CHAPTER 8

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PLANNING SERVICES FOR TORTURE SURVIVORS

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IN THIS CHAPTER

The existing programs for torture survivors in the United States represent a wide variety of models for structuring services for torture survivors. Each program became aware of the needs of torture survivors in its own way. Some have been providing services for two decades and others are just entering the field.

Although the field of torture treatment is in its infancy, a body of knowledge has been developing over the last twenty years through accumulated clinical experience and research. Chapter 1 outlines the history of the torture treatment movement. Chapters 3 through 7 describe in some detail the major service components of programs for torture survivors: social services, psychological services, legal services and medical services.

This chapter gives additional information for program planners on needs and resource assessment, financing, choices in structuring services, and training and supporting staff in this demanding work.

This information can be used to plan specialized programs for torture survivors. It can also be used by mainstream health, social service, or legal service providers who want to adapt their existing services to serve torture survivors.

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ABEER AND OMAR, now living in Amman, Jordan, were forced to leave Baghdad after the fall of Saddam Hussein.

STEPS IN PLANNING SERVICES

The major tasks involved in planning to provide services are:

1. ASSESS NEEDS AND existing resources. Interview key stakeholders from communities affected by torture who might be beneficiaries of increased or enhanced services for their views on needs.

Inventory the agencies and individuals in the community who are already providing services to refugees and other immigrants and assess how their missions and practice may or may not make them logical partners.

2. DETERMINE THE POSSIBLE sources of financial support for services for torture survivors and the challenges in financing these services.

3. DECIDE THE RANGE AND LIKELY model of services. If planning to provide only one type of service, make a plan for how a torture survivor can be connected to other needed services. Keep in mind that many programs have begun based on available professions or funding, and expanded those services as part of a vision for integrated services when new resources became available.

4. DECIDE WHETHER TO INCORPORATE approaches for preventing torture into the program plan.

5. DECIDE HOW PROGRAM STAFF will receive the training and support on the job they need in order to carry out their roles effectively. In particular, program leaders must develop a plan for managing vicarious

trauma and its impact on clients, staff, and the organization.

Details on pursuing each step follow.

Assessing the needs of survivors and existing resources

Before designing a program it is important to find out who are the torture survivors in the community, what kinds of needs they have, and who is already trying to address those needs and with what success. If this step is omitted, you may find that few people are knocking at the door for services, too many agencies are competing for the same few funding dollars, and/or you repeat mistakes already made by others.

INVENTORY AGENCIES AND INDIVIDUALS IN THE COMMUNITY

Who else in the community also works with refugees or torture survivors? By collaborating with others who share a common vision, you can avoid competing for limited funds, duplicating services, and putting unnecessary limits on services. State refugee coordinators are a good starting point for the inventory process. They can be located via the Web site of the Office of Refugee Resettlement, www.acf.dhhs.gov. Look for programs that are already serving immigrants from affected communities and programs whose missions seem compatible.

Existing programs for torture survivors in the United States reflect a wide range of missions. Organizations' missions are focused on the following types of services and programs:

- Treatment services exclusively for torture survivors, i.e., stand-alone torture treatment programs
- Treatment services for a particular group, e.g. Khmers, Bosnians
- Immigrant services, e.g. resettlement agencies
- Human rights advocacy, e.g. legal advocacy organizations
- Services based on a specific discipline, e.g., cultural psychiatry, legal aid for the poor
- Services for a designated patient population, e.g. mainstream clinics in areas with high immigrant populations

Each mission offers strengths and weaknesses in providing services for torture survivors. Most important, an organization or individual interested in developing services for torture survivors must find an honest basis in mission for doing the work and anticipate where the mission may pose limits on or contradictions with what is needed to help.

If there are not many organizational resources in your community, are there interested individuals? Many existing programs started with committed individuals, taking time from their primary jobs to assist torture survivors or asylum seekers.

INTERVIEW KEY STAKEHOLDERS FROM THOSE COMMUNITIES AFFECTED BY TORTURE

It is imperative to collaborate with affected communities to determine their needs. Ask the following questions of members of such communities: What is the range of ethnicities torture survivors are likely to come from in your community? Does the program plan to serve everyone who is eligible for services, depending on capacity, or does the program

A SURVIVOR PERSPECTIVE ON SERVICES

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Dianna Ortiz, an American who was tortured in Guatemala, writes in *The Mental Health Consequences of Torture* from the perspective of survivors: "Talk therapy is not the only form of treatment that has proved useful. Some survivors use traditional medicines, such as natural remedies prepared by traditional healers. Others favor techniques such as body work, massage, aroma and sound therapy, special breathing and relaxation exercises, or the ancient spiritual tradition of shamanism."

plan to serve particular ethnic communities? If the torture treatment program grows out of one serving a specific ethnic community, is it open to serving torture survivors from other countries with varying linguistic needs?

In order to obtain accurate demographic information, program planners need to go beyond state refugee admissions or the usual sources for public health information. Refugee admissions vastly underestimate the actual number of refugees because they do not include secondary migration.

They also do not include immigrants who did not officially come as refugees but who may be torture survivors. School districts' English-language-learner statistics provide good proxy information on actual immigrants with children from various language groups in the community, but may exclude highly affected populations such as Liberians, whose primary language is often listed as English.

There is little local epidemiological information on torture prevalence because immigrants are usually not questioned about this exposure by health professionals. Mutual aid associations, churches and mosques serving immigrants, and literature searches for studies of similar populations abroad may provide information and numbers on populations that have experienced higher levels of torture and war trauma.

Once you have assessed who the torture survivors are in your community, how best can you provide services to them? If services are intended for just one or a few linguistic groups, the program may need fewer interpreters because it can use staff who speak the languages of its clients. If services are open to a wide range of ethnicities, you will need to think through the linguistic needs of prospective clients and how to meet them.

Programs that move into torture treatment from a base in serving a particular ethnic group may assume that they can continue to serve only that group. However, there are several potential problems with that approach.

First, if a program receives funding from the Torture Victims Relief Act, those funds are earmarked for torture survivors, and not particular ethnic groups. If yours is the only such program in your city, you may not exclude a client based on ethnicity alone. Second, many torture survivors have deep mistrust of people from their own country, based on the particular conditions in which the torture occurred. (See Chapter 2 for more information.) Some ethnic-specific programs may replicate the divisions that developed during conflicts in the home country.

How receptive are key stakeholders to the ways in which you plan to organize services? Do your program goals fit within culturally acceptable limits? If the proposed program serves clients from many ethnic groups with differing cultural needs, how flexible can it be when providing services? For example, group approaches to psychological services may be very popular with some people and not well accepted by others. Torture survivors from countries with no history of mental health services may be reluctant to access those services without additional education about what they are, how privacy is assured, and how their health beliefs about certain symptoms and their causes match up with the provider's.

Existing programs that serve torture survivors differ in range of served populations. Some programs limit services to specific ethnic groups. Other programs are based in a particular geographic area with one or several new immigrant groups. The majority of programs serve a multiethnic population based on their status as torture survivors. In addition to interviewing key stakeholders from affected communities, consult with existing programs that serve the same ethnic groups the proposed program plans to serve.

Financial Support for Services

Torture survivors often have limited financial resources; their life's accumulations may have been stolen or lost through exile, and the symptoms of torture and the limitations of their immigration status may

FOR MORE INFORMATION

For more information on how torture affects communities, see **CHAPTER 2.**

Case story

Building services using a decentralized network model

A program serving torture survivors in the Midwest began in 1998, arising out of the refugee resettlement process. One of the early program organizers worked as a counselor at a local counseling program.

She had been involved in the Sanctuary movement of faith-based organizations providing aid and comfort to Latin American refugees fleeing torture and persecution in the political upheaval of the 1980s.

By the early 1990s, she began identifying refugees who were suffering from posttraumatic stress disorder. She organized a local coalition of agencies and individuals already providing services to refugees who could address their need for mental health services.

The partners included a psychiatrist, in-home services, emergency outreach programs, and counseling programs. Using a case management model and a decentralized network of services, the informal network then began applying for funding as a group.

Clinical members of the network provided training for

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educational, medical, and mental health professionals serving survivors. Referrals came from the local International Institute, medical clinics, friends and former clients, and other mental health providers.

Clients came from many countries, and the project contracted interpreters as needed. Grants funded staff, who were paid a nominal amount. The clinical director reported the advantage of their informal network was a focus on delivering services, despite limited funding.

The disadvantage was the ability of partners to withdraw: "more freedom, more vulnerability."

In the summer of 2001, the service network incorporated as a nonprofit public benefit corporation. That status enabled it to initiate projects on its own and to seek grant funds.

Services for torture survivors flowed from a more general mission — to help refugees function at the highest level possible, thus enabling them to adjust successfully to life in a safe environment. Key staff were the clinical director and the administrative director.

This functioning network did not receive funding from the Office of Refugee Resettlement (ORR) as authorized in the Torture Victims Relief Act (TVRA) in 2003, but received some TVRA funding through the United Nations Voluntary Fund for Survivors of Torture. With limited funding, the network was still able to provide services to about 40 torture survivors per year.

In 2004, the network joined with their county's Mental Health Board, one other treatment program, and four legal/asylum organizations to apply for TVRA funding under ORR.

They collaborated in order to avoid competing with each other for limited funds. They were one of eight programs to receive new ORR funds in late 2004.

prevent them from working. Direct client billing will be one of the least likely sources of funding for an agency working with survivors of torture, although it maybe possible with some individuals who still have personal financial resources or insurance.

Individuals and organizations who are interested in developing services for torture survivors will need to consider multiple sources of funding: individual donors and charitable foundations, medical insurance, funding from state programs and legislatures, and federal funding that is both targeted for torture victims and available more generally. As in any nonprofit organization, a diversified base of donors insures long-term financial stability.

This section begins by describing the Torture Victims Relief Act of 1998, not only because it is a dedicated pool of funding specifically for services for torture survivors, but also because it provides a legal description of what "services for torture survivors" comprise. Unfortunately, the amounts appropriated by Congress do not meet the needs of current programs, so TVRA funds should not be seen as a likely source of funding for new programs.

TORTURE VICTIMS RELIEF ACT

The Center for Victims of Torture worked closely with key members of the United States Congress to enact the Torture Victims Relief Act (TVRA) of 1998, which provides:

Assistance for treatment of torture victims — the Secretary of Health and Human Services may provide grants to programs in the United States to cover the costs of the following services:

- Services for the rehabilitation of victims of torture, including treatment of the physical and psychological effects of torture
- Social and legal services for victims of torture
- Research and training for health care providers outside of treatment centers, or programs for the purpose of enabling such providers to provide the services described in Paragraph 1 of the legislation

When the TVRA was reauthorized in 2003, it acknowledged differences between the United Nations and the World Medical Association in defining torture. (See chapter one for these definitions.) For purposes of determining eligibility for funding, the U.S. legislation used a definition given in Section 2340(1) in Title 18, United States Code:

> …an act committed by a person acting under the color of law specifically intended to inflict severe physical pain or suffering (other than pain or suffering incidental to lawful sanctions) upon another person within his custody or physical control.

This definition encompasses the use of rape or other forms of sexual violence. The term "under color of law" is defined as *when a person acts or purports to act in the performance of official duties under any law, ordinance, or regulation***.** As in the case of many recent conflicts in Africa (e.g. in Liberia, Sierra Leone, Congo, Rwanda) where there are competing rebel groups and semiautonomous militias that engage in torture as a weapon of war — human rights

FOR MORE INFORMATION

Current torture treatment programs are listed in the Appendix on **PAGE 103.**

organizations have generally understood those groups to have pretentions of governance or be *sub rosa* proxies for official government action, and thus covered by the law.

The TVRA funding guidelines allow the following activities to be deemed eligible for funding, either as a whole or in varying combinations: medical, psychological, social, and legal services. If the applicant does not propose to provide all allowable services, then it is expected to show how the missing services can be accessed by a client. Partnerships with other providers are allowed as a means to insure all components are available. TVRA legislation also allows funds to be used for training service providers outside of treatment centers. As a result, those services (in theory) enable the building of networks of individuals and organizations as well as full-service treatment centers. The domestic portion of the funding is routed through the Office of Refugee Resettlement, housed in the U.S. Department of Health and Human Services.

Without a substantial increase in current appropriation levels, TVRA funds are not large enough to maintain existing treatment centers, much less establish new treatment centers in high-need areas and also support dissemination activities for networks and mainstream providers.

Individuals and organizations who are interested in developing services for torture survivors will need to consider many other, often creative, sources of funding. Some programs have succeeded in garnering funds from medical billing, state funding, private foundations, and individual donors. Not all current treatment programs receive federal funding under the TVRA. Some had been providing services for more than 10 years before the Act was passed.

UNITED NATIONS VOLUNTARY FUND FOR VICTIMS OF TORTURE

About 20 percent of TVRA funds are routed through the United Nations Voluntary Fund for Victims of Torture, which was established by the General Assembly in 1982. These funds are distributed internationally, with a small amount going to existing United States torture treatment programs.

The UN Voluntary Fund collects voluntary contributions from UN member nations, then distributes those contributions to nongovernmental organizations and treatment centers for the purpose of assisting victims of torture and their relatives whose human rights have been severely violated as a result of torture. The Fund also may provide limited support to projects for training health care professionals specializing in the treatment of victims of torture.

FUNDING LEGAL SERVICES FOR TORTURE SURVIVORS

Some legal services for torture survivors who are eligible by income guidelines are funded through general funds for legal aid under the Legal Services Corporation. However, the Illegal Immigration and Reform Responsibility Act of 1996 made undocumented immigrants, including asylum seekers, often *not* eligible for services through Legal Aid, unless they meet one of several technical categories specified in a policy document that was released in 2003 (Federal Register*,* 2003). An example of this model of legal services for torture survivors is the Legal Aid Foundation of Los Angeles.

In some states, legal services for indigent immigrants seeking protection in the United

States are provided by private attorneys working on a *pro bono* (donated services) basis. *Pro bono* work is encouraged by many state bar associations. Examples of this model are Human Rights First and Minnesota Advocates for Human Rights. Chapter seven was written by attorneys working for Minnesota Advocates for Human Rights, which has worked in partnership with CVT since its formation.

A third funding source for legal services is law schools. A number have established *pro bono* clinics in immigrant law for student-training purposes and may be staffed by very experienced immigration attorneys on the faculty. Examples of programs embedded in law schools are at Georgetown, Villanova, Harvard, and St. Mary's in Houston.

VOLUNTEERS AND IN-KIND SERVICES

Many existing torture services programs make extensive use of volunteers. The Center for Victims of Torture uses over 300 volunteers a year and has a dedicated staff person to manage this program. Examples of non-clinical roles include "community guides" for clients, ESL tutors, drivers, speakers bureau members, office assistants, and research assistants.

Examples of clinical roles include forensic evaluators, surgeons and other specialists, dentists, therapists, and physical and massage therapists. A clinical volunteer program requires a higher level of screening, training, and ongoing supervision.

THE CENTER FOR VICTIMS of Torture headquarters in Minneapolis, Minn.

Volunteers and donated services serve several aims. First, they keep the cost of providing comprehensive services down. Second, if you are careful to track the number of hours provided by volunteers and the value of donated services, these may sometimes be used as matching funds for other grants. Third, volunteers are a visible means of demonstrating the support you and your mission enjoy in the community, which can serve to attract local funding. Finally, volunteers are likely to become program donors or advocates themselves. They help to create a local constituency for torture victims and the program.

Volunteers should be treated as staff, subject to the same standards, accountability, and assistance as paid staff. Before starting to use volunteers a program must develop policies and procedures for recruitment, screening, and orienting any volunteers. This includes writing job descriptions and determining how liability issues will be handled. Confidentiality and boundary issues need to be addressed. Consult with a local program that has a well-developed volunteer program. Many state governments also maintain an office to encourage and support volunteerism.

There are also issues specific to programs for torture survivors in using volunteers, such as managing volunteers who may have their own trauma histories and avoiding any religious proselytizing with vulnerable clients from diverse religious backgrounds. For this reason, it is important to consult with other torture treatment programs that use volunteers by contacting them directly or by contacting the CVT National Capacity Building Project staff for a recommendation.

BUILDING A SUSTAINABLE ORGANIZATION THROUGH THE GOVERNANCE STRUCTURE

In creating a robust and durable organization, special attention should be paid to creating a strong governance structure or board of directors. Some organizations treat board development as a *pro forma* legal requirement, perhaps filling it with staff members or inexperienced volunteers. This misses an important mechanism for building new ties to the community and deprives the organization of a stabilizing influence that can help mitigate the internal dynamics of vicarious trauma.

Organizational consultants often emphasize recruiting board members who, in their mix, supply the three W's: wealth, wisdom, and work. Wealth includes personal philanthropy by the board members, but also those who have connections to resources the organization will need to carry out its mission. Wisdom may include those who know the field of trauma, but in most communities the staff will become the experts in this field and outgrow such oversight from the board. Rather than using the board to create a superstaff, it is important to include those with expertise in fields of importance to the organization but which may not exist on staff, especially not on a full-time basis. CVT has found it very useful to include health administrators, especially CEOs and other high-level administrators, who understand the dynamics of the health care delivery business and the public policy issues that will affect its working environment; media and communications specialists; lawyers; business and political leaders; and top-level government administrators. Effort is made to create a nonpartisan board by assuring voices from varying political persuasions within the board.

Every community faces an extraordinary array of needs competing for attention and resources. An independent board of directors makes its own judgments about how the rehabilitation of torture survivors fits into the mix of necessary services that must exist to create successful communities. The payoff for the organization is that, having made that judgment, the board is the bridge back to the rest of the community to testify to the importance of this problem and the role the organization plays to solve it on behalf of the whole community. Rather than giving up power to a strong board, a staff is thus greatly strengthened in its capacity to achieve its mission.

DECIDING ON THE RANGE AND MODEL OF SERVICES TO PROVIDE

Over the several decades that torture treatment programs have existed in the United States, many different models of intervention have been created to respond to the diverse needs of torture survivors. Differences in models can result from a number of factors: needs and desires of specific ethnic groups served, theories of practice in treatment, available resources, special expertise, and clinical experience.

CVT'S PROGRAM MODEL

THE CENTER FOR VICTIMS OF Torture (CVT) in Minnesota is a stand-alone, multi-disciplinary treatment center serving primarily asylum seekers from a large number of countries.

CVT's integrated approach to treatment includes the following services: medical treatment, nursing care, psychotherapy, physical therapy, social work, and massage therapy.

Clients are guided through three stages of healing either individually or through a group model. These stages are:

SAFETY AND STABILIZATION:
Re-establishing health and trust

GRIEF AND MOURNING:
Working through what happened

RECONNECTION:
Getting back to community, love and work.

All services are provided on an outpatient basis in facilities in Minneapolis and St. Paul. CVT's clinics are located in renovated older homes, in environments that are as home-like and welcoming as possible.

An estimated 50% to 60% of client visits require the services of skilled interpreters trained at CVT. If a client needs additional medical or specialty services, they are referred to community providers.

Resource access issues are facilitated by a large number of volunteers, such as drivers, befrienders, ELL instructors, and job counselors, etc. CVT works closely with *pro bono* attorneys who are recruited and trained by a local legal human rights organization.

CVT provides direct services to about 225 people a year, roughly two-thirds of whom are continuing clients. About the same number of people are referred to other services in the community.

SAMPLE CASE MANAGEMENT MODEL FOR MULTIDISCIPLINARY SERVICES

INITIAL AND ONGOING CONTACT between a client and a case manager can be very helpful. The case manager documents trauma history, builds and maintains rapport throughout the client's treatment, is aware of ongoing needs and barriers, and serves as a general resource for the survivor.

INFORMED BY ONGOING case-planning discussions with the treatment team, the case manager can assist with scheduling or referrals to the appropriate multidisciplinary health care providers.

FOR EXAMPLE, torture survivors are often unable to benefit initially from in-depth psychotherapy due to their multiple psychosocial needs. Case managers may assist survivors with such psychosocial needs, teach relaxation strategies either individually or in groups, and refer them to a psychotherapist at the time they are most able to take advantage of this modality.

SIMILARLY, SURVIVORS WITH SEVERE depression or intrusive and hyperarousal symptoms of PTSD can be referred directly to a psychiatrist for treatment. Those with physical symptoms or sequelae from their torture can be referred first to primary care physicians.

CASE-MANAGEMENT DUTIES may be shared among the multidisciplinary treatment team, which often includes social workers, nurses, psychologists, and psychiatrists, depending on availability.

THE CASE MANAGER HAS PRIMARY responsibility for coordinating the survivor's care needs and informing others of changes in these needs. Similarly, it is helpful to share group educational and therapeutic services among team members who are able to provide them.

STRUCTURING TRAUMA TREATMENT teams in this manner also allows for more time-intensive resources requiring highly trained staff, such as individual psychotherapy, to be used in a more efficient manner, as clients will begin this intervention once their immediate psychosocial needs have stabilized.

MODELS OF TREATMENT AND SERVICE PROVISION IN THE UNITED STATES

Below are the primary types of models categorized by organizational structure and range of services, drawn from current program examples. The Web site for the National Capacity Building Project contains organizational profiles and updated contact information on participating programs. Go to www.cvt.org and click on Building Healing Communities.

1. MODELS BY ORGANIZATIONAL STRUCTURE: The choice of organizational structure often follows from the mission. Stand-alone programs bear all the burdens and benefits of independence: building a board of directors, finding and maintaining resources, strategic planning and leadership. But these centers provide most services needed by torture survivors in a "one-stop shopping" framework. Hospital or university-based programs may draw upon academic expertise and institutional strength. Programs embedded in larger agencies may encompass a greater range of services for the client or reflect a particular ethnic expertise, but may suffer from a lack of attention or compete internally for funding.

Decentralized collaborations are a way to share scarce resources and still provide all or most components of healing. They may also be a means to increase community support in welcoming new refugee groups. They may, however, lack enough of a strong center to grow or mature and may, in particular, have more difficulty accumulating knowledge and improving clinical skills.

2. MODELS BY RANGE OF SERVICES: Multidisciplinary centers have developed successful trauma treatment models that integrate medical, psychological, social, somatic, and legal components. A variety of treatment models may be applied in treating survivors of torture. The essential components involve creating a supportive environment, establishing a trusting relationship, and providing appropriate multidisciplinary services at a time when the individual may best avail him or herself of that treatment.

Decentralized referral networks offer a choice, especially when a full-service specialized torture treatment program may not be financially feasible for your community. A program that links together different agencies and individuals can leverage existing resources and start providing intentional services for torture survivors with less funding. Many programs have started with the vision and energy of committed individuals and later expanded as more resources became available.

Single-service programs have developed a special expertise that is of vital importance to torture survivors and may serve as a source of learning for others in the torture treatment movement. Currently, programs that provide legal services for asylum seekers are the most common examples of single-service programs receiving TVRA funding. These programs have close relationships with agencies providing torture treatment services so that their clients have access both to evaluation services and treatment.

Prevention strategies

In addition to direct services for torture survivors, torture treatment programs and human rights organizations may include preventing torture in their mission statements. For example, the mission of the Center for Victims of Torture is "to heal the wounds of torture on individuals, their families, and their communities and to stop torture worldwide."

In the field of public health, prevention is generally categorized as primary prevention, directed at averting a potential health problem; secondary prevention, directed at early detection and intervention to delay onset or mitigate a health problem; or tertiary prevention, directed at minimizing disability and avoiding relapse. Tertiary prevention can take place within the context of individual treatment or within a community setting targeting an affected population.

Prevention, as it applies to torture, may operate outside the usual boundaries of health and include a wide range of tactics and targets. The New Tactics in Human Rights Project, coordinated by the Center for Victims of Torture, encourages creative use of tactics, drawing from many sectors, to protect and extend human rights around the world and is an example of prevention of torture. A workbook and series of tactical notebooks are available online at www.newtactics.org.

The following are examples of primary and secondary prevention strategies:

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"THEY ASKED ME to give them a sewing machine," said Morie Momah, 50, of Gbalahun, Kailahun district in Sierra Leone. "I said, 'I don't have one ...' He was a tall man. I could not know his name ... He cut my arm off and they ran into the bush."

1. LEGAL ADVOCACY FOR JUSTICE AND ACCOUNTABILITY OF PERSECUTORS: The Center for Justice & Accountability (CJA, www.cja.org) in San Francisco works to deter torture and other severe human rights abuses around the world by helping survivors hold their persecutors accountable. CJA represents survivors in civil suits against persecutors who live in or visit the United States. CJA is pioneering an integrated approach to the quest for justice that combines legal representation with referrals for needed medical and psychosocial services, and outreach to schools, community organizations, and the general public.

2. COMMUNITY EDUCATION ON TRAUMA EFFECTS AND COPING: Education in communities affected by torture is a key secondary prevention strategy. When survivors recognize the common aftereffects of torture and understand that their symptoms and coping responses are a normal response to traumatic events, they are more likely to seek help. Also, community education builds awareness of available treatments for survivors and their families.

Trauma coping strategies are behaviors that have helped other trauma survivors to feel better. Trauma survivors may consider exploring one or more of these strategies in order to facilitate their own recovery.

3. SCREENING, ASSESSMENT, AND EARLY TREATMENT OR REFERRAL IN THE PRIMARY CARE SETTING: Despite ongoing needs and the potential for great benefit from mental health services, many refugees do not perceive they are in need of treatment, nor do they conceptualize their trauma symptoms in terms of Western mental health concepts. Many are reluctant to access mental health services even when referred.

For these reasons, primary care providers are often the only health care professionals available to detect and treat the problems resulting from trauma. The roles of physicians and nurses are well known and accepted across cultures. Thus, primary care providers provide a critical entry point for identifying trauma survivors needing help, providing treatment in the primary care setting, if appropriate, and using their ongoing relationship to facilitate successful mental health referrals. Early intervention in treating trauma symptoms is important in preventing future disability and prolonged suffering.

Torture treatment specialists, such as psychologists and psychiatrists, may work with primary care providers in clinics that see high numbers of refugees likely to have experienced torture. These specialists help providers to recognize the effects of torture and provide treatment when possible. They also work to minimize stigma regarding seeking mental

TRAUMA EDUCATION INCLUDES INFORMATION THAT:

- NORMALIZES TRAUMA experiences and symptoms
- REVIEWS SYMPTOM course and prognosis
- DESTIGMATIZES mental health care
- REVIEWS THE EFFECTS of additional stress in exacerbating symptoms
- RELATES TRAUMA, stress, and somatic symptoms
- FACILITATES appropriate grieving
- PROVIDES AWARENESS of successful trauma treatment methods
- EMPHASIZES medication compliance
- REVIEWS IMPORTANT self-healing or coping strategies

health treatment and may facilitate successful referrals of torture survivors to mental health professionals.

4. PREVENTION STRATEGIES USED BY TREATMENT CENTERS OUTSIDE THE UNITED STATES: Some torture rehabilitation centers outside of the United States conduct a variety of preventative efforts.

While many are specific to their settings and not directly applicable to the United States, they may stimulate ideas of approaches in your community.

One such effort in East Asia involves outreach to isolated, rural areas using mobile clinics. A physician and legal staff member travel to the rural site and conduct general sensitization trainings regarding the effects of torture and treatments available. They also document abuse reported by local populations for use in their advocacy efforts against those who perpetrate, sponsor, and condone torture. Moreover, these mobile clinics inform the public as well as torture survivors of their rights and redress available to those who have been harmed.

In many countries, torture occurs in prisons and police detention centers. Many torture rehabilitation centers target such places by providing medical services to prisoners. Through these visits they are able to treat torture survivors, document additional torture, educate guards about the effects of their actions, and use their documentation to advocate changing institutional policies with appropriate decision-makers.

Some treatment centers in East Africa have trained police or military officials as a strategy to prevent torture. Through sensitization about human rights, the effects of physical and psychological abuse, and legal statutes, centers have been helpful in changing norms of behavior among police and military officials. Trainings have also been conducted among the judiciary on the practice of torture in a specific country, its effects on victims, and how this may affect their testimony or willingness to press charges. These approaches and many others can be found through the New Tactics in Human Rights Project (www.newtactics.org).

FOR MORE INFORMATION

For more information on public education strategies, see **CHAPTER 5.** Another source is CVT's publication, *Helping Refugee Trauma Survivors in the Primary Care Setting,* online at **www.cvt.org.**

TRAINING AND SUPPORTING STAFF

Working with torture survivors is specialized and challenging work. Staff who work in torture treatment programs are mission-driven individuals. However, many in the field have written about the effects that working intimately with clients who have been severely traumatized can have on the caregivers. The effects have been summarized as vicarious traumatization or secondary trauma. Vicarious traumatization has been defined as "a transformation in one's inner experience resulting from empathic engagement with clients' traumatic material" (Pearlman and Saakvitne, 1995). The effects on the provider have been discussed in earlier chapters of this book, along with suggestions for self-care. (See Chapters 3 and 6.)

Besides self-care, an organization needs to manage the effects of secondary trauma on staff, clients, and the organization as a whole. Secondary trauma can affect staff morale, staff retention, and the quality of services to clients.

For the program planner, two aspects of

minimizing and managing vicarious or secondary trauma are especially relevant. One is adequate training; the other is institutional policies and mechanisms to support staff in their work.

RESOURCES FOR TRAINING STAFF IN TORTURE TREATMENT PROGRAMS

Training staff in the skills and knowledge needed to provide effective interventions with torture survivors happens at various points in a program's development. In a new organization, staff who will be working primarily with torture survivors will need in-depth training and orientation to the history and issues of the torture treatment and human rights movements across the globe, as well as focus on the research base and clinical skills needed to provide effective care.

Volunteers, *pro bono* professionals, and specialty providers within a referral network will need sensitization and skills training.

Once a program has developed a level of expertise through experience working with survivors of torture, it may seek to disseminate its expertise to others whose work includes but does not focus exclusively on torture survivors — students, other professionals interested in taking up the work, and refugee leaders. Training curricula and approaches must be tailored to the audience and trainers must be clear about what they expect from participants as an outcome of the training offered.

As outlined in Chapter 3, providers need to develop the following four core competencies when working with torture survivors:

- Knowledge of the life experiences and resettlement issues of refugees and asylees
- Understanding the dynamics of torture and the long-term effects of torture
- Cultural competence in working with traumatized people
- Working with effectively with skilled interpreters

These core areas form the general foundation for training content.

The field of torture treatment is in its early stages, pulling in expertise from earlier work on posttraumatic stress disorder and trauma in veterans, battered women, and abused children. Only a few higher education programs and traumatic stress institutes exist that prepare clinicians to provide treatment to victims of extreme political violence. Torture treatment programs have needed to provide internal training and capacity-building to supplement the training available in traditional higher education.

The Torture Victims Relief Act also funds training activities. Since 2000, the Center for Victims of Torture has received TVRA funds to organize training and capacity-building activities for programs providing services to torture survivors that are funded by TVRA, or are members of the National Consortium of Torture Treatment Programs. CVT maintains a parallel project working with specialized treatment centers in countries where torture is prevalent.

Training and capacity-building strategies include two-day institutes, conference calls, small subgrants, self-assessment tools, web resources, and phone consultation with various content experts. For more information visit the Center's National Capacity

TRAUMA-COPING STRATEGIES

REDISCOVERING
innate resiliency

INCORPORATING
regular physical exercise

DEVELOPING HELPFUL
relaxation techniques

FACILITATING
spirituality and religious beliefs

RECREATING
meaning in life

ENCOURAGING
employment and hobbies

STRENGTHENING
social connections

MINIMIZING
maladaptive coping

LIMITING EXPOSURE
to trauma reminders

Building Project Web Resource Center at www.cvt.org.

A number of programs have developed training materials, videos, and web content as part of this process. All are available to others either for a cost or for no charge via their organizations' Web sites. Current programs and their sites are listed in the Appendix of this guide.

POLICIES TO MINIMIZE EFFECTS OF SECONDARY TRAUMA ON STAFF

It is important that organizations internally practice the democratic and human rights principles that they support and provide fair treatment to their employees. The components of an institutional approach to reducing staff stress and secondary trauma include adequate health insurance, paid time off, continuing education, and resources with which to do the work with clients.

Opportunities for staff members to control aspects of their work and opportunities for job variation and breaks from direct trauma client work also help minimize the results of secondary trauma. An excellent article to read on this subject is "Helpers' Responses to Trauma Work: Understanding and Intervening in an Organization" (1995) by Rosenbloom, Pratt, and Pearlman.

Supportive connections among staff members are established with structured, planned means of talking about stress and secondary trauma built into the workplace. These means including procedures for debriefing after crises, critical incidents, or difficult work situations. On-going support groups provide opportunities to notice symptoms within oneself or in other group members.

Support groups can form among members of a profession, such as the organizations' social workers, or develop from multidisciplinary work teams. Debriefings can take place in large groups, such as staff meetings, or in meetings as small as one-to-one discussions with a co-worker, supervisor, or senior clinician.

Building these components into a program for torture survivors has budgetary and structural implications that must be taken into account.

Funding is often unpredictable in the world of nonprofit organizations, and this can add to the stress within an organization working with trauma survivors. Clinicians must build long-term relationships of trust to help survivors recover. Therefore, economic instability, staff reductions, and other fluctuations in staffing have professional and moral implications, as well as personal ones.

The organization should invest in sound financial systems and personnel to improve planning and minimize disruptions. That should include building a cash reserve that would allow the organization to fulfill its commitment to its clients despite sudden downturns.

Torture survivors carry a great deal of fear and transmit it to the organization. Earlier chapters have discussed how to handle this clinically. Managerial leadership can help the process by creating an organization that is well connected to the community and to powerful stakehold-

ers who will support its mission and encourage its success.

The clinical process is enhanced when torture survivors perceive that the organization works to protect them and their families. Strong ties to members of Congress, for example, can often be built through their local staff who provide constituency services, such as refugee resettlement and asylum cases. Visits to the center with staff and clients by public officials (mayors, governors, members of Congress, etc.) can develop strong bonds to the organization, but also give clients the opportunity to be listened to and respected by people with power.

TRAINING TO BUILD NETWORKS OF SUPPORT FOR TORTURE SURVIVORS IN LOCAL COMMUNITIES

Most mature torture treatment programs have begun to offer training and outreach to health and social services professionals and policy-makers. Such mainstream training can increase the number of torture survivors able to receive services and educate the next generation of professionals about the special needs of immigrant populations. Also, influential members of the community can be sensitized to the problem of torture and can play active roles in defending and expanding human rights.

More established torture treatment programs also train volunteers as a strategy for expanding support for torture survivors.

Volunteers, in addition to expanding the quantity and breadth of services available to survivors, may also become program donors, program advocates, and advocates for human rights in general.

Another approach to training is to create indepth, ongoing interactions with refugee-led mutual assistance associations, or refugee-focused nonprofit organizations that offer special services beneficial to torture survivors.

Refugee-led organizations typically assist torture survivors with a variety of needs. Some conduct health education or trauma education efforts, while others provide supportive or educational groups for survivors.

Such services are greatly enhanced by ongoing consultation with torture rehabilitation center staff. Collaborations between refugee-focused organizations and torture treatment programs are mutually beneficial, allowing the exchange of specialized knowledge about certain issues and referrals for specialized services (e.g., with a legal organization serving refugees and/or asylum seekers).

Training an ever wider audience has the obvious appeal of stretching limited funds to cover a greater number of torture survivors. Specialized torture treatment programs, through years of engagement with torture survivors from many different countries, create a knowledge base of best practices.

Knowledge dissemination can only work if the specialized torture treatment programs continue to grow and learn. These programs serve as "centers of excellence" and visible beacons of hope for survivors of torture around the world. ■

REFERENCES

Pearlman, L.A. & Saakvitne, K.W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors.* New York: W.W. Norton & Co.

Rosenbloom, D., Pratt, A., & Pearlman, L. A. (1995). Helpers' responses to trauma work: Understanding and intervening in an organization. In B. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp. 65-79). Lutherville, MD: Sidran

ADDITIONAL RESOURCES

http://www.compasspoint.org
CompassPoint Nonprofit Services

Many publications and CompassPoint Board Café e-newsletter are "short enough to be read over a cup of coffee."

http://www.mncn.org
Minnesota Council of Nonprofits

This organization sells a variety of publications at low prices that are useful for nonprofits across the country, such as *No Surprises: Harmonizing Risk* and *Reward in Volunteer Management, Handbook for Starting a Successful Nonprofit*

http://www.nonprofitrisk.org
Nonprofit Risk Management Center

The mission of this organization is to help nonprofits cope with uncertainty. It offers a wide range of services (from technical assistance to software to training and consulting help) on a vast array of risk management topics (from employment practices, to insurance purchasing to internal controls and preventing child abuse). The Nonprofit Risk Management Center does not sell insurance or endorse organizations that do.