Evaluations EIDHR

Torture rehabilitation centres Europe

human european consultancy in partnership with the Netherlands Humanist Committee on Human Rights and the Danish Institute for Human Rights

Januari 2005

By Sara Guillet, Gisela Perren-Klingler and Inger Agger

human european consultancy

This report is the outcome of an evaluation commissioned by the European Commission on projects financed in the field of the European Initiative for Democracy and Human Rights (EIDHR). The EIDHR is a European Union programme that aims to promote and support human rights and democracy in third countries. Information on activities and actions can be found on the EIDHR website: http://www.europa.eu.int/comm/europeaid/projects/eidhr/index_en.htm

human european consultancy
Hooghiemstraplein 155
3514 AZ Utrecht
The Netherlands
Tel +31 30 634 14 22
Fax +31 30 635 21 39
office@humanconsultancy.com
www.humanconsultancy.com

Table of Contents

human european consultancy

Abbreviations

APT	Association for the Prevention of Torture
COMEDE	Comité médical pour les exilés
DRC	Democratic Republic of Congo
EC	European Commission
ECHR	European Convention on Human Rights
ECPT	European Committee for the Prevention of Torture
EIDHR	European Initiative for Democracy and Human Rights
GCR	Greek Council for Refugees
HR	Human rights
JHA	Directorate of Justice and Home Affairs of the European Commission
IRCT	International Rehabilitation Council for Torture Victims
MD	Medical doctor
M&E	Monitoring and evaluation
MF	Medical Foundation for the Care of Victims of Torture
MRCT	Medical Rehabilitation Centre for Torture Victims
NGO	Non-governmental organisation
OMCT	World Organisation Against Torture (*Organisation Mondiale contre la Torture*)
UNVFVT	United Nations Voluntary Fund for Victims of Torture
WHO	World Health Organisation

Executive summary

Introduction

The European Commission (EC) Communication on the European Union's role in promoting human rights and democracy in third countries has four priorities for the use of the European Initiative for Democracy and Human Rights (EIDHR), one of which is support for the fight against torture. For several years, the EC has funded centres for the rehabilitation of victims of torture in many countries. The number of such centres has grown considerably in recent years. Those outside the EU are funded from budget line B7-701 and those inside the EU from budget line B5-813.

This evaluation concerns four European-based organisations: Primo Levi (France), the Medical Foundation for the Care of Victims of Torture (UK), EXIL – Centre médico-psychosocial pour des personnes exilées et pour des victimes de torture (Belgium), and the Medical Rehabilitation Centre for Torture Victims (Greece). These four organisations are currently being funded by the EIDHR to run torture rehabilitation projects and have submitted proposals under the 2003 Call for Proposals for torture rehabilitation centres. These proposals were preliminarily retained by the selection committee and it was decided that their final approval would be conditional on the results of an evaluation of the current activities.

The results of this evaluation – in terms of impact, relevance and design, effectiveness, efficiency and sustainability of the projects – will be the elements taken into consideration for the final decision regarding the acceptance of the new proposals.

The EC also wished to take advantage of this evaluation to obtain complementary information to the Evaluation launched in October 2003[1] with the objective to asses the statement made by torture rehabilitation centres that their work contributes towards the prevention of torture. In this respect, the evaluation team was requested to address the following points:

- Which policies and strategies the centres have formulated themselves about how to contribute to the prevention of torture: objectives, outputs, activities.
- The extent of any verifiable indicators used by the centres to measure the impact of their work, both as regards the rehabilitation of victims and the prevention of torture.
- Whether or not prevention activities detract from the medico-psychological work of the centres.
- Whether or not prevention work has any beneficial/detrimental effects on the victims themselves.
- The opinions of other local human rights non-governmental organisations (NGOs) which work exclusively on prevention, if these exist.

1 L.H.M. van Willigen, I. Agger, T. Barandiarán, P. Khanal, *Evaluation EIDHR: Torture rehabilitation centres, MEDE European Consultancy*, November 2003.

- The extent to which alternative sources of funding are available in the country for either rehabilitation or prevention activities.

Findings

Main findings from the rehabilitation projects

The findings as reported in this synthesis report are based on four case studies (which you find in seperate annexes), each centre having its particular context, methodology and structure. In spite of this diversity, the evaluation team can draw the following general conclusions regarding the impact, relevance, design, effectiveness, efficiency and sustainability of rehabilitation centres for torture victims in Europe.

Impact

The centres' ability to reach their target group varies: in some cases, the number of patients represents less than 1% of the asylum seekers arriving yearly while, in other cases, it amounts to 8%. The impact on patients is difficult to assess in quantitative terms as, in three out of four centres, there is no comprehensive database with a computerised patient-tracking system. In qualitative terms, interviews with beneficiaries and stakeholders suggest that the projects have some impact on the victims' rehabilitation. This impact is greater when the therapeutic programme includes occupational therapy or other activities designed to reconstruct a social network around the patient, which contribute to his/her integration in the host society; this is not the case in all centres.

The centres can have some institutional impact on the mainstream health system through training and capacity building projects. However, this impact remains weak, as most centres included in this evaluation only have loose links with the national health systems. The same can be noted with respect to the institutions involved in asylum issues: when offered by the rehabilitation centres, training and awareness-raising activities for asylum officers do have some impact on the asylum procedure.

Relevance

Rehabilitation of torture victims has not been integrated into the national health systems in the countries visited. The four projects offer the beneficiaries a treatment which, in most cases, they could not receive in a regular hospital. In the four countries stakeholders who had an interest in the issue of combating torture, but were not directly involved in the four centres that were evaluated, considered that the project was relevant.

Design

All four projects are designed for torture victims as well as, in the case of two of them, for victims of 'organised' or 'political' violence. Referral rates show the level of integration of the centres into the national networks involved in the asylum field. Although the four centres propose interdisciplinary and holistic assistance, their methodologies vary and they offer a more or less wide range of services to the beneficiaries. Activities do not always include group therapy, gender-specific activities and occupational therapy aiming at empowering the beneficiaries alongside the therapeutic process and at supporting integration in the host country. The designs of the four evaluated projects lack objectively verifiable indicators to monitor the work undertaken. Although in some centres some of the staff are former patients and/or refugees, in none of them are patients involved in project design.

Effectiveness

Although in general the expectations of the patients seem to be fulfilled, some patients drop out of treatment. The centres were unable to provide the evaluation team with the drop-out rates (except for one centre) nor could any conclusions be drawn from this fact. In all centres, effectiveness is served by the commitment of the teams. However, it can be further improved if the methodology and the management are more professionalised. In all centres, monitoring and evaluation (M&E) processes are only beginning and there is still some reluctance and/or lack of knowledge on how to identify evaluation tools and indicators to measure and assess the impact of the work.

Efficiency

In the four centres, activities and strategies adopted are consistent with the financing agreement in terms of both the content and timeliness. The four centres achieve more than what is covered financially thanks to the contribution of volunteers. Due to the weaknesses in data collection, two centres are unable to give an estimate for the average cost of treatment per patient.

Sustainability

In spite of the concern and efforts by the centres to attract other funds, there are no alternatives found for making the transition from EC funding to other funding and for securing additional sources of support.

In the four countries visited, the governments do not comply with their obligation under the Convention Against Torture *"to ensure that the victim of an act of torture [is given] (…) the means for as full rehabilitation as possible"* by providing the centres with long-term financial support.

At policy level, none of the rehabilitation projects is sustainable in the sense that the future of their work is secured, for example by integration into the mainstream health system. Furthermore, it has not been a priority in the centres' strategies to empower the mainstream health system to provide holistic treatment to torture victims.

Main findings from the prevention projects

Many activities aimed at contributing to the prevention of torture have been identified in the course of this evaluation of four European rehabilitation centres. For the purpose of this evaluation, and in a European context, three categories of prevention activities were identified:

- Primary prevention activities aim to prevent the occurrence of torture. They are oriented towards the countries of origin of the victims. They involve *inter alia* awareness-raising, lobbying for legislative changes in conformity with international standards and denouncing cases of torture.
- Secondary prevention activities are implemented in the host country. They refer to the prevention of the recurrence of torture, i.e. protection of the victims, through the provision of medical certificates to support asylum applications and capacity-building for asylum officers on the issue of torture and its consequences.
- Tertiary prevention activities involve the provision of adequate medical, psychotherapeutic, psychosocial and/or psychiatric care to victims of torture, aiming to prevent the long-term consequences of torture. It refers to the rehabilitation of torture victims.

Based on the fact that both prevention and rehabilitation are part of the fight against torture, this evaluation leads to the conclusion that rehabilitation activities can have some impact on the prevention of torture. In Europe, the primary task of rehabilitation centres is treatment of torture victims – 'tertiary prevention'. This case study, based on four rehabilitation centres, shows that in most cases the centres have very little impact on primary prevention, whereas they have some impact on secondary prevention.

The evaluation team acknowledges some relevance in the centres' involvement in the prevention of torture at all levels. However, while all centres have the potential to contribute to prevention, most are either unable or unwilling to design a comprehensive prevention policy, based on verifiable indicators included in a logical framework and with precise objectives, outputs and activities.

Whether this potential can be realised depends on the context, the strategies, the human and financial resources and the level of collaboration with human rights (HR) NGOs. Consequently, it would be counterproductive for donors to encourage the centres to strengthen the prevention component of their programme, since it may lead them to develop activities which have little impact, with insufficient resources or expertise and which might detract from their medico-psychological work.

For those centres which choose to become active in torture prevention at all levels, the evaluation proposes a number of measures aimed at improving their impact in this field. These measures include setting up an evaluation and monitoring system. For example, while it can be assumed from discussions with stakeholders that some patients are better protected from removal if their asylum application is based on a medical certificate, none of the evaluated centres know the refugee recognition rate among the patients whom they have provided with such a certificate. Further measures include the development of closer partnerships with HR NGOs whose main focus is the prevention of torture: information collected from patients can nourish their projects on torture prevention.

Recommendations

The evaluation team recommends the European rehabilitation centres:

In the field of rehabilitation:

- To enhance the effectiveness of rehabilitation processes by including factors pertaining to the social and political context of the torture victims (in the country of origin as well as reception), such as forced migration, weighty and restrictive asylum procedures, lack of family and other networks, lack of integration into a new culture, lack of meaningful working conditions, lack of adapted education and lack of financial resources, rather than focusing exclusively on the medico-psychological factors.
- To enhance effectiveness and efficiency through the development of and effective implementation of M&E systems, including setting up database, patient-tracking systems etc.
- To enhance effectiveness and efficiency through better coordination between centres in Europe and sharing experiences of rehabilitation.
- To open up to other groups dealing with psychological and social consequences of torture, organised violence and violence of all origins (familial, criminal etc).
- To increase the institutional impact of their work by developing and implementing strategies to channel their expertise into the mainstream national health system.

In the field of prevention:

- To refrain from being involved in prevention activities where their expertise and human resources are not sufficient for the effective and efficient implementation of such activities.
- To build up stronger partnership with HR NGOs so that the information collected from patients is not lost and can nourish NGOs' projects on torture prevention and contribute to the effectiveness of their prevention activities.
- To use their expertise in the issue of torture to increase their input on asylum issues, through the provision of medical reports to support individual asylum applications and through effective training of asylum officers and include tracking the effects of their input on asylum issues in their M&E processes.
- To share experiences between rehabilitation centres to increase expertise in the preparation of medical reports based on the Istanbul Protocol.

The evaluation team recommends the European Commission:

- To develop an integrated policy, including aspects of prevention and rehabilitation, based on open definitions of these two concepts, so that some activities can be eligible under both headings.
- To organise a workshop on the role of rehabilitation centres in the prevention of torture.
- To facilitate the coordination between European centres in the implementation of M&E systems.
- To help the centres in their efforts to make the transition from EC funding to other funding, especially by reminding the states of their obligation towards this group of people, in order to increase the financial sustainability of the centres

1. Introduction and methodology

1.1 Objectives

The European Commission has requested an evaluation of four different torture rehabilitation programmes in France, Belgium, the UK and Greece, in order to assess the relevance, efficiency, effectiveness, impact and sustainability of the four ongoing projects. The evaluation is also intended to provide guidance and make recommendations for a decision from the EC regarding the approval of the new proposals that each of the centres has submitted to the EC under a Call for Proposals issued in 2003. All four proposals have been pre-selected in principle by the Selection Committee for further funding, but the signing of a new contract has been made conditional on the results of this evaluation.

In addition, the EC has decided to take advantage of this evaluation to obtain complementary information to the evaluation undertaken in October 2003 with the objective of assessing the statement made by torture rehabilitation centres that their work contributes towards the prevention of torture[2] (see Annex 7).

This report presents the experts' findings following their visit to each centre. It also aims to examine whether, in a European context, rehabilitation activities have an impact on the prevention of torture.

1.2 Background

For many years the EC has funded centres for the rehabilitation of victims of torture in many countries, through the EIDHR. The number of such centres has grown considerably in recent years and the EC has found it timely to review its funding policy, especially concerning the emphasis to be assigned to the support of torture prevention activities. Considerations about a shift in funding policy already started some years ago.

A report to the EC by the European Human Rights Foundation[3] in 2000 discusses and recommends a more focused strategy for EU funding initiatives in the field of rehabilitation of victims of torture. It argues that the EC should decide whether funding through the EIDHR should focus on torture prevention initiatives. The report also recommends that, if EIDHR continues direct support of rehabilitation centres, the types of rehabilitation work eligible for EU-funding should be clearly defined.

2 L.H.M. van Willigen, I. Agger, T. Barandiarán, P. Khanal, *op.cit.*

3 European Initiative for Democracy and Human Rights. *EHRF monitoring report on EU-supported organisations providing rehabilitation for survivors of torture.*

In an EC Communication from 2001 on the EU's role in promoting human rights and democracy in third countries, four priorities are set out for the use of EIDHR, one of which is support for the fight against torture. The Communication also reflects a clear decision regarding the focus of its future support for combating torture. The Communication states that *"in seeking to be an agent of change, the EU should ensure that it focuses as much as possible on prevention, including through human rights education of the police and other possible agents of torture"*. The rehabilitation centres for victims of torture have argued that the distinction between rehabilitation and prevention is artificial and that a reduction of funding for rehabilitation activities will have an adverse effect on the prevention of torture. For this reason, EIDHR wished to evaluate torture rehabilitation programmes, in order to assess the effectiveness and impact of these programmes in relation to the argument that the work of torture rehabilitation centres contributes towards the prevention of torture.

An EC Programming Update from January 2003[4] clarifies that the emphasis on prevention should include a strengthened prevention component at local and regional levels:

- Within the activities carried out by the rehabilitation centres.;
- Through bolstering the work of ombudsmen.
- Through training of key personnel (e.g. prison staff, police officers, doctors and lawyers).
- Through monitoring and reporting of incidences of torture in third countries.

The previous evaluation report on torture rehabilitation centres based on case studies in Nepal and Peru, and interviews with key persons in the United Kingdom and Denmark[5], concluded that the rehabilitation of victims of torture and the prevention of torture are interrelated and that rehabilitation centres do contribute to the prevention of torture. However, the possibilities, extent, effectiveness and impact of prevention activities depend on the contextual situation, the chosen strategy with regard to the rehabilitation and prevention approach, the composition of the staff and the existence of other human rights organisations in the area and the collaboration with these organisations.

1.3 Methodology

The evaluation was carried out through the study of documents concerning the torture rehabilitation programmes, case studies of rehabilitation programmes in Paris (June 2004), London (July 2004), Brussels (September 2004) and Athens (October 2004) and interviews with key persons.

4 European Initiative for Democracy and Human Rights, *Programming Update 2003*, Brussels, Commission Staff Working Document, 20 January 2003.

5 L.H.M. van Willigen, I. Agger, T. Barandiarán, P. Khanal, *op.cit.*

In Paris, the team visited the Primo Levi Association – Care and Support for Victims of Torture and Political Violence, in Brussels EXIL – Medico-Psychosocial Centre for Refugees and Victims of Torture, in London the Medical Foundation for the Care of Victims of Torture and in Athens the Medical Rehabilitation Centre for Victims of Torture.

During the fieldwork, the team interviewed staff members and beneficiaries of the programmes. The team also interviewed some representatives of local and international organisations in the human rights movement, as well as representatives of the authorities in the countries concerned. At the end of each mission, the preliminary findings were shared with the directors of the respective centres.

Main research questions

The four case studies (see annex 2-5) are the main input for this synthesis report, which not only summarises the findings and recommendations of the case studies, but also addresses the issue of the impact of rehabilitation work on the prevention of torture.
With regard to the issue of impact of rehabilitation on prevention, the terms of reference (ToR) for this study request information on the following specific points:

- Which policies and strategies the centres have formulated themselves about how to contribute to the prevention of torture: objectives, outputs and activities.
- The extent of any verifiable indicators used by the centres to measure the impact of their work, as regards both the rehabilitation of victims and the prevention of torture.
- Whether or not prevention activities detract from the medico-psychological work of the centres.
- Whether or not prevention work has any beneficial/detrimental effects on the victims themselves.
- The opinions of other local human rights NGOs which work exclusively on prevention, if these exist.
- The extent to which alternative sources of funding are available in the country for either rehabilitation or prevention activities.

Structure of the report

After a brief introduction to different perspectives on the concept of prevention and rehabilitation, which will help the reader to understand the approaches of the four centres to their work, the report will summarise the findings and recommendations of the four case studies in Chapter 2.

Subsequently the report will address the main research questions regarding the impact of rehabilitation work on prevention in Chapter 3.
Chapter 4 will summarise the main conclusions and give the recommendations

Team composition

The team that visited the centre in Paris comprised two international experts, Sara Guillet (Team Leader), specialist in international human rights law, and Dr Inger Agger (psychosocial expert), specialist in torture rehabilitation. The team that visited the centres in Brussels, London and Athens comprised Ms Sara Guillet (Team Leader) and Dr Gisela Perren-Klingler (medical expert), specialist in project evaluation and transcultural psychiatry/psychotherapy.

Constraints

The team only had three days to visit each centre, which made it impossible to observe activities outside the four capitals. Also, there were limited opportunities to meet with representatives of other human rights organisations. It would have been an advantage if the centres had had the opportunity to give their comments on the draft report, but this was not possible due to time constraints. It would also have been an advantage for the synthesis if the four centres had been visited by the same consulting team.

All interviewed staff members and beneficiaries received the team with great openness and readiness to share their viewpoints and working methods.

The team would especially like to thank Dr Hans Otto Sano from the Danish Institute for Human Rights and Marcel Zwamborn from mZet consultancy for their valuable feedback received throughout the process.

2. Rehabilitation and prevention: two ways of combating torture

2.1 Prevention

Within this study, prevention means activities that are intended to ensure that torture does not happen while rehabilitation refers to the time after a person has been subjected to torture, when their symptoms and sufferings are treated.

An overview of NGO practice shows a variety of activities under the heading 'prevention'. Some NGOs argue that prevention should be strictly understood as a threefold activity with the aim of promoting international standards, monitoring places of detention and capacity-building (for law enforcement or prison officers). Other NGOs would, as part of the prevention activities, send out urgent appeals about detainees facing risk of torture, considering this as a last-minute prevention initiative[6].

The EC has an inclusive rather than a restrictive approach to prevention activities, which ranges from awareness-raising about international standards to legal support for victims, as can be concluded from the *Guidelines*[7] for EC grant applicants responding to the call for proposals for 2004 on prevention of torture. According to these *Guidelines*, the type of actions which are eligible for funding as prevention activities are focused on third countries. They include support for activities to raise awareness about the *Optional Protocol to the UN Convention Against Torture* and to promote its signing, ratification and effective implementation. Other activities eligible for support include training of key personnel, awareness-raising and lobbying activities, tracking the supply of torture instruments, research and publication into torture practices and legal support for individuals (including legal advice, lobbying, redress and awareness-raising).

For the purpose of this evaluation of the four European centres and the description of their strategies and programmes of work, the evaluation team has used the pragmatic concept of prevention displayed in the EC guidelines. The evaluation team interprets these guidelines on prevention as covering activities that, by common understanding, are supposed to contribute to prevent torture from happening.

In the former study submitted to the EC on this issue, the following distinction was proposed for activities aimed at prevention: on the macro (international and national), meso (institutions and organisations) and micro (community, family and individual) levels[8].

6 E. Sottas and P. de Sénarclens, 'Prévention : complémentarité de l'action de l'APT et de l'OMCT', in *20 ans consacrés à la réalisation d'une idée, Recueil d'articles en l'honneur de Jean-Jacques Gautier*, APT, Geneva, 1997.

7 EuropAid 11511/C/G.

8 L.H.M. van Willigen, I. Agger, T. Barandiarán, P. Khanal, *op.cit.*, p. 17.

This evaluation will follow this approach in examining the impact of rehabilitation on prevention:

- Primary prevention is prevention at the macro level: it is legislative, with all its consequences (legislation, education, regulation and litigation). In a European context these activities are mainly oriented towards the countries of origin of the victims. However, one should be very alert towards breaches in the European context: accountability for HR violations by police officers (army, border and prison officers), their theoretical and practical education about human rights and independent investigations in cases of breaches of their obligations. Litigation and condemnation are still not implemented with all their consequences in many European countries. Education of many different groups including the 'normal citizen' and in schools is a primary preventive activity on the meso level.
- Secondary prevention is prevention on the meso and micro level and it refers to the prevention of the recurrence of torture, i.e. early protection and support of the victims. In this context medical reports can play a role, by protecting the torture victim from refoulement and a possible return to a place where he/she was tortured. Another part of secondary prevention, care for victims immediately after their exposure to torture, is almost never possible in Europe, because of the long and complicated flight itineraries. Some of the countries which share borders with states which do not belong to the Dublin Treaty may have a special obligation for secondary prevention for their arriving asylum seekers.
- Tertiary prevention (treatment), on the micro level, is the provision of adequate medical, psychotherapeutic, psychosocial and/or psychiatric care to victims of torture so that the consequences of torture do not become chronic or deteriorate, i.e. the rehabilitation of torture victims.

In the conclusions and recommendations the evaluation team will return to the issue of the link between prevention and what is commonly understood as rehabilitation.

2.2 Rehabilitation

Rehabilitation is a broad notion, including medical, social and psychological aspects. For example, the United Nations Voluntary Fund for Victims of Torture (UNVFVT) practice of supporting projects illustrates a trend in rehabilitation based on a holistic approach, combining psychological, medical, social, legal and financial assistance: *"These types of assistance are interdependent and mutually reinforcing, when they are jointly offered, in terms of their impact on the victims' lives, responding to the multifaceted nature of the effects of torture on the individual"*[9].

9 Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment to the 59th session of the General Assembly, A/59/324, 1 September 2004, par. 59.

The *Draft basic principles and guidelines on the rights to a remedy and reparation for victims of violation of international human rights and humanitarian law* consider that rehabilitation is a form of reparation which *"should include medical and psychological as well as legal and social services"*[10]. Following this line, several NGOs and rehabilitation centres consider *legal support* to the victim's asylum claim as part of a rehabilitation process, acknowledging the positive psychological effect for a torture victim in Europe of being recognised as a refugee. According to another view, promoted by the EC *Guidelines* on torture, legal support should only relate to activities to prevent torture and obtain redress, whereas advice on refugee status falls within rehabilitation measures provided for the welfare of torture victims[11].

Some of the above-mentioned rehabilitation activities may have an impact on torture prevention. For example, providing legal aid and a medical report to support a patient's asylum claim can increase his/her chances of being granted refugee status and reduce the risk to the patient of being returned to his/her country, where he/she may be tortured again. The collection of a patient's testimony can be viewed both as part of the healing and rehabilitation process, but also as a preventive action, because the testimony can be used for awareness-raising about torture, denouncing this practice or for a criminal proceeding (lodging a universal jurisdiction complaint against the perpetrator of torture). On this issue, the UN Special Rapporteur on torture notes that *"legal and socio-political initiatives that aim at condemning torture, bringing perpetrators to justice and providing reparation are essential factors in alleviating the impact of torture on its direct and indirect victims"*[12].

The diversity in the common understanding of prevention and rehabilitation shows that these concepts should not be defined in a rigid way. Prevention and rehabilitation are closely interrelated and strict definitions would entail the risk of limiting creativity and new developments in the field of torture rehabilitation and prevention.

10 C. Bassiouni, 'The right to restitution, compensation and rehabilitation for victims of gross violations of human rights and fundamental freedoms' - *Final report of the Special Rapporteur*, E/CN.4/200/62, 18 January 2000. This report is a revised version of the *Principles* drafted by T. van Boven.

11 *Guidelines on torture*, European Commission, 2002.

12 Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment to the UN General Assembly, A/59/324, 1 September 2004, par.56.

3. Case studies from four European centres

3.1 PRIMO LEVI

EuropeAid/B5-813/2001/2069: "Medical care and assistance to victims of torture and political repression", implemented by Primo Levi, Paris, France. Start date: 01/07/02. Expiry date: 30/06/05. The project aims to provide support to refugees who are victims of torture and their family members through the provision of medical and psychological treatment and social support. Other objectives are: training for professionals working with asylum cases, public awareness activities and lobbying public authorities.

Primo Levi is a small rehabilitation centre with a part-time clinical staff equalling only two full-time psychotherapists, one social worker, almost one (85%) medical doctor, and one third (30%) of a physiotherapist position. The main aim of the centre is to provide rehabilitation through medical, psychological and social support to victims of torture and their families. Preventive activities are aimed training of professionals, public awareness activities and lobbying of governmental institutions. In 2003, the centre had 340 patients. The same year, the French authorities registered 52,204 new asylum applications. This very small percentage of patients among the refugee population raises questions regarding the centre's impact.

The EC funding of 500,000 Euro represents 31% of the budget, which will expire on 30 June 2005. The new proposal relates to the continuation of the ongoing activities of the centre from July 2005 until 2007. Its first year therefore overlaps with the previous programme. However, for the first year of the project (2004-05), the proposal consists of new activities concentrating more on training, lobbying and research activities. The EC funding applied for is for 500,000 Euro and represents 40% of the total funding of Primo Levi. As for the previous programme, it covers all the activities of the centre.

Approach to rehabilitation

No specific verifiable indicators are made available by the centre to measure the impact of its work, both as regards the rehabilitation of victims and the prevention of torture. The clinical, psychoanalytical approach of the centre seems to have a negative impact on its flexibility to respond to changes in the actual environment. As the social conditions of asylum seekers and refugees deteriorate in France, the centre has difficulties with adapting to these changes by, for example, placing more emphasis on social assistance and less on psychotherapy. The creation since 2002 of small rehabilitation units for torture victims in three other cities with direct involvement of Primo Levi staff is a possible *multiplier effect* of the project.

In quantitative terms, one of the four objectives set out in the project was not reached: the number of patients treated increased only by 15%, whereas the project aimed at a 40% increase. The centre has a six-month waiting list. The development of group therapy, under the new proposal, may respond to some extent to this problem. From a qualitative perspective, according to the four patients met by the team, the medical treatment provided – involving doctors, psychotherapists, a physiotherapist and a dentist – is effective. But the legal and social support provided to patients by one social worker and two volunteers appears to be insufficient in relation to the very important needs of patients. The centre does not favour the organisation of self-help groups or any other activities for occupying and integrating patients.

Approach to prevention

Although the centre's mandate includes the defence of human rights in the world, in particular the prevention of torture, the centre considers itself primarily as a care centre. This explains why, even though the centre appears to be in a key position to contribute to preventive activities (since it is itself an association of human rights NGOs involved in torture prevention), most strategy-building efforts have been focused on the rehabilitation mandate. As a small rehabilitation centre working in the European context, the centre contributes to the secondary prevention of torture at the individual level, through individual legal support and medical assessments for asylum applications (non-refoulement), and at a higher level through training for professionals from the health, social and education sectors, lobbying the French authorities and raising public awareness. It also contributes to the prevention of torture in Turkey, through its participation in a 'Turkey Committee', which supports activists from the Turkish Human Rights Foundation, an NGO managing several rehabilitation and treatment centres in Turkey and whose staff members are subject to arbitrary arrests and unfair trials. According to the centre, such activities have contributed to protecting members of the Turkish Foundation from torture and arbitrary detention. But the added-value of the centre's participation in this Committee, which brings together several human rights NGOs, was not obvious.

The wider impact of the preventive work seems mostly related to an increased awareness among governmental authorities and the French public about the human rights violations that many asylum seekers and refugees have suffered, and their difficult living conditions in France. This 'increased awareness' is, of course, difficult to document but seems plausible to the consultants.

It appears that the centre is working to achieve the preventive objectives of the project by July 2005. However, the lack of a monitoring and evaluation (M&E) system makes it difficult to undertake a minimal systematic assessment of the effectiveness of the prevention programme.

Moreover, most strategies developed by the centre have been focused on the health care mandate and there are, as yet, no global strategies for how the centre plans to combine rehabilitation with preventive work.

The centre has, as a result of discussions with the evaluation team, expressed its willingness to develop such strategies and also indicators for measuring effectiveness and impact, both with respect to rehabilitation and prevention.

Secondary prevention consists mainly of providing asylum seekers with medical reports certifying that they have been subjected to torture. Asylum seekers submit these certificates during the asylum procedure to underpin their asylum application.

Sustainability

Financially, the project has no strong sustainability without EC funding. Support from the French government and agencies remains uncertain and, if confirmed, will not be increased. Support from the UN Voluntary Fund depends on decreasing contributions from Member States

In France, many torture victims must receive treatment in the governmental clinical system which, in general, does not provide specific treatment for torture victims, even though the clinical system has vast experience in treating consequences of family and other violence. However, the creation of a specific consultation in three hospitals in other French cities, inspired by the Primo Levi Association and with direct involvement of Primo Levi staff in training and networking activities, is a way to ensure the sustainability of the project at a policy level. It would be important to view the activities of Primo Levi in relation to the activities of other centres, such as COMEDE, which has been working in a university hospital (Le Bicêtre) for 20 years and which is in permanent contact with local centres.

Recommendations

Following their evaluation, the consultants recommended that the EC give a positive response to Primo Levi's funding application.

The following recommendations were made to Primo Levi:

- A systematic monitoring and evaluation system needs to be developed, which includes collection of data at the beginning and end of treatment. Monitoring of length of treatment, drop-outs and reasons for ending treatment also needs to be initiated.
- The centre needs to be more flexible in its approach to the change in the French environment for asylum seekers and refugees, responding to the increasing social problems of torture victims. The centre might consider having more social services and fewer psychotherapeutic staff.

- The centre could expand its preventive activities by providing training on the UN Convention Against Torture to institutions involved in asylum issues, provided such a project does not detract from the rehabilitation work and the trainers have the necessary qualifications to transmit skills and knowledge.
- As a preventive activity, the centre could make the information collected from the patients in the course of its rehabilitation work more accessible, by posting testimonies of victims of torture on its website, as a documentary source. The centre needs to increase efforts towards the promotion of its preventive and rehabilitative work, in particular through media coverage.

3.2 The Medical Foundation

EuropeAid/B5-813/2001/2067: "Rehabilitation for survivors of torture", implemented by the Medical Foundation for the Care of Victims of Torture, London, UK. Start date: 01/01/2002. Expiry date: 31/12/2004. The project aims to provide holistic support in order to rehabilitate refugees and asylum seekers who are survivors of torture. Other objectives are: lobbying campaign at national and international level. The new proposal aims to provide specialist training and support to voluntary organisations and health providers who work with torture survivors in the UK.

The Medical Foundation (MF) was set up in 1985 under the auspices of the Medical Group of Amnesty International. The Foundation has 73 full-time paid staff and 135 part-time paid staff (including 70 interpreters), who altogether make up the equivalent of 116 full-time paid staff. In addition, 223 volunteers contribute to its work, 78 of them involved in direct clinical work, 35 in clinical support projects, 62 in legal work and the rest in other parts of the Foundation's work. In 2003, 3,604 clients were treated at the Foundation. The same year, 49,370 people applied for asylum in the UK (representing almost half the level of previous years).

The EC funding of 1,289,981 Euro represents 57.55% of the budget of the ongoing project (hereafter "the London project"), which covers the centre's mainstream rehabilitation activities in London and will expire on 31 December 2004. Another parallel new proposal refers to a project (hereafter "the UK-wide project") aimed at empowering existing networks of voluntary organisations and health providers in the country in order to serve victims of torture through a UK-wide network.
It will run for three years, starting in December 2004. The EC funding applied for is for 850,000 Euro and represents 46.5% of the total funding of this specific UK-wide project.

Approach to rehabilitation

The Foundation's aim is to treat torture victims 'holistically', which means that rehabilitation is implemented through medical, psychosocial and material support. It includes the provision of medical reports to some asylum seekers. This approach is reflected in both evaluated projects. From a global perspective, the two therapy projects are well designed (although lacking objectively verifiable indicators) and relevant to the rehabilitation needs of torture victims in the UK, particularly as MF says it is the only rehabilitation centre which has been operating country-wide during the last two years.

Counselling of the clients is the central approach for all the patients, partly by volunteers, for whom control and supervision processes should be enhanced. This approach may, in many cases, be one of the reasons for the long duration of treatment. The opinion that torture victims need long-term treatment and that new and more efficient methods of treatment do not suit the multicultural approach should be increasingly challenged.

For a long time MF continued to function as it did from the start, when all the active people were volunteers willing to help victims in need and when evaluation of effectiveness of treatment was not an urgent issue. MF has now become a large organisation, paying salaries to many people, although it still operates partly with volunteers. In order to improve effectiveness, a two-person monitoring and evaluation unit was introduced under the EC project to deal mainly with monitoring and evaluation of therapeutic processes. It faced a lot of internal resistance at the beginning, which explains why its achievements after two years are still very limited. But the consultants felt confident that the ongoing organisational changes in MF will enhance this process. It will, in the long run, enable the Foundation – as well as potential donors – to evaluate more concretely the impact and the effectiveness of the treatment provided. Their work could even be of relevance to other smaller European centres for prevention of torture and treatment of torture victims, who do not have the means to do this basic theoretical monitoring and evaluation work.

At the moment, due to the lack of a reliable database, some important figures such as the number of consultations per patient and drop-out figures are missing, which makes it difficult to evaluate the project's impact in quantitative terms. Nevertheless, the impact of the project on rehabilitation can be noted partially from interviews with clinical staff and beneficiaries. There is no provision for the impact and multiplier effects to be quantified in the new, UK-wide project either.

One can nevertheless assume that it will have an impact, as it aims to develop a UK-wide network of voluntary organisations (refugee groups, advocacy projects, counselling services and interpreters) and health providers (GPs, community mental health teams, hospital staff and health visitors) by training them in how to address the needs of torture victims. This could also be the beginning of integrating care for torture victims into the mainstream health sector.

Approach to prevention

The Foundation has a specific unit, the Department for Public Affairs, exclusively dedicated to prevention. However, MF insists that the two rehabilitation projects also include prevention activities.

The Department for Public Affairs aims to achieve primary prevention through advocacy work at the national and international level (press releases, publication of country reports, lobbying to change national and international legislation, supporting legal prosecution of perpetrators etc.). At the national level, both the MF projects evaluated have a secondary prevention objective, i.e. to prevent asylum seekers from being returned to their country and run the risk of being tortured again. This is done through training of Home Office officials in charge of assessing asylum applications filed by torture victims and provision of medical certificates to support patients' asylum applications. According to stakeholders interviewed, these activities have had an impact on several institutions involved in asylum issues in the UK, such as the Home Office.

The prevention activities are implemented in a professional manner, the publications are competently and carefully written. Consequently, the impact of this preventive work in the UK may be assumed to be successful to a certain extent, although no indicators have been designed. Their impact outside Europe has neither been evaluated nor proven.

Sustainability

Both projects are financially relatively sustainable as MF receives regular support from many different donors. Funds from other donors have already been secured for part of the UK-wide project.

At a policy level, on the one hand the UK-wide project may improve MF integration into the national services for the care and treatment of victims of violence and, through that process, enable mainstream services to improve care and treatment of refugees and torture victims. On the other hand, professionals from MF could improve their psychotherapeutic technique by learning new approaches from the mainstream services.

Recommendations

Following their evaluation, the two consultants recommended that the EC give a positive response to MF's funding application for its capacity building programme in the UK.

They recommended to MF:

- To provide the Monitoring and Evaluation Team with increased support, so as to enable it to report as soon as possible on its ongoing work both on rehabilitation but also on prevention activities. Monitoring and evaluation research should be performed in coordination with other European centres.
- To improve the effectiveness of its methodology at the intake stage. This would imply that the intake interviews should consist of three sessions at the most, followed by an evaluation session with a highly qualified and experienced clinician with a medical or psychological background. This evaluation session would be the place to decide collectively which patients are going to be looked after immediately, which patients can be referred to other places and which patients can be put on a waiting list; indications for immediate treatment should also be formulated.
- To have stricter supervision and control mechanisms for the volunteer as well as the professional counsellors. For volunteers, supervision should be compulsory at least once a month, and each time any of them has to present a case. For professionals, supervision should be discussed in the group and the effectiveness of outside supervision should be evaluated once in a while.
- To set up a periodic monitoring system for assessing the effectiveness as well as efficiency of ongoing counselling and psychotherapeutic interventions at least every five sessions.
- To put up visible EU logos in the entrance halls of their main building in London, as well as in any centre of the UK-wide project supported by EU funding. The logo should also be included on their headed paper and on their publications.

3.3 EXIL

EuropeAid/B5-813/2001/2085: "Medico-psychological rehabilitation of men, women and children who are victims of human rights violations and torture", implemented by EXIL, Centre médico-psychosocial pour des personnes exilées et pour des victimes de torture, Brussels, Belgium. Start date: 01/01/2002. Expiry date: 31/12/2004. The project aims to provide support to refugees who are victims of torture and their family members through the provision of medical and psychological treatment and social support. The activities of the project are addressed to four main target groups: women, children and their families, adolescents and men.

The work of EXIL began in 1976, under the name COLAT (Colectivo Latino Americano de Trabajo psicosocial), after the arrival of several young medical professionals as refugees in Belgium, who had fled Latin America where they had been tortured themselves.

In 1987, the organisation extended its geographic mandate and changed its name to EXIL. Rehabilitation and integration of victims of torture and/or organised violence is the main activity of this centre. The centre relies primarily on paid staff, with 31 employees, who in total make up the equivalent of 19 full-time paid staff. In addition, several volunteers contribute to the work of the centre. In 2003, 1,239 clients were seen at EXIL. During that year 17,000 people sought asylum in Belgium, which is slightly over half the number of asylum seekers in 2000.

The EC funding of 1,560,000 Euro represents 49.93% of the budget of the ongoing project. The new proposal relates to the continuation of the former project. It will run for three years, starting in December 2004. The EC funding applied for in the next project is for 1,500,000 Euro and represents 45% of the total funding of the centre.

Approach to rehabilitation

The philosophy of care at EXIL builds on a systemic approach, caring for the patients at three levels: medical, psychological and social. Patients are offered an inter-disciplinary and comprehensive service by a multicultural team including: general medical care, health education, psychiatric assessment and treatment, psychotherapy, family therapy, child and adolescent therapy, physiotherapy, psychomotor therapy, parenting training, casework and social work. The centre also issues forensic medical reports to document torture and ill-treatment in support of asylum applications and offers practical assistance to some patients. No legal assistance is provided but patients can be directed to pro bono lawyer networks. The centre assists the refugees in (re)constructing a social network, because they consider a new social network essential for the well-being of the refugees, be they torture victims or not, and also, in the longer term, for an adequate integration into Belgian society.

For the moment, due to the lack of a reliable database, figures such as the number of consultations per patient and drop-out rates are missing. No objectively verifiable indicators have been identified nor has any monitoring and evaluation system to measure the impact of the rehabilitation work, which makes it impossible to assess the project's impact in quantitative terms. A patient-tracking system and a systematic data collection system is currently being set up and tested. It is expected to be operational in early 2005. The development of such a programme will need specific supplementary funding to obtain an internally networked computer system, where every clinician can enter data immediately after sessions from every therapy room.

However, in qualitative terms, the interview with two patients, the attendance at a clinical supervision session, the systemic and behavioural approach of the psychotherapists, the thoroughly planned and continuous supervision of all therapies, are guarantees for efficient treatment.

This modern and efficient therapeutic approach includes many different cultural backgrounds, also employing professionally trained refugees as therapists. Given the number of staff and the number of patients, this centre is the most efficient in terms of output. There is no waiting list for new patients.

The consultants were able to conclude that the project's objectives in relation to the rehabilitation of torture victims through general therapeutic activities and specific activities, as well as to the prevention of violence – especially family and youth violence – are achieved. However, no clear strategy has been drawn up to achieve the project's objective of promoting the participation of torture victims in actions for the protection of human rights. Its achievement in this area is therefore limited to a few events.

In the health sector, since it has been accepted as an official centre for mental health, EXIL has achieved a partially institutional position in the mainstream Belgian health system. However, after almost 30 years of existence, one may question the centre's capacity or its willingness to integrate its services completely into the normal mainstream of national medical and psychosocial services, empowering the mainstream services to deal effectively, humanely and efficiently with this group of victims, as it does with other victims of violence.

As all efforts are focused on clinical work, there are no resources available for increasing the project's impact outside EXIL, except through ad hoc interventions, or for planning its complete integration into the Belgian mainstream health system. In this sense its impact is still as it was at the beginning, a service parallel to the Belgian mainstream health system.

Approach to prevention

EXIL's preventive activities are defined as preventive measures to improve patients' health. This is implemented with great care. However, EXIL has never been strongly focused on the prevention of torture, arguing that it would detract from the medico-psychological work of the centre, since there is no appropriate staffing to develop preventive activities and the personnel of the centre are unwilling to restrict the time they spend on clinical work. As the centre's doctrine is not to focus its attention on torture, but rather on healing, integration and peace, the testimonies of patients (which exist in written and electronic form have never been used in a preventive perspective. Within Belgium, the main activity of the centre contributing to preventing torture victims from being returned to their home countries is the work performed by the Medical Examination Group in providing medical reports. However, the percentage of patients provided with a medical report by EXIL for recognition of refugee status is not known.

This activity is neither conceived as a preventive activity nor as a central service at the centre, but rather as a helping gesture for the integration and rehabilitation of patients. Other preventive activities are EXIL's few interventions within NGOs platforms involved in advocacy.
So in the country, the centre has never striven to have a planned and coherent strategy on prevention, leaving that to other NGOs. Outside Belgium, the impact of the centre's projects in Chile and the Democratic Republic of Congo (DRC) is limited.

Sustainability

The project has some relative financial sustainability. It depends 44% on the EC contribution. Unforeseen changes (such as, in 2002, a severe budget cut by the UNVFVT) have serious effects on the whole budget. However, part of the project is financed by the Belgian authorities, as EXIL is recognised as a bi-communitarian (French and Flemish), specialist Centre of Mental Health. It is not clear why the centre does not get more funding from the government, as it is integrated into the Belgian health system. Increased governmental funding would decrease the vulnerability to changes in funding from other donors and would enhance sustainability.

Over almost 30 years the centre has regularly trained around a dozen psychotherapists (psychologists and psychiatrists) and social workers each year in systemic psychotherapy for refugees and torture victims, and it is a recognised training institution. It has more demands than it can respond to, as it is known as a centre in which one can learn and be closely supervised. Although this capacity building of the mainstream health system is not measurable, it can be presumed to have an important longer term effect.

Recommendations

Following their evaluation, the two consultants recommended that the EC give a positive response to EXIL's funding application for its programme in Belgium.

The following recommendations were given to EXIL:

- To start with the planning and implementation of a computer program to procure basic hard data about numbers of patients, intensity of treatment, treatment programmes and their combinations, drop-out rates, number of treatment hours, costs per hour of treatment, duration of treatments, costs per patient etc.
- To provide the World Health Organisation (WHO) research team with increased support, so as to enable it to report as soon as possible on the ongoing work both in terms of treatment effects and outcomes and of prevention activities.
- To develop a systematic monitoring and evaluation system, based on the WHO research, in coordination with other European centres.

- To develop a proactive approach and build up a strategy on awareness raising and advocacy among Belgian authorities dealing with asylum issues.
- To put up visible logos of the EU in the entrance halls of their buildings. The logo should also be included on their headed paper and on their publications.

3.4 MRCT

EuropeAid/B5-813/2001/2104: "Comprehensive care for torture victims in Greece", implemented by the Medical Rehabilitation Centre for Torture Victims, Athens and Thessaloniki, Greece. Start date: 01/11/2001 Expiry date: 31/10/2004. The project aims to provide support to refugees who are victims of torture and their family members through the provision of medical and psychological treatment and social support. Other objectives are: training for health and law professionals, police and staff dealing with asylum cases; public awareness activities; and supporting the members of the Balkan Network. The new proposal relates to the continuation of the project for another three years but with activities only based in Athens.

MRCT was founded in Greece in 1989 by a victim of torture, with the support of the medical team of the Greek section of Amnesty International. The centre's staff comprises 12 people (six part-time and six full-time, including five medical staff, two social workers and one legal adviser), making up the equivalent of eight full-time paid staff. In addition, about 60 volunteers (one part-time psychologist, one part-time press officer and a network of 55 medical doctors (MDs)) contribute to the work of the centre. In 2003, about 250 patients were treated in the centre (of whom 108 were new patients). The same year, 8,000 people were registered as asylum seekers in Greece and about another 8,000 persons were in the country as non-registered asylum seekers.

The EC funding of 565,153 Euro represents 60% of the budget of the ongoing project. The new proposal relates to the continuation of most activities of the centre for three years, starting in December 2004. The EC funding applied for is for 399,557 Euro and represents 50% of the total funding of MRCT. As for the previous programme, it covers most activities of the centre, but only in Athens.

Approach to rehabilitation

MRCT in Athens offers a psycho-social-medical rehabilitation package to refugees and victims of torture. However, it suffers from many different challenges and shortcomings: a patient load representing not even 1% of the refugees arriving each year raises concern as to its impact and questions regarding the desirability of dealing with greater numbers of patients, as well as the general lack of alternative/available services in Greece.

Although the lack of comprehensive data makes it difficult to give a quantitative assessment, interviews at MRCT made it clear that the drop-out rate was significant. This results in some frustration among the staff and raises questions as to the quality of the services provided.

The centre still functions as a small charity NGO, although two social workers, a full-time psychologist, an MD and a network of voluntary MDs support the refugees using its services. Its evolution towards a more efficient and professionally managed health care centre is hampered by financial, political and personal factors. In particular, the centre struggles with institutional complexities of the Greek state: it is currently not in a position to work with the Greek Ministry of Health to care for the health of arriving asylum seekers, not even for the sake of border health control (controlling the import of epidemics and transmissible diseases).

Approach to prevention

MRCT understands prevention as primary and secondary prevention of torture, in and outside Greece. Human rights advocacy, awareness raising, denunciation of ill-treatment and torture through local police and lobbying to adapt the Greek aliens legislation to European standards are methods which might have some impact on the prevention of torture in the long run. A part-time lawyer, who is also the Greek member of the European Committee for the Prevention of Torture (ECPT) and a member of the Greek Refugees Appeal Board, is active in lobbying for refugees: urging the Greek authorities to improve their asylum law, to take over basic health care of arriving refugees, etc. However, this work requires more human resources, a better strategy and support at an international level through European pressure on the national authorities. To date, these efforts are hampered by the reluctance shown by the Greek authorities to develop an institutional relationship and to engage in an ongoing dialogue with the centre. To some extent, the MRCT personnel also seem reluctant to consider the authorities as important partners for the necessary dialogue about the design and implementation of an adequate asylum policy.

The medical certificates are said to be decisive in the asylum procedure and nearly all of the few people who were recognised as refugees in Greece last year seem to have had a medical report from MRCT.

Some prevention activities are said to be undertaken by providing a base for the BAN (Balkan network of centres for victims of torture) and, previously, for the MENA (Middle East and North African Network). However, it is not clear whether one-day conferences really provide thorough training, be it in rehabilitative or preventive aspects. The same holds true for the one-day training of police officers in how to deal with tortured asylum seekers, which is offered twice a year. No indicators as to the effectiveness or impact of the training have been elaborated.

Sustainability

The project is barely financially sustainable, as MRCT has not (yet) found any private donors and there is no official long-term support commitment from the Greek authorities. Funds received from the Greek authorities are never long-term funds and are always received on a personalised level.

It is essential to call upon the relevant ministries to comply with their obligations towards refugees – in a European context – and to support the valuable and important services provided by MRCT, something which might have to be done by the EC.

Recommendations

MRCT has an important role to play in Greece but a number of adaptations are required so that this centre can increase its impact, effectiveness, efficiency and sustainability. With this perspective, the experts recommended that the EC fund the new three-year project and monitor and support MRCT's efforts in the implementation of the following recommendations:

- To develop a vision of the centre's mission, including short, medium and long-term strategies involving all the different professionals of the centre. The specific strategies must be coherent so that they comply with the centre's mission.
- To improve an institutional dialogue with the authorities on issues of mutual interest such as health or asylum issues.
- To enhance the quality of medical reports and introduce a central quality control of treatment intervention through a centralised medical file of the patients in the centre.
- To improve the database, in coordination with other European centres, and introduce a patient-tracking system monitoring progress in treatment every three months
- To develop a gender-specific approach, with specific care for women and single males, helping them to (re)construct social networks. Group encounters, led by a therapist, might be one possibility.
- To adapt the psychologist's tasks so that he treats more patients gives more training or organises group and family therapy sessions or self-help groups and other social and/or occupational activities in groups.
- To review the employees' tasks and monitor their time allotment in relation to real consulting time, outreach work and lobbying time.
- To allot time and money for regular supervision by an external professional for the social workers and psychotherapist(s); and by the psychologist for the interpreters, in order to prevent burnout.
- To give more time, be more professional and devise other fundraising activities.
- To put up visible logos of the EU by the door (and write the centre's name in the Latin alphabet as well), in the entrance halls and waiting room, mentioning EU funding.

3.5 Comparative analysis of the findings from the four centres

Approaches to rehabilitation

According to the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, *"a combination of medical assistance, financial support, social re-adaptation, legal redress and, in some cases, public acknowledgement is crucial. Only interdisciplinary assistance that integrates these various aspects can ensure adequate, effective and prompt reparation commensurate to the gravity of the violation and the harm suffered"*[13]. In other words, according to the Special Rapporteur the *interdisciplinary and holistic* assistance to torture victims ensures effective rehabilitation.

The four evaluated centres may share this vision. However, in their daily practice they apply it in diverse manners. The assumption of all four centres is that the psychological and somatic problems of their clients are closely (and causally) linked to their experience of torture and organised violence. Questions about other causes, such as forced migration, lack of family and other networks, lack of integration into a new culture, lack of meaningful working conditions, lack of financial resources – social and political rather than medico-psychological factors – have often been neglected. EXIL in Brussels is the only centre where this broader social political perspective is evident, maybe due to the number of their clinicians who have their own experiences of torture and exile and act according to these real experiences and to their political vision.

Institutional sustainability of the centres

Treatment and rehabilitation should clearly be tasks of the mainstream public health services of the (European Union Member) States in which the centres are located. Where these services have failed to meet their obligation, NGOs have started rehabilitation and treatment programmes for torture victims. All over Europe, centres for the rehabilitation (or treatment) of victims of torture have been established and do function to some extent. Indeed, some of them have been operating since the very beginning of the awareness in Europe at the beginning of the 1970s about the physical and mental impact on a victim of torture practices. However, at the beginning no centre thought of the need to finally integrate their expertise into the national public health sector. This attitude persists today in the centres visited, which tend to think that only they are capable of rehabilitating victims of torture. This is a sort of 'ivory tower' thinking, but it is also a serious flaw as regards sustainability[14].

13 Report of the Special Rapporteur on torture, *op. cit.*, par.58.

14 Some of the centres have been more successful than others in their strategy for integrating their work into the public health services of their country. A successful case in point is the Stuttgart centre, established less than 10 years ago by the Protestant Church. It has never applied for EC funds and is well integrated into the main health care system, as e.g. it also treats victims of (German) family violence, is active in the rehabilitation of trafficked women and works in close cooperation with the police. It has now been asked to become part of the official medical – psychotherapeutic – structures, is reimbursed by the official health insurance schemes and is in a position to provide officially recognised post-graduate training for psychotherapists.

All four centres included in this evaluation have only loose links with the national health systems. It is interesting to note that their pioneering work with victims of violence in the 1970s has not been used in the implementation of strategies in the emerging European preoccupation with family violence, violence against women and children, child abuse etc. Their pioneering experiences have, unfortunately, not been integrated into the national health systems. It is as if the experience of torture and political violence is something so different from 'normal national' violence that no link between the two forms of violence would be possible. This attitude might be valid when seen from the perspective of the reasons for the violence, however, it is only partly valid from the perspective of the medical and psychological effects of the violence on individuals and communities.

The only centre which has started to investigate this potential is EXIL, in a study on family violence and its prevention in refugee families, undertaken jointly with the WHO collaborating centre of the Catholic University of Louvain. The partial funding of EXIL as a centre for mental health by the local authorities is a step in the direction of integrating it into the local mainstream health facilities.
The lack of strategy of the four centres to integrate their work centres into the national health systems threatens the long-term sustainability of their work. There is a risk that their accumulated knowledge and experience will disappear when the centres cease functioning due to organisational malfunctioning or lack of funding.

Today, in Europe, the national health systems are increasingly aware of the difficulties of treating migrants from many parts of the world and have to find ways of dealing with this issue. It is evident that the European health systems have a legal obligation to provide the migrant populations with care that is adequate and equal to that provided to the indigenous population. The existing centres for treating psycho-social consequences of family violence can profit from the know-how of the centres for the rehabilitation of torture victims and vice versa. This might be a chance for the centres to obtain a better connection to university units specialised in psycho-traumatology and to become more effective in their treatment approaches. It would also be a way of integrating the specific (transcultural) experiences of the centres into the national health system. Mainstreaming this expertise into one single channel would, of course, also help to enhance the integration of the specific group of persecuted and often forced migrants into a 'normal' group of clients of national health systems.

However, this integration needs a long-term strategy, with mutual cooperation from both sides. The national health systems must be sensitised about their obligations and their capacity to care for this specific group of migrants.

They will have to learn from or be informed by the centres about how to approach this specific group and what sort of training to give to the basic health care providers in each national system. It is not clear whether the national health systems or the centres themselves have resisted this view[15], nor to what extent and within what timescale this integration will have an impact on the centres.

Policies and strategies formulated by the centres about their contribution to the prevention of torture

The evaluation conducted in 2003[16], with Nepal and Peru as case studies, came to the conclusion that rehabilitation centres do to a certain extent contribute to the prevention of torture. It identified criteria according to which the possibilities, extent, effectiveness and impact of prevention activities depend.

This evaluation, conducted in a European context, views the situation slightly differently: the four centres visited are all involved in some sort of prevention. However, they have four very different concepts of what this means, as will be explained below. Also, their policies for torture prevention lack a coherent strategy and/or are so limited that their added-value is not visible. All four centres consider themselves primarily as health care centres. Consequently, most efforts are being focused on their rehabilitation mandate.

Whether or not rehabilitation centres are involved in prevention is not influenced by their school of thought: it mainly depends on their financial resources and the human capacity to undertake such activities. The evaluation team cannot escape the impression that the emphasis of the EC on prevention has induced the centres to formulate activities under the heading prevention, without much consideration of how preventive activities can fit into their 'core business'. EXIL is the only centre that openly takes the position that it is not working on prevention and that its central interest is the well-being and (bi-cultural) integration of the refugees into the receiving society. The three other centres visited have included prevention as part of their projects. Among them, one – the Medical Foundation, i.e. the most financially sustainable of the four evaluated centres – has developed a global strategy to contribute to the primary prevention of torture, in the countries of origin of the patients and at the international level.

However, the policies and strategies that the centres have formulated themselves to contribute to the prevention of torture are not the same for primary, secondary and tertiary prevention, as will be explained below.

15 Apart from COMEDE in Paris, which has always considered itself as a special service which channels (all sorts of) migrants to the appropriate local French facility.

16 H.M. van Willigen, I. Agger, T. Barandiarán, P. Khanal, *op. cit.*

Primary prevention

Does knowledge from therapies about torture techniques and the impact on those who have been tortured and have practised torture change anything at the primary prevention level, i.e. save individuals from torture in their countries of origin? Primary prevention activities function at a macro level: they consist of projects aimed at awareness-raising in society at large of those who belong to groups which are at risk of practising torture (members of law enforcement agencies), at legislative changes (with regulation and litigation) and at changes in organisational and institutional set-ups that facilitate and condone torture and are not geared towards preventing torture.

At a meso level prevention activities consist of education, e.g. through capacity building among law enforcement officers, prison officers, etc. and undertaking legal proceedings against perpetrators. Primary prevention at the European and international level must be differentiated. In Europe, the ECPT plays an important role in this respect and its recommendations can have a great impact on governments.

The commitment proclaimed by the centres to primary prevention has in practice only been translated into potentially effective projects in centres where some of the staff have enough time and resources to undertake such work and where the centres have close links with human rights NGOs.

The Medical Foundation is the only one out of the four centres visited to have developed a global strategy to contribute to the primary prevention of torture, internationally and in the countries of origin of the patients. Although common sense leads one to agree with the claim that knowledge about torture and mechanisms that induce organised violence and torture will contribute directly or indirectly to combating torture (more effective standard setting, codes of conduct, etc., see Chapter 4), this claim is not sustained by results from MF's prevention projects (or those of any of the other centres). Whereas it may not be fair to put the burden of proof entirely on MF, one might expect that its projects and strategies were designed in a way that enabled a more clear link between the project activities and the impact on prevention of torture to becomes apparent.

No primary prevention activities are planned at MRCT. At Primo Levi, these activities are mainly focused on one country (Turkey). The two centres, Primo Levi and MRCT, lack the financial and human resources to conceive a global primary prevention strategy with clear objectives, outputs and activities.

On the basis of their findings, the evaluators come to the conclusion that primary prevention projects, which fall within the remit of human rights NGOs, should not be the most important task of rehabilitation centres, unless they have the financial and human resources to build up global strategies in collaboration with other human rights NGOs. Where they lack the resources to take the lead in prevention projects, the centres could strengthen their collaboration with human rights NGOs and build a bridge to ensure that primary prevention can, if needed, rely on information gathered during treatment of victims.

Secondary prevention

In Europe, secondary prevention mainly relates to the provision of forensic medical reports to patients who are considered to have been tortured. It also includes the training of officials involved in the asylum procedure.

The quality of the medical reports varies a lot, as well as the centres' commitment to share their expertise in this field with the mainstream health system. In the four countries visited, stakeholders insisted on the importance of the centres' medical reports. Correct medical report writing, according to the Istanbul Protocol, is a skill which every MD should have learned during his or her training. General practitioners, somatic medical specialists and psychiatrists can, if interested, learn this skill quite easily. Medical faculties/schools should train their students in the Istanbul Protocol, when training them in dealing with migrants' health problems. No centre has yet managed to introduce this topic into the medical faculties. MF contributes with its expertise to the awareness-raising among officials involved in the asylum procedure.

In training medical and legal personnel involved in the asylum procedure, the centres aim to ensure that torture victims will be taken care of adequately i.e. that they should not be detained, that they should have access to the asylum procedure, that they should be interviewed in an appropriate manner etc. Some of the centres, such as EXIL and Primo Levi, have neglected this type of contribution to secondary prevention, although there may be room for cooperation with the institutions concerned and it would not involve significant resources. MRCT's half-day training of the police twice a year is insufficient to fulfil the training needs and it may, as a reverse effect, be used as an excuse by the authorities for not doing anything better. However, in order to be effective such training has to be ongoing and is intensive and demanding time wise. If not done thoroughly, the personnel is 'trained', but really only superficially. The time requirements of such training are often underestimated and 'therapists' are not always motivating trainers.

Human rights NGOs, such as the Association for the Prevention of Torture (APT) and OMCT, and national bodies have started to train law enforcement officials, while some medical faculties have started programmes for post-graduate training. The centres could contribute with their knowledge, however, none of them has managed to initiate contact with the relevant responsible persons.

Tertiary prevention

Tertiary prevention relates to treatment of torture victims and is the main purpose of all four centres. The evaluation of all four centres leads to the conclusion that tertiary prevention would benefit from an improved monitoring and evaluation system of the rehabilitation processes (see 3.5) and opening up to other national groups dealing with the rehabilitation of victims of all sorts of violence.

Rehabilitation

The use of verifiable indicators

All centres, although to varying extents, show some reluctance or difficulties vis-à-vis the implementation of a monitoring and evaluation system. As a consequence, in all four centres monitoring and evaluation are insufficient, not only with regard to primary and secondary prevention activities, but also with regard to the tertiary prevention level, which belongs to their core activities. The identification and use of monitoring and evaluation tools would be important to increase the centres' impact on primary and secondary prevention activities as it would improve their overview and expertise on torture patterns among their patients.

Primo Levi has established an efficient database which might become a basis for developing a systematic M&E system. However, the staff has so far remained reluctant to do any other evaluation apart from team discussions and supervision sessions. The fact that this is an important requirement by the EC may become a strong incentive to change this attitude.

It has taken the Medical Foundation almost 20 years for M&E to begin to become part of the development and implementation of a strategy. Resistance to scientific and organisational innovations has proven to be a problem in the attitude of many of the centre's staff. Consequently, in this NGO involving an equivalent of 116 full-time paid staff and 223 volunteers, no figures are available about the length of treatment, the number of consultations needed per patient, drop-out rates or indicators for successfully completed treatments. Only in 2002, with EC support, was an M&E unit set up, with promising prospects for the Foundation – and initial reluctance are now starting to fade. Indicators taking into account the transcultural setting are still being identified and the unit will need considerably more time to define its first indicators. Once published, they might also be useful for other centres.

EXIL is starting to set up a patient-tracking system and to pave the way for the implementation of an M&E system. The first step was made in 2003 when the WHO collaborating centre at the Catholic University of Louvain, chaired by EXIL's president, entrusted EXIL with the task of conducting a research study to monitor the impact of the therapeutic interventions with refugee families and to examine how EXIL's experience can model intervention strategies with Belgian families for preventing ill-treatment of children and family violence. The research, which is limited to EXIL's work with families and adolescents, will at some point provide the team with the necessary tools to extend this evaluation to other EXIL target groups.

MRCT has set up a database to enable the team, as a second step, to monitor in the not too distant future the effectiveness of their clinical interventions, through the development of a monitoring and evaluation system. The research project planned with the International Rehabilitation Council for Torture Victims (IRCT) was never finalised. Based on this unsuccessful experience, the centre decided to abandon its evaluation activities, data collection and patient registration plan.

Prevention

Prevention programmes must be evaluated and monitored differently from treatment programmes. Indicators for efficient preventive programmes might be more difficult to decide upon and evaluate than one thinks. Institutional changes are a necessary consequence of the legal process and a precondition for further implementation of prevention of torture. However, this will not be enough for effective primary prevention. In different parts of the world, the societal, educational and political settings are not yet ready to really implement an effective preventive policy.
Finally, the evaluation – and the ongoing monitoring – will have to be based on many different indicators to ascertain the efficiency of torture prevention programmes.

This explains why none of the evaluated centres are measuring the impact of their preventive work on the basis of verifiable indicators. The large number of different parameters on the one hand and the lack of consensus in the scientific and HR communities, on the other hand, mean it will be a long time before sound basic verifiable data are defined and operational.

Do prevention activities detract from the medical and psychological work of the centres?

In most of the centres 'preventive activities' (and each of them means something different by this) are not done at the expense of clinical work. The question may be raised, however, regarding centres with a waiting list. In one of them, MF, this is not relevant since this centre has a specific Department for Public Affairs involved in prevention activities.

This is not the case at Primo Levi, where the consultants were not convinced about the relevance and impact of some of the preventive activities, in particular given the fact that this centre has a six-month waiting list. At EXIL, the argument for not being involved in prevention is that it would detract from its primary tasks as a mental health centre, i.e. medical and psychosocial work.

None of the centres put any pressure on the patients to become part of primary or secondary preventive activities. Medical treatment may help increase the victim's ability to cope and search for justice and patients could be supported by the centres in participating in preventive activities – something which might also contribute to their individual healing process.

None of the centres have been able to develop verifiable indicators as to the effectiveness of preventive activities. The number of books, of days of training or even of persons trained are not sufficient indicators of impact, not at the national and even less at the international level. However, the consultants recognise that it is not an easy task to develop such indicators.

Does preventive work have any beneficial/detrimental effects on the victims themselves?

Primary prevention at a macro level – legislation (with regulation and litigation) – may have a beneficial effect on torture victims (micro level) in the sense that the condemnation of perpetrators can procure some late satisfaction that justice has been done. However, it can also entail a difficulty in psychotherapy, as the patient may think that he/she will feel better if justice is done and this may thus prevent him/her from working through his/her personal experience. Therapeutic experience also shows that such patients decompensate at the moment when justice is done. This is a technical difficulty which only experienced therapists can handle.

At a meso level, education may have a positive effect because citizens educated about torture may have a different approach to and more solidarity with asylum seekers. It only has a negative effect if it is done to the detriment of rehabilitation activities.

Secondary prevention – through medical reports – must be considered as beneficial, provided that asylum is considered the best choice for the victim of torture with all its secondary negative effects: uprooting, homesickness, social descent, unsatisfactory work etc. *"The bread of exile is very hard"* (quote from a Chilean refugee).

Secondary prevention through early intervention after torture has only beneficial effects, where it is possible.

The opinions of other local human rights NGOs which work exclusively on prevention, if these exist	There is an atmosphere of mutual trust and respect between the local human rights NGOs consulted and the evaluated centres and some cooperation, often on national lobbying platforms on asylum issues. Cooperation is sometimes institutionalised. For example, Primo Levi was created by five NGOs[17]; and an MRCT board member is also a member of the board of the Hellenic League. This does not always imply a tight and daily collaboration, as each organisation's roles are very different, but it gives room for efficient cooperation for lobbying the national authorities on particular issues.
Availability of alternative sources of funding	With the exception of MF, which is largely funded by private donors, the evaluated centres find it difficult to identify alternative sources of funding for rehabilitation activities and they do not tend to raise funds for their prevention activities, instead using the EC's funds for this.

17 Christian Action for the Abolition of Torture, Amnesty International, Lawyers without Borders, Doctors of the World and Trêve.

4. Impact of rehabilitation on prevention in a European context

4.1 Relevance of European rehabilitation centres being involved in prevention

In Europe there exist many HR NGOs and bodies such as the ECPT, an intergovernmental body, which are completely dedicated to primary and secondary prevention, with specially trained personnel and explicitly geared resources. They carry out their tasks freely, professionally, with a lot of dedication and are almost never threatened. However, none of them has the capacity for rehabilitating victims of torture.

The rehabilitation centres may have some potential to play a role in preventive work at the institutional level (meso level) and at the community, family and individual level (micro level). However, their core responsibility is – as formulated in their origins – rehabilitation of victims of torture and prevention of re-exposure (non-refoulement or ill-treatment by local European law enforcement personnel).

In the countries from which the victims originate: primary prevention

European rehabilitation centres have the potential through their assistance to torture survivor groups to support the development of a community-based human rights movement in some of the countries of origin – a movement that could play a significant role in calling for justice and campaigning against torture. In contrast to preventive activities of rehabilitation centres, in Latin America for example, the consultants did not see much evidence of this strategy in the European centres visited. Only EXIL sets out *"promoting the participation of torture victims in actions for the protection of human rights"* as one of the objectives of its therapeutic programmes, but it appeared that only a few activities were organised in line with this objective, which was not achieved on the basis of a comprehensive strategy. The centres might focus more on the mobilising aspects – also in relation to their group rehabilitation work.

The information collected from treating patients should not be lost: therapists can play a role in documenting torture. Through their direct and close contact with torture victims, the centres can collect data and document torture in a more detailed way than other human rights NGOs which are not involved in rehabilitation. This documentation can act as a national and international pressure on governments.

The centres can also draw attention through the media to the plight of asylum seekers who are also torture victims, and the publicity that such cases attract can act as an important pressure on national governments. The centres can also send testimonies of torture to international NGOs such as Amnesty International.

In the countries in which the victims are treated: secondary prevention

Support can be given by providing adequate medical, psychotherapeutic and/or psychiatric care to victims of torture and their families who mitigate the effects of torture and empower victims to fight for justice and to combat torture in their country of origin. As the Special Rapporteur on torture points out: *"Obtaining reparation for violations undergone has a very important psychological effect for the victims. Conversely, testifying to obtain reparation can have a significant destabilising effect, with the possibility of an emotional collapse requiring psychological attention"*. Here, there would be some scope for European centres to encourage their patients, as part of their rehabilitation process, to seek justice and reparation in Europe and to provide them with the necessary psychological support throughout the legal process. But such an activity is almost non-existent in the evaluated centres. Although the consultants did not find clear evidence of the political empowerment of many rehabilitated victims, they still see the rehabilitation process as a potential enabling environment for individual empowerment. The various centres might be more attentive towards supporting the political empowerment of their clients.

The expertise developed by the centres in dealing with torture victims can be shared with relevant institutions. Therapists or social workers working in rehabilitation centres have a unique background for training medical professionals and institutions involved with asylum issues (including police officers) in the physical and psychological effects of torture. For example, training asylum officers in interviewing torture victims is a means to increase their awareness and to improve the quality of their work when dealing with such people. Such training helps to comply with the legal obligation not to send asylum seekers back to their/a country where they risk being subjected to human rights abuses, including torture This work is complementary to the training of other human rights organisations.

4.2 Obstacles to the rehabilitation centres' involvement in prevention

European centres face many obstacles in trying to be involved in primary and some aspects of secondary prevention.

- Lack of an institutional/ mainstreaming strategy: all centres consider themselves primarily as health care centres, where most activities which are not strictly speaking related to the treatment of patients would be defined as prevention. However, neither the staff's expertise nor the financial resources are sufficient to define a global strategy for prevention, based on identified objectives and outputs.

And even where the resources and the expertise are there (as in MF), no objectively verifiable indicators have been identified in the logframe to monitor the impact of the preventive activities.

- Lack of expertise: clinical staff are not naturally qualified for torture prevention activities.
- Difficulty of finding the right language: a therapist who treats victims of police torture will have a problem in encountering police officers to train them and might not be able to overcome his or her (maybe unconscious) reluctance, hate or fear towards them. This will hamper training efforts.
- Lack of financial support: most centres feel they are in a precarious financial situation and seek to consolidate their primary mission – rehabilitation of torture victims – even by confirming that they do prevention, in order to obtain more funding.
- Lack of adequate human resources: developing prevention activities may detract from rehabilitation work, which is unfortunate, as the centres' core expertise is rehabilitation.

4. 3 Need for increased collaboration with HR NGOs

According to the experts' findings in the course of this evaluation, increased collaboration between rehabilitation centres and HR NGOs which are active in the prevention of torture is absolutely essential all over the world, but especially in Europe. This would enable many of the rehabilitation centres to come down from their ivory towers and have direct and more intensive contact with other actors in the field of HR.
But at the same time, the centres are in a key position to collect information on torture in many countries from direct victims and this is the first step in primary prevention. However, this information is usually lost because the centres do not know how to use it for this purpose or do not have the time and resources to use it.

This is why human rights NGOs and rehabilitation centres should work in closer cooperation: the former could be an invaluable source of information to the latter. More specifically, both sides need to map out strategies (objectives, activities) for co-operation and exchange.

4.4 Criteria to be used in judging whether rehabilitation activities play a role in prevention of torture

The evaluation of the four centres shows that the impact of rehabilitation activities on prevention varies considerably according to the following factors:

- Political contexts in and outside Europe are not comparable and play an important role regarding prevention and rehabilitation.

- Some insights have been gained already in Greece, where the political context is very different and incomparable with other European countries (with regard to torture prevention and to expertise in rehabilitation and protecting asylum seekers, as well as to NGO culture etc.) .
- Strategies for prevention have been described earlier. They must be coherent, as soon as they exceed some aspects of secondary prevention (such as writing medical reports).
- In many cases, the staff are heavily occupied with rehabilitation in the centres and have no free resources to do more than the writing up of medical reports. In other cases, there might be enough staff to do more (like in MF).
- The level of collaboration with HR NGOs. The effectiveness of primary prevention in and outside Europe will only be reached by close and non-competitive collaboration between the rehabilitation centres and other HR NGOs, where each of them contributes its part to a global strategy.

These factors were also identified after an evaluation of rehabilitation centres in non-European countries[18]. They also apply in a European context.

The following indicators can be identified for evaluation and monitoring of the impact of rehabilitation activities on prevention:

- Data collection and documentation: this information could be defining indicators, however, the real impact of preventive activities on torture is difficult to measure, as there is no baseline (nobody knows how many people are currently tortured and if some are less heavily tortured today than previously as a result of preventive activities).
- Existence of monitoring and evaluation mechanisms and procedures: these procedures, if regular and thorough, render possible a follow-up in time, where one can perceive an evolution in the human rights situation and in the torture patterns, an increase in adequate investigations of violations, numbers of court cases against perpetrators, judgements, convictions and redress activities.
- Collaboration and networking: setting up a strategy and framework for consultations between HR NGOs and rehabilitation centres.
- Contribution to awareness-raising.
- Numbers of training sessions and participants from the different professional groups, law enforcement personnel, military and judicial system. This will, however, not be enough. The effect of the training must be followed up again by M&E activities, to prove whether education and training has achieved its goals.
- Awareness-raising and training of health care professionals.
- Adoption of new legislation for the protection of HR.

18 L.H.M. van Willigen, I. Agger, T. Barandiarán, P. Khanal, *op.cit.*

Annex 1: Terms of reference

Title: Torture rehabilitation centres – Europe

Reference:
EuropeAid/B5-813/2001/2085
EuropeAid/B5-813/2001/2067
EuropeAid/B5-813/2001/2104
EuropeAid/B5-813/2001/2069

1. Outline of the evaluation

The evaluation will consider four different torture rehabilitation programmes currently financed by the EC in France, Brussels, the UK and Greece. The evaluation shall assess the relevance, efficiency, effectiveness, impact and sustainability of the four ongoing projects. The evaluation shall also provide guidance and make recommendations for a decision from the EC regarding the approval of the new proposals that each one of the centres has submitted to the EC under a Call for Proposals launched in 2003. All four proposals have been in principle pre-selected by the Selection Committee for further funding, but the signing of a new contract has been made conditional on the results of this evaluation.

- EuropeAid/B5-813/2001/2085: "Medico-Psychological rehabilitation of Men, Women and Children who are Victims of Human Rights Violations and Torture, implemented by EXIL, Brussels, Belgium. Start date: 01/01/2002. Expiry date: 31/12/2004.
- The project aims to provide support to refugees victims of torture and their family members through the provision of medical and psychological treatment and social support. The activities of the project are addressed to four main target groups: women, children and their families, adolescents and men.

  The new proposal refers to the continuation of the ongoing project for 2005-2007.

- EuropeAid/B5-813/2001/2067: "Rehabilitation for survivors of torture", implemented by the Medical Foundation for the care of victims of torture, London, UK. Start date: 01/01/2002. Expiry date: 31/12/2004.
  The project aims provide holistic support in order to rehabilitate refugees and asylum seekers who are survivors of torture. Other objectives are:
  - Lobbying campaign at national and international level.

The new proposal aims to provide specialist training and support to voluntary organisations and health providers who work with torture survivors in the UK.

- EuropeAid/B5-813/2001/2104: "Comprehensive care for torture victims in Greece", implemented by the Medical Rehabilitation Centre for Torture victims, Athens and Thessaloniki, Greece. Start date: 01/11/2001 Expiry date: 31/10/2004.
  The project aims provide support to refugees who are victims of torture and their family members through the provision of medical and psychological treatment and social support. Other objectives are:
  - Training for health and law professionals, police and staff dealing with asylum cases.
  - Public awareness activities.
  - Supporting the members of the Balkan network.

  The new proposal refers to the continuation of the project for another three years but with activities only based in Athens.

- EuropeAid/B5-813/2001/2069: "Medical care and assistance to victims of torture and political repression", implemented by Primo Levi, Paris, France. Start date: 01/07/02. Expiry date: 30/06/05.
  The project aims to provide support to refugees who are victims of torture and their family members through the provision of medical and psychological treatment and social support. Other objectives are:
  - Training for professionals working with asylum cases.
  - Public awareness activities.
  - Lobbying of public authorities

  The new proposal refers to the continuation of the ongoing activities of the centre from July 2005 until 2007. For the first year of the project (2004-05) the proposal concentrates more on training, lobbying and research activities.

The evaluation will also provide elements for the assessment of the effectiveness and impact of the programmes implemented by the four rehabilitation centres in relation to the argument that the work of torture rehabilitation centres contributes towards the prevention of torture

2. Background

The EC Communication on the EU's role in promoting human rights and democracy in third countries has four priorities for the use of EIDHR, one of which is support for the fight against torture.

For several years, the European Commission has funded centres for the rehabilitation of victims of torture in many countries. The number of such centres has grown considerably in recent years. Those outside the EU are funded from budget line B7-701 and those inside the EU from budget line B5-813. This latter budget line is likely to return to the Directorate of Justice and Home Affairs (JHA) in 2005, to be managed with the European Refugee Fund.

The Communication states that *"in seeking to be an agent of change, the EU should ensure that it focuses as much as possible on prevention, including through human rights education of the police and other possible agents of torture"*.

In response to this, the Commission has begun a gradual shift in the focus of its financing away from rehabilitation of victims towards torture prevention. However, the torture rehabilitation centres have argued that their work contributes towards the prevention of torture. The Commission wishes to evaluate the strength of this argument by examining the work of two four torture rehabilitation centres that the Commission has funded for some time.

This evaluation will concern four Europe-based organisations that are currently being funded under the EIDHR for torture rehabilitation projects and that have submitted proposals under the 2003 Call for Proposals for torture rehabilitation centres.
These proposals were preliminarily retained by the Selection Committee and it was decided that their final approval would be conditional on the results of an evaluation of the current activities. The reason for this is to ensure continuity of funding – the preparation and signature of the new contracts should be done before the ongoing contracts expire, which excludes relying on the assessment of the organisation's final reports for the preparation of the new contracts.

The results of this evaluation (in terms of impact, relevance and design, effectiveness, efficiency and sustainability of the projects) will be the elements taken in consideration for the final decision regarding the acceptance of the new proposals. The findings and recommendations issued will be considered if/when preparing the new contracts.

The Commission also wishes to take advantage of this evaluation to obtain complementary information to the Evaluation launched in October 2003 with the objective to asses the statement made by torture rehabilitation centres that their work contributes towards the prevention of torture [1].

3. Issues to be studied

Impact

Assess the extent to which the benefits received by the target groups are having a wider overall effect on a larger number of people. The evaluators are expected to review the following:

- What unforeseen positive or negative effects of the project are evident?
- What are the multiplier effects arising from the project?

Relevance and Design

Verify the relevance of the project's activities to meet the needs of the target groups and beneficiaries and assess the design of the ongoing contract and the new proposal submitted by each one of the four organisations. In particular the evaluators should focus on:

- The extent to which the beneficiaries of the project are victims of torture?
- Have the needs of the patients been properly identified?
- The level and quality of patients' participation in the formulation of the programme
- The quality and comprehensiveness of assumptions made and risks identified during the design stage
- The degree of flexibility of the design of the programme to respond to changes in the programme's implementation environment

Effectiveness

- Assess the degree to which the project purpose has so far been achieved – what difference has the project made in practice as a result of the activities? Particular attention should be given to the fact that processes are both an end and a means to an end. Evaluators are expected to focus on:
- The extent to which the therapies/services provided by the centres meet the needs of the target groups? The evaluators may suggest improvements in the therapies applied that the centres should incorporate in future programmes to be more effective.
- The extent to which the organisation has developed evaluation tools and indicators to measure and assess the impact of its work?

1 MEDE 2003 Evaluation report on Torture rehabilitation centres.

- The extent to which the external environment (political, economic, security) affects the achievement of the programme purpose.
- Are the expectations of the patients being fulfilled?
- Are there any unplanned benefits arising from the project?
- The extent to which flexibility (if necessary) is applied in the implementation of activities

Efficiency

Assess the extent to which programme resources are being utilised efficiently, in particular:

- The quality of programme management, reporting, financial management, personnel management, procurement, monitoring and evaluation systems
- The degree to which actual activities and strategies adopted are consistent with the financing agreement in terms of both the content and timeliness
- The adequacy of resources (financial, human and capital) provided for the programme, with particular regard to division of responsibilities for the management of the contract and the medical and psychological activities with the patients.
- The extent to which project expenditures are justified by the benefits, with particular regard to the average cost of treatment per patient.

Sustainability

In this regard, factors that contribute to the sustainability of the benefits derived from the programme should be reviewed. In particular, the evaluators should focus on:

- What kind of consequences would the withdrawal of EC support for the sustainability of the Centre have? What would the Centre do in such an event?
- To what extent is EC funding necessary for the implementation of the new proposal?
- To what extent is treatment for torture victims not covered by the national health-care system?
- To what extent is there a strategy for securing sources of financial support for continuing project interventions?

Visibility

Analysis of whether the recipients/partners/beneficiaries involved in the programme are aware of the support provided by the European Commission.

Impact of rehabilitation on prevention

The consultants are requested to address the following question:

How effectively does the work of EU-located centres for the rehabilitation of torture victims contribute to the prevention of torture (a) in the countries from which these victims originate (b) in the countries in which they are treated and (c) at the international level? This will be particularly relevant as regards the treatment of refugees and minorities.

Inter alia, attention should be paid to the following aspects:

- Which policies and strategies the Centres have formulated themselves about how to contribute to the prevention of torture: objectives, outputs, activities
- The extent of any verifiable indicators used by the Centres to measure the impact of their work, both as regards the rehabilitation of victims and the prevention of torture
- Whether or not prevention activities detract from the medico-psychological work of the centres
- Whether or not prevention work has any beneficial/detrimental effects on the victims themselves
- The opinions of other local human rights NGOs which work exclusively on prevention, if these exist
- The extent to which alternative sources of funding are available in the country for either rehabilitation or prevention activities.

(describing the activities is included in the first indent; the assessment of the consultants as to whether the activities which are defined by the Centres as having an impact on prevention can actually work as such should be separate, see next few lines)

The consultants should make an assessment of the effectiveness of the strategies of the Centres that are meant to have an impact on prevention of torture. Also, the consultants should formulate recommendations regarding the criteria to be used in judging whether rehabilitation activities play roles in prevention of torture

4. Methodology

The main reference documents will be the project proposals/ contracts (including the logical frameworks and detailed budgets) and the activity reports (see attachment for the list of documents). The EuropeAid Project Manager of this programme will be available to discuss and provide further documentation on the projects before the mission takes place.

As regards the question of the impact of rehabilitation on prevention the main reference documents will be the EHRF 2002 monitoring report and MEDE 2003 evaluation report. The MEDE 2003 report also serves as a format for the report of this evaluation.

The evaluation techniques and research methods will be:

- study of documents/ materials related to the torture rehabilitation projects
- discussion with the relevant EC project manager before the mission takes place
- interviews with staff and current and former participants in the project's activities
- interviews with representatives from local and international organisations and experts in this area including civil society stakeholders and advocacy groups

A proposal for a programme of interviews will be made by the evaluation expert before the mission takes place, discussed with the representatives of the organisations, who can give suggestions and input, and then discussed and agreed with the EC task manager.

The mission will present and discuss its major findings and recommendations to the director/ staff of each of the Centres at the end of each mission.

5. Expertise

The evaluation will require two or three international experts with the following profile:

- Two experts should be English and French speaking.
- One international expert (team leader) with experience of evaluation of rehabilitation centres for torture victims and with a background in social science; consultancy and practical project experience necessary.
- One or two international experts with experience of cooperation with rehabilitation centres with a medical background.

6. Work plan and time schedule

a) Work plan

Activity	Number of days Coordination (TL)	Number of days Centres[a]
• Inception reading of documentary material • Preparing available documentation from EU-funded centres	3 wd	
• Preparation of country visits		4 x 1 wd x 2 p
• Mission to the respective centres in France, UK, Belgium and Greece.		4 x 3 wd x 2 p
• Interim Report per Centre		4 x 2 wd x 2 p
• Overall evaluation report (draft)	1 wd	2 wd x 3 p
• De-briefing in Brussels	1 wd	1 wd x 1 p
• Final report Final Draft of report	2 wd	
Total	7 wd	55 wd
Overall total:	**62 working days**	

a. Each Centre will be assessed and visited by two experts.

b) Time schedule

Deadline for draft: 15 October 2004

Deadline for final report:29 October 2004

c) Communication

Reports (draft and final) to be submitted by MEDE European Consultancy to:

- Tim Clarke, Head of Unit EuropeAid F3, Timothy.Clarke@cec.eu.int
- Mario Rui Queiro, EuropeAid F3, Mario-Rui.Queiro@cec.eu.int
- Sonia Herrero, EuropeAid F3, sonia.herrero@cec.eu.int

Annex 2: Final report PRIMO LEVI

Evaluations EIDHR

PRIMO LEVI

Torture rehabiliation centres Europe

human european consultancy in partnership with the Netherlands Humanist Committee on Human Rights and the Danish Institute for Human Rights

Januari 2005 By Sara Guillet and Inger Agger

human european consultancy

This report is the outcome of an evaluation commissioned by the European Commission on projects financed in the field of the European Initiative for Democracy and Human Rights (EIDHR). The EIDHR is a European Union programme that aims to promote and support human rights and democracy in third countries. Information on activities and actions can be found on the EIDHR website: http://www.europa.eu.int/comm/europeaid/projects/eidhr/index_en.htm

human european consultancy
Hooghiemstraplein 155
3514 AZ Utrecht
The Netherlands
Tel +31 30 634 14 22
Fax +31 30 635 21 39
office@humanconsultancy.com
www.humanconsultancy.com

Abbreviations

AI	Amnesty International
AVRE	Association pour les Victimes de la Répression en Exil (*Association for the Victims of Repression in Exile*)
CADA	Centre d'accueil pour les demandeurs d'asile (*Governmental residence for asylum seekers)*
CFDA	Coordination française pour le droit d'asile (French Coordination on Asylum)
CNCDH	Commission nationale consultative des droits de l'Homme (*French National Con sultative Commission on Human Rights)*
COMEDE	Comité médical pour les exilés (*Medical Committee for Exiled Persons*)
CRR	Commission de Recours des Réfugiés (*Refugees Appeal Board*)
EC	European Commission
EIDHR	European Initiative for Democracy and Human Rights
FASILD	Fonds d'aide et de soutien pour l'intégration et la lutte contre les discriminations (*Fund to Help and Support Integration and the Fight Against Discrimination*)
NGO	Non-governmental organisation
OFPRA	Office français de protection des réfugiés et des apatrides (*French Office for the Protection of Refugees and Stateless Persons*)
UNHCR	United Nations High Commissioner for Refugees
UNVFVT	United Nations Voluntary Fund for Victims of Torture

Executive summary

One of the objectives of this evaluation is to assess the ongoing project at the Primo Levi Association and to provide guidance and make recommendations for a decision from the European Commission (EC) regarding the approval of the new proposal that Primo Levi has submitted to the EC. In addition, this evaluation should also provide general elements for an overall assessment – including three other European rehabilitation centres – of the effectiveness and impact of the programme in relation to the argument that the work of torture rehabilitation centres contributes towards the prevention of torture. With these objectives, a team of two consultants visited Primo Levi in Paris from 10 to 12 June 2004, interviewed staff and beneficiaries and collected data about the work of the centre.

Primo Levi is a small rehabilitation centre the main aim of which is to provide medical, psychological and social support to victims of torture and their families. Aims directed at prevention are to train professionals, to carry out public awareness activities and to lobby government institutions.

The wider *impact* of Primo Levi's work is related to an increased awareness among government authorities and the public about the human rights violations, which many asylum seekers and refugees have suffered in their homelands, as well as their difficult living conditions in France. Although the lack of a monitoring and evaluation system hinders a systematic assessment of the *effectiveness* of Primo Levi's rehabilitation programme, there is a problem from a quantitative perspective with the often very extended treatment processes, resulting in a six-month waiting list. However, from a qualitative perspective, the psychotherapeutic treatment of individual patients seems to be effective, although legal and social support elements of the treatment need to be increased. The centre is *efficiently* managed with a well-qualified and experienced staff.

The programme is *relevant* in the French context, meeting important needs of the beneficiaries. However, the clinical, psychoanalytical approach of the staff limits the flexibility of the centre to respond to the changing environment in France, with deteriorating circumstances for asylum seekers and refugees resulting in increased need for social and legal assistance. There has been no participation of patients in the *design* of the programme, which is almost exclusively based on an individual approach – although the beneficiaries interviewed by the consultants expressed the need for more group-oriented activities. The project has limited sustainability without EC support.

Although the centre appears to be in a key position to contribute to *preventive activities* (since it is itself an association of human rights NGOs involved in torture prevention), most strategy-building efforts have been focused on rehabilitation. However, without detracting from its rehabilitation work, the Primo Levi Centre could enhance its impact on prevention by developing a clear strategy for the preventive work.

Recommendations

- A systematic monitoring and evaluation system needs to be developed, which includes collection of data at the beginning and end of treatment. Monitoring of length of treatment, drop-outs and reasons for ending treatment also needs to be initiated.
- The centre needs to be more flexible in its approach to the change in the French environment for asylum seekers and refugees which means that the social problems of torture victims have increased. The centre might consider having more social service and less psychotherapeutic staff.
- The consultants recommend that the centre expand its preventive activities by providing training in the UN Convention Against Torture to institutions involved in asylum issues, provided such a project does not detract from the rehabilitation work.
- As a preventive activity, the centre could make the information collected from the patients in the course of its rehabilitation work more accessible by posting testimonies of victims of torture on its website, as a documentary source.
- The centre needs to increase efforts towards the promotion of its preventive and rehabilitative work, in particular through media coverage.

1.Introduction and methodology

1.1 Objectives

This evaluation of the Primo Levi Association is part of an evaluation of four different torture rehabilitation programmes currently financed by the EC in France, Belgium, the UK and Greece. The objective of the evaluation was to assess the relevance, efficiency, effectiveness, impact and sustainability of the ongoing project at the Primo Levi Association. The evaluation should also, however, provide guidance and make recommendations for a decision from the EC regarding the approval of the new proposal that Primo Levi has submitted to the EC under a Call for Proposals launched in 2003. The proposal had in principle been pre-selected by the Selection Committee for further funding, but the signing of a new contract was made conditional on the results of this evaluation. The evaluation should also provide elements for the assessment of the effectiveness and impact of the programme implemented by Primo Levi in relation to the argument that the work of torture rehabilitation centres contributes towards the prevention of torture.

1.2 Background

The EC Communication on the EU's role in promoting human rights and democracy in third countries has four priorities for the use of the European Initiative for Democracy and Human Rights (EIDHR), one of which is support for the fight against torture. The Communication states that, *"in seeking to be an agent of change, the EU should ensure that it focuses as much as possible on prevention, including through human rights education of the police and other possible agents of torture"*. In response to this, the EC has begun a gradual shift in the focus of its financing away from rehabilitation of victims towards torture prevention. However, the torture rehabilitation centres have argued that their work contributes towards the prevention of torture. The EC wished to evaluate the strength of this argument by examining the work of four European torture rehabilitation centres that it has funded.

1.3 Methodology

The evaluation was carried out through the study of documents and a three-day visit to the Primo Levi Association, which included collection of qualitative data through interviews with staff and beneficiaries and quantitative data by accessing the centre's database. The team also interviewed a representative of Amnesty International (AI) in Paris. Before leaving Primo Levi, the team shared and discussed its preliminary findings and recommendations with the staff during a debriefing session.

The team comprised two experts, Ms Sara Guillet (Team Leader), specialist in international human rights law, and Dr Inger Agger, specialist in torture rehabilitation. The staff of Primo Levi received the team with great openness and readiness to share their viewpoints and working methods.

The staff of the centre did receive the draft report for comments, which have been added to the final report as annex 4.

1.4 Constraints

The limited time frame did not allow the team to visit other centres assisting torture victims and there was only time to visit one human rights organisation (Amnesty International) concerned with the situation of asylum seekers and refugees in France. AI is also a partner of the Primo Levi Association. The team was, therefore, not able to obtain opinions from several other actors about Primo Levi. Although it had the opportunity to interview beneficiaries (selected by Primo Levi), the team was not allowed to observe treatment sessions or educational activities.

2. PRIMO LEVI Association – Care and Support for Victims of Torture and Political Violence

2.1 Introduction

The beneficiaries of the Primo Levi Association care centre are foreigners who have fled their country, where they had suffered torture and political violence, and who have applied for refugee status in France to the French Office for the Protection of Refugees and Stateless Persons (*Office français de protection des réfugiés et des apatrides*, OFPRA). Asylum seekers who are not recognised as refugees by OFPRA may appeal to the Refugees Appeal Board (*Commission de Recours des Réfugiés,* CRR). The total admission rate in France was 14.8% in 2003 (16.9% in 2002). In 2003, OFPRA registered 52,204 new asylum applications.

Although there has been an increase in state social support and in the resources allocated to the OFPRA and the CRR in order to reduce the length of the procedure, asylum seekers live in increasingly precarious conditions. They are not allowed to work and they are entitled only to a monthly 'integration allowance' of 280 Euro for one year, although the average application procedure takes more than a year. Only 10% to 15% asylum seekers are provided with state housing and the majority have to pay for private housing or find accommodation with compatriots.

It is expected that the new legislation (December 2003), while reducing the length of the application process, will put additional legal and social constraints on applicants, hence placing them in critical conditions for the lodging of their asylum application.

2.2 Overview of the rehabilitation centre

The Primo Levi Association, which was founded in 1995, is an association of five organisations: Christian Action for the Abolition of Torture, Amnesty International, Lawyers without Borders, Doctors of the World and Trêve. Some of the key staff of Primo Levi had previously worked at the Association for the Victims of Repression in Exile (*Association pour les Victimes de la Répression en Exil*, AVRE), another Paris-based torture rehabilitation centre.

It is a small rehabilitation centre with a part-time clinical staff equalling only two and a half full-time psychotherapists, one social worker, almost one (85%) medical doctor and one third (30%) of a physiotherapist position. Other staff include an administrative director (80%), a secretary (100%) and an editor. In addition, a dozen volunteers contribute to the centre's work.

From 1 July 2002, Primo Levi began receiving EC funding for the programme "Medical care and assistance to victims of torture and political repression" (EuropeAid/B5-813/2001/2069).

The EC funding of 500,000 Euro represents 31% of the budget, which will expire on 30 June 2005.

The project aims to provide support to refugees who are victims of torture and their family members through the provision of medical and psychological treatment and social support. Other objectives are: training for professionals working with asylum cases, public awareness activities and lobbying of public authorities.

The new proposal refers to the continuation of the ongoing activities of the centre from July 2005 until 2007. Its first year therefore overlaps with the previous programme. However, for the first year of the project (2004-05), the proposal consists of new activities concentrating more on training, lobbying and research activities. The EC funding applied for is for 500,000 Euro and represents 40% of the total funding of Primo Levi. As for the previous programme, it covers all the activities of the centre.

Beneficiaries

When Primo Levi started, 80% of the patients were referred for treatment by the centre's partner organisations or other organisations receiving asylum seekers. Now, 60% come spontaneously – 'by word of mouth' – and the remaining 40% are referred by other organisations. There is a six-month waiting list.

In 2003, Primo Levi had a total of 340 patients[1]: 160 *new* and 180 follow-up patients. This should be compared to the reality of 52,204 asylum seekers in France[2], approximately half of them living in or around Paris. The fact that such a small percentage of asylum seekers go to Primo Levi may be explained by the existence of other centres offering similar services in Paris and other cities.

Of the 160 *new* patients 63% described themselves as torture victims, 6% as victims of detention only, 29% as family members of torture victims, while 3% had not given any information about torture at intake[3]. 45% of the patients were male adults, 24% female adults, 17% unaccompanied minors and 17% were children. In total 55% of the new patients in 2003 were women and children (including teenagers).

The great majority (69%) of the new patients in 2003 were from Sub-Saharan Africa. 13% were from South Eastern Europe, 9% from the former Soviet Union, 4% from Northern Africa, 3% from Asia and 1% from the Middle East. Many of the patients came from fairly good social and economic conditions in their countries of origin and have suffered a radical decline of status in Paris.

1 See Annex 3 for more statistical information.

2 52,204 new asylum applications were filed at the French Office for the Protection of Refugees and Stateless Persons (OFPRA) in 2003.

3 The information about torture background is based on a questionnaire that patients fill in when they apply for admission to the centre. This information is transferred to a database. The database is not updated when further information is obtained about the patients during psychotherapy or medical treatment.

During the first half of 2003, 14% of the patients *dropped out* of treatment: they missed an appointment and did not return for a minimum of six months. Primo Levi attributes this to a variety of reasons such as lack of motivation for psychotherapy, need for only a few medical consultations or departure from Paris.

The new proposal includes group therapy for about 80 mothers (in three groups of eight mothers per year) and awareness-raising, preventive activities about human rights for 60-75 adolescents (in one group of 20-25 adolescents per year). Other preventive activities proposed are exchange of scientific information with national and international professionals and information campaigns directed at government institutions, the general public and academics in general.

Other beneficiaries of the programme are the people targeted by the training and awareness-raising activities of the Primo Levi Association. They include professionals from the mainstream health care sector, teachers and secondary school students.

Methodology

In 2003, 64% of the total number of patients received medical treatment, 61% psychotherapy, 36% legal and social support, 7% physiotherapy and 5% dental care (each patient usually receives various types of assistance).

The therapists working at Primo Levi all have a psychoanalytic orientation, although they do not describe their therapy for torture victims as 'psychoanalysis'. Psychotherapy consists primarily of individual therapy, but Primo Levi has also run a few group therapies (a group of adolescents from Kosovo and a pilot group of mothers with a very low rate of attendance). The centre also treats families, but mostly separately (one therapist for each family member). For children, the therapists use play therapy. The average session lasts 45 minutes and 30 minutes for adolescents. The centre does not have any overview of the average number of sessions needed by a patient, but explains that treatment may last from six to 18 months, some treatment processes last for many years.

Either a doctor or a psychologist refers patients for physiotherapy. Two thirds of the referrals are women and the physiotherapist thinks that this is due to resistance among many male patients – often with a 'militant identity' – to being touched by a (female) physiotherapist. The female patients have often suffered sexual torture. The physiotherapist uses the Feldenkrais method and one treatment can take from one week to one year. 14% of the patients drop out of treatment and the centre has no information about why this happens.

Legal and social assistance is provided for patients after they have seen a doctor or a psychologist, if it appears that their social problems are detrimental to the treatment, which is often the case for asylum seekers (nearly 80% of the patients who were admitted in 2003). The social worker must often address the enormous social problems of asylum seekers, such as lack of housing, food and schools for their children. She tries to solve these problems by informing patients of their rights and the procedures they have to follow and by pressurising local authorities. The social worker, assisted by two voluntary legal advisors, also offers legal support for asylum applications.

During the last two years the centre has run courses once a week for 41 professionals from the education sector in four schools which have a large numbers of children from war-torn countries about how to understand and integrate children affected by war into normal school activities.

2.3 Impact

The impact of the project on beneficiaries is hampered by a six-month waiting list.

At policy level, according to centre staff, the wider overall effect of the benefits received by the patients at the centre as well as the professionals trained by centre is mostly related to an increased awareness among government authorities and the wider public about the human rights violations that many asylum seekers and refugees have suffered and their difficult living conditions in France. It is, of course, difficult to document 'increased awareness', but the consultants find it plausible. In its documentation for asylum cases and the constant pressure of the social worker to improve the living conditions of asylum seekers, the centre is confronting the authorities almost daily with the situation of torture victims living in France.

The awareness raised about the plight of torture victims by the centre among the authorities seems to have had the unforeseen *positive* effect that authorities pay real attention to the documentation from the centre in asylum cases and welfare cases. An unforeseen *negative* effect related to the same issue would seem to be the possibility that some asylum seekers mainly request help from the centre in order to obtain social and legal assistance, although the main mandate of the centre is to provide health (including mental health) care.

The creation since 2002 of the Toulouse Consultation, the Grenoble Rehabilitation Centre and the Nantes Network are *multiplier effects* of the project, inspired by the Primo Levi Association and with direct involvement from Primo Levi staff in training and networking activities.

2.4 Relevance and design

In general, the national health care system does not specifically cover treatment for torture victims. A lot of torture victims are treated by the mainstream clinical sector. Quantitatively, the Primo Levi Association plays a limited role in Paris (where about half of the asylum seekers live), as there are other institutions offering rehabilitation services to torture victims in the city, such as the Medical Committee for Exiled Persons (*Comité médical pour les exilés*, COMEDE), AVRE and Parcours. Many patients are referred to the centre by social services, governmental housing services for asylum seekers (*Centre d'accueil pour les demandeurs d'asile*, CADA) or by the mainstream health care system. Outside Paris, a few specialist structures have been set up in hospitals in Toulouse, Marseilles and Grenoble, based on Primo Levi's experience.

The centre meets important needs of the beneficiaries, of whom 63% in 2003, and 73% in the first months of 2004 described themselves as victims of torture at intake. These needs are evaluated during the first meeting at the centre to which patients are invited after having filled in a request for treatment in which they are asked to explain their past experiences of repression and their current problems. Different sheets are provided, according to the patient's age or situation (child, adolescent or adult). The type of treatment is decided after the first meeting. The staff often find that the patients are not able to define their expectations precisely.

The centre has no systematic monitoring and evaluation system, although it has developed a good database, providing information on the types of patient groups, their countries of origin and the types of treatment provided. The data were computerised in the course of 2002. This database should be an important evaluation tool when indicators have been set up. The team has not so far felt the need to set up a systematic monitoring and evaluation system. It is argued that the weekly team meeting, bringing together doctors, psychotherapists, the physiotherapist and the social worker, has been the most adequate way of exchanging information and analysing each patient's situation and treatment. However, the team understands the necessity for developing its monitoring and evaluation system in order to become accountable and has made a commitment to identify best practices and set up indicators to monitor and measure the impact of the centre's work.

The lack of a systematic monitoring and evaluation system makes it difficult to verify the extent to which patients are really victims of torture on the basis of quantitative data. However, the clinical staff estimate that the percentage of torture victims is even higher than found at intake, based on the information which emerges during treatment.

In addition, without systematic monitoring and evaluation the centre is not able to perform a critical analysis of the relevance of the treatment provided. The 34 (14%) patients who dropped out of treatment in 2003 may represent a group of patients whose needs have not been met.

There is no participation whatsoever of patients in the formulation of the programme. The consultants asked both patients and staff about this issue and neither patients nor staff had even considered this a possibility.

The assumptions made and risks identified in the logframe during the design stage of the ongoing project and the new proposal are not very comprehensive or of high quality. This seems to be related to the rather rigid clinical approach of the centre, which places high emphasis on the psychotherapy process and gives less importance to reflections on a meta-level about methodology and social and political factors.

The above-mentioned clinical, psychoanalytical approach also has an impact on the flexibility of the centre to respond to changes in its implementation environment. Currently, as the social conditions of asylum seekers and refugees are deteriorating, the centre has difficulty in adapting to these changes. This could be done, for example, by placing more emphasis on social assistance to the patients and less on psychotherapy, developing occupational therapy, self-help groups and any other activities to help patients to reconstruct a social network in the hosting country.

2.5 Effectiveness

The project has four main objectives: to increase by 40% within three years the centre's capacity in terms of patients treated; to set up a training centre for professionals in the health and social sector and to promote the creation of other centres in France and support centres abroad; to organise awareness-raising activities; and to lobby the French authorities on human rights and asylum issues. In 2004, not all of these objectives had been met.

40% increase in number of patients treated

It was not possible to achieve the quantitative objective of a 40% increase in patients. There has been an increase in the number of patients treated (+15%) and in the number of consultations given (+6%) since the beginning of the project in 2002. But the length of treatment and the amount of consultations per patient have also increased, in a way which had not been foreseen by the centre. The average number of consultations per patient is estimated by the centre to be 10.

This figure covers a very diverse reality, with many treatment processes – including medical, psychotherapy and social assistance – lasting from one to two years, some five years and one even 15 years. One reason for the lengthy treatment processes might be the increasingly difficult situation faced by the patients (difficult asylum procedures, social precariousness of applicants).

Furthermore, non-EC contributions to the budget were not sufficient to recruit additional staff as planned under the contract. As a consequence, 340 patients are now receiving treatment at the centre, as opposed to the 500 expected under the project. It is unlikely that this will change before the end of the project, in July 2005.

In fact, in the ongoing project, with a part-time staff corresponding to only two full-time psychotherapists, one social worker and almost one doctor, the centre's staff is too limited to cope with all the requests for treatment, which have increased by 20% within one year. This results in adult patients having to wait six months before their first consultation. Adolescents, who had been spared the waiting list until recently, now have to wait three months. This is one of the centre's main concerns, as some patients require urgent treatment. Under the new proposal, group therapy will be offered as an option to some patients and this is expected, to some extent, to solve the waiting list problem. However, the pilot group of mothers had a very low attendance, which raises questions about the centre's expertise in organising group therapies.

From a qualitative perspective, the four patients met insisted that the treatment received at the centre was effective. Two of them had been referred to Primo Levi after being treated in the mainstream health care sector in a way they found less appropriate to their needs. All of them had also been in contact with the social worker. However, it seemed that their social needs, including the need to rebuild social ties, were very important. In addition to the social activities offered by the social worker outside the centre (holidays for children, cinema tickets etc.), self-help groups or activities workshops at the centre could be a complementary way of solving this problem. Faced with the increasingly precarious living conditions of the patients, particularly since the adoption of the new law on asylum in 2003, the centre is currently working on adapting its methods of work to match this development. At the time of this evaluation it has not yet drawn up a new strategy in this respect.

Training for professionals from the health, social and education sectors and support of other centres

The centre has organised several training sessions (an average of one per month) for professionals from the mainstream health care and social sector.

Through its project on children, it has also held a series of workshops in schools, involving schoolteachers working with children who are victims of torture. Occasionally, the centre has trained interns from other rehabilitation centres or human rights associations in non-EU countries (Morocco and Rwanda, for example).

With the 'Turkey Committee', which brings together several NGOs based in France, Primo Levi supports activists from the Turkish Human Rights Foundation, an NGO managing several rehabilitation and treatment centres in Turkey and whose staff members are subject to arbitrary arrest and unfair trials. Trial observation missions have been organised and joint press releases have been published with NGOs from the 'Turkey Committee'. According to the centre, such activities have contributed to protecting members of the Turkish Foundation from torture and arbitrary detention.

Awareness-raising activities in France

Awareness-raising activities include the organisation of a conference on the International Day in Support of Victims of Torture (26 June), a workshop on human rights for secondary school students (pilot project in 2003) and the publication of a quarterly bulletin (4,000 copies). The added value of these activities on torture prevention seems weak, particularly as the activities of the centre receive little media coverage. The centre is not adequately staffed to be able to promote its activities in the media, nor does it consider it as a priority.

Lobbying the French authorities

The centre takes an active part in the French Coordination on Asylum (*Coordination française pour le droit d'asile*, CFDA), a collective of NGOs (with the United Nations High Commissioner for Refugees (UNHCR) as an observer) which acts as a watchdog for asylum procedures in France and publishes joint positions on this subject. It also follows the work of the French National Consultative Commission on Human Rights (*Commission nationale consultative des droits de l'Homme*, CNCDH), but with limited input. Although the results of these activities are difficult to measure, the high level of commitment from the Primo Levi association within these networks places it in a good position to exert some influence on the French authorities. These lobbying activities are covered by the current contract until July 2005 and are therefore included in the new proposal for the second and third year only.

The consultants are concerned that all the centre's activities aimed at contributing to the prevention of torture may detract from its primary health care mandate, particularly given the six-month waiting list (see 2.9.1).

2.6 Efficiency

The contract is well managed by the Administrative and Financial Manager of the centre. The medical and psychological activities with the beneficiaries are the responsibility of the Director of the centre. Both of them share staff management activities with the President. The staff is qualified and all staff members have had previous experience before being recruited to Primo Levi. They have received internal training after appointment.

The two doctors, the five psychotherapists and the physiotherapist work part-time. Within half a day at the centre, one psychotherapist sees five to six people, a doctor sees a maximum of 10 patients, the social worker sees six people, the physiotherapist sees six patients, the person in charge of the first meeting sees three people and one lawyer sees three people. An external supervisor comes once a month for the psychological supervision of the staff. This supervision takes place during one of the team's weekly clinical meetings.

The team is committed and experienced and the working atmosphere appears to be productive and positive. The centre achieves more than is financially covered, as ten volunteers contribute to the work at various levels (e.g. the dentist give free consultations at her surgery, the accountant comes two days a week and two lawyers come half a day each for legal support for asylum seekers).

All staff members have access to continuing professional training. In 2004, for example, the social worker received training on the new asylum legislation, the director of the centre attended a workshop on management, a psychotherapist was trained in children's therapy and the assistant director received training in interviewing techniques. This, added to the fact that all clinical staff work part-time at the centre and are also involved in prevention activities, contributes to avoiding 'burnout' among the professional staff.

The average cost of a consultation amounts to 100 Euro. 20% of the cost of the doctor's and the physiotherapist's consultations is reimbursed by social security.

Financial resources provided for the programme seem adequate and, in general, activities and strategies adopted are consistent with the financing agreement. The level of non-EU contributions was not sufficient to recruit a third doctor as had been foreseen under the contract with the EC.

In 2003, 27% of the patients treated at the centre needed the assistance of an interpreter. All interpreters are professionals recruited by a specialised organisation (*Inter Service Migrants*), which has provided them with specific training. They receive additional information about Primo Levi's mandate and the patients' profile when they start working there. Their involvement appears to be managed in a cost-effective manner (consultations grouped according to language) and so as to facilitate patient confidence (as far as possible patients have the same interpreter for each consultation).

2.7 Sustainability

EC support represents 37% of the centre's budget. Other funders are: French ministries and agencies (37% – of which 10% comes from the Prime Minister, 6% from the Fund to Help and Support Integration and the Fight Against Discrimination (*Fonds d'aide et de soutien pour l'intégration et la lutte contre les discriminations*, FASILD), 7% from the Population and Migration Directorate, 3% from the Health Ministry and 5% from the region *Ile de France*), the UN Voluntary Fund for Victims of Torture (UNVFVT) (12%), the European Fund for Refugees (13%) and various NGOs (7%). The project has no sustainability without EC funding.

Most efforts aim to maintain funds at the current level, as it seems unlikely, in the French context, that the French contribution will be increased. The same estimates can be made regarding UNVFVT, since states' contributions to this fund are not increasing. Together with the European Network of Centres for the Care and Rehabilitation of Torture Victims, Primo Levi has called upon states to increase their voluntary contributions to UNVFVT. In 2003, as the centre's situation had reached a critical point, efforts were made to attract funds from individual donors. The centre describes this as an exceptional measure and it seems the prospects remain uncertain for increasing income from private funds.

EC funding is therefore necessary for the implementation of the new proposal.

2.8 Visibility

The EC logo is displayed at the entrance of the centre. Publications and the website refer to the EU financial support.

2.9 Impact of rehabilitation on prevention in a European context

Although the centre considers itself as a care centre, primarily devoted to the rehabilitation of torture victims, its mandate also includes the defence of human rights in the world, including activities relating to the prevention of torture. The centre, being itself an association of five organisations, four of which are human rights NGOs involved in torture prevention, is in a position to contribute to prevention activities.

However, it seems that most strategy-building efforts have been targeted at the health care mandate: the centre does not seem to have global strategies intended to have an impact on prevention of torture.

To date, the centre has not defined specific verifiable indicators to measure the impact of its work, both as regards the rehabilitation of victims and the prevention of torture. In practice, the impact is evaluated internally through staff meetings. Nevertheless, the centre has expressed its readiness to work in this direction. This work should be facilitated by the integration of the centre within various networks of stakeholders locally (mainstream professional sector), nationally (human rights NGOs) and internationally (European Network of Centres for the Care and Rehabilitation of Torture Victims).

In the European context, the centre contributes to the prevention of torture on the individual level, through legal support and medical assessments for asylum applications (non-refoulement) and on a broader scale through training for professionals from the health, social and education sectors, lobbying the French authorities and raising public awareness.

Detraction of prevention activities from the rehabilitation work

Developing prevention activities with the current human resources would detract from the medico-psychological work of the staff involved and have detrimental effects on the victims themselves. As there are no specialised staff in charge of prevention activities, the implementation of these activities may contribute to the six-month waiting list. On the other hand, the centre argues that the contribution of health care staff to prevention activities may help to prevent them from burnout. Under the new proposal, an increase in 10% of the staff working time is anticipated.

In this respect, the human rights workshop for students proposed under the new project may have a detrimental effect.

Even though it will target a large number of students, (one group per year involving two schools, in total three groups involving six schools during the three-year period), it is difficult to identify the impact of this workshop on torture prevention and to understand why it is considered as a priority to involve the centre's staff in this activity. The centre could develop a strategy on prevention that would detract less from its rehabilitation work. For example, other target groups could be identified which would keep this type of activity closer to the centre's human rights mandate, in order to achieve prevention activities, such as institutions involved in asylum issues.

On the other hand, some ongoing activities which have a preventive dimension could simply be better highlighted, without entailing many additional resources not derived from the centre's primary rehabilitation mandate. This would increase the focus put on rehabilitation vis-à-vis prevention. For example, as a care centre, Primo Levi is in a key position to collect testimonies and clinical data from victims of torture and political violence. However, few activities involve the publication of testimonies, although the centre considers this as an important dimension of its mandate. These activities include the publication of the quarterly bulletin *Mémoires*, with articles referring to the repressive past of some patients. It also includes a yearly report with case studies to UNVFVT, but this is not made public. Such testimonies could contribute to the condemnation of torture and support prevention activities undertaken not only by the centre but also by other NGOs specifically involved in the prevention of torture. Without breaching the confidentiality and anonymity of the patients, the centre could consider ways and means to render these testimonies accessible to a wider public, for example by posting them on its website.

In general, the centre does not devote many efforts towards media coverage of its activities, whereas this could be a way to raise awareness among the public and contribute to prevention.

With regard to prevention on the individual level, medical assessments form an important tool to prevent asylum seekers from being exposed to torture again if they are returned to their country, as these assessments help them to convince the officers in charge of the risk assessment process during the asylum procedure. In this respect, rehabilitation constitutes a key dimension of the prevention activities conducted by the centre. There is nevertheless an ongoing reflection at the centre on the negative effects the issuing of medical certificates has on the rehabilitation work. In particular, the staff argue that it puts them under heavy pressure to allow social concerns to take priority in relation to the medical aim of the centre. In addition, the time required for rigorous medical assessment is not compatible with the urgency with which asylum seekers need the certificate. However, nearly 80% of the patients who came to the centre in 2003 are asylum seekers and expect this document to increase their chances of being granted refugee status.

In 2003, the centre issued medical certificates to 59 patients. The percentage of patients who were recognised as refugees and who had been issued with a medical certificate by the centre is not known.

Beneficial or detrimental effects of prevention activities on the victims

The centre is very concerned not to undertake any activities involving the victims which might have a detrimental effect on their treatment. In this respect, the staff were originally reluctant to organise interviews with beneficiaries of the centre for this evaluation. In general, it does not appear that prevention activities have a detrimental effect on the victims. On the contrary, some activities such as training of mainstream professionals or workshops with school teachers, have a direct and outreach benefit for the victims. Others, such as publications of case studies, may carry an important symbolic weight as the formal recognition of the victims' suffering, but this is not part of the centre's strategy.

3. Conclusion

The following main points were the conclusion of the consultants after the visit to the centre. The conclusions were discussed with the staff of the centre.

3.1 Impact

The four beneficiaries interviewed were very pleased about the help they had received and would have been in a very difficult position without the assistance of the centre. According to centre staff, in the wider overall perspective, the benefits received by the patients and the other target groups of the centre are related to an increased awareness among government authorities and the public about the human rights violations that many asylum seekers and refugees have suffered and their difficult living conditions in France. This 'increased awareness' is, of course, difficult to document, but seems plausible to the consultants.

The awareness raised about the plight of torture victims by the centre among the authorities seems to have had the unforeseen *positive* effect that authorities pay real attention to the documentation from the centre in asylum cases and welfare cases. An unforeseen *negative* effect related to the same issue would seem to be the possibility that some asylum seekers mainly request help from the centre in order to obtain social and legal assistance, although the main mandate of the centre is to provide health (including mental health) care.

The creation since 2002 of the Toulouse Consultation, the Grenoble Rehabilitation Centre and the Nantes Network are *multiplier effects* of the project, inspired by the Primo Levi Association and with direct involvement from Primo Levi staff in the training and networking activities of these projects.

3.2 Relevance and design of the ongoing contract and the new proposal

The Primo Levi Association has a unique position in France due to the very limited number of other organisations and structures offering assistance to torture victims in the country. This should be seen in the perspective of the high number of asylum seekers and refugees who have been submitted to torture and political in their countries of origin. In addition, in France there are also a considerable number of 'illegals' (without papers[1]) who are also treated at the centre. The fact that many patients are referred to the centre by social services and CADA also shows that the centre is an important actor in the French asylum and refugee care system.

1 This expression ('*sans papiers*') refers to foreigners who have not been granted refugee status and have no other legal grounds for living in France. They are likely to be returned to their country, but often escape identity checks and stay in France.

The new activities proposed in the new proposal represent less than 10% of the total activities. Although they fit into Primo Levi's mandate, one of them (awareness-raising among secondary school students) does not seem to derive from a real priority need in the French context nor to have been developed with a long-term strategy perspective. The other two activities – group therapy and research activities – do seem relevant.

The design of the new project could be improved by involving the beneficiaries in the planning of project activities – both current and future. This could also contribute to the further empowering of beneficiaries in addition to therapeutic process. Currently, there is no involvement of beneficiaries in this respect and neither the staff nor the beneficiaries interviewed during the evaluation had considered this possibility. In general, the team does not consider that it would be appropriate to introduce other therapeutic methods such as self-help groups or social group activities.

3.3 Effectiveness

The centre was unable treat as many patients as expected according to the project (340 rather than 500). Other objectives – training of professionals from the mainstream sector and supporting other centres; raising awareness in France; lobbying the French authorities – are met through the current project.

There are weekly clinical team meetings discussing the situation of the patients, but there is no systematic internal monitoring and evaluation system, for example there is no registration of why 10% of patients ended the therapy in 2003 and why 14% patients dropped out in 2003. The team does not feel the need for this type of analysis.

Although the average number of consultations per patient is estimated by the centre to be 10, this figure covers a very diverse reality where many treatment processes – including medical, psychotherapy and social assistance – last from one to two years, some five years and one even 15 years. This might contribute to the waiting list of six months. One reason for the lengthy treatment processes might be the increasingly difficult situation faced by the patients (asylum legislation, social precariousness of asylum seekers).

The centre, which considers itself primarily as a care centre, is nevertheless faced with a dilemma because of the increasingly difficult social environment in which the patients live and it seems to be inadequately staffed to cope with these enormous social needs. Moreover, this can be detrimental to the therapeutic work.

The team is committed and experienced and the working atmosphere appears to be productive and positive.

3.4 Efficiency

The management of the centre appears to be competent and effective.

A fine database has been established and is taken care of in a very skilled manner. This is a good basis for b

3.5 Sustainability

The project has no real sustainability without EC funding. Support from the French government and agencies remains uncertain and, if confirmed, will not be increased. Support from UNVFVT depends on states' contributions, which are decreasing.

3.6 Visibility

The EC logo is displayed at the entrance of the centre and publications refer to the EC funding.

3.7 Impact of rehabilitation on prevention in a European context

Although as a small rehabilitation centre, the Primo Levi Association is neither willing nor able to give primary focus to prevention, it contributes to the protection of human rights, including the prevention of torture, through several activities. This is achieved both for individual cases (legal support for asylum applications) and from a general perspective by lobbying the French authorities and raising awareness among the public. In addition, it has developed good and professional information material (quarterly bulletin, *Mémoires*, and yearly reports). The impact of the preventive role of the centre's activities is increased by its integration into NGO networks, both in France (CFDA) and in Europe (European Network of Centres for the Care and Rehabilitation of Torture Victims). However, among the awareness-raising activities carried out by the centre, some did not appear to have an impact on the prevention of torture (e.g. human rights education for secondary school students) or to be given adequate priority. Without detracting from its rehabilitation work, the centre could enhance its impact on prevention by developing a clear strategy in this respect.

References

- Primo Levi Report of activities 2002 and 2003.
- *Mémoires*, quarterly bulletin of the Primo Levi Association
- Primo Levi case studies, submission to the UN Voluntary Fund for Victims of Torture.
- *Evaluation EIDHR: Torture Rehabilitation Centres*, MEDE European Consultancy, November 2003.
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.
- Council Directive 2003/9/EC of 27 January 2003 laying down minimum standards for the reception of asylum seekers [Official Journal L 31 of 06.02.03].
- European Commission Communication on the EU's role in promoting human rights and democracy, May 2001, COM (2001) 252 Final.

Annex 1: Itinerary

Wednesday 16 June 2004:

- Travel Copenhagen – Paris (Inger Agger)
- Team meeting

Thursday 17 June 2004:

- Meetings with President and staff of the Primo Levi Association
- Meeting with Amnesty International

Friday 18 June 2004:

- Meetings with beneficiaries and staff of the Primo Levi Association

Saturday 19 June 2004:

- Meeting and debriefing of staff of the Primo Levi Association
- Travel Paris – Copenhagen (Inger Agger)

Annex 2: People and organisations interviewed

- Sibel Agrali-Karatop, Director, Primo Levi Association
- Claude Bietry, Physiotherapist, Primo Levi Association
- Juan Boggino, Psychotherapist, Primo Levi Association
- Véronique Bourboulon, Psychotherapist, Primo Levi Association
- Janine Dardare, Social and Educational Assistant, Primo Levi Association
- Patrick Delouvin, Responsible for Refugee Assistance, Amnesty International
- Diane Kolnikoff, Coordinator for Associated Activities, Primo Levi Association
- Catherine Pinzuti, Assistant to the Director, Primo Levi Association
- Hubert Prévot, President, Primo Levi Association
- Rémi Renon, Administrative and Financial Manager, Primo Levi Association

Five beneficiaries (two from Congo-Brazzaville and three from Angola)

Annex 3: Statistics

Type of persecution undergone – new patients

	July-Dec 2002			2003			Jan-May 2004		
	new		follow-up	new		follow-up	new		follow-up
Torture victims	49	54%		101	63%		43	73%	
Detention only	5	6%		9	6%		5	8%	
Family members	34	38%		46	29%		10	17%	
No information	3	3%		4	3%		1	2%	
Total	90			160		180	59		158

Based on information given during the first interview (see details on the topic on page 11 in the 2003 activity report) (probably understated because of unwillingness to disclose this information during the first contact).

This information is not collected and updated later in a formal manner during the treatment. Most patients mentioned at least two or three items (primarily torture and detention). This overlap is not presented in the above table.

Gender and age of new patients

	July-Dec 2002			2003			Jan-May 2004		
	new		follow-up	new		follow-up	new		follow-up
Adult men	38	42%		72	45%		30	51%	
Adult women	34	38%		39	24%		17	29%	
Children	12	13%		27	17%		4	7%	
Unaccompa-nied minors	6	7%		22	14%		8	14%	
Total	90			160			59		

Status of new patients (when they arrived in the centre)

Asylum seekers	67	74%		94	59%		37	63%	
Refugees	11	12%		50	31%		13	22%	
Resident permit	7	8%		2	1%		0	0%	
Illegal	5	6%		14	9%		9	15%	
Total	90			160			59		

Information on 'drop-outs' - first half of 2003

Number of drop-outs during the first half of 2003:			34	among	241	patients
		i.e.	14.1%	of patients		
Date care began for drop-outs in first half of 2003	Number of drop-outs in first half of 2003	Number of drop-outs in first half of 2003 as percentage of their in-take year		Total number of patients during the first half of 2003		
1998	1	0.4%		241		
1999	1	0.4%				
2000	3	1.2%				
2001	6	2.5%				
2002	15	6.2%				
2003	8	3.3%				
Total	34	14.1%	of patients			
Drop-out: patient who missed an appointment in the first half of the year and never came back afterwards -> minimum six months without any contact: can be considered as having 'dropped out' (no formal closure or end of treatment).						

Treatment ended during the first half of 2003 (no new appointment given)

Number of treatments ended during the first half of 2003:			24	among	241	patients
		i.e.	10.0%	of patients		
Year treatment began	Number of treatments ended during the first half of 2003	Number of patients whose treatment ended in first half of 2003 as percentage of their intake year				
1998	1	0.4%				
2000	3	1.2%				
2001	9	3.7%				
2002	8	3.3%				
2003	3	1.2%				
Total	24	10.0%	of patients			

End of treatment: patient who attended an appointment and never came back afterwards (because no other appointment was proposed or the patient did not ask for one) -> minimum six months without any contact: can be considered as having put an end to the treatment upon verification. Each of the three cases of treatment started and ended in 2003 corresponds to patients having met a psychotherapist only once (no genuine treatment demand or person 'not ready').

Origin of new patients

	New patients in 2002 (July-Dec)		New patients in 2003		New patients in 2004	
North Africa	11	12%	7	4%	3	5%
Sub-Saharan Africa	46	51%	111	69%	48	81%
South East Europe (incl. Turkey)	18	20%	20	13%	8	14%
Former Soviet Union	8	9%	14	9%	0	
South America	1	1%	0	0%	0	
Caribbean	1	1%	2	1%	0	
Asia	5	6%	5	3%	0	
Middle East	0	0%	1	1%	0	
	90	100%	160	100%	59	100%

Type of care for all the patients (new & follow-up)

	2002		2003		2004	
Number of beneficiaries of :	(whole year)				(Jan-May)	
Medical treatment	158	48%	216	64%	128	59%
Psychological treatment	180	55%	207	61%	138	64%
Physiotherapy	29	9%	25	7%	19	9%
Legal and social support	119	36%	122	36%	94	43%
Dental care	not avail-able		18	5%	9	4%
Total patients	329		340		217	
Note: information on care in 2002 is not available for the second half of the year; only figures for the whole year are presented.						
Comment: many patients have more than one type of care.						

Information on employees

Staff members	Position	Activity rate	No. of hours per week
AGRALI Sibel	Director	80%	32
BIETRY Claude	Physiotherapist	30%	12
BOGGINO Juan	Psychotherapist	40%	16
BOURBOULON Véronique	Psychotherapist	40%	16
DARDARE Janine	Social worker	100%	40
D'ELIA Helena	Psychotherapist	40%	16
HEAU Emmanuel	Physician (medical doctor)	35%	14
HENRIQUES Cécile	Editor	Freelance	
JOUSSEMET Mireille	Physician (medical doctor)	50%	20
KOLNIKOFF Diane	Psychotherapist	40%	16
PINZUTI Catherine	Secretary, responsible for first interviews	100%	40
RENON Rémi	Administrative and Financial Director	80%	32
SANDLARZ Eric	Psychotherapist	40%	16
Note: many volunteers participate in the activity of the association.			

Annex 4: Comments Primo Levi association

We have taken good note of the evaluation report and appreciated the overall sincere concern for our present and future activities and their enhancement. We do however wish to respond to certain observations and recommendations and also give the EC additional information on certain points.

Rigorous approach

The Primo Levi care centre was designed as a health care centre primarily concerned with addressing the physical and mental health complaints due to torture and other forms of political violence. It is our clinical work, notably in the mental health domain, that is most appreciated by our working partners and the associative field. We are considered irreplaceable for our qualitative approach, taking the necessary time with each individual, confronting deep suffering with widespread repercussions with the possibility to do so in one's own language. This rigorousness has unfortunately seemingly been translated in the evaluation as "rigid" ness.

Social and legal assistance as a complement to health care

Social and legal support is an integral part of our work, but is considered complementary to our main concern which is health care. With only the equivalent of 2 full-time psychotherapeutic staff, less than one full-time medical staff and one full-time social worker, the imbalance, with regards to patients' expressed and observed needs, is really in the psychotherapeutic field (the waiting list for psychological services comprises 100 patients!).

Social and legal services are numerous in France. Many associations specialised in receiving asylum-seekers provide high-quality support, especially social and legal. A third of our patients require such support, accompaniment they haven't been able to find (or haven't looked for) elsewhere. The work is tedious and often unrewarding (for lack of institutional solutions!) but for the time-being no needy patient has been turned away for lack of time (there is no waiting list for social and legal services).

Of course, if in time we realize we should increase staff in the social and legal field, we wouldn't hesitate to do so. But recommendation #2 to "consider having more social work and less psychotherapeutic staff" doesn't seem relevant as it would mean no less than changing our project at the base! Moreover our numerous observations made about the change in the French environment for asylum-seekers and refugees called for increased political lobbying for institutional responses. If not, social and legal challenges would remain unanswered.

Prevention activities

Concerning preventive activities, indeed, as is suggested in the recommendations, we are eager to elaborate better means of contributing to more efficient prevention through strategic planning, expansion of activities in this area and through better media coverage of what actually is done and achieved.

We are very proud to be able to inform already the EC, that our association has recently been awarded the Prize for Human Rights of the French Republic under the theme of Prevention of Torture (amongst 116 candidate projects). Concomitantly we received a letter from the Director of the United Nations and International Organizations Directorate of the French Foreign Affairs Ministry, informing us that our lobbying for more French contribution to the UN Fund for victims of torture has paid (we are informed of a 25% increase for 2005) and that France will be signing "as soon as possible" the facultative protocol to the convention against Torture.

We thank the EC for its continuing interest in our work and readily engage to apply all recommendations.

The Primo Levi association

Annex 3: Final report Medical Foundation for the care of Victims of Torture

Evaluations EIDHR

Medical Foundation for the Care of Victims of Torture

Torture rehabiliation centres Europe

human european consultancy in partnership with the Netherlands Humanist Committee on Human Rights and the Danish Institute for Human Rights

Januari 2005 By Sara Guillet and Gisela Perren-Klingler

human european consultancy

This report is the outcome of an evaluation commissioned by the European Commission on projects financed in the field of the European Initiative for Democracy and Human Rights (EIDHR). The EIDHR is a European Union programme that aims to promote and support human rights and democracy in third countries. Information on activities and actions can be found on the EIDHR website: http://www.europa.eu.int/comm/europeaid/projects/eidhr/index_en.htm

human european consultancy
Hooghiemstraplein 155
3514 AZ Utrecht
The Netherlands
Tel +31 30 634 14 22
Fax +31 30 635 21 39
office@humanconsultancy.com
www.humanconsultancy.com

Abbreviations

AI	Amnesty International
BMA	British Medical Association
COMEDE	Comité médical pour les exilés (*Medical Committee for Exiled Persons*)
DRC	Democratic Republic of Congo
ECHR	European Convention on Human Rights
EIDHR	European Initiative for Democracy and Human Rights
GP	General practitioner
HO	Home Office
ICC	International Criminal Court
IND	Immigration and Nationality Directorate
MD	Medical doctor
MF	Medical Foundation
MH	Mental health
MHC	Mental health care
MP	Member of Parliament
NASS	National Asylum Support Service
NGO	Non-governmental organisation
NHS	National Health Service
PHC	Primary health care
PTSD	Post traumatic stress disorder
RC	Refugee Council
RCT	Rehabiliterings- og Forskningscentret for Torturofre (*Rehabilitation and Research Centre for Torture Victims*)
UAM	Unaccompanied minor

Executive summary

The Medical Foundation for the Care of Victims of Torture (MF), established nearly 20 years ago, was one of the first centres established in Europe to care for victims of torture,. Like the other centres founded at about the same time, Rehabilitation and Research Centre for Torture Victims (*Rehabiliterings- og Forskningscentret for Torturofre*, RCT) in Copenhagen, the Medical Committee for Exiled Persons (*Comité médical pour les exilés*, COMEDE) in Paris and the centre for refugees in Utrecht, the founders were medical doctors (MDs) who, as human rights (HR) activists, started their projects because nobody seemed able to address the specific needs of this then new group of asylum seekers. Although every asylum seeker and refugee in the UK has the right to be treated and rehabilitated by the National Health Service (NHS), and there are many local NGOs outside London active in dealing with victims of violence, MF is the only organisation exclusively committed to the rehabilitation of victims of torture and at the same time active in the prevention of torture.

The objective of the report is to evaluate two projects, both run by MF. The first one is an ongoing project in London which has been operated for nearly 20 years by the centre. It treats victims of torture through the so-called 'holistic approach'. The second, newer project serves victims of torture UK-wide. It is the first time that MF has applied for EU funds to continue this UK-wide project, which consists of providing treatment, rehabilitation and prevention of torture and its consequences through a UK-wide network. This network, apart from offering treatment as in the London Project, aims to empower already existing networks in the service of specific help to torture victims and, to a lesser degree, the prevention of torture.

As part of the evaluation, a team of two consultants visited the Medical Foundation for the Care of Victims of Torture in London from 14 to 16 July 2004, interviewed staff and beneficiaries and collected data about the work of the centre.

Summary of conclusions

The two MF projects, the one located in London and the UK-wide Project, have two aims: to treat torture victims 'holistically' and to prevent torture. The lack of a reliable database makes it difficult to evaluate the impact of the London Project in quantitative terms. Nevertheless, the impact of the project on rehabilitation can be ascertained in part from interviews with clinical staff and beneficiaries. Through prevention activities, the project also has an institutional impact.

The design of the two therapy projects is good and flexibly adapted to changing needs. Both projects are relevant to the rehabilitation needs of torture victims in the UK.

As an overall conclusion and in general terms, it can be said that the rehabilitation objective seems to be met, although MF lacks a systematic internal monitoring and evaluation system to assess the projects' effectiveness in more precise terms. To date, there is only the enthusiasm of former and current clients, referral of new clients and a long waiting list. But little is known about the patients' needs and the reasons for their satisfaction. In order to improve effectiveness, two years ago the Director introduced a two-person monitoring and evaluation unit. This will, in the long term, enable MF – as well as potential donors – to evaluate properly the impact and effectiveness of the treatment at MF. This work might even be of relevance to other smaller European centres for the prevention of torture and treatment of torture victims, who do not have the means to do this basic theoretical work.

With regard to the prevention objective of the projects, human rights advocacy, publication of country reports, awareness raising, condemnation and encouraging patients to lodge complaints are methods which certainly have some impact on the prevention of torture. The publications are competently and carefully written. Their impact and effectiveness outside Europe is neither evaluated nor proven.

The management of the projects is efficient, but EC support is not made visible in either project.

MF, being a large charitable organisation, has enough resources to ensure the sustainability of both projects.

Recommendations

Following their evaluation, the two consultants recommend the EC to give a positive response to MF's funding application for its capacity building programme in the UK.

They recommend MF:

- To provide the Monitoring and Evaluation Team with increased support, so as to enable it to report as soon as possible on its ongoing work regarding both the rehabilitation as well as the prevention activities. Monitoring and evaluation research should be performed in coordination with other European centres.
- To improve the effectiveness of its methodology at the intake stage. This would mean that the intake interviews should consist of three sessions at the most, followed by an evaluation session with a highly qualified and experienced clinician with a medical or psychological background.

This evaluation session would be the place to decide collectively which patients are going to be looked after immediately, which ones can be referred to other places and which ones can be put on a waiting list; indications for immediate treatment should also be formulated.

- To have stricter supervision and control mechanisms for the volunteers as well as the professional counsellors. For volunteers, supervision should be compulsory at least once a month and each time any of them has to present a case. For professionals, supervision should be discussed in the group and the effectiveness of outside supervision should be evaluated occasionally.
- To set up a periodic monitoring system to assess the efficiency and effectiveness of ongoing counselling and psychotherapeutic processes at least every five sessions.
- To put up visible EU logos in the entrance halls of the main building in London, as well as in any centre of the UK-wide Project supported by EU funding. The logo should also be included on MF's headed paper and publications.

1. Introduction and methodology

1.1 Objectives

This evaluation of the Medical Foundation for the Care of Victims of Torture (MF) is part of an evaluation of four different torture rehabilitation programmes currently financed by the European Commission (EC) in France, Belgium, the UK and Greece. The objective of this evaluation was to assess two different projects:

- Rehabilitation of Survivors of Torture in London (hereafter 'the London Project')
- Capacity Building in the UK (hereafter 'the UK-wide Project')

It will assess the relevance, efficiency, effectiveness, impact and sustainability of the two projects. As MF is not currently applying for funding for the London Project, this evaluation will refrain from making specific recommendations to the EC as to the funding of this project. The UK-wide Project being the central target of this evaluation, the report will provide not only guidance but also recommendations for a decision from the EC regarding the approval of the UK-wide Project. The proposal had in principle been pre-selected by the Selection Committee for further funding, but the signing of a new contract was conditional on the results of this evaluation. The evaluation should also provide elements for the assessment of the effectiveness and impact of the programme implemented by the MF in relation to the argument that the work of torture rehabilitation centres contributes towards the prevention of torture.

1.2 Background

The EC Communication on the EU's role in promoting human rights and democracy in third countries has four priorities for the use of European Initiative for Democracy and Human Rights (EIDHR), one of which is support for the fight against torture. The Communication states that, *"in seeking to be an agent of change, the EU should ensure that it focuses as much as possible on prevention, including through human rights education of the police and other possible agents of torture"*. The torture rehabilitation centres have argued that their work also contributes towards the prevention of torture.

Two specific questions have guided the whole evaluation process. The first one is about the function, possibility and effectiveness of prevention. The second question is how to evaluate the effectiveness of interventions, be they therapeutic or preventative. Accountability in such services can only be exercised if valid evaluating and auditing methods are used.

Prevention programmes will have to be evaluated and monitored differently from treatment programmes. Indicators for efficient preventative programmes might be more difficult to decide upon and evaluate than one thinks. If laws for the protection of human rights and against torture are drafted and approved by parliaments, this unfortunately does not mean that they are respected. Although a precondition for further prevention work, it is not enough, as compliance with such laws (and legal prosecution for violation of these laws) is not automatic. Institutional changes are a necessary consequence of the legal process and a precondition for further implementation of prevention of torture. However, this will not be enough for effective prevention. In different parts of the world, the societal, educational and political settings are not yet ready to really implement an effective preventative attitude. Finally, the evaluation – and the ongoing monitoring – will have to be based on many different indicators to ascertain the effectiveness of torture prevention programmes.

For the treatment programmes evidence-based, quantifiable and replicable answers will have to be provided to the question about effectiveness. The difficulty in this respect consists of having valid and transculturally acceptable ways of testing it, as MF attends a wide variety of patients with extremely different cultural backgrounds. Before introducing such methods, questionnaires will have to be constructed because, as far as the evaluators are aware, no serious, transculturally valid psychological test yet exists. Quality evaluation in psychiatry and psychotherapy is an activity which is still in its tentative and exploratory phase, even in culturally homogenous treatment programmes. It is all the more difficult to evaluate the effectiveness of treatment programmes with heterogeneous populations and where social aspects are intimately intertwined in the treatment outcomes, such as being a refugee, problems of adapting to a new country etc.

A more thorough reflection on the relationship between prevention of torture and treatment of victims of torture, as well as the respective evaluation possibilities is to be found in the synthesis report.

This evaluation focuses on the project implemented from 1 January 2002 to 30 December 2004, which covers the centre's mainstream rehabilitation activities in London. The new proposal refers to the UK-wide Project, which aims to empower existing networks of voluntary organisations and health providers across the country in order to serve victims of torture through a UK-wide network. The EC funding applied for is for 850,000 Euro and represents 46.5% of the total funding for this specific UK-wide project.

1.3 Methodology

The evaluation was carried out through the study of documents and a three-day visit to MF in London. This included collection of qualitative data through interviews with staff, target groups (health providers, community workers and torture victims) and a variety of other stakeholders (see Annex 2).

The team was comprised two experts, Ms Sara Guillet (team leader), specialist in international human rights law, and Dr Gisela Perren-Klingler (medical expert), specialist in project evaluation and transcultural psychiatry/psychotherapy. Before leaving MF, the team shared and discussed its preliminary findings and recommendations with the Director and the Development Manager during a debriefing session.

The staff of the centre did receive the draft report for comments, which have been added to the final report as annex 3.

1.4 Constraints

It was not possible to evaluate the UK-wide Project locally by travelling to Manchester and Glasgow to gain a view of the pilot projects that have been implemented with non-EC funds. However, a number of phone interviews with various actors involved in this project in and outside MF gave sufficient information for the purpose of the evaluation.

2. The Medical Foundation for the Care of Victims of Torture

2.1. Introduction

Asylum in the UK

The beneficiaries of MF are asylum seekers and refugees who were victims of torture or political violence in their country. They are applying for refugee status at the Immigration and Nationality Directorate (IND), where they have to show that they meet the criteria laid down in the 1951 Convention relating to the Status of Refugees. Their claim is assessed on the basis of their credibility, the current political situation in their country, evidence of the country's human rights record and, if applicable, medical evidence of torture and abuse. If the asylum application is refused, the applicant still has appeal rights with the Immigration Appellate Authority and the Immigration Appeals Tribunal. In addition, the Home Office (HO) may consider granting either 'Humanitarian Protection' (the HO recognises that there is a real risk of death, torture or other inhuman or degrading treatment, which falls outside the strict terms of the 1951 Refugee Convention) or 'Discretionary Leave' (serious medical condition making travel or return dangerous or removal would contravene the individual's human rights; there may also be other practical or legal obstacles making removal impossible)[1]. In 2003, 49,370 people applied for asylum in the UK (representing almost half the level of previous years).

The 1999 Immigration and Asylum Act introduced the policy of 'dispersal' to ease the disproportionate burden on support services in London and the South East of England. Under the dispersal programme, people whose claim for asylum is still being assessed by the HO are dispersed to local authorities around the country. In 2004, the National Asylum Support Service (NASS) – the authority responsible for providing accommodation and subsistence support to asylum seekers who meet certain criteria – was supporting 53,410 asylum seekers outside London[2], with the largest numbers in Yorkshire and Humberside, the North West, West Midlands, North East and Scotland (Glasgow is the city with the largest concentration of dispersed asylum seekers).

Overview of the Medical Foundation for the Care of Victims of Torture

The work of MF first began in the 1970s under the auspices of the Medical Group of Amnesty International (AI). In 1985, MF was set up to provide victims with medical treatment, counselling and therapy and to document evidence of the practice of torture.

In its first years of existence, MF clinicians and counsellors were seeing around 750 clients a year. In 2003, 3,604 clients were referred. Today they are offered a multi-disciplinary and comprehensive service including:

- medical, psychiatric and psychological consultation, assessment and treatment
- rehabilitation, short and long-term – through psychosocial care, casework and counselling, physiotherapy, complementary therapies and group and family work

1 These discretionary statuses have replaced the 'Exceptional leave to remain' (ELR) that was operated until 1 April 2003.

2 This quoted figure does not include asylum seekers who fall outside NASS criteria.

- forensic medical reports to document torture and ill-treatment in support of claims for asylum
- practical assistance including small financial grants as well as with getting help from housing and welfare agencies

In addition to its work with patients, MF also plays a role at the national and international level in raising public awareness and lobbying government departments through:

- documenting evidence of torture
- researching and publishing objective findings about torture and organised violence
- educating public opinion and decision-makers about torture and its possible somatic, psychological and social consequences
- supporting the implementation of international human rights laws as well as standards of medical ethics against torture
- campaigning to improve the legislative framework in the UK for the treatment of survivors of torture

By January 2003 MF had supported some 35,000 torture victims and members of their families, mainly asylum seekers and refugees, although some clients are survivors of Far East prisoner of war camps and victims of violence in Northern Ireland.

The total number of clients referred to MF in 2003 was 3,604 (39,7% women and 59,4% men; children represent 11% of the men's and 5% of the women's group)[3]. Of all the clients referred and then discussed by the Referrals Panel, the proportion of adult clients accepted for a clinical assessment was 21%. Of the remaining 80%, clients were accepted for medico-legal reports by the Legal Team, by the Children and Adolescents Team, by the Family Team or in some cases referred on to another, more appropriate agency. No data are available to provide an accurate rate of refusal at the referral stage.

Turkish clients represent the largest group referred to the MF, at just over 12%, followed by Iran (8.8%), Democratic Republic of Congo (DRC) (6.5%), Iraq (6.2%), Eritrea (4.7%), Kosovo (4.2%), Ethiopia (4%) and Uganda (3.9%). Most clients had a profession in their country. At least 59% of clients are still awaiting a decision regarding their asylum application and 19% were refused asylum although the data are not clear as to whether or not this percentage includes those awaiting appeal or judicial review. Preliminary MF data (with 34% of missing date) tend to indicate that 19% of patients are referred by the Red Cross, 14.2% are self-referred, 9.6% are referred by a legal practice, 8.9% by a GP, 3.4% through personal contact and 1.8 by the NHS.

3 All the data mentioned above are quoted from the *Clinical audit and evaluation of the Medical Foundation for the Care of Victims of Torture Clients in 2003 prepared for the European Commission (European Initiative for Democracy and Human Rights – Rehabilitation of Torture Survivors B5-813) in January 2004*. According to MF itself, this study is not fully reliable as it was drafted with a significant percentage of missing data.

The preliminary data illustrate that 58% of the clients said they were imprisoned / politically detained outside the UK, 48% said they had suffered physical violence / torture and 37% said they had suffered mental/psychological torture. The estimated cost of treatment is about 100 Euro per hour per patient.

Some years ago MF started to network with some smaller European centres – mainly from Germany. However, because of lack of funding this networking activity has not achieved a great deal.

2.2. Overview of the two EIDHR projects

Rehabilitation of Survivors of Torture ('the London Project')

Through this project, MF has been performing its mainstream activities in London as a rehabilitation centre for victims of torture and organised violence. The target group is refugees and asylum seekers who have come to the UK from over 90 countries world-wide. They have either been tortured themselves (i.e. direct victims) or are family members of torture victims who have witnessed such acts (i.e. indirect victims) and are in need of help. The main activities of this project aim to provide them with support, in London, through a wide range of services, including: general medical care, psychiatric assessment and treatment, psychotherapy / counselling, family therapy, child and adolescent therapy, physiotherapy, casework, welfare rights work, material support and legal counselling. The project also aims to prevent torture in the patients' countries of origin, in particular through advocacy, awareness-raising and training. This project covers a three-year period from January 2002 to December 2004.

Capacity Building in the UK ('the UK-wide Project')

This project is a response to the dispersal programme implemented by the UK government from April 2000 (see section 2.1.1). The aim of the project is to improve medical and psychosocial services for torture victims by providing training to voluntary organisations (refugee groups, advocacy projects, counselling services and interpreters) and health providers (GPs, community mental health (MH) teams, hospital staff and health visitors) who work with torture victims in the UK. The target groups are, in addition to refugees and asylum seekers, health professionals and community workers. The main activity is to provide direct clinical services to survivors of torture and specialist training of and support to non-profit groups and health providers. Other activities will be clinical supervision for health workers, clinical case support, mapping and coordination of types and levels of services in dispersal areas.

This project has gone through a pilot phase: for several years MF has been providing *ad hoc* support to local health providers and community workers in the UK. In 2002, MF opened its first centre outside London, for torture victims living in the North West of England.

Some conclusions can hopefully be drawn from the three-year pilot phase in order to evaluate the relevance of this project, foresee its impact, effectiveness and efficiency and consider its impact on prevention.

MF has recently established a Monitoring and Evaluation Unit, as part of the London Project, which will be involved in both projects.

2.3 Impact

The London Project

The London Project mainly addresses 'the survivors', people who have survived torture. Their nationality and asylum status is not important – this means that British nationals would also be accepted as clients if they alleged they had been tortured. However, at the moment all the clients are asylum seekers, refugees or people who have not been recognised as refugees (also illegal residents).

It is not known how many of these people have consulted MF, nor how many times: have they been seen only once and then referred to another institution, have they been seen three to five times for a medico-legal report, have they been seen by a counsellor or by a psychiatrist? The drop-out rate is not known either, because there has not yet been any evaluation about people who do not come back. The attitude is that torture victims all need long-term treatment and that patients like to come.

MF says that its therapeutic and social interventions – as well as its medico-legal reports – benefit more people than the individual directly affected: their partners and children also gain from the experience. It is said that in this way the quality of life of all these groups also profit from an intervention with a single person.

Besides clinical activities, the London Project also includes activities related to the prevention of torture, which have had some impact at an institutional level. These activities include collecting information about torture methods in specific countries (e.g. *Every morning just like coffee*, a publication on torture in Cameroon), briefing Members of Parliament (MPs) on rape as a method of torture and training HO officers on interviewing torture victims. These are all means of increasing awareness among the various institutions involved with torture victims and of improving the quality of their work when dealing with these people. Although it cannot be quantified, this institutional impact was clearly perceived through various interviews at MF and with various stakeholders.

However, the prevention effect of these activities in the countries from where torture is described has yet to be proven.

No knowledge exists either about the impact of the volunteers' work when they leave MF and go on to work with other clients, nor about the expertise they have acquired to work with victims of violence and in a transcultural setting.

The UK-wide Project

Through the UK-wide Project, MF will provide clinical services to torture victims and implement capacity building and support activities to health providers, interpreting services and voluntary organisations working with torture victims.

Although the impact and multiplier effects are not quantified in the project, it can be assumed that an important number of people from the target groups will be involved, in particular through training sessions. Community groups who have received MF training have subsequently been better equipped to provide advice and support to the mainstream system. Already in 2004, thanks to the network-building process during the pilot phase, around 600 health professionals (GPs, health visitors and basic mental health workers) and community workers can provide better informed professional support to torture victims. As a positive effect of the project, the capacity of the NHS in dealing with victims of any violence (such as domestic violence or working accidents) can be enhanced (multiplier effect). Another positive effect is that the London staff of MF have an opportunity to acknowledge their expertise by training target groups outside the capital. This is also a way of preventing burnout of MF staff who spend all their time working with torture victims in individual sessions.

Ultimately, the beneficiaries are victims of torture – asylum seekers or refugees – who have been dispersed throughout the UK. They will benefit from the training programme, because community workers and health providers will know better how to cope with their specific demands and needs. With an increased local MF capacity and an empowered mainstream health system, an increasing number of asylum seekers will be likely to have an MF assessment and subsequent referral to appropriate services.

2.4 Relevance and design

The London Project

The types of assistance offered to torture victims are: medico-legal reports; psychotherapy (individual and group psychotherapy, family therapy, clinical psychology, somato-psychotherapy and movement therapy); therapeutic services for children (especially unaccompanied minors (UAM)) and adolescents; casework / counselling; physical therapy; and material help (relief payments from the Crisis Intervention Fund). Patients have no direct input into the programme design. A few staff members are former patients.

Although there are many community groups supporting asylum seekers and refugees in the UK, and although the mainstream health care system does admit torture victims, MF considers itself as the only structure designed to provide such a wide range of services to torture victims[4]. On the basis of several interviews undertaken for the purpose this evaluation[5] with civil society groups and representatives of the British authorities, as well as two patients, the project appears to be relevant to these stakeholders. As an example, the fact that the government agreed that if an asylum seeker is a torture victim and needs the specialised care of MF, the individual should be accommodated nearby, is an indication of the relevance of its work (even though this has changed because of the dispersal policy).

The project was designed following the assumption that there would be 6,000 patients to treat and support per year, on the basis of yearly increases in the number of refugees and asylum seekers who are victims of torture. However, asylum figures in the UK have dropped and the numbers of patients at MF have remained stable, with about 3,600 patients referred yearly. The waiting list problem has nevertheless not been solved and new applicants have to wait for about 20 weeks before they can be seen for counselling and about four weeks before they can see a doctor, unless they are referred to the Early Intervention Team, in which case they do not have to wait.

The project design has been adapted to the evolution of the British asylum system. For example, the Early Intervention Team has brought a flexible response to the increased rapidity of asylum procedures. As another example, increased social and welfare needs of patients has required MF to put more time into dealing with these issues than into face-to-face therapy. The fact that all patients are seen by caseworkers/counsellors seems an adequate response to this environment. However, account is not taken of the fact that material support (housing, provision of small financial grants, etc.) from the person who also does the therapy, can have a significant influence on therapeutic processes.

4 Other centres exist, such as the Refugee Therapy Project where well-known British psychotraumatologists and a university professor of psychiatry are engaged, offering psychotherapy, medical reports etc. in at least 10 languages, and a centre in Northern Ireland, opened after the Omagh bombing, which now also treats refugees. AI's publications have a similar approach to some of MF's (e.g. the book on torture *A glimpse of hell*).

5 See Annex 2.

This is especially the case, if the counsellors are not conscious of the danger of taking a power position, which – if not thoroughly considered – is detrimental to a psychotherapeutic process. The danger of rendering the patient dependent on the service is real and the long treatment time observed (albeit with many pending questions because of lack of basic quantifiable data) might be one of the consequences.

Although MF is primarily a health care and rehabilitation centre, torture prevention is presented as an important objective of the project: as a charity organisation created by Amnesty International, MF follows this human rights approach and its clinical work also serves as the basis for advocacy and awareness-raising activities undertaken by MF's Department for Public Affairs. It has also developed some overseas outreach work and training both in the UK and abroad.

It should be noted that the project design does not have objectively verifiable indicators to assess these prevention-oriented activities. According to interviews with stakeholders involved in these prevention activities – such as the HO, the British Medical Association –, the dimension of the project related to torture prevention in the UK is relevant.

The UK-wide Project

In 2000, the Government began its now established programme of 'dispersal' (see section 2.1.1). Health professionals were, at that point, overwhelmed by the fact that they suddenly had to care for torture victims, a new group of survivors of violence. The UK-wide Project has been designed according to MF experience in pilot projects implemented at a local level in the UK.

Even before the implementation of the dispersal programme, demands for specific training had already been addressed by different specialists from MF (working with interpreters, psychological reports, forensic medical reports, training or information on human rights, advice on working with torture victims and clinical services for torture victims). Training had been provided to professionals from primary care, social services, schools and colleges, mental health services, local authorities and to voluntary organisations and community groups. Often, part of the training consisted of empowering the professionals to use their already existing skills such as grief counselling, management of the effects of domestic violence and treatment of psycho-somatic complaints – dedramatising the work with torture victims. These trainings were and partially continue to be delivered by London MF staff. For evaluation purpose, trainees are given an evaluation questionnaire which they are requested to fill in and hand back to MF staff. However, the evaluation questionnaire is only about the 'experience' and the satisfaction of the participants, not about the effect of the training on the treatment effectiveness through newly learned techniques.

In April 2000, as a specific response to the dispersal programme, a more structured project – the Breathing Space Project – was set up in Manchester in partnership with the Refugee Council and the Camelot Foundation. As a continuation of this joint programme, MF set up an office in Manchester in 2002. This office now has three full-time professional staff (one project coordinator, one administrator and one counsellor), one part-time professional (training officer) and 11 part-time volunteer caseworkers and counsellors. On this model, another MF office has opened in Glasgow with two full-time professional staff (one project coordinator and one administrator) and a team of 10 volunteers. In July 2004, MF announced the opening of another office in Newcastle. The centres are planned as focal points for a national network which already partly exists separate from MF, but needs coordination. Some stakeholders interviewed for the purpose of this evaluation insisted that MF should contribute to the empowerment of the existing network rather than seek to add on new services.

Based on these previous and ongoing experiences, the project seems to be well-designed and to rely on appropriate staffing. The ongoing recruitment of regional training officers, by a newly recruited London-based training coordinator and trainers' trainer, will strengthen MF capacity to design and perform training schemes that are relevant to specific local needs. In this perspective, it should be ensured that forthcoming trainings are thoroughly designed according to needs already known and to be defined.

Between April 2003 and June 2004, the Regional Development Team at MF received 264 requests for assistance, including training, from the target groups. This is an indication of the relevance of the project. Among these 264 requests, 17% of the demands came from voluntary organisations, 29% came from primary care services, 2% from mental health services and 13% from the Mental Health Care (MHC) Team. To meet these requests, as an example, the training plan in Manchester foresees one in-house training day for 12 agencies in the region and 15 training days for mixed groups of counsellors and MH workers. The training sessions that have already taken place, as well as the documentation provided to trainees (which was also provided to the consultants), seem tailored to the expressed needs of the target groups. The general view expressed by various stakeholders interviewed in the course of this evaluation was that the training provided met their needs. There are no indicators established yet as to the efficiency of the training.

To date, the funds for the Manchester, Glasgow and Newcastle offices have been partly secured. With EC funding, MF is planning to increase the capacity of these existing centres and to open a new office in Leeds. In addition, it is now raising funds with a view to opening an office in Birmingham.

2.5 Effectiveness

The London Project

The two projects' objectives are rehabilitation of torture victims and preventing torture through advocacy work at the national and international level.

In order to monitor the effective achievement of these objectives, the project has set up a Monitoring and Evaluation team employing two research workers (one works one day a week, the other works full-time): *"to conduct a clinical audit and statistical analysis of data, in order to improve management structures and evaluation of clinical work; develop and instigate internal evaluation procedures; carry out a thorough clinical audit"*. However, it appears both from the first *Clinical audit and evaluation report* prepared by the Monitoring and Evaluation team, and from the consultants' visit to MF, that many further improvements are required before the database becomes a reliable tool and before objectively verifiable and quantitative indicators are identified. In the future, it is intended that this evaluation will exclusively address the efficiency of clinical work. The multiplicity of the intake and referral forms has, as a first step in the process, been overcome and there now exist only three forms: one for intake, one for intermediate (process-oriented) evaluation and one for closure. The initial reluctance by some of the staff to fill them in properly seems to be becoming less significant. The consultants are confident that the ongoing cultural and organisational changes underway at MF will enhance this process.

At this stage, the evaluation of the effectiveness of the two projects can therefore not rely on objectively verifiable indicators, but only on information collected by the consultants during their visit. However, there is growing awareness that MF has to be accountable and to carry out an evaluation of the therapeutic processes as well as, in the longer run, of its activities related to the prevention of torture.

Rehabilitation of torture victims

Following this visit, several observations can be made about the effectiveness of the project, based on the achievements in relation to the rehabilitation objective.

When speaking with MF clients one gets the impression that the therapists fulfil a very important role for their clients. *"…she is like my mother…. , when I have seen her, I feel good for a few days…"* is a typical comment from a client.

However, it is not clear whether it is the practical and material support or the 'therapeutic' session (which should be oriented to changes in the capacity of the patient to cope with his or her outside world as well as the inside one), which are giving rise to these feelings. The two patients of the two counsellors met by the evaluation team are long-term patients and do not seem, to a clinician's eye, to be well.

The question of whether the real needs of the target groups are met is difficult to answer. When MF was starting its activities nearly 20 years ago, all over Europe it was unknown what this target group – refugees (regardless of their legal status) who had been tortured – really needed. However, much more is now known about the effects of torture (and of family violence) and about similarities and transcultural differences in using and interpreting help through psychotherapy (or counselling). Today the objective of such interventions should be: the shortest possible, the most empowering possible, as far as possible centred around universally present (e.g. physiological) signs and symptoms and the least interpretative (because this is culture-dependent and therefore not easily managed by a European counsellor or therapist for persons from other cultures). The often-mentioned, long-term relationships with clients should be the exception – even with children (UAMs) and adolescents.

As much as expectations (any 'help') are met (especially in the important work of writing medico-legal reports for asylum seekers), one wonders whether underlying needs can be fulfilled. As there are no reliable statistics, there is no means of evaluating this, not even regarding the question of how much less symptomatic or how much more integrated and functional patients are at the end of the 'holistic therapies' or how long an average intervention lasts.

The lack of monitoring and evaluation of the different processes with clients at MF has certainly also led to the very long – and undesirable – waiting lists. One of the responses has been to put clients into groups, after they have benefited from one-to- one treatment. Although some therapists consider group therapy as a priority, in many other cases clinicians or counsellors think that their client is not yet ready for group therapy. Group work as a second choice shows that there is only little knowledge /inclination to work in group settings, otherwise groups would not be considered a second choice, is mainly the case at the moment.

The indication as to what sort of support is to be offered – whether mainly social or more psychological or psychosocial – is not clearly made at the client's intake. The screening of the client's needs and expectations should be made in a maximum of two to three sessions.

Then a decision should be taken – with the help of a highly qualified and experienced clinician – as to whether to refer the client to another service outside MF or, if he or she is to stay at MF, what service will be most appropriate. This would probably be one measure to cut waiting lists down.

Possibly the separation of the people offering social and psychotherapeutic help would be another means of shortening therapies and clarifying the functions of the therapists.

Utilisation of modern psychotherapeutic 'power techniques' with clients might be another possibility to render psychotherapy more efficient. Last but not least, the introduction of local healers and trained peers from the same ethnic group and 'self-help groups' might be more effective. It is not clear whether the observable 'flexibility' in the intervention strategy is professionally indicated or more geared to the expressed needs and expectations of the clients.

Torture prevention

The project includes advocacy work through lobbying at national and international levels to promote and protect human rights and to stop torture world-wide. Following their visit, the consultants noted a number of achievements in line with this objective, including:

- Advocacy towards British authorities involved in asylum procedures: publications of booklets to help IND caseworkers to appreciate the evidence they are given, thus contributing to an accurate decision-making process for asylum applications or applications on other grounds (such as 'Humanitarian Protection'). For example, the book *Mental health services in Kosovo* shows that these services are as yet under-staffed and ill-equipped and that they are not attended by people suffering from post traumatic stress disorder (PTSD) or by raped women. Such findings are likely to give a stronger basis to Kosovan asylum applicants about whom the HO argues there are no obstacles for their removal.
- Lobbying the UK Parliament: the MF report on *Rape as a method of torture* aims to encourage a change in the UK asylum jurisprudence, which does not consider rape as torture.
- Training HO staff: training workshops for caseworkers on interviewing asylum seekers (four to six workshops a year).
- Challenging the quality of asylum decisions, both on individual cases and from an overall perspective (cf. report *Right first time?*). Although MF is not the only challenger[6], it gives the HO an indicator of its work.
- Lobbying public authorities to ensure conformity of UK legislation with international standards on torture (e.g. targeting health authorities on the implementation of EU directives laying down minimum standards for the reception of asylum seekers).
- Lobbying on country situations at an international level (UN Commission on Human Rights).

6 Cf. above. The UNHCR has also recently undertaken a quality assessment of IND decisions.

These methods seem to be quite efficient at a national level. However, there are no clear indicators established to monitor these preventative effects at the international level.

The UK-wide Project

Although the UK-wide Project has not been implemented yet with EC funding, its effectiveness can, to some extent, be assessed on the basis of the three-year pilot phase developed since 2002. Since the Monitoring and Evaluation Team has not had sufficient data in the last few years to perform its work in relation to the pilot phase of the project, the following observations are not based on specific evaluation indicators to measure the effectiveness of the project. Based on MF and other stakeholders' interviews as well as on very limited statistical data, they give strong indications of the effectiveness of the activities undertaken by MF throughout the UK and lead the consultants to conclude that the UK-wide Project will make a difference.

Training schemes

Training courses have empowered professionals from the mainstream health system (training of GPs, health visitors, etc.), which results in increasing the rehabilitation prospects for dispersed asylum seekers and refugees who have suffered torture. The effectiveness of the training programme is expected to be increased through the recruitment of training officers, including a 'train the trainers' officer who is already in post. Although no 'train the trainers' session had been planned in the project, interviews at MF made it clear to the consultants that this would be organised in the near future for the benefit of London staff members who will be involved in training health providers and community groups throughout the country.

Improved clinical services and use of alternative therapies

Community groups have received assistance to set up counselling services. Also, where regular counselling services have become saturated, GPs and community groups in the UK have been co-operating to provide shorter psychosocial interventions (English courses, art or gardening schemes, etc.).

Networking

Local networks have been developed or strengthened with the support of MF regional development staff, rendering referrals, treatment and social support more accessible to torture victims.

Support for asylum applications

Asylum seekers have better chances of being recognised as refugees by the British authorities if GPs have been trained to draft medical reports.

Trained GPs may include in their reports that they have received MF training, which is likely to make a real difference, as the British authorities seem to give more weight to MF medical evidence. It is, however, difficult to quantify this observation, as asylum seekers rarely give any feedback on the outcome of their asylum application.

The dispersal programme raised some concerns when it first started, because the structures required were not in place (lack of counsellors, lack of specific training for mental health services, negative perception of asylum, etc.). However, it has now become clear that MF UK-wide activities are contributing to establishing an adequate clinical and social framework. Although the external environment can affect the implementation of the programme positively or negatively, with local attitudes ranging from helpfulness in the reception of asylum seekers to hostile refusal to understand why they should receive specific attention from health providers, the MF regional development team has demonstrated good adaptability to local specificities.

However, some dangers and considerations will have to be taken into account by the regional development team members: some beneficiaries of the programme contacted by phone raised concerns as to possible increased difficulties in fund-raising for small community groups, should MF set up an office in their region. Some also underlined the necessity for MF to acknowledge and respect the already existing expertise.

According to the project application, *"a key measure of project success (i.e. the rehabilitation of survivors of torture) will be a series of mid-term, final and ex-post evaluations taken at six months, 12 months, at discharge and annually"*. Evaluation reports are to be submitted to various management staff, including the Monitoring and Evaluation Team, in order to test the relevance, efficiency, effectiveness, impact and sustainability of the project. This commitment was made again to the consultants during their visit. It is hoped that the ongoing cultural and organisational changes at stake at MF will enhance this process.

2.6 Efficiency

The London Project

The project management is of good quality and highly professional. MF has 73 full-time paid staff and 135 part-time paid staff (including 70 interpreters), who altogether make up the equivalent of 116 full-time paid staff. In addition, 223 volunteers contribute to the work of MF, 78 of them involved in direct clinical work, 35 in clinical support projects, 62 in legal work and the rest in other parts of MF's work (figures from August 2003).

The staff comprise a good mixture of age, gender, profiles and backgrounds and work in an open and collaborative atmosphere.

From these general figures, about 20 persons are involved (most working part-time) in the EC-funded project. Clinical staff involved in the project report to the Clinical Director; staff involved in activities related to torture prevention report to the Director of Public Affairs. The interpreters are professionals recruited directly by MF, some of them former patients.

The management has understood its responsibility for accountability and has introduced a monitoring and evaluation unit, headed by a clinical psychologist who has a lot of experience in the evaluation of the effectiveness of interventions in MH from the NHS. The resistance of the counsellors and therapists may be due to many different reasons, including a reluctance to do paperwork and a feeling that being evaluated is a way of being judged (and by non-therapists). The attitude of the pioneers, that something had to be done before one could identify evaluation criteria, was understandable and acceptable 20 years ago when MF started and it was based on the HR activism of the founders. However, 20 years later, with their own, as well as other European experiences, time has come to start asking what helps, what is detrimental and how one can become more efficient and professional. To ask for figures does not mean that one is not concerned by HR – even though in some groups this is still the attitude.

In London MF has just moved into a new building, donated by a supporter, constructed to suit the needs of survivors of torture. The building has an impressive architecture, with corridors which are illuminated by natural light and curved, so as not to recall the 'dark straight corridors' of – certain – places where torture is practised.

The UK-wide Project

Documentation provided to the consultants during their visit, as well as the renewed commitment of other donors for the pre-existing part of the project (i.e. the Manchester office, set up in 2000), indicate that there is high-quality programme management, reporting and staff management of the pilot project in Manchester, where the financial resources have been used efficiently. Therefore, there is some guarantee that EC resources supporting the expansion of the project will be used in a similar manner. The project is coordinated in London by the Regional Development Team, which includes a coordinator and an assistant, both very much committed to the project. As the resources for the pilot programme were adequate, one can assume that the planning for financial, human and capital resources for the expansion will prove consistent for the implementation of the UK-wide Project.

The staff at MF London are committed to contributing efficiently to the training sessions planned in the country. At the time of this evaluation, all the non-EC funds applied for for the expansion of the programme have been secured.

As many patients will be treated by professionals from the network (not depending financially on MF), it will not be possible to determine the per capita cost.

2.7 Sustainability

The London Project

The London Project is being implemented with a 60% EC contribution. This present evaluation does not aim to make recommendations on the continuation of this contribution, nor is MF requesting further EC support at this stage. Given the central nature of the activities implemented through this project, it is assumed that MF will raise funds for the continuation of the project, to guarantee that these activities can continue. Although torture victims may be covered by the national health care system, there is less provision for comprehensive psychosocial and legal support than at MF. In addition, although training efforts in the last few years have empowered many clinicians from the mainstream system to deal with torture victims, MF still remains the main rehabilitation centre in the UK. However, after nearly 20 years of existence, MF should be more aware of transferring ever more of its know-how and skills to the official health and social care systems, in order to ensure long-term sustainability.

The UK-wide Project

The UK-wide Project relies on the EC contribution for 46% of its budget and its full implementation would slow down considerably without EC support. The local consequences would be that, even though torture victims in the areas targeted by the project could receive treatment in the mainstream health care system, this treatment would be less adequate and effective. At a policy level, the project has a good level of sustainability, as it aims to empower the national health care system for treating torture victims. Once a nation-wide network is established, multiplier effects will develop.

With a dozen staff members in the fund-raising department, MF is constantly trying to develop its core funding, now amounting to 68% of its total budget. This is a sustainability factor and it may give project managers some flexibility in the implementation of their programmes.

2.8 Visibility

Neither project has good visibility. The EC logo should be seen in the entrance of the building as well as on publications and letters.

2.9 Impact of rehabilitation on prevention in a European context

MF was originally created through an Amnesty International initiative and has always followed a human rights approach. It has seen one of its tasks as the prevention of torture. It uses knowledge from treatment to publish country reports, in order to draw public attention and raise awareness about the practice of torture. Prevention activities have been developed in the UK and aimed at other countries – condemning countries where torture is practised and from which MF patients come. MF also uses therapies in order to motivate survivors to publicise their ordeals or condemn a torturer they have recognised in the UK. The official view at MF is that public condemnation can be an integral part of the healing process and therefore of therapy and that in this sense therapy and prevention activities can be intertwined.

Prevention in the UK

MF is developing several activities aimed at ensuring that Article 3 of the European Convention on Human Rights (ECHR) is properly applied, i.e. preventing torture victims from being removed from the UK (non-refoulement). Based on its rehabilitation work, MF provides some patients with medical reports (approximately 900 reports a year), which are recognised as important medical evidence by IND caseworkers. These caseworkers have received policy instructions from the HO to suspend the consideration of an asylum claim if there is evidence on the file that MF has agreed to write a report. While this used to be restricted to London-based asylum seekers, this service is now also available to asylum seekers UK-wide, where several GPs have received MF training to write medical reports.

It is important to note that MF has a long-standing relationship with the British authorities. Hence these activities are backed by a constant dialogue with the HO and other relevant departments (IND and NASS), on both a formal and an informal level, thus increasing their impact. Through this dialogue, individual cases are raised and reviewed and country reports and thematic studies are formally submitted to interested HO officers. Also legislative changes are proposed or challenged.

Prevention in the patients' countries of origin

In publishing country reports, it seems that MF brought its added value to the work done by human rights NGOs. For example, the report *Rape and other torture evidence in the Chechnya conflict: documented evidence from asylum seekers arriving in the UK* (which was made public in Moscow at a press conference organised jointly with Memorial, Human Rights Watch and Amnesty International) presents evidence of torture which other human rights NGOs are not in a position to collect easily on the ground, where victims may be more fearful to speak. In this sense, country reports bring a contribution to the condemnation of torture in the patients' country of origin. However, this activity has only targeted a limited number of countries, as there is only one full-time member of staff working in this area.

MF activities aimed at combating impunity also contribute to prevention in countries of origin. These activities are focused on the International Criminal Court (ICC) (collection of testimonies with a view to feeding into ICC complaints), the universal jurisdiction clause in partnership with the NGO Redress (collection of testimonies from victims when the perpetrator of the torture they have gone through has been identified in the UK; this has only happened twice, with an unsuccessful outcome i.e. the perpetrator was not arrested) and the European Court of Human Rights, although this option has remained theoretical.

Prevention at the international level

The awareness-raising in the UK and in Europe about torture of substantial numbers of asylum seekers, even those from countries which, as members of the Council of Europe (such as Russia), have signed the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, is important, so that HR activists can go on pressuring for changes with evidence in their hands. Country reports are used to lobby UN Member States at the UN Commission on Human Rights (e.g. written statement submitted to the annual session of the Commission in February 2004).

In addition, overseas outreach work in Guatemala, Somaliland and Israel, Gaza and the Occupied Territories is said to be a further contribution to prevention, although the consultants did not have the means to assess its actual impact.

Indicators to measure the impact of the prevention work

Several indicators might be identified to measure the impact of the work on prevention, such as legislative, procedural and social changes in the treatment of asylum in the UK, change of attitudes in government forces (police, army) in countries where torture rages, condemnation and finally conviction of perpetrators with hopefully its deterrent effects. At MF, indicators remain to be identified by the Department for Public Affairs. However, at this stage these indicators are not measurable to prove the impact of torture prevention.

Detraction of prevention activities from the rehabilitation work

Prevention activities are undertaken by staff from the Department of Public Affairs (who are not involved in clinical activities, thus ensuring that this does not have negative consequences on the rehabilitation work). Rehabilitation work and preventive activities are closely inter-related: in its approach to prevention, MF aims to utilise the information collected through the clinical process with a view to denouncing torture, raising public awareness, supporting the asylum claims of torture victims and seeking redress. It always does so only with the informed consent of the patient concerned.

Beneficial or detrimental effects of prevention activities on the victims

Patients are either not involved in prevention activities or they have given their informed consent for disclosure of their experiences (e.g. in country reports). Thus, preventative activities flow out of the work with patients and some therapists are of the opinion that part of the healing process for victims of torture is to testify, at least in front of the therapist, with an option to use these testimonies later as the basis for condemnation, accusation or proof in court. This attitude, correctly managed in the therapeutic process, can enhance the healing of psychological and emotional wounds caused by torture.

3. Conclusion

3.1. Impact

Due to the lack of a reliable database, some important figures such as the number of consultations per patient or drop-out rates are missing, which makes it difficult to evaluate the project's impact in quantitative terms. According to the beneficiaries interviewed, health care and social support provided to them by MF have helped their rehabilitation process. Clinical staff note that the treatment provided to the beneficiaries also has an impact on members of their families. According to stakeholders interviewed, prevention-related activities implemented under the London Project have had an impact on several institutions involved in asylum issues in the UK, such as the Home Office with whom MF has periodic meetings. This can be achieved particularly through country and thematic publications which increase awareness of the practice of torture and through training of officers in charge of assessing asylum applications filed by torture victims.

Since the UK-wide Project has only been partly implemented through a pilot project (without EC support), its overall quantitative impact cannot be assessed at this stage. One can nevertheless assume that it will have an impact, as it aims to develop a UK-wide network of voluntary organisations (refugee groups, advocacy projects, counselling services and interpreters) and health providers (GPs, community MH teams, hospital staff and health visitors) by training them in how to address the needs of torture victims.

3.2. Relevance and design

The design of the London Project covers most activities implemented by MF as a health care centre since it was created, offering a wide range of services to torture victims. No other group in the UK has become active in addressing similar topics in the same combination. Amnesty International may be inspired by MF's country reports and give them support through public condemnation. However, MF has remained the only explicit therapy provider for asylum seekers in London as elsewhere in the UK. Only when the dispersal programme was set up, was the need for the expansion of rehabilitation for torture victims in places other than London suddenly felt and the UK-wide Project was started. After 20 years since its establishment this can be considered both as a capacity to respond flexibly and as a mark of quality, because no other group had felt it to be necessary to develop more services. However, it can also be considered as a failure to integrate the service into the normal mainstream of medical and psychosocial services, empowering the NHS to deal effectively, humanely and efficiently with this group of victims, as it does with other victims of violence.

Stakeholders involved in or targeted by MF torture prevention activities – such as the HO or the British Medical Association (BMA) – consider the activities as relevant. However, the project design does not have objectively verifiable indicators to assess these prevention-oriented activities.

The UK-wide Project was designed as a response to the government's dispersal programme. Its current design derives from the Manchester pilot project which, according to the documentation and interviews with several actors involved, was well designed and relevant to the changing needs of dispersed asylum applicants.

3.3. Effectiveness

The two projects aim to rehabilitate torture victims (providing treatment, psychosocial and material assistance). The London Project also aims at preventing torture through advocacy work at the national and international level (press releases, publications, lobbying to change national and international legislation, supporting legal prosecution of perpetrators, etc.).

For a long time MF functioned as it did from the start, when all the people actively involved were volunteers and the main and urgent question was how to help victims in need. At that time, the evaluation of effectiveness, regarding treatment interventions, as well as preventive activities, was not a pressing issue.

Since then, MF has become a large organisation, paying salaries to many people, although it still operates partly with volunteers. At this stage accountability becomes more urgent. It should be taken seriously for the sake of the people treated (the shortest and best treatment), but also for the donors (the most value for their money). Last but not least, evaluation is important for paid and volunteer workers. Evaluation of their interventions would show them the objective usefulness of their work.

Today at MF there is an awareness of these necessities and a willingness to comply with them. The evaluation and monitoring unit has been set up for precisely this reason. The unit deals mainly with the monitoring and evaluation of therapeutic processes. It has started to follow the assessment of patients (e.g. a thorough psychological and medical diagnosis) and the evolution of the process (e.g. the disappearance of symptoms, integration into work and care for the family). Evaluation as to the efficiency of therapeutic processes in the specific transcultural context of MF will be possible at a certain point in the future, and this in a quantifiable way. It will partly depend on the working capacity of the team and partly on the collaboration of the therapeutic teams.

As to the evaluation of the effectiveness of the prevention of torture, this is much more difficult. Parameters indicating the efficiency of prevention are multiply determined and not easily defined (not even in such simple topics as cancer prevention). Parameters for measuring prevention of torture will have to include not only medical and psychological, but also societal and political processes and changes. Qualitative and maybe at some stage also quantitative indicators will have to be formulated and defined. The large number of different parameters on the one hand and the lack of consensus in the scientific and HR communities, on the other hand, mean it will be a long time before sound basic verifiable data are defined and become operational.

Although the EC-funded UK-wide Project has not been fully implemented yet, the evaluation of its pilot stage allows the conclusion to be drawn that its objectives are in the process of being met in the places where it has started. In particular, dispersed asylum seekers are now more likely to find appropriate services in towns where, with the support of this project, an adequate clinical and social framework is being developed.

3.4. Efficiency

The management of both projects seems very professional and efficient. Many volunteers are involved in all MF activities, so that the organisation can achieve more than is financially covered. However, supervision and control mechanisms for caseworkers/counsellors could be improved, particularly for volunteers.

3.5. Sustainability

Both projects are financially sustainable, as MF receives regular support from many different donors. Funds from other donors have already been secured for part of the UK-wide Project.

At a policy level, the UK-wide Project may improve MF integration into the national services for the care and treatment of victims of violence and, through that process, enable mainstream services to improve care and treatment of refugees and torture victims. This would be another aspect of the project's sustainability.

3.6. Visibility

The EC contribution is not visible in either project.

3.7 Impact of rehabilitation on prevention in a European context

The rehabilitation activities at MF produce some of the information gained for preventative activities. The country or thematic reports, which begin from information in therapy, can also be of use in smaller centres in the rest of Europe. At the same time, some therapists consider testimonials or even accusations of perpetrators as integral parts of a completed therapy. In this sense rehabilitation and prevention are intimately intertwined and partially enhance each other. These intertwined activities can also be of use for information and inspiration in the European context.

However, the assessment of the impact of rehabilitation on prevention of the occurrence of torture is not possible, neither in a European context nor on the wider scale.

References

- Yearly reports of the Medical Foundation
- Smith, Ellie, *Right First Time? Home Office asylum interviewing and reasons for refusal letters*, Medical Foundation for the Care of Victims of Torture, February 2004.
- Peel, Michael, *Rape as a method of torture*, Medical Foundation for the Care of Victims of Torture, 2004.
- *Improving the speed and quality of asylum decisions*, Report by the Comptroller and Auditor General, House of Commons, 22 June 2004.
- *Evaluation EIDHR: torture rehabilitation centres*, MEDE European Consultancy, November 2003.
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.
- Council Directive 2003/9/EC of 27 January 2003 laying down minimum standards for the reception of asylum seekers [Official Journal L 31 of 06.02.03].
- European Commission Communication on the EU's role in promoting human rights and democracy, May 2001, COM (2001) 252 Final.

Annex 1: Itinerary

Tuesday 13 July 2004

- Travel Zurich – London (Gisela Perren-Klingler)
- Travel Paris – London (Sara Guillet)

Wednesday 14 July 2004

9.00 AM	Malcolm Smart, Director, and Gordon Wills, Associate Director
10.00 AM	Visit to the Medical Foundation
11.00 AM	Alex Sklan, Clinical Director and Project Manager
12.00	Meeting with a patient
1.00 PM	Emma Williams, Regional Development Coordinator and James Tomlinson, De velopment Manager
2.00 PM	Penny Smith, Senior Caseworker/Counsellor
3.00 PM	Meeting with a patient
4.45 PM	Andrew Keefe, Specialist Team Manager at the Refugee Council

Thursday 15 July 2004

9.00 AM	David Dunford, Senior Caseworker at the Immigration and Nationality Directo rate, HO
10.00 AM	– Dr Sherman Carroll, Director of Public Affairs (Sara Guillet) – Attending a supervision session with Penny Smith (Gisela Perren-Klingler)
11.00 AM	– David Rhys-Jones, Parliamentary Officer (Sara Guillet) – Attending a staff meeting, where specific topics were discussed mainly about MF's 'corporate identity' (Gisela Perren-Klingler)
12.00	Ellie Smith, Human Rights Researcher
1.00 PM	Lunch
2.00 PM	Sheila Melzak, Child and Adolescent Therapist, and Jocelyn Avigad, Family Ther apist
3.30 PM	Ann Sommerville, Medical Ethics Group, British Medical Association
4.30 PM	Phone calls with Jude Boyles, Project Coordinator in Manchester, and with volun tary organisations and health providers in the UK involved in the new project (see Annex 3)

Friday 16 July 2004

9.00 AM	Phone calls with voluntary organisations and health providers in the UK (see Annex 2)
10.00 AM	Nimisha Patel, Audit and Evaluation Coordinator
11.00 AM	Malcolm Smart, Director, and James Tomlinson, Development Manager
1.00 PM	Lunch
2.00 PM	Gill Hinshelwood, Senior Physician, Coordinator of the doctor's team
3.00 PM	Emma Williams, Regional Coordinator
4.00 PM	Danny Hearty, Training Coordinator
5.00 PM	Departure to airport

Annex 2: People and organisations interviewed

Medical Foundation Staff:

- Jocelyn Avigad, Family Therapist
- Gordon Wills, Associate Director
- Jude Boyles, Project Coordinator in Manchester (phone interview)
- Dany Hearty, Training Coordinator
- Gill Hinshelwood, Senior Physician, Coordinator of the doctor's team
- Nimisha Patel, Audit and Evaluation Team Coordinator
- David Rhys-Jones, Parliamentary Officer
- Alex Sklan, Clinical Director and Project Manager
- Malcolm Smart, Director
- Ellie Smith, Human Rights Researcher
- Penny Smith, Caseworker/Counsellor, leader of 'Team B'
- Jim Tomlinson, Development Manager
- Sheila Melzak, Child and Adolescent Therapist
- Emma Williams, Regional Department Coordinator
- Two beneficiaries (one from Kosovo and one from Iran)

Other stakeholders:

- Alison Callaway, General Practitioner to asylum seekers, Anchor Centre, Coventry (phone interview)
- Jane Fraser, Counsellor, Re-Examination, Advice, Counselling and Help (REACH) (phone interview)
- Gill Gibbons, Leeds Asylum Seekers Support Network (LASSN) (phone interview)
- Andy Keefe, Specialist Team Manager, the Refugee Council
- Ann Sommerville, Medical Ethics Groups, British Medical Association
- James Welsh, Medical Coordinator, Amnesty International (phone interview)

Annex 3: Comments Medical Foundation

Many thanks for the evaluation report. I have two points which need to be amended:

1. P13 UK wide Breathing Space Project was not set up in Manchester. It was London based with a national brief.
2. P16 Groupwork

All new clients are considered for FOG (Finding our Ground) groups. Many who graduate from FOG groups go on to more therapeutic groups. In this way groupwork is a first option to be considered.

Annex 4: Final report EXIL

Evaluations EIDHR

EXIL

Torture rehabiliation centres Europe

human european consultancy in partnership with the Netherlands Humanist Committee on Human Rights and the Danish Institute for Human Rights

Januari 2005 By Sara Guillet and Gisela Perren-Klingler

human european consultancy

This report is the outcome of an evaluation commissioned by the European Commission on projects financed in the field of the European Initiative for Democracy and Human Rights (EIDHR). The EIDHR is a European Union programme that aims to promote and support human rights and democracy in third countries. Information on activities and actions can be found on the EIDHR website: http://www.europa.eu.int/comm/europeaid/projects/eidhr/index_en.htm

human european consultancy
Hooghiemstraplein 155
3514 AZ Utrecht
The Netherlands
Tel +31 30 634 14 22
Fax +31 30 635 21 39
office@humanconsultancy.com
www.humanconsultancy.com

Abbreviations

ADDE	Association pour le droit des étrangers (*Association for the Defence of Migrants' Rights*)
ADDH	Aide pour le Développement Durable et Humanitaire *(Aid for Sustainable* and Humanitarian Development)
ASBL	Association sans but lucratif (*not-for-profit organisation*)
CGRA	Commissariat général pour les réfugiés et les apatrides *(General Commissioner's Office for Refugees and Stateless Persons*)
CIRE	Coordination et Initiatives pour Réfugiés et Étrangers (*Coordination and Initiatives for Refugees and Migrants*)
CPAS	Centre Public d'Aide Sociale (*Public Centre for Social Assistance*)
CPRR	Commission Permanente de Recours des Réfugiés (*Refugee Appeal Board*)
DRC	Democratic Republic of Congo
ECHR	European Convention on Human Rights
EIDHR	European Initiative for Democracy and Human Rights
MD	Medical doctor
OE	Office des étrangers (*Foreigners' Office*)
PTSD	Post traumatic stress disorder
UAM	Un-accompanied minor
WHO	World Health Organisation

Executive summary

The objective is to evaluate a centre, EXIL, which cares for and treats survivors of torture and organised violence. It was established nearly 30 years ago by then refugees who were themselves survivors of torture in Chile. Because of this, the approach to victims of torture is unique for a centre located in Europe. The view of the centre's staff is that people who have been subject to torture and/or organised violence are normal people subject to abnormal violent experiences and that they have the resilience to reconstruct their lives, even in exile. What they need is a helping hand to overcome their experience, to adapt to a new situation in order to integrate – without losing their original identity – into the receiving society. It is thought that this process needs around three years of care, at the beginning often more intense, becoming gradually less so with time.

The centre has a systemic view of the human being as part of larger systems – family, friends, community – in which realities are co-constructed. The intervention is medico-psychosocial, which means that nearly all patients are first seen by a nurse and /or general practitioner, but then always accompanied by a psychotherapist. The rest of the intervention is planned according to the specific needs of the person.

The centre does not have a torture prevention policy, arguing that this would detract from its primary mandate as a care centre.

As part of the evaluation, a team of two consultants visited EXIL in Brussels from 21 to 23 September 2004, interviewed staff, beneficiaries and other stakeholders and collected data about the work of the centre.

Recommendations

Following their evaluation, the two consultants recommend EXIL:

- To start with the planning and soon the implementation of a computer program to procure basic hard data about numbers of patients, intensity of care, treatment programmes and their combinations, drop-out rates, number of treatment hours, costs per hour of treatment, duration of treatments, costs per patient etc.
- To provide the World Health Organisation (WHO) research team with increased support, so as to enable it to report as soon as possible on the ongoing work, both in terms of treatment effects and outcomes and of prevention activities.
- To develop a systematic monitoring and evaluation system, based on the WHO research, in coordination with other European centres.
- To develop a proactive approach and build up a strategy on awareness raising and advocacy among Belgian authorities dealing with asylum issues.

- To put up visible logos of the EU in the entrance halls of their buildings. The logo should also be included on their headed paper and on their publications.

The consultants recommend that the EC give a positive response to EXIL's funding application for its programme in Belgium.

1. Introduction and methodology

1.1 Objectives

This evaluation of EXIL is part of an evaluation of four different torture rehabilitation programmes currently financed by the EC in France, Belgium, the UK and Greece. It will assess the relevance, efficiency, effectiveness, impact and sustainability of the project. The proposal had in principle been pre-selected by the Selection Committee for further funding, but the signing of a new contract was made conditional on the results of this evaluation. The evaluation should also provide elements for the assessment of the effectiveness and impact of programmes in relation to the argument that the work of torture rehabilitation centres contributes towards the prevention of torture.

1.2 Background

The European Commission (EC) Communication on the European Union's role in promoting human rights and democracy in third countries has four priorities for the use of the European Initiative for Democracy and Human Rights (EIDHR), one of which is support for the fight against torture. The Communication states that *"in seeking to be an agent of change, the EU should ensure that it focuses as much as possible on prevention, including through human rights education of the police and other possible agents of torture"*. The torture rehabilitation centres have argued that their work contributes towards the prevention of torture.

Two specific questions have guided the whole evaluation process. The first is about the function, possibility and efficacy of prevention. The second question is how to evaluate the efficacy of interventions, be they therapeutic or preventive. Accountability in such services can only be exercised if valid evaluation and auditing methods are introduced. Staff motivation also benefits from staff knowing what they do at an evidence-based and quantifiable level.

For the treatment programmes, evidence-based, qualitative, quantifiable and replicable answers will have to be produced to the question about effectiveness. As EXIL cares for a wide variety of patients with extremely different cultural backgrounds, evaluation procedures are not easy to conceptualise. A promising start in evaluating the effectiveness of the interventions was made in a research project funded by the WHO collaborating centre at the Catholic University of Louvain. This research project had two aims: to evaluate the global effectiveness of the therapeutic interventions with refugee families and to ask how this experience can model intervention strategies with Belgian families for preventing ill-treatment of children and family violence.

Quality evaluation in psychiatry and psychotherapy is an activity which is still in its tentative and exploratory phase, even in culturally homogenous treatment programmes. It is all the more difficult to evaluate the effectiveness of treatment programmes with heterogeneous populations and where social aspects are intimately intertwined in the treatment outcomes, such as being a refugee, problems with adapting in a new country etc.. As EXIL's intervention philosophy takes all these parameters into account, the research work bore some promising findings.

Primary prevention of torture is understood in this context as a pedagogical intervention aimed at the population, in families and in schools, teaching peaceful communication.

A more thorough reflection on the relationship between prevention of torture and treatment of victims of torture, as well as the respective evaluation possibilities, Is to be found in the synthesis report.

This evaluation focuses on the project implemented from January 2002 to December 2004. All the activities are considered and evaluated from the point of view of preventive and treatment activities.

The new proposal refers to the continuation of the ongoing activities of the centre for three years, starting in December 2004. The EC funding applied for is for 1,560,000 Euro and represents 49,93 % of the total funding of EXIL. As for the previous programme, it covers all the activities of the centre.

1.3 Methodology

The evaluation was carried out through the study of documents and a three-day visit to EXIL in Brussels. This included collection of quantitative and qualitative data through interviews with staff, beneficiaries and a variety of stakeholders (see Annex 2).

The team comprised two experts: Ms Sara Guillet (team leader), specialist in international human rights law, and Dr Gisela Perren-Klingler (medical expert), specialist in project evaluation and transcultural psychiatry/psychotherapy. Before leaving EXIL, the team shared and discussed its preliminary findings and recommendations with the Director, the Coordinator and the Programme Coordinator.

The staff of the centre did receive the draft report for comments, which have been added to the final report as annex 3.

2. EXIL, medico-psychosocial centre for people in exile and torture victims

2.1 Asylum in Belgium

The beneficiaries of EXIL are foreigners who have fled their country where they have suffered torture and organised violence. Most of them have applied for refugee status in Belgium. The asylum application follows two stages. First, it has to be made within eight days of arrival in the country at the Foreigners' Office (*Office des étrangers*, OE), which makes a decision about the admissibility of the application after interviewing the applicant. Admissible applications are referred to the General Commissioner's Office for Refugees and Stateless Persons (*Commissariat général pour les réfugiés et les apatrides*, CGRA). In the second stage, the CGRA calls the applicant for another interview, in order to assess whether the application meets the Geneva Convention criteria. Asylum seekers who are not recognised as refugees by the CGRA may appeal to the Refugee Appeal Board (*Commission Permanente de Recours des Réfugiés,* CPRR). The overall admission rate in Belgium was 27% in 2003. Asylum applications have been decreasing since 2000. In 2003, 17,000 people sought asylum in Belgium, whereas 42,000 applications were registered in 2000. The length of the asylum procedure varies from six months to six years.

Once an asylum seeker has introduced an application, he/she is registered at a residence for asylum seekers (*centre d'accueil*). During the assessment stage for admissibility, asylum seekers are provided with food and accommodation at the centre and receive emergency medical care; they do not receive any financial help. Once their application has been declared admissible, they can receive additional social support (clothes, furniture, material support and medical care) through a public centre for social assistance (*Centre Public d'Aide Sociale*, CPAS). Asylum seekers whose application has been refused by the CGRA and CPRR may have further grounds for appeal (e.g. if their state of health requires specific treatment which is not available in their country or for other humanitarian reasons) but they are not entitled to any social or medical assistance, except in limited cases under the emergency medical aid scheme (*Aide médicale d'urgence*).

2.2 Overview of EXIL

The work of EXIL first began in 1976, three years after the arrival of several young medical professionals as refugees in Belgium, who had been tortured themselves. They established a small centre, called COLAT (Colectivo Latino Americano de Trabajo psicosocial) to help their compatriots and political refugees from other Latin American countries to overcome their traumatic experiences. Parallel to that, the young medical doctors (MDs) trained in different medical specialties, the founder and current director of EXIL in psychiatry and systemic psychotherapy.

In 1987, with a decline in the numbers of Latin American patients and the arrival of other refugee groups, the centre changed its name to EXIL. Rehabilitation and integration of victims of torture and / or organised violence is the mainstream activity of this centre.

Today the intervention objective is still the same: to treat the consequences of violence experienced and to prevent further consequences, such as family or other violence (e.g. criminality) and to enhance integration. The target groups have changed with regard to their geographical origins, but not in relation to their experiences – experience of torture or organised violence (direct victims and their family members and indirect victims).

The project offers medical, psychological and social support to refugees who are victims of torture so that they can overcome the consequences of torture and organised violence suffered in their countries of origin. At the same time, it is considered that these interventions also open a door to learning to cope with the experience of exile and being able to adapt to the new situation in Belgium. The aim is also to construct a transitional social network for people in exile, until they are integrated in the receiving society.

Each treatment programme also has a health education element, with the goal of enabling patients to become active in and responsible for preventive measures in personal health, primary and/or secondary.

Beneficiaries

The beneficiaries of the project are refugees and asylum seekers who are victims of torture or of organised violence – who have been either tortured themselves (direct victims) or are family members of torture victims (indirect victims) in need of help.

In the first years of the existence of the Centre, called COLAT at the time, clinicians were seeing around 550 clients a year. In 2003, 1,239 clients were seen at EXIL (52% women, 31% men and 17% children and adolescents), from very diverse socio-political backgrounds. Sub-Saharan African clients represent the largest group referred to EXIL, at 34%, followed by 30% from the Middle East, 19% from Eastern Europe and 15% from Asia. No statistical data exist about the patients' asylum status; some of them are illegals, having exhausted all appeal possibilities. The total number of treated patients since the beginning of EXIL is 17,490.

Patients are referred to the Centre by their *Centre d'accueil* (reception centre), by medical doctors, sometimes by the CGRA and by schools etc. However, no precise data are available.

The philosophy of care at EXIL is a systemic one, caring for the patients at three levels: medical, psychological and social. Patients are offered an inter-disciplinary and comprehensive service by a multicultural team including general medical care, health education, psychiatric assessment and treatment, psychotherapy, family therapy, child and adolescent therapy, physiotherapy, psychomotor therapy, parenting training, casework and social work. The centre also provides forensic medical reports to document torture and ill-treatment in support of asylum applications (37 medical reports were issued in 2003). In addition, the centre offers some practical assistance for patients who are in need (money for schoolbooks, transport, etc.). No legal assistance is provided but patients can be directed to pro bono lawyers' networks.

Patients go through the following reception process: after a first contact, normally by telephone, sometimes at the reception desk, they are referred to one of the four existing care groups – there is one each respectively for men, women, families (including children) and adolescents. However, before that patients are normally referred to the nurse and/or a general practitioner, because the initial complaints are most often somatic. The needs of new patients are analysed in inter-disciplinary meetings, where therapy procedures are also planned.

There is no real waiting list. Patients are seen for the first time within four weeks, if urgent within one week. Later on they are always by a psychotherapist. The first consultation with the psychotherapist always includes the social worker. Group settings nearly always accompany the individual therapy, with the aim of the (re-)construction of a social network. If needed, one of the social workers provides support in mobilising the existing local social services, legal aid or, in some cases, material support. Patients who do not appear to belong to the centre's target group are directed towards other health centres.

The average individual session lasts 45 minutes. Patients see a psychotherapist once a week at the beginning of the process, then once or twice a month. The centre does not have any overview of the average number of sessions needed by a patient, but explains that treatment normally lasts from six months to three years (very rarely four or five years). It is not known by how many different professionals each patient has been seen. However, since it is the philosophy of the centre, it is known that nearly everybody is seen by a psychotherapist. No information is available regarding drop-out figures and there has been no evaluation about people who do not continue to attend.

Besides its work with patients, EXIL is developing some limited outreach activities in some refugee residences (organising group counselling and psycho-education about violence and its consequences with unaccompanied minors (UAMs)), in schools (organising group counselling and psycho-education about violence and its consequences with UAMs and children from three schools in Brussels) and through research work.

The centre is currently doing a research study in cooperation with the WHO regional collaborating centre on how to assess its work with families, children and adolescents. This is part of a process started in order to monitor and evaluate scientifically and with quantitative data the quality of the centre's clinical work with refugees. However, WHO has an additional interest in the research, which is to produce a model of best practice for preventive work in family violence. This is planned to be of help to Belgian families as well as the refugee families. This is a sign that EXIL's work is highly respected by scientific bodies. Modelling of EXIL's experience by WHO is planned. For EXIL, this research is the first step in a longer-term strategy aiming at setting up a monitoring and evaluation system to assess other aspects of their work.

Staff and infrastructure

The centre mainly relies on paid staff, with 31 employees, who altogether make up the equivalent of 19 full-time paid staff. In addition, a few volunteers contribute to the work of EXIL. A befriending project has been ongoing since 1995, relying on volunteer 'godparents'. Two volunteer 'godmothers' are coordinating this project and about 130 families or individuals have been involved within the last nine years. 10 volunteer interpreters contribute to the centre's activities on a regular basis (they only receive a small financial compensation). About 10 students contribute each year to the centre as interns.

Among the clinical staff, one psychotherapist, two psychologists and three social workers and the coordinating interpreter are employed full-time. The director, the clinical coordinator, three psychologists, one physiotherapist who does psychomotor therapy, one other physiotherapist, three general practitioners, one coordinator for medical reports and one nurse are employed part-time. All part-time clinicians have another place of work, which keeps them in touch with the mainstream health system.

Among the administrative staff, one coordinator and one accountant are full-time employees, while three persons work on reception. Furthermore there are two secretaries and two men who work part-time to look after the premises and do small repair work. The new project proposal adds one assistant coordinator and an additional person for reception.

Most of the staff have been trained in systemic psychotherapy at the Louvain Catholic University, others are planning to undergo this training. The staff also attend other specific professional training within their working hours, at their own expense.

Supervision of the work of the professionals is guaranteed at an official level for psychotherapists, general practitioners, social workers, students, interpreters and the reception team. Care for everyone working at the centre and sensitive listening to emerging needs and subsequent offers to respond to these needs may be one of the factors which enable the team to deal with the numerically vast and psychologically taxing workload, without showing any signs of burn-out.

The offices are located in two adjacent buildings close to the centre of Brussels. In one building EXIL occupies three out of four floors, in the other one they occupy one floor. The rooms are assigned according to their function, not to persons, i.e. there is a reception and an adjacent waiting room and a room for the staff. Therapists have no fixed room, which means that with each patient they have to go hunting for a free room. Under the new project, additional working space will be available. Computers are only installed in a few rooms – the experts counted four computers. The Medical Examination Group's experts interview their clients in their own offices, another sign of the flexibility of the centre concerning space.

The atmosphere, which one would expect to suffer from this loose organisation, limited space and permanent adaptation, is however, although very busy, very cheerful, friendly and caring. A lot of people have been working at EXIL for over four years, several people for 10 to 15 years, one for 20 years.

Networking

In the human rights field, the centre is in ongoing and close contact with human rights organisations such as Médecins Sans Frontières, Amnesty International and the Human Rights League and argues that these NGOs echo EXIL's concerns towards the relevant official authorities. It also takes part in the periodic coordination of watch-dog platforms on asylum issues. However, these networking activities occur on a personal level, often outside of 'working time' with patients and it seems that the staff do not consider this as sufficiently important to mention. In this sense, the activities also do not show a clear systematic planning at the national level. Although there is no avoidance behaviour towards collaborating with local networks, there is no strategy to include them regularly or to do active outreach work with them. Collaboration is based on individual contacts rather than on an institutional strategy. This might also simply reflect the compartmentalisation of actors in Belgium. In spite of this loose networking, EXIL is considered by other actors as the main reference point for rehabilitating torture victims.

In the clinical field, some therapeutic processes may imply the constitution of an *ad hoc* network of professionals, particularly with regard to adolescents: as part of the assessment of the therapeutic process, the coordinator of the adolescent programme convenes meetings with professionals from the patient's school, CPAS, lawyer etc., in order to discuss his/her needs and avoid overlaps.

At the international level, EXIL participates in some meetings of the European Network of Rehabilitation Centres for Torture Victims, is doing some training at EXIL España in Barcelona and has a link with human rights activities in Chile and the Democratic Republic of Congo (DRC).

2.3 Impact

There are no objectively verifiable indicators to measure the impact of the rehabilitation work. The logframe proposes a number of loose indicators such as improvement of the medical and social situation, reduction of medication, enhancement of coping skills, which, in practice, are not assessed through a systematic monitoring and evaluation system either during the treatment or once the patient has left the programme. However, monitoring and evaluation do take place at the individual therapeutic level: changes in the patient's behaviour, as well as in the family system are followed, observed and written down in the individual medical files and regularly monitored and evaluated in weekly supervision sessions.

A patient-tracking system and a systematic data collection system is currently being set up and tested. It is expected to be operational in early 2005. For the time being, at an internal level, the frequent case supervision follows the development of each patient and in this sense a clinical, evidence-based quality control is guaranteed.

Impact on beneficiaries

The project addresses mainly direct and indirect 'survivors' in exile, people who have survived torture and their family members. As EXIL has a systemic view of its interventions, it is evident that its therapeutic and social interventions, as well as its medico-legal reports, benefit more people than the individual patients with whom there is direct contact: their partners and children benefit as well. It is said that the quality of life of all these larger groups also gain from the intervention with a single person.

No measurable data exist about any multiplier effect; this effect has never been quantified, although one of the core concerns of EXIL is to reach family members as well through its clinical work, which is congruent with its systemic conception of therapy.

The pilot project on best practice in the prevention of family violence and child abuse might, in the long run, also have a multiplier effect for Belgian families.

Institutional impact

Through its internship programme, EXIL has, over the years, had some empowering and multiplying effect in the professional mainstream. Each year EXIL accepts at least 10 students as interns to work on its premises and to learn about how to deal with refugees who are torture victims: psychiatric training, clinical psychology training, pre-clinical psychology and social work. Some of these students later on apply for jobs at EXIL.

As all efforts are focused on clinical work – a huge work load for a small and very motivated team – there are no resources available for increasing the impact of multiplying or other training work outside EXIL. An unforeseen positive effect of the project is the increasing amount of requests made to the Centre by various institutions for training, experience-sharing and awareness-raising activities. However, EXIL's responses to these requests are only on an *ad hoc* basis. There is no comprehensive strategy in this respect. And yet, given both the reliable expertise developed by EXIL and the readiness of some stakeholders such as the CGRA to develop tighter relationships, it seems that a lot could be done to improve the project's institutional impact without involving a lot of resources.

Interviews with EXIL and stakeholders made it clear that the work of all actors involved with asylum seekers – clinicians, human rights associations, Belgian authorities assessing asylum applications, etc. – is highly compartmentalised. This may be one explanation for the project's lack of a wider institutional impact. Another reason is that EXIL has not taken a pro-active role in this respect.

There is only sporadic media coverage of the centre's activities. The centre does not have a website. Under the new project, an assistant coordinator will develop these aspects.

Impact on prevention

The centre's clinical work has an impact on *prevention in health issues*; however, this is only indirectly linked to torture prevention.

At an individual level, the nurse teaches patients about the looking after their health (individual primary prevention). People with chronic disease are taught how to adapt in the best possible way to this disease and how to stay healthy in all other aspects of their lives (individual secondary prevention).

At a community level, the activities of EXIL in peace education and prevention of family violence have an important primary preventive role. They are based on the analysis that migrant families and /or adolescents (especially the unaccompanied ones) are at high risk of transmitting their violent experience of persecution, torture and forced exile to their social networks – including the next generation – hence protracting violence in Belgium. The preventive activities include: training for good parenting skills in the families group; teaching teachers about how to deal with violent behaviour by adolescents; listening to and training violent adolescents in specific groups for UAMs and other adolescents in different schools (thereby probably also promoting the prevention of delinquency among this group).

A direct impact of the project on *torture prevention* results from the work of the Medical Examination Group, a group of nine trained GPs and two psychiatrists. Asylum applicants who are provided with a medical report have a better chance of being recognised as refugees in Belgium and therefore protected from removal to a country where they might be tortured again. Medical reports produced by EXIL are said to be more effective in Belgian asylum procedures than those produced by doctors outside of EXIL. This activity is conceived neither as a preventive activity nor as a central service at the centre, but rather as an accompanying helping gesture for the integration and rehabilitation of patients.

2.4 Relevance and design

EXIL is one among about two dozen mental health centres (*centres de santé mentale*) in the Brussels area. Some of them also operate a multicultural approach and admit migrants, but EXIL is the only centre offering a comprehensive interdisciplinary approach; in particular, other mental health centres do not employ medical doctors.

The types of assistance proposed are: psychotherapy (individual and group, family therapy, child and adolescent therapy), training for parenting skills, socialising groups, clinical psychology, somatic medical care, physiotherapy, psychomotor therapy, social work and material support and to a lesser extent medico-legal reports. The mainstream health care system does admit torture victims, but does not provide interpreting services and patients cannot be offered this wide and permanently coordinated range of services. EXIL seems to be the only institution to deliver medical reports for asylum claims (according to lawyers interviewed, some medical doctors may provide such reports, but without specific training and, therefore, with less significant results).

The interdisciplinary approach has been translated into the programme structure. Patients are taken care of within one of the four teams – children and their family, women, men and adolescents – composed of a variety of professionals. The programme management committee ensures overall coordination through regular meetings.

Patients who are in treatment have no input into the mapping of the programme, however, many professionals are themselves refugees (including a psychiatrist from Rwanda, one from Chile, a nurse from Congo, at least two professionals from Latin America, some from the Middle East and some young students from Eastern Europe etc.). Even if they are not all victims of torture, they are all victims of organised violence. This fact ensures that – with the different origins of the 'refugee professionals' – attention is given to the changing needs of changing populations. A number of former patients are employed in the programme: e.g. the reception desk is run by three people from three different countries, two of whom are former patients. The director of the centre is himself a survivor of torture and has benefited from psychotherapeutic help from a Belgian colleague. In this sense, the knowledge about consequences of organised violence and forced migration and the difficulties of adapting in a new country is based on practical and personal experience. People employed at EXIL know what it means to look for help after a traumatic experience. It also is a sign of hope for many of the patients, as they see proof that rehabilitation is possible.

The question of whether the real needs of the target groups are met is difficult to answer objectively, given the lack of a systematic monitoring and evaluation system. However, both the systematic needs assessment made at intake and the profile of the staff give some guarantee that the changing needs of the patient populations are taken into account. Beneficiaries and stakeholders interviewed for the purpose of this evaluation consider EXIL as the most effective mental health care centre for refugees who are victims of torture and/or organised violence, in terms of both time and effect.

It is estimated that 70% of patients are torture victims (no precise data are available). Whether a patient has been tortured is not always known at the outset, as it may only be disclosed during the course of the treatment.

Patients are involved in some socialising activities, such as visiting places around Belgium (women's group), cooking (men's group), residential camps (women's and adolescents' group) etc. The two patients interviewed, who felt very lonely in their personal surroundings, were enthusiastic about these activities.

The multicultural professional staff – more females than men – already possesses a wide range of language skills. In addition to the multi-professionalism, this is a real asset for the beneficiaries of the centre. In 2003, the centre ended its cooperation with an external interpreting service and decided to set up its own interpreting unit, coordinated by one full-time interpreter, who sees this as an improvement of the service provided to the patients.

The project design lacks a monitoring and evaluation system to verify the relevance of the treatment provided. The logical framework does not propose objectively verifiable indicators. For example, its does not provide information about the number of beneficiaries, their situation at intake, length of treatment, the number of treatments completed etc. The ongoing internal evaluation, focused on children and families and on adolescents, will contribute to setting up a systematic evaluation tool for all programmes.

2.5 Effectiveness

The whole team at EXIL is interested and enthusiastic in assessing their effectiveness, and open to any innovation. However, at this stage, the effectiveness assessment of the project cannot rely on objectively verifiable indicators, but only on oral and written information collected by the consultants during their visit.

The two main objectives of the programme laid out in the project proposal are:

- The integral treatment and healing programme for refugees, victims of torture and organised violence.
- The participation of torture victims, along with the centre's staff, in actions of solidarity and for the protection of human rights.

The therapeutic programme

The therapeutic programme consists of general treatment activities (medical, psychotherapeutic and social consultations, group therapies, family therapies, training for good parenting etc.) and specific activities adapted to beneficiaries according to their gender, particular situation and needs.

According to the project proposal the therapeutic programme pursues three objectives.

The first objective of the therapeutic interventions is: to be the shortest possible and the most empowering possible to enable victims of torture and organised violence to leave their experiences behind and to start a new, safe life in a new place, to integrate into the new society, while preserving their cultural roots. All means are used, from medication to body work, psychotherapy, play therapy for children, training for parenting skills, group therapies in which not only the therapists speak (although they are always present) but also patients share meanings and problems and develop connections with each other.

The second objective, the (re)construction of social networks is achieved through the *'groupes de parole'* organised in each of the four teams (women, men, families with children and adolescents), in which participants do not only speak, but also take part in joint activities (cooking workshop, visits around Belgium, etc.). This summer a residential camp for families with their children was set up for the first time. Similarly the godparenting programme for adolescents (mainly UAMs) aims to introduce them into the local community through their Belgian godfathers/mothers. Interestingly, the Belgian authorities have started to be interested in this programme, because till now the UAMs only had an official tutor. The godparents do not have any tutorial role, but they assist the UAMs with their integration into Belgian society. Since it began in 1995, over 100 UAMs have been involved in this programme. Many of these relationships are still ongoing, one godmother telling the evaluators that her 'UAM' is now married and has a baby and that she feels like a grandmother.

The third objective of the interventions, enhancing the general health of the patients and empowering them to look after themselves, is reached by many different means, including home visits by the nurse to see how they can be guided to a healthier lifestyle. The men's cooking group is one result of this project: they learn how to cook healthy food, to enjoy eating in a group, etc.

Visible monitoring and evaluation systems are non-existent. This makes it impossible to assess the project's impact in quantitative terms and verify objectively the extent to which patients are rehabilitated. Due to the lack of a reliable database, figures such as the number of consultations per patient or drop-out rates are missing. In qualitative terms, the interview with two patients, the attendance at a clinical supervision session, where cases were presented and discussed with openness and rigour, and discussions with therapists give an idea about the quality of the therapeutic interventions. The training and the view of the centre's psychotherapists and their systemic and behavioural approach are another guarantee not only for efficient treatment, but also a sign of their effort to ensure patients receive the shortest possible psychotherapy treatment.

Because of EXIL's systemic approach, their therapies and social interventions also benefit the patients' families. The consultants' observations lead them to conclude that all services provided help with the rehabilitation and integration of the patients.

The personal and systemic changing processes and developments of patients in therapy are monitored and evaluated continuously in clinical supervision sessions, be it at an individual level or in the respective groups of professionals. The group sessions, although heavy and time consuming as a process, connect and coordinate activities, motivate intervening professionals and tune in each individual intervention to the view of the system. They also evaluate the adequacy of interventions and encourage changes to approaches, if they do not seem adequate. The minutes of these sessions exist in hand-written form for each patient, but it is impossible to use them for official evaluation purposes because of the complexity of the processes. However, this would be possible for a retrospective study with a considerable investment of time (of research staff). No official evaluation and monitoring data are yet available.

Since 2003, a project sponsored by the Health Minister and the WHO collaborating centre in Brussels (not covered by EC funding) has employed two researchers – a clinical psychologist and a student in psychology. They are conducting a clinical evaluation of the effectiveness of the interventions achieved at EXIL with the family and adolescent groups. After preliminary studies about the constitution of groups, introducing informed consent for the families and informing the clinicians, a set of quantitative tests and qualitative investigations have been introduced and applied to all the participants. The small team is in the process of working on the results and of pairing groups for predictability. In the next stage they plan to determine where effectiveness can be proven and where it can still be enhanced. Not only will symptoms be investigated, the coping capacity (sense of coherence) and satisfaction of patients will also be included in the study. EXIL sees this pilot study as a means to enable the centre to improve management structures and clinical interventions at a later stage and also believes that it will provide a basis for further ongoing monitoring and evaluation. Depending on the availability of adequate funding, EXIL intends to learn the lessons from this research and use the investigation tools in order to improve the monitoring and evaluation of all their interventions.

Participation of torture victims, together with the centre's staff, in actions of solidarity and for the protection of human rights.

A few activities are organised in line with this objective; however, this is not done on the basis of a comprehensive strategy.

Such activities include the celebration of Women's Day on 8 March, involving patients from the centre, and the presentation by a second generation adolescent who went to Chile looking for the roots of his tortured and exiled father and made a film about it. The vision of the film attracted more than 100 people and had to be shown three times. The audience was mainly Latin American.

2.6 Efficiency

The contract is well managed by the coordinator, whose tasks include the administrative and financial management of the centre. The clinical activities with the beneficiaries are the responsibility of the director and the clinical coordinator. These activities are divided into four programmes (men, women, families and children and adolescents), each of them coordinated by a full-time professional. The whole team meets once a month.

31 people are employed at the centre, most of them working part-time, corresponding to a staff of 19 full-time employees. This figure has to be appreciated in the light of the number of patients consulting the centre yearly (1,239 in 2003): EXIL is a small centre coping with a major workload.

The total budget divided by the number of patients represents about 800 Euro per patient but it is not known how many consultations are given per patient. Therefore it was not possible to find out the cost per patient of treatment at EXIL. However, given that a patient needs treatment for between one and three years, the average cost per patient seems low, compared to other centres.

Project reporting would be improved if the reader was provided with more precise information (e.g.: important information is missing from the following extract: *"in 2003, meetings were organised with a number of partners to assess networking"*. What meeting? Which partners? What were the results?). The same remark may be applied to the new project proposal.

Financial resources provided for the programme seem adequate and, in general, activities and strategies adopted are consistent with the financing agreement. One wonders, however, why no budget line was clearly identified for the development of monitoring and evaluation activities under the new project, since these activities have been emerging in the recent years. It is not clear from the budget to what extent the different activities outside Belgium, be they in Chile, in Barcelona, or in the DRC, are funded by the EC programme.

2.7 Sustainability

The project is being implemented with a 44% EC contribution. Other contributions come from two main Belgian institutions: MARIBEL (17%) and the Commission Communautaire Commune de Bruxelles (30%). These two contributions, mainly as salaries, are based on the Belgian legislation which enables certain non-profit organisations (ASBL) to obtain this support for an indefinite length of time if they have been recognised as mental health centres, which is the case for EXIL.

Due to a reduction in states' contributions to the UN Voluntary Fund for Victims of Torture, the Fund has decreased its contribution to all its beneficiaries; for EXIL the Fund's contribution decreased to 6% of the overall budget, causing a number of difficult adjustments during the last two years.

Under the new project, EXIL is requesting a 45% contribution from the EC. The centre's funding strategy has permitted the contribution of two Belgian funders to be increased (although, in proportion, the share of funds remains stable), but public resources available in Belgium are limited and the prospect of seeing them increased further is poor. This strategy has so far not identified many alternatives for making the transition from EC funding to other funding and for securing additional sources of support to continue the project. It is hoped that the assistant coordinator, to be recruited under the new project, will pave the way towards developing funding through private donors, probably a long process.

Institutionally, the fact that the project is the continuation of a programme which is almost 30 years old offers some guarantee for its sustainability. In addition, some limited initiatives (such as training students in therapeutic work with torture victims) may contribute to experience sharing and capacity building within the mainstream health system. However, the project lacks a comprehensive strategy in this respect.

2.8 Visibility

The project has poor visibility. The EC logo should be displayed in the entrance of the building as well as on publications and letters

2.9 Impact of rehabilitation on prevention in a European context

EXIL has never been strongly focused on preventive activities for the prevention of torture, arguing that it would detract from the medico-psychological work of the centre. In contrast, prevention activities regarding health issues for patients and their families do take place regularly and are very well planned. However, there is no strategy to undertake systematic prevention of torture work.

Prevention in Europe

In Belgium, EXIL has the view that its rehabilitation activities have an impact on primary, secondary and tertiary prevention in health issues. They define it in the following way:

- Primary prevention is teaching patients how to handle their physical health and preventing family violence.
- Secondary prevention is caring for patients who suffer from chronic diseases, such as diabetes, hypertension etc. by teaching them what to do to preserve their health and how to take their medication regularly (patients are provided with an 'organiser' pill box with compartments which make it clear to the patient, what medication he/she has taken each day and what he/she still has to take);
- Tertiary prevention is providing treatment to torture victims, which is the central activity of the centre.

Prevention activities such as specific prevention of torture and organised violence are less evident. The only activity of the centre that contributes to monitoring Belgium's compliance with the obligation not to sent asylum seekers back to a country where they are in danger of being tortured is the work performed by the Medical Examination Group. The percentage of patients provided with a medical report by EXIL and who were recognised refugees is not known. The CGRA sees these reports as important (although relative) medical evidence for the officers assessing asylum claims. CGRA officers include a psychologist. Interviewing officers may request him to assess asylum applicants without a medical report but for whom there are reasons to believe that they have been exposed to torture. He is also requested, in some case, to do a second assessment based on a medical report provided by EXIL.

The testimonies of patients (which seem to exist in written and electronic form) have never been used in an effort to denounce and prevent torture. As the centre's doctrine is not to focus its attention on torture, but rather on healing, integration and peace, use has not yet been made of the testimonies. The main focus of the centre is not so much geared towards the past, but more towards the future of the patient and his or her social network.

Some years ago, EXIL founded a branch in Barcelona as a way of networking and awareness-raising in a country where the affects and after effects of the Civil War and the Franco regime have never been worked through, not even by professionals who deal with the psychological consequences of Spain's history. However there is – again as in Belgium – no connection with local projects (such as the newly founded post-trauma organisation, SEPET (Sociedad Española para el estrés traumático) or the network of Spanish psychologists who work for the Basque victims of torture or the group working with the victims of terrorism).

Prevention in Chile

Having been a political activist in his country of origin, the current director and one of the founders of the centre still regularly goes back to his country, Chile. There he is in contact with the local HR NGOs such as CODEPU (Comite de Defensa de los Derechos del Pueblo). One of the activities of all these organisations is combating impunity, which is part of a primary prevention programme. EXIL, which is collaborating with these centres (partly funded by the same EC budget line), has, however, not given a clear and concrete concept or description of its input into these organisations.

EXIL is also engaged in a project supported and funded by the State of Chile on training teachers in peace education. It aims at raising awareness of risks of political repression, dictatorship and systematic use of torture where conflict management mechanisms are lacking. EXIL's participation consists of funding the participation of its director as an expert in the consequences of organised violence and child abuse and in the necessity of doing this sort of primary prevention.

Prevention in the DRC

EXIL has contributed to the mapping of a project in Kinshasa led by ADDH (*Aide pour le Développement Durable et Humanitaire*), OMC (*Œuvre Médicale Cogie*),
and a local rehabilitation centre for displaced persons and torture victims. Its contribution consists of providing support to project management activities, training trainers to raise awareness among the target groups and share experiences of working with torture victims. The target groups include officials involved in decision-making in the field of torture prevention, law enforcement personnel, prison officers, military officers etc. The project has not started yet as it is still awaiting financial support from the EC in the DRC.

Indicators to measure the impact of the work towards prevention

Several indicators might be identified to measure the impact of the work towards prevention, such as legislative, procedural and social changes in the treatment of asylum in Belgium and Chile, change of attitudes in government forces (police, army) in countries where torture is perpetrated, condemnation and finally conviction of perpetrators with hopefully its deterrent effects. However, at this stage, these indicators are not measurable to prove the impact of torture prevention. The requests for training, participation and cooperation addressed to EXIL from different sources, at the national level in Belgium as well as at the international level, might be one indicator of the quality and, hopefully, efficacy of their approach. For the future it will be important to plan indicators and measures with regard to their proven efficacy.

3. Conclusion

3.1. Impact

The project's institutional impact is quite limited. The centre does not have a planned and coherent strategy on training and advocacy to strengthen its impact, particularly towards institutions involved in assessing asylum applications. In the health sector, since it has been accepted as an official centre for mental health, EXIL has achieved a partially institutional position in the mainstream Belgian health system. Also, the regular training of students with different professional backgrounds – MDs, psychiatrists, clinical psychologists and social workers – must have had some impact on the mainstream system. But after almost 30 years of existence, one may question the centre's capacity or its willingness to integrate the services completely into the normal mainstream of national medical and psychosocial services, empowering the mainstream services to deal effectively, humanely and efficiently with this group of victims, as it does with other victims of violence. Because all efforts are focused on clinical work, there are no resources available for increasing the project's impact outside EXIL, except through *ad hoc* interventions, or for planning its complete integration into the Belgian mainstream health system. In this sense its impact is still as it was at the beginning, a service parallel to the Belgian mainstream health system.

The project has an important impact on prevention in health care matters as to the health of its own patients. However its impact on primary and secondary torture prevention is limited and lacks a clear strategy.

3.2 Relevance and design

EXIL's intervention strategies take into account all three levels of intervention – somatic, psychological and social – in a creative and innovative way and are steadily adapting to the changing needs of their clients, according to their origins. The design of EXIL as a health care centre offers a wide range of services to torture victims. The staff includes refugees as well as former patients, offering a multicultural approach and good language skills to the beneficiaries. No other group in Belgium is addressing similar topics in the same combination. Other centres have been founded recently in Belgium, an indicator of still unsatisfied needs of refugee who are victims of torture and organised violence in the country.

Stakeholders involved in care for refugees say that EXIL is the most efficient and effective carer for victims of organised violence and torture. However, the project lacks a monitoring and evaluation system to verify this assessment.

3.3. Effectiveness

The project's objectives in relation to the rehabilitation of torture victims through general therapeutic activities and specific activities, as well as to the prevention of violence – especially family and youth violence – are achieved. Therapies are said usually to finish with mutual consent, i.e. the patient and the therapist agree that they have reached the goal formulated at the beginning of therapy. The staff say that they have only a few unfinished treatments where patients have dropped out. The communitarian approach of the staff, concerned with the reconstruction of social networks, avoids from the beginning the situation where the therapists become "the only person who really cares" about the patient. This means that the end of a therapeutic process is not protracted and thereby liberates therapists for new patients.

No clear strategy has been drawn to achieve the project's objective aiming at promoting the participation of torture victims in actions for the protection of human rights. Its achievement is therefore limited to a few events.

Although EXIL has always had the flexibility to adapt to new groups of refugees, and to integrate a really multicultural and multi-disciplinary team, it continues to function mainly as at the beginning: to help torture victims to heal and to become productive and adapted members of the receiving society.

Clinical evaluation of the quality of the therapeutic processes has been, since the beginning, a central aim of the many group supervision sessions. It is interesting to note that the staff seem satisfied with the investment of this time, as the attendance at these meetings is good. The atmosphere in these meetings is open and collaborative and enhances learning. The team is very eager to know about the evaluation research started about the effectiveness of their work on family violence. They are prepared to learn from the results, in order to provide even better care to their clients. This project might be able to prove that treatment – i.e. tertiary prevention – can lead to some primary prevention in terms of prevention of family violence.

The team is also conscious of the urgent need for a computerised patient-tracking system to assess the progress of their clinical work. The development of such a programme will need specific supplementary funding to obtain an internally networked computer system, where every clinician can enter data immediately after sessions from every therapy room.

3.4. Efficiency

The management of the project is very professional and efficient. Supervision for control of the quality of clinical work and the prevention of staff burnout is well established and efficient. With a limited staff, the centre copes with a heavy workload.

3.5. Sustainability

The project depends 44% on the EC contribution. As the team – and therefore the whole budget – is quite small, unforeseen changes which arise during the course of a year (such as the doubling of interpreting prices), have serious effects on the whole budget.

Part of the project is financed by the Belgian authorities, as it is recognised as a bi-communitarian (French and Flemish), specialised centre of mental health. It is not clear why the centre does not get more funding from the government, as it is integrated into the Belgian health system. The vulnerability to changes in funding would then be lessened and sustainability enhanced.

3.6. Visibility

EC contribution is barely visible in the project (one logo with stars, without any text in the corner).

3.7 Impact of rehabilitation on prevention in a European context

The impact of the centre's rehabilitation activities on the direct primary prevention of torture is restricted to some important but limited areas such as the delivery of medical reports to patients in support of their asylum application or EXIL's periodic involvement in NGO platforms involved in advocacy. At the moment, there is no appropriate staffing to develop more preventive activities, as the personnel of the centre unwilling to restrict the time they spend on clinical work.

References

- Fedasil et Croix-Rouge de Belgique, *L'assistance psychosociale et thérapeutique des demandeurs d'asile*, Brussels, April 2004 (http://www.fedasil.be).
- Fedasil, *L'accueil des demandeurs d'asile en Belgique : état du droit et de la pratique*, Brussels, April 2004 (http://www.fedasil.be).
- Ligue des droits de l'Homme, *Migration et asile : détresses en transit*, Chroniques n°104, Brussels, July/August2004
- A. Vanoeteren, *Recherche sur les besoins et ressources en région bruxelloise en matière de prise en charge psychosociale pour réfugiés / demandeurs d'asile*, recherche-action de l'asbl Ulysse, February 2003.
- L. H. M. van Willigen, I. Agger, T. Barandiarán, P. Khanal, *Evaluation EIDHR: Torture rehabilitation centres,* MEDE European Consultancy, November 2003.
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.
- *Council Directive 2003/9/EC of 27 January 2003 laying down minimum standards for the reception of asylum seekers* [Official Journal L 31 of 06.02.03].
- *European Commission Communication on the EU's role in promoting human rights and democracy*, May 2001, COM (2001) 252 Final.

Annex 1: Itinerary

Monday 20 September 2004:

- Travel Paris – Brussels (Sara Guillet)
- Travel Zurich – Brussels (Gisela Perren-Klingler)

Tuesday 21 September 2004:

9.30 AM	Meeting with the Director, Coordinator and Programme Coordinator
10.30 AM	Visit to EXIL
11.30 AM	Meeting with the Adolescents' Programme Coordinator
1.00 PM	Meeting with the Women's Programme Coordinator
2.00 PM	Meeting with the Director
3.00 PM	Attendance at the Programme Management Committee
5.00 PM	Meeting with the Men's Programme Coordinator
6.00 PM	Team meeting

Wednesday 22 September 2004:

9.30 AM	Meetings with beneficiaries
10.15 AM	Meeting with volunteers coordinating the befriending project
11.00 AM	Meeting with one of the general practitioners
11.30 AM	Participation at a meeting on EXIL's research on assessing their work with chil dren and adolescents with a view to producing a model of best practice
2.00 PM A	ttendance at a beneficiary's consultation with a psychiatrist (G. Perren-Klingler) Meeting with EXIL Coordinator (Sara Guillet)
3.00 PM	Meeting with one of the social assistants
4.00 PM	Attendance at a supervision session
5.00 PM	Meeting with the social assistant at a Red Cross residence for refugees
6.00 PM	Team meeting
8.00 PM	Attendance at a film presentation at EXIL "Mi padre, mi historia" by A. Lubbert, Belgian son of a Chilean refugee

Thursday 23 September 2004:

9.00 AM	Meeting with the Coordinator of the Association for the Defence of Migrants' Rights (Association pour le droit des étrangers, ADDE)
10.00 AM	Attendance at the monthly staff meeting
1.00 PM	Meeting with the Coordinator of the Medical Examination Group (MEG)
2.00 PM	Meeting with the Coordinator of the interpreters
3.00 PM	Meeting with the nurse
4.00 PM	Travel Brussels – Paris (Sara Guillet)
	Travel Brussels – Zurich (Gisela Perren-Klingler)

Annex 2: People and organisations interviewed

EXIL staff:

- Jorge Barudy, Director
- Maria-Gladys Busse, Women's Programme Coordinator
- Jean-Yves Crappe, Social assistant
- Claudia Galaz, researcher assessing EXIL work with children
- Froduald Gataraiyha, Adolescents' Programme Coordinator
- Nathalie Gilbert, Coordinator of the Medical Examination Group (MEG)
- Marie-Louise Leonhardt and Anne van der Wielen, volunteers coordinating the godparenting project
- Anne-Pascale Marquebreucq, Programme Coordinator
- Martine Mengeot, Coordinator
- Hazel Mumum, Coordinator of the interpreters
- Akes Nkeso, Nurse
- Etienne Van Durme, Men's Programme Coordinator
- Claire Vuylsteke, General practitioner
- Ramaris Zapata, researcher assessing EXIL work with adolescents
- Two beneficiaries (one from Rwanda and one from Georgia)

Other stakeholders:

- François Bienfait, Deputy Commissioner, General Commissioner for Refugees and Stateless Persons (CGRA) (phone interview)
- Emmanuelle Delplace, Co-director, Human Rights League (phone interview)
- Isabelle Doyen, Coordinator of the ADDE
- Isabelle Hodiamont, Social assistant at a Red Cross residence for refugees
- Natacha Foucard, Programme Coordinator, UN Voluntary Fund for Victims of Torture (phone interview)
- M. Joris, Commission communautaire commune (phone interview)
- M. Lafere, asylum officer, Amnesty International - Belgian Section (phone interview)
- Françoise Leroux, lobbying department, Coordination and Initiatives for Refugees and Migrants (*Coordination et Initiatives pour Réfugiés et Étrangers*, CIRE) (phone interview)
- Laetitia Schul, psychologist, Médecins Sans Frontières - Belgium (phone interview)
- Jacques Sepulchre, Fonds MARIBEL Social (phone interview)
- Alain Vanoeteren, Coordinator, ULYSSE (phone interview)
- Céline Verbrouck, lawyer (phone interview)

Annex 3: Comments from EXIL

Comments from EXIL:

We are very happy with the content of the experts' evaluation report. It corresponds in all particulars to what the consultants communicated to us, both the positive aspects and the recommendations, which we have already taken into account.

We do not wish to add anything or make any further comments. This report displays the same qualities as our meeting with the experts - that is, it is very professional.

Annex 5: Final report Medical Centre for Victims of Torture, Athens

Evaluations EIDHR

Medical Centre for Victims of Torture, Athens

Torture rehabiliation centres Europe

human european consultancy in partnership with the Netherlands Humanist Committee on Human Rights and the Danish Institute for Human Rights

Januari 2005 By Sara Guillet and Gisela Perren-Klingler

human european consultancy

This report is the outcome of an evaluation commissioned by the European Commission on projects financed in the field of the European Initiative for Democracy and Human Rights (EIDHR). The EIDHR is a European Union programme that aims to promote and support human rights and democracy in third countries. Information on activities and actions can be found on the EIDHR website: http://www.europa.eu.int/comm/europeaid/projects/eidhr/index_en.htm

human european consultancy
Hooghiemstraplein 155
3514 AZ Utrecht
The Netherlands
Tel +31 30 634 14 22
Fax +31 30 635 21 39
office@humanconsultancy.com
www.humanconsultancy.com

Abbreviations

BAN	Balkan Network of centres for the rehabilitation of torture victims
CRTV	Center for the Rehabilitation of Torture Victims
ECPT	European Committee for the Prevention of Torture
EIDHR	European Initiative for Democracy and Human Rights
GCR	Greek Council for Refugees
HR	Human rights
IRCT	International Rehabilitation Council for Torture Victims
MD	Medical doctor
MENA	Middle East and North African Network
UNHCR	United Nations High Commissioner for Refugees
UNVFVT	United Nations Voluntary Fund for Victims of Torture

Executive summary

The objective of the report is to evaluate the work of the Medical Rehabilitation Centre for Victims of Torture in Athens (hereafter MRCT). MRCT was created 15 years ago by a torture victim. Today, it is the only rehabilitation centre for torture victims in Athens. The centre treats victims of torture through a so-called medico-psycho-social approach. It has also developed activities aiming at preventing torture, through training of the police – as the police is the main institution dealing with asylum seekers arriving in Greece – and awareness-raising activities. Networking activities in the Balkans are also part of the project.

As part of the evaluation, a team of two consultants visited the MRCT from 11 to 13 October 2004, interviewed staff and beneficiaries as well as other stakeholders (see Annex 2) and collected data about the work of the centre.

Summary of conclusions

As reliable data are only partially available, it is difficult to evaluate the impact of the project in quantitative terms. Nevertheless, some impact of the project on rehabilitation can be noted from interviews with clinical staff and beneficiaries. As a general comment, the clinical work of the centre, based on a holistic and interdisciplinary approach, is of good quality. Through prevention activities, the project also has some minimal impact on the institutions involved with asylum seekers.

The therapy project is designed to rehabilitate victims of torture and to support their asylum application through medico-legal reports.

With regard to the prevention objectives of the project, human rights advocacy, awareness-raising, condemnation of ill-treatment and torture through local police and lobbying to adapt the Greek legislation on aliens to European standards are methods which might have some impact on the prevention of torture in the long run. The project also aims to undertake capacity building and lobbying of Greek institutions and authorities involved in asylum issues.

European Commission (EC) support of the project is not made visible.

MRCT still functions like a small charity NGO and its evolution towards a more efficient and professionally managed health care centre is hampered by financial, political and personal factors.

First, MRCT faces great difficulties in obtaining financial support at the national level. Government offices are inclined to support projects abroad rather than within Greece, although this is exactly where their help is most needed and their responsibilities are most striking.

This lack of continuous support for the centre prevents it from consolidating and becoming less dependent on EC funding. It leads to a sort of vicious circle, due to the fact that every project is suffocated at the beginning because of the impossibility of finding funds to balance possible EC funding. As a consequence, the centre leads a life in limbo, with minimum resources to ensure the daily activities of the centre are maintained, but not enough to improve the work based on a long-term strategy. This vicious circle is detrimental to creativity, flexibility and impact.

Secondly, the Greek authorities are reluctant to develop an institutional relationship and to engage in an ongoing dialogue with the centre and their responses remain very dependent on personal acquaintance with specific individuals at MRCT. Other institutions interviewed in the course of this mission have also stressed their difficulty in developing a constructive dialogue with the authorities, due partly to a lack of 'NGO culture' in Greece and partly to the reluctance of the authorities. However, to some extent the MRCT personnel also seem reluctant to consider the authorities as important partners for the necessary dialogue about the design and implementation of an adequate asylum policy.

It is essential to call upon the relevant ministries to comply with their obligations towards refugees – in a European context – and to support the valuable and important services provided by MRCT, something which might also have to be done by the EC.

Thirdly, in some cases the personal commitment or 'historical legitimacy' of the staff unfortunately seem to be considered as more important than efficiency and professionalism. This may be another hindering factor for the evolution of the centre.

Recommendations

The consultants recommend the EC to fund the new three-year project under the condition of a tight outside monitoring system in order to support MRCT's efforts in the implementation of the following recommendations.

They recommend MRCT to:

- Develop a vision of the centre's mission, including short, medium and long-term strategies involving all the different professionals at the centre. Preventive activities should be planned in a way that they can go beyond one-off activities. The specific strategies must be sufficiently coherent as to comply with the centre's mission.
- Improve an institutional dialogue with the authorities on issues of mutual interest such as health issues or asylum issues.

- Enhance the quality of medical reports and introduce a central quality control of treatment processes and material support interventions through a centralised medical file for each patient at the centre.
- Improve the database, in coordination with other European centres, and introduce a patient-tracking system (number of new and former patients, drop-outs, consultations per patient, children and adolescents, medical certificates issued to torture victims etc.), monitoring progress in treatment every three months.
- Develop an approach based on the patient's specific situation (such as age, gender, family), with specific care for women and single males, helping them to (re) construct a social network. Group encounters, led by therapists might be one possibility.
- Adapt the clinicians' tasks so that they treat more patients, give more training or organise group and family therapy sessions or self-help groups and other social and/or occupational activities in groups.
- Review the employees' tasks and monitor their time allotment in relation to real consulting time, outreach work and lobbying time.
- Take measures to prevent burnout including: regular supervision by a professional from outside for the social workers and psychotherapist(s) and by the psychologist for the interpreters; schedule periodic and rigorous staff meetings; and use the patient-tracking system to assess the impact of the staff work on beneficiaries.
- Develop a global strategy to improve access of torture victims to the centre, including through stronger networking with all stakeholders (such as the Greek Council for Refugees (GCR) and the United Nations High Commissioner for Refugees (UNHCR)).
- Give more time, professionalism and inventiveness to fund raising.
- Put up visible logos of the EU by the door (and write the centre's name in the Latin alphabet as well), in the entrance halls and waiting room, mentioning EU funding.

1. Introduction and methodology

1.1 Objectives

This evaluation of the MRCT in Athens is part of an evaluation of four different torture rehabilitation programmes currently financed by the European Commission (EC) in France, Belgium, the UK and Greece. The objective is to assess the relevance, efficiency, effectiveness, impact and sustainability of the ongoing project. The report will provide guidance but also recommendations for a decision from the EC regarding the approval of the new proposal. The proposal had in principle been pre-selected by the Selection Committee for further funding, but the signing of a new contract was made conditional on the results of this evaluation. The evaluation should also provide elements for the assessment of the effectiveness and impact of the programme implemented by the MRCT in relation to the argument that the work of torture rehabilitation centres contributes towards the prevention of torture.

1.2 Background

The EC Communication on the EU's role in promoting human rights and democracy in third countries has four priorities for the use of the European Initiative for Democracy and Human Rights (EIDHR), one of which is support for the fight against torture. The Communication states that, *"in seeking to be an agent of change, the EU should ensure that it focuses as much as possible on prevention, including through human rights education of the police and other possible agents of torture"*. The torture rehabilitation centres have argued that their work contributes towards the prevention of torture.

Two specific questions have guided the whole evaluation process. The first one is about the function, possibility and efficacy of prevention. The second question is how to evaluate efficiency of the centre's interventions, be they therapeutic or preventive. Accountability in such services can only be exercised if valid evaluation and auditing methods are used.

Prevention programmes will have to be evaluated and monitored differently from treatment programmes. Indicators for efficient preventive programmes might be more difficult to decide upon and evaluate than one thinks. If laws for the protection of human rights and against torture are drafted and approved by parliaments, this unfortunately does not mean that they are respected. Although a precondition for further prevention work, it is not enough, as compliance with such laws (and legal prosecution for violation of these laws) is not automatic. Institutional changes are a necessary consequence of the legal process and a precondition for further implementation of torture prevention.

However, this will not be enough for effective primary prevention. In different parts of the world, the societal, educational and political settings are not yet ready to really implement an effective prevention policy. Finally the evaluation – and the ongoing monitoring – will have to be based on many different indicators to ascertain the effectiveness of torture prevention programmes.

For the treatment programmes, evidence-based, quantifiable and replicable answers will have to be provided to the question about effectiveness. Quality evaluation in psychiatry and psychotherapy is an activity which is still in its tentative and exploratory phase, even in culturally homogenous treatment programmes. It is all the more difficult to evaluate the effectiveness of treatment programmes with heterogeneous populations and where social aspects are intimately intertwined in the treatment outcomes, such as being a refugee, problems with adapting to a new country etc..

A more thorough reflection on the relationship between prevention of torture and treatment of victims of torture, as well as the respective evaluation possibilities, is to be found in the synthesis report.

This evaluation focuses on the project implemented from 1 November 2001 to 30 October 2004. The new proposal refers to the continuation of most activities of the centre from November 2004 until October 2007. The EC funding applied for is for 399,557 Euro and represents 50% of the total funding of MRCT. As for the previous programme, it covers most activities of the centre.

1.3 Methodology

The evaluation was carried out through the study of documents and a three-day visit to MRCT in Athens. This included collection of quantitative and qualitative data through interviews with staff, beneficiaries and various stakeholders (see Annex 2).

The team was composed of two experts, Ms Sara Guillet (team leader), specialist in international human rights law, and Dr Gisela Perren-Klingler (medical expert), specialist in project evaluation and transcultural psychiatry/psychotherapy. Before leaving MRCT, the team shared and discussed its preliminary findings and recommendations with the Director, the Administrative Director and the Medical Director during a debriefing session.

The staff of the centre did receive the draft report for comments, which have been added to the final report as annex 3.

2. The Medical Rehabilitation Centre for Torture Victims, Athens

2.1. Asylum in Greece

The beneficiaries of MRCT are foreigners who have fled their country, where they have suffered torture and organised violence. Some of them have applied for refugee status in Greece. The asylum application proceeds according to the following stages. Like any foreigner entering the country illegally, regardless of whether this occurs at the borders or on Greek territory, if they are arrested before submitting asylum applications asylum seekers are placed in detention for having breached Greek migration legislation. According to the United Nations High Commissioner for Refugees (UNHCR)[1], some immigration detention centres do not meet minimum standards.

From here, detainees are subject to deportation within three months. If their deportation, which is suspended pending examination of their asylum application, is not completed within this period of three months, the detainees, whether they are asylum seekers or not, must be released in accordance with the relevant legislation (Act 2910/2001). After their release they will be asked to leave the country by themselves or, if they have submitted an asylum application, they will have the right to stay in Greece until a final decision on their application is issued. The application must be filed with the police (Ministry of Public Order). UNHCR expresses concern regarding access to asylum.

In 2003, 8,000 people were registered as asylum seekers in Greece, but the current capacity of reception centres was limited to less than 1,200 places in eight centres across the country[2]. According to the estimate provided by the Greek Council for Refugees (GCR), there are another 8,000 non-registered asylum seekers in the country. The administrative authorities are is supposed to interview registered asylum seekers within three months. In practice, however, in the Athens area where most of asylum applications are submitted, this interview with the competent police officers of the Athens Aliens Police Department does not take place before a minimum of six months and sometimes the delay may be up to 12 months. In the meantime, the document regularising individuals as asylum seekers cannot be issued and they experience difficulties, for instance in accessing medical treatment, social assistance etc. There is no free legal aid in Greece. However, asylum seekers have the right to work, but once again only after their interview has taken place and their 'asylum seeker's special document' has been issued.

On the basis of this interview, officers of the local Aliens Police Department, or the local Security Police Departments where Aliens Police Departments do not exist, the Ministry of Public Order makes a decision on the asylum application.

1 UNHCR Position on Important Aspects of Refugee Protection in Greece, July 2004.

2 Operated by the Hellenic Red Cross, Voluntary Work Athens, Elinas, Doctors of the World, Social Solidarity and the National Youth Foundation.

Interviews are decentralised, whereas decision-making is totally centralised. Applicants who have not been granted refugee status may appeal to the same authority, i.e. the Ministry of Public Order, who will make a final decision (which can only be overturned by the Supreme Court). The Refugee Appeal Board provides the Ministry with a recommendation about each application, but its role is only advisory. This consultative body is composed of various representatives of the authorities, a UNHCR representative and a member of the Athens Bar Association, who is currently also the MRCT legal adviser (she is also currently the Greek member of the European Committee for the Prevention of Torture (ECPT)).

In 2002, the refugee recognition rates dropped dramatically to 0.3% (36 people) for Convention Status and 1.0% overall (100 people) including humanitarian status (as compared to 11.2% and 22.4% respectively in 2001). According to UNHCR, "*this negative trend is to a large extent due to the fact that all decisions taken by the Ministry of Public Order at first instance in 2003 were negative, whereas positive recommendations made by the Refugee Appeal Board were often overturned by the Minister. Furthermore, persons, who, according to international principles as well as the Greek national law should be granted complementary protection (humanitarian status), such as persons who would be at serious risk of torture, inhumane or degrading treatment or generalised violence in a conflict situation, are generally denied this protection*".

2.2 Overview of the centre

The work of MRCT first began in 1989, developing from the activities of the medical team of the Greek section of Amnesty International. The founder is a medical doctor (MD), the daughter of a tortured political activist who was herself arbitrarily detained on political grounds. The founders were encouraged by the International Rehabilitation Council for Torture Victims (IRCT) Copenhagen to start providing refugees who are victims of torture with medical treatment, social support and psychotherapy. Although the founder herself is a torture survivor and the centre is open to all victims, Greek nationals have never used its services.

Under the EC project, MRCT has been performing its activities in Athens as a rehabilitation centre for victims of torture. The activities of the project aim to provide general medical and specialist care, psychological assessment and psychotherapy, psycho-pharmacological and psychiatric treatment, some physiotherapy, material support and legal counselling. The target group for rehabilitation is refugees who claim to have been tortured. They are offered individual psychotherapy exclusively; family members can receive some support from the social workers.

Social support to the patients and family members is mainly material (finding a place to stay, finding work, receiving whatever donations the centre has at its disposal at that moment). It is accompanied by individual, face-to-face counselling by social workers, but with no clear goal, once the material help has been achieved. No strategy exists for how to connect patients to existing groups and to (re)construct a meaningful social network. One of the effects is that the clients, although their most urgent problems may have been solved, seem to feel lonely, sad and homesick and come back to the centre, because it is the only friendly place for them.

The project also aims to contribute to the prevention of torture in Greece through the participation in and organisation of training seminars and advocacy activities. These activities will continue under the new project. However, there is no concept of nor strategy for preventive activities. It seems as if they were only performed because they have to be part of the project.

The centre operates in the centre of Athens. However, the main influx of asylum seekers is in the Greek islands of the Dodecanese, where they are detained as 'illegals' or 'aliens'. Unfortunately, there is no actual on-the-spot support, maybe one reason why such a small number of asylum seekers find their way to MRCT. Another reason might be that the nameplate of the centre – located in central Athens – is written only in Greek letters, probably not readable by the average asylum seeker.

Beneficiaries

The target group is refugees and asylum seekers who have come to Greece from many countries world-wide. They have either been tortured themselves (i.e. are direct victims) or are family members of torture victims. A large number of asylum seekers are young unmarried males. In 2003, MRCT saw 108 new patients; no precise data exist about the number of patients from former years. However, the professionals give an estimate of about another 120 patients they continue to treat from former years. 15% are women and 85% are men; children and adolescents are not mentioned separately. Clients from Turkey represent the largest group with 21%, followed by Iran (19%), Sudan (18%), Iraq (16%) and 25% from many other different countries. While 8% were illiterate, 30% had completed compulsory schooling, 30% had completed university or gained a technical degree and 32% had not completed their training for various reasons. The patients' legal status varies as follows: 12% never applied for asylum, 77% have a pending application, 3% have been rejected in the first instance and 5% have received a final rejection[3]. Illegal residents are therefore also cared for.

The 108 new patients in 2003 represent less than 1% of the total number of asylum seekers in Greece (8,000 registered and 8,000 non-registered asylum seekers).

3 All figures are based on 2003 data, except for the legal status figures which are based on data from the first half of 2004 as 2003 data were not available.

This reflects a weakness in victims' access to the centre. As a comparison, the Brussels-based rehabilitation centre EXIL had 1,239 new patients in 2003 for a population of 17,000 new asylum seekers the same year.

59% of the patients are referred by the GCR, 6.5% are referred by Amnesty International, 13% are self-referred and the rest come through different ways, including in some cases through police referral.

MRTC estimates that it has supported a total of some 3,000 torture victims and members of their families, since it was founded 15 years ago.

Methodology

Therapeutic programme

The patients are offered a multi-disciplinary and comprehensive service including medical, psychiatric and psychological consultation, assessment, treatment and rehabilitation through social work, some physiotherapy and some practical assistance. The therapeutic programme includes the provision of forensic medical reports to document torture and ill-treatment in support of claims for asylum.

The psychotherapeutic approach is based on individual cognitive-behavioural techniques. No family, group, gender or age-specific (minors and adolescents) treatment is offered. A new psychologist has been appointed from the beginning of November 2004, who was trained in Vienna, Austria. However, it was not possible to find out to which psychotherapy and psychotraumatology school he belongs.

According to the centre's data, the services which the patients request from MRCT are: medical report (42%), medical aid (33%), psychological aid (12%), legal aid (7%), material aid (3%) and help to find a job (3%).

Each client is first seen by the social worker, who takes a history of his/her persecution and torture which led to flight. Then he/she is assessed by the MD, who establishes a document which describes torture marks, if any, and their compatibility with the description by the client. No waiting list exists to go through this intake procedure. Then, if needed, the patient is referred for further medical assessment and treatment which cannot be offered at the centre to one of the 55 medical specialists of MRCT's voluntary network in Athens and/or to the centre's psychologist. This network appears to the evaluation team to be efficient and responsive.

Since illegal and registered asylum seekers have no right to access medical care in Greece unless their situation requires an emergency intervention, physicians from this volunteer network provide assessment and treatment in hospitals, arguing that an emergency situation is occurring.

The psychologist – or a medical specialist – might also refer the patient to the psychiatrist if psychotropic medication is needed. Some cases are referred on to other, more appropriate agencies. In a few cases, the centre also cares for some people whose intake interview made it clear that they had not been victims of torture or ill-treatment. This care consists mainly of providing them with material assistance (housing, nappies for children etc.), if emergency help from other groups cannot be provided quickly enough (some other organisations have a long waiting list).

The length of a typical session with the psychologist is about an hour and a half. The full-time psychologist sees about two or three patients per day. The psychiatrist – who is employed 30% – sees four patients per week on average. The MD – employed 70% – sees two to four patients per week for torture assessment (in order to provide them with a medical report) and general health assessment. The distribution of workload does not seem very cost-effective. New cases are discussed in the group and a collective decision is made as to the type of support required. Medication is provided free to the patients by MRCT.

It is not known how many sessions per patient take place, nor whether patients leave because they feel better or frustrated or because they move away. No information is available regarding drop-out figures and no evaluation exists about people who do not appear again.

The centre only provides individual therapy. Families may receive a visit from the social workers (17 visits in 2003) and some specific activities are organised by the social workers for some of the patients' children, such as a visit to the zoo or a holiday camp (three activities in 2003).

Prevention programme

Under this heading, the centre is developing public awareness and advocacy activities consisting of the commemoration – through a public conference, a TV programme or other methods – of the International Day in Support of Victims of Torture (26 June) or International Human Rights Day (10 December). The centre produces a publication (in Greek) about its activities twice a year and gives support to the Balkan Network of centres for the rehabilitation of torture victims (BAN) publication also twice a year (cf. 2.2.4 on networking).

In addition, the centre operates a 'training programme' (more of an awareness-raising programme) which consists of organising two one-day seminars each year for 15 to 30 police officers from the asylum and aliens department of the Ministry of Public Order, in cooperation with UNHCR. However, the centre has no concept of or strategy for prevention. Its activities are mainly reactive, not proactive, a fact which may lie in the core view of the centre's mission: care for and rehabilitation of victims of torture.

Networking

This activity consists of the organisation of a number of two-day seminars each year, bringing together representatives of rehabilitation centres from the BAN. The BAN was created in 1993 with the aim *"to coordinate the activities of the centres which are members of this network; these activities, include: rehabilitation activities, seminars, workshops and conferences to promote knowledge and awareness-raising on torture, prevention activities (dissemination of information of human rights abuses, human rights education)"*. Within the ongoing project, only four of the planned six meetings were organised; the fifth one will take place after the end of the contract, while the sixth meeting will not take place at all. This networking activity is poorly reflected on the BAN website and in a newsletter twice a year, a sign of the of the lack of strategy. The evaluation team cannot escape the impression that although the centre's involvement in the BAN enables it to receive some funds from Greek donors who are not interested in funding activities in Greece, it does not enhance the quality of the services offered in the region.

Staff and infrastructure

The centre staff comprises 12 people (six part-time and six full-time). The medical staff comprises one mental health coordinator – a psychiatrist who is also the president of the centre – (30%), one psychologist (100%), one MD (70%) and one medical secretary (100%). The administrative staff comprises two social workers (each of them working 100%), one legal advisor (40%), one administrative director (25%), one research assistant (100%), one secretary (100%), one accountant (25%) and one cleaner (30%). They make up the equivalent of eight full-time paid staff. In addition, one part-time volunteer psychologist and one part-time volunteer press officer are also part of the staff.

Except for the psychiatrist, the medical/psychological paid staff do not have other places of work. They say they keep in touch with the mainstream health system through continuous training or conference attendance. The presence of a network of 55 volunteer doctors may be another way for the centre to be in touch with the mainstream health system. This network may be further improved through systematic data collection of staff activities with MRCT's patients.

Three interpreters work on a regular basis with the centre, as their languages cover most interpreting needs. Additional interpreters may be hired occasionally, if needed, and the research assistant, who is Georgian, can help with interpreting for Russian when needed.

No psychological supervision of the staff exists and no measures are taken in order to avoid burnout of professional staff. All they can do is share their problems amongst themselves (*"at the bar"*) whenever they feel the need.

The staff salaries are low, based on the argument that there is no money to increase salaries and that the staff are very committed to their work in the centre. This could also become a burnout factor and is an approach which might also prevent the centre from becoming more professional.

The infrastructure is adequate for the purpose of rehabilitation. It consists of a two-floor apartment, one of them belonging to MRCT's founder and MD, who has made it available to the centre.

Networking

Contacts with the two other rehabilitation centres in Greece – in Thessaloniki (Center for the Rehabilitation of Torture Victims, CRTV) and Ioannina – are almost non-existent. Through its former EC project, MRCT had a partnership with CRTV, but this will not continue under the new project, as CRTV is no longer involved solely with torture victims since it has received funds to work on trafficking issues.

The centre cooperates with other human rights (HR) NGOs, such as the GCR, as well as with UNHCR.

The NGOs involved with migrants and asylum seekers have established a good networking system via the internet; through this approach all the NGOs concerned can register their clients, so that each professional from the network can check what type of support is being provided to any individual client. This project, called EQUAL is managed by the National Youth Foundation with EC support. The system, combined with the daily personal contacts between the NGOs, is an efficient way of ensuring follow-ups, while avoiding overlaps and abuses. However it has to be stressed that only a very small number of asylum seekers consult all these structures. Outreach activities are occasional, with no strategic planning, normally in conjunction with UNHCR information-gathering initiatives and obviously do not reach large groups of the possible beneficiaries.

At the regional level, MRCT plays a role by coordinating the BAN and, in the past, developing a similar coordination for the Middle East and North Africa Network (MENA). MRCT's president also chairs the BAN.

At the international level, MRCT has been involved very closely with the IRCT, particularly during the presidency of MRCT's MD at the IRCT (1998-2003). Today, this relationship seems to have become looser, although MRCT continues to be a member of the IRCT net.

2.3 Impact

Impact on beneficiaries

The project mainly targets people who have suffered torture. 108 patients consulted the centre in 2003. It is estimated that about another 120 patients continue to be seen from earlier years of intake. No estimates exist about the percentage of tortured refugees. Any benefits received by the patients from MRCT are important to them in a country where, generally speaking, asylum seekers are in an unenviable situation. However, it is not easy to assess these benefits in more precise or even quantitative terms.

It seems that a significant proportion of patients drop out, although the centre does not know the precise drop-out rate. The psychotherapist wonders whether this is because patients have profited from therapy and/or found work outside Athens (since registered asylum seekers have the right to work in Greece) or because of dissatisfaction. He considers this a real cause for therapist burnout, because he only rarely completes psychotherapy with a patient, knowing that the patient is feeling better and deciding by mutual consent to stop therapy. This raises concerns about the conceptualisation and planning of psychotherapeutic interventions and the provision of information to the patients about the objectives of the therapy process, the patients' motivation and compliance and thus the effectiveness of the assisted rehabilitation process.

In qualitative terms, however, this perception was partly balanced by two interviews the consultants had with patients. According to these two beneficiaries (who had been identified by MRCT for the purpose of this evaluation), MRCT had an invaluable impact on their psychological and social rehabilitation process. A man from Congo had been in touch with other NGOs who had been unable to provide him with relevant social support: he was sleeping in the street until he was directed to MRCT, where the social worker found him a place in a residence. He was also very grateful for the psychological support he had received, which – as he stated – had helped him to overcome the suffering caused by persecution. However, after 11 months, he was still feeling lonely and had not been able to (re)construct a social network in his host country.

A woman from Belarus had also had unhelpful experiences with other NGOs and it was only once she was in the hands of MRCT that she felt she was provided with the social and psychological support she needed. Although she had come to Greece 18 months earlier with her husband and son, she was the only member of the family to go through therapy, still seeing the psychologist once a week. Her husband was receiving some help from the social worker. This woman was recently recognised as a refugee.

MRCT says that its therapeutic and social interventions – as well as its medico-legal reports – benefit more people than the individual directly affected: their partners and children also gain from the experience. However, it should be noted that a large number of the patients are young, single males.

Institutional impact

Through the BAN, MRCT activities seem to have some outreach effect, although these are more limited than expected, since only four out of the six meetings scheduled in the project proposal have taken place. The centre's activities are presented in a rather one-sided manner, as the programmes show that only MRCT members provided the training to the participants. There was no evidence of active teaching participation by other members of BAN. The BAN impact would be stronger if these meetings really served as a forum for exchanging different – or similar – views, creating common strategies, sharing experiences of the different participants. In the health sector, the project has some very limited impact, through occasional training sessions or conferences attended by health professionals, as well as through an MRCT internship programme, in which two students spent one semester with MRCT.

The project has some impact on the implementation of the asylum policy, through the organisation of a one-day seminar twice a year in collaboration with UNHCR. This seminar is provided to up to 30 police officers who deal with asylum seekers, to give them some basic knowledge about psychological reactions in people who have experienced torture and whose situation and behaviour might require particular and appropriate attention by police officers.

Unfortunately, no cooperation exists either with the Ministry of Health or with the Ministry of Public order, either at policy level or about training issues. This considerably restricts the potential impact of the centre's activities.

Some public awareness raising activities take place through television broadcasts, in newspapers and to mark specific dates. The impact of these activities cannot be quantified but must be assumed.

The centre's lawyer does lobbying work at the Ministry of Justice, follows case law and points out contradictions between Greek and European legislation, but so far to no avail.

2.4 Relevance and design

The types of assistance offered to torture victims are: medico-legal reports; psychotherapy (only individual psychotherapy); social work; and physiotherapy offered free by a physiotherapist who used to work at MRCT. Material help with received donations is offered to needy patients. The centre estimates that most patients are torture victims, although the exact proportion is not known. Patients have no direct input into the programme design. One of the interpreters is a former patient. No specific activities are offered which are adapted to beneficiaries according to their gender, particular situation and needs (e.g. lonely patients).

Asylum seekers in Greece have no right to medical care, except for emergencies, during the whole process of reception until they are recognised as statutory refugees. Medical care for refugees is also provided by groups from Médecins Sans Frontières and Médecins du Monde. However, MRCT is the only organisation to care specifically for torture victims. It is interesting to note that, in 2003, of the officially recognised 8,000 asylum applicants per year and the estimated grey zone of another 8,000 illegals who have not (yet) applied, only 108 persons have found their way to MRCT. Although the consultants did not obtain a thorough explanation of this phenomenon, a partial explanation must be that the services of MRCT are not well known in the refugee community. Some community groups, such as the Turkish and Kurdish groups, support asylum seekers and refugees and know the centre and use it, whereas other groups of refugees do not have supportive national networks.

Another explanation lies in the geographical location: the majority of asylum seekers enter Greece through the islands of the Dodecanese – some of which are located only about one mile from Turkey – where MRCT is not present. The needs of these people, some of whom have been victims of torture, are not addressed properly. A project to carry out (secondary) torture prevention at the very point of entry of asylum seekers into Greece – mainly on some of the islands of the Dodecanese – when torture marks may still be visible, was designed in collaboration with the GCR. The project did not start because MRCT did not receive funding either from national bodies or from the EC. However, the consultants believe that a project addressing the initial needs while people are being detained by the Greek police would make an important contribution.

During the (normally occurring) medical reception screening (for communicable diseases) screening asylum seekers for experiences of violence and directing people who have had such experiences towards MRCT would make a difference, by providing early clinical support in cases of acute suffering, as well as giving the people concerned the possibility of obtaining recognition as refugees more quickly, perhaps through fresh medical evidence.

The MRCT project was designed to look after about 100 new patients per year, in addition to patients from previous years, and to do an estimated maximum 10 days of training activities, mainly targeted at the BAN and the police. Clinical work is organised in such a manner that no waiting list exists and it seems that patients can receive the treatments necessary for their symptoms. The fact that all patients are seen by one of the social workers is a guarantee that the social rehabilitation needs of the patients are dealt with. However, the inability to provide the six training sessions planned for the BAN shows that the project design is not adapted to the personnel and financial capacities of MRCT.

Although MRCT is primarily a health care and rehabilitation centre, torture prevention is presented as an important objective of the project. This is why MRCT takes part in coordinating the BAN, trains some police officers and has a voluntary journalist who produces a number of press releases each year about torture in and outside of Greece, asylum seekers' conditions, refugees etc. This dimension of the project seems particularly relevant in a country where ECPT has noted a number of violent acts by the police, where the press regularly reports on beatings of asylum seekers by the police and where only 0.3% of asylum seekers are recognised as refugees. However, in order for it to become efficient, the design of the prevention programme would have to be redrawn completely in a vision of a general prevention strategy. It would also have to be made more visible in the project proposal, which simply sets out a list of activities (as in the former project where some eventually remained unimplemented).

The project design includes a logframe with a number of objectively verifiable indicators to monitor the rehabilitation activities. In practice, however, these indicators are not used. For example, no patient-tracking system has been set up to monitor the 'clinical improvement' indicator and the number of patients from previous years who still come to the centre in 2004 is not known, which makes it impossible to check the 'number of clients' indicator and the 'number of closed files'. It should be noted that the project design does not have objectively verifiable indicators to assess the prevention-oriented activities either.

The provision of medical reports is a particularly relevant aspect of the project. The evolution of the political environment and the drop in the refugee recognition rate from 11.2% to 0.3% within two years, has undoubtedly resulted in increasing the patients' expectations of the medical report. They hope that the centre will be able support their asylum application, providing the Ministry of Public Order with 'evidence' of the risk of persecution they would face if removed from Greece. In addition, the 1999 legislation on the refugee recognition procedure made an implicit reference to MRCT when it stipulates, "*if before or during the interview the interviewed alien claims he has been submitted to torture of if there are serious indications to this end, the alien is referred to a specialist on matters pertaining to the treatment of torture victims, who makes a report on the existence or not of injuries of maltreatment or of indications of such type of suffering from serious torture*" (Article 2(4)).

The project design meets these particular needs of the patients, among whom 46% (i.e. 47 people) came to the centre in 2003 because they wanted a medical report. MRCT does not require beneficiaries to be treated at the centre in order to be issued with a medical certificate but it seems that a lot of them are regular patients.

2.5 Effectiveness

The previous project lists seven objectives:

- Direct support to the victims of torture and their families: medical, psychological, social support.
- Training: health and law professionals and students; police and civilian personnel assigned to handle political asylum cases.
- Public awareness activities related to torture and other human rights violations: public events; maintenance of MRCT website; creation and maintenance of CRTV website; publication of MRCT's journal.
- Development of fund raising capabilities.
- Client registration.
- Evaluation and monitoring of the efficiency of the planned activities.
- Networking: training activities among the BAN member centres; maintenance of the BAN website; publication of the BAN journal.

These seven objectives were pursued by MRCT and CRTV, who was MRCT's partner organisation for the purpose of this project.

The new project pursues the same objectives, with the important exception of objectives 4, 5 and 6 and the fact that CRTV is no longer a partner of MRCT.

For the sake of clarity and in order to facilitate the effectiveness assessment, it can be considered that these seven specific objectives relate to the main following objectives: rehabilitative and therapeutic activities, preventive activities and networking activities.

At this stage, the evaluation of the effectiveness of the project cannot rely on objectively verifiable indicators, but only on information collected by the consultants during their visit. However, there is some awareness that MRCT has to become accountable and to perform monitoring and evaluation of the therapeutic processes as well as, in the longer term, its activities related to the prevention of torture. Indeed some members of the team consider this to be a central tool for prevention of burnout, as the proof of the effectiveness of their interventions would give them professional satisfaction.

The rehabilitative – therapeutic activities

Following this visit, several observations can be made about the effectiveness of the project, based on the achievements related to the rehabilitation objective.

After speaking with two MRCT clients, one has the impression that the centre fulfils an important role for them. The two patients interviewed by the consultants about their experience with MRCT (a Belarusian and a Congolese asylum seeker) make it clear that for both of them the medical assessment of their health complaints linked to torture, the medical report about the consequences of torture, their psychotherapy, as well as the social assistance they were provided with, have helped them to get over their difficult experiences and to start working, a first step for integration into a new host society.

The interventions of the centre are short and are planned not to be longer than six to 12 months. This might partly explain why there is no waiting list for patients. Although the therapeutic programme seems to meet most needs of the target group, who cannot find any similar service in Greece, the consultants believe it could be more effective and better adapted if specific activities were developed according to the beneficiaries' gender or particular situation. Some support for (re)constructing a social network in the new society might be very helpful. This could be achieved through group work – be it with a therapeutic objective, with an occupational or relational objective or as a self help group.

The provision of a medical report is presented as a component of the rehabilitation process. As pointed out earlier, due to the legislation and the political context in the field of asylum, the centre's medical reports are considered as very important, not only by the patients but also by the relevant institutions.

Asylum seekers are believed to have better chances of being recognised as refugees by the Greek authorities if MRCT has drafted the medical report. Most people recognised last year as refugees had received a medical report from MRCT. In addition, the Supreme Court's case law recognises the importance of the MRCT reports. Consequently, this appears as the most important function of MRCT in view of the worsening political climate vis à vis asylum seekers (if you have an MRCT report stating that you have been tortured, you stand a chance) and it is the most frequent reason for asylum seekers to turn to MRCT. These elements highlight the importance of the medical reports and the unique position of the centre to provide such reports. This should also encourage MRCT to improve the quality of its medical reports, in order to ensure their stricter conformity with the requirements of the Istanbul Protocol: e.g. describing the physical and psychological marks observed in the medical examination and linking them (causally and with a certain probability) to the torture experienced. It might be crucial for asylum seekers for other MDs outside of Athens or Thessaloniki to be trained in the adequate examination of such patients and in writing medical reports.

As part of the project, a database of 'client records' was designed, which would enable the team to have access to basic data about their patients. The goal of this data collection was to monitor in the not too distant future the effectiveness of the clinical interventions, through the development of a monitoring and evaluation system. In this perspective a research project was initiated in cooperation with IRCT, entitled "Qualitative study of the long-term impact of an interdisciplinary treatment course on psychological health and social functioning of torture survivors" (in conformity with objective 6 of the project proposal), but it was never finalised. Based on this unsuccessful experience, the centre decided not to resume any evaluation activity and to leave aside its data collection and patient registration plan. The consultants believe that, on the contrary, patient registration should not only continue under the new project, it should be specified in many directions, such as follow-ups of therapeutic processes, drop-outs etc., even if the centre does not yet have the expertise to develop a reliable monitoring and evaluation system on this basis.

Torture prevention

Although the design of the project proposes some balance between therapeutic and prevention activities, the effective implementation of prevention work has proved to be very difficult in practice. At a national level, advocacy and lobbying seem to be extremely hard, given the political and economic situation in Greece. In spite of this, some members of the team try again and again to develop fruitful contacts with representatives of the government, at the Ministry of Public Order, Ministry of Health, Ministry of Foreign Affairs and at the Parliament. The fact that the legal advisor is also the Greek member of ECPT probably facilitates some of these contacts.

However, this has not yet resulted in the establishment of an ongoing institutional dialogue between the centre and the authorities, who consider MRCT as one NGO among many others. They do not see MRCT as a partner in the implementation of their asylum policy, including non-removal and respect for the European Directives laying down minimum standards for the reception of asylum seekers, etc.

It is astonishing that the Greek authorities give the centre financial support for projects outside Greece (BAN), but nothing for its work at the national level. In this way they do not comply with their basic obligations towards asylum seekers. Not even the Ministry of Health considers MRCT as fulfilling an obligation of the ministry, namely to care for asylum seekers' health and to provide them with comprehensive and appropriately adapted services, at least in accordance with their obligation to minimal standards.

In spite of this difficult context, the centre enjoys several assets to contribute to the prevention of torture: its unique position in the country, the respect it is accorded by the authorities and its integration in the national network of actors involved in asylum issues. According to stakeholders interviewed for the purpose of this evaluation, including UNHCR with whom MRCT has a close partnership for some training activities, the centre's contribution to capacity-building activities for police officers has some added-value and should be continued. However, the current two short (half-day) trainings per year are too limited.

Other activities, such as awareness-raising through public events, are less obvious contributions to the prevention of torture. They seem to be organised spontaneously, on an *ad hoc* basis, in the absence of an overall strategy. No clear indicators are established to monitor their preventive effects either at national or at international level.

Networking activities

At the national level, contacts with other rehabilitation centres in the country (in Thessaloniki and Ioannina) seem almost non-existent, in spite of the partnership implemented under the ongoing project.

The BAN publication activities are functioning satisfactorily with some limited support from MRCT, whereas the MENA project has been stopped.

2.6 Efficiency

The project is managed by a committed team with insufficient human and financial resources, corresponding to eight full-time employees. It is not possible to measure the time devoted to the centre by the network of 55 MDs, but one may assume that this represents a meaningful contribution to its activities.

It was not possible to determine the average cost of treatment per patient.

Human resources are not always organised in a rational way. Some important tasks are performed by part-time staff. For example, the Administrative Director is only employed 25%; this may be sufficient to manage the EC contract efficiently but it is not adequate to develop new funding perspectives. In other cases, full-time personnel perform tasks which should not fall within their remit and this seems to detract from their regular activities. For example, the psychologist designing and managing the database.

The clinical activities are the responsibility of the mental health coordinator, who is also the Director of the centre. In practice, however, these activities (just as most activities of the centre) are planned and decided through a process in which the founder of the centre still has a predominant role. A change in this process would undoubtedly have positive consequences on the programme, staff and financial management. Unless management is improved, the centre will remain in this limbo state: with minimum resources to ensure the daily activities of the centre, but not enough to improve the work based on a long-term strategy.

2.7 Sustainability

The ongoing project is implemented with a 60% EC contribution. Under the new project, MRCT is requesting a 50% EC contribution. Other contributions to the project came from Greek public donors (Parliament, Ministry of Health and Ministry for Foreign Affairs) and from the UN Voluntary Fund for Victims of Torture (UNVFVT).

Under the new proposal, at the time of drafting this report, no guarantee for non-EC support exists, except from the UNVFVT, whose contribution (11% of the new project) is expected to remain stable in the short term.

In the previous years, contributions from the Greek authorities have been granted as *ad hoc* support (the centre is not covered by the country's health care department) and partly directed at MRCT's activities outside Greece, while treatment for torture victims is not covered by the national health care system. So far there has been no institutional long-term financial support by the Greek authorities. The lack of an 'NGO culture' in the country is not a sufficient explanation for this, given the respect enjoyed by the centre in the country and its unique role in the asylum field.

In this context, withdrawing EC support would have fatal consequences on the sustainability of the centre. Although it is aware of this difficulty, the centre's efforts to attract other funds have not been fruitful. For example, it is particularly striking that the expensive recruitment of a consultant for 18 months as part of the former project, with the aim of developing the centre's fund-raising capacity, proved to be a fruitless investment. This activity did not, as had been hoped, allow the centre to develop an outlined strategy for transition from EC funding to other funding and for securing sources of support for continuing projects.

From a policy perspective, the project's sustainability cannot yet be guaranteed, as there are no structural solutions for integration into the mainstream health sector.

2.8 Visibility

Although the publications and headed paper bear a logo showing that the centre is supported by the EC, in the building itself no such sign is displayed. The EC logo should be visible next to the bell at street level, in the entrance of the building and in the reception area.

2.9 Impact of rehabilitation on prevention in a European context

MRCT lacks an overall vision and strategy (goal, objectives and outputs) for prevention. It was originally created by a survivor of torture in Greece and an HR activist. Prevention of ill-treatment of asylum seekers by the Greek police is one of the goals of the centre. The fact that some of the medical reports are considered in the asylum process to give evidence about torture also pinpoints the efforts of the centre in preventing torture by trying to stop the authorities from returning asylum seekers to their country of origin. The support and coordination of BAN is considered not only a preventive, but also a peace promoting activity in the Balkans. However, all these activities appear spontaneous and reactive rather than reflected in strategic planning.

Indicators to measure the impact of the work on prevention

Several indicators might be identified to measure the impact of the work on prevention, such as legislative and procedural changes, adaptation to European norms of asylum legislation in Greece, change of attitudes in the Greek forces of public order (police, army) where torture still occurs, public condemnation and, finally, conviction of perpetrators with hopefully deterrent effects. However, at this stage, in spite of ECPT efforts, these indicators are not visible and even less measurable to prove the impact of torture prevention.

Detraction of prevention activities from the rehabilitation work

As preventive activities through lobbying are mainly done by the lawyer no detraction from therapeutic activities occurs. The working capacity of the medical doctor – who mainly prepares and writes the medical reports and does not treat patients – broadly allows the dedication of some time for preventive activities.

Beneficial or detrimental effects of prevention activities on the victims

It is hoped that local preventive activities, such as prevention of torture by the Greek police, make some difference. However, the effect of the previously mentioned prevention activities is not really known (e.g. through an independent investigation against police officers and maybe even a lawsuit against some of them).

3. Conclusion

3.1. Impact

The main objective of the MRCT is the rehabilitation (medical and psychosocial) of refugees who have been tortured. With 108 new patients last year, the impact on the actual number of asylum seekers in Greece is quite limited. The medical reports seem to give the applicants a better chance of being recognised as refugees and therefore of being able to stay in Greece.

The project has some institutional impact through a half-day training course, twice a year, for about 50 police officers, but this is restricted by the absence of institutional dialogue with the authorities. It also has some impact on the legislative process and case law, thanks to personal contacts between the legal adviser and the Ministry of Justice.

3.2. Relevance and design

The project is designed to implement basic rehabilitation services, including legal assistance, medical reports, social assistance and psychotherapeutic and psychiatric care for asylum seekers or illegals, as well as prevention activities in Greece. These activities and services are considered relevant by stakeholders involved in the care for refugees such as the GCR or UNHCR. However, the project does not reach the most needy and most numerous groups of 'aliens' on the islands of the Dodecanese.

The project design does not have any objectively verifiable indicators to assess either the rehabilitative or the prevention-oriented activities.

3.3. Effectiveness

The effectiveness in relation to the objective of rehabilitation of torture victims relates to the quality, the successful completion of the therapy programme and drop-out. Drop-out rates can be an indicator of the effectiveness or otherwise of treatment: if a patient drops out, s/he is no longer treated so it seems likely that s/he does not feel there are any positive effects. Also, the therapist has no feed back about the satisfaction of the patient or about progress in the (possibly vital) healing and rehabilitation process. The intervention techniques described by the psychologist can be successful if completed.

According to the two beneficiaries interviewed (chosen by MRCT), the health care and social support provided to them by MRCT have helped their rehabilitation process.

Clinical staff note that the treatment provided to the beneficiaries also has an impact on members of their families, for the minority who come to Greece with their families. However, there are no indicators or more specific data about this. The centre's impact on beneficiaries should be enhanced through more specific activities, adapted to the patient's situation or gender. However, compared to the number of asylum seekers in Greece, this impact is very restricted.

Another question related to effectiveness concerns one of MRCT's major roles: supporting asylum seekers in the application procedure by providing medical reports. MRCT is effective here, by supporting through medical evidence the claim of an asylum seeker that s/he has been tortured. However, this service can be provided for only a very limited number of applicants. The centre also establishes reports stating that torture is likely not to have happened, in spite of the applicant's statements, but no data exist as to the number of such reports.

MRCT is still functioning as it did at the beginning, when all the people involved were volunteers and where the main and urgent question was how to help victims in need. Evaluation of effectiveness, regarding treatment interventions as well as preventive activities has not so far been an urgent issue.

The development of a monitoring grid (client database records) has started to provide some data about the clients and, in the future, it must be developed to provide more data for monitoring and evaluating clinical activities. Ongoing improvement of the database must be planned and budgeted.

Although MRCT has not budgeted for the client records project, this work was achieved through the dedication of the psychologist

3.4. Efficiency

In spite of the team's commitment, the centre has had many difficulties in efficiently managing the EC project. Processes cannot be managed, since there is no monitoring and evaluation system. The management decided to stop the process of designing the planned monitoring and evaluation in view of a previous unsuccessful experience. Money should be managed more efficiently (e.g. money was wasted on a fundraising consultant which produced nothing). Staff and volunteers should be better managed, in order to change their attitude towards cooperation with authorities. In short, financial and human resource management as well as staff management should be enhanced to ensure a more professional and less personalised development of the centre.

In addition, clinical supervision of the psychologists, social workers and interpreters should be organised and might enhance the quality of reflection about their services.

3.5. Sustainability

The project is barely financially sustainable, as MRCT has not (yet) found any private donors. Funds received from government sources are never long-term funds and are always received on a personalised level, i.e. because a potential donor knows a professional from MRCT.

It is essential to call upon the relevant ministries to comply with their obligations towards refugees – in a European context – and to support the valuable and important services provided by MRCT, something which might have to be done by the EC.

3.6. Visibility

The EC contribution is not made visible enough in the project.

3.7 Impact of rehabilitation on prevention in a European context

At the national level, MRCT can have some impact on the prevention of torture, particularly in Greece where torture is unfortunately still an issue (cf. published ECPT reports on Greece). This is even more true for aliens and a lot still needs to be done before the Greek authorities comply with the European Directive on the minimum standards for the reception of asylum seekers. MRCT's activities are urgently needed to lobby the authorities in this respect.

It would be desirable for the MRCT's lobbying activities to be given more consistency and importance. However, these activities are time-consuming and more may just not be possible for the small team.

At the regional level, the support given to BAN has some wider larger European influence, as in many of the other Balkan countries the problems are similar to those found in Greece. The Greek experience may help the members of BAN to proceed faster and more directly in their own endeavours in rehabilitation, treatment and prevention of torture and organised violence.

References

- *Anthropina*, published by the MRCT, 1989-2001, special issue in English, 2001.
- *Evaluation EIDHR: Torture Rehabilitation Centres*, MEDE European Consultancy, November 2003.
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.
- Council Directive 2003/9/EC of 27 January 2003 laying down minimum standards for the reception of asylum seekers [Official Journal L 31 of 06.02.03].
- European Commission Communication on the EU's role in promoting human rights and democracy, May 2001, COM (2001) 252 Final.

Annex 1: Itinerary

Sunday 10 October 2004

- Travel Paris – Athens (Sara Guillet)
- Travel Zurich – Athens (Gisela Perren-Klingler)

Monday 11 October 2004

10.00 AM	Meeting with the President, Administrative Director, Medical Director, Legal Advisor and Psychologist
1.00 PM	Visit to MRCT
2.00 PM	Meeting with the Psychologist
3.00 PM	Meeting with the interpreters
4.00 PM	Meeting with the Social Workers
5.00 PM	Meeting with two beneficiaries
6.00 PM	Team meeting

Tuesday 12 October 2004

9.30 AM	Meeting with the Administrative Director
11.00 AM	Meeting with the accountant
12.00	Meeting at the Greek Council for Refugees
2.30 PM	Attendance at the weekly staff meeting
5.00 PM	Meeting with the Legal Advisor
6.00 PM	Team meeting

Wednesday 13 October 2004

10.00 AM	Meeting at the Ministry for Health
11.30 AM	Meeting with the Director and Mental Health Coordinator
1.00 PM	Debriefing session with the President, Administrative Director, Medical Director and Legal Advisor
3.00 PM	Meeting at UNHCR
4.00 PM	Travel Athens – Paris (Sara Guillet)

Thursday 14 October 2004

- Travel Athens – Zurich (Gisela Perren-Klingler)

Annex 2: People and organisations interviewed

MRCT staff:

- Ioanna Babassika, Legal Advisor
- Alexis Caniaris, Administrative Director
- Nikos Carachalios, Accountant
- Roza-Lisa Lykourezou, Social Worker
- Marina Maitzourane, Research Assistant
- Christina Michailidou, Medical Secretary
- Dimitris Pantazis, Psychologist
- Dora Papazafeiri, Social Worker
- Maria Piniou-Kalli, Medical Director
- Demokritos Sarantidis, President and Mental Health Team Coordinator
- Georgia Strimbakou, Secretary

Other stakeholders:

- Petros Mastakas, Director, Greek Council for Refugees
- Kalliope Migirou, Coordinator, Legal Assistance Unit, Greek Council for Refugees
- Eleni Spethanou, Legal Assistance Unit, Greek Council for Refugees
- Maria Stavropoulou, Protection Officer, UNHCR
- Natacha Foucard, Programme coordinator, UN Voluntary Fund for Victims of Torture (phone interview)
- Ms Mavrantzodou, Director of Mental Health Department, Ministry for Health

Annex 3: Comments MRCT Athens

This is our response to the consultants' report. We tried to be as brief as possible without expanding into theoretical discussions, although such a discussion maybe required since it seems that we are not in a common point of departure. The big issue is the evaluation of our activities related to (what we call) rehabilitation as well as prevention. Providing comprehensive care to refugees is a very complex issue. Rehabilitation units are not just mental health units or health units. Opportunities and limitations differ from country to country and from area to area within the same country. This is perhaps the reason for not having agreed even on minimum standards, let alone quality assurance programs, after so many years in "business".

Since we wanted to be very brief, we mentioned only the issues that we disagree. All in MRCT believe that overall the evaluation was a very positive experience. It made us reconsider our work and correct omissions or mistakes that we do not notice during the every day routine.

Impact

Rehabilitation impact: The consultants found the impact on rehabilitation "quite limited" (pg 23), mainly because the number of served clients represents a smaller than expected percentage of the torture victims among the asylum seekers in Greece. Taking into account that we do not have a waiting list, there should be other reasons, not directly related to our center. One possibility is that our referral sources (particularly GCR) do not consistently refer torture victims to us, either because they do not ask their clients whether they were tortured or not or they do not think it is important. Whatever the reasons, we will discuss this issue with GCR and the other referral sources.

Institutional impact: We think that the criticism here is unfair. The consultants acknowledge the difficulties that other organizations face trying to have a dialogue with the Greek authorities. Law enforcement personnel's brutality, particularly towards immigrants and refugees, has in several occasions been exposed by the media, reported by the Greek Ombudsman and criticized by relevant international organizations, including UN. However, the impact is practically none. We have tried to have this dialogue but without success. In fact, we came to the point to feel satisfied that the Ministry of Public Order allows (in fact orders) the police personnel to attend our seminar.

As for the Ministry of Health, perhaps the consultants would have a different opinion, if they knew how the National Health System in Greece operates. Being part of this system since its beginning in 1985, I can assure you that it is a closed system with no room for cooperation with other health delivering units, even with those that belong to the public sector, such the University hospitals and IKA, the largest insurance organization in Greece. It would be unrealistic to even think that a small NGO could have institutionalized cooperation with the Ministry.

Just as an example we approached the Welfare Department of the Ministry of Health and requested to have reimbursement for the medication we provide to our clients. The Director readily agreed to provide funding up to € 3,500 per year. This lasted only one year. The following year, our request was turned down due to "budgetary restrictions".

Relevance and design

The issue of accessing asylum seekers in Dodecanese was discussed during the consultants' visit and we are surprised to see that this issue appeared in the report in a negative way. We mentioned that we had submitted an application to Europaid three years ago in partnership with GCR, after having secured not only the cooperation but the contribution of local authorities as well. Unfortunately the project was rejected for "administrative reasons", which means that in the application package one or more documents were missing. Obviously the project did not reach the technical evaluation stage. I sent two letters inquiring more specific explanations. I received no answer. Even if these "administrative reasons" were so grave, we could have corrected them and reapply in the next call. But frankly, the way our application was treated, we were not sure if the second time we would have a better chance, since we did not know what went wrong previously. All these were explained to the consultants.

Effectiveness and Efficiency

We have criticized ourselves for not being able to come up not only with verifiable indicators but to evaluate all our activities. We were very clear when we discussed with the consultants the reasons for dropping the part of our project entitled "Evaluation and monitoring of the efficiency of the planned activities". It was not dropped "in view of a failure" (pg 24) as the consultants seem to believe. We tried to collaborate with two different experts. None of them followed their commitment. The mere fact to include the issue of evaluation in both our project and in the seminars of BAN meetings shows our interest in the issue. Naturally, we should be blamed for not being able to implement the relevant part in our project.

There is no "state of the art" regarding the issue of evaluation of a rehabilitation unit for torture victims and it is still open. Established standards, criteria and indicators do not exist yet. IRCT has this issue on its agenda for some years now with no results, perhaps because it spent resources on the evaluation of treatment outcome. I believe that we all agree that the evaluation of the treatment outcome is practically useless. If one looks up in the relevant literature, the same argument has been discussed for the evaluation of mental health units. We cannot go into details expanding on this issue.

We can only say that one can apply the best treatment possible (whether psychotherapy or pharmacotherapy) by an expert but there would be no result if the client sleeps on a park bench or he/she spends 3 or 4 years uncertain about the outcome of his/her asylum application.

The same goes for the drop rate. Drop rate can have several reasons and the fact is that many of our clients move to other areas in Greece where there is a prospect to have even a small income. As we all know our refugees do not receive any financial support by the Greek state and they are on their own.

Nevertheless, we can agree that we have to try to establish some criteria that can give an idea on how efficient we are. Following the consultants' suggestion, we have already created a monitoring system for the follow up of our clients, which it is now in a pilot phase. Also the issue of the evaluation was an issue in the last BAN meeting, since it was part of the training seminars in the project. Hopefully we will make some inroads in the near future.

Sustainability

We have made great efforts to find private donors to support our center. The results are very disappointing. First, private donors outside Greece (such as the Oak Foundation) instantly reject our application because we operate in an EU country. Second, the private sector in Greece is not interested in funding an organization that helps refugees. Three private donors told us off the record that funding our organization is not compatible with the profile they want to show in the Greek society. GCR persuaded a number of radio stations to participate in a radio-marathon with very limited success. UNHCR a few years ago went into a big fund raising campaign, supported by the media with televised spots. Again the outcome was very limited.

The cooperation with the fund-raising consultant attests to the fact that we have tried all we could to secure funding from other (than EU) sources. Of course judging from the results, the consultants are on the safe side to say that "it is particularly striking that the expensive recruitment of a consultant during 18 months under the former project with the aim to develop the center fund raising capacity has proved to be a useless investment" (pg 21). However if we have not done this, we could have been criticized for not having included this activity, the cost of which was eligible in the 2001 call. Besides "useless investment" is not perhaps the right expression, since the consultant carried out the task she was hired for. She trained the personnel on established fund raising methods. The skills of the personnel on this issue improved. If this was not transformed into bringing money to our center, it has to do with the reasons we mentioned in the previous paragraph.

Consequently our only hope is the public sector that is the Parliament and various ministries. Within the given reality, we may say without hesitation that we have been very successful.

Visibility

We changed the signs at the entrances of both the building and the office, making visible EU contribution.

General comments

- Greek government has never specifically funded BAN activities. Funds were given to MRCT "to support its activities". The Greek government funds activities in the Balkan region as its contribution to the Stability Pact in the Balkans and are not related to our project.
- It is not correct that "no precise data exist about the number of patients from years" (pg 10). In our interim and final reports we have regularly included data about the number and characteristics of our clients. Besides our database has been in use since 1997 and we can easily extract data.

Response to the Recommendations

1. This point is vague. The center's mission is clear: To provide care to refugees - torture victims and implement activities mainly in the issue of advocacy. Our obligation is to implement the submitted project. Long term strategies are political decisions that the Board of our organization has to decide and implement, based on available resources.
2. We have addressed this issue
3. Medical records. There is always room for improvement. However the consultants acknowledge the fact that the Supreme Court based one recent decision on our report. Apparently our medical report serves its purposes in Greece. Central quality control of treatment processes. We have analyzed the issue of quality in our services. We firmly believe that the priority is to develop indicators and criteria, both explicit and implicit. In the meantime we started registering all our activities and developing a scale to monitor the clients' occupational and social performance.
4. We have established a tracking system which is in a testing phase.
5. This is a good point. We will register all the needs the client has, not just issues concerning his medical or psychological condition that we are doing so far.
6. We have explained the reasons for not having group (therapeutic or self supporting). First we do not have a group expert, second the various ethnic and language backgrounds make it very difficult. I would add that group is not a panacea.

7. This will be part of the clients' tracking system.
8. We do not see (and we have never seen) signs of burn out in our staff. This point is expressed by the consultants, as if burn out will necessarily inflict our organization.
9. We addressed this issue and will take the necessary steps
10. This issue has also extensively discussed previously
11. It has already taken care of.

Dimocritos Sarantidis MD
Project Leader
President of MRCT Board
Deputy Director, Dept of Psychiatry
Evangelismos General Hospital