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effective criminal justice



Rehabilitation Support for Survivors of Torture

A Case Study: Freedom from Torture Rehabilitation Model

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‘The expectation that we can be immersed in suffering and loss and not be touched by it is as unrealistic as expecting to walk through

***water without getting wet'* [Kitchen Table Wisdom: Stories That Heal, Rachel Remen (1996)]**

1. Background information

In November 2010 started a three-year project, co-funded by the European Union, to counter torture in prisons and other places of deprivation of liberty in nine former Soviet Union countries. The project's objectives included advocacy for holistic and comprehensive programmes of rehabilitation based on existing models of international good practice.

Given its expertise on this topic, Penal Reform International sought the cooperation of the organisation Freedom from Torture in this project. The organisation's main role in this project was to create information exchange and training programmes on principles and approaches to 'holistic Rehabilitation' for legal and clinical experts working with survivors of torture in 9 CIS countries. More information about this training programme and our understanding of 'holistic rehabilitation' can be found on the [Penal Reform International website](#).

1.1 About this publication

This case study builds on the discussions around the principles of holistic rehabilitation which emerged during the Torture Prevention project's training programme which was designed and facilitated by Freedom from Torture.

Following the training, the clinical, social and legal staff at Freedom from Torture pulled together the organisation's current thinking around what needs to be in place on a state level and on a service level in order to ensure survivors of torture are able to realise their right to rehabilitation.

The framework and principles outlined in this document are not intended as proposals for THE model of rehabilitation, nor is this document advocating that Freedom from Torture espouses the BEST model or approach. Instead, the aim is to share Freedom from Torture's current rehabilitation approach as a case study in order to promote dialogue and share learning with rehabilitation services within the EU funded Torture Prevention Project of PRI.

1.2 About Freedom from Torture – a history

Freedom from Torture, then the Medical Foundation for the Care of Victims of Torture, began its work under the auspices of Amnesty International's Medical Group in 1985.

Just the previous year, the United Nations Convention against Torture had been adopted by the UN General Assembly on 10 December 1984. This international human rights instrument was established to prevent torture around the world.

In addition to the relevance of Freedom from Torture's medical expertise for survivors of torture living in the UK, forming a human rights organisation of physicians was crucial on an international level at this time, as one of the founders Dr Betty Gordon explains:

“It was horrific to see that physicians had been involved in torturing people – either by complicity or, in some cases, using their expertise to exercise torture. Professionals were being drawn into a political system that was oppressing people (including in the UK and Northern Ireland) and physicians were colluding or supervising torture situations. We began campaigning and challenging South Africa’s medical board regarding Steve Biko. We were campaigning for physicians to support human rights.”

Dr Betty Gordon, Founder

Operating at first from a hut in the yard of the Amnesty International office – which we called ‘the Wendy House’ - the six founding members under Helen Bamber’s¹ leadership began work documenting evidence of torture through provision of consultation for survivors and campaigning against human rights violations.

Recognising the need for development of expert services for torture survivors, the founders created a new entity: the Medical Foundation for the Care of Victims of Torture. The organisation was set up to provide survivors with medical treatment, counselling and therapy and to document evidence of torture.

The vast majority of Freedom from Torture clients are refugees or asylum seekers, coping not only with the long-lasting physical and psychological effects of the torture they experienced but also with the trauma of loss and living in exile.

The staff and volunteers secured three rooms in London’s decaying National Temperance Hospital in late January 1986 and saw 45 clients that year. The organisation grew quickly, treating a peak of 2,000 clients in one year in the early 1990s. Every space available was used to see clients – even the stairs. It then moved on to premises in Grafton Road in Kentish Town, London, where the organisation continued to expand in response to the growing need – staff from that time remember queues of clients waiting outside to be seen.

This growth took the organisation onwards to raise funds for a place where torture survivors would have a real sense of care and calm, in (2004) the head office of Freedom from Torture moved into one of the few purpose-built treatment centres for torture survivors in the world in north London.

A major shift was to come in the early 2000s when a change in government policy to disperse asylum seekers around the country meant that Freedom from Torture had to adapt by opening centres across the UK to meet the needs of survivors of torture. Putting down roots first in Manchester to provide services for clients in the North West, the move set in motion a shift to a truly national organisation, operating out of five centres from 2010 (London, Manchester, Birmingham, Newcastle and Glasgow) and offering a capacity building service in the Yorkshire Humberside region.

Over the past 28 years, Freedom from Torture has received over 50,000 requests for help. Clients have come from over 80 countries around the world, with significant numbers recently from Iran, Sri Lanka, Afghanistan and the Democratic Republic of Congo.

Today, Freedom from Torture continues to offer a holistic approach to rehabilitation for survivors of torture. Each centre provides medical consultation, forensic documentation of torture and psychological therapies and support, as well as practical help for survivors as they try to rebuild their lives. Freedom from Torture offers specialist support for adults, families, separated young people and children.

¹ For more information about Helen Bamber, please see: <http://www.helenbamber.org/our-directors/>

As a human rights organisation, Freedom from Torture also aims to educate the public and decision makers about torture and its consequences through our survivor activism and other awareness-raising efforts, while advocacy work strives to ensure that the UK honours its international obligations towards survivors of torture, asylum seekers and refugees.

Freedom from Torture also provides training and support to other organisations that come into contact with torture survivors, such as healthcare services, legal representatives, as well as community and voluntary organisations, in order to ensure that survivors can access the services they need wherever they are in the UK.

1.3 Terminology used in the case study

Throughout this case study, Freedom from Torture refers to its client group as ‘survivors’ of torture as opposed to the term ‘victim’ of torture utilised in the legal and human rights sector.

In the legal and human rights sector, ‘victim’ is an important term used to clearly define who has had a wrong done to them (ie, the injured, the one tortured). The term victim is used to capture that torture is not limited to practices resulting in physical injuries, and need not be life-threatening to constitute torture. It also seeks to communicate that not only the persons subjected to torture directly are victims, but also their families. The term is often used in parallel with the term ‘perpetrator’ to describe the one carrying out the act of injury or torture in criminal or human rights cases.

At Freedom from Torture, the psychological therapists were very concerned with how this legal use of the term ‘victim’ was often carried by the individual beyond any legal proceeding and became a part of the individual’s identity. As a rehabilitation service, Freedom from Torture’s goal is to support an individual or family move from this often disempowering view of themselves as a ‘victim’ to a more empowering place of ‘survivor’. Thus, throughout this case study, Freedom from Torture has used the term ‘survivor’ to reflect the goal of rehabilitation. (see paragraph 6.1.1 for more on this topic)

2. Right to rehabilitation

2.1. Worldwide torture rehabilitation movement

Freedom from Torture is part of worldwide torture rehabilitation movement that includes some 140 independent organisations spanning 70 countries². These rehabilitation centres share certain characteristics but the social and political environment in which they operate will heavily influence how each of them work. For instance, Freedom from Torture operates, alongside other EU based organisations, in what could be described as a host environment, a receiving country for people in exile rather than, say, a country in current or post conflict.

Rehabilitation centres hold a symbolic value in terms of the politics of torture rehabilitation; they also hold a valuable knowledge base that collectively spans more than 25 years. The rehabilitation movement is also characterised by the principle that prevention and rehabilitation are interrelated.

2.2. Defining Rehabilitation

² www.IRCT.org

In 2012, the Committee Against Torture issued *General Comment No.3* on the Implementation of article 14 by State Parties. In paragraph 11 of the *General Comment*, the Committee Against Torture defines rehabilitation as:

The Committee affirms that the provision of means for as full rehabilitation as possible for anyone who has suffered harm as a result of a violation of the Convention should be holistic and include medical and psychological care as well as legal and social services. Rehabilitation, for the purposes of this general comment, refers to the restoration of function or the acquisition of new skills required by the changed circumstances of a victim in the aftermath of torture or ill-treatment. It seeks to enable the maximum possible self-sufficiency and function for the individual concerned, and may involve adjustments to the person's physical and social environment. Rehabilitation for victims should aim to restore, as far as possible, their independence, physical, mental, social and vocational ability; and full inclusion and participation in society.³

There is no single path to "rehabilitation" as defined in paragraph 11 of the General Comment. In many regions, especially in post-conflict areas, the focus is on community-based psychosocial interventions that include the development of healing group processes at the local level to support rehabilitation. In other areas/regions (often in host/third countries) the focus is on individual psychotherapy interventions to support rehabilitation.

In principle, Freedom from Torture welcomes the Committee's definition of rehabilitation and in particular the focus on functioning⁴. In practice, Freedom from Torture also conceptualise rehabilitation as a right to access both a 'process' (ensuring *how* staff work is rehabilitative) and an 'outcome' (the goal of *what* staff do is rehabilitation) with the aim to enable the maximum possible self-sufficiency and restoration of physical, psychological and/or social functioning.

Freedom from Torture promotes rehabilitation as a conceptualised outcome referring to 'the restoration of function for the individual concerned (...) enabling the maximum possible in self sufficiency...and can be assessed by reference to the quality of life (...) as indicated by patients themselves'⁵.

The right to rehabilitation is interlinked with most other human rights, such as the right to fair trial, right to due process, right to health, right to education, rights of the child, right to private and family life, right to free association and so on. Thus the right to rehabilitation should be considered in the round, thus fully and thoroughly with all aspects considered. Furthermore, the right to rehabilitation is a right for all regardless of gender, race, ethnicity, religion, age, ability, class, culture, education level, sexuality or immigration status.

³ Committee against Torture; 19 November 2012. *General Comment No. 3 of the Committee Against Torture, Implementation of article 14 by State Parties*. Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment <http://www2.ohchr.org/english/bodies/cat/docs/GC/CAT-C-GC-3.pdf>

⁴ 'Functioning' in this context is used to describe a person's ability to get by in everyday life – if someone is not functioning well due to trauma, this may mean they struggle to get out of bed, manage their time, take care of personal hygiene needs, shop/feed themselves and so on.

⁵ Smith, Patel, MacMillan. *A Remedy for Torture Survivors in International Law: Interpreting Rehabilitation - Discussion Paper*. Medical Foundation for the Care of Victims of Torture. 2010. (www.freedomfromtorture.org)

3. Rehabilitation framework for survivors of torture

3.1. Responsibilities of the State - international law

In order for 'as full rehabilitation as possible' to be an achievable aim for survivors of torture and their families, robust national legislation and policies should be in place which support and foster rehabilitation services, including:

- 3.1.1. Article 14 of the Convention Against Torture should be specifically named and enshrined in domestic law.
- 3.1.2. In addition, there should be relevant, measurable and transparent policies and procedures put in place that enable survivors of torture to realise their right to rehabilitation.
- 3.1.3. Acknowledgment that Article 14 is applicable to all victims of torture and acts of cruel, inhuman or degrading treatment or punishment (paragraph 1⁶) and that a person should be considered a victim regardless of whether the perpetrator is identified, apprehended, prosecuted or convicted (paragraph 3⁷)
- 3.1.4. The obligation in Article 14 under the Treaty is both for the recipient state as well as for the torturing state.
- 3.1.5. As emphasised by the Committee in paragraph 12, States must be able to demonstrate recognition that as an aspect of the right to a remedy, the right to rehabilitation 'does not refer to the available resources of State parties and may not be postponed'⁸.
- 3.1.6. State parties are responsible for creating conditions for rehabilitation services (paragraph 15⁹). This means that
 - rehabilitation services are fully supported (and thus not interfered with, intimidated or forced to breach client confidentiality and so on). This relates not only to specialist torture rehabilitation services but also those services which are part of the mainstream and/or national health service such as orthopaedic or neurological services;
 - organisations or groups which provide medical, psychological, practical/social and/or legal rehabilitation services are allowed to operate legally and transparently;
 - organisations or groups which provide rehabilitation services are allowed to safely and openly seek and receive funding from international, regional, national or local trusts, grants, or donors.
- 3.1.7. When reporting on their compliance with the Convention, States should provide information on: rehabilitation services available to victims of torture or ill-treatment and their accessibility, as well as the budget allocation for rehabilitation programmes and the number of victims that have received torture-specific rehabilitation services; and the methods available for assessing the effectiveness of rehabilitation programs and services, including by developing relevant indicators and benchmarks (paragraph

⁶ Ibid, page 1

⁷ Ibid, page 1

⁸ Ibid, page 3

⁹ Ibid, page 4

46¹⁰). Freedom from Torture also considers that the appropriateness of rehabilitation services as well as the safety and security of the rehabilitative context, including client confidentiality (in relation to objective factors) are other criteria which States should be required to report against.

3.1.8. The provision of services for survivors should comprise of access to both mainstream as well as specialist rehabilitation services for survivors. Survivors may need a range of support and thus should not be prohibited from mainstream rehabilitation services if they are in receipt of care or support from specialist services or vice versa.

3.1.9. In essence, States should openly adopt and strive to achieve all the principles regarding their duty under Article 14 of the Convention Against Torture, including:

- Inclusion of all survivors regardless of gender, ethnicity, religion, sexuality, age and so on
- Accountability, transparency and assured independence for providers of rehabilitation services

3.2. Holistic rehabilitation services for survivors of torture – general principles

Specialised rehabilitation services must be made available for the victim or survivor of torture at multiple levels. Paragraph 13¹¹ of the General Comment No.3 on Article 14 outlines what these ‘specialised’ services should include:

- ‘a procedure for the assessment and evaluation of an individual’s therapeutic and other needs, based on, among others, the Istanbul Protocol’. Based on the assessment of need the service may include a wide range of inter-disciplinary measures¹², such as
 - ‘medical, physical and psychological rehabilitative services;
 - re-integrative and social services;
 - community and family-oriented assistance and services;
 - vocational training, education etc.
- ‘A holistic approach to rehabilitation which also takes into consideration the strength and resilience of a victim is of utmost importance’.
- ‘Furthermore, victims and survivors may be at risk of re-traumatisation and have a valid fear of acts which remind them of the torture or ill-treatment they endured. Consequently, there should be a high priority placed on the need to create a context of confidence and trust in which assistance can be provided. Confidential services should be provided as required’. This context relates both to the attitude and approach of clinicians, legal and support staff and to the physical environment of care. That environment should be structured to

¹⁰ Ibid, page 10

¹¹ Ibid, page 3

¹² In reality “specialised” rehabilitation services will never be able to provide all the required medical and physical rehabilitative services that are needed by survivors. For example, x-rays, scans, surgery will usually not be provided by specialist organisations, but through the mainstream health service of the state. Hence, it is essential that states recognise the independence and confidentiality of state health services, as well as appropriate training of health service clinicians and staff on issues for them in working with patients who are torture survivors.

minimise features that are likely to remind survivors of the torture or ill-treatment they have endured.

- These specialised services should be delivered by clinicians and other professionals who have had appropriate training in how to work with highly traumatised individuals and families including survivors of torture.

Freedom from Torture has previously proposed three inter-related minimum criteria for assessing the adequacy of rehabilitation services in the context of Article 14 obligations which clarify or elaborate on many of the concepts outlined above in General Comment No. 3 on Article 14:

3.3. Criterion 1 - Rehabilitation services must be *appropriate* for torture survivors

Appropriateness refers to the standard of rehabilitation services available to torture survivors and, where relevant, their families. In addition to the quality features already set out by the Committee in General Comment No. 3 (and referred to above), Freedom from Torture encourages services to recognise:

- ⤴ that a **holistic approach usually requires services delivered by a multi-disciplinary team**;
- ⤴ that **long-term therapy and support must be available for those requiring it** (this is important because the consequences of torture are often pervasive and enduring);
- ⤴ gender sensitivity – **survivors of torture should be able to specify whether they would prefer rehabilitation services to be provided by women or men and such requests should be met** (this is very important in the context of torture rehabilitation because of the high proportion of survivors – both female and male – subjected to rape and other forms of sexual violence); and
- ⤴ That **children and young people** (both those who have been separated from their families and those who remain with their families, whether in exile or not) have **rehabilitation needs requiring specialist multi-disciplinary service development and provision**. (This should be specified regardless of separate obligations set out in Article 39 of the UN Convention on the Rights of the Child which, of course, only apply to States parties to that treaty and which, in any case, are not explicitly framed as an aspect of the right to a remedy).
 - There is now much evidence to suggest that experiences of torture are likely to affect the physical, emotional and neuro-biological development of children and young people by delaying development or rendering it uneven. Thus chronological age may not be consistent with developmental age and needs to be taken into account when assessing young torture survivors and designing and delivering rehabilitation services for them. Rehabilitation work with child soldiers is also particularly complex because of their dual status as both victims and enforced perpetrators.
- ⤴ That **in some circumstances it is necessary in therapeutic terms to view the family, as a whole, as a 'victim of torture'**. Frequently, multiple members of a family have experienced torture either directly or indirectly (for example where children are present during the rape of a parent). It may be very difficult for some members of a family to disclose their experiences (for example a father who feels unable to disclose that he was raped) and disclosure, particularly for young girls and boys, may take a very long time especially if there

is a strong sense (including for children) that there is a need to protect other members of the family. In these complex cases a holistic assessment should address the needs of the family as a whole with careful consideration given to each individual family member as well as to subgroups including the parents as a couple and children as siblings, with services delivered accordingly.

3.4. Criterion 2 – rehabilitation services must be *accessible* to torture survivors

Rehabilitation services must be accessible to torture survivors, in law and **in practice**, thus services must be:

- ⤴ accessible **geographically**;
- ⤴ accessible **linguistically** through the provision of quality interpreting services (as required);
- ⤴ **sufficiently resourced and staffed for early assessments to take place and for treatment to commence within a reasonable timeframe** so that further deterioration of a survivor's psychological and physical health is avoided;
- ⤴ **available without discrimination** on grounds including race, colour, ethnicity, sex, age, religious belief or affiliation, sexual orientation, identity, language, religion, political or other opinion, national or social origin, property, birth, mental or other disability, health status, economic or indigenous status or other status (the principle of non-discrimination applies to the obligation to provide 'as full rehabilitation as possible');
- ⤴ **capable of quickly identifying those torture survivors whose clinical needs are urgent or who are particularly vulnerable**, including children and young people, the elderly, those with severe mental or psychological health problems, especially those at risk of self-harm and those with physical disabilities, illness and acute injuries requiring prioritisation;
- ⤴ **capable of working with and accepting referrals from other agencies to identify torture survivors who would not otherwise come to the attention of the service** including because of cultural denial and other social and cultural norms. This is particularly the case with women or children who may be seen as the possession of their husbands or fathers and therefore beyond the remit of state or voluntary intervention. In these contexts, it is often the case that family honour takes precedence over safety, protection and rehabilitation following torture and this is a powerful barrier to accessing rehabilitation services.

3.5. Criterion 3 – the environmental context in which rehabilitative services are offered must be *safe and stable*

Environmental factors and lack of security or stability that impede or prevent access will render available services inadequate. In this context, the concept of safety has both **objective** and **subjective** dimensions:

- *Objectively*, it may not be safe for torture survivors to approach and access rehabilitation services. For example, where conflict or political instability is ongoing, torture survivors may not be able to access rehabilitation services because there is a risk of discrimination, further reprisals or breach of confidentiality by service providers. In these situations, the independence of rehabilitation service providers from torturing elements within the state or otherwise is of critical importance.
 - Moreover, the accessibility criterion cannot be considered to have been met if torture survivors are not able to reliably access regular appointments with service

providers for other reasons beyond their control during the period of the rehabilitation programme. Such reasons might include the geographical situation and resource limitations of the service provider or constraints arising from the social welfare circumstances of the torture survivor, including inadequate financial and housing provision sufficient to render the survivor's recovery environment unstable.

- *Subjectively*, the effectiveness of the rehabilitative process is dependent on the extent to which the torture survivor feels safe disclosing torture and is assured of the safe and stable context of rehabilitation. This also means that in a context where societal attitudes to torture survivors entail hostility, disbelief, blame, stigma or shaming (for example, with rape victims, or those with severe mental health problems), or when experiences of injustice are not acknowledged officially nor their dignity publicly validated, survivors may feel hindered or unsafe to approach rehabilitation services.

4. Rehabilitation services - "Overarching Frame":

It is clear from discussions so far as part of the PRI Torture Prevention Project that there are differences between and within rehabilitation services and experts in each country because of the unique legal, socio-political and demographic situations. For example, some services work with clients who are victims of torture carried out by the state in which they still currently live; while other services, including Freedom from Torture, mostly work with clients from other countries who are claiming asylum or other forms of protection.

The clinical approaches and good practice outlined in this section stem from internal discussions currently taking place within Freedom from Torture. The organisation has started a process of learning from practice which will refine its own model, so the approach outlined in this case study is not the organisation's final or static model for rehabilitation. Instead, Freedom from Torture intends to use the clinical governance cycle (see page 20) to continually reflect on and develop the organisation's standards of practice.

4.1. Theoretical foundations¹³

Survivors of torture have experienced more horror than anyone should in a lifetime, yet their suffering does not necessarily end when the torture stops. The journey back into society can be a painful struggle although recovery is possible. As professionals working with survivors of torture, a rehabilitation centre's aim is to help people rebuild their lives and rediscover the full physical, emotional and psychological health that torture has stolen from them.

Suedfeld describes four key states which perpetrators seek to induce in those they torture¹⁴:

- Debilitation (physical and mental weakness)

¹³ References cited in this section:

- Suedfeld, P (1990) Psychology and torture. Hemisphere, New York,
- Baker, R. (1992) "Psychosocial Consequences for Tortured refugees seeking asylum and refugee status". In M. Basoglu (ed.), Torture and its Consequences, Current Treatment Appendices. (Cambridge: Cambridge University Press).
- Herman, J. (1992) Trauma and Recovery: The Aftermath of Violence--from Domestic Abuse to Political Terror.

- Dependency (material and psychological)
- Dread (“...a constant state of fear and anxiety”)
- Disorientation (unpredictable treatment which undermines the person’s capacity to develop coping mechanisms).

Freedom from Torture’s rehabilitation work aims to counteract these effects.

This frame respects the humanity of survivors and views them as the bearers of the full range of human rights and fundamental freedoms. This means that survivors have a human right to as full a rehabilitation as possible; protection from harm; and to flourish and lead fulfilling lives.

Survivors also have a right to fully participate in the development and running of the service and to equality and transparency of treatment.

Survivors are essentially healthy, resilient people who have been through and survived extraordinary experiences.

4.2. Principles of models of treatment

The Freedom from Torture clinical model as a whole is best described as a “Psychosocial Model of Well-being” in that the practitioners act upon the internal and external world issues which impact upon the survivor’s health and well-being and the interactions between them. As practitioners work with the *whole* person, practitioners act upon the biological, psychological and social dimensions of the survivor’s experience.

- The service is *integrative*, requiring practitioners to have a core theoretical model but to be flexible and aware of and competent in other models and able to deploy these as required by the particular client they are working with at any given time.
- Cultural Sensitivity: Freedom from Torture respects cultural diversity and strives to avoid making assumptions about thinking or behaviour based on a practitioner’s own cultural frame of reference. This requires an open ‘curiosity’ and exploring meaning with each client.
- Freedom from Torture is committed to working anti-oppressively with survivors and will explore the differences between therapist and client and how power might impact on the therapeutic relationship.
- The service is *holistic* in that it meets a range of complex needs, including complex trauma. Practitioners work with the whole person, not fragments of the person.
- Practitioners therefore consider and engage with physical pain and physical illness as part of a multi-disciplinary service to survivors.
- Practitioners work within clear clinical boundaries which are negotiated with survivors.

For those survivors of torture who have fled to a new country for protection, Baker (1992) notes there may be additional multiple traumas which can arise (often referred to as the ‘Triple Trauma paradigm’),

- The Trauma of torture
- The Trauma of seeking asylum
- The trauma of being a refugee¹

We therefore engage with these multiple traumas through use of a three dimensional framework focusing on:

- Safety
- Remembrance & Mourning
- Connection to the new society

(Judith Herman, 1992)

- Clinical practitioners work closely with legal representatives, policy and advocacy experts as well as campaigners within the organisation on areas of client experience affected by national government policies and procedures.
- Practitioners engage actively with casework on welfare and other practical issues.
- Practitioners explore how survivors are disempowered as people who are oppressed (and depending on the context, further disempowered as refugees seeking protection).
- Practitioners engage with and seek to prevent risk and complex vulnerability including: suicide, self-harm, neglect, child protection issues domestic violence and sexual exploitation. Further risks and vulnerabilities include re-incarceration or multiple detentions (and thus risk of further torture and ill-treatment). For survivors of torture seeking asylum in a host country, there is also the additional risk of removal to the country of origin (*'refoulement'*).
- Freedom from Torture's therapeutic work is long-term, but not "open-ended": practitioners in the organisation recognise the importance of maintaining a position of positivity about the survivor's recovery and that working towards an ending can be therapeutically beneficial for someone who has experienced traumatic losses.
- Freedom from Torture perceive survivors as rights bearers, as autonomous and capable of making decisions about their needs, treatment and future and this is respected within the clinical work.
- Freedom from Torture designs and fits services around the needs of the survivor.
- Freedom from Torture is committed to the continual improvement of the therapeutic work and to measuring its effectiveness.
- Practitioners provide psycho-education to survivors and work collaboratively to help them develop a range of tools to manage their traumatic responses:
 - Psychological therapists engaging with the processing of traumatic experiences will also be working alongside the survivor to develop tools/skills to the survivor for managing traumatic responses that enable such work to be undertaken. This work will build on any tools or resources the survivor has already developed in managing their experiences and will include education around trauma and its impact.
 - All psychological therapists have had either formal trauma training or attended internal trauma courses and will have at their disposal a range of tools that can be shared with clients. These will include techniques for example to manage anxiety and panic, grounding techniques for managing flashbacks and nightmares, sleep hygiene tools and distraction techniques which can be helpful for managing day to day.
- As a rehabilitation service in a 'host country' working with survivors who are going through - or have been going through - the UK asylum system, Freedom from Torture:
 - works with the asylum and asylum support systems and addresses clients' lack of awareness / information
 - provides services in languages relevant to survivors, directly or through interpreters.

4.3. Holistic approach

The goal of a perpetrator is to attempt to 'kill' a person without causing their death. While torture is used to fragment, break and destroy a person, the aim of rehabilitation is to help put them back together. Torture has such a devastating impact that an individual survivor may need help on a number of levels to effectively rebuild their life. Holistic rehabilitation takes into account the varied and complex needs of a torture survivor. The goal of holistic rehabilitation is to assist a survivor in

rebuilding their life and to feel healthy, safe and whole once more. Holistic rehabilitation strives to ensure that a survivor is not only self-sufficient but is also empowered to engage with and proactively contribute to their community.

Holistic rehabilitation services are interdisciplinary and can include doctors, psychiatrists, psychologists, psychotherapists, physiotherapists, casework-counsellors, lawyers, social welfare workers, teachers and community outreach workers. Ideally, each professional does not just refer a client to other services to meet the range of needs but engages in multidisciplinary discussions about the client with experts from other disciplines (ie, the psychologist, doctor and lawyer reviewing a case together). A rehabilitation approach can be described as holistic when it looks at the survivor of torture as a whole person and supports all of their needs – clinical, welfare, legal, policy and so on.

As professionals, it is important that service providers remember the person behind the label ‘torture survivor’. This whole person is so much more than the torture they have experienced. It is important to think about their life before the torture as well as the effects the torture has had on them. Looking at the wider person in the context of their life-history may shed light on why certain individuals have been targeted for torture. For example, in some contexts people are targeted because of social identity groups they are part of (real or perceived), such as gender, race, religion, age, ability, class, culture, ethnicity, education, sexuality, spirituality, political activity, etc.

There are a number of strands involved in helping a survivor to rehabilitate:

- Working with the survivor to promote their **health and wellbeing** is one such strand. A practitioner would do this by supporting the survivor to access health services (such as helping them register with a doctor, encouraging them to consult with their doctor/nurse about their health concerns and ensuring they know how to explain these concerns to the doctor/nurse and also advocating for the survivor with the doctor/nurse where necessary). In many countries, medical doctors are essential members of the team due to the lack of cultural or societal awareness of how psychological therapies can support rehabilitation and/or how trauma may impact individuals and communities emotionally and psychologically. Thus many survivors express psychological problems through somatic complaints because they may perceive this as a ‘safer’ way to express their needs or because they are unaware of the psychological root of their problems. As such, trauma treatment in many countries, such as Georgia¹⁵, begins with the doctors who then may eventually be able to encourage a client to engage in a psychotherapeutic process.
- Another strand of holistic rehabilitation may be providing **psychological support** for the survivor. This can be achieved through a variety of traditional and alternative therapeutic interventions according to a survivor’s unique needs. (more detail below)
- A third strand of holistic rehabilitation involves working therapeutically with the survivor and their **family** so that healing takes place within the family, and for the survivor, within the family unit.
- **Practical support or social welfare** is a fourth strand of holistic rehabilitation. This might include assistance with employment, accessing disability benefits/government support, advocating for the client with other professionals or agencies, providing emergency financial grants, food and clothing and advocating for children at schools.

¹⁵ Lela Tsiskarishvili of the Georgian Centre for the Psychosocial and Medical Rehabilitation of Torture Victims (GRCT) raised this important note on the essential role medical doctors often play trauma teams.

- A fifth strand of holistic rehabilitation involves working with the survivor so that they can achieve **economic self-sufficiency**. This might include supporting clients to access social welfare /social security benefits existing in the country, helping them to find paid work or running teaching sessions with clients so that they learn how to manage their finances in their new context.
- A final strand of holistic rehabilitation is “**justice**”. This could include supporting the client to explore which avenues are open to them for seeking justice. There are many different ways in which a survivor of torture can achieve a sense of justice, including pursuing criminal conviction of the perpetrator or a civil case for damages and, for some, exhaust the domestic remedies and get their case to a regional human rights mechanism (such as the European Court of Human Rights or the African Court on Human and People’s Rights). Also, in refugee hosting countries, this could include support in gaining refugee status under the UN Refugee Convention. In some contexts, utilising the court system is not safe or not feasible, thus communities and individuals may need to think creatively about alternative ways of achieving a sense of justice (such as ‘transitional justice’ programmes).

4.4. Clinical Models Deployed within the Framework:

Therapeutic models employed within Freedom from Torture’s framework include: Humanistic Counselling, Psychodynamic Counselling & Psychotherapy, Psychoanalytic Psychotherapy, Systemic Psychotherapy, Transactional Analysis, Horticultural Psychotherapy, Music & Art Therapy, Brief Therapy, Cognitive Behavioural, and Physiotherapy amongst others. The organisation is also committed to exploring and developing the use of evidence-based therapies including Trauma-based CBT, EMDR, Narrative Exposure Therapy (NET) and Cognitive Analytic Therapy (CAT) and other therapies such as “Tree of life”, where the approach can be shown to benefit the survivor and is delivered within a broad therapeutic relationship following the phases and principles of this framework and not in isolation.

Treatment is provided to individuals, groups, couples and families. Length of treatment varies according to the needs and (wherever possible) preferences of the survivor, ranging from time-limited to long term (but not open-ended).

A range of group-work approaches are offered, including psychosocial, psycho-educational and psychotherapeutic approaches.

4.5. The Client Journey

The service needs to ensure it is mindful of the needs and challenges clients face in their journey to recovery and rehabilitation.

At the **Intake** and **Assessment** stages, managers and clinicians need to consider the needs of the survivor and which form of treatment would be most beneficial for them. This can be done by considering which of the “**Three Dimensions**” are most relevant to the survivors experience at that stage. Psychological therapists at Freedom from Torture also consider locating the survivor on the “Trauma Grid” (Papadopoulos, R¹⁶) to distinguish between negative effects (e.g. PTSD, distressful psychological reactions, ordinary human suffering), “neutral” effects (resilience) and positive effects (Adversity Activated Development) on the individual, family, community and society / culture levels. These considerations can assist therapists to negotiate and agree the most appropriate forms of treatment for survivors.

¹⁶ Papadopoulos, Renos K. (2006) Refugees and Psychological Trauma: Psychosocial Perspectives.

The Three Dimensions:

“Dimension” is preferred here to “Phase” in recognition that moving between “Safety”, “Remembrance & Mourning” and “Connection”¹⁷ is not a linear process. Survivors can have recurring safety needs throughout their rehabilitation process for instance, and therapists may need to pay attention to two or more of these dimensions simultaneously.

4.5.1. The Dimension of Safety:

Psychological therapists at Freedom from Torture think of safety in the *physical* sense, assisting the client to gain access to housing (through welfare advice / casework) or in some contexts, protection through medico-legal report, for instance, and also in the *psychological* sense of safety from distressing symptoms such as flashbacks or nightmares. Psycho education around symptom management / casework to resolve practical safety issues are features of work in this dimension.

Addressing physical safety will involve considering the physical health of the survivor as well, through considerations of pain within therapy sessions, physiotherapy and medical interventions by medical staff. When working with a survivor of rape for instance, practitioners should consider not only the psychological impact on the survivor but assess also for physical injury or sexually transmitted diseases.

4.5.2. The Dimension of Remembrance & Mourning:

For many survivors of torture, recounting the narrative of their experiences of torture and traumatic loss can be therapeutically beneficial, reduce distressing symptoms such as nightmares or intrusive thoughts and help to integrate the experience into their life story. However, it is important to first build a relationship of trust with the survivor and allow them to move at their own pace. It may take a very long time for some survivors to feel safe enough to fully relate the story, if they ever reach this stage. Therefore at Freedom from Torture, practitioners aim to provide “non-verbal” therapies where possible or other media for the survivor to explore the story. This can include psychodynamic / psychoanalytic approaches around working with the unconscious to recover repressed material.

The nature of the therapy provided and the expectation that the story will be disclosed should be discussed with the survivor at the beginning of the work at the contracting stage so they are fully informed of what to expect.

Techniques such as the “Tree of Life” approach where groups of survivors are brought together specifically to tell their stories may also be considered here.

It is recognised that practical, external world issues can impinge upon the telling of the story. Clinicians and clinical supervisors need to be aware of the risk of collusion with a survivor’s attempts to use practical issues (such as lack of employment or need for housing) defensively to avoid thinking about more troubling traumatic material.

For the telling of the story to be therapeutically helpful, space needs to be allowed for the emotions surrounding the events to be heard, explored and contained.

¹⁷ as described by J Herman, see page 10

The story can often come out in fragments over a long period of time. The therapist's role is to hold the different strands of the story and help the survivor construct a coherent narrative. This acts against the fragmenting impact which torture has on the self.

4.5.3. The Dimension of Connection:

Torture can cause the "splitting off" of aspects of the self which therapy can assist the client to reconnect with. This happens with families where narratives can become split. This process is complicated if the family itself is physically separated/fragmented or there are dangers around contacting the family (for fear of reprisals).

The survivor often needs to reconnect to the resilient aspects of the self or connect to those parts of the self which have developed through adversity.

Issues around trust of the therapist's adherence to confidentiality can hinder disclosure and need to be addressed. Being able to trust is a prerequisite for being able to connect or relate to others.

Sometimes therapist and survivor have to "look out" together to the outside world and connect to it, through, for example, religious, community or cultural networks. Seeking redress will be part of this process, although where the survivor is considering seeking redress, we need to think about the survivor's defensive use of redress as a way of acting out revenge fantasies rather than thinking about their meaning.

Some groups of survivors, including perpetrators who later become victims and child soldiers require a different approach: the survivor needs to be prepared to look at what they did as well as what was done to them – both are part of their identity and need to be recognised / heard. Another example is a family which was tortured but where there is also domestic violence present – again both are part of the family and need to be considered / owned. This is part of reconnection and needs to be borne by the therapist, however horrific.

Clinicians working with different linguistic groups (including those in asylum contexts) also need to consider whether the long-term use of an interpreter can hinder connection with the wider society by undermining a client's efforts to learn the mainstream language.

4.5.4. Note on "Communality":

Group work contributes to survivors' *safety* (e.g. orientation and psycho-education groups), *remembrance & mourning* (e.g. "surviving trauma") and (re)-connection (specific ethnic/political groups).

Groups using media such as art, music or nature make our services accessible to survivors who are not at first able to speak directly about their torture.

Reconnection work could also be aided by an initial group-work phase with one to one sessions for those clients who still require them afterwards.

4.6. Knowledge & Skills

Working in the way outlined in this case study is highly complex and psychological therapists of whatever discipline or background working within this framework need to have a wide range of knowledge and skills, including:

4.6.1. Knowledge

- National health systems and legislation, welfare legislation, human rights legislation, and immigration/asylum legislation (if relevant), clients rights under these areas and how to access services
- Organisational remit
- A relevant language or languages other than the national language sufficient to be able to conduct therapy sessions with clients from diverse ethnic/linguistic backgrounds; and/or skills in working with interpreters in a clinical setting (as relevant)
- Knowledge of the psychological impact of trauma and torture on individuals
- Knowledge of a range of psychotherapeutic approaches and theories, including integrative, psychodynamic / psychoanalytic, humanistic and systemic and how these can be applied to work with torture survivors
- Comprehension of the impact of torture (and exile, if relevant) on individuals and families across the full range of ages and phases of the life cycle
- Comprehension of approaches to the assessment and management of serious risk of self-harm and suicide
- Awareness of power and difference, including race and gender and the impact of this on the outcome of therapy
- Training in at least one of a range of evidence based approaches to trauma therapy including Trauma-based CBT, Narrative Exposure Therapy and/or EMDR.
- Comprehension of the impact of cultural difference on understandings of the impact of trauma and exile, health, illness and recovery
- Knowledge of the range of mental illnesses and approaches to treatment

4.6.2. Skills

- Ability to carry out holistic psychological and social assessments of survivors of torture sufficient to gain an understanding of their needs for assistance in these areas
- Ability to intervene with survivors of torture in crisis
- Ability to assess and manage serious risk of self-harm and suicide
- Ability to assess and work therapeutically with people with a range of severe and enduring mental illnesses
- Therapeutic skills in working with trauma survivors experiencing: PTSD, loss, guilt, shame, depression, pain, displacement
- Counselling skills, including: empathic listening, understanding of boundaries, building and maintaining a trusting relationship
- Ability to assess and work with the full range of risk affecting a torture survivor in his/her community context, including suicide / self-harm, removal, homelessness etc
- Ability to employ a range of clinical approaches including group and individual
- Ability to work with a range of clients including adults, young people and children
- Ability to work in a culturally sensitive and anti-oppressive manner
- Casework / advocacy skills
- Caseload management

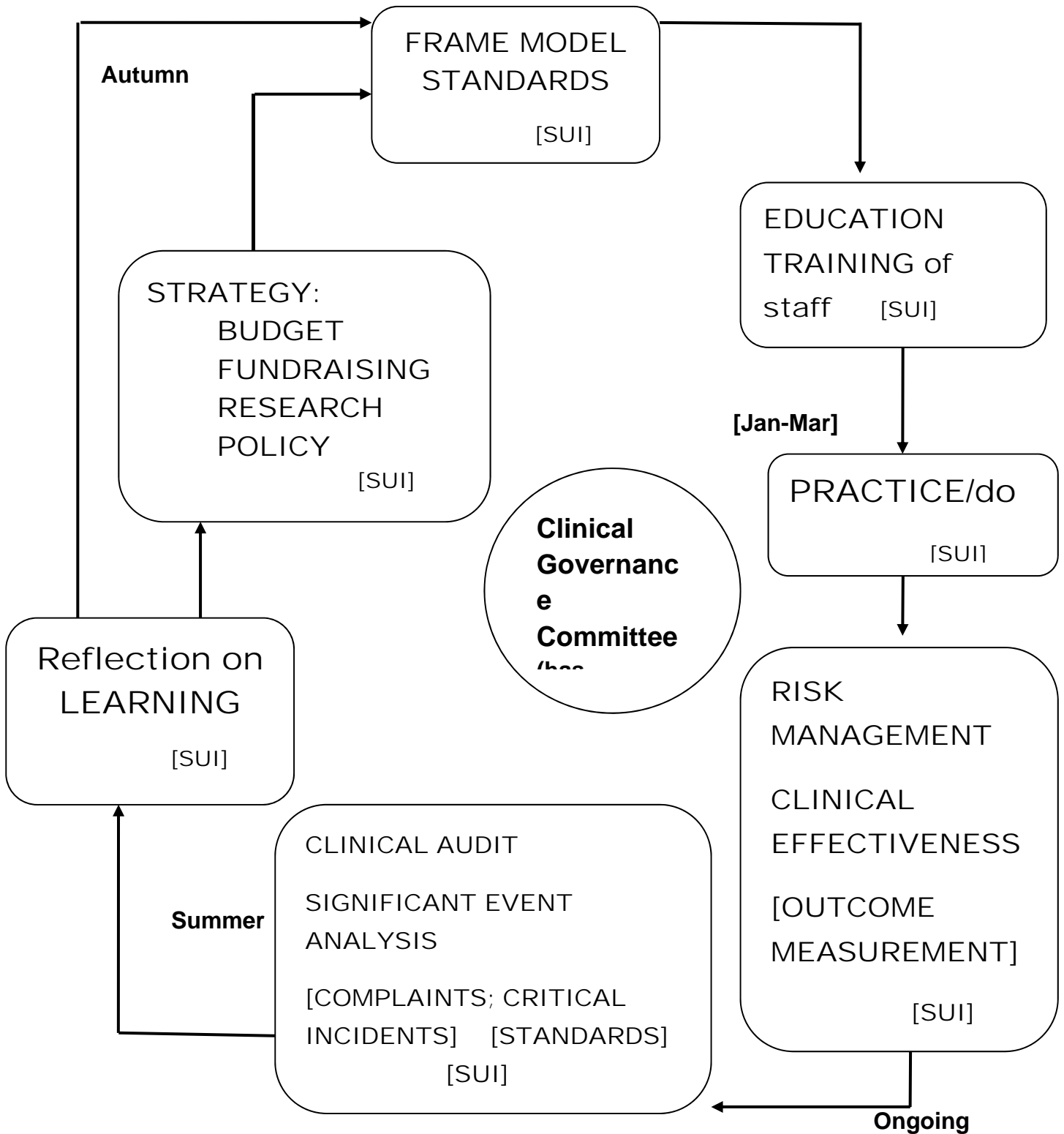
- Report writing
- Record keeping / file management
- Computer skills (including word processing software, email, databases)
- Ability to work in a multi-disciplinary system
- Team working
- Ability to supervise other therapists clinically
- Ability to train other clinicians

4.7. Clinical governance cycle

As discussed at the beginning of this document, there is no single model, nor a singular way to run a rehabilitation service for survivors of torture. However, it is recommended that services agree a process and timeline and the needed steps and protocols to monitor the service and ensure it is actually delivering a safe, appropriate and effective service. Ideally, this process would include built in time and systems to foster an ongoing flow of planning, doing, evaluating and with the aim of continual improvement.

Freedom from Torture has recently agreed the following 'clinical governance cycle'. It is still in the early stages of deliberate implementation and includes the following:

Clinical Governance Cycle – Freedom from Torture example



SUI = SERVICE USER INVOLVEMENT

5. Structures and systems – Clinical and therapeutic work

5.1. Allocation and remit

Rehabilitation services need to develop a national set of referral guidelines that outline the remit for those accepted for a holistic assessment at the service, dependant on centre capacity. A clear remit can help ensure that referrals are appropriate and help other service providers or members of the community understand who can access your service.

For example, the Freedom from Torture remit:

For example, Freedom from Torture can only work therapeutically with a small number of survivors and so have developed criteria that helps staff to prioritise complex cases, ie survivors who are profoundly traumatised, whose social situation is poor and who are unable to access or make use of mainstream services.

Freedom from Torture’s remit is as follows:

“The clients of Freedom from Torture are survivors of torture and organised violence and the families of those survivors. By “torture and organised violence” we mean both severe physical and severe mental suffering deliberately inflicted on a person in the custody or under the control of such organised bodies as police and security forces and other agencies of governments, military and paramilitary units, and organised non-state actors. The forms of harm we include as torture include rape and sexual violence perpetrated by these bodies and actors. In our work, torture includes those abuses described above experienced as a prisoner of war or at the hands of superiors in the victim’s own military unit and also the exposure of child soldiers to gross violence. It does not include the violence suffered by adult military personnel in a combat situation.”

In addition to mental health needs, survivors may have additional needs relating to daily practical concerns, such as employment or poverty issues, physical health and other social and personal vulnerabilities that create a complex set of needs. For clients who are also seeking international protection, they may have additional needs and stresses relating to their asylum claim in the host country (language barriers, social isolation, racism and so on). A rehabilitation centre will need to be able to address the range of complex needs by adhering to a holistic approach.

Each centre will have the practices and processes that work best for their context, but ultimately, rehabilitation services will need to hold regular meetings with relevant, ideally multi-disciplinary staff, to consider referrals. An assessment is offered soon after referral (with a psychological therapist best able to meet the needs of the survivors/s, whether the client is a family, child, young person or adult).

5.2. Intake and Assessment (including risk assessment)

Assessments should be holistic and should include in most contexts a medical assessment. The aim of the initial assessment is to develop a comprehensive understanding of the impact of torture on the individual psychologically, physically and socially. Thus in the initial assessment it is recommended that practitioners explore the survivors current situation in terms of housing and

income, community, education, family context, and immigration status (if relevant) as well as their physical and psychological needs and symptoms.

At Freedom from Torture, the assessment process starts with the survivor defining the problem and setting the treatment goal (rather than starting with diagnosis and treatment). In other words, the assessments consider, in a holistic way, the person and their needs as reported by them and observed by the therapist.

There are many reasons why this approach has been adopted by the wider torture rehabilitation movement. Across the torture rehabilitation movement it has been studied and is recognized that torture survivors often present with symptoms that are considered within the diagnostic for PTSD. However these studies also show that torture survivors also frequently present with additional symptoms, including; symptoms affecting cognition, energy, form and frequency of thought, mood affect and disturbances, occupational and social disturbances, personality changes or adaptations following torture, alterations to world view, perceptual difficulties (including hallucinations) and unexplained physical symptomology. Also, most interventions are carried out under conditions that are unpredictable, unstable and responding to a diagnostic checklist with a prescribed therapy could perhaps limit the therapist's ability to respond in a holistic and sensitive way. In addition it may result in an unintentional silencing of the client's narrative which would define what the main issues are for them.

How long a service can dedicate to an initial assessment will vary depending on the context. For example, the initial assessment may be brief when there is an obvious need for an urgent/immediate response. In other contexts, a practitioner or service may be able to space the assessment over several sessions in order to establish a more trusting relationship and allow the client to share their narrative and their priorities in their own time. Regardless of how long a practice will allow for an initial assessment, it is good practice to ensure that the approach fosters a comprehensive and collaborative process that enables a survivor/s to explore the range of interventions and casework that might be needed and should be prioritised.

All client assessments include a **risk assessment** – this includes an assessment of any potential risk of suicide or self harm. It also includes any relevant assessment of risk of violence or harm from others, such as domestic violence, child protection, racist attacks and so on. Assessors should also monitor potential human rights of survivors which are in jeopardy (for example, the right to health) or other risks which may harm the safety and well-being of the survivor such as destitution.

Once accepted for psychological therapy, a therapeutic 'contract' is developed that aims to address the needs of the whole person, rather than just their psychological state. It is important that this contract is co-created by both the psychological therapist and the client so that both parties are in agreement on a realistic desired outcome of the therapeutic process as well as the practical arrangements which will shape the scope of what the therapy may entail and the length of time the client and psychological therapist will work together.

In some contexts, assessment may also need to include an element of psycho education, where therapists may offer a framework for a survivor to understand their responses to trauma. This framework must be a shared understanding and take into account the range of cultural beliefs that survivors may have to psychological distress. A shared understating of trauma and its impact must be a collaborative endeavour, but normalising traumatic responses and educating survivors about what we know about the impact of torture and trauma is a fundamental part of the assessment process and early therapeutic work.

After assessment, it is recommended that rehabilitation services include a protocol for all psychological therapists to discuss a new client's contract in his/her supervision and that the contract is then negotiated with a client/s if working with a family. In clinical supervision and casework management / review meetings, clinicians, supervisors and clinical managers should bear in mind the Three Dimensions and underlying principles and consider whether the work adheres to these principles and within which of the dimensions the survivor's needs rest at that particular moment. Also, the extent to which the conduct of the therapy enhances or undermines the tasks required by the relevant dimensions needs to be considered.

Whilst it is accepted that this is not a linear process, respecting the survivor's natural resilience and right to flourish and develop requires us to work towards and encourage recovery. Review meetings and supervisions should consider, for example, the point at which the survivor might be ready to move into the remembrance dimension or from there to connection and whether anything the therapist might be doing or omitting to do might be holding the survivor back.

5.3. Clinical case management

There are many ways of defining or interpreting 'case management' but in this document the term is used to reflect the responsibility the organisation has to each client's episodes of care and journey towards rehabilitation.

It is important for rehabilitation services to have an agreed case management policy or protocol that all staff are aware of and apply – the main reasons include:

- Accountability – to ensure client safety, it is important that there is a named staff member who holds overall responsibility for a client – someone who is ultimately 'keeping an eye on' the client. This is especially important in centres where a client may be supported by multiple therapists.
- Regular reviews – with the priority focus on continual assessment of risks for the client and how they are progressing with the therapeutic support.

Each rehabilitation service will have their own ways of ensuring accountability and responsibility for a client's 'journey'. Freedom from Torture has adopted a 'key worker' protocol:

Freedom from Torture Key Worker Protocol

DEFINITION

A keyworker is the person with primary responsibility for the episode(s) of care being followed by a Freedom from Torture client.

An episode of care is the treatment being provided by a clinician or group of clinicians. It has a distinct beginning, middle phase and conclusion, recorded by Freedom from Torture documentation: referral forms (external or internal); periodic case review; closing statement forms (where the episode of care is recorded as ended).

RESPONSIBILITIES OF THE KEYWORKER

- To ensure that the careplan is agreed and recorded on client's file
- To ensure that the client is receiving the most appropriate care and support
- To co-ordinate other support from Freedom from Torture or external agencies if and when appropriate
- To refer on to the appropriate service either within or external to Freedom from Torture as and when appropriate
- To convene case conferences as and when appropriate
- To carry out periodic case reviews
- To ensure that all documentation is completed before keyworking responsibilities are relinquished

WHEN DOES KEYWORKING BEGIN?

A keyworker is allocated to a client once they have been accepted as a client of Freedom from Torture. This means that at the assessment stage, the client does not have a keyworker, although some work may be done with the client in times of crisis, etc.

Once a client has been accepted by Freedom from Torture, a keyworker will be allocated. At internal referral, once a client has been accepted by a new team, that team take over keyworking responsibility for the client. It is the Team Manager's responsibility to ensure that all clients allocated to the team have a keyworker, and that periods of absence by the named keyworker are covered in case of emergency or crisis.

Any care or support provided by an external agency may also be co-ordinated by a keyworker or several keyworkers if the client is accessing more than one service.

EPISODES OF CARE

A client's journey through Freedom from Torture may be through sequential episodes of care, concurrent episodes of care, or a combination of both.

5.4. Data and information management – client records

Patient information is confidential and must be dealt with in strictest confidence at all times, subject to the rules and procedures set out by the rehabilitation centre, in accordance with any domestic laws as applicable. The rehabilitation centre has a duty to maintain the integrity and confidentiality of patient information to the highest standards at all times.

Rehabilitation centres need to create, receive and maintain patient records for clinical purposes, research, and to support human rights work. A rehabilitation centre will therefore need to expect staff to maintain and deliver high quality standards of care and this includes good record keeping.

5.4.1. Definitions

The DAMA Data Management Body of Knowledge (DAMA-DMBOK) defines **data management** as, "the development, execution and supervision of plans, policies, programs and practices that control, protect, deliver and enhance the value of data and information assets."¹⁸ Data management is a huge area of work, so in this working document, we will focus on client records.

Record management is the practice of maintaining the records of an organisation from the time they are created up to their eventual disposal which is commonly known as record life-cycle. This may include classifying, storing, securing, and destruction (or in some cases, archival preservation) of records.

A record can be either a tangible object or digital information: for example, birth certificates medical x-rays, office documents, databases, application data, and e-mail. A record comprises of information in any format (e.g. digital. physical), in any location (e.g. central database server, standalone PC, filing cabinet, archive storage) which is created, received, or maintained by the organisation in the transaction of activities or the conduct of its affairs, and kept as evidence of such activity.

¹⁸ See www.dama.org

The practice of records management may involve:

- Planning the information needs of an organisation
- Identifying information requiring capture
- Creating, approving, and enforcing policies and practices regarding records, including their organisation and disposal
- Developing a records storage plan, which includes the short and long-term housing of physical records and digital information
- Identifying, classifying, and storing records
- Coordinating access to records internally and outside of the organisation, balancing the requirements of confidentiality, data privacy, and public access.
- Executing a retention policy on the disposal of records which are no longer required for operational reasons; according to organisational policies, statutory requirements, and other regulations this may involve either their destruction or permanent preservation in an archive.

Records management principles and automated records management systems aid in the capture, classification, and ongoing management of records throughout their lifecycle. Such a system may be paper based (such as index cards as used in a library) or may be a computer system, such as an electronic records management application.

5.4.2. Health care records

A health care record is confidential and must be dealt with in strictest confidence at all times, subject to the rules and procedures set out by the rehabilitation, in accordance with the law as it applies from time to time. The rehabilitation centre has a duty to maintain the integrity and confidentiality of patient information to the highest standards at all times.

The rehabilitation centre should create, receive and maintain patient records for clinical purpose, research, and to support its own work as outlined in our mission statement. In creating a health care record the documentation itself should:

- Reflect consistency of information relating to the physical or mental health or condition of a individual
- Have been made by or on behalf of a health professional in connection with the care of that individual
- Support day-day activities which underpin the delivery of care
- Support evidence-based practice
- Support sound administrative and managerial decision-making, as part of the knowledge base of the rehabilitation centre services
- Meet legal requirements and regulatory requirements (see below for more information)
- Assist medical and other audits
- Support improvements in clinical effectiveness through research
- Support archival functions by taking account of the historical importance of material and the future needs of research
- Protect the interest of the rehabilitation centres activities, developments and achievements

Policies or guidelines for creating a health care record should reflect the remit of the record and be “fit for purpose”.

The patient record should be available in the right place at the right time to support effective client contact and provide continuity of care.

5.4.3. Ensuring good practice in client record management – accountability and legal responsibilities

All Clinical Managers or Directors and the Chief Executive Officer (CEO) share managerial responsibility for all relevant staff to comply with policies, procedures and guidelines relating to client record keeping, ensuring that due care is taken at all times.

All who are involved in clinical care, provision of advice, advocacy, are responsible for keeping clear, legible, accurate records including **all** relevant clinical/legal findings, any decisions made, continuity of care, systematic reviews, risk management, information given to clients and other treatment prescribed or provided.

Good practice recommends the following minimum standards for practitioners:

- All entries in a patient record are authenticated and the author signature is displayed and all entries must be dated. As a minimum the record should include a signature, printed name and title/credential. If there are two people with the same surname making entries within the client file, they must both use their full name signature/name. A full name/signature may be required by law e.g. legal forms.
- Patient records should be inviolate and unalterable. Once the action has occurred, nothing from the record should be deleted or altered. All recordings should be dated, and where information is added to an existing hard copy record, i.e. annotations, the additional information should be initialled and dated. A record must show completeness and accuracy and be legible. **Illegible documentation can put the client at risk and undermine the continuity of their care.**
- All facts and pertinent information related to an event or care treatment including an incident are clearly documented. Incident reporting is a fundamental part of our health care arrangements. **When a risk to client safety occurs, the facts of the occurrence must be documented within the patient record a separate Incident Report Form.**
- Records must be **objective and worthy of independent scrutiny**. In the event of an investigation or legal proceedings where these records are examined, their content can be critical to the patient's best interest and the rehabilitation centre's integrity and reputation.
- The **condition of the client, their response to care and any deviation from treatment (including the reason for it)** always needs to be included. All entries must be complete and contain all significant information. When writing entries, staff should strive to use language that is specific rather than vague or generalised.
- The patient record is intended to **support effective care through effective organisation of the patient record**. The filing of documents is the responsibility of all that have involvement with the client and it should be filed in chronological order.
- A **black/dark pen** should be used so photocopies can be taken for legal purposes if necessary.

5.4.4. Client's Access Rights to Information Rights

Each state will have its own domestic legislation relating to a client's rights to access their information. For example, in the UK services must comply with the Data Protection Act 1998 which permits clients to make an adequate request (in writing), to be supplied with a permanent copy of

any information held on computer about them, and/or to be supplied with permanent copies of any written records held.

Even if domestic legislation does not require it, it is good practice to provide patients with all of the information that it holds for or about them (subject to certain exemptions). In order to do this, it is vital to ensure that all of our patient information is traceable and maintained in good order¹⁹.

Requests for access should be centrally managed and processed by a senior manager or operational manager overseeing this area of work within the rehabilitation centre in accordance with the provisions of the Act.

A patient should also be able to apply for inaccuracies in their record to be corrected. The health/legal professional should either make the necessary correction or a note can be made in the relevant part of the record of the matters alleged to be inaccurate. Care must be made not to simply obliterate information that may have significance for the future care and treatment of the client or for legal purposes.

5.4.5. Client Record Security²⁰

It is the responsibility of all involved with the client file to maintain security and to ensure confidentiality. This is of vital importance for those rehabilitation services operating in regions where the perpetrators are in the same community as the survivors/victims – if state officials including the police were to ‘raid’ the rehabilitation service, the information held about a client could be used against the client and potentially put them at risk of further torture and ill-treatment.

- Services should endeavour as much as possible to obtain safe storage facilities for paper based client records. In high risk areas, this may include off-site storage for archive files in areas that only a few key staff know of or are able to access.
- Systems should be put in place to track a client record when it is away from the normal storage area (referred to as circulation). Often this is handled by simple written recording procedures. However, many modern record environments use a computerised system involving bar code scanners and so on.
- When (in exceptional circumstances) duplicate records are held, clear reasons/justifications should be made and recorded onto a computer database system and should reflect this in rehabilitation patient confidentiality policy.
- Client records should never be left in ‘unsafe areas’, for examples in staffrooms, mail rooms, patient waiting areas, canteens/kitchens, on/near photocopiers, toilets, meeting rooms or behind reception desks.
- Patient records are the property of the organisation and therefore records should never be taken off site.
- If the rehabilitation centre has an out of hour’s emergency service, then any care or treatment should be documented/ recorded in the same manner as normal working hours.
- If there is a need to transfer patient records to regional centres or offices, then this should be done in a secure manner ensuring the complete patient record is intact. Using a secure courier service is advisable as most courier services offer a tracking facility which can reduce the risk of the client’s file getting lost in transit. Any computerised system on patient care

¹⁹ This includes photographs and film collections assembled by medical and other staff as part of their work within the rehabilitation centre as well as to other personal records.

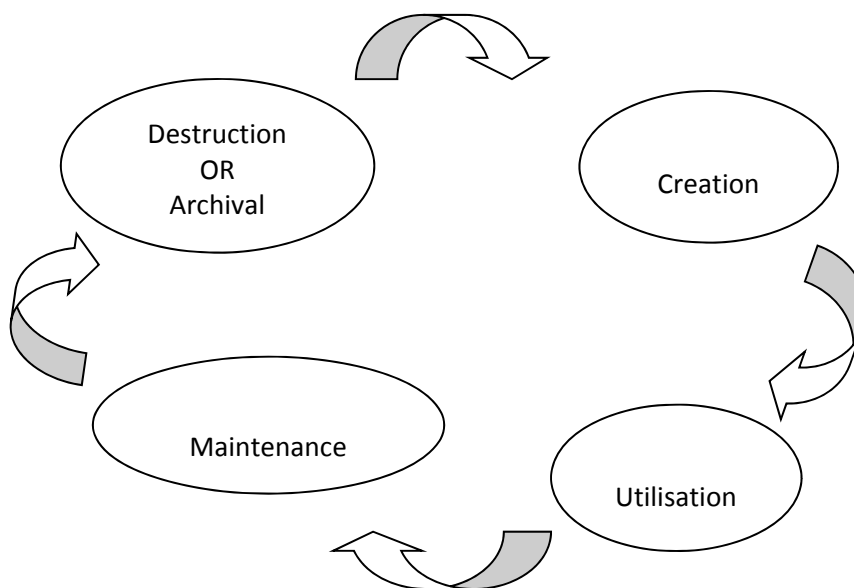
²⁰ See: [The 1995 European Parliament Directive on the ‘Protection of Individuals with Regard to the Processing of Personal Data and on the Free Movement of Such Data’](#)

endorsed by the organisation should record when a request was made, by whom, when a patient record was transferred, date and acknowledgement of receipt of the file.

- The general principles of records management and security apply to records in any format. Digital records (almost always referred to as electronic records), however, raise specific issues. It is more difficult to ensure that the content, context and structure of records is preserved and protected when the records do not have a physical existence. This has important implications for the authenticity, reliability, and trustworthiness of records.
- For digital client data, it is recommended that appropriate firewalls are in place and Information and Communications Technology (ICT) experts should be consulted. Some rehabilitation services in high risk areas may wish to back up electronic data off site onto an external hard drive that is located in a secure place (and known to only a few staff).

5.4.6. Record Retention

The life cycle of record management begins when information is created and ends when the information is destroyed. The picture below provides a simple reflection of the entire record retention process. The goal for organisations is to manage each step in the record life cycle to ensure record availability. The creation of information is easy to establish, and most organisations do not have concerns when creating or using information. However, when maintaining information, various issues may arise.



Storing records: Records must be stored in such a way that they are accessible and safeguarded against environmental damage.

Disposal of records: Disposal of records does not always mean destruction. It can also include transfer to a historical archive, museum, or private individual. Destruction of records ought to be authorised by law, statute, regulation, or operating procedure, and the records should be disposed of with care to avoid inadvertent disclosure of information. The process needs to be well-documented, starting with a records retention schedule.

Record Retention Requirements: Each state will have different requirements for different types of client records, thus you will need to ensure your policy and practice complies with your domestic legislation. For example, in the UK, medical records of adults must be retained for 20 years.

At a minimum, record retention schedules must:

- Ensure patient health information is available to meet the needs of continued patient care, legal requirements, research, education, and other legitimate uses of the organisation
- Include guidelines that specify what information is kept, the time period for which it is kept, and the storage medium on which it will be maintained (e.g., paper, microfilm, optical disk, magnetic tape)
- Include clear destruction policies and procedures that include appropriate methods of destruction for each medium on which information is maintained

5.5. Models of Supervision

‘Trauma is contagious’ [Trauma specialist, Cameroon]

Each rehabilitation centre or service has a responsibility to safeguard the health and well-being of its staff and volunteers. As such, organisations should create and implement systems and structures of support for staff, including managerial and clinical supervision.

Staff who work directly or indirectly with traumatised clients, such as survivors of torture, will be impacted by this work. While, many staff will feel they are ‘positively’ impacted by their work with survivors of torture, many will also find that there are times when they are ‘negatively’ impacted by working with vulnerable and traumatised clients.

How a member of your staff is negatively impacted will vary for each individual – it is a very personal response. If left unchecked and unsupported, staff may suffer symptoms that are detrimental to their work, their personal life, and their health – the impact can fall on a spectrum and include various levels of severity such as:

- Burn out
- Compassion fatigue
- Secondary traumatic stress
- Vicarious trauma

There are multiple definitions of ‘vicarious traumatisation’, but the definitions that are often used within Freedom from Torture come from: Bloom (2003), “The cumulative transformative effect on the helper of working with survivors of traumatic life events.” (p.459) Or, “a state of exhaustion & dysfunction – biologically, psychologically, & socially as a result of prolonged exposure to compassion stress” (Figley, 1995)

Broadly speaking, vicarious traumatisation is characterised by symptoms such as apathy, exhaustion, disillusionment, an alienated attitude towards clients and feelings of guilt and failure (Fineman and Maslach 2006). However in cases that involve torture, reactions can be even more severe with workers developing symptoms of Post Traumatic Stress Disorder (PTSD), threatening nightmares and anxiety disorders (Pross 2006). The specific severity of these symptoms when related to torture survivors vindicates the need for efficient and comprehensive monitoring and therapeutic methods for dealing with vicarious trauma.

5.5.1. Managerial supervision

Research indicates a strong correlation between 'vicarious traumatisation' and 'burnout'. Thus as a service, it is important to recognise the impact of overworking on staff:

- Heavy / complex case loads
- Long hours
- Fast pace / inadequate breaks

Each psychological therapist should therefore have their caseload supervised and monitored by a Clinical Manager, who agrees and sets a caseload that is appropriate for the practitioner. The caseload is dependent on the severity and complexity of the caseload as well as balancing supervisory and external development work being undertaken. It is recommended that no more than four clients are seen daily in most circumstances.

5.5.2. Clinical supervision

It is recommended that all medical and psychological therapists within a rehabilitation centre (paid or volunteer) should have a minimum of 1.5 clinical supervision hours per month. Good practice recommends that Clinical Supervision is provided by an external qualified clinical supervisor for those employed at a rehabilitation centre. Clinical Supervisors should be qualified/accredited or registered in the appropriate therapeutic discipline of their supervisee and be supervised on their supervisory work appropriately.

Due to the frequent crises in the work and the impact of working intensively with trauma and with survivors living in poverty, rehabilitation services may wish to explore a range of additional approaches and methods to support staff well-being such as Peer Supervision Groups or developing a culture whereby clinical staff can access de-briefing and peer support as and when needed.

Staff who are not therapeutically trained, such as lawyers, doctors, interpreters, researchers and administrators should also be offered regular supervision by a psychological therapist due to the nature of the work they are engaged in creating additional clinical supervisory demands above other management or practice supervision.

5.5.3. Resource list

Bloom, S. L. (2003) *Caring for the Caregiver: Avoiding and Treating Vicarious Traumatisation*. In Gardino, A., Datner, E. and Asher, J. (Eds.) (2003) **Sexual Assault, Victimization Across the Lifespan**. Medical Publishing (p.459)

Davies, C. (2004) **Impact: a qualitative study of the effects of working with survivors of torture on counsellor/caseworkers**. M.sc. thesis, University of Essex.

Figley CR. Compassion fatigue as secondary traumatic stress disorder: An overview. In: Figley CR, editor. *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. Brunner-Routledge; New York: 1995. pp. 1–20.

Fineman, S. and Maslach, C. (2006) Signs and Symptoms of Burnout. In: Pross, C. (2006) *Burnout, Vicarious Traumatisation and its prevention*. **Torture**, 16 (1) p.2.

Hudnall Stamm B. ed. (1999) **Secondary Traumatic Stress: Self Care Issues for Clinicians, Researchers and Educators**. Baltimore, Siridan Press

McCann, L. And Pearlman, L. A. (1990) Vicarious Traumatization: a framework for understanding the psychological effects of working with victims. **Journal of Traumatic Stress**, 3 pp. 131-149.

Pearlman, L. A. (1999) Self Care for Trauma Therapists: Ameliorating Vicarious Traumatization. In: Hudnall Stamm, B. ed. **Secondary Traumatic Stress: Self Care Issues for Clinicians, Researchers and Educators**. Baltimore, Sidran Press, pp.51-64.

Pross, C. (2006) Burnout, Vicarious Traumatization and its prevention. **Torture**, 16 (1) p.2.

<http://www.headington-institute.org/Default.aspx?tabid=2649>

6. Structures and approaches – Work with the public

6.1. Survivor participation in work with the public– general principles

When striving to adhere to a human rights based approach, it is vital that current and former clients are allowed the space and feel skilled and supported enough to participate in various areas of work.

Freedom from Torture works with a range of individuals who have experienced torture (both current and former clients) in activities to promote the rights of torture survivors including raising awareness of torture, influencing decision-makers and the public to press for positive change in the protection of survivors' rights, both in the domestic and international spheres.

If a rehabilitation centre wishes to support survivor participation and activism, it will require the investment of significant time and resources into working with clients in order to achieve the objectives while ensuring best practice. The details outlined below in some areas demonstrate a number of interim-practices Freedom from Torture staff have been following in the organisation's efforts to develop best practice.

6.1.1. Establishing a language of *survivor* activism

The experience of torture is intended to silence individuals but also to strip away a person's sense of self, disempowering them and reducing them to the status of a 'victim'. Whilst an important goal of holistic rehabilitation is to support survivors of torture in finding and regaining their individuality, survivor activism is another, empowering means for survivors to reclaim both their personal 'voice' and their dignity.

At the root of this process is language and the way survivor activists choose to present, and see, themselves as they work to raise public awareness and/or to influence governments to bring about change. Moving from a language of 'victimhood' to one of 'survival' is both a natural, and a necessary, point of departure in light of the fact that survivors are not just participants in the context of survivor activism; they are the 'experts'. Survivor-led activism is a powerful mechanism for change precisely *because* those individuals speaking out about their experiences and expressing their opinion on what needs to change do so from a position of absolute authority.

6.1.2. Interviewing clients – Freedom from Torture research, communications and campaigning material

Staff at Freedom from Torture regularly conduct interviews with survivors of torture for a range of research and for work with the public through communication and campaigns, including web publication; promotion through social media; print newsletters; features distributed through partner organisations networks; short illustrative "case studies" for use in larger documents (eg Annual Review); web based actions; and larger research publications. The interviews of clients are used:

- To contribute to thematic features, where the content from the interview will be presented alongside factual information or commentary (eg learning from a survivor's experience to illustrate the impact of a policy issue and garnering their views on potential solutions)
- For documentary purposes (eg to help illustrate patterns of abuse occurring in specific countries)
- To develop material where the focus of the output is primarily their individual story (written up in the first person or third person carrying significant content in quotation)
- To provide a survivor perspective of how any given issue affects clients, supported by a call to action directed to a decision maker

- To develop client-led features, where the survivor has an “open brief” to choose the issues they would like to speak out about (see more on this below)
- To collect data and evidence of issues facing survivors of torture for research purposes (Research issues are detailed in a separate section below).

To ensure the organisation’s approach and practices are not disempowering or oppressive, and minimise risk to the client, Freedom from Torture has established policies, procedural agreements and training for staff on good practice in interviewing survivors of torture for communication purposes. The organisation endeavoured to create a policy which includes best practice for each phase of the interaction, including:

- Background preparation ahead of an interview: For example, establishing roles with clinicians / interpreters; when relevant (eg. invited to do so by client, through initial conversation with their clinician), reading information from a client file in advance, to avoid coverage of specific issues in an interview;
- Conducting the interview: ensure a safe and private space in a comfortable setting; take the time to establish a rapport; establish consent (ensure that the person is giving ‘informed’ consent)
- Follow-up: record the work conducted in the client file as well as any research/press/communication team files; record consent forms in both client and team files as well; arrange a second meeting with client to agree material for use (or liaise through clinician).

6.1.3. Survivor involvement in research, communications and campaign work

Freedom from Torture is committed to identifying and developing platforms for survivors we work with (clients and former clients) to **speak out on their own terms and in their own words**, as opposed to simply being “written about”. For example, Freedom from Torture’s campaigner developed a series of client-led features to mark International Year of Youth, celebrating young survivors (important both for survivor empowerment and campaigns outreach targeting young people but also a culture shift about the way in which the sector talks about survivors, attempting to shift focus from a victim care-based approach to a strengthened positive image of survivors) – see [Year of Youth](#) on the Freedom from Torture website. In all thematic communications material, where possible staff, we try to use as much of the interview as possible in the survivor’s own words.

Freedom from Torture publishes the work of members of our [Write to Life](#) group in print publications, on the web and seek placement in media outlets. While workshops revolve around chosen themes (eg, journeys, food, bodies) there is no pressure placed on the individuals to explore any particular subjects in their work. In a recent annual anthology, the writers’ poetry and prose was illustrated by photos they had taken with cameras provided by Freedom from Torture and introduced by auto-biographies the Write to Life participants had written, rather than biographies developed by an editor.

Staff are committed to developing good practice ourselves and encouraging others across the organisation to involve survivors in the **concept-development stage of communications projects**, rather than nearer the end (eg. adding survivors’ stories to a previously agreed concept). For example, having taking an integral role in shaping, developing and providing material for our recent *Poverty Barrier* research report (aimed at illuminating experiences of poverty amongst survivors living in the UK, and its impact on their long-term recovery from trauma), the Survivors Speak OUT network (SSO) are helping map out how best to take the organisation’s policy recommendations to a public audience. Working closely with Freedom from Torture’s Marketing, Communications and Campaign teams, survivors and SSO network members are heavily involved in the design of

campaign material and awareness-raising strategy. The network will also be leading on the implementation of this strategy, taking modelled education materials into schools, universities and to activist and community groups. Whilst this process has proved far from seamless, the degree of engagement is vital nonetheless. Realistically, fully involving survivors in concept-development of all communications projects will take some time before it is standard practice. Also, staff at Freedom from Torture are highly aware of the potential difficulties involved, including determining appropriateness of exposing clients to internal organisational processes, as well as time and budget pressures existing within a project.

6.1.4. Informed consent

It is not enough to ask the client to sign a consent form. In order to minimise the risk to clients, the following considerations should be taken into account:

- ‘Informed’ consent – it is important that the individual understands what they are giving consent for and what that means in the given context. For example, a client needs to be fully aware that it is not simply about agreeing to allow Freedom from Torture to use a client’s story on the web, but that the story may be used on the web and reach far beyond the UK, thus friends/ family/ community in other parts of the world may read their ‘story’, that it may have an impact on others associated with them, that it may be read by a government official, and that once out in the public domain, it cannot be pulled back.
- Specificity of consent – is the organisation gaining consent for a one-off project? Or, is the organisation hoping that the material can also be used in other, unknown, future projects? It is good practice to check that the client is clear about the primary and any additional/potential ways their story may be used.
- Protect anonymity – To protect the client, it is recommended that staff take all needed measures to protect clients’ anonymity to reduce the risk of further persecution or public backlash. This includes not only an individual’s name, but also any other identifying facts such as area of residence, place of employment, specific details of their experience such as exact dates and location of detention and so on.
- Time-span – it is also recommended to check the clarity about the timeframe of the client’s consent – is this an ongoing consent meaning that your organisation can use their story at any time in the future? Or is the consent time-bound and thus the story can only be used that month/year? It is also good practice to check in and get updated consent from the client any time you are intending to use their material, even if they have already signed a consent form. The client may wish to say ‘no’ to future use because of changes in their personal circumstances.
- Audiences – to help the client give informed consent, they will need to be clear about who the audience will be – who will have access to their story (this includes potential for global access through web).
- Organisations are also encouraged to ensure the client knows of any potential risks to them or their families by sharing their story. What is the potential public response to the story (eg comments on media websites)?
- In most cases, the consent form is a text document. However it may be worth exploring alternative ways to maintain a record of consent as there are concerns regarding trauma and

flashbacks that this may invoke for individuals who were previously tortured into signing confession statements and so on.

- Thus, organisations are encouraged to check the language that is used in the forms; and
- Staff may also wish to reflect on any potential power dynamics that may impact how able a client feels to refuse consent (a client may feel obligated to give consent for fear of losing access to the therapeutic support, for example, or a young client may feel obligated to give consent if asked by an elder).

6.2. Working with the media

What all journalists want is a great story – they want emotion and impact - things that make the reader/listener/watcher pay attention. For the journalist, generally, the more sensational, scandalous and shocking the story, the better.

Journalists also want to give their audience a good idea of who they're talking to so they may ask questions about their personal life/background. It is important to set out with the journalist the boundaries for these personal questions and let the client know they don't have to answer these, or indeed any questions they feel uncomfortable answering.

Journalists can be very pushy, persuasive and direct – it is important that the staff member and the client are strong enough to answer their tough, probing and challenging questions, or if necessary, to just say 'I'm not prepared to answer that'.

6.2.1. Different media

The context in each country will be different but similar principles will apply:

a) Print and online media

No two newspapers will interpret issues in the same way. Some newspapers will be more sympathetic to the issues facing survivors of torture and the work of torture rehabilitation services. Other newspapers will be much less sympathetic to an organisation's aims, and perhaps even loudly negative about services that work with survivors of torture. As a consequence journalists from the latter papers should be treated with a lot more caution and scepticism. If a client is to be interviewed by a journalist from a newspaper that is usually not very sympathetic towards survivors of torture, it is important to fully establish the basis of their story and why they want to speak to a torture survivor. Unless an organisation has a long, strong, trusted relationship with a journalist, staff and clients should always be wary of a journalist's intentions.

News stories are generally going to have a short quote or two from the client so it is important that what the client says is clear and impactful. With longer 'feature' stories there is more opportunity to talk at length about their story.

It must be brought to clients' attention that printed material can be easily picked up, especially with the internet, and therefore is more permanent. It could affect future job and other prospects, which the client must be made fully aware of.

The good thing about interviews with print/online journalists is that it is possible to clearly get your messages across and on some occasions it may be possible to send them a quote in the client's name, which can be a useful alternative to doing an interview.

b) Radio and TV

Interviews on radio and TV can either be live or pre-recorded. It is important to get from the journalist a list of the sort of questions they want to ask.

Before the internet, once someone had said something on radio or TV it was unlikely to be heard again and so was less permanent. However, with the internet most TV and radio shows can much more easily be listened to again, which is an important consideration for clients. Generally, many more people watch national TV and radio than read newspapers so there's a much bigger audience.

It is important to agree on use of the client's voice, image, name, details such as country or region of origin before conducting an interview.

6.2.2. Good practice working with the media

If an individual is not happy to speak to a journalist directly but would like written information passed to them, Freedom from Torture follows a similar process to ensure appropriate use and the individuals' understanding of the potential impact and the variables connected to the work (eg partial use, re-printing etc).

At Freedom from Torture, staff are prepared to lose media opportunities because there is not enough time to follow correct procedure with clients as well as due to the frequent problem of not being able to source recommendations from clinicians quickly enough. For example, an illustrative case which had been deployed anonymously in advocacy negotiations with the UK Border Agency following the clients signing of the generic consent form in her file, would have significantly added to the value of the organisation's media work, but staff would not have used this case publicly without gaining further specific consent from the client. Following up with the client by telephone to check on this, the press officer was not satisfied that she fully understood the implications, so did not put the information forward.

With proactive media work, an organisation is much more in control of choosing the journalist, the clients to be interviewed and the issues and topics put forward – though it is still important to be well prepared for the interview. When working on proactive media work, it is best to strive to work closely with clients to prepare well in advance and ensure greater involvement in putting together the stories to pitch to media.

With reactive media work it is important to get the full facts, including any details, from the journalist establishing what they want, who they want to speak to, where and how they want to do the interview and their deadline. It then becomes a negotiation between the clinician, the client, the press officer and the media outlet about which, if at all, of their requests can be met.

6.2.3. Involving survivors of torture in media work

It is highly beneficial for the organisation to ensure clients' voices are represented in the media to present first-hand commentary on the impact of specific issues on torture survivors such as experiencing torture in a given context, failures in the justice system, poverty, enduring a risk of return to detention (and thus more torture) - this is usually far more powerful than a staff member or academic speaking for survivors, and consequently more attractive to media outlets.

As with engagement in other forms of communications work, the process can be highly fulfilling for clients if conducted safely and appropriately (this is based on positive feedback from clients and

their clinicians), including demonstrating that audiences external to Freedom from Torture care about what they have to say.

Media work represents a higher level of risk in terms of material being used from the interview that the interviewee might not wish to see in the public domain (eg. something said on the spur of the moment, or a detail given about a family member without concealing their identity), as the individual will not necessarily have copy approval/be able to watch broadcast footage before it goes out (though we push media outlets for this wherever possible).

Involving a client in media work will usually involve the following steps:

- Identifying relevant interviewees through liaison with clinicians
- Seeking initial agreement from client to participate – ideally a three-way meeting with clinician, client and the press officer, explaining more about the media request, their involvement, boundaries, timelines
- When possible, the introduction of a client to a journalist before the on-screen/print interview to take wider testimony before narrowing focus or to prepare both the journalist and the survivor for the actual interview. (note: in the UK, it is extremely rare (never) for news journalists to do this. Only those working on films or documentaries might have the time to do this).
- Negotiation of the location/setting for the interview: It may be that the survivor would feel more secure being interviewed at the rehabilitation centre instead of a TV/radio studio, for example.
- Further telephone call/meeting between the press officer and client to prepare in detail for the interview, including deciding on what should be said and excluded. This discussion is very important not only to ensure that the individual is prepared and all considerations have been taken to protect their identity, and their family's safety, but also so the interview will result in high quality material for the media outlet and to minimise any reputational risk to the organisation (eg preparing a client to avoid significantly contradicting a core organisational value, such as justification of torture); client to sign a consent form in addition to any media outlet consent form; feedback to clinician, and retain signed (or declined) consent note in client file.
- Briefing the media outlet: discuss the material to avoid, for example what the individual is not comfortable talking about or that their identity must be protected (Freedom from Torture's policy is to try to use *only* a pseudonym with journalists and not reveal clients real names to avoid any slips – the press officer may therefore refer to “client X” in communication with journalists beforehand until this is agreed). The press officer may need to pass on written background information on the client if so requested to avoid covering in it in the interview, which should be agreed with the client.
- Meeting with the client on the day of the interview before the journalist arrives. It is a good idea to have some practice/mock interviews with the client so they are better prepared for the sort of questions they are likely to face and to go through any **key messages** if relevant (ie, in the cases when the survivor is supporting an organisation's campaign messages). Make sure the client feels comfortable in the interview space and introduce them to the journalists. During a newspaper or pre-recorded interview, the press officer should take notes identifying any problematic areas (eg where anonymity compromised) and feedback to both the client and journalist, or just the journalist if appropriate, to ask for these areas to be removed in the edit.
- Where possible, arrange for copy approval or viewing of broadcast material before it airs. Keep the client and clinician informed of the progress with the media interview including timeline for publication/broadcast; any media responses, viewing figures etc.

- After the interview it is important to find out from the client how the experience was for them. For example, they may not want to do any more interviews. If the press officer was present during the interview it is important for them to feed back to the client, noting things that went well and areas that might need to be improved. Press officers should also listen to interviews on TV and radio and give appropriate feedback. The press officer may also want to give the client any media coverage they achieved.

6.3. Campaigning and survivor activism

Where possible campaign development and initiatives should involve a survivor perspective and input. At Freedom from Torture, campaign material is being developed in collaboration with a handful of survivors. This involves working together to develop the idea of a survivor journey from 'story' development, to consultation on designs from a creative company, through to near final approval. This is to ensure that our campaigning approach is truly reflective of the survivor's voice rather than only staff understanding of what the experience is.

6.3.1. Basic principles when working with and for survivors in campaigning work:

- Gaining '**informed consent**' – giving full information and providing examples to ensure understanding; explain how the information could be used (including when, where, who will see it), including the risks and opportunities associated; where possible, people should be given time to consider consent;
- **Respecting confidentiality** and choices as to what information they give us and how the organisation is allowed to use it;
- Thinking about the organisation's '**duty of care**' – minimising risk of re-traumatisation; being considered about the information staff ask for and whether it is needed; stay mindful of the time we are taking from individuals; ensure budget so the organisation can cover their expenses for their travel (and time if relevant); consider **over-exposure** of 'story';
 - To help minimise the impact of re-traumatisation, ensure adequate and appropriate support structures and systems are in place for the clients and the needed time and energy is planned for – support processes can include debriefing immediately after an interview or speaking event, and checking in a few days later and offering follow up support.
 - Also be mindful, that even when not asking a survivor to repeatedly retell their torture experience for campaigning purposes, speaking about issues such as poverty or community stigma can also be stressful and very difficult for clients.
- **Anonymity** – It is not just about changing a name but ensuring the campaigning materials do not disclose someone's identity through the information told in their 'story';
- Gathering and understanding of how survivors want to be involved and **managing expectations** through honest and transparent communication;
- Being clear about **boundaries** and role as a campaigner;
- Appropriate use of respectful **language**, avoiding sensationalising, using inappropriate language that is commonly used, consider cultural and political context, where the information could be read and who by etc;
- **Respecting the narrative** – avoid gaining consent for a story for one purpose and shaping it/adapting it for using it for another purpose whereby their 'story' is no longer theirs, i.e. giving focus to a part of the story that the organisation deems as appropriate without consulting gaining permission;
- Where possible, giving people opportunity to '**sign off**' on content featuring their story before publication/distribution etc;
- Giving people appropriate **contact details** and letting them know how to be in touch in case of questions, concerns etc;

- **Follow up** – if interested, letting people know what happened and giving them a copy of the publication, digital print out, and possible engagement in relevant follow up if appropriate.

Campaigns & Communications work with survivor groups – examples from Freedom from Torture:

1 - *Survivors Speak OUT Network*

The Survivor Speak OUT network began in 2009. Initially, the focus was on building the skills and confidence of former clients who were interested in survivor activism. In early 2011, Survivors Speak OUT began actively speaking out for the rights of torture survivors. The network consists of approximately 14 former clients from Asia and Africa and is coordinated by a network member and decisions, wherever possible, are taken together as a network.

Network members are engaged in different activities aimed at creating change including speaking out at events including community and faith-based groups as well as to youth audiences, engaging with decision makers at closed meetings; speaking to the media; and contributing to material for the web.

Survivors Speak Out is currently looking to grow as a network to involve more active members' representatives of all regions, different backgrounds and both genders. The network is developing their branding as well as tools to build capacity and support their work. This is supported by the Freedom from Torture's Survivor Activism Coordinator.

Campaigns & Communications work with survivor groups – examples from Freedom from Torture:

2 - *Write to Life*

Write to Life is a creative writing group run by a (non-clinical) paid staff member, and supported by voluntary writing mentors (professional writers) who participate in workshops and work with clients regularly on a one to one basis. Potential members of the group (existing clients and others who are no longer in therapy) are identified and referred to the coordinator by their clinicians according to set criteria. Potential members are interviewed by the group coordinator. If both the coordinator and the potential member agree they are a suitable match for Write to Life, the potential member is invited to attend several trial workshops. If the individual shows sufficient interest and commitment, the new member is allocated a one-to-one writing mentor. Consent forms are signed by clients when their work is published in the annual anthology.

Freedom from Torture is currently working with relevant internal staff to resolve a number of issues and improve practice on several fronts, including:

- Improving the provision of clinical supervision for the coordinator, the writing mentors and group administrator – the aim of the clinical supervision is to provide support to the staff/volunteers working directly with the members of Write to Life and manage the risk of vicarious traumatisation. Clinical supervision of staff and volunteers will also ensure that the clients' best interests are being served through the work of the group and allows clinical services management at Freedom from Torture has oversight over the programme;
- To ensure a communication flow with key workers for clients still in treatment where necessary (particularly where they are not seeing a clinician frequently), including on practical problems they are facing in their lives; and that the boundaries of confidentiality are clearly set and respected by mentors;
- Improving the referral system, including a written consent process at the beginning of a writer's engagement with the group;
- Suitability of mixing clients and former clients in a workshop setting.

6.3.2. Challenges & Opportunities working with survivor activist groups:

- Gain valuable experiences and opinions to support a rehabilitation centre's work aimed at upholding the rights of torture survivors;
- It is common for individuals within a group and/or the organisation supporting an activist group to have differing expectations about the group's aims, outcomes, outputs and/or approaches. This can lead to conflict between members or between the members and the coordinator; or it can lead to a disconnect between the 'agreed strategy' and the 'actual outputs'. Thus it is important that the coordinator continually checks in to ensure all the members have a realistic expectation about what the group can achieve and that there is consistency and consensus about the approach and outcomes.
- To truly engage members, the coordinator needs to maintain a facilitative approach, listening to and absorbing *all* opinions proffered, in order to ensure that all voices are heard before some consensus can be reached. This consensus is paramount – potentially more so than the content of the decision itself.
- Keeping the network always in a space of action and not just allowing it to become a fundraising or publicity tool for the rehabilitation centre;
- Services need to stay mindful of how a survivor's current personal situation may impact on their availability and level of engagement. A survivor's level of vulnerability may go up and down depending on their daily circumstances (eg loss of job, family bereavement, or outcome of a court hearing for example, may impact on how much capacity they have to engage in activism work).
 - Ongoing communication is essential so staff are aware of what is going on in a survivor's life so the service is aware of what support may be needed;
 - Pace and timeline of activism projects may be need to change;
 - Regular and consistent communication is a challenge, therefore, services need to find alternative ways to communicate – some of which may be more affective but more expensive and resource/time intensive;
- If the activist group is coordinated or led by staff or volunteers who are not therapeutically trained, there will be a need to make sure appropriate structures and support are in place.

6.4. Principles for Research Methods and Procedures

Rehabilitation services and centres working with survivors of torture will collect data and information relating to the impact of torture on the survivors and document torture for legal purposes. The data collected is to support the rehabilitation services: maintaining internal records which advise clinicians of the client need, to track the clinical interventions offered to individuals and groups and so on.

However, many rehabilitation services and experts are also keen to provide not just rehabilitation (through the provision of direct clinical or social interventions), but also to undertake policy negotiations, lobbying and awareness raising in order to prevent further torture and improve living conditions for survivors and their families. A key tool needed to underpin policy negotiations or awareness raising work is research.

Thus, rehabilitation services are encouraged to explore new ways and methods for using their client data and evidence of torture that can feed into local and international human rights initiatives to prevent torture and protect survivors. It is recommended that rehabilitation services partner with respected, trained and qualified research specialists (such as universities or human rights organisations) to assist with research.

However, before embarking on any research projects, rehabilitation services have appropriate protocols, policies and practices in place in order to ensure research and data collection is conducted in an ethical, empowering and effective manner.

A number of international organisations have developed recommendations regarding the conduct of research. Further guidance can be drawn from standards developed on related methods of work, for example on the investigation and documentation of cases of torture such as the Istanbul Protocol on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment.

To help services reflect on the steps needed, Freedom from Torture has compiled a range of relevant international standards of research methods and procedures for data collection, documentation and information sharing, including data protection, informed consent and so on:

6.4.1. General comments on research practices

- The World Medical Association states that physicians should “support global and local action to better understand the health consequences both of abuse and of the denial of rights for increased services for victims” (World Medical Association²¹).
- With specific reference to victims of torture or cruel or inhuman or degrading treatment, the World Medical Association states that “the careful and consistent documentation and denunciation by physicians of cases of torture and of those responsible contributes to the protection of the physical and mental integrity of victims and in a general way to the struggle against a major affront to human dignity” (World Medical Association²²).
- Any intervention in the health field, including research, must be carried out in accordance with relevant professional obligations and standards (Council of Europe²³).

6.4.2. Duty of Care

- According to the World Medical Association’s Declaration of Helsinki, “It is the duty of physicians who participate in medical research to protect the life, health, dignity, integrity, right to self-determination, privacy, and confidentiality of personal information of research subjects” (World Medical Association²⁴).
- The interests and welfare of the individual should have priority over the sole interest of science or society (UNESCO²⁵). Social researchers must strive to be aware of the intrusive potential of their work. They have no special entitlement to study all phenomena. The advancement of

²¹ [World Medical Association, Resolution on Violence against Women and Girls, October 2010](#)

²² [World Medical Association, Resolution on the Responsibility of Physicians in the Documentation and Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment, Adopted September 2003, amended October 2007](#)

²³ [Council of Europe, Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, 04/04/1997](#)

²⁴ [World Medical Association, Declaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects, Adopted June 1964, Last amended October 2008](#)

²⁵ [UNESCO, Universal Declaration on Bioethics and Human Rights, 19/10/2005](#)

knowledge and the pursuit of information are not themselves sufficient justifications for overriding other social and cultural values (Social Research Association²⁶).

- Research that is not conducted in accordance with the canons of science and that is not scientifically valid is unethical. Research activities should be approved by an appropriately constituted ethics committee. Psychiatrists should follow national and international rules for the conduct of research. Only individuals properly trained for research should undertake or direct it. Because psychiatric patients constitute a particularly vulnerable research population, extra caution should be taken to assess their competence to participate as research subjects and to safeguard their autonomy and their mental and physical integrity (World Psychiatric Association²⁷).

6.4.3. Informed Consent

- The UN Istanbul Protocol sets out that “an absolutely fundamental precept of modern medical ethics is that patients themselves are the best judge of their own interests. This requires health professionals to give normal precedence to a competent adult patient’s wishes rather than to the views of any person in authority about what would be best for that individual.”²⁸
- No research on a person may be carried out, [subject to certain provisions] without the informed, free, express, specific and documented consent of the person (Council of Europe²⁹).
- The World Medical Association’s Declaration of Helsinki states with regards to research involving human subjects that “a potential subject’s freely-given informed consent must be sought, preferably in writing. If the consent cannot be expressed in writing, the non-written consent must be formally documented and witnessed” (World Medical Association³⁰).
- In situations where information about the research and participant consent is conveyed verbally, it is recommended that the information be recorded on and read from or cued by a written information sheet; verbal consent should also be taped in order to provide a record (British Psychological Society³¹).
- A checklist of points on the informed consent form that participants are expected to sign might typically include:
 - (a) That their participation is voluntary,
 - (b) That they are aware of what their participation involves,
 - (c) That they are aware of any potential risks (if there are any),
 - (d) That all their questions concerning the study have been satisfactorily answered (British Psychological Society³²).
- For procedures of a torture investigation, the UN Istanbul Protocol states that “from the outset, the alleged victim should be informed, wherever possible, of the nature of the proceedings, why his or her evidence is being sought, if and how evidence offered by the alleged victim may be used. Investigators should explain to the person which portions of the investigation will be public information and which portions will be confidential. The person has the right to refuse to

²⁶ [Social Research Association, Ethical Guidelines, December 2003](#)

²⁷ [General Assembly of the World Psychiatric Association in Madrid, Madrid Declaration on Ethical Standards for Psychiatric Practice, 25 August 1996, most recently enhanced 12/09/2005](#)

²⁸ [United Nations, Istanbul Protocol – Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 2004](#)

²⁹ [Council of Europe, Additional Protocol to the Convention on Human Rights and Biomedicine, concerning Biomedical Research, Strasbourg, 25.I.2005](#)

³⁰ [World Medical Association, Declaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects, Adopted June 1964, Last amended October 2008](#)

³¹ [British Psychological Society Guidelines for Ethical Approval, August 2007](#)

³² [ibid](#)

cooperate with all or part of the investigation. Every effort should be made to accommodate his or her schedule and wishes. The alleged torture victim should be regularly informed of the progress of the investigation.”³³

- Consent is a process, not a single event. Adequate time must be given to provide patients with relevant information, as well as the opportunity to request further clarification (Standing Committee of European Doctors³⁴).
- Children and adolescents may not have the capacity to give informed consent to being research subjects. However, their assent must be obtained. Assent should take into account the age, maturity and psychological state of the child involved. If the child is unable to give assent, the “proxy consent” of a parent or legal guardian is required (International Association for Child and Adolescent Psychiatry and Allied Professions³⁵).
- When involving individuals who may be considered to be vulnerable, extra care must be taken in the provision of information about the research, and promoting the individual’s autonomy when seeking consent (Royal College of Nursing (UK)³⁶).

6.4.4. Confidentiality (Privacy)

- The UN Istanbul Protocol stresses that the duty of privacy and confidentiality is a fundamental principle and a professional duty.³⁷ Exceptions to this norm exist, both legally and ethically, but not from a human rights research perspective.
- The World Medical Association identifies three principles of confidentiality:
 - Autonomy relates to confidentiality in that personal information about an individual belongs to him or her and should not be made known to others without his or her consent.
 - Confidentiality is [...] important because human beings deserve respect. One important way of showing them respect is by preserving their privacy.
 - Trust is an essential part of the clinician-patient relationship [...] The basis of this trust is the ethical and legal standards of confidentiality that healthcare professionals are expected to uphold (World Medical Association³⁸).
- The identities and personal data of clients must be kept confidential, whether or not confidentiality has been explicitly pledged. It should be made clear who should and who should not be able to gain access to personal data and what grounds are reasonable for them doing so (Social Research Association³⁹).
- The UN Istanbul Protocol states that “Non-identifiable patient information can be freely used for other purposes”, for example in the collection of data about patterns of torture or maltreatment.⁴⁰ The World Medical Association advises that “the use of de-identified data does not usually raise issues of confidentiality.”⁴¹ However, the UK Social Research Association believes that “Even data that does not enable identification should not be passed on without

³³ [United Nations, Istanbul Protocol – Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 2004](#)

³⁴ [Standing Committee of European Doctors, Informed Consent, 03/05/2001](#)

³⁵ [IACAPAP \(the International Association for Child and Adolescent Psychiatry and Allied Professions\), Ethics Declaration, 2006](#)

³⁶ [Royal College of Nursing \(UK\), Research ethics, First published 2004, last reviewed March 2009](#)

³⁷ [United Nations, Istanbul Protocol – Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 2004](#)

³⁸ [World Medical Association, Medical Ethics Manual, 2009](#)

³⁹ [Social Research Association, Ethical Guidelines, December 2003](#)

⁴⁰ [United Nations, Istanbul Protocol – Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 2004](#)

⁴¹ [World Medical Association, Declaration on Ethical Considerations regarding Health Databases, 06/10/2002](#)

consent and should be stored safely with restricted access” (Social Research Association December⁴²).

6.4.5. Anonymity

- Person-based information needs to be maintained in a non-identifiable form (EuroSOCAP⁴³). The use of de-identified data does not usually raise issues of confidentiality (World Medical Association⁴⁴).
- Personal data and information should not be disclosed nor should it be possible to infer a client’s identity when such data is used in research reports (Social Research Association⁴⁵).
- Data can be anonymised in several ways:
 - Pseudonymisation (World Medical Association⁴⁶)
 - Encryption/Codification/ Aggregation (EuroSOCAP⁴⁷)
 - Use of separate databases in which clinical information is separated from patient identifier information (EuroSOCAP⁴⁸).
- When the intention is made to render data anonymous, clinicians “must inform patients of their intention to anonymise data and the precise effect that this will have—specifically the inability of patients to access their data and to know what is being done with it”. Data subjects must still be informed of the purposes of intended processing of data after it has been rendered anonymous. Anonymisation should be used in cases where that data does not need to be kept in personal form and it is not known for what purposes it might be used” (EuroSOCAP⁴⁹).

6.4.6. Working practices/Human Rights Methodologies

For information relating to human rights research methodologies and the working practices of human rights organisations, see the following websites:

- Human Rights Watch (www.hrw.org)⁵⁰
- Amnesty International (www.amnesty.org)
- the UN Office of the High Commissioner for Human Rights (specifically about human rights monitoring)⁵¹

6.4.7. Outcome of research

Clients’ information entered into a research report are entitled to be informed about the outcome of the study and to share any benefits that result from it (World Medical Association⁵²)

⁴² [Social Research Association, Ethical Guidelines, December 2003](#)

⁴³ [EuroSOCAP, coordinated by Professor Roy McClelland, Queen's University Belfast, European standards on confidentiality and privacy in healthcare July 2005](#)

⁴⁴ [World Medical Association, Declaration on Ethical Considerations regarding Health Databases, 06/10/2002](#)

⁴⁵ [Social Research Association, Ethical Guidelines, December 2003](#)

⁴⁶ [World Medical Association, Declaration on Guidelines for Continuous Quality Improvement in Health Care, Adopted November 1997, Amended October 2009](#)

⁴⁷ [EuroSOCAP, coordinated by Professor Roy McClelland, Queen's University Belfast, European standards on confidentiality and privacy in healthcare July 2005](#)

⁴⁸ *ibid*

⁴⁹ *ibid*

⁵⁰ <http://www.hrw.org/en/node/75141>

⁵¹ [Office of the High Commissioner For Human Rights, PROFESSIONAL TRAINING SERIES No. 7 Training Manual on Human Rights Monitoring, 2001](#)

⁵² [World Medical Association, Declaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects, Adopted June 1964, Last amended October 2008](#)

6.5. Training and capacity building

Survivors of torture have the right to access mainstream and other specialist services as outlined in article 14 of the Convention Against Torture. However, Freedom from Torture, like most specialist rehabilitation centres across Europe, has a limited capacity to the number of survivors of torture the organisation can assess, treat and support.

Therefore, a key priority of the organisation is to engage with external service providers to ensure that mainstream health care services, other specialist voluntary programmes and services in other sectors (such as legal, housing, employment etc), have the needed skills, knowledge and appropriate attitude to work ethically and effectively with survivors of torture. To that end, most rehabilitation services will also endeavour to provide training, consultation or other capacity building support to key external stakeholders.

Freedom from Torture wants individuals and teams in the clinical and legal professions to change their practice to be more ethical and better suited to the needs and rights of torture survivors, thus the trainers utilise experiential and participatory methodologies. This training and capacity building approach is grounded in adult learning theory – evidence has proven that experiential and participatory methods and approaches can foster safe environments in which to explore new ideas, challenge negative beliefs, and boost confidence as well as teach skills and expand knowledge.

6.5.1. Participatory practices

It is good practice to encourage the participants to take an active role in the training and to assume responsibility for their own personal learning. To that end, it is recommended to engage the learners/participants through:

- the pre-training assessment to identify learning needs;
- developing different learning methods which take into account diverse learning preferences (such as visual diagrams, role plays, observation of good practice, lectures and so on);
- the delivery of learning (i.e. ensuring that the training is actively engaging and allows time for doing and reflecting; also ensuring that the training environment is inclusive and safe);
- actively seeking the participants' feedback throughout the training, not just at the end;
- evaluation of training programmes and impact assessments;
- ensuring that in all the previous stages equal opportunities and diversity issues are considered and encompassed, guaranteeing access and respect for all participants.

6.5.2. Experiential learning

Traditional training is 'teaching' or thinking focussed; the experiential learning approach is a triad of thinking, feeling and doing, all in a safe, structured environment. The approach actively involves the participants, instead of treating them as passive recipients of knowledge. It recognises that adult learners bring with them a personal set of ideas, skills, attitudes, and experiences that influence how they interpret their surroundings and their approach to work. These personal experiences also influence what they will take away from any training or learning context. Experiential learning approaches therefore focus on beliefs as well as facts, attitudes as well as practices. It is important to build on the strengths of each participant by recognising and highlighting their strengths and successes in the training session. This can include identifying the participant's areas of expertise and acknowledging their contributions.

Thus, instead of telling a participant what they should know or do, the experiential learning approach - from the design through to the facilitation of exercises - provides structures for participants to:

- process, analyse, and reflect on issues and challenges; and
- generate their own thoughts and ideas for solutions and good practice.

Facilitators take an active role in challenging myths and misunderstandings, and provide opportunities for new learning both via sharing participants' experiences and knowledge and by referring to current theories and trends.

Furthermore, before the first meeting in the training room, it is helpful to invite participants' input and thinking, so they are engaged with the training before they even arrive and take active responsibility for their learning.

6.5.3. Capacity building

There are two components to 'capacity building':

- When supporting external service providers so that they are better equipped to work with survivors of torture, the engagement should involve more than just a reflection on clinical or therapeutic good practice, but also explore the policies, structures and protocols that need to be in place to ensure there is a safe and stable working environment that fully supports the wide range of needs of survivors. For example, in the UK context, Freedom from Torture trainers often will discuss the importance of an agreed organisational protocol/policy on working with interpreters just as well as train on good practice in working therapeutically with an interpreter.
- The term 'capacity building' can also be used to cover the range of learning support that the trainer can offer to foster confidence and full application of learning. Thus, in addition to 'classroom' or training time, a facilitator can offer pre or post training study visits, follow up consultation, clinical observation, joint clinical work, clinical case reviews, and/or supervision.

6.5.4. Assessing the training need

It is recommended that when providing a bespoke training programme to an external organisation, the trainer/facilitator should carry out a Training Needs Analysis (TNA – also called Training Needs Assessment). The TNA is an in-depth assessment of the recipient organisation's training needs and priorities. Each team and organisation is unique - working within different contexts and using a variety of models and approaches. Conducting a needs analysis allows the facilitator to better understand how the external service works so as to ensure the training is relevant and effects the desired changes. A TNA also helps to determine what training is most relevant for people's jobs/duties and the knowledge, skills and experience they already have. This ensures the training is pitched at the appropriate level.

6.5.5. Training and capacity building policies and strategic priorities

Each organisation will need to create their own training policy and strategy appropriate in their context – it is recommended that this strategy includes the organisation's key aim and mission; outlines the training approach and standards that all staff should strive to work towards, and the target services/organisations that are deemed priority for training and capacity building engagement.

A case example – Freedom from Torture’s training and capacity building strategy

Mission of Freedom from Torture’s training and capacity building function:

To engage in dialogue and collaborative multidisciplinary learning opportunities that promote change in practice and attitudes. The aim is to ensure that survivors of torture are able to realise their right to access quality and appropriate services that support their rehabilitation, especially services related to their well-being and protection.

Overall aims:

1. To enhance the quality of services (relevant to both well-being and protection) available to survivors of torture and organised violence
2. To improve access to services (relevant to well-being and protection) for survivors of torture and organised violence
3. To promote awareness and best practice that respects the rights of survivors
4. To promote collaboration among relevant organisations and services related to the rights and needs of survivors

Training priorities

Currently, Freedom from Torture’s key criteria for agreeing to provide training for a service or organisation is that it:

- Provides a service for, or that is needed by, survivors of torture
- The service may be clinical, legal, practical, social, and/or health (and relevant education staff for young people)
- The service may be statutory or voluntary
- The service may specialise in supporting marginalised groups or may be a mainstream service with a remit that is relevant to the well-being or protection needs of survivors

Priority is to be given to those individuals and organisations that are currently providing a direct service needed by survivors of torture. (Students, universities, human rights campaigners, researchers and services that don’t provide a direct service are lower priority). Within this, key factors to consider when assessing priority or urgency of a training request or target include:

- a) **Referral potential** – a service that Freedom from Torture can directly refer a client to for support; and/or a service that may identify survivors of torture who could be referred to Freedom from Torture
- b) **‘Frontline’** services that may identify potential survivors of torture in need of support in a community – including primary care health teams, social or practical support services for asylum seekers etc.
- c) Relevant services located **in an area with limited quality** service provision where high numbers of survivors of torture are living
- d) Teams or services with a **short waiting list and/or capacity to quickly respond to emergency or complex needs** of survivors of torture so as to expand the range of services that Freedom from Torture can refer clients to
- e) Services that **relate to the protection of survivors** of torture and/or that work in a statutory body that all survivors of torture must navigate (legal representatives, asylum decision makers and so on)
- f) A service that has the **potential of a sustainable future** (measured via previous history, funding secured, dedicated staff, strategic plans etc)
- g) Potential of further access to vital experts, teams or organisations following a successful training or capacity building intervention (ie, **opportunities which may open doors to key priority targets**)