classification system for international application. The aim of the classification is to offer a common standardized language and a corresponding frame of concepts to describe health and associated conditions.

ICF is a bio-psycho-social model emphasizing the interaction between the components. ICF consists of two parts. The first part comprises descriptions of body functions and the anatomy of the body, including mental functions, senses and pain as well as activity and participation which correspond with functioning. The other part comprises descriptions of environmental and personal factors, which correspond with contextual factors.

In the ICF project for traumatised refugees a multidisciplinary selected group of experts have

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selected a core set of domains or categories most relevant for the target group. This core set is the basis of the evaluation of functioning, disability and health condition of the clients.

The purpose of implementing ICF is:

- to develop a multidisciplinary documentation tool to describe the overall condition of health,
- to develop a documentation tool to monitor rehabilitation achievements, i.e. to compare measurements before and after an intervention.

The paper comprises a presentation of ICF related to traumatised refugees and the preliminary results of the pilot project.

The completion of the pilot project presented is expected around spring 2009.

### **Major points raised by the presenter:**

- The definition of rehabilitation provided is one where the emphasis is put on the whole life situation, not only on symptoms.
- The interaction of concepts (body functions (impairment), activities (limitation), capacity to participate in social life (restriction). The approach combines environmental and personal factors.
- The ICF classification chart was also presented. The presenter stressed that you should be very concrete about the selection of evaluation issues and criteria.
- The presenter also presented the pilot project that is being currently implemented with the seven partner organisations in Denmark. The aim of the project is to develop a multidisciplinary instrument of documentation to describe the overall health condition of the client and the criteria for the selection of the clients. The evaluation of 6 clients is done by each of the participating centre. The evaluation happens during the treatment and 8 months after the treatment.

The Delphi-method was used for the selection of core sets for the purpose of the study. The core sets were selected by the expert group. Specific chapters were selected in regard to every concept (body functions, activities and participation).

There are 1154 core factors all together, but only a number from them have been selected for this particular study. The study is interdisciplinary, with social and clinical workers (clinicians) collaborating.

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### **Discussion - Questions and comments**

Comment by **Nimisha Patel**, Medical Foundation UK: this project is a very important advancement. Over the years, the methodology for evaluating our clinical work has been difficult and fraught with complexities. This research could be of benefit to us all in different centres, to enable us to evaluate better our work, so that we know whether what we are doing is helpful and how, but also so that funders can be satisfied that we are using their money wisely.

In response to the question about the geographical applicability of this classification, **Ulrik Jørgensen** said that now they apply it in various areas in Denmark: When you are doing research and comparing the scores from one part of the codes to another, you actually should make the selection of codes that are the most necessary to your research, the most interesting. The goal is, of course, to make the codes internationally applicable.

12.00 – 14.00	<b>Session 2:</b> <b>Small group discussions</b> <b>'Walk and talk' plenary: questions and discussion</b>
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In small groups, participants were asked to discuss the following issues:

- 1) In our centres, what examples do we have of research activities?
- 2) Is research necessary to our daily work and why?
- 3) What issues arise in our centres/work when we try to do research?

The results of the discussion were presented in a poster created by each small group. These posters were displayed to enable all to look at and discuss in the 'walk and talk' plenary.

## **Poster 1**

### **Examples of research**

- Evaluation
  - projects,
  - client groups,
  - country specific,
  - professional helpers,
  - how to measure outcomes
- Documenting / comparing
- Qualitative / Quantitative Research

### **Why? Perspectives**

Advocacy

Funding

Evaluation of efficiency

Exchange of best practice

Need objectivity

### **What issues arise in conducting research in our centres?**

Resources / limited funding

Some projects need to be long term

Research vs Therapy?

Objective?

Participants left – cannot access

Social differences – gender

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How do you use the results of the research?

Not often used – dissemination

Misuse of the research

## Poster 2

### Research examples:

- 2 out of 5 centres have ongoing studies
- all have +/- systematic documentation, e.g. intake, monitoring (clinical), minutes of meetings

### Necessary?

Ranges from low to high priority

In favour:

- own curiosity
- accountability
- evaluation of results
- documenting environmental / social changes (advocacy)

Against:

- Urgency of need to provide help
- Target groups too marginalized
- Scarcity of resources

## Poster 3

### Examples of research activities

- 1) Monitoring + Evaluation: **structure + impact** - tool for daily work
- 2) Efficacy study: to determine values of clinical intervention
- 3) Therapeutic alliance. Cultural practice of interpreters
- 4) Analysing clinical practice

### Issues

- funding
- embedding + managing research
- methods (appropriate + adapted)

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- benefits + **constraints** of joint projects with 3rd parties (e.g. university)
- non-aligned agenda

### Issues/Problems

- No avenues for adequate dissemination
- need to use research results to effect change
- capacity + multidisciplinary approaches
- marketing research into efficacy of an advocacy

## Poster 4

### Research is important

- perspective of clients - “consumers report”
- qualitative data
- depending on purpose (e.g. advocacy and fundraising – any data good because so few exist)
- test ICF in different contexts
- hard to measure results: various levels (individual / family / etc.; need of trying new instruments)
- cost-effectiveness: demonstrate usefulness; donors' request; advocacy need
- to connect “consumers” needs and evaluation and cost-efficiency

## Poster 5

### Examples of research activities

#### RCT

Clinical trials – expensive

documentation – falaka

consequences of treatment

psychiatric research – PTSD / Brain damage

progress analysis

prevalence of torture study (Bangladesh)

action oriented research (regionalised in communities)

political economy of victimhood

prevention – who are perpetrators and why?

assessment instruments (Albania, Guatemala)

legal

### **How is research defined?**

- all types throughout centres
- statistical analysis (ALL)

Effects of asylum process on health (Ulysse)

- times of treatment
- numbers of people

Outcomes of medical treatment (TOHAV and all)

Isolation in prison

Policy/legal

Monitoring systems public attitudes to torture

Working conditions for clinicians

Total outcomes test (Centrum 45) – based on questionnaire

Client focused

Issues with compliance

### **Research vital for**

- fundraising
- improving practice
- prevention
- access
- advocacy
- therapy
- challenging impunity
- providing tools for campaigning
- reflection

### **Issues**

- Relevance
- Internal resistance
- Ethics of research with client group
- Where does the research agenda come from?
- Prioritization
- Difficulty of raising money for research
- Client involvement

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- Who is research for?
- People – appropriate experience
- Methodology
- Network coordination
- Different perspectives
- Cost + money + time

15.30 – 17.30	<b>Session 3: Plenary discussion. Presentations: example of research</b>
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Chairperson: Jan Ole Haagesen, RCT Denmark.

**Presentation by Leanne Macmillan (Medical Foundation for the care of Victims of Torture, UK)**

**“Human rights research: An overview”**

**Abstract**

*(Full version is available in the compilation of ppt. files in the zip. file)*

This talk will include a brief overview of the importance of documenting torture survivors experiences for the purposes of human rights advocacy. It will look at the appropriate approaches to the use of client data for human rights purposes and the role of survivors in determining how information they provide is used. Obvious issues about consent and confidentiality will be explored. Finally, while human rights research methods are well established, the experience of the Medical Foundation in doing human rights and clinical research to support its advocacy work will be explored.

This presentation included a brief overview of the importance of documenting torture survivors' experiences for the purposes of human rights advocacy. It looked at the appropriate approaches to the use of client data for human rights purposes and the role of survivors in determining how information they provide is used. Obvious issues about consent and confidentiality were explored. Finally, while human rights research methods are well established, the experience of the Medical Foundation in doing human rights and clinical research to support its advocacy work was explored.

Leanne started by raising a question why it is important to conduct human rights research. She highlighted the following aspects:

- Interdisciplinary approach to human rights studies (though, qualified interdisciplinary research is rare in reality)
- For what purpose do you need this type of research?
- In terms of the delivery of rights, everything is more complex than combining only social and legal disciplines.

It is always important to look at the client group and their needs/expectations. Human rights are very concrete because they have a direct impact at the community level. So, human rights theoreticians can do important work, but practical level will be still more crucial and appropriate to study and analyse how HR are implemented and fulfilled.

In her presentation, Leanne paid attention to the following aspects:

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- Sources of human rights (documents, jurisprudence, policy guidelines)
- The specific features of human rights (They are defined and guaranteed internationally. They are applied to every state. They are universal, interdependent, indivisible and interrelated. They cannot be taken away, with the only exception of emergency situations).
- Duties of the state to respect and protect HR and prevent their violations.
- An important factor is whether the funding is available from the state to protect and guarantee the rights of torture survivors.
- Implementation of HR is a very problematic issue. It differs from one country to another.
- Research is highly correlated with the practical implementation of HR. People can be observed on the ground, in order to learn if their rights are guaranteed. This type of direct observation helped to set up many important standards.
- HR research should be done in the consistent and systematic way to ensure that certain standards are maintained and to grasp an understanding of what is still needed.

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Jan Haagesen stressed the importance of the topic once again and that HR should be utilized in our work. Then, he introduced another speaker.

**Presentation by Peter D. Brigham mag. art. psych., Treatment Director/psychologist RCT-Fyn Odense, DK.**

**“Treatment and rehabilitation of traumatised refugees: A research overview”**

**Abstract**

*(Full version is available in the compilation of ppt. files in the zip. file)*

Peter D. Brigham talked about HTA (Health Technology Assessment) and the findings that their organization has acquired in this research. He presented the publication on HTA for treatment and rehabilitation of PTSD conducted in the Regional District of Southern Denmark.

In the fall of 2008, the regional district of southern Denmark – home to trauma centres : RCT-FYN, RCT South Jutland, and CETT – published a report/literature review of scientific research involving the treatment and rehabilitation of patients with PTSD, with a particular focus on traumatized refugees. The review was created under the perspective of a Health Technology Assessment (HTA) which attempts to examine elements of: technology, organization, patients and economy when working with treatment of PTSD.

This presentation provided an abbreviated presentation of this report, addressing the following issues:

- primary literature/research sources,
- findings and conclusions of the HTA derived from literature,
- potential insights from the HTA for treatment of traumatized refugees.

Literature sources:

- Australian and English guidelines.

Technologies: psychosocial treatment methods.

Therapy types: psycho-education.

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How does it all apply to PTSD and refugees? There are actually only few studies conducted that measure the treatment effect of traumatised refugees.

Major findings of this study:

- Evidence points at synergic effect between psychosocial treatment and psychopharmacological treatment.
- There is a connection between the psychosocial resources of the patient with PTSD and gains made from different psychosocial treatments.
- The contact established between the therapist and the client is an important active effect-mechanism.
- Family-based interventions are clearly beneficial.

Other outcomes/aspects of the research conducted:

- From evidence to practice and then to best practice with the help of such research.
- The following related elements in treatment are important:
  - Phase 1: establishing safety and stabilization
  - Phase 2: reworking grief and loss
  - Phase 3: rehabilitation, learning to live with PTSD, breaking up the isolation.
- Another important point is the constitution of interdisciplinary approach – therapeutic milieu.

Conclusions:

- Rehabilitation of traumatised refugees is a particularly complex area of treatment.

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Jan Haagesen (RCT Denmark), the chairperson, said that Danes started investing in such type of research. This research is not only about PTSD, but also about social and physical exile.

Then he introduced the next speaker, Nimisha Patel from the Medical Foundation, who also teaches at the University of East London in the UK.

### **Presentation by Nimisha Patel (Medical Foundation for the Care of Victims of Torture, UK)**

#### **“Integrating health research and human rights research on torture: Challenges and Opportunities”**

##### **Abstract**

*(Full version is available in the compilation of ppt. files in the zip. file)*

This paper will attempt a preliminary analysis of research on torture, as evidenced in clinical/health research and in human rights research. It will begin with a (tentative) typology of both clinical/health research and human rights research related to torture, outlining some strengths, weaknesses and gaps emerging from such an analysis. It is recognized that in the context of limited resources, competing demands, inter-professional differences and for some centres, unstable political and economic contexts, research is often not a priority, or simply not viable, even where there is great commitment to it.

The tenet of this paper is that there may be merit in attempting to conduct research which integrates both clinical and human rights approaches and priorities, wherever possible. That said, such an integration raises many challenges, including epistemological, theoretical, methodological, ethical and professional. Nevertheless, the opportunities arising from the conduct of such research may inspire us to address some of these challenges, even if we cannot reconcile some of the fundamental differences. The paper concludes that there is a need for both traditional health/clinical and human rights research as well as for *integrated* clinical/human rights research - which perhaps should be seen less as a (un)necessary evil, and more as an opportunity to meet our strategic aims in combating torture and in ensuring high standards of care and services for torture survivors.

In her presentation, Nimisha Patel talked about current research in the field of torture – from human rights research field and clinical research on torture. She said that she was going to outline its gaps and strengths and then to talk about the potential and challenges of integration of the differing approaches to research in this field.

She started her presentation with the following quotation from one of her clients: *“What is the point of talking about human rights, what are my human rights when I am not even human? ...*

She stressed that this was a very grounding statement for her – because when we do research, we should always remember that at the centre of all research activities are human beings - they are not numbers, statistics or diagnoses – but human beings.

Major points in her presentation:

- HR research combines legal studies, comparative politics, anthropological and psychosocial studies. Torture-related research combines human rights, anthropological, psychological and medical research. She went into details with regard to each of these four fields indicated.
- Evidence-based practice – Hierarchy: Opinions of clients are considered the last level of evidence (type 5). The hierarchy is strict, rigid and acknowledged internationally - although, this hierarchy can be also considered very problematic on theoretical, philosophical and practical grounds.
- Gaps, weaknesses, strengths in current research on torture:
  - Conceptual ambiguity: e.g. definitions of Human rights? Health / self / recovery?
  - Theory-driven: HR (realist, structuralist, constructivist); Health (biomedical, social, psychological, community, systematic, socio-materialist).
  - Uni-disciplinary
  - Epistemology
  - Methodology-driven: quant or qualitative / validity and reliability
  - Distant from practice and policy: HR practice and policy? Clinical evidence and policy – evidence-based?
  - Values and power-absent.
- Focus of study that can be diverse. It covers state, community, family and individual levels. Basically, we are looking at the same issue from different angles.
- Research Questions:
  - Why the progress is slow? Why the torture continues?
  - Why do people torture?
  - What can be done to prevent torture?

- Challenges for Integration:
  1. Conceptual
  2. Epistemological
  3. Ethical challenges (how we position the survivors of torture in such research?, etc.)
- Professional challenges:
  - Interdisciplinary dialogue and understanding
  - Hierarchic threatened – whose experience of most important?
  - Threats to professional identities?
  - Professional mutual respect
  - Living with “mess”, complexity and uncertainty
- Organizational challenges:
  - Resources
  - What is driving the research
  - Who has a voice: role of clients?
  - Big Brother is watching... Who is Big Brother?
  - Watching the ball, not the game
  - Managing change: the research always implies change and transition
  - Change: loss and uncertainties
- BUT... always ask about the research question, research objectives, beneficiaries, recipients, dissemination, risk of misuse.
- Conclusions:
  - Research is a tool – the means, not the end
  - Research is a political act

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**Key issues that arose during the discussion of the three presentations presented at the Session 2 and 3:**

- When you talk about the prevention of torture, you have to look at the social relations and state institutions to find out about the cases of torture. Anthropologists can be pretty helpful in such research.
- We are normative, when we create and use international documents - the Convention against Torture is our most important international document.
- Evidence-based research. How do we apply it? It's difficult to apply evidence-based research in other contexts. Usually, it applies only to the given situation at a given point of time.

It is indeed very difficult. But one can try to challenge oneself and study what is conventional and what is not conventional.
- Helping torture survivors is the major objective of research on torture. The purpose is apparently to learn how we can use the voice of our clients to improve the world. We also

have to have a very clear clinical agenda, and political, too. We want to improve the world. Research is also about improving our knowledge and how we can use it to improve the world. While providing care to a specific client, we want to help this particular person but while doing research, we are looking for the results that will result in changes wider than the individual client.

- The right to health. People tried to define it and it appears to be difficult. However, we should remember that this is the crucial right that our clients need. The right to health is an argument that we have not been using enough to make the states do what they are ought to do.

What is the content of the right to health: what are the requirements in the country of residence of the victim and in the country of exile of this victim? So far, we have not answered these questions. The right to health – there are other studies done, but not so much study in our field of specialization.

- People think that what we are doing is objective, but it can be also more subjective. One type of research is more biased than another. One can use the research for different reasons. It's impossible for any research to be objective.
- Suggestion was made for those who do not have so much experience with particular research methods to share their opinion about what might be the topics for reflection that the Network can discuss in the future.
- Human rights research is done for the purpose of proving that there is torture and what we can do to prevent it in the future. We should look across all the rights to look for a solution.
- Human rights are also dynamic. Therefore, we must continue working on the definition of torture. Officials expect the clear criteria for instructions. They can't define for us at a certain point. So we have to define it ourselves first and bring it to them in order to make them comply.
- There is always one thing you can be sure about. In every study in the end it is stated, more research is needed. Another point: it's only truth when there is a research about it.

## Day 2 - Thursday, 7 May 2009

09.15 - 17.00	Session 4, 5, 6: Network Working Groups
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Elise Bittenbinder and Nimisha Patel explained the organization of the day and provided technical details on where each working group will be located. The groups were to work individually during the whole day.

There were the following working groups:

- 1) **Research.** Leader and coordinator– Nimisha Patel, Medical Foundation UK
- 2) **Legal issues & Advocacy.** Leader and coordinator - Leanne Macmillan, Medical Foundation UK
- 3) **Fundraising.** Leader – Jan Schaart, Foundation Centrum'45, Netherlands
- 4) **Clinical Discussion Group.** Leader and coordinator - Else Ryding, OASIS Denmark. Facilitator for the French speaking group – Marc Walter, EXIL Barcelona.
- 5) **Assessment and Documentation Group.** Leader and coordinator – Camelia Doru, ICAR

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Romania.

*Note: The overall composition of groups can be found in the list of participants (see the compilation of files from the meeting).*

### **Research Working Group**

**Leader and coordinator: Nimisha Patel, Medical Foundation UK**

#### **Topics discussed:**

- How research can help to improve the work of rehabilitation centres and their services provided
- Some research on legal aspects of clients' care and protection
- Health policy-related research and misuse of research by policy makers
- Asylum seekers – and experiences and research needs specific to asylum seeking torture survivors
- Therapeutic alliance – when clinical team works with the interpreters. Training interpreters.

The following agenda was set up:

- 1) Reflecting on our discussions on research yesterday, Day 1, in small groups;
- 2) Presentations of ongoing or future research projects people were engaged in;
- 3) There is some overlap on Working Groups' interest in research - we may come back to a bigger group to share our ideas and have a discussion with the Legal and Advocacy Working Group and the Assessment and Documentation Working Group.

**Why are we doing research?** Conducting research is important for the improvement of services provided by the organizations and advocacy. Research helps to understand and learn what works better and why.

Research can be done in the form of case studies to learn about best practice as well as challenges that organizations face in their work. For instance, which impact the reports provided by the centres have on the decision to grant or not to grant the status of an asylum seeker.

Mid-term and long-term follow-up and outreach are also necessary to learn that you are doing the right work. Thus, research can help to learn which treatment work under what conditions and if not, what are the factors leading to failures in practising it.

Research can also help to prove what the clients need and what is in their best interest. The results of such research can be used to show the authorities which services they should support in the first run, as well as to define the more feasible guidelines for health commissioners, social services and other public services that work with refugees and victims of torture.

**Dissemination.** Publishing the work that is being done, and not only scientific work, helps a lot in proceeding with our activities. It's a possibility to transmit your work and share it with others, and this is what is largely missing now. Many of our peers even do not know what our work is about. Even the professional documentation can be of great for help to learn about what works and what does not work in our field. Indeed, it is not always easy due to the lack of time and/or capacities. Clinicians, for instance, are not so much into the writing compared to researchers. Most of them simply do not know how to write about their work.

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**Organizational issues.** Not all the organizations of the Network have specific research projects running or specific research departments. Therefore, the focus should be on how to facilitate other centres that do not have research activities and are not involved in research activities of other organizations. In this regard, issues of organizational capacity (HR and finances) were paid particular attention given that the opportunity of doing research directly depends on the size of organization and availability of resources.

**Interdisciplinary research: Issues and Questions.** It is important to bear in mind that due to the specifics of our work our research should be clinically-oriented. For instance, yesterday it was not clear how HR research could be linked to clinical research.

The situation in various universities with regard to the research on the treatment of refugees and torture victims was discussed. *Pim Scholte (Equador, The Netherlands)* stressed that the faculties in the universities to which the staff of their organization are connected have biomedical orientation and their members expect you to be involved in the scientific work. Considering the existence of these structural connections, we should try to sell more socially-oriented research within biomedical streamline. This is the trick, how to include it into the biomedical interest that all our organizations share. In this context, the question was raised if more socially-oriented research can be regarded as an autonomous field when it comes to the treatment of refugees and torture victims – without having to resort to biomedical approaches alone. So far, socially-oriented research gets little priority in medical departments, because you are forced in the format and agenda these departments work with.

On the other hand, the context in UK is slightly different – though biomedical approaches do largely predominate. In the University of East London, where *Nimisha Patel (Medical Foundation)* works, there is a research group on critical psychology where they are interested in various aspects and do not focus on positivist, biomedical research but draw on critical approaches to research which take into account context, social and cultural and political issues and experiences of marginalisation and oppression. In this environment, one could feel more supported, and have greater flexibility and independence in terms of the kind for research that can be carried out.

Usually, it is extremely difficult to create projects that involve specialists from different fields, given that it is not clear who is going to fund such projects.

Methodology is another important issue related to the interdisciplinary research. How to develop the methodology for such research? In fact, it is much easier to stick to symptoms, but it does not provide a comprehensive picture of problems. Nevertheless, research coming from different specialists is equally important. In our field, medical people have to avoid becoming 'anti-social', while other specialists should not become 'anti-medical': "In that sense, we are condemned to work together."

### **General constraints for research in the area of refugees and torture**

Several issues related to funding were discussed. In different countries the situation with how the organizations secure their funding varies greatly. In some organizations, the majority of funding comes from public sources, while others rely on the grants provided by large political and international donors. For the organizations which receive their funding from public sources, it is easier to keep up to the necessary research activities given the consistency of this source, in comparison to political foundations and international donors.

The constraints imposed on the research can be external. So what can be done to overcome them? First, all the figures and facts that to prove the need for research activities the organization is planning to do should be thoroughly documented. This documentation can help to prove that the research is needed and also to plan which issues the research will address. The research makes the necessity of our work visible, and thus people can learn about the work we are doing and issues we are confronted with.

Another problem is that the topic of torture or refugees is extremely sensitive and complicated.

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How can you talk about torture without having people being frightened and disgusted with the topic? The challenge is an important topic for the public, while avoiding its “banalization” at the same time.

Another factor is motivation. Staff should feel motivated to conduct research activities and contribute to ongoing research in other organizations.

The issue of databases and monitoring systems and organizational constraints related to their use were also discussed. One of the biggest constraints is to ensure that a holistic approach is adopted and that we need to use minimal data on clients for advocacy, monitoring, etc. However, the issue of confidentiality is very challenging and due to it we often have incomplete data to work with. Therefore, it is important to define which type of data we actually need, for what and how we are allowed to use this data.

### Research topics of shared interest:

- ICF covers lots of important areas, but it doesn't cover all of them. How would you approach the issue of **dignity**? The definition of dignity is still contradictory in different countries, but a number of core patterns have been already defined. This includes social well-being, mental well-being, and environmental well-being.
- Another concept of interest might be the concept of **social capital**. It is experimental, but it's very interesting to work with it. *Ecuador (The Netherlands)* has worked with this topic (*please, refer to Pim Scholte for more details*).
- The work with disabled people and the concept of **impairment** and how it goes together with disability. The real problem is being considered inferior. What is the value system that people with disabilities have? The value system is very important when it comes to work with refugees or victims of torture.

Another major question is how to reconcile the system of values we are working with and the conflicts that occur in such work. There a lot of projects going on with various methods.

- It is important to consider the **natural resources of people**. This might be very beneficial for the clients and their empowerment.
- **ICF** is another important instrument that has to be further applied in research. The most difficult part is to select the codes and decide on how we score them. Communication with the clients is another important issue. How do we ask the clients about the codes? You have to interpret them to make the codes understandable to them, which requires lots of work to do.
- There are no **relevance-based methods** that are used in the work with refugees. This might be another interesting issue to address.

### Examples of research in progress/planned:

- How to work with **psycho-biological factors** in various cultural contexts. Experts in mental health and their role in the treatment process. The communicative aspects in the interaction between the professional staff and clients. For instance, the definitions of stress, pain differ in various cultures. The question is how these differences should be addressed in order to establish effective communication with clients. The work of collaborating centres in this area should be further studied. For instance, a good example of collaboration in stress research can be found in Denmark (*for details, please, refer to Franz Baro, EXIL Brussels*).
- How to work with **the concept of universality** that is applied to socio-political concepts used in the area of international development cooperation and democracy assistance (e.g. human rights, democracy). By translation we imply not only the linguistic translation, but

how these concepts are defined in the policy of international donors and how we translate these concepts into the local societal and state model, as well as in the local system of values (*for details, please, refer to Yulia Schulte, BAFF Berlin*).

- The **comparative analysis of medical treatment** of torture victims. The research should also draw on comparing practices of medical staff in various centres. The objective is to find out what knowledge exists about torture and how it is conceptualized in different countries. Approaches to defining the concepts of access, rehabilitation and treatment are given particular attention. The countries studied are Spain and Ireland. The methodology applied: questionnaires and interviews with the medical staff (*for details, please, refer to Monika Weissensteiner, EXIL Barcelona*).
- The importance of legal and medical reports and their quality. Research questions: How do we improve the quality of our legal and medical reports for clients? What impact does the report usually have? The research highlights the potential for misuse/misinterpretation of clinical information provided in reports (e.g. in the court).

Methodology: Mixed methodology, using quantitative and qualitative methods, including discussions with medical and legal practitioners to define quality criteria for such reports, ratings of reports retrospectively, statistical analyses. Also, qualitative analysis (legal and clinical) on interpretation of clinical information on torture survivors by the immigration courts. The research is ongoing (*for details, please, refer to Nimisha Patel, Medical Foundation UK*).

#### **Suggestions on how to promote and disseminate research within the Network:**

- 1) In lots of places, preliminary research has started but most of it remains uncompleted. The problem with the preliminary research and reports is that it is not published internationally and therefore, we are not able to learn about the research activities that our colleagues attempted to undertake. Acknowledging that there might be different reasons as to why people do not disseminate their work internationally, we can try to disseminate more information about work results and ongoing research projects within the Network – at Network meetings, using poster presentations etc.
- 2) Another suggestion was to facilitate the exchange of the information about the institutions participating in the Network, so that all the members can better learn about each other's work. For this end, a user friendly questionnaire had been developed 6 years ago, updated and distributed at least 4 times to date by the Research Group (2003, 2004, 2005, 2006). The findings were reported by Nimisha in previous meetings, and in Antalya by Ulrik Jorgensen. It was decided then that the questionnaire could be modified and re-distributed periodically. There was general agreement that this would be useful to try again. Ulrik and Nimisha will take this forward.

17.30 - 18.30	<b>Presentation: “Centre under Pressure. The case of Memoria, Republic of Moldova.”</b>
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**Camelia Doru on behalf of Ludmila Popovici**

**“Centre under Pressure. The case of Memoria, Republic of Moldova.”**

*(The full version is available in the compilation)*

Camelia Doru (ICAR, Romania) made a presentation on behalf of Ludmila Popovici, Director of Memoria, an NGO working with torture survivors in Moldova. Members of Memoria were persecuted by local public authorities and policy for protecting the participants of the demonstration who became victims of torture and ill-treatment.

Background: Following the announcement of preliminary parliamentary election results on April 6, 2009, which showed that the Party of Communists of the Republic of Moldova was winning approximately 50% of the votes, the opposition rejected the results, accusing the authorities of falsification in the course of counting the votes and demanded new elections. In response, opposition and NGO activists had organized protest demonstrations in Chisinau on April 6th and 7th.

The demonstration had escalated into a riot on April 7th, with protesters attacking the parliament building and the presidential palace, throwing stones at the buildings and the riot police guarding them. In the afternoon of April 7th, the rioters had broken into the parliament building, looted it and setting it on fire. Police forces had regained control of the city centre by April 8th, arresting several hundred protesters. Following the arrests, numerous cases of excessive force usage including beatings and torture by the police were reported by the detainees.

*(See [http://en.wikipedia.org/wiki/Moldovan\\_parliamentary\\_election,\\_2009](http://en.wikipedia.org/wiki/Moldovan_parliamentary_election,_2009) for more details on the parliamentary elections in Moldova and civil unrest, as well as links to other sources that reported on this event).*

*See also the press release by the Amnesty International Moldova available in the compilation of the documents distributed during the meeting.*

**The following issues were discussed:**

- What can we do when our own/ sister centres are in trouble? If the centres try to protect the victims of torture and abuse, they can be subjected to persecution from the authorities and put themselves under direct threat. The Network needs to discuss (a) in which way we can support centres in trouble and (b) setting up guidelines by the Network on how we may offer support as the Network to Network members and how we may intervene in such situations.
- Participants discussed the situation in Moldova and particularly the situation for Memoria. There was a suggestion to pass on the information on the situation faced by Memoria to FRONTLINE in Dublin, as well as to other human rights organizations that might be of help. Another suggestion was to use the procedure of urgent appeals available at the UN Special Rapporteur on Torture and Special Rapporteur on Human Rights Defenders, and possibly write to the UN High Commissioner for Human Rights to request a country visit.
- Leanne Macmillan (Medical Foundation UK) offered to prepare a statement/letter about Memoria and the situation in Moldova that the Network members could use in their national contexts to disseminate both at the international and national level to key and relevant people. There was considerable discussion on the possible content of such a letter, where and how it could be used and the logistics of organising logos, signatures etc. from signatories from the Network.

## Day 3 - Friday, 8 May 2009

### 9.30 - 10.30 Session 7: Network Working Groups

The groups continued working in their groups to summarize the results of their discussions from Day 2.

### 10.30 - 11.30 Plenary: Brief reports from Working Groups and Clinical Discussion Group

During this plenary session, each Working Group and Discussion Group reported back, summarising their discussions. The posters with the main issues discussed in each group were prepared, and provided herewith:

- 1) **Research Working Group.** Leader – Nimisha Patel, Medical Foundation UK.
- 2) **Legal issues & Advocacy Working Group.** Leader - Leanne Macmillan, Medical Foundation UK.
- 3) **Fundraising Working Group.** Leader – Jan Schaart, Foundation Centrum'45, Netherlands.
- 4) **Clinical Discussion Group.** Leader - Else Ryding, OASIS Denmark. Facilitator for the French speaking group – Marc Walter, EXIL Barcelona.
- 5) **Assessment and Documentation Working Group.** Leader – Camelia Doru, ICAR Romania.

#### Research Working Group: Summary of key issues discussed

Leader – Nimisha Patel, Medical Foundation UK

Question posed: is research is an (un)necessary “evil” or an exciting opportunity?

#### Issues

1. For us to be motivated to do/engage in research it needs to be relevant to our clinical work
2. Research – priority in most centres – but even if it is – funding? Is it prioritised?
3. External forces to do research are many ... but also needs
4. Internal drivers – motivation + willingness to do research from within our centres
5. There is a need for all kinds of research, so we move from the traditional evidence hierarchy (where RCTs, SRs are seen as less biased and higher level of evidence) to an approach where various types of research (qualitative and quantitative, case studies, client opinions etc.) can be equally valued and prioritised – each seen as contributing to the whole in terms of evidence.
6. Dissemination is key – but consider: to who, why, how, issues of ‘generalisability’ or ‘transferability’
7. Search for “whole picture” – can seem huge, impossible, overwhelming – not be deterred, begin with small research questions, work together, make a start – see it as an ongoing, collaborative venture.

8. Uses & misuses of research.
9. Research can 'change the world': practice, research methods, organizations and policies. It can change things in both positive and negative directions.
10. To do research in this area – we need to start with better defining what our practice / model/package/service constitute: elements, professions.

Questions we have to address:

What are we doing?

Why?

How do we do it?

Does it work?

**Plenary discussion:** A suggestion was made to talk about collaborative research projects within the network and how such projects can be organized.

Particular research topic to work with might include the constructions of health, recovery and well-being after the treatment as a victim of torture. Medical Foundation UK has already conducted pilot studies on this issue, and is doing current research in this area – which is part of a larger project to conduct a Systematic Review (in progress) and to develop an routine monitoring outcome tool for torture survivors. This research will yield opportunities to collaborate with other Network centres (e.g. validating the outcome tool) (*for further details, please, contact Nimisha Patel from the Medical Foundation UK*).

Similarly, the ICF project in Denmark may be useful for many centres, and there may be opportunities for Network members to collaborate further down the line.

It was also argued that so far there have been no studies that prove that the interdisciplinary research is effective. The success of the interdisciplinary research depends on how you define the target to make the comparison from different disciplines possible.

**Particular needs / steps to be taken:**

- Nimisha promised to send an email after they have systematized their research timetable so that later on, when appropriate centres who are interested in collaborating may be involved. Participants also asked if it is possible to receive the posters with the research information from the Medical Foundation. (All posters presented at the Network meeting are in the attached zip folder).
- Ulrik Jørgensen (Oasis, Denmark) informed the participants that the first report on ICF will be completed in October. They are planning to publish an article about it and get it translated into English (he stressed that all the research work is done in Danish). He will also look for an opportunity to translate the final report. He proposed to have a dialogue with those from the participants who are interested in **implementing ICF** and make it part of the next meeting agenda.
- The Network can start with identifying small particular questions that the members can start working with and create specific research projects.

### Legal Issues & Advocacy Working Group

Leader - Leanne Macmillan, Medical Foundation UK

#### Legal & Advocacy

1. Round Table  
Issues – Common?
  - Europe wide?
2. Place: within the Network  
within our organisations  
within our disciplines
3. Way Forward

#### Issues

- Identification of Survivors
- Do survivors know their Human Rights?
- Do rehabilitation workers know human rights of survivors
- Challenges and opportunities of interdisciplinary approaches

B: Adequate Housing

#### Issues:

- Survivors Voices heard:
  - o access
  - o for purpose of:
    - awareness
    - prevention
    - change
    - accessing rights
    - funding
- Clinical voice does not equal one clinical voice
- Action
- Code of conduct

#### Possible key Issues:

- Rehabilitation
  - Failure of the State
- And obligations (private actors)  
“Due diligence” =>

#### RIGHT TO HEALTH

- practical issues
- indicators – need x (can't read)
- ?'s of adequacy standards
- Working across areas of: law, mental health, disability, HIV/AIDS, Public health, development world...

## ACTIONS

1. Propose to steering committee
2. Do literature review on indicators and share
3. Look at right to health standards in our countries
4. Email "tree"
5. Book: Right to Health: Resource Manual for NGO's

**Major issues and plenary discussion:** The group stressed the importance of combining research and advocacy in the work of the Network. How do we advocate for the rights of the clients? Law and legal issues are not sufficient and they should be combined with research and findings of clinicians in order to make efficient advocacy.

The group stressed that the discussion about this issue was already raised within the Network last year. Elise Bittenbinder and Jan Schaart, members of the Network Board, have been dealing with advocacy issues for a long time. To be more effective, the Network has to decide on how to address legal and advocacy issues in its work both at the level of the Network and individual organizations, as well as how to advocate for its activities in the EU-wide context.

**Suggestions:** A proposal was made to focus on the **right to health** at the next meeting:

- content of the right to health
- literature review and development of guidelines.

### Fundraising Working Group

Leader - Jan Schaart, Foundation Centrum'45, Netherlands

*For minutes of Fundraising Working Group, see Appendix 1*

Financial crisis: other ways of funding

- private
- corporate
- fr foundation
- broaden up our activities

Normal agenda:

EIHRD / ERF / UN Voluntary Fund

Mental health – EU Health Fund

Twinning:

- more and more cooperation
- start informal

### Clinical Discussion Group

Leader - Else Ryding, OASIS Denmark

Facilitator for the French speaking group – Marc Walter, EXIL Barcelona

#### Summary of topics addressed

Summary for French-speaking group and mixed English/French-speaking group sessions, submitted by Beatrice Patsalides, Centre Primo Levi, Paris)

For summary by Else Ryding (Oasis, Denmark) - see Appendix 2

1) In response to the organizers' proposal to discuss the topic of « **best practice** » several responses and critiques were formulated:

**a)** the topic was thought to be too broad and needed to be narrowed down, made more specific in terms of defining economic framework for each centre determining work conditions and patient populations (asylum seekers vs. Refugees with status vs. Migrants etc.), therefore defining also parameters of interventions (psychoeducational, psychotherapeutic, psychiatric, social, group, etc.). Conclusion that the term « best practice » needed to be modified in response to local conditions, patient populations and varying degrees of patient vulnerability necessitating different kinds of treatment and socialization approaches.

**b)** The term « **best practice** » was criticized as suggestive of the existence of one single idealized way of practice or clinical/theoretical approach that, supposedly, « best » responded to victims'/survivors' needs and demands – this implication was rejected and the term was replaced by « good enough practice » - along the lines of Winnicottian thought – suggesting that each single centre, and perhaps, to some extent, each patient required a treatment and intervention approach individually adapted to his or her specific situation.

**c)** Further parameters that elicited various comments, critiques, and differential definitions from various participants were:

- Notion of **trauma**: « Post-traumatic stress disorder » - a symptom-defined *state* vs. trauma seen as a life-long and ongoing *process* with varying times and degrees of emergence of traumatic content and of traumatic memory. Here, questions arose as to the importance of the patient's situation within the continuum of *victimhood* (importance of recognition as a victim on legal and symbolic plane at one point in time) --- *survival* (living beyond victimization) --- *going on living* (living beyond survival, in the sense of not being exclusively determined by survival), and in regards to a potential, often very problematic, at times impossible social integration process. With the processes of traumatic memory suggesting that the continuum must not be thought of as a linear progression from victimization to survival to going on living with a supposed, again idealized, « symptom-free » « ending », but rather as an ongoing process that includes moments of return and revisiting of traumatic scenes that are constantly being reshaped and reworked into the person's psychic fabric and life.
- Notion of **timing** of interventions was highlighted as an important aspect for treatment: the timing for the patient to work through traumatic scenes/content; disagreement here among clinicians in regards to the question of « who holds the knowledge » about this timing, and who initiates the confrontation with it, - the patient? The clinician? - evidently the clinician's theoretical framework determines the answers to such questions, with extremes lying with the behavioral (exposure) and, on the other end of the spectrum, the psychoanalytic (patient's demand gives cue) approaches.
- Similarly, **treatment** « **success** » or « **recovery** » are notions that are differentially defined

according to **treatment philosophy**, determining, in turn, treatment methods. The clinical discussion group encompasses a wide range of theoretical differences based on different notions of selfhood, importance (or not) of cultural differences, and varying definitions of agency (to name only a few, clinicians adhere to behaviorist, cognitivist, systemic, psychoanalytic, etc. schools of thought).

**2) Some variables were recognized as essential for discussion and for formulations of « good-enough » practices:**

**a) Language and interpretation:** While the need for interpreters was asserted by some clinicians and relativized by others (who prefer to work either without a third presence, in acceptance of linguistic imperfection, or who prefer anonymous interpreters by telephone) it was agreed upon that if live interpreters were used, they should be professionally trained and supervised.

**b) Interdisciplinary competencies and difficulties related to working in interdisciplinary teams** Recognized as an element of « group work », essential for the rebuilding of the social link that is being attacked by political violence. Every discipline within the interdisciplinary team – legal, social, clinical (med/psy/physiotherapy.), advocacy...- is endowed with a political function, whether directly or indirectly. Caregiving institutions recognized in their function of providing a « transitional space » (again, a Winnicottian concept), allowing for, among other things, working through of traumatic history, symbolization, mourning, social (re-)inscription and creation of new social links.

**c) Family therapy:** Agreement was reached among clinicians that background knowledge about the transgenerational transmission of trauma determines the importance of being mindful of the family (spouses, partners, (grand-) parents, children, extended family) as a context in which the individual's trauma is being shaped and enacted, and the family links and relations that are being affected by the patients' trauma history. Differential opinions in the clinical group about the direct and immediate inclusion of patient's family in the therapeutic interventions (questions of timing, again), versus the idea of « keeping the family in (the therapist's) mind » even if family members do not participate in therapy. In contrast, some clinicians regretted the scarcity of family therapy that, so they felt, should be systematic for all victims/survivors.

**d) Patients' social isolation as ongoing problem:** Given the fact of a consistently adverse environment – society in general that stigmatizes/marginalizes not only the population of refugee victims of torture, but also impedes/attacks (as brutally exemplified by the recent Moldavia case) the treatment centres and caregivers, let alone the pathogenic and perverse nature of the asylum process – the question of how to address patients' social integration remains of prime importance (and difficulty). Discussions and presentations occurred of various models of group interventions, patient-initiated and/or centre-initiated, psychotherapeutic and/or psycho educational (with the intent to de-pathologize the therapeutic treatment process as « learning »-process, thus making it culturally more acceptable).

**e) Quality of therapeutic relationship** of prime importance for treatment results (as recognized by research). Taking into account here the threefold structure of the therapeutic field: the victimized patient//the caregiver//the Third (society, the Law, language, etc.). Clinicians agreed that particularly in the work with victims/survivors of political violence the Third needed to be made explicit by the therapist who, at a certain point in time, cannot remain silent (since his/her silence would prolong and reiterate the denial of the reality of torture), but is called upon to take a stance vis-à-vis the survivor's affirmation that torture has in actuality occurred, (that it continues to occur), and that it constitutes a violation of human rights and of international law.

**Therapeutic intervention constitutes in that sense a political act, inasmuch as research, training, advocacy – since it involves an act of recognizing and denouncing the existence and practice of torture and its dehumanizing effects.**

**f) Themes and conflicts that emerge in clinical work – some therapeutic approaches and/or methods – questions as to how and when to help patients work through trauma.**

Essentially, the combined English/French-speaking group agrees to disagree on these issues. Group members agree that, in some point in time, patients need to confront and work through traumatic experiences, but fundamentally disagree as to how and when this has to happen, and who initiates this work. This disagreement implies the question of « who is the expert ? » - the patient? The therapist? (or, more radically posed: is there an « expert » at all? Why do we need « experts », what does this need for « expertise » in the field of psychic knowledge correspond to? A need for mastery, control, omnipotence so as to compensate for our helplessness, lack of knowledge, and pervasive sense of deficiency?) Here we confront and expose our vastly different treatment philosophies, see under 1c).

**g) Specific examples of conflict emerging in treatment: Repercussions of violence and aggressivity in transference/counter transference:**

- repercussions on the patient: how has the patient internalized violence? Is there enactment of violence in the family, domestic violence, or violence against children?
- Repercussions on the caregiver: counter-transference responses
- effects of violence and of the unsymbolized/ unsymbolizable aspects of trauma on the institution (see: institutional transference – the institutional processes mirror the patients' processes: disorganization of the team, splitting and polarization of conflicts, acting out, transgressions, boundary violations, etc.)

**h) Importance of conceptualizing and keeping in mind the institution's (as well as each individual caregiver's) therapeutic frame**

Notions of containment, awareness and respect of limits and boundaries, confidentiality (and how to treat c. in a pluridisciplinary team), abstinence (from enactments). Pay attention to idealization of caregivers, pressure to provide for everything and immediately, ongoing emergency mode, patients' ever increasing needs; temptation to identify with the projections of omnipotence, possible fascination with traumatic content, etc. Necessity of supervision as part of institutional structure, as well as personal therapy as a precondition for performance of therapy interventions.

**Special proposals made during plenary discussion:**

- It was suggested to organize more presentations of the clinical discussion groups. There was a proposal that the clinical discussion takes place in a **Clinical Working Group** that can run the discussions on a regular basis. The establishment of such a Working Group may also include the creation of a special web page. Peter Brigham requested that the Steering Committee consider the request for the Clinical Discussion group to be made into a Working Group. Possible topics suggested for the next year's discussion - **recovery, various client groups**. The coordination will be done by Peter Brigham (RCT Fyn, Denmark).

### **Assessment and Documentation Working Group**

Leader – Camelia Doru, ICAR Romania

#### **1. Monitoring and evaluation project (M & E project):**

5 centres to join forces to develop a revised and expanded monitoring and evaluation system with optional sub-sections for victims of other forms of violence (*Project outline in Annex I. See the zip.file with the compilation of workshop documents*).

Justification: The language of the donors and the political authorities are more or less the same and more inclusive

- ERF's call for proposals 2007 refer to: victims of violence and torture: war, combatants, gender based violence, detention, serious medical needs....
- EU's 2003 Directive for reception of asylum seekers refer to vulnerable groups: Torture, rape, other serious acts of violence.
- Council of Europe's health ministers' 2007 declaration on migrants refer to: victims of torture, trauma, and gender based violence.

#### **FUTURE ACTION:**

- Asked who could support the work for such project:  
Norway (Tromsö centre indicated that it could contribute until September).
- Agreed that the fundraising group should to be informed about the need to identify funding for this project.

#### **2. Producing evidence for efficacy of Centre interventions for victims of torture**

Evidence based therapeutic and rehabilitative interventions for victims of violence are possible and necessary:

Specific example: Proposed controlled clinical trial of psychosocial support group intervention for Iraqi refugees in Romania (*Project outline in Annex II. See the zip.file with the compilation of workshop documents*).

#### **FUTURE ACTION:**

- Centres to be asked to consider other specific intervention efficacy assessments and a possible joint project for several such studies.
- Agreed that the fundraising group should to be informed about the need to help identify funding for such individual or joint projects.

**Suggestions:** Camelia Doru suggested applying for additional support to the UN Voluntary Fund, which is valid only for the centres that receive funds from the UNVF. She invited participants to join the Working Group for further discussion. This Working Group thought about exploring the topic of **psychosocial intervention** at the next meeting and including this topic in the new application.

12.00 - 13.45	<b>Closing plenary session</b>
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**Reseda** made a brief presentation on the French-speaking network of caregiving organizations that works with psychological and social issues, prevention and health. It was announced that the **next meeting** of this Network will take place on **26 June 2009 in Marseilles**. Please, address **Beatrice Patsalides (Primo Levy, France)** for further details.

The floor was then given to **Franz Baro (EXIL Brussels)** who made a presentation on “A creative minority”. In his presentation, he talked about various torture issues in relation to the previous conflicts and current conflicts. He also reflected on the topic of professional burnout of those specialists who deal with cases of torture on the regular basis.

The summary of the major points from this presentation is provided below:

*(Full version is available in the compilation of ppt. files in the zip. file)*

- CIA torturing and its costs to USA: The question that Obama has to tackle now is that the US was raised as a state with torture. However, torture gives you very dubious information and you can verify only the little part of it. This practice is very expensive for the US. He also stressed possible negative consequences of torturing for the political activities.
- Impact of a minority: Recommendation to read Arnold Toynbee: “A Study of History”. He described the concepts used and explored in the book. He paid particular attention to the definition of a minority. Central standpoint: As a minority you can try to achieve something only by integrating and hiding among other groups.
- Marry best values of minority and majority: To survive you as a minority you need to stick to the best values important for your minority and merge them with the best values of the majority. If this marriage happens, there is a new step toward.
- The background on the concept of “a creative minority” was provided. Daniel Ellsberg, top decision maker in the White House and the Pentagon, wanted to inform the public how Pentagon used torture in war-making. He smuggled the documents from Pentagon and disseminated this information through the journalists who shared his values. This is how they created “a creative minority”. In their actions, they opted for anti-war making.
- Franz Baro demonstrated statements made by decision makers regarding the torture or the destruction.
- Conclusion: a minority is small, marginal, vulnerable, BUT creative.

**Elise Bittenbinder**, Chairperson of the Network, suggested leaving this presentation made by F.Barro without discussion, given that the presentation is self-sufficient and everyone can explore its content in his or her own way.

Then, she proceeded with **the summary of the points that the Network has to tackle:**

- Clinical Discussion Group to become a Working Group. The Steering Committee will discuss this issue together with the initiators from the Clinical Discussion Group.
- The proposal of Camelia Doru to get the data the Network needs when we approach the fundraisers. She suggested approaching the UNVF to get information about the centres and collect it together. The motion was settled.
- Terms of Reference: the TORs need to be further discussed, based on specific points raised at the Dublin meeting in 2008, and an agreement reached at this meeting in Barcelona. Special thanks were expressed to Nimisha Patel for writing the TOR with

contributions from others.

- Another concern raised: It is difficult to find out how the decision-making process in the SC is taking place. Probably, minutes from our meetings should be made public and accessible to every interested party. Participants said that the possibility of preparing the minutes depends on the capacity of organisations, but brief minutes, recording key decisions can be made available to all Network members. The Terms of Reference will be amended to ensure this point is included, and the final version circulated to all by email.

**Nimisha Patel** (Medical Foundation UK) in closing the meeting, thanked all the participants for their work and very interesting and stimulating discussions. She expressed her hope that the Network will continue working with the issue of research in the future.

She also provided feedback on the reasons why the programme underwent some changes on Day 1. To clarify the situation, she mentioned that originally there were 7 Network centres who were working together on a research project, but due to a disagreement with regard to one person involved in the project, EXIL, Barcelona had decided to withdraw from this project and subsequently those partners due to present on this project in Barcelona decided to withdraw the presentation.

The Chairperson and members of the Steering Committee expressed thanks to EXIL Barcelona, and particularly Ines for ensuring the perfect organization of the meeting, all the preparatory work done and for their superb hospitality throughout the last few days.

**Leanne Macmillan** (Medical Foundation UK) presented the draft statement/letter on the situation in Moldova that would be emailed to all participants. She also presented a list of measures that could be undertaken both by the Network and individual organizations that the participants represent:

Individually:

- To write an open letter as a group that shares the concern. Letter can be sent to:
  - Own government MFA
  - Own national professional organizations for doctors, psychologists, psychiatrists, HR defenders

The things that we can do together as a group:

- UN Special Rapporteur on HR Defenders
- Frontline – NGOs working with HR defenders

It was decided that the organisations should send the agreement to include the name of their organisations in the list of signatories to Leanne. For final letter and related documents, see Appendix 3.

After that, Elisa Bittenbinder made an announcement with regard to the **next meeting**. It was previously discussed that the next meeting would be held in Moldova. But due to the very difficult situation that Memoria centre in Moldova is going through, as evidenced by the presentation by Camelia and in light of the discussions at the Network on Moldova it was agreed that Moldova would not be the location for the next 2010 meeting. Jan Ole Haagensen (RCT, Denmark) and Ulrik Jorgensen (Oasis, Denmark) made a proposal to organize the next meeting in Copenhagen, jointly hosting the event. Further issues related to research could be included in the agenda of the next meeting.

Elise urged the participants to get an invitation for the meeting as early as possible. The emails can be taken from Monika Weissenssteiner, EXIL Barcelona ([monika.w@gmx.net](mailto:monika.w@gmx.net)).

## APPENDIX 1 – Minutes of Fundraising Working Group

### Jan Schaart (Centrum 45, Netherlands)

#### Present:

Belgium	Mouton	Pascale	Exil Brussels
Belgium	de Radigues	Laetitia	IRCT Brussels
Turkey	Uelgen	Mehmet	TOHAV/TRM
		Veyi	Istanbul
France	Janin	Laurence	Primo Levi Paris
Germany	Kammerlander	Anni	Refugio München
Germany	Spoehr	Holger	BAFF Berlin
Netherlands	Schaart	Jan	Centre'45 Amsterdam
Romania	Holst	Erik	ICAR Bucharest
Spain	Conzalez	Laura	Exil Barcelona
Switzerland	Volkmar	Erika	Appartenances
			Lausanne
UK	Keep	Charles	Medical Foundation
			London
UK	Parton	Rob	Medical Foundation
			London
Austria	Glanzer	Edith	Zebra Graz

#### Thursday 7th of May

On Wednesday there were plenary sessions; Jan therefore opened the first fundraising workgroup session on Thursday. The group agreed to the suggested agenda; starting with presentations before the normal agenda.

#### **Presentations on corporate, foundations and private fundraising**

- Erika Volkmar held a presentation (see handhold); investing time in corporate organisations is not always about sponsoring but about creating involvement, sometimes this leads to fundraising (up to 2 million euro). Its networking and can be done in each country; to start you can search for organisations who are leaded by migrants.
- Rob presented (see handhold) how to fundraise from foundations. It showed that hard work can bring some money; if the communication is on a high level. The Medical Foundation gets 10% of their income 800.000,- pounds out of this source.
- Charlie took us into the world of private donors (see handhold); because of the very professional approach the Medical Foundation is successful. It's very clear you need professionals to do the job.

#### **Presentations on diversification/ self financing**

- Erika Volkmar told about interpreter activities in Appartenances and the possibility of starting a business
- Jan Schaart told about the holding structure of Centre'45 in which specific knowledge on psycho trauma is sold. Centre'45 also tries to earn money from training and education. This is done by new hired staff.

The overall conclusion is that centres are much more willing to learn from each other and in many centres there is a discussion about a new strategy because of the difficult financial position centres are in. We talked briefly about Turkey; there is not only a financial problem but also a very hard political situation.

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## **Normal agenda**

### **1. EIDHR**

Laetitia gave an update; funding by EIDHR will not be easy. More organisations ask for money and the quality of proposals increased. The new person in charge of torture related projects at EIDHR (Sara Sighinolfi) started in April. We think it is important to have an introduction in June. Laetitia arranges a date; Laetitia, Pascale, and Jan will participate in this meeting.

Laetitia will check with centres did get money in the last call for proposals and will share this information with the group so centres can contact them and learn how it should be done to increase their chances.

Laetitia mentions the EIDHR meeting in June about the EIDHR evaluation amongst EU-centres; Erik, Laetitia,

Pascale and Rob will participate in this meeting. (this meeting is scheduled on the 3<sup>rd</sup> of June – it is also foreseen to talk about the next EIDHR call for proposals on torture).

Laetitia advised to have the proposal read by an external reader, to make sure the project ideas flow well. Also the IRCT office in Brussels is very willing to help (make sure this is done in time and not for the last day). For Turkey there are special funds in the EU.

### **2. European Refugee Fund**

It is divided into two parts - 90% is managed by the member States to support their priorities (and part of this money is returned to the EC because it has not been spent), and 10 % is for trans-European projects. Call for proposals every year.

### **3. Other EC funds**

Laetitia explains that funding in EU is not easy, as they are managed by their respective Directorate Generals websites (except for all the projects outside the EU which are managed by Europe Aid). The IRCT is making an overview and within one month this can be found on the IRCT website.

- **Integration Fund for Migrants:** for integration projects. You have to apply on national level – normally it is for migrants and not for refugees related project but Refugio managed to receive funds from them.
- **EU health fund:** is on mental health and gives possibilities in cooperation with other centres; <http://ec.europa.eu/eahc/news/news.html>  
[http://ec.europa.eu/health/phdeterminants/lifestyle/mental/projects\\_mental\\_health\\_en.htm](http://ec.europa.eu/health/phdeterminants/lifestyle/mental/projects_mental_health_en.htm)
- **Education funds:** in EU there is some funding for education projects
- **Daphne:** The programme is managed by Justice, Liberty and Security Directorate General, for projects for violence against women and children. Call every year.

### **4. UN Voluntary Fund**

The UN voluntary fund has a budget of €10 million and sponsors 200 projects. As a network we worked on 6 selected countries in order to increase their contribution to this fund. We were successful on this project. Eric will make an update. Eric also tries to arrange a meeting with our network; Eric, Jan, Laetitia and Anni will participate.

### **5. Council of Europe/European Parliament**

Council; on the 27<sup>th</sup> of November there was a meeting, prepared by Remi, with the EU Network and the Steering Committee on Human Rights; Erik Holst attended this meeting. Although it was a very good meeting we didn't receive any result yet (we asked for a recommendation from the Council to all governments for financial support of the national centres). Jan will contact the secretary of the Steering Committee.

EU Parliament; in June we have the MEP elections. Every centre can do their own national lobby on refugee and torture issues. We agreed to wait until the new members are installed and the commissions on foreign affairs and justice are established. Then, in September/October we can try to get in touch with them to talk about our concerns etc. In this meeting the Medical Foundation,

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Laurence, Pascale, Laetitia, Jan and Eric will participate.

### **Friday 8th of May**

**State funding:** most West EU countries think about it (France, UK) and Germany is active to get it. For the Swiss the regions are very important, in Romania it will take a very long time. It helps when an government accepted the EU directive on refugees. If needed both, the IRCT & EU network, can help centres in there national strategy.

**Twinning:** after a short discussion it seems too early to start a project on this theme. Most of the centres need there energy in there own centre and on the national level. France is making a French speaking cooperation, Germany is active in the BAFF. The Medical Foundation and Centre'45 are willing to help other centres.

**Evaluation:** we worked hard and learned a lot from each other. It would be great if we had continuity in this network so we hope to see everybody next year in Copenhagen.

## **APPENDIX 2 – Minutes of Clinical Discussion Group**

### **Else Ryding (OASIS, Denmark)**

*Report from this group is divided between Beatrice Patsalides, who reports from the French speaking group and the final discussion in the clinical group, inclusive our proposal to the steering committee and the undersigned, who report from the planning group, the clinical group and results from a little questionnaire.*

#### **General**

In the group were 26 persons from ten countries: Switzerland, France, Germany, Netherlands Spain, Denmark, Italy, Belgium Austria and Norway. Group leaders were a collective of Peter Brigham, Ala Elczewska and Else Ryding from Denmark. The preparation for the clinical group had focused on the theme: “good practice” as a way to structure the discussions so that these could move further than case presentations and may be find some common good experiences. Besides that a little questionnaire, had been made to get some information of the conditions of the clinical work with refugees and it were handed out.

There had been expressed wishes to split the group into an English and French speaking group and one person wanted to make en presentation of how to work with families.

We started the first meeting as a whole group to make plans for the discussions. It was accepted to split in two language groups and it was also accepted to focus on “good practice” as a common guiding principle for the discussions in both groups. We chose four common main headlines as: family, interdisciplinary intervention, social integration, and exposure. It later turned out that the theme of good practice did not function well as a general principle. Some of the objections were that when speaking of “good practice” you may conclude, that what you else did was not good enough and the examples of practice turned out to be too complex to press into priorities. But there seemed to have been very constructive discussions and sharing of professional experiences.

#### **The English speaking group**

The group concentrated on the family theme as almost everybody had many experiences with families and considered it central for the clinical work. To focus on families is a big help for the children as they can begin to experience the family as a support system. When they get some explanation of their parents behaviour – which can be very hard and fear provoking for them- it helps them not to put too much guild on their shoulders an be better able to find their own role in the family as children and not little grown ups.

Asking for resources in the family helps both parents and children. The resources can often be forgotten because the parents often will concentrate on their own problems. But the family members have different resources and calling on them can make the common resources grow in the family and the effect of the trauma is getting smaller. It can make it possible to see and develop the coping strategies of both parents and children.

In war and persecution the normal attachment between parents and children often are broken and it is considered healing for both parts to focus on rebuilding and strengthening the bonds between them. To help the parents see their children more clearly both with their problems and their resources can help the parents to open up for their responsibilities for their children and in this way empower the parents in their role as parents. This will also empower the parents’ personal identities.

To help rebuild and make structures in the families support the whole family. It is about both the normal hierarchy of adult and children and the history of the family. It can be healing to rebuild the

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common family memory from the single member's fragmented memories. To reframe the meaning of crises and the strategies for survival can support the family cohesiveness and the integrity of the individual members.

Psycho-education about the impact of trauma on the person and the functions of the symptoms and psycho-education about the different problems when settling as a family in exile was considered to be helpful to demystify the sufferings and empower the families and the individuals. Some had experiences with working with genograms – family trees- which could support building a sense of normal life, remembering and connecting to good life, that has been there before and make hope of re-establish it again.

There was a discussion about victims, survivors and perpetrators. It was a broad opinion that refugees profit mostly by being seen as survivors instead of victims, as it validates their fight for living. But in some cases it gave them more respect to be treated as victims, because in their homelands it could be combined with being a war hero. This gave them too a right to get war pension. On that background, many would expect that our welfare systems could provide them with the same status by giving them pension. The issue about perpetrator was a little difficult, because as a therapist you are expected to treat everybody who needs help and on the same conditions even a killer of other people. This was difficult for some. A soldier is a killer, a man who has killed an enemy without being a soldier can also consider himself to have behaved rightly and even be considered a hero from his countrymen. Have these people had a second choice? There were no easy answers. It is difficult to work with also because this issue often is associated with secrets within the family. Often the woman in the family did not know about her husband's actions, he has not dared to tell, some times they know and ask the therapist to help the husband. The children often know- told by a body therapist- because they feel it through the body.

Another difficult theme was about people still being fighters even if the conflicts are years ago or thousands miles away. In these families this attitude is conveyed to the children especially the boys and gives them big troubles integrating in the actual society.

It was generally agreed among the group that supervision is very important when we deal with that heavy material. We have to take care of own boundaries. A central common theme we just mentioned was that interdisciplinary interventions were considered of extreme importance for our daily work.

### **Presentation**

Ala Elzcewska made an inspiring presentation of the family group in RCT Copenhagen. It offers interdisciplinary treatment to families. The family is the unit but besides that parents and children are offered treatment in different constellations. The families can frequent the treatment 1-4 hours per week, 1-2 times each week, 12-24 months. The treatment is based on the following phases: planning, networking with local authorities and other contacts, stabilizing, genogram making and conclusion. Everybody is welcome to contact Ala for more information.

### **Questionnaire**

We asked questions about the conditions of the organizations. The purpose was just to give a hint of the conditions. Not to make an exact registration. 12 organizations gave their response.

### ***Economy***

#### ***Economic base***

- 7 have the economic base exclusive in local/state authorities
- 3 have the economic base divided between local/state and private funding – one of these from EU
- 1 have 30% local/state funding, 17% private funding and 53% users payment.

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#### *Yearly budget*

The span was from 150.000 – 4 mill. €, with 1-2 mill € as the most common budget.

#### **Purpose of the organization**

Emphasis was on rehabilitation of traumatized refugees, including treatment, social support and education in various degrees.

#### **Organization of the institutions**

The picture showed variety: 4 were self-governing, 2 were self-governing and NGOs, 1 only part of the psychiatry, 2 self-governing and part of the psychiatry and 2 were organized both as self-governing, part of the psychiatric and asylum seekers system and as NGOs.

#### **Employees**

In all the range was from 6 – 180 (only one) with clusters of 6 institutions from 20-50 and 5 institutions from 6-16 employees. The most common professions were: psychologist: (12 institutions), social workers (10 institutions), psychiatric doctor (9 institutions) and physiotherapists (9 institutions) and administration of course and others of various professions as fundraiser, research, librarian, gynaecologist, forensic physician, anthropologist, child social worker, cultural-linguistic mediator (8 institutions). 2 -5 institutions had employed: medical doctors, nurses, teachers, lawyers, artists and volunteers.

In each institution the number of psychologists varied from 1-8, social workers 1- 5/8, psychiatric doctors 1-2, physiotherapists 1- 6. The number of the other professions varied from 1-3 employees. The only and big institution with 180 employees had 25 psychologists, 16 social workers, 6 psychiatric doctors and 3 physiotherapists, 20 teachers, 50 volunteers, 10 in administration and 100 interpreters.

In our view it gives an interesting picture of the proportion of groups of professions in the institutions.

#### **Services**

- 4 institutions offered legal counselling, 9 social counselling, 10 psychological counselling.
- 10 institutions offered therapeutic treatment and 6 medical treatment.
- 5 institutions offered practical help.
- Other form of services were: family rehabilitation, group-based school with specific topics, language courses, job preparation courses, housing.

#### **Type of treatment categories**

The treatment offered is distributed rather similarly over all five categories. 8 institutions offer group treatment, 11 individual treatment, 8 couple treatment, 8 family treatment and 7 treatment to children and youngsters.

### **APPENDIX 3 – Letter regarding Moldova**

Dear Sir / Madam,

The Moldova letter to review SR on HRD has now gone to the Special Rapporteur, apologies for the delay. We used as many of the logos that we received (but we did not have all of them). Please could you now send this letter on with the attachments to the following, as you deem appropriate in your own country contexts:

- Ministry of foreign affairs
- Human rights defenders NGOs (if any)

It may not be appropriate to send this to any Republic of Moldova consular or embassy representatives given that it might put others at risk, so please send only to your own ministries of foreign affairs.

We will share any feedback we get from the UN system.

Thank you for your quick attention to this and be assured that we moved as quickly as we could.

Best wishes, Leanne

Leanne MacMillan  
Director, Policy and External Affairs  
Medical Foundation for the Care of Victims of Torture

#### **OPEN LETTER from the EUROPEAN NETWORK OF REHABILITATION CENTRES FOR SURVIVORS OF TORTURE**

Mrs. Margaret Sekaggya  
Special Rapporteur on the situation of Human Rights Defenders  
Office of the High Commissioner for Human Rights  
Palais Wilson  
United Nations Office  
CH 1211 Geneva 10  
Switzerland

Dear Mrs. Sekaggya,

The European Network of Rehabilitation Centres for Survivors of Torture comprises over 40 rehabilitation and human rights organizations from across Europe. We represent organizations concerned with the care, treatment and protection of survivors of torture. We write to you today following our recent annual meeting as a Network to bring to your attention the situation of colleagues in Moldova.

We are confident that you are abundantly aware of the serious human rights abuses including torture and other forms of ill-treatment by state officials in recent weeks in the Republic of Moldova. We are aware that this matter has been raised by others in the international and regional human rights system however, we are keen to draw to your attention the plight of our colleagues who seek to directly assist torture survivors.

The undersigned members of the European Rehabilitation Network were gravely concerned to

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learn of the current situation of our colleagues in Moldova. They were not able to attend the meeting due to the situation in their country, however, we received a credible report from them about the incidents of torture they have directly witnessed as part of their rehabilitation work. A copy of a report that documents some recent cases of ill-treatment and torture is attached for your reference.

Our colleagues have expressed their concerns about the safety of their families and themselves given that in carrying out their professional responsibilities they bear direct witness to abuses by the state. We share their view that this exposes them to risk and it is well-established that health and legal professionals who document torture are often at risk.

As health and legal professionals who work with torture survivors on a daily basis mainly in countries where we can carry out our work free from interference or threat, we are deeply concerned about the individual risks our colleagues in Moldova are under in their efforts to carry out their work. We would specifically draw your urgent attention to the risks our colleagues face at Memoria, an independent rehabilitation centre in Moldova.

As you know, there are well-established international standards that guarantee the independence of medical professionals in the carrying out of their duties in relation to torture survivors and other victims of violence.

We are writing to you in your capacity as Special Rapporteur on the situation of Human Rights Defenders and urge you:

to carry out a country visit to investigate concerns about professionals working with survivors of state abuse  
to make direct enquiries about our colleagues at Memoria with a view to ensuring their safety and ability to carry out their vital work as human rights defenders  
to present your findings to the government of the Republic of Moldova.

We gratefully acknowledge your intervention in this regard and appreciate your every effort to defend those who seek to defend human rights.

Sincerely yours,

Appartenances, Switzerland  
Association Mana, France  
Association Primo Levi, France  
BAFF (Bundesweite Arbeitsgemeinschaft der psychosozialen Zentren für Flüchtlinge und Folteropfer), Germany  
Behandlungs Zentrum fuer Folter Opfer und Verfolgte, Germany  
EMPATHY, Georgia  
Equator Foundation, Netherlands  
EXIL, Belgium & Spain  
Foundation Centrum '45, Netherlands  
ICAR Foundation, Romania  
IRCT International Rehabilitation Council for Torture Victims  
Medical Foundation for the Care of Victims of Torture, United Kingdom  
OASIS, (Treatment and Counselling for Refugees) Denmark  
OSIRIS, France

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RCT, Denmark

REFUGIO Muenchen, Germany

Rehabilitation and Research Centre for Torture Victims (RCT), Denmark

RVTS-West, Norway

SAMIFO - Salute Migranti Forzati, Italy

TOHAV /TRM - Foundation for Society and Legal studies/Torturer Rehabilitation Centre, Turkey

TRC - Rehabilitation and research centre for torture victims, Denmark

Ulysse, Belgium

Zebra, Austria

Zentrum für Flüchtlingshilfen und Migrationsdienste, Germany

cc. Professor Manfred Nowak, Special Rapporteur on Torture