Mapping Report

March 2023

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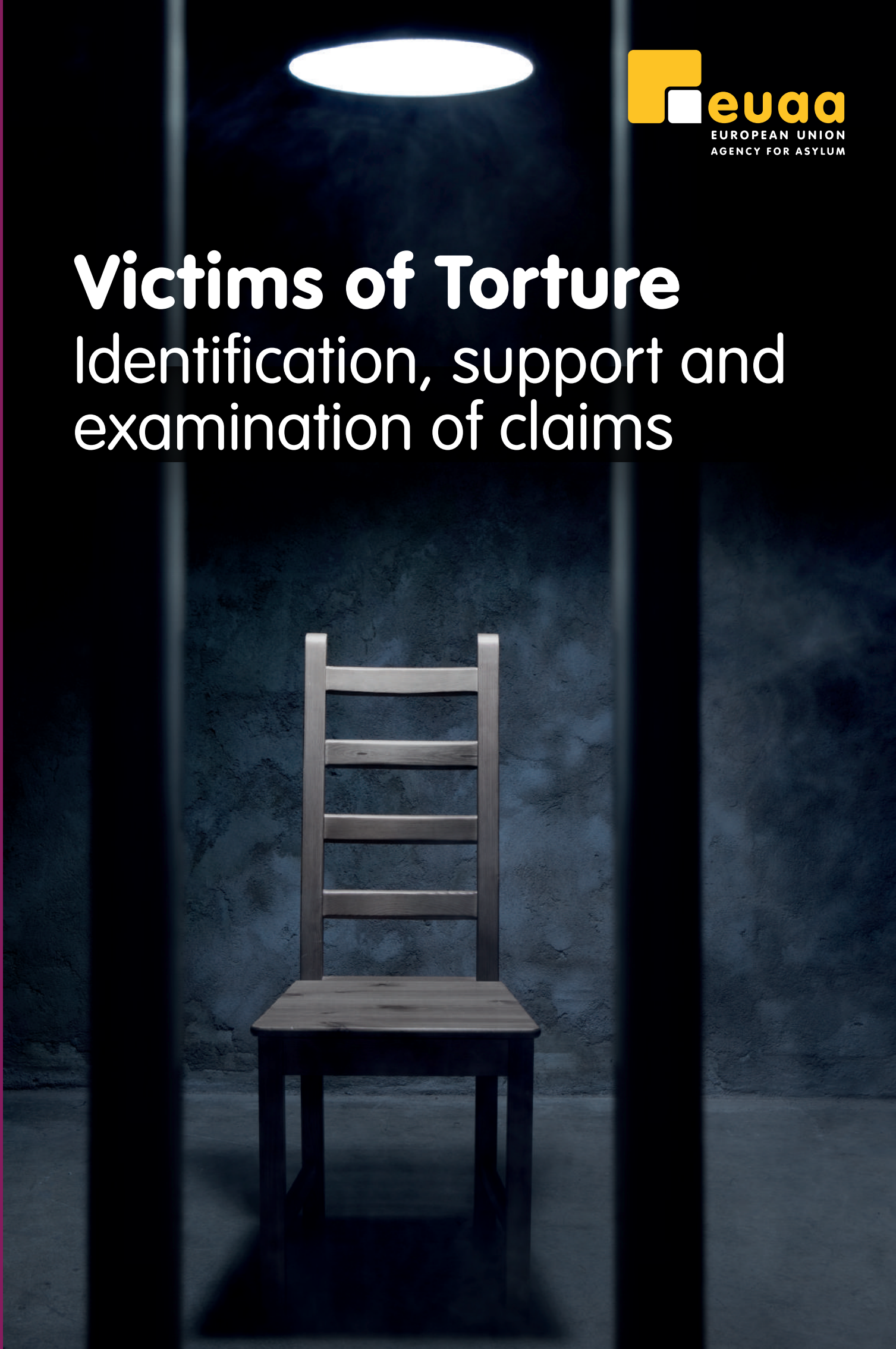
EUROPEAN UNION
AGENCY FOR ASYLUM

Victims of Torture

Identification, support and examination of claims



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On 19 January 2022, the European Asylum Support Office (EASO) became the European Union Agency for Asylum (EUAA). All references to EASO, EASO products and bodies should be understood as references to the EUAA.

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Contents

List of abbreviations **5**

Introduction **6**

EUAA support on the topic of torture 6

1. Legal framework and terminology **9**

1.1. Asylum procedure 10

1.2. Reception conditions 11

1.3. Temporary protection 13

2. The identification of victims of torture **14**

2.1. Self-identification and disclosure 16

2.2. Context of identifying victims of torture 17

2.2.1. Professionals involved in the identification of VoT 18

2.3. Referrals to a medico-legal assessment 18

2.4. The Istanbul Protocol and the medico-legal reports 21

3. Examination of the application for international protection **23**

3.1. Personal interview 23

3.2. Special procedural guarantees in the interview 25

3.3. Evidence assessment 26

3.3.1. The use of medico-legal reports during the examination of the claim 27

3.3.2. Country of origin information 29

3.3.3. Special procedural guarantees related to evidence assessment 29

3.4. General support measures 30

4. Reception, support services and rehabilitation **32**

4.1. Adequate standard of living and additional provisions 32

4.2. Treatment and rehabilitation services 35

4.3. Support provision to children who are VoT 36

4.4. Victims of torture and detention 36

5. Data and research on victims of torture in Europe **39**

6. Concluding remarks and way forward **40**

6.1. Seven components for administrations to safely and effectively support victims of torture 40

7. References **46**

List of abbreviations

Abbreviation	Definition
APD (recast)	**asylum procedures directive —** Directive 2013/32/EU of the European Parliament and of the Council of 26 June 2013 on common procedures for granting and withdrawing international protection (recast)
CSO	civil society organisation
EHCR	European Convention on Human Rights
EUAA	European Union Agency for Asylum
EU+ countries	Member States of the European Union and associated countries
Member States	Member States of the European Union
MoU	memorandum of understanding
PTSD	post-traumatic stress disorder
QD (recast)	**qualification directive —** Directive 2011/95/EU of the European Parliament and of the Council of 13 December 2011 on standards for the qualification of third-country nationals or stateless persons as beneficiaries of international protection, for a uniform status for refugees or for persons eligible for subsidiary protection, and for the content of the protection granted (recast)
RCD (recast)	**reception conditions directive —** Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013 laying down standards for the reception of applicants for international protection (recast)
UNCAT	United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
UNHCR	United Nations High Commissioner for Refugees
VEN	vulnerability experts network
VoT	victim(s) of torture and other forms of inhuman or degrading treatment or punishment

Introduction

Torture is a profound concern of the world community. Its purpose is to destroy deliberately not only the physical and emotional well-being of individuals but also, in some instances, the dignity and will of entire communities. It concerns all members of the human family because it impugns the very meaning of our existence and our hopes for a brighter future ([1])**.**

According to estimates from the International Rehabilitation Council for Torture Victims shared in a 2018 report ([2]), around 400 000 torture survivors lived in the European Union alone in 2010, that is prior to the most recent refugee movements into Europe. The same report estimates that 30 % to 60 % of applicants for international protection seeking medical attention are survivors of torture. In 2017, the Fundamental Rights Agency (FRA) indicated that no comprehensive data is available on victims of torture (VoT) who arrive in Europe, are identified by the authorities and go through the asylum procedure in the EU+ countries ([3]).

EUAA support on the topic of torture

In this context, EU+ authorities sought the support of the EUAA to respond to the needs of VoT and deal with their claims for international protection.

The EUAA has been engaging on the topic since 2016, along with national authorities and civil society organisations. The Agency provided support through the organisation of meetings to facilitate exchange and learning and has also developed guidance material which includes reference to VoT.

Several topics relating to torture have been put forward to be the subject of further guidance. These include appropriate interview techniques, tailored approaches to evidence assessment, documenting signs of torture and practices for cooperation between stakeholders in case the applicant for international protection has experienced torture.

Below is a list of support activities conducted by the EUAA on the topic of torture.

([1]) OHCHR, *Istanbul Protocol – Manual of the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, 2022, p. XX, making reference to: Iacopino V., *Treatment of survivors of political torture: commentary*, Journal of Ambulatory Care Management, vol. 21 (2) (1998), pp. 5-13.

([2]) European Network of Rehabilitation Centres for Survivors of Torture, *Refugee survivors of torture in Europe. Towards positive public policy and health outcomes*, 2018.

([3]) FRA, *Current migration situation in the EU: Torture, trauma and its possible impact on drug use*, 2017, p. 2.

EUAA thematic meetings

Istanbul protocol, reception and examination of the claim – 22-23 June 2022
The thematic meeting discussed the Istanbul Protocol generally, the updates to it made in 2022 ([4]), medico-legal assessments, adjusting reception conditions to the needs of victims of torture, and examining applications for international protection from VoT. The meeting was organised for the EUAA Vulnerability Experts Network, the Asylum Processes Network and the Reception Network to participate together. It was conducted online over two half days and attracted experts from the 19 EU+ countries ([5]).

The impact of trauma on memory – 22 June 2021
The meeting, organised by the EUAA vulnerability team, focused on trauma, how trauma can impact memory (fragmented memory, victims being not ready to talk about the past etc.), and how victims of torture with strong cases for asylum, yet without identification and appropriate support during the asylum process, struggle to effectively present their case. The meeting was attended by representatives from 21 EU+ countries ([6]).

Special procedural guarantees – October 2016
The meeting, organised in collaboration with UNHC, focussed on the identification and special procedural guarantees for persons subjected to torture and other serious forms of psychological, physical or sexual violence.

EUAA survey – February 2022

The survey ([7]) was addressed to the determining and reception authorities of EU+ countries and to the actors engaged in supporting such authorities ([8]). The reception and determining authorities of each country shared one consolidated answer. A total of 19 EU+ countries ([9]) participated in the survey, 18 of which are Member States of the EU.

([4]) For a brief overview of the 2022 updates to the Istanbul protocol, see: Perez-Sales, *The 2022-revised version of the Istanbul Protocol: orientation kit for people in rush*, in TORTURE – International Rehabilitation Council for Torture Victims, published by Journal on Rehabilitation of Torture Victims.
([5]) Belgium, Bulgaria, Croatia, Cyprus, Czechia, Denmark, France, Germany, Greece, Italy, Lithuania, Luxembourg, Malta, Netherlands, Norway, Republic of Serbia, Slovakia, Slovenia, Sweden.
([6]) Belgium, Bulgaria, Croatia, Cyprus, Czechia, Denmark, France, Germany, Greece, Italy, Lithuania, Luxembourg, Malta, Netherlands, Norway, Republic of Serbia, Slovakia, Slovenia, Sweden.
([7]) The survey covered 10 sections: 1. General Information, 2. Definitions, 3. Identification of VoT, 4. Referral, 5. Medico-legal assessment and medico-legal reports (MLR), 6. Examination of the claim, 7. Reception & Support Services and Rehabilitation, 8. Knowledge, Capacity and Training, 9. Data collection and research, 10. Other.
([8]) 3 civil society organisations (CSOs) from Greece, 1 CSO from France and 1 CSO from Portugal, all part of the EUAA Vulnerability Experts Network (VEN), participated in the survey.
([9]) Austria, Belgium, Bulgaria, Croatia, Czechia, Cyprus, Denmark, Finland, France, Germany, Greece, Croatia, Italy, Luxembourg, Netherlands, Portugal, Slovenia, Spain, Sweden, Norway.

Practical Guide: Qualification for international protection ([10])
Practical Guide: Evidence assessment ([11])
Practical Guide: Personal Interview ([12])

These core practical guides on the examination of applications for international protection outline the principles, methodology and legal basis for the examination process, including information on adjustments to be made in case of special procedural needs. The practical guide on qualification also includes direct references to torture.

Country of origin information and country guidance

Several COI reports include information that is relevant in the examination of applications for international protection lodged by victims of torture. This includes profiles that are more likely to have experienced torture, as well as torture in prison or detention (as an example, see the reports on Syria, Afghanistan, Iraq and Eritrea).

Country guidance is country-specific common analysis and guidance developed by the EUAA together with a network of senior-level policy officials from EU+ countries. Country guidance documents represent the joint assessment of Member States of the situation in main countries of origin and include in-depth common analysis and guidance on qualification for international protection, based on recent, reliable country of origin information. They include information that is relevant in the examination of applications for international protection from victims of torture, including profiles that are more likely to have experienced torture, as well as torture in prison or detention.

([10]) EASO, *Practical guide: Qualification for international protection*, April 2018.
([11]) EASO, *Practical Guide: Evidence Assessment*, March 2015.
([12]) EASO, *Practical Guide: Personal Interview*, December 2014.

1. Legal framework and terminology

The right to be free from torture or inhuman or degrading treatment or punishment is firmly established under international and EU law. The Universal Declaration of Human Rights ([13]), the International Covenant on Civil and Political Rights ([14]) and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT) ([15]) prohibit torture and other forms of inhuman and degrading treatment or punishment. The European Convention on Human Rights ([16]) and the Charter of Fundamental Rights of the European Union ([17]) similarly prohibit such acts.

Article 1(1) and 1(2) UNCAT ([18])

… the term 'torture' any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.

This article is without prejudice to any international instrument or national legislation which does or may contain provisions of wider application

Terminology note: on the context of this report, the term 'torture' is understood to encompass torture and other forms of inhuman or degrading treatment or punishment. In this report 'victims of torture' (VoT) also refers to applicants for international protection who may have experienced torture, while it is yet to be ascertained through the asylum procedure whether their past experiences qualify as 'torture'.

([13]) See Article 5 of UN General Assembly, *Universal Declaration of Human Rights*, 10 December 1948, 217 A (III).
([14]) See Article 7 of UN General Assembly *International Covenant on Civil and Political Rights* the International Covenant on Civil and Political Rights, United Nations General Assembly resolution, 2200A (XXI), 16 December 1966. United Nations, Treaty Series, vol. 999, p. 171.
([15]) UN General Assembly, *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, 10 December 1984, United Nations, Treaty Series, vol. 1465, p. 85.
([16]) See Article 3 of Council of Europe, *European Convention for the Protection of Human Rights and Fundamental Freedoms, as amended by Protocols Nos. 11 and 14*, 4 November 1950, ETS 5.
([17]) See Article 4 of European Union, *Charter of Fundamental Rights of the European Union*, 26 October 2012, 2012/C 326/02.
([18]) UN General Assembly, *Convention Against Torture*, 1984, op. cit., fn. 15.

1.1. Asylum procedure

The Common European Asylum System applies more favourable provisions than the UNCAT for the definition of torture in the context of the asylum procedures. While the UNCAT requires that the act of torture be inflicted by or at the instigation of a public agent, the recast qualification directive ([19]) (QD (recast)) states that the agents of persecution or serious harm may also be non-state actors in the context of qualification for international protection. ([20])

Jurisprudence relating to asylum does not often distinguish between torture and other forms of inhuman or degrading treatment, while it requires that ill-treatment attain a certain level of severity. Several factors can concur to reaching the required level of severity, depending on all circumstances relating to the application, such as: duration of ill-treatment, physical and mental effects, the gender, age and health status of the person. Similarly, a specific purpose is not required for inhuman/degrading treatment to qualify as such. ([21])

In this context, the responding EU+ countries in the survey on victims of torture and other forms of inhuman or degrading treatment or punishment noted that their national legislation does not generally differentiate between torture and other forms of inhuman or degrading treatment. Some countries however specified that their national legislation on asylum requires no purpose for inhuman or degrading treatment to qualify as such, unlike the case for torture. In addition, several countries noted that their national legislation specifically lays down that torture and other forms of inhuman or degrading treatment can take the form of sexual violence and psychological terror, such as forced nudity and verbal threats.

Victims of torture can qualify for refugee status when their past treatment is linked to reasons of persecution. If there is no link to reasons of persecution, subsidiary protection status can be granted to applicants who have suffered treatment or punishment that amount to torture or other inhuman and degrading treatment considered sufficiently severe in nature. ([22])

Related EUAA publication – '*Practical Guide: Qualification for International Protection*'

This guide supports in the examination of applications for international protection and in the application of the legal criteria on who qualifies for international protection. In particular, the section 'Torture or inhuman or degrading treatment or punishment' (p. 28) refers specifically to qualification for international protection in case of past experiences of torture.

The recast asylum procedures directive (APD (recast)) provides guarantees for applicants with special procedural needs, including in case of torture, rape or other serious forms of

([19]) Directive 2011/95/EU of the European Parliament and of the Council of 13 December 2011 on standards for the qualification of third-country nationals or stateless persons as beneficiaries of international protection, for a uniform status for refugees or for persons eligible for subsidiary protection, and for the content of the protection granted (recast) (OJ L 337, 20.12.2011).
([20]) See EASO, *Practical Guide: Qualification for international protection*, April 2018, p. 28.
([21]) On the matter, see EASO, *Practical Guide: Qualification for international protection*, April 2018, p. 28-29.
([22]) See Article 15(b) QD (recast).

psychological, physical or sexual violence. In accordance with such guarantees, applicants must be provided with the support they need to enjoy their rights and comply with their obligations while the use of special procedures will be limited if it is not possible to provide adequate support during such procedures. ([23])

The APD also stipulates that Member States must arrange for a medical examination where they deem it relevant if the applicant shows 'signs that might indicate past persecution or serious harm' ([24]).

Recital 31 APD (recast)

National measures dealing with identification and documentation of symptoms and signs of torture or other serious acts of physical or psychological violence, including acts of sexual violence, in procedures covered by this Directive may, inter alia, be based on the Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Istanbul Protocol).

1.2. Reception conditions

Article 14(1) UNCAT ([25])

Each State Party shall ensure in its legal system that the victim of an act of torture obtains redress and has an enforceable right to fair and adequate compensation, including the means for as full rehabilitation as possible. In the event of the death of the victim as a result of an act of torture, his dependants shall be entitled to compensation.

The above UNCAT provision touches on the accommodation and rehabilitation of victims of torture. Its relevance for the asylum procedure lies on the fact that health care and rehabilitation often take place during stay in reception.

([23]) See Article 24 APD (recast).
([24]) Article 18 APD (recast).
([25]) UN General Assembly, *Convention Against Torture*, 1984, op. cit., fn. 15.

On this matter, the Charter of Fundamental Rights states that

Article 35 Charter of Fundamental Rights

Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all the Union's policies and activities.

Article 17(2) of the recast reception conditions directive (RCD (recast) stipulates that material reception conditions must ensure an 'adequate standard of living' for asylum seekers, which consequently also protects their mental health. Article 18(3) RCD (recast) also specifies that 'Member States shall take into consideration gender and age-specific concerns and the situation of vulnerable persons in relation to applicants within the premises and accommodation centres …'. This provision is also relevant when accommodating victims of torture.

The obligation to provide necessary medical or other assistance to applicants who have special reception needs, including appropriate mental health care where needed, is captured under Article 19(2) RCD (recast) and is an important element when accommodating victims of torture. This point is also highlighted Article 25(1):

Article 25(1) RCD (recast)

Member States shall ensure that persons who have been subjected to torture, rape or other serious acts of violence receive the necessary treatment for the damage caused by such acts, in particular access to appropriate medical and psychological treatment or care.

Finally, Article 11 RCD (recast) underlines the importance of vulnerability, mandating that 'Member States shall ensure regular monitoring and adequate support' of vulnerable persons in detention.

1.3. Temporary protection

The temporary protection directive ([26]) also regulates access to medical care and other assistance for vulnerable persons.

Article 13(2) TPD

The Member States shall make provisions for persons enjoying temporary protection to receive [...] medical care. [...] the assistance necessary to medical care shall include at least emergency care and essential treatment of illness.

Article 13(4) TPD

The Member States shall provide necessary medical or other assistance to persons enjoying temporary protection who have special needs ...

([26]) Council Directive 2001/55/EC of 20 July 2001 on minimum standards for giving temporary protection in the event of a mass influx of displaced persons and on measures promoting a balance of efforts between Member States in receiving such persons and bearing the consequences thereof (OJ L 212, 7.8.2001).

2. The identification of victims of torture

" Victims of torture need time to build trust and gain confidence to be able to speak of certain incidents "*

Quote by a survey respondent

During the thematic meetings held in 2021 and 2022, in other exchanges on the topic of torture and in the survey conducted in February 2022, it was pointed out that victims of torture and other forms of inhuman or degrading treatment or punishment normally do not disclose their traumatic experiences easily. Early identification can therefore be challenging.

You can find below examples of challenges to the identification of VoT shared by EU+ countries.

Trauma, Stigma and Shame

Torture triggers feelings of shame and guilt in many victims. It is often a challenge for the professionals engaging with VoT to find the right words to address those acts, without being perceived as intrusive or even insulting.

Lack of qualified professionals addressing VoT

Training on torture and its possible impact on an individual is not always available for all personnel dealing with VoT or with the examination of claims related to torture. Case officers may struggle to find the right approach to identify VoT during the personal interview while limiting the risk of re-traumatisation for the applicant. Medical officers or professionals working for civil society organisations (CSOs) and trained on medico-legal assessments and documentation are not always officially certified or acknowledged by determining authorities in first and second instance. As a result, their reports are not always accepted as evidence. Lastly, the number of specialists, particularly in field of mental health and trauma, supporting vulnerable applicants including VoT throughout the procedure is insufficient in a number of EU+ countries.

Lack of an enabling environment

Insufficient time to create an atmosphere of trust with applicants during their stay in reception ([27]) and during the personal interview is a main challenge, in addition to language and cultural barriers.

Medical documentation submitted to substantiate the claim

In some countries, medical certification issued by CSOs and other entities not officially entrusted with the conduction of medico-legal assessments is not accepted for the purpose of substantiating the claim. Some countries highlighted that, at times, the quality of medical certification is not sufficient for it to be considered reliable evidence of torture. This may be for a number of reasons, such as: it includes recommendations on how to assess the case, does not document signs of torture, or mainly relies on the applicant's statements. Finally, the cost of acquiring a certification of torture seems to be high when applicants self-refer.

Evidence assessment and credibility issues

Case officers may face difficulties to distinguish between signs of mental health concerns due to traumatic experiences like torture and signs of distress due to post-migration stressors. Furthermore, if the applicant is unwilling or unable to disclose information on the experienced torture, it becomes hard for the case officer to duly assess these elements when examining the claim, particularly in the absence of conclusive physical, emotional or psychological signs of torture. Some respondents also raised a credibility issue, in light of the high number of claims related to torture or other serious forms of violence that are insufficiently substantiated by statements or other corroborating evidence

Lack of appropriate accommodation for persons with specific needs

Immediate availability upon arrival of protected accommodation for persons with specific needs is limited. This hinders vulnerable applicants from stabilising, until they are ready to reach out to the relevant professionals and self-identify.

([27]) For more information refer to Section 4.1. 'Adequate standard of living and additional provisions'.

Lack of communication, coordination and cooperation

The survey's result suggest that the communication, cooperation and coordination between asylum authorities, reception authorities and the health sector in some EU+ countries could benefit from improvement. There appears to be gaps in how certain information on applicants is exchanged between those stakeholders. This could lead to case officers facing unexpected situations during the interview with a potential VoT, which could be avoided with a prompt and correct sharing of information, or to applicants not receiving sufficient information before and after a medical exam (e.g. the certificate for torture is given only to the victim who might not be aware of the need to share it with the determining authority). Lastly, the health bodies and those conducting medico-legal assessments are not always aware of what exactly the determining authorities need for the examination of a case. As a result, medico-legal reports may not always be fully relevant.

2.1. Self-identification and disclosure

VoT are often apprehensive to disclose traumatic experiences. A possible reason pointed out in the meetings and confirmed by the survey, is the applicants' possible mistrust in the authorities, as perpetrators of torture in the applicants' country of origin might have been part of authorities (e.g. government officers, police and military, medical professionals ([28])).

It was also pointed out that sexual violence and torture may be seen as a very private matter. Some applicants therefore prefer to only mention that violence happened, avoiding details, particularly when those are related to sexual violence. While both men and women suffer the consequences, men seem often even more impacted by feelings of shame and guilt when sexual violence is involved. Applicants might suffer from post-traumatic stress disorder (PTSD) which can affect their capacity to talk about their experiences of violence.

Other reasons that may make it difficult for VoT to recount the whole of their experiences include the lack of recognising themselves as victims (yet) or fear of repercussions against family. A lack of understanding on the side of the applicant that any information shared with officials is treated with confidentiality adds to the challenges linked to self-disclosure.

Every applicant is different and has a different way of coping with past experiences. Therefore, in some cases, applicants might also avoid thinking of violent past events as part of their coping strategy (defence mechanism).

Lastly, some applicants might not be aware that the violence they endured can be defined as torture or that there could be an actual risk if they return to their country of origin. They might not necessarily look at things from a theoretical or legal point of view and might come from a

([28]) Some survey respondents indicated that officials wearing uniforms can be counterproductive when engaging with VoT.

country or place where violence is widespread and common or might have suffered forms of violence which could be more subtle and psychological in nature.

2.2. Context of identifying victims of torture

The identification of VoT can take place at any stage of the asylum process. Therefore it should be seen as an ongoing and collective effort by those responsible for the identification of vulnerable applicants. Only a few countries indicated that they use a standardised screening tool to identify VoT. Using these screening tools (torture) upon arrival seems to create, once used by trained staff, an additional opportunity to timely identify such applicants.

The practicability and possibility of early identification was also discussed in the context of the New Pact on Migration and Asylum, with the Proposal for a regulation introducing a screening at the external borders ([29]) requiring identification of vulnerabilities within 5 days. According to many participants to the EUAA thematic meeting held in 2021, a 5-day timeline is challenging for professionals and potentially puts applicants with serious trauma and other vulnerabilities, particularly the less visible ones (e.g. applicants with mental health concerns, victims of trafficking, survivors of rape, LGBTIQ+) at risk of being overlooked.

As also confirmed by the findings of the survey, victims of torture are often identified later in the asylum path, mainly at the stage of the personal interview. In some cases, identification can also take place during the appeal or when preparing for return.

([29]) Proposal for a Regulation of the European Parliament and of the Council introducing a screening of third country nationals at the external borders and amending Regulations (EC) No 767/2008, (EU) 2017/2226, (EU) 2018/1240 and (EU) 2019/817 (COM (2020) 612 final). See section 3 of the Explanatory Memorandum, p. 13, making reference to the 5 to max 10 days for the identification of vulnerabilities.

EXAMPLE OF PRACTICE ON VoT AND MEDICAL SCREENING

In **Luxembourg**, the National Reception Office works in close cooperation with partners, like the Red Cross and Caritas, that are responsible for the reception and initial accommodation of asylum seekers in more than 60 different structures. Luxembourg has taken a pro-active approach to identify victims of torture at a very early stage (upon arrival) by inserting indicators of torture into medical screening. Since adoption of this practice, more cases have been identified and adequate support has been provided at an early stage. Nevertheless, identification is still challenging in particular in absence of physical evidence or indications of torture. Generally, identification is supported by a Red-Cross ethno-psychological team at the first reception centre, by a specialised medical-psychological team from the Directorate of Health, and by any other doctor who normally provides a certificate raising a suspicion of torture. Such certificate can be provided by any doctor, not necessarily a forensic or legal doctor. Where needed, the applicant can benefit from their right to access psychological/psychiatric support as soon as they arrive in the first reception facility. They can also be referred to the national mental health network.

2.2.1. Professionals involved in the identification of VoT

Different professionals can be involved in the identification of VoT as it is an ongoing and collective effort taking place throughout the procedure.

The main actors are:

- **Medical professionals:** public health authorities carrying out a first medical screening and initial vulnerability screening at the borders, during disembarkation as well as in hotspots and reception facilities.
- **Lawyers and case officers:** VoT might be identified by such professionals during the personal interview and the eligibility assessment.
- **Staff working in reception** (including CSOs): social workers, health care providers (psychologists, psychiatrists, general practitioners, specialists in gynaecology, traumatology etc.), protection officers and other reception personnel could detect VoT during the course of their work and daily tasks.

Some EU+ countries also recognised that the interpreters supporting officials and applicants could benefit from additional training to recognise indicators of torture and reduce barriers for self-disclosure.

2.3. Referrals to a medico-legal assessment

Once an applicant has been identified as a potential VoT, the necessary **referrals** are made to certified professionals authorised to conduct medico legal assessments. While in some EU+ countries there is a referral mechanism connecting the reception and determining authorities

to those conducting such assessments, a coordinated collaboration is lacking in other countries.

Most survey's respondents reported that the main reasons for referring an applicant to a medico-legal assessment are physical and psychological signs of torture and a statement from the applicant, followed by sensory signs ([30]) of torture. In some EU+ countries, referral to a medico-legal assessment, generally at the expense of the state, can also be triggered when the applicant refers injuries from torture, substantiated by a medical certificate.

Medico-legal assessment can be omitted in the following cases:

- The injuries are not questioned.
- The applicant will be granted refugee status or subsidiary protection status.
- Comprehensive lack of credibility of the applicant's statements.
- The situation in the country of origin has changed and the risk of torture or ill-treatment no longer exists.

When there are indications that an applicant might be a VoT, a medico-legal assessment can be requested by the reception authority, the determining authority or the applicant. It emerges from the survey that determining authorities request such assessments slightly more often than reception authorities or applicants themselves.

In this regard, it is important to point out that in some EU+ countries the determining authority has an obligation to initiate a forensic medical examination when the applicant has reported a potential torture experience which is relevant to the examination of the asylum application. In other countries, this is a prerogative but not an obligation of the authorities. However, even when not requested by the authority, it is the applicant's right to consult a medical professional of their choice to further substantiate the claim for international protection and provide additional evidence.

The procedure for referral to medico-legal assessments in cases involving children is similar to the one for adults – with the involvement of additional stakeholders (particularly the guardian/legal representative) to ensure the best interests of the child.

Many participants in the meetings and the survey highlighted that during **medico-legal assessments** police or military personnel are not present nor take an active part.

While applicants can and should have access to a medico-legal assessment where required, challenges still exist in some EU+ countries. Respondents mainly flagged the insufficient number of professionals to support with (mental) health concerns, including professionals appointed to conduct medico-legal assessments.

Long waiting lists to take part in such assessments often lead to applicants missing their appointments due to general fatigue, depression, or inability to manage themselves. Lack of

([30]) For example: the applicant does not seem to notice when people talk to them; they need several repetitions of what has been said; they show signs of withdrawal or move in an unusual way (e.g. walking on toes can indicate beatings on feet's soles / phalanges).

childcare for the children of applicants during the assessment appointments, and lack of interpreters with the relevant knowledge of medical terminology were also mentioned as obstacles to access medico-legal assessment. General practitioners referring applicants to medico-legal assessments lack at times awareness of signs of torture and do not know the correct procedure, as pointed out to an extent in the survey.

EXAMPLE OF PRACTICE TO OVERCOME CHALLENGES RELATED TO MEDICO-LEGAL ASSESSMENTS

In **Sweden**, the determining authority and the Swedish Red Cross have established a memorandum of understanding (MoU) to perform the medico-legal assessment of cases of torture in accordance with the Istanbul Protocol. It includes the provision of training to case officers on topics related to torture.

Cases are referred only if a medico-legal assessment is considered necessary for the examination of the claim (for instance, no assessment is requested when the claim is already considered credible or when the statements clearly and comprehensively lack credibility). The applicant's consent is always required. The assessment results are typically conclusive in indicating whether the physical and/or psychological injuries are in fact the consequence of torture.

A general discussion on structural changes potentially needed in some EU+ countries in the public health care system to cater for applicants with special needs including VoT might be useful (integration of health care provision to asylum seekers, refugees and migrants).

Some EU+ countries allow the presence of a support person chosen by the applicant during the examination, or ensure that the applicant is accompanied by staff from the national authorities or CSOs. In the case of children, a guardian or legal representative is present.

Interpretation services are mainly provided by reception authorities, CSOs and, less frequently, by the determining authorities or the services conducting medico-legal assessments. Therefore, when an applicant decides autonomously to get a medico-legal assessment, they also need to arrange interpretation on their own.

As to the cost of medical assessment, most respondents indicated that they are normally covered by the authority requesting the assessment. One country indicated that advance payment is requested from the applicant, who will then be refunded upon presentation of an invoice. Depending on the country and personal circumstances (i.e. the kind of support and types of assessments required), costs vary between 90 EUR and 2 380 EUR per medico-legal assessment.

2.4. The Istanbul Protocol and the medico-legal reports

The **Istanbul Protocol** ([31]) is a set of international standards that guide the investigation of victims of torture and other cruel, inhuman or degrading treatment or punishment. The protocol assists professionals with the documentation of signs of torture or other inhuman treatment. There is no standard operating procedure (SOP) on how to apply the protocol, whose aim is nevertheless to guide medical, legal and mental health professionals in examining specific methods of torture. The Istanbul Protocol can therefore be used to assist professionals investigating psychological and physical torture and to document injuries and psychological effects on the victims.

Most countries participating in the survey indicated that first-line staff and case officers do not receive internal guidance on how to read the Istanbul Protocol and the related assessment reports. Similarly, information material for applicants is limited. In one country however, information material explaining the medical assessment process and the Istanbul Protocol is provided to staff and applicants alike.

Regarding the **recording of findings**, about 2/3 of the responding EU+ countries indicated not to have any standardised templates to record findings during the medical-legal assessments. Some follow the Istanbul Protocol while others do not. The reasons for this point mainly to a lack of knowledge of the Istanbul Protocol among those conducting the examination, or to the fact that its use is perceived as too time-consuming.

It was also mentioned that in some cases the medical evidence is inconclusive and so-called '*dixit*' medico-legal reports are submitted, i.e. reports relying primarily on the applicant's statements, not substantiated by sufficient medical proof ([32]).

Participants in thematic meetings indicated that at times professionals focus on a medical examination only, while the examination should include also a psychological assessment and look at the effect of trauma and injury on victims.

According to thematic meetings participants, it is crucial to have a **common understanding** on what medico-legal assessments need to capture and how the information is to be presented and treated, including in court. Therefore, more awareness of the Istanbul Protocol and its use by the different stakeholders involved is considered important.

For the purpose of the examination of the asylum claim, a **medico-legal report** needs to answer the questions reported in the following box.

([31]) See OHCHR, *Istanbul Protocol*, op. cit., fn. 1, 2022.

([32]) As pointed out by respondents, there are however instances where the acts of torture have taken place long time ago and physical marks might not be visible anymore. The importance of ensuring that applicants are given the benefit of doubt is to be highlighted.

Checklist for the medico-legal report

- Are the physical and psychological findings consistent with the alleged report of torture?
- What physical conditions contribute to the clinical picture?
- Are the psychological findings expected or typical reactions to extreme stress in the cultural and social context of the individual ([33])?
- Given the fluctuating course over time of trauma-related mental disorders, what is the time frame in relation to the torture events? At what stage of the recovery path is the individual?
- What other stressful factors are affecting the individual (e.g. ongoing persecution, forced migration, exile, loss of family and social status)? What impact do these issues have on the victim?

Does the clinical picture suggest a false allegation of torture?

If the medico-legal report does not provide answers to these questions, further information can be requested. For more details that should be captured with the assessment, refer to the revised version of the Istanbul Protocol ([34]).

For more information on how medico-legal reports are used during the examination of the claim, see Section 3.3.1. 'The use of medico-legal reports during the examination of the claim'.

([33]) The unique cultural, social and political implications that torture has for each individual influence the ability of that person to describe and speak about it. What is considered disordered behaviour or a disease in a culture may not be viewed as pathological in another. On the matter, refer to OHCHR , *Istanbul Protocol*, op. cit., fn. 1, 2022, p. 116, section 493.

([34]) OHCHR, *Istanbul Protocol*, op. cit., fn. 1, 2022.

3. Examination of the application for international protection

EU+ countries generally recognise the need to adjust the approach to the personal interview and evidence assessment when examining applications for international protection from VoT. Being tortured is a traumatising experience that may result in severe physical and psychological consequences. Methods of torture such as beating on the head, suffocation, near drowning or starvation can lead to brain injuries or memory impairments. Trauma, stigma and shame may affect the applicant's capability or willingness to share these experiences. As a result, claims related to torture pose several challenges to case officers throughout the examination process. This chapter presents the main outcomes in relation to examining asylum claims from VoT.

3.1. Personal interview

EU+ countries highlighted that interviewing VoT presents significant challenges to case officers, mainly related to the following topics.

- **Identification of VoT during the personal interview**, due to difficulties for the victims to talk about the torture they experienced. Respondents mostly associated this with stigma and shame which may affect the applicant's willingness to open up, and the impact of trauma which may hamper the applicant's capacity to recall and talk about traumatic experiences. Cultural taboos and language barriers are also considered to contribute to the applicant's reluctance to speak about experiences of torture. According to a few respondents, the setting of the personal interview, which is often limited to one hearing within a set time, may also contribute to inhibiting some applicants from disclosing past traumatic experiences.
- **Risk of re-traumatising victims of torture** when asking them to recall past experiences. EU+ countries highlighted the difficulties in finding the right balance between the need to elicit information that is necessary for the assessment of the claim and avoid re-traumatisation when interviewing VoT.

This section outlines tailored-made interview techniques and specific procedural guarantees mentioned by EU+ countries that may help to overcome these challenges. To help prevent re-traumatisation during the personal interview, the authorities should be able to rely less on detailed recounts of traumatic experiences from the applicant. To this end, EU+ countries generally consider appropriate to use tailored-made interview techniques and to gather as much evidence as possible from other sources.

Among the measures in place in EU+ countries, participants mentioned the following:

- focussing questions on the events leading up to the traumatic event, the circumstances around it, what approximately happened during the event and its consequences, rather than dwelling on details relating to the traumatic event itself;
- giving the applicant control in telling their story, allowing them to freely explain their narrative at their own pace with little interference from the case officer.
- providing case officers with training on how memory functions and how traumatisation can affect it, to inform the questions asked during the personal interview.

Specific approaches to the interviews adopted in certain countries to reduce VoT's difficulties in sharing their experiences are described below.

EXAMPLES OF PRACTICE ON INTERVIEWING APPROACHES FOR VoT

In **Denmark**, the cognitive interview method is used for interviewing potential VoT. The method builds on psychological research on how to elicit information on past traumatic events. This approach recognises the central role of the applicant's narrative and, by giving them the possibility to freely share their story, allows the applicant to feel in control of the interview situation. This helps reducing the risk of re-traumatisation. This approach first focuses on building a connection with the applicant by clarifying how the interview will be held, stating their rights, having a small talk to make the applicant feel more at ease. This is followed by the free narrative with no interruptions from the case officer, to leave space for silence and to give applicants the time they need. Then the case officer looks at the free narrative and breaks it into smaller sections in relation to the torture experience and asks further open questions (closed questions would be used exceptionally). This part focuses mainly on how the torture has affected the applicant. The last phase of the interview touches upon the next steps, with the purpose of concluding the interview with a forward-looking and positive atmosphere for the applicant. Case officers are trained to apply this approach. They are taught how trauma affects the brain and its ability to store memories, and how to handle applicants who are experiencing flashbacks or other symptoms of trauma.

Belgium assesses how the torture may have impacted the applicant's ability to express themself to determine what kind of information the applicant can be expected to provide during the personal interview. A medical assessment of the applicant's ability to be interviewed can be requested when such ability is uncertain. The procedural guarantees that can be beneficial to the applicant during the interview are assessed and put in place. If it is established that the applicant's severe psychological condition would hinder the collection of sufficient information through the personal interview, other ways of examination are additionally explored, such as interviewing family members if suitable, or gathering evidence from other sources available to the determining authority.

France fosters a comprehensive approach to the personal interview with VoT and traumatised persons, which takes into account the interview set-up and other aspects relevant for VoT. In particular, interview techniques avoid eliciting statements on highly traumatic events and asking intrusive questions. On the contrary. the questions mainly touch upon the circumstances before or after the traumatic event, rather than the event itself. Before moving to the core of the interview, a safe space is ensured and an atmosphere of trust is established by explaining the role of the participants, the purpose of the interview, and the reasons why traumatic past events may be discussed. Showing body scars is also prevented by explaining to the applicant that case officers have no medical expertise and that this measure aims to respect the applicant's dignity and privacy. However, available medical evidence is given particular consideration. If needed, the interview can be postponed, and applicants in need are referred to socio-medical professionals, on a voluntary basis. To do so, medical evidence is not required.

Related EUAA publication – '*Practical Guide: Personal Interview*'

The guide provides a structured step-by-step approach to the personal interview which can be used as a basis to build more tailored approaches. In particular, the practical guide outlines the steps that can be taken in preparing, opening, conducting and closing an interview.

3.2. Special procedural guarantees in the interview

EU+ countries show a good level of convergence in the special procedural guarantees ([35]) that are applied during the personal interview. The guarantees aim at facilitating an atmosphere of trust, making the applicant feel more comfortable, reducing possible barriers to sharing experiences and fears, and reducing the risk of re-traumatisation. These procedural guarantees include in particular the following ([36]).

- In almost all countries, **additional time** is allowed to conduct the personal interview. Allowing applicants to tell events and experiences at their own pace, without time constrictions, increases the chances of them opening up, recalling and sharing more information.
- In almost all countries, an **additional interview** is offered when the applicant is not fit to complete the ongoing interview to the best of their capacity.
- In almost all countries, potential VoT can **choose the gender** of the interviewer and of the interpreter. In addition, one country gives VoT the possibility to bring their own interpreter to the interview, though not to replace the interpreter officially appointed by

([35]) To learn more about indicators and special guarantees regarding applicants with special needs, you can also refer to the EUAA tool on Identification of Persons with Special Needs (IPSN).

([36]) With variations in each EU+ country, the guarantees outlined in this Section may be applied also to other vulnerable persons, depending on the specific needs.

the authority. The interpreter of choice of the VoT can attend the interview next to the officially appointed interpreter but any costs must be borne by the applicant.

- In the majority of the countries, VoT are allowed to bring a **person of trust** to their personal interview, either a professional (such as social worker, psychologist, legal counsellor following the applicant's case) or other person of trust.
- In around half of the countries, case officers **brief the interpreter** ahead of the personal interview, to make sure that they are aware of the sensitivity of the topics that may be discussed and are better prepared to conduct their assignment in a professional and sensitive manner.
- A few countries mentioned that specific attention is dedicated to the **setting of the interview**. This may include the use of specifically designed premises that provide a calm area, with warm colours and accessibility for those who live with physical impairments. Particular attention can also be paid to measures that further ensure confidentiality, avoid disturbing elements and the possibility to conduct the interview in a location close to the applicant's place of living, considering their special situation.

As with other vulnerable applicants, particular attention is given to explaining the purpose of the interview and what is expected from the applicant, including how and why past experiences are discussed. Confidentiality is also emphasised, with the purpose of building trust and increasing the applicant's readiness to disclose information.

3.3. Evidence assessment

Most of the EU+ countries that participated in the thematic meetings and survey mentioned credibility assessment as one of the main challenges faced by case officers when examining asylum claims from VoT, in particular due to the following reasons:

- the limited ability of the applicant to provide detailed, complete, coherent and consistent statements due to factors such as trauma, brain injury, limitations related to memory, stigma and shame;
- the difficulty to establish whether the signs of violence stem from torture in the country of origin or habitual residence, or rather from psychological, physical or sexual violence suffered during the journey;
- the absence of documentary evidence;
- the lack of a standardised approach in issuing medical reports (e.g. in accordance with the Istanbul Protocol), which increases the difficulty to use them as basis for findings also considering that case officers do not have medical competences.

Factors that may lead to distortions are considered in the credibility assessment and measures to reduce their potential negative impact on credibility are taken into account when gathering and assessing relevant evidence.

Related EUAA publication – *Practical Guide: Evidence Assessment*

This guide provides a structured step-by-step approach on assessing evidence. In particular, it shows how individual and circumstantial factors that may lead to distortions can be taken into account in the examination of a claim (see Section 2.4. at page 14).

3.3.1. The use of medico-legal reports during the examination of the claim

When it is considered difficult for a victim of torture to provide detailed and coherent statements, more weight is often given to other available evidence, in particular medico-legal assessments. However, the actual weight given to medico-legal reports in the overall evidence assessment may vary depending on the method that was used for the medical assessment. This is due to the fact that medico-legal assessments conducted in a standardised manner and in accordance with the Istanbul Protocol take into consideration the psychological, emotional and physical signs of torture or other inhuman treatments, as well as the impact of such treatment on the person. Other types of medico-legal assessments may be able to substantiate only certain aspects of past treatment depending on the way they are conducted and the signs they document.

Different types of medico-legal assessments may be used in different countries. In approximately 1/3 of the responding countries, medico-legal assessments are conducted in accordance with the Istanbul protocol, while in most countries they are conducted in accordance with national guidelines or practice.

Furthermore, some EU+ countries specified that medico-legal reports are generally not requested when they would not affect the outcome of the credibility assessment, for example in the following situations:

- the claim is already substantiated and found credible based on statements and other evidence;
- the claim is found clearly not credible based on the statements and other evidence available in the application;
- the experience of torture is not directly relevant for the outcome of the application, for example: refugee status is already granted based on other reasons; the situation in the country of origin has changed in a manner that there are good reasons to consider that past experiences relating to torture would not be repeated; torture happened outside the country of origin.

Some countries described in detail their national practices on requesting medico-legal assessments to support the examination of the application. These examples of practices are illustrated below.

EXAMPLES OF PRACTICE ON REQUESTING MEDICO-LEGAL ASSESSMENTS

In **Sweden**, the referral to a medico-legal assessment is not done immediately after there are indications of torture. The determining authority first requests the applicant to provide a medical certificate to substantiate their claim. As part of the applicant and the authority's duty to cooperate in the substantiation and examination of the claim, the determining authority instructs the applicant on how the medical certificate on physical and/or psychological health can be obtained. If the medical certificate indicates that the applicant is a victim of torture, it is generally considered the duty of the determining authority to gather more evidence relating to the claim, along the lines of the ECtHR judgement on R.C. v. Sweden.

ECtHR, 2010, *R.C.* v *Sweden* ([37]), paragraph 53

Firstly, the Court notes that the applicant initially produced a medical certificate before the Migration Board as evidence of his having been tortured [...]. Although the certificate was not written by an expert specialising in the assessment of torture injuries, the Court considers that it, nevertheless, gave a rather strong indication to the authorities that the applicant's scars and injuries may have been caused by ill-treatment or torture. In such circumstances, it was for the Migration Board to dispel any doubts that might have persisted as to the cause of such scarring [...]. In the Court's view, the Migration Board ought to have directed that an expert opinion be obtained as to the probable cause of the applicant's scars in circumstances where he had made out a prima facie case *as to their origin. It did not do so and neither did the appellate courts. While the burden of proof, in principle, rests on the applicant, the Court disagrees with the Government's view that it was incumbent upon him to produce such expert opinion. In cases such as the present one, the State has a duty to ascertain all relevant facts, particularly in circumstances where there is a strong indication that an applicant's injuries may have been caused by torture. [...]*

The medico-legal assessments are conducted only upon the applicant's consent, as taking part in such assessment is considered voluntary.

In **France**, applicants may undertake a medical assessment on a voluntary basis. The national authorities and relevant stakeholders aim to refer applicants to the assessments early in the asylum procedure, to enhance early identification of VoT and referral of cases to appropriate care. Similarly, the referral of applicants by the reception authorities to appropriate psychological and medical care before they are interviewed by the determining authority helps in conducting the interview. The determining authority engages in open communication, cooperation and exchange with mental health professionals who intervene together with the determining authority. The aim is to enhance the determining authority's expertise, foster mutual understanding of what could be improved and developed, and

provide a frame for partners to report on individual cases, for instance cases of applicants suffering from severe PTSD.

3.3.2. Country of origin information

COI may also be given more weight in the evidence assessment in case it is difficult for a VoT to provide detailed and coherent statements due to the factors mentioned above in this chapter. Approximately half of the EU+ countries that responded to the survey reported that COI, including specific information on torture, is available to case officers. COI reports generally cover broader topics in which torture is a relevant consideration, such as prison conditions, the conduct of security forces and non-state actors, the effectiveness of the justice system and extra-judicial practices.

To specify that signs of torture need to take into account specific country contexts, the Istanbul Protocol notes that the 'knowledge about regional practices of torture and ill-treatment is important because such information may corroborate an individual's account of these' ([38]).

EXAMPLE OF PRACTICE: PRODUCING COI REPORTS IN RELATION TO TORTURE

In **Sweden**, case officers can rely on specific COI reports focussing on torture in prison. They include information on the prevalence of torture, the groups that are more at risk of being tortured, the methods of torture that may be used and how authorities in the country respond to torture.

3.3.3. Special procedural guarantees related to evidence assessment

Since VoT may have challenges in substantiating their claim with documentary or other evidence, EU+ countries mentioned that they apply some special procedural guarantees ([39]), as detailed below. ([40])

- Half of the responding countries take into consideration the specific challenges VoT may have to gather information and feel ready to talk about past experiences. As a consequence, they **ensure that the scheduling of the interview allows sufficient time for the applicant to prepare** for it.

([37]) ECtHR, judgment of 9 March 2010, *R.C. v Sweden*, No 41827/07, ECLI:CE:ECHR:2010:0309JUD004182707.
([38]) See OHCHR, *Istanbul Protocol*, op. cit., fn. 1, 2022, paragraph 131.
([39]) To learn more about indicators and special guarantees regarding applicants with special needs, refer to the EUAA tool on Identification of Persons with Special Needs (IPSN).
([40]) With variations in each EU+ country, the guarantees outlined in this Section may be applied also to other vulnerable persons, depending on the specific needs.

- The great majority of the countries guarantee **extended deadlines** and additional time to submit documentary evidence, such as medical evidence or psychological assessments, after the personal interview.
- In half of the responding countries, the determining authority ensures **referral** to a medico-legal assessment and/or other medical and/or psychological assessment when this can help the applicant substantiate their claim. Similarly, referral is provided when this can bring more information on the applicant's personal circumstances relevant for the examination of the claim. Upon the applicant's consent, the referral can be done directly by the determining authority, in cooperation with the reception authority and other professionals, or by providing the applicant with the necessary information and contacts of the relevant services.

3.4. General support measures

In addition to measures in relation to the personal interview and evidence assessment, EU+ countries mentioned the horizontal measures below intended to generally support the examination of claims related to torture. ([41])

- **Case officers with specific expertise.** Around half of the countries ensure the availability of specialised staff. The examination of applications related to torture is entrusted to specialised case officers, while experts on torture or more broadly on vulnerable groups are available for consultation. It was also noted that case officers are trained on how trauma, stigma and shame can manifest in the applicant's behaviour.

EXAMPLES OF PRACTICES ON SPECIALISED STAFF

In **France**, a group of experts specialised in trauma and torture has been operating since 2013 to support with the examination of asylum applications lodged by victims of torture and other applicants experiencing trauma. These experts conduct or participate in the conduction of the personal interview, give advisory opinions on individual cases, develop guidelines on people suffering from trauma, provide training sessions to other case officers, and ensure dialogue with all relevant stakeholders (medical community, specialised NGOs etc.). Moreover, considering that the methods of torture may differ from one country to another, the members of the group specialise in specific geographical areas. Therefore, case officers can refer cases for advisory opinion to the members of the group of experts who have specific expertise on the relevant country of origin.

- **Legal assistance**. In almost half of the responding countries, potential VoT are offered free-of-charge legal aid during the first instance examination of their claim.

([41]) With variations in each EU+ country, the support measures outlined in this Section may be applied also to other vulnerable persons, depending on the specific needs.

- **Prioritisation**. Applications related to torture are prioritised in almost all responding countries. Most of these countries prioritise all applications from VoT, while others prioritise such applications only under certain circumstances. These circumstances can include health considerations, psychological conditions that can be aggravated by a prolonged asylum procedure, existence of other protection concerns and other circumstances that are assessed on an individual basis.
- **Exemption from the accelerated procedure**. Potential VoT are exempted from the accelerated procedure in half of the responding countries. Just few of such countries apply the exemption categorically, while the majority applies it under certain circumstances only. These circumstances can include the need to put in place special procedural guarantees that cannot be ensured in the context of an accelerated procedure, including when the applicant needs medical support to be able to substantiate their claim, or other circumstances that are assessed on an individual basis.

4. Reception, support services and rehabilitation

Half of the EU+ countries participating in the survey confirmed to have an established referral system to flag cases of presumed victims of torture and to request medico-legal assessments. Some pointed out the availability of a holistic support system which includes treatment for the damage caused by torture and access to services like psychological support not only for the VoT but also for family members, to strengthen resilience. Other respondents indicated that the existing channels for referral and support, including communication between different stakeholders, could benefit from improvement.

EXAMPLES OF PRACTICES FROM RECEPTION AUTHORITIES

Flagging presumed VoT during the initial phase of reception (e.g. first medical examination) and, upon their consent, refer them to further services such as a psychologist or legal counselling was indicated as beneficial.

To support applicants who are not covered yet by the national health insurance, some EU+ countries established dedicated medical centres that VoT can use for purpose of meeting their basic needs. The services provided cover medication and, where necessary, medical laboratory services.

Providing applicants with access to psychological and psychiatric support as soon as they arrive in the first reception facilities is also considered beneficial. In **Luxembourg,** such specialised services are provided through a working agreement between the **National Reception Office** and the **Red Cross** whose deployed ethno-psychological team is responsible for screening people with mental disorders and setting up monitoring outside the accommodation facility.

Proactive sharing of information on applicants from the reception authorities to the determining authorities – with the applicant's full information and consent – can also ensure that procedural guarantees are observed from the very start.

4.1. Adequate standard of living and additional provisions

Article 17(2) RCD (recast) stipulates that material reception conditions must ensure an 'adequate standard of living' for asylum seekers, thus protecting their mental health. The

EUAA guidance on reception conditions ([42]) also stresses the importance of taking the needs of vulnerable groups into account.

EXAMPLES PROVIDED ON HOW EU+ COUNTRIES ENSURE STANDARDS

Accommodation

- A vulnerability assessment is conducted to prioritise the accommodation needs of vulnerable applicants. They are primarily accommodated according to their personal circumstances ([43]), for example: rooms with private bathroom; special departments for families; specific units for applicants with mental health-related challenges; envisaging safety zones for UAMs.
- Applicants with special needs like VoT are accommodated temporarily in support centres located close to specialised support services (e.g. rehabilitation, group counselling etc.).
- People with PTSD do not to have to queue for food or other essential items.

Support provision

- Specialised support is provided ([44]) with a focus on access to psychologists, psychiatrists, physiotherapists and dental care.
- Applicants are informed ([45]) about the possibility to contact professionals and psychologists within the reception facilities.
- Round-the-clock support and access to health care, including through general practitioner services available by phone([46]),and presence of security staff.
- Possibility to take a free-of-charge medical exam, if appropriate/requested by the applicant.

The local authorities managing these activities are obliged to:

- activate support and rehabilitation programmes in an agreed and continuous manner with the local health service;
- schedule referrals to the mental health departments;

([42]) EASO, *Guidance on reception conditions: operational standards and indicators*, September 2016.
([43]) See the EUAA guidance on reception conditions, op. cit., fn. 42: 'STANDARD 10: Ensure that the inside and outside infrastructure of housing designated to accommodate applicants with reduced mobility is adapted to their needs.'; 'STANDARD 11: Ensure sufficient security measures' and Indicator 11.6 referring to specific arrangements to be made for applicants with special needs.
([44]) See the EUAA guidance on reception conditions, op. cit., fn. 42: 'STANDARD 29: Ensure access to necessary health care, at least level of emergency care and essential treatment of illnesses and serious mental disorders' and in particularly also 'Indicator 29.8: Specific arrangements are in place for applicants with special medical needs'.
([45]) See the EUAA guidance on reception conditions, op. cit., fn. 42: 'STANDARD 30: Ensure the applicant receives and understands phase-relevant information on benefits and obligations relating to reception conditions.'
([46]) See the EUAA guidance on reception conditions, op. cit., fn. 42: 'STANDARD 18: Ensure that applicants have adequate access to a telephone to make calls concerning procedural, legal, medical and educational issues.'

- guarantee a connection with the local mental health service by means of a MoU that details the levels of operational collaboration needed to support specific interventions.

Specialised training for staff

- The staff working in accommodation facilities received mandatory training on the needs of vulnerable populations, e.g. victims of trafficking, victims of female genital mutilation/cutting, LGBTIQ+ persons. Further training on psychological first aid and PTSD is provided to enhance the skills of staff and better prepare them for their daily duties ([47]).

Streamlining work with applicants with special needs

- Specific guidelines are in place regarding the care, rehabilitation and treatment of mental disorders of refugees and people who suffered torture, rape or other serious forms of psychological, physical or sexual violence. Specific training and refresher programmes targeting health personnel are also available.

Additional provisions

- In accordance with the recast versions of the APD and RCD, victims of torture are entitled to specific support following the registration of their application. Survey participants were invited to share if their country has additional provisions which are applicable to victims of torture even **before** their claim was submitted. Over half of the respondents indicated that no additional provisions are in place in their country; roughly 1/3 replied that they are not sure whether such additional provisions exist, while the remaining informed that special provisions are in place addressing persons who are considered vulnerable and have not submitted their claim yet.

A few EU+ countries shared examples of additional provisions which apply not only to victims of torture but generally to applicants with special needs. You can read them in the table at the next page.

([47]) See Article 25(2) RCD (recast): 'Those working with victims of torture, rape or other serious acts of violence shall have had and shall continue to receive appropriate training concerning their needs, and shall be bound by the confidentiality rules provided for in national law, in relation to any information they obtain in the course of their work.'

PROVISION OF ADDITIONAL SERVICES TO APPLICANTS WITH SPECIAL NEEDS			
Flexibility in accommodation	**Specialised support**	**Strengthening skills in the relevant workforce**	**Memorandum of understanding (MoU)**
Availability of a flexible and scalable modular structure ([48]) that can be adapted to the needs of the applicants (e.g. wide doors for wheelchair users).	Availability of an ethno-psychological team to detect possible vulnerabilities of applicants as early as possible, to ensure adequate care, assistance and transfer to the health system (especially referral to specialist doctors).	Availability of tailored training and refresher sessions for relevant staff (from asylum/reception authorities and health sector) on torture and other emerging issues (e.g. sexual and gender-based violence, traffic in human beings etc.).	Availability of formal agreements with specialists (authorities and CSOs) to facilitate access to health care, including mental health services.

4.2. Treatment and rehabilitation services

About 2/3 of the survey respondents indicated that psychosocial support and access to psychotherapy is available to victims of torture, followed by medical support services (e.g. physical rehabilitation and psychiatric care). It emerges however that legal counselling services and other often needed social support services are not necessarily prioritised.

Some survey respondents shared that a number of support services are covered through ad hoc funded projects ([49]). While highly valued and appreciated by the authorities, the continuation of such services and the connected services might not always be granted.

Referrals of presumed VoT to specialised health care are often initiated by general practitioners. Specialised care services provided on a need-basis are mostly supplied outside

([48]) This flexible modular structure was presented by Luxembourg. It is flexible, can be adjusted continuously and takes into account feedback from operational accommodation structures.

([49]) An example shared was: '*Qualification of the health protection system for services to third country nationals suffering from mental distress and/or diseases related to addiction' of the Asylum Migration and Integration Fund 2014-2020 (AMIF); specific projects were funded with the aim of strengthening local governance for the containment and management of the impact on the territory of situations of mental distress and/or pathologies related to drug and alcohol addiction. The strength of these AMIF projects is the continuous implementation of a network of integrated services between the public (ASL, Municipality, Prefectures, Police Headquarters) and the private social sector, favouring the implementation and improvement of project activities in different territories*'.

the reception centres, in the framework of the existing health and support system and in cooperation with other state bodies and non-governmental organisations.

The national health services were mentioned as the main actor covering the costs of rehabilitation services. No country indicated that victims of torture are required to pay for rehabilitation services themselves, as long as the applicant was referred 'by the system', in which case the support is state-sponsored. However, if the applicant chooses to access private actors, they might have to pay themself. An exception might be dental services.

Lastly, the majority of EU+ countries provide free-of-charge support to the family members of victims of torture in need of it.

4.3. Support provision to children who are VoT

In most EU+ countries, children are provided with certain safeguards, including adjusted reception conditions, in light of their minor age and inherent vulnerability. Survey respondents also shared information on additional adjustments, support and rehabilitation services offered to VoT below the age of 18.

ADDITIONAL ADJUSTMENTS AND SERVICES FOR CHILDREN

- Specialised and prolonged health care (in some cases including treatment of an aesthetic nature).
- Involvement of guardians to ensure close collaboration between the stakeholders and to safeguard the best interest of the child throughout the process.
- Screening of all minors by youth health care services, which ensures the actual referral of the minor to specialised health care services.
- Child-appropriate accommodation, including reception centres for minors within a small-scaled facility and safety zones for unaccompanied minors.
- Tailored support considering the actual age and maturity of the minor (is the minor a small child or a teen?).
- For all children, not specifically victims of torture, different standards in reception and support apply (e.g. access to public psycho-social support services).
- The reception facilities hosting unaccompanied minors are staffed around the clock.

4.4. Victims of torture and detention

Only a few countries taking part in the survey indicated that once an applicant has been identified as having special needs (including a confirmed victims of torture), detention is ruled

out. If the applicant is identified as a victim of torture while already in detention ([50]), the detention is stopped according to the vulnerability situation.

In regard to detention, the RCD states the following:

Recital 20 RCD (recast)

In order to better ensure the physical and psychological integrity of the applicants, **detention should be a measure of last resort** and may only be applied after all non-custodial alternative measures to detention have been duly examined. Any alternative measure to detention must respect the fundamental human rights of applicants.

This provision requires even more attention when dealing with vulnerable groups like children or applicants with special needs, for example VoT.

Other EU+ countries which participated in the survey indicated that certain provision are put in place to safeguard vulnerable applicants in detention.

EXAMPLES OF PRACTICE: ADDITIONAL SAFEGUARDS FOR VULNERABLE APPLICANTS IN DETENTION

- Periodic verification of the existence of conditions of vulnerability that require special assistance measures (e.g. social and health services provided in the detention centres).
- Access to health care, counselling and social services depending on the personal circumstances.
- Daytime activities are provided.
- Access to legal aid.
- MoUs with public entities and/or private non-profit organisations ([51]) to provide relevant services in detention facilities.

It emerged from the survey that vulnerable applicants are granted access to services and medical treatment under the same standards as other detainees. One EU+ country indicated

([50]) See the general guarantees envisaged in Articles 9 and 10 RCD. Article 11 RCD also states: 'Where vulnerable persons are detained, Member States shall ensure regular monitoring and adequate support taking into account their particular situation, including their health.'

([51]) Reference was made for example to Doctors of the World (MdM) whose mission includes: addressing the health condition of detainees; preventing the deterioration of chronic conditions; whenever possible, offering out-patient treatments; assisting in dealing with infectious diseases within the detention area and in case of release from the detention cooperate with the health sector. MdM also trains detention centres' personnel to deal with episodes of acute disease and treatment follow-up.

that there is no standardised way to provide services to vulnerable applicants placed in detention.

1/3 of survey respondents indicated that the quality of services provided in detention facilities in EU+ countries is assessed through external monitoring mechanisms. For example, UNHCR or the Public Defender of Rights or Ombudsmen service can be involved to ensure that services are up to standard and monitored regularly.

It was also indicated that the Council of Europe's Committee for the Prevention of Torture and the experts group on Action against Trafficking in Human Beings (GRETA) have free access to the facilities. Some countries shared that an independent public body, such as an Ombudsman, monitors and supervises the detention conditions.

The survey also highlighted that while monitoring mechanisms are in place in most countries, detainees are often not informed about it and do not know how to make a complaint if they feel that their rights are violated.

5. Data and research on victims of torture in Europe

The thematic meetings on torture and the 2022 EUAA survey have been very useful to learn more about the needs of the authorities and of those working with VoT within the EU asylum system, including professionals from CSOs. At the same time, it has emerged from these activities that quite rarely do EU+ country authorities collect data on how many victims of torture are identified and processed. For example, 1/4 of the responding countries in the survey indicated not to have any statistical data on VoT in their country.

It can therefore be challenging for the authorities to assess what works and where improvements should be made. Analysing the existing support and the procedures in place could inform a strategic improvement of the interventions addressing victims of torture and other vulnerable groups, to the benefit of applicants and officials alike.

EXAMPLES OF RESEARCH AND AWARENESS-RAISING INITIATIVES

Norway: Independent assessment

Norway launched an assessment of its asylum system in relation to claims related to torture, that was conducted by an independent entity, Fafo ([52]). During the 2022 thematic meeting, the Norwegian authorities and Fafo shared and discussed findings from the assessment report. The document is publicly available and covers considerations shared by first-line staff, experts and applicants, summarised as recommendations ([53]).

France: Guidance and awareness

The French office for the protection of refugees and stateless persons (OFPRA) organised in 2018 a round table discussion on the topic of addressing trauma in asylum seekers. You can watch the recording on YouTube.

Sweden: Research on VoT

The Swedish Red Cross carried out a review of decisions from the Swedish Migration Agency and the migration courts to shed light on how asylum cases involving allegations of torture and ill-treatment are assessed. The study is available online. Two more research reports on the prevalence of trauma linked to torture can be accessed here and here

([52]) Fafo is an independent social science research foundation that develops knowledge on the conditions for participation in working life, organisational life, society and politics, the relationship between politics and living conditions, as well as on democracy, development and value creation.

([53]) You can find a summary of the report here.

6. Concluding remarks and way forward

The findings indicate that the systematic and early identification of victims of torture in EU+ countries can be improved. Due to delayed identification, crucial physical and psychological evidence of torture to support an asylum claim could be unavailable at the time it is needed. As a result, the procedural safeguards envisaged by Article 24 APD (recast) may not be put in place.

The Istanbul Protocol can support and guide the discovery process. It sets the framework on how to do so by providing the standards to document signs of torture. In order to set up a qualitive identification and support system for victims of torture, it is important for Member States to invest in the resources and time needed to respect the standards of the Istanbul Protocol.

In relation to medico-legal reporting, it is crucial that psychological assessments are also considered. Close collaboration between the authorities requesting a medico-legal assessment and those in charge of providing it is crucial to allow for a meaningful and effective follow-up.

Specialised and trained staff, both reception officers and case officers conducting the personal interview, is also crucial for the early identification of VoT and to mitigate the risk of re-traumatisation.

6.1. Seven components for administrations to safely and effectively support victims of torture

The following seven components will facilitate EU+ authorities to have a VoT-centred approach and provide the relevant support to vulnerable groups like victims of torture in reception and during the personal interview.

Figure 1: Seven components to equip administrations to support VoT

- **Component 1:** Guidance on VoT

Operational guidance for reception officers and other staff supporting victims is useful to allow for a harmonised approach across the different entities involved. Clear roles and responsibilities in identifying and managing such cases (multidisciplinary approach) is of benefit to the professionals involved and to the applicants alike. Such guidance on VoT is to be communicated to the staff involved in handling such applicants.

Guidance covering all phases of the examination – namely personal interview, credibility assessment, qualification and aspects related to procedural guarantees – can help inform the examination of claims related to torture. Moreover, guidance on referral of applicants with specific procedural and other needs identified during the examination of the claim, as well as country guidance providing specific information on torture in the covered countries, further facilitates the work of case officers.

- **Component 2:** Safe and trusting environment

Creating a safe and welcoming atmosphere at the reception centre is important. This also includes access to activities, daily routine, and interaction between first-line officers and applicants and among applicants themselves. Support staff like social workers and nurses (with a background in psychiatry, psychology or trauma) can be helpful too.

Smaller rooms (accommodating one or two persons only) within the reception centres could be allocated to vulnerable applicants such as VoT or be used in case of emergency or crisis. Living in a less stressful environment for a certain time period can help applicants in distress, including VoT, to better adjust.

In the context of the personal interview ([54]), setting up a positive and relaxed atmosphere is an important aspect to facilitate self-disclosure for VoT. To this end, it is helpful to adopt a neutral and positive attitude, showing empathy and avoiding to display signs of authority. It is also important to build a rapport with the applicant at the beginning of the interview. Providing information on how the interview is conducted, reaffirming the confidentiality of the process, stating the case officer's intention to cooperate with the applicant in the process, and explaining the purpose of taking notes during the interview can contribute to this. Having the possibility to bring a person of trust to the interview can further contribute to facilitate self-disclosure.

It is also vital that the case officer is informed of the applicant's vulnerabilities ahead of the personal interview. Such information helps the officer to prepare accordingly. In case specific needs arise during the interview, and depending on the circumstances, it might be advisable to postpone the interview. This is particularly important if the applicant is not in the position to meaningfully participate or when there is a need to better understand the applicant's personal circumstances and possible factors of distortion (such as mental health concerns).

During the interview, leaving space for free narrative and preferring open-ended questions may support VoT in disclosing information on past experiences. Informing VoT about the possibility to bring forward new elements of their claim at every step of the process is also considered an important step to facilitate VoT in the substantiation of their claim.

On organisational matters, the personal interview should not be scheduled too close to the initial arrival, to allow VoT to stabilise, understand their rights and obligations as well as the importance of disclosing information on their claim, before the interview is conducted. Conducting the interview in more than one appointment could also further contribute to building trust and facilitating self-disclosure. Gender considerations should also inform the assignment of case officers and interpreters to a case, particularly when sexual violence is an element of the claim.

Familiarisation by case workers with COI is vital to understand the specificities of the practices of torture in specific countries.

Finally, while security personnel is present in some reception facilities and locations where personal interviews take place, the presence of actual police is seen as counterproductive and does not provide a sense of safety to many applicants.

- **Component 3:** Information provision

The care circuit and the specific measures are to be explained to VoT to ensure access and continuity of care in the long term where necessary. Applicants should also be supported to access professional services (e.g. legal advice or healthcare) and to connect with other members of civil society, UNHCR and additional relevant actors. This is also valid for applicants placed in detention [(55)].

([54]) Refer also to Section 3.1 'Personal interview' and Section 3.2 'Special procedural guarantees in the interview'.
([55]) Refer also to the general provision on guarantees in Articles 9 and 10 RCD (recast)

- **Component 4:** Appropriate services

A formal agreement with specialists to provide improved and quicker access to psychological and psychiatric care (outpatient and inpatient) for vulnerable applicants such as VoT can be useful. Therefore, a stronger investment in involving the health sector in the provision of services to applicants, with a focus on psychiatrists and psychologists, is important. This would be beneficial to provide support not only to VoT but also to their families.

Such formal agreements should also involve specialists who have been certified to conduct medico-legal assessments and provide reports which will be accepted by the determining authorities. Certified specialists conducting medico-legal assessments, who may come from the health authorities and/or CSOs, are to be made aware of the referral system put in place. On this matter, see component 5 below.

Once specialists have conducted a medico legal assessment, which should always consider psychological signs of torture as well, findings are to be recorded preferably in a standardised reporting format applicable throughout the country. The reports should capture the elements that case officers might need to process the application. The Istanbul Protocol provides standards and guidance for such reporting, including when limited time is available for an assessment. A medico-legal assessments is to be requested only when necessary. Avoiding re-traumatisation of the applicant should be part of the consideration.

It would also be important to ensure that any needs of applicants (e.g. health needs, broadly-speaking) are covered **before** the personal interview. If the applicant is in pain due to sickness for example, they might not be in a position to meaningful speak about past experiences as this would not be their immediate priority. Applicants may need support to timely communicate such concerns to the determining authorities.

- **Component 5:** Coordination and referral

Ensuring a comprehensive approach in supporting VoT will require the creation of a formal referral system in which all stakeholders are aware of their responsibilities. A MoU between relevant stakeholders is useful (see also component 4 above). Regular cooperation with medical and mental health professionals and other services helps establish channels for the prompt referral of applicants before and after the personal interview, or for any follow-up that may be needed. Formal agreements with specialists for referral can also reduce barriers regarding payment for services, because the channels, roles and responsibilities including payment have been clarified before services are provided.

The procedure also benefits from the availability of a referral system to designated qualified medical professionals for the conduction of the medico-legal assessment. Medico-legal reports can help the case officer assess the applicant's ability to effectively participate in the procedure and can support the evidence and eligibility assessment in the absence of sufficient statements or other evidence. The importance of obtaining the informed consent of the applicant before referral was also highlighted in the survey.

- **Component 6:** Support tools

Reception, medical officers and vulnerability officers in particular could benefit from screening and assessment tools which include indicators of torture. Screening and assessment can be seen as opportunities to identify such applicants and provide a platform for self-identification.

Certain tools and guidance touch upon cross-cutting issues and should therefore be used. Protection questionnaires (or other tools used to identify and assess vulnerabilities, e.g. on gender-based violence) can also be helpful.

Checklists or templates for case officers with indicative topics to possibly explore during the personal interview with VoT can be useful, notwithstanding the fostering of a case-by-case individualised approach. The EUAA Tool for Identification of Persons with Special Needs (IPSN Tool) can also facilitate the identification of potential victims of torture.

- **Component 7**: Specialised staff

It is important to provide staff with targeted, specialised and systematic training and capacity building on victims of torture or other forms of serious violence and trauma, in particular for case officers conducting the personal interviews.

The EUAA training module on interviewing vulnerable persons ([56]) is seen as a good starting point. Trainings courses could focus on tailored interviewing techniques that consider the effects of trauma on the functioning of memory and the psychological effect that trauma can have on applicants. A peer-to-peer approach based on regular meetings among specialised case officers, quality managers and COI researchers to exchange experiences and challenges appears to be good practice in terms of capacity building.

Training courses can underpin the appointment of specialised staff or specialised teams to handle cases related to torture. Once trained, these experts can function as focal persons for vulnerable persons, including VoT, and support colleagues with their expertise. By sharing their knowledge, they can function as multipliers. It is also useful to enter collaboration agreements so that designated and qualified medical professionals are attached to the authorities to conduct thorough and reliable medico-legal assessments. On the matter, see also components 4 and 5.

Targeted training ([57]) on the specific needs of VoT, addressing all national staff in contact with asylum seekers, is equally important. Workshops on how to identify defence mechanisms sometimes used by traumatised persons is a good example of a training topic to offer to all case officers. Another topic could be an introduction to the Istanbul Protocol as guidance for first-line professionals.

([56]) See in particular the courses on 'Interviewing children', 'Interviewing vulnerable persons' and 'Asylum interview method' of EUAA, *Training Catalogue 2022/2023*, pp 21, 34 and 35.

([57]) Since 2013, all OFPRA caseworkers follow a training course on how to receive asylum statements based on severe forms of violence and suffering. The course is delivered by the NGO Forum Réfugiés Cosi (member of the EUAA VEN advisory group). A group of referents, experts on torture and trauma, was also established in 2013. The group is in charge of supporting decision-making and leading continuous training on these issues (training activities have been reinforced in 2022).

Finally, first-line officers and medical specialists involved in assessing VoT need to be knowledgeable of the rights, entitlements and legal framework related to torture and be able to communication such information to the applicants.

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