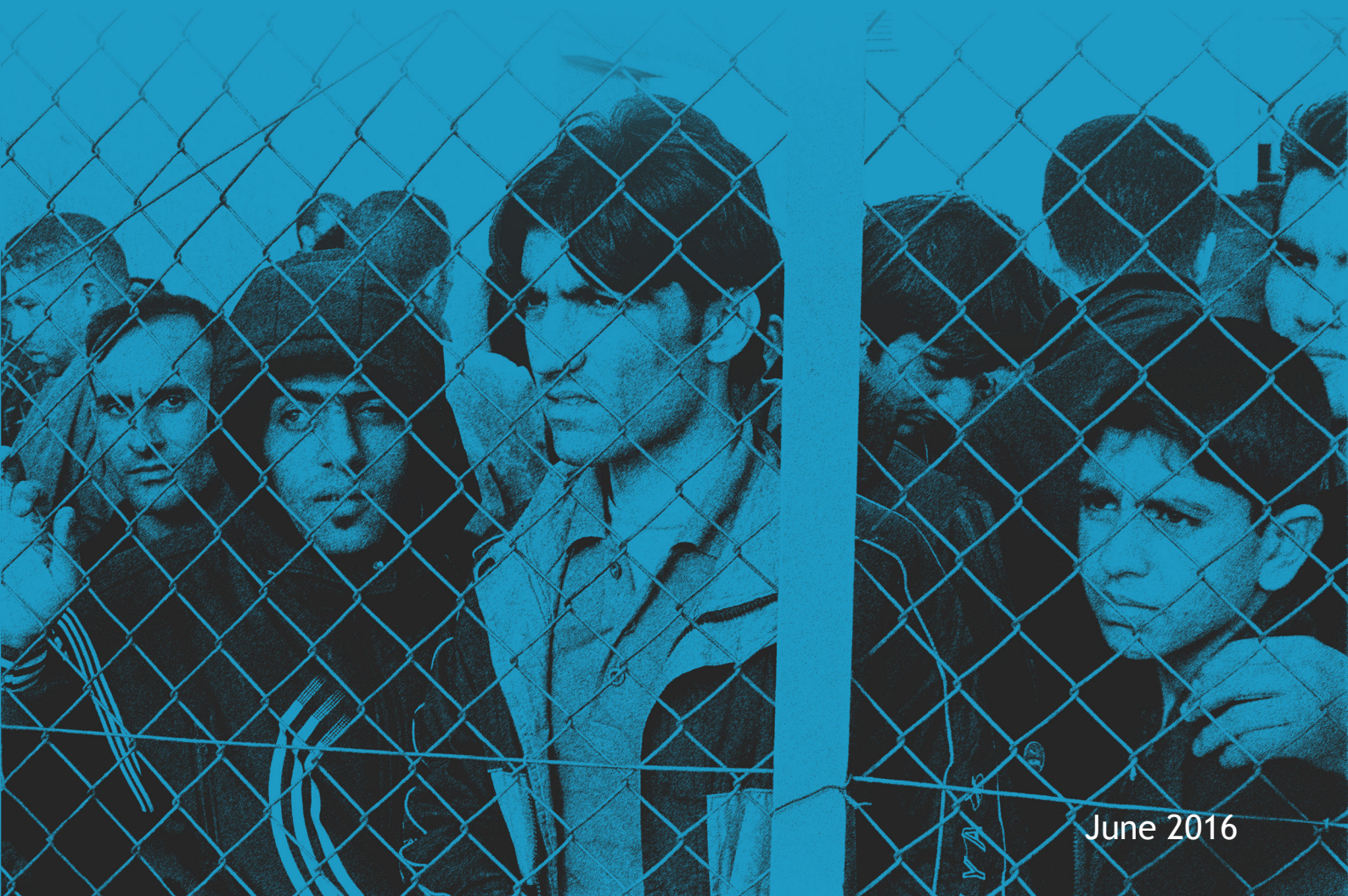
Freedom from Torture
Medical Foundation for the Care of Victims of Torture

From Torture Cell to Therapy Room
Survivors' Journeys to Rehabilitation



June 2016

Learning points from Freedom from Torture's roundtable event

1. Introduction

On 3 December 2015, Freedom from Torture convened a roundtable meeting for a group of humanitarian organisations including the International Rehabilitation Council for Victims of Torture, Médecins Sans Frontières, Doctors of the World, Physicians for Human Rights, the Office of the UN High Commissioner for Refugees and the International Organization for Migration to meet with survivors of torture, clinicians and other experts in the field to discuss the question of the provision of rehabilitation to survivors of torture in the context of mass migration, with particular emphasis on the current refugee crisis in the Middle East and Europe.

The number of refugees in or travelling to Europe was then at a level unprecedented since the second world war. Just a few days later, on 7 December, the UNHCR stated that more than 911,000 refugees and migrants had arrived in European countries since January 2015, with over 3,550 lives lost during their perilous journeys.

At the beginning of the year, the main route was the dangerous trans-Mediterranean voyage from Libya to Italy but by the year's end this had shifted to the shorter but equally fatal voyage from Turkey to the Greek islands.

Over 75 per cent of those arriving in Europe had fled conflict and persecution in Syria, Afghanistan or Iraq. Many took the long haul, by bus, train, taxi and foot across the Balkans to northern Europe. At year's end, around 70 percent of refugees travelling to Europe were young men but this was later to change as women and children became the majority.

Many of these refugees are survivors of torture, people who have been imprisoned and tortured, and who now seek asylum in a safe country. Seeking asylum, with all the dangers that involves, makes them more vulnerable.

What can agencies, whether working in international relief, local support or active in destination countries do to support torture survivors on their journeys to safety? Or will such efforts be ineffective or even counterproductive? Do refugees need medical or psychological support or just practical help to complete their journey? What should be the role of governments, and are international refugee organisations able to cope? These are just some of the questions that the roundtable set out to ask and attempt to answer, drawing on the huge expertise and experience of the agencies present.

This paper is the result of those discussions and traces typical survivor journeys from detention in a torture cell, through release and post-release in the country of origin, through the journey to Europe and across Europe to arrival in the UK or other country of destination. The paper considers the opportunities and barriers to the identification and rehabilitation of survivors throughout the journey and the critical clinical issue of when exactly rehabilitation can begin. Finally, a series of recommendations are made for the UK and other European states and for agencies providing services to torture survivors in the crisis, aimed at improving the chances for survivors to be identified and have their right to rehabilitation fulfilled.

Rights of torture survivors

Detainees have a right to:

- not be tortured or subjected to inhuman or degrading treatment or punishment - an absolute right
- a medical examination
- health care
- communication with family members and legal counsel

Torture survivors seeking protection have a right to:

- not be forcibly returned to a country where they face a substantial risk of further torture or persecution (non-refoulement)
- health
- redress, including rehabilitation
- family life
- privacy (including data protection)
- non-discrimination

2. Identification and protection of survivors of torture and other vulnerable refugees

2.1 In detention

Access to prisoners in detention is important in order to prevent and mitigate the horrific consequences of torture. Registration of detainees by an independent authority or humanitarian organisation such as the International Committee of the Red Cross and inspection of detention facilities by independent monitors such as the UN Sub-Committee on Prevention of Torture can help to prevent torture, improve detention conditions and ensure access to healthcare and information for detainees, including those being subjected to torture. These processes are possible in some countries, though not all.

Torture is practised in over 140 countries around the world, according to Amnesty International. The total prison population in the Middle East, Africa and Asia is over 1.5 million, according to World Prison Brief.

Where humanitarian organisations are able to visit detention centres, this can also give detainees the opportunity to speak with various degrees of freedom and open channels of communication with their families, which has a positive impact on their psychological state.

In some countries, detainees are taken out of official detention centres to be tortured elsewhere in a bid to disguise torture or evade responsibility for it. The detainee in effect then “disappears” and cannot be monitored unless and until they are returned to the official detention centre or they manage to secure release.

Other detainees are held and tortured in unofficial detention facilities, beyond the reach of independent monitors, their families and healthcare providers.

It is also important to keep under consideration the problem of doctors or other health professionals participating in torture which can also lead to deep distrust of health services following release for those who survive.

2.2 Escape or release from detention

Societal and community attitudes to survivors can affect identification torture often causes stigma and shame, which may discourage a survivor from disclosing or discussing it with their family, community and/or health and legal professionals.

The early identification of survivors is essential, though, to their accessing protection and rehabilitation. In practice it is very difficult to achieve due to stigma and fear of reprisal in the community and, later, due to the survivor’s perceived need to ‘hold it together’.

Putting early identification into practice can be highly challenging:

- Survivors may be uncertain initially that the agencies trying to engage with them can be trusted and that cooperating really will lead to protection and assistance;
- If an agency insists on or even tries to encourage disclosure, this could be construed as coercion;
- Attempting any form of systematic

identification would require extensive resources and also raise questions around who would do the identifying – for example which agencies and type of staff, with what training and experience, how and where?;

- Identification will not always be compatible with survivors' immediate needs: the survivor's priority might be to keep moving, to keep up with relatives and not be stuck when a border closes, rather than to have treatment; and
- The situation and context of each torturing state will be different and these need to be considered.

Participants also emphasised that torture does not just affect survivors themselves – their families are also impacted. For example, where a father is tortured, the wife and children will usually need protection and often psychological assistance as well.

2.3 Refugees in camps, host communities and urban settings

The vast number of refugees and people seeking protection in the Middle East, Africa and now Europe presents enormous logistical problems for efforts to identify and support survivors of torture caught up in these flows. Increasingly, many of the refugees in the Middle East and Africa are living in urban settings, rather than organised camps, making their access to services, support and identification even more difficult.

UNHCR figures: 59.5 million "forcibly displaced" people in the world

19.5 million refugees.
51% are under 18.
42,500 become forcibly displaced every day.

The IOM (International Office of Migration) carries out health assessments of those refugees accepted into UN resettlement programmes before the refugees travel to the UK or elsewhere for resettlement. A record of the assessment and the individual's needs is then sent to the relevant local authority in the UK or elsewhere. This provides an opportunity to identify survivors of torture amongst this group.

Whole families and communities can be affected by torture and trauma and other experiences of loss and displacement, and planned psychological interventions need to take this into account by addressing needs at family and community levels.

2.4 Journey to Europe

Harsh conditions, the limited scale and long delays of resettlement programmes and diminishing hope of conflict resolution in their countries of origin are impelling many refugees to leave refugee camps and host communities in neighbouring states and to take their chances by reaching Europe through informal routes instead. These journeys are fraught with risk.

Over 3,550 people drowned in the Mediterranean attempting to reach safety in Europe in 2015 alone.

Participants emphasised the fact that refugees and other migrants en route to and travelling across Europe are moving very quickly. They are reluctant to stop in one place long enough to engage in identification and rehabilitation processes as they are afraid of getting "stuck" where they do not want to be. They have low confidence in the European relocation system, which is an impediment to more thorough health assessment processes.

In those countries where reception centres are provided, people will often stay long enough for identification to take place. Often, though, only short-stay transit centres are available: for example, one participant described a centre in Croatia where people stay for about an hour only before moving on, which makes it very difficult for non-governmental organisations (NGOs) to access them. Other opportunities exist for identification where health services are available and accessible to migrants.

The option of self-assessment or self-recording was discussed, whereby a survivor might take photographs of their own scars with a mobile phone. This was, however, felt to have several risks, including:

- The danger of authorities then using this fact against the survivor in their claim for asylum by claiming they could not be that traumatised if they were able to do this: survivors might be seen as too resilient and not in need of help in that the survivor could be viewed as being less traumatised as they are able to cope with viewing and recording of their scars and this could be seen as undermining their need for protection in some way.
- Asylum decision-making authorities might dismiss data not from "official" sources, on the basis that it is self-serving and unverified.
- There were also data protection issues concerning the sharing of photos of this sort (e.g. where an image goes from a phone to the "Cloud")

Overall, however, participants considered that such issues were not insurmountable and use of technology should be explored further.

It was felt it may be easier for professionals to produce a record of physical scarring without having to go into the details of the story of torture but this is less easy for psychological wounds and scars.

There is also the issue of the availability of a confidential space to undertake the examinationLack of a calm, private and confidential space to speak will further act against disclosure; disclosure in an unsafe setting could be re-traumatising for the person concerned.

Survivor input:

- Survivors worry that information about themselves given to a health professional in one country will be used against them when they claim asylum in another country, under the Dublin Regulation (which requires asylum seekers to claim asylum in the first European Union country they reach). For example, migrants and refugees may be offered hospital care, but refuse it for these reasons. This is especially true where there is no post-identification plan in place regarding on-going protection and rehabilitation.

- Survivors report a sense of wanting to keep quiet about having been tortured due to a fear it could make them more vulnerable at a time when they most need to draw on inner strength, as well as the experience of meeting people who could have helped but did not notice their distress. One participant shared an example where this led to a survivor being forcibly removed because their history and needs were not understood.

- Survivors report the key importance of knowing how information will be used and what confidentiality and data protection policies are in place. Survivors will be uncertain and suspicious and will need information to be repeated in a calm and not forceful manner. Ethical gathering and use of information will increase survivors' confidence in the identification process.

2.5 Europe

There are several very worrying trends in the way European states are responding to the crisis, including pushing borders further south and east (to Turkey, for example) and closing them off to keep people out; failure in public discourse to distinguish refugees from economic migrants; stigmatisation of asylum seekers and police measures designed to create a "hostile environment" for asylum seekers, including use of detention and ankle bracelets; and the use of identification processes by governments which look and feel

like criminal processes.

Participants acknowledged that there is a need for states to gather information about the people arriving in their territory, but that it mostly appears to be used for punitive purposes and to exclude, whereas it also needs to be used to help survivors and other asylum seekers to gain access to services.

The situation is fluid, and arrival numbers increase and decrease; however, daily averages of 5,000 were reported in Greece at the end of 2015. Eighty four percent of the people arriving in Europe in 2015 were from the global "Top Ten" refugee-producing countries, all of which are "countries of concern" according to the UNHCR.

70% are young men travelling alone or in groups and 12% of women are pregnant, often carrying young children too.

UNHCR expects 250,000 migrants to enter Greece in 2016, even after the closure of the border with Turkey.

Identification of torture survivors and other vulnerable asylum seekers is imperative for asylum seekers and governments, but for two very different reasons: survivors are interested in protection and rehabilitation whereas governments are concerned with the control of their borders and security issues.

Participants noted that identification can create vulnerability: where an asylum seeker is officially identified as a survivor in one country, this can be used against them if they claim asylum in another country, under the Dublin Regulation.

The numbers of refugees and migrants arriving in Europe through countries such as Greece creates a logistical problem concerning how to match resources to demand. Participants described evidence of migrants not deemed to be from the "right" countries being turned away at the borders, without having their cases and circumstances looked at. (The deal between the EU and Turkey to reduce the number of refugees and migrants crossing into Greece has worsened the situation.)

The challenges of identification and service provision to a population on the move continue during the journey within and across Europe. Many participants described how refugees and other migrants are still desperate to move on due to fears that borders might close and often refuse offers of medical or psychological assistance. One participant shared an example of a woman in the early stages of labour who refused to go to hospital for fear that the group she was travelling with would move on without her.

- Survivor input: People entering a new country often do not speak the language of that country and have no idea of the culture or what to expect. Different cultural contexts can create barriers to identification. For example many survivors are disbelieved by lawyers or asylum decision-making authorities for avoiding eye contact, even though this is a cultural expectation in their country of origin in such circumstances.

Once a survivor reaches the UK or other country of destination, they then have to apply for asylum in order to gain protection. The process itself, which includes the need to disclose torture in stressful situations such as Home Office interviews or tribunal hearings is a further cause of distress.

Any detention environment, including immigration detention, could be associated with torture. Although there are differences between detention centres where people are tortured in countries of origin and immigration

centres in countries of asylum, there can still be violence in the latter and, even where this is not the case, the mere fact of detention often causes the traumatised survivor to relive their past experiences, with serious mental health implications. The uncertainty about the length of immigration detention is also a destabilising factor for the detainee, who is left in a state of limbo.

3. Rehabilitation of survivors of torture: what is possible and when can it begin?

3.1 In detention

The most important priority for a detainee who is being tortured is that the torture stops and they are released. Rehabilitation will usually be a lesser priority at that point.

Some clinical experts view it as impossible to begin rehabilitation while the situation of threat still exists. The question therefore is how the international torture rehabilitation movement can respond to the needs of those people still in detention.

Others feel that the journey to rehabilitation can begin in detention if certain conditions are met, including access by humanitarian organisations to detainees to monitor their treatment and the impact on them. Detainees should also be given the opportunity to talk to someone trustworthy during their detention. Access to families also has a positive effect.

3.2 Escape or release from detention (in the country of origin or detention)

Survivor participants described themselves as being “almost dead” upon release from detention, such is the physical and psychological impact of torture.

For large numbers of survivors, if not the majority, there is often a delay of months or years before they are able to leave the country where they were tortured if they are able or wish to leave at all. Seeking rehabilitation in the country where they were tortured is therefore the only option. Accessing rehabilitation in such circumstances can be very difficult.

Torturing states differ widely in their approach to the treatment of survivors post-release from detention and the extent to which they allow or inhibit the provision of rehabilitation and access to rehabilitation.

- Some states inhibit or prohibit rehabilitation services from working with survivors of torture as a way of denying that torture happens.
- Other states have specialist rehabilitation centres and/or experts overtly or covertly supporting survivors of torture. The services available will differ according to circumstances and the organisations involved.

Whether the survivor was released or escaped can also make a difference.

- If the survivor escaped from detention, their most urgent priority will be protection and security, often involving going into hiding from officials (including health professionals) and flight from their community and/or country.
- Those who are released from detention may try to integrate back in their community but remain fearful of authorities (including health professionals) and/or prioritise meeting their immediate needs for food, shelter and first aid over longer-term rehabilitation support.

In the initial stages following release or escape from detention, the support of family members and the community is very important for the survivor and local community services can be very helpful, where they exist.

If there is an entire community sharing the same experience, it may be easier for survivors to disclose torture and survivors may feel more comfortable accessing the right services. While some detainees or ex-detainees may want their torture to be reported to the police, others will be frightened of the consequences, which may delay disclosure as well as prevent access to rehabilitation and other forms of redress.

For those who may be relatively safe from further detention or torture in their home country after release, stigma and shame may

be an additional factor impacting a survivor's ability to realise full rehabilitation – for instance, survivors often struggle to find work or support themselves and their family. Poverty may further impact a survivor's ability to access appropriate services. Those seeking help for mental health problems can also be stigmatised. This further inhibits disclosure.

- Survivor input: The stigma attached to torture can be so intense that disclosure within the community can lead to ostracisation, whether due to fear that hosting the survivor will attract further adverse attention from the authorities or because of assumptions that if someone was tortured, they must have been a 'bad' person or posed some sort of risk to society.

Awareness-raising about torture and its impact and the reasons people are tortured, is therefore essential to encourage more people to come forward.

Health professionals whom survivors meet soon after release or escape need to be able to help survivors open up and talk about their experiences, but there can be difficulties with this, particularly where health professionals are perceived as being complicit in torture.

3.3 Refugees in camps and host communities

Those survivors who are able to reach and be accepted into a well-organised refugee camp are able to access a range of services, especially if the camp is run by an international agency such as UNHCR. Provision to survivors outside of recognised camps is less well-organised and in many cases non-existent, unless they are in a country with an established rehabilitation service with the resources to meet the required level of need.

There is a lot of consensus about and knowledge of how to promote psycho-social health and well-being in refugee camps and tools which can be employed. Access to social support and family networks and information about the situation and processes the survivor is in are all essential ingredients of this.

In UNHCR camps:

Refugees are registered by UNHCR officials who gather basic information and record it on the UN database (called "Progress"). Where disclosures of violence and torture are made at this stage, they will be recorded. There are also often community-based protection mechanisms run by refugees themselves, and UNHCR staff work with these mechanisms. Community workers are trained to pick up information and identity even for those who are not willing to communicate, for example because of fear. Where survivors are thus identified, they can be referred to a specialised service. This works best where staff and community workers are proactive about approaching people who may not be communicating their needs. A serious problem is that torture survivors and other refugees can sometimes get stuck in camps and be unable to leave for decades.

The reasons why an individual or a family might choose to stay in or leave a camp in a particular country to travel to Europe are complicated and can include perceptions of relative levels of safety but also of life-chances and economic opportunities. For instance, there are Syrian families who have been in camps in Lebanon or Jordan for several years but have only just decided to leave due to an escalation of bombings.

International Organisation for Migration (IOM)

The IOM is currently implementing the Mediterranean Response Plan (MRP). The Plan has four main aims:

1) Protect basic rights;
2) Address the drivers of irregular migration;
3) Promote a safe, orderly and dignified journey, including access to legal help; and
4) Develop partnerships for growth.

The plan addresses the needs of refugees and migrants making informal journeys to Europe across either the Eastern Mediterranean into Greece or the Central Mediterranean route from Libya up to Italy. In addition, IOM is involved in the UK's Syrian Vulnerable Persons Resettlement Programme (VPR), arranging travel for those accepted onto the scheme and accompanying them on the journey:

- This programme aims to resettle 20,000 vulnerable Syrians in the UK over five years, starting with one thousand refugees arriving before Christmas 2015. The scheme only accepts Syrians from neighbouring countries. The UNHCR, UK Home Office and local authorities in the UK are all involved. There has been some engagement of voluntary sector service providers, but not enough.
- The "vulnerability criteria" used to select refugees for the scheme include: women and girls, survivors of violence and torture and those with significant medical needs.

3.4 En route to Europe

There are projects en route in Lebanon, Jordan, Turkey, and Greece. Mental health assessments in Greece find that many people, whether they have survived torture or not, are suffering with severe trauma fleeing war or conflict and the direct or witnessed experience of violence, and feelings of loss and grief, including grief at the loss of family members along the route. Conditions along the route are horrific. For example, participants shared reports of people sleeping in muddy fields in Slovenia and Greece.

According to participants, the Central Mediterranean route remains the most dangerous, with most deaths happening along that route. The route through the Western Balkans changes frequently due to certain borders and crossings constantly being fenced off. It was suggested that new routes are opening up:

- For example, there was also an emerging "Arctic Route" through Russia into Norway, being used mainly by Afghans. People are only able to travel across this route on bicycles. The bikes need to be ditched on the border and those with certain types of brake are not allowed into Norway. The difficulties with this route will only worsen over the winter, when temperatures can fall to minus 25 to 30 degrees.

Along the Western Balkans Route there are health centres in transit zones, run by the Red Cross and the IOM. Thus services do exist: the real question is how to get people to access them quickly, especially in big population concentrations.

People are refused services along the way. For example, participants explained that between Syria and Europe people are refused accommodation and other services because they do not have documents, even if they have money.

Community-based networks have a role to play as well as a good system of registration. However, people migrating from the same country often do not trust each other (for example, because they come from different sides of a conflict) which can make community-based approaches problematic: survivors may not know who to trust in their community.

The International Rehabilitation Council for Torture Victims (IRCT) has attempted to develop rehabilitation services in Libya, training local clinicians to create rehabilitation centres, but they struggled to do this due to hostile local conditions. The shifting political conditions and violent manifestations of the influence of stigma (the centre was shot at on several occasions) emphasised the importance of thorough risk assessment before such an enterprise is undertaken. IRCT now concentrates on nurturing individuals rather than on establishing centres in Libya. By contrast, two centres have now been successfully established in Iraq.

There is also no cross-border health referrals system in Europe or a common database of migrants or refugees and their health needs which complicates continuity of care. Service providers along the route have very little capacity relative to the current demand.

Some participants thought rehabilitation on the routes across Europe was not possible because this is a crisis situation: people are moving too quickly and avoid contact with authorities.

There is a really important question of when there is sufficient safety and security to begin rehabilitation in these circumstances:

- Early journey: The survivor's priorities are to reach a safe place and gain access to psychological first aid. It is much easier at this stage for a survivor to talk about torture if they are travelling with members of their community so this is a significant factor. Full rehabilitation is not necessarily what refugees want along the route: many will want treatment for the symptoms of trauma so they can move on. Others will not want help with symptoms at all, preferring approaches which foster their resilience and enable them to cope with the journey itself and immediate survival needs.

- It was felt that certain forms of brief intervention could be beneficial during the journey, including: information sessions, group sessions with intermediaries there to identify those with the most acute symptoms, religious or spiritual activities or help from cultural intermediaries who are often survivors themselves. Peer to peer support is an effective method for establishing trust but could be re-traumatising for those involved in delivery. There will be some people, though, who want to talk and it is very important to listen to them.

- Arrival in a safe country: Many survivors, once they reach a safe country or their preferred country of destination will be anxious about obtaining asylum, and anxieties in "the here and now" need to be addressed, not necessarily what happened before, i.e. torture. This can include anxiety about racism, discrimination and homelessness as well as the physical impact of torture. Some felt that psychological help should be postponed till the survivor is in a more stable situation. Alternatively, others felt that early interventions could concentrate on providing stability so that more in-depth therapeutic work can then take place.

- Survivors need at least a minimum of safety and security before they can explore and address earlier traumatic experiences. How much safety and security will depend on the individual, but services need to remember that the survivor will continue to experience high levels of distress and trauma even if they struggle to engage. Services need to work holistically to build safety and help survivors to engage in rehabilitation.

Survivor input:

- One torture survivor explained that rehabilitation can begin in transit: she gave the example of social activities set up in Calais, and how helpful these and the sharing of information can be to refugees in such situations.

- Another torture survivor explained that suppression of his torture experience, including the pain from physical injuries, was essential to help him keep going during his long journey to safety and that this made disclosure and rehabilitation impossible at that time.

- Survivors speaking directly with survivors is very beneficial in helping people to believe that they will be safe and will receive help. One survivor gave an account of visiting the camp in Calais and being trusted by the people there because she was a survivor of torture.

- It is very important for health professionals to share what they are recording and why. One person was told that a record of a physical examination was being made for her use when she reached safety but that she did not need to discuss being tortured with anyone until she felt safer and found someone she could trust. The doctor gave her a record of the assessment and explained what was happening at every step. She therefore felt she was in control of the information; she felt respected and in control of her own health.

Examples of approaches and good practice:

- ✓ **Doctors of the World** is exploring what is possible en route: it is felt that individual counselling could do more harm than good because long-term follow-up is not possible, but that it is possible to work with traumatised people to strengthen their coping mechanisms. There is often a delay between the traumatic event and the onset of Post Traumatic Stress Disorder or "PTSD" and work can be done in the meantime to mitigate the effects. Such interventions (which include the use of Cognitive Behavioural Therapy or "CBT") can make rehabilitation easier when it does start later on.

- ✓ **Doctors of the World** is already providing several activities which can contribute to rehabilitation, through their clinics across Europe. These include: social activities, child-friendly spaces, group counselling, advocacy and collecting testimonials. Staff try to foster coping mechanisms and are exploring single session therapy, control-focused behavioural development and CBT. It is also mapping services and looking at how to make this available on smart phones.

- ✓ **Psychological first aid**: This is a technique developed by the World Trauma Foundation (WTF), which comprises a single session intervention and can identify those in serious need of assistance. WTF is running a training programme in this intervention in Greece.

  Médicins Sans Frontières uses this intervention in Greece with groups for those with acute needs. This offers the chance to normalise symptoms but sometimes is not possible due to the numbers of people arriving.

- ✓ In Norway there are projects to educate family members to teach their children to understand trauma. The approach is designed for big populations of traumatised people.

3.5 In Europe

Common health problems identified among migrants arriving into Europe as part of these flows include hypothermia, influenza and psychological distress, with chronic diseases such as diabetes also present. Access to medication is a real problem and conditions on the route make health conditions worse. Other health problems are caused by the journey itself, including cuts, blisters, stomach problems, breathing difficulties and foot pain.

Doctors of the World has clinics all the way along the migrant route within Europe - both mobile and static clinics, and is working in reception centres and camps. Doctors of the World staff find the environment very challenging to work in as the population is highly fluid: flows change rapidly due to political decisions, which makes it very difficult to plan. Some projects are longstanding (e.g. in Greece, Germany and France). These partnerships are a strength as they can respond quickly, but coping with sudden influxes is very difficult.

In the camp in Calais, there are social activities organised every day at midday which help people to relax. They help them to feel welcome and to open up and provide safe interactions with others and some sense of normalisation.

Where a torture survivor can get to another country, there is the issue of whether they know about or are able to find services there. Children who have been tortured or affected by torture can be very resilient and may be able to hold themselves together for much longer until they reach a place of safety, but after that it can take them a long time to recover.

Refugees arriving in the UK through resettlement programmes are dispersed to local authorities which might not have the capacities or services to support them. The new Syrian Vulnerable Persons Resettlement Programme involves dispersal of people to many areas in the UK with no experience of receiving traumatised refugees or of providing services for them. There has been insufficient coordination with voluntary sector services providers, such as Freedom from Torture, to enable matching of Syrian refugees with areas where specialist services exist or could be created.

Where health assessments are available, waiting times vary widely. General health assessments will not necessarily detect torture: whether the assessments are carried out by NGO or public sector staff, the levels of training and experience of the assessor and whether the survivor is ready to disclose at that particular moment are all factors which impact on disclosure.

Many participants indicated that operating in Europe has been hard: states and philanthropic funders have been very slow to respond and the number of countries involved has caused issues with registration of medical staff and drug purchasing for mobile clinics.

Participants described the Calais camp as "like a swamp" and the conditions, including police violence, exacerbate trauma: migrants face the uncertainty of not knowing what will happen next or whether they will reach their destination and, if yes, whether they will be accepted and supported to integrate.

A further issue is that children are often treated as adults, which adds to the level of harm they experience.

There was agreement among participants about the importance of medical support in European immigration detention centres. The emphasis should be on urgent health needs and identifying survivors of torture to facilitate their release from detention, given the re-traumatising effect of detention.

4. Recommendations / Next steps

A. For the UK and other European governments

1. Administrative, police and border control staff involved in registration of asylum seekers should be trained to engage sensitively with survivors of torture and other vulnerable refugees.
2. Further funding is required to improve reception centres and processes and medical and legal support for survivors and other vulnerable refugees on the move through European transit countries.
3. Survivors of torture should be protected from immigration detention because of the acute risk of re-traumatisation.
4. States need to do more to counteract negative and toxic beliefs and discourses about refugees and asylum seekers and migrants in general, among politicians, media and the public.
5. Asylum decision-making processes should ensure torture survivors are not forcibly returned to any state where adequate rehabilitation is not available or accessible or where the rehabilitation environment is not safe or stable, irrespective of whether there is a future risk of torture or persecution on return.

B. For service providers supporting torture survivors on the move across Europe

1. Brief, effective models of mental health and therapeutic intervention tailored to the speed at which people are moving need to be developed for those in transit, for example by supporting survivors to manage symptoms and avoid PTSD.
2. Services should be sensitive to the fact that survivors' most important needs during their journey are for food, shelter, positive reinforcement, accurate information about travel routes and transport, and provision of cell-phones and WI-FI to maintain contact with friends and family. Provision of this information also helps to build trust.
3. When possible and consent is given, services should identify people with specific health needs and advise other providers on the next point of the journey of their needs in advance of their arrival.
4. Creation of peer support programmes and recruitment of survivor professionals into services will make these more effective for and accessible to survivors.
5. Ideally health assessments of torture survivors should be symptom-based, not history-based in the first instance, to build trust and minimize re-traumatisation.
6. Services need to be aware of and appropriate to, the particular developmental and age-related needs of children and young people (including separated children and young people) who have survived torture.The potential for documentation of torture en route should be explored further for both protection and torture accountability purposes. Health professionals should be trained to document scars and other signs of torture without expecting disclosure from the survivor if they are not ready to do so until they reach safety.
7. Further work is needed to develop "hand-held records" and secure methods of sharing information to promote continuity of care and so that treatment for torture survivors and other vulnerable refugees can take place over the whole journey.
8. Provision needs to be made for the self-care of professionals providing services

because of the stressful working conditions and risk of vicarious traumatisation.

C. Outstanding/emerging research

1. Research should be undertaken to assess the extent to which the Dublin Regulation operates as a barrier to the rights to health and rehabilitation for torture survivors on the move.
2. A set of indicators should be developed to assess the extent to which rehabilitation is possible in a given torturing state. One such indicator could be whether or not the state accepts that torture takes place in that country. Another would be the level of political will within the state to support rehabilitation. States of asylum should use this information in decision making processes, as in Recommendation A.5, above. It should also be considered by international bodies reviewing a given state's compliance with Article 14 of the UN Convention Against Torture.
3. Further research needs to be carried out to establish the number of torture survivors among refugee populations, including those on the move across Europe.