IRCT Contribution to DG Home's consultation on the future of Home Affairs Policies in the Post-Stockholm Agenda

International Rehabilitation Council for Torture Victims

Borgergade 13
P.O. Box 9049
DK-1022 Copenhagen K
Denmark
Tel +45 33 76 06 00
Fax +45 33 76 05 00
irct@irct.org
www.irct.org

Brussels Liaison Office
205, Rue Belliard
B-1040 Brussels
Belgium

Tel +32 2 230 15 04
Fax +32 2 230 15 49

Geneva Liaison Office
Rue de Varembé 1
P.O. Box 16
CH-1211 Geneva 20 CIC
Switzerland

Tel +41 (0)76 221 5959

INTRODUCTION

Victims of torture in the European Union amount to potentially 945 000 asylum seekers[1] and 200 000 European citizens[2], many of the latter reaching an old age nowadays and being confronted with correlated health issues. The entry of Croatia in the EU in July 2013 also brought along victims of mass rape and torture during the past conflict.

There is a great body of classical and current scientific research on the mental health consequences of psychological trauma. The most commonly diagnosed disorders following traumatic experiences[3] are post-traumatic stress disorder (PTSD) and depressive disorder. A significant number of victims of violence and trauma develop post-traumatic stress disorder (PTSD) and depressive disorder, most commonly a combination of the two. In refugee populations, the rates of PTSD and depression vary widely depending on the sample, with prevalence rates ranging from 4% to 86% for PTSD and 5% to 31% for depression[4]. A recent study of Steel et al. (2009) provides a meta-regression of the largest set of epidemiologic surveys in the refugee and post conflict mental health field. A total of 161 articles reporting results of 181 surveys comprising 81 866 refugees and other conflict-affected persons from 40 countries were identified. After adjustment for methodological factors, torture emerged as the strongest substantive factor associated with PTSD and cumulative exposure to potentially traumatic experiences (PTEs) was the strongest substantive factor associated with depression. The unadjusted weighted prevalence rate reported across all surveys for PTSD was 30.6% and for depression was 30.8%[5].
These proportions lead us to the conclusion that, in 2012 only, 106 711 of the 348 730 asylum seekers and unaccompanied minors who entered the EU where potentially suffering from PTSD.

[1] 30,6% of the 3 097 065 Asylum seekers who have entered the EU between 2002 & 2012 (Eurostat figures). No official EU-wide figures are available about the proportion of refugee status as only partial figures are collected. As an indication, in 2005 and 2006, respectively 19.9% & 27.9% of asylum seekers received a refugee status in the EU, though some countries remained unreported.. No figures were reported on other subsidiary protection status to be further added to these results.

[2] Victims of former national repressive regimes

[3] Based on the classification system of the Diagnostic and Statistical Manual of Mental Disorders DSM, 4th edition - DSM-IV

[4] Hollifield et al., 2002

[5] Please see further explanations on the scientific rationale in the PROTECT manual

The situation of victims of torture in Europe defines them as a highly vulnerable group. For all asylum seekers, refugees, undocumented or destitute migrants, being part of ethnic minorities and immigrant groups exposes them strongly to multiple discriminations (on the basis of their origins firstly, then on the basis of gender and/or age)[6]. Furthermore, difficult socio-economic conditions, low access to basic health care and even less access to specific rehabilitation services increases their vulnerability as victims of torture. They then suffer, above their own difficulties linked to trauma, from social exclusion, which is recognised as an important factor affecting their health and well-being. The diversity of origins of victims also leads to difficulties to organise and integrate themselves and thus increase their isolation, making them even more vulnerable.

In its Communication from 2009 on reducing health inequalities in the EU[7], the Commission states that **specific attention has to be paid to vulnerable groups as "the issue of health inequality including reduced access to adequate health care, can be qualified as one which involves their fundamental rights".**

The International Rehabilitation Council for Torture Victims (IRCT) is an independent, international health-based human rights organisation, which promotes and supports the rehabilitation of torture victims, promotes access to justice and works for the prevention of torture worldwide. Our members comprise more than 140 independent organisations in over 70 countries (31 centres in 28 EU countries).Our work is governed by these member organisations. Today, we are the largest membership-based civil society organisation to work in the field of torture rehabilitation and prevention.

In its advocacy actions focusing on the European Union Internal issues in the frame of Asylum and migrations, the IRCT focuses in particular on:

- The appropriateness of asylum procedures and reception conditions with relation to the treatment of victims of torture, in particular concerning issues such as the need for early identification, the need for medical examination and documentation according to the Istanbul Protocol, the need to be excluded from fast-track processes and detention among others;
- The need for protection-oriented measures at the border, allowing an early identification, fair and dignified treatment and the absolute respect for non-refoulement obligations;
- The need for special care and support to be given to unaccompanied minors, the huge majority of which are suffering from trauma;
- The need for early access to appropriate basic healthcare including psychological and psychiatric services with the use of interpreters if needed;

[6] FRA EU-MIDIS Data in focus Report 5

[7] COM(2009) 567 final

- The need for the accessibility, appropriateness and availability of specialised holistic rehabilitation services for victims of torture throughout Europe, including psychotherapy, social work, physiotherapy and support to integrative measures such as access to education, professional training and work.

POST –STOCKHOLM AGENDA

In May 2010, the Stockholm Programme paid no specific attention to the situation of torture victims and only mentioned vulnerable migrants and victims of violence within the following articles:

- **Article 2.3.3:** "*All forms of discrimination remain unacceptable. The Union and the Member States must make a concerted effort* ***to fully integrate vulnerable groups****, in particular the Roma community, into society by promoting their inclusion in the education system and labour market and by taking action to prevent violence against them. For this purpose, Member States should ensure that the existing legislation is properly applied to tackle potential discrimination. The Union will offer practical support and promote best practice to help Member States achieve this. Civil society will have a special role to play.*
  Vulnerable groups in particularly exposed situations, such as women who are the victims of violence or of genital mutilation *or persons who are harmed in a Member State of which they are not nationals or residents,* ***are in need of greater protection****, including legal protection. Appropriate financial support will be provided, through the available financing programmes.*"
- **Article 5.1**: "*The strengthening of border controls* ***should not prevent access to protection systems*** *by those persons entitled to benefit from them, and* ***especially people and groups that are in vulnerable situations****. In this regard,* ***priority*** *will be given to* ***those in need of international protection*** *and to the reception of* ***unaccompanied minors***."
- **Article 6.1.7.:** "***Unaccompanied minors*** *arriving in the Member States from third countries represent a* ***particularly vulnerable group*** *which requires special attention and dedicated responses, especially in the case of minors at risk. This is a challenge for Member States and raises issues of common concern. Areas identified as requiring particular attention are the exchange of information and best practice, minor's smuggling, cooperation with countries of origin, the question of age assessment, identification and family tracing, and the need to pay particular attention to unaccompanied minors in the context of the fight against trafficking in human beings. A comprehensive response at Union level should combine* ***prevention, protection*** *and assisted return measures while taking into account* ***the best interests of the child***."
- **And finally Article 6.2**: "*The European Council remains committed to the objective of establishing a common area of protection and solidarity based on a common asylum procedure and a uniform status for those granted*

*international protection. While CEAS should be based on **high protection standards**, due regard should also be given to **fair and effective procedures** capable of preventing abuse. It is crucial that individuals, regardless of the Member State in which their application for asylum is lodged, **are offered an equivalent level of treatment as regards reception conditions**, and the same level as regards procedural arrangements and status determination. The objective should be that similar cases should be treated alike and result in the same outcome"*

While the IRCT is pleased with some of the measures and legislative developments taken to implement these aspects of the Stockholm Programme, many crucial issues remain unaddressed or are improperly implemented. Revisions of the Common European Asylum System (CEAS) have created new conditions for the EU member states to identify, through an individual assessment, whether an applicant is a vulnerable person who has special reception and/or procedural needs, such as a victim of torture. The revised system will surely improve the conditions and safeguards for vulnerable asylum seekers.

GENERAL COMMENTS AND PRIORITIES IDENTIFIED BY THE IRCT AND ITS MEMBER CENTRES

Keeping in mind that the transposition period for Member States to adopt the revised legislation in their national legislation is two years, we call on the Commission, from the first moment, to ensure that:

- Member States comply with their obligations in relation to the treatment of vulnerable asylum seekers through **direct assistance** in the field **from the first moment that an asylum seekers enters** a given Member State and **through support of rehabilitation centres for torture victims** (e.g. financial, infrastructural, by shared consultations with national authorities). It must be ensured that this practice also applies to applicants subjected to Dublin regulations. This also implies (the creation of) **a functioning screening and monitoring mechanism** for **early identification** at the borders and in retention centres to guarantee that asylum seekers will be screened for their potential vulnerability. This will ensure that victims of torture can be identified and protected **as soon as possible**.
- In addition, **when identified as vulnerable, asylum seekers should have a guaranteed and direct access to qualified and specialised health care**. Member States should be strongly encouraged to exempt victims of torture from accelerated procedures and those countries where there are strong indications that torture is practised should immediately be removed from the safe third countries list. Protection of torture victims must be an overriding principle when transposing the Directives, above other considerations. Member States should also ensure that sufficient financial and institutional support is provided to treat victims of torture. Furthermore, legal avenues to access international protection should be promoted and asylum seekers should be provided with information about the procedures in a form and language which they understand.

- To implement the right to rehabilitation, it is essential that all European bodies dealing with victims of torture in particular and vulnerable migrants in general adopt a **victim-centred approach** and ensure synergies and cooperation between all stakeholders, whether at national or European level, at the different stages of the procedure. A feasibility study on the accession of the EU to the Convention against Torture should be requested as a first step to ensure the consistency of obligations to Member States, either via the EU or directly.
- Within the asylum process, asylum seekers who are awaiting a decision on their status should be **regularly screened for signs of trauma**. This should become a widespread practice of authorities and practitioners, especially considering that signs of trauma might (re)appear at different stages during the asylum process, and not just at the moment of arrival. The asylum procedure should also allow for **sufficient timing** in order to gather elements to prove torture and substantiate asylum applications; which entails that victims of torture should be excluded from fast-track procedures.
- **Trainings for national authorities, their officials and border guards** are essential to guarantee compliance of the EU member states to adequately screen and handle the asylum process of vulnerable asylum seekers, as foreseen by law.
- **The principle of non-discrimination should be strongly upheld** to guarantee equal protection, and access to medical care including psychiatric and/or psychotherapeutical treatment when needed, to all those asylum seekers who enter the EU. At the moment, asylum seekers are, in practice, often not benefiting from their basic rights upon arrival in the EU.

Recent revisions to the CEAS: insufficiencies and issues left unaddressed

1.) The new Reception Conditions Directive:

- The identification of vulnerable persons with special reception needs:

Chapter IV, which includes Articles 21 to 25, contains provisions for vulnerable persons and establishes a two-step approach. In order to determine if an applicant has special reception needs, Member States first need to identify whether the applicant is a vulnerable person or not**.** This means that **not all vulnerable persons could be defined as having special reception needs**.

Article 22 states that *"in order to effectively implement Article 21, Member States shall assess whether the applicant is an applicant with special reception needs. Member States shall also indicate the nature of such needs. That assessment shall be initiated within a* ***reasonable period of time*** *after an application for international protection is made and may be integrated into existing national procedures. Member States shall ensure that those special reception needs are also addressed, in accordance with the provisions of this Directive, if they become apparent at a later stage in the asylum procedure [...]"*

This article establishes assessment mechanisms to identify whether an applicant is a vulnerable person or not, which **is a positive development** as this Article **presents**

important safeguards for applicants with special needs. Still, the "reasonable period of time" during which the assessment should be carried out leaves **too much discretion** to the Member States and should therefore be the subject of a close monitoring during the coming transposition and implementation phase.
Article 22 (c) states that *"only vulnerable persons in accordance with Article 21 may be considered to have special reception needs and thus benefit from the specific support provided in accordance with this Directive."*
The problem in this provision lies in the fact that, before Article 22 becomes applicable, it should be determined whether a person is vulnerable or not. As mentioned above, **by the inclusion of a "reasonable period of time" to determine whether someone is vulnerable, the special reception needs for vulnerable applicants might not be accessible as quickly as necessary for those in need**.

- Victims of torture – Right to rehabilitation:

Article 25 states that "*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 care**."*

Once an applicant is considered to be a victim of torture, this Article crucially refers to their **right** to rehabilitation. Still, the mentioning of "appropriate medical and psychological care" leaves **too much space for the interpretation of the Member State**. Therefore, the IRCT strives to improve the interpretation of this provision by referring to the General Comment No. 3 (2012) on the obligations of States parties under Article 14, as agreed upon by the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*. In this general comment, the Committee against Torture "*affirms that the provision of means **for as full rehabilitation as possible** for anyone who has suffered harm as a result of a violation of the Convention should be **holistic** and **include medical and psychological care as well as legal and social services***[8]". As all EU Member States are party to the UNCAT, this obligation should be enshrined into the approach they will take in transposing and implementing article 25 into their national law.

[8] General Comment No. 3 of the United-Nations Committee against Torture on the implementation of article 14 by States Parties, para.11: "*The Committee affirms that the provision of means for as full rehabilitation as possible for anyone who has suffered harm as a result of a violation of the Convention should be holistic and include medical and psychological care as well as legal and social services. Rehabilitation, for the purposes of this general comment, refers to the restoration of function or the acquisition of new skills required by the changed circumstances of a victim in the aftermath of torture or ill-treatment. It seeks to enable the maximum possible self-sufficiency and function for the individual concerned, and may involve adjustments to the person's physical and social environment. Rehabilitation for victims should aim to restore, as far as possible, their independence, physical, mental, social and vocational ability; and full inclusion and participation in society.*"

- Detention of vulnerable migrants and unaccompanied minors:

Article 11 on detention of vulnerable persons and applicants with special reception needs states in paragraph 1 that "*The health, including mental health, of applicants in detention who are vulnerable persons shall be of **primary concern** to national authorities. Where vulnerable persons are detained, Member States shall **ensure regular monitoring and adequate support** taking into account their particular situation, including health".*

This article **remains vague and open to the interpretation of a Member States** by the wording of "*primary concern*" and "*adequate support*". It also **lacks a time-frame for the regular monitoring**. In addition, the agreed provision might lead to a detention of victims or torture, or unaccompanied minors, without a clear medical evaluation. Again, a close monitoring on the transposition and implementation of this article should be set up and alternatives to detention specifically explored for vulnerable asylum seekers and victims of torture in particular.

Article 11(3) states that *"unaccompanied minors shall be detained only in exceptional circumstances*". However, there is **no clear exclusion** for unaccompanied minors, or for victims of torture, to be detained. Our experience unfortunately shows that unaccompanied minors are **systematically** subjected to a high level of traumatisation due to their age, their loneliness and the ordeal they underwent to reach Europe. In addition, Article 11(5) allows Member States to derogate from some obligations established in the same article, such as the possibility for detained minors to engage in leisure activities or the obligation to separate female asylum seekers from male asylum seekers in detention, when detention occurs at a border post or in a transit zone (airports, for example). These derogations might undermine the protection of vulnerable persons. As the definition of duly justified cases is not included, this provision leaves **a wide margin of interpretation** to the Member States.

Furthermore, no reference to medical expertise, carried out by a qualified expert, is included in the provision. Such expertise should be **obligatory** before the detention of any vulnerable asylum seekers to ensure that detention will not have a detrimental effect on the health of the applicant. As torture mostly occurs during detention by police or armed forces or others, being detained will systematically re-enact the trauma and generates retraumatization in the victim. The health of vulnerable persons, especially those who have suffered traumatic experiences, will always deteriorate in detention as being demonstrated by JRS report "*Becoming vulnerable in Detention*". Overall, the agreed provision might lead to a detention of victims or torture, or unaccompanied minors, without clear medical expertise.

- Access to health care:

Article 19 on health care is a welcome addition to the Directive. Article 19 (1) reads that *"Member States shall ensure that applicants receive the necessary health care which shall include, at least, emergency care and **essential treatment** of illnesses and of **serious mental disorders**."*
However, the inclusion of "*essential*", just as with the inclusion of "*serious*" to mental disorders, leaves **a large discretion** for interpretation that is **potentially**

harmful. This means that some forms of depression, which could potentially seriously affect the applicant's ability to function, could be left untreated.
Article 19 (2) states that "*Member States shall provide necessary medical or other assistance to applicants who have special reception needs, including* ***appropriate mental health care*** *where needed."*
Although the provision refers to rehabilitation, the obligation to provide "*appropriate health care*" to applicants with special needs still **leaves too much space for the interpretation** of Member States. Nevertheless, here again, the interpretation of Article 14 of UNCAT by the General Comment No. 3 should set the standards at a high level as all EU Member States are bound by it.

Conclusion and necessary improvements:
The new Reception Conditions Directive is a clear improvement to the 2003 version, and its provisions now explicitly consider the situation of vulnerable asylum seekers, such as victims of torture. **Member States are now legally obliged to screen asylum seekers for vulnerable applicants with special reception needs**.
Still, as outlined above, some provisions remain ambiguous and leave too much room for the interpretation of Member States, which could potentially endanger the rights of victims of torture.
Presently, most EU Member States do not have a procedure in place to identify vulnerable asylum seekers with special needs because the EU law provisions have not been properly transposed. **The Commission must therefore use strong political pressure to ensure that Member States implement the new legislation properly and give full effect to its provisions.**

2.) The new Asylum Procedures Directive:

- <u>Early identification and accelerated procedure:</u>
  Recital 23 (a) stipulates that applicants with special procedural needs should be excluded from accelerated and border procedures. According to Article 24 applicants with special procedural needs who are considered to have suffered torture, rape or other serious forms of psychological, physical or sexual violence should be excluded from the accelerated procedures.
  Nevertheless, this provision is **legally vague** in its phrasing, and it is **very doubtful** whether victims of torture will in practice be adequately screened and excluded from the accelerated procedure. In addition, the requirement to give vulnerable persons time and support, and the exemption from the accelerated or "manifestly unfounded" procedures, have not been included in the Directive.
  According to Article 24 Member States must, in line with Article 22 of the Directive, also ensure that applicants in need of special procedural guarantees are identified **within a reasonable period of time**. The provisions leave **too much discretion** on Member States to interpret what a "*reasonable period of time*" is, especially in consideration of the importance of the early identification of vulnerable persons throughout the asylum procedure. Still, the provision makes clear that if people are

identified as having special needs at a later stage, they should be given **the same guarantees**, taking into account the fact that certain traumatic disorders may only be revealed after a period of time.

- Medical-legal Reports:
  According to Article 18, there is an obligation for Member States to ensure that officials receive training to raise their awareness of symptoms of torture and of medical problems which could adversely affect the applicant's ability to be interviewed.
  The requirement for Member States to share the burden by placing a duty on the authorities to request a medical examination, carried out by a medical professional, is also a step forward in providing more safeguards to victims of torture and trauma in the asylum procedure.
  Still, a Member State is only obliged to arrange for a medical examination when it "*deems it relevant*" for the assessment of the asylum application. Nevertheless, the IRCT wishes to stress that as the European Court of Human Rights ruled in *RC v. Sweden*, a State has the **duty** to ascertain relevant facts, particularly in asylum cases involving allegations of torture.[9]

The IRCT insists on the fact that the Istanbul Protocol is **the only internationally recognised** set of standards to be followed regarding the documentation and evidence of torture. The necessity for States to adopt the Istanbul Protocol as the only suitable set of standards is explicitly mentioned in the UN Committee Against Torture's Concluding Observations on the combined fifth and sixth periodic reports of the Netherlands[10], which clearly indicates the international recognition of the

[9] *In RC v Sweden, the ECtHR judged that the State has* ***a duty to ascertain all relevant facts, particularly in circumstances where there is a strong indication than an applicant's injuries may have been caused by torture****. An Iranian asylum applicant alleging that he had suffered torture in Iran submitted a medical certificate, confirming that injuries on his body were likely to have been originated from torture. The Swedish authorities refused to accept the medical report as proof of torture and the asylum application was rejected. At the request of the ECtHR the applicant submitted a further forensic medical report; its findings strongly indicated that the applicant had been tortured. The Court considered that if the state had any doubts about the applicant's medical evidence, it should have arranged for an expert report on its own initiative. The Court considered that "****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****." See RC v Sweden (Application no. 41827/07), Judgment of 9 March 2010.* See *RC v Sweden* (Application no. 41827/07), Judgment of 9 March 2010.

[10] See the Committee Against Torture's Concluding observations on the combined fifth and sixth periodic reports of the Netherlands, adopted by the Committee at its fiftieth session (6-31 May 2013), para. 12: "*The Committee is also concerned that during medical examinations that form a part of asylum procedure, individuals are primarily assessed on their ability to be interviewed while disregarding their eventual needs of treatment and support due to ill-treatment, torture or trauma suffered.* ***This practice of not using the Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or***

instrument. The European Commission must therefore strongly advise Member States to implement this set of standards.

Member States can designate the medical professionals who can carry out the medical examinations. This could arguably impact on the **quality and impartiality** of medical reports as, unfortunately, PTSD and trauma are not part of the basic clinical curricula and only few clinical professionals can be considered as duly qualified to document the link between PTSD and trauma. Besides, ethics in medicine imposes that an applicant should be free to choose an independent medical expert to conduct the examination.

Finally, applicants must- if not carried out by the State- arrange the medical examination **at their own costs**, which places an **unreasonably heavy burden** on them or on the NGO-led rehabilitation centres that are compelled to provide it for free, regardless of their own structural financial difficulties and their need for sustainable funding.

Conclusion and necessary improvements:
The transposition and implementation of the Directive must be closely monitored **to exclude vulnerable applicants from accelerated procedures by implementing the current provisions as strictly as possible.** Member States must take measures to allow applicants to have access to **qualified medical professionals**, who are familiar with the pathologies usually affecting victims of torture and medical-legal reports must be given **an appropriate weight** as **crucial tools** to prove the alleged torture or mistreatments. Member States should adopt the standards set by the Istanbul Protocol regarding evidence of torture. As recommended by the revised Directives, the medical/psychological examination and reports should be requested as soon as possible and therefore financed by the States to enable their authorities determining refugee status to consider all important sources of information in order to take the best possible decision from the early stages of the asylum procedure and prevent the symptoms of trauma from becoming more chronic.

Degrading Treatment or Punishment (Istanbul Protocol) as a means for establishing a link between the asserted ill-treatment in the asylum application and the findings of actual physical examination is not in conformity with the requirements set out in the Istanbul Protocol (arts. 3 and 10).
The Committee recommends that the State party take measures:
(a) To identify asylum seekers with specific needs as early as possible by ensuring that during the medical examination as part of asylum procedure the applicants are assessed for both their capacity to be interviewed properly as well as their eventual needs of treatment and support due to ill-treatment, torture or trauma suffered;
*(**b) To apply the Istanbul Protocol in the asylum procedures and to provide training thereon for concerned professionals to facilitate monitoring, documenting and investigating torture and ill-treatment, focusing on both physical and psychological traces, with a view to providing redress to the victims**”**.*

FUNDING FOR REHABILITATION

In the European Union, only very few rehabilitation centres are supported by their State: the Netherlands and Sweden stand as exceptions with State funding levels close to 100%. Very few centres can nowadays benefit from EIDHR[11] funding, as they used to until 2010, as the scope of the instrument changed and activities located on the EU territory can now only be eligible if they are necessary and directly linked with the implementation of a project in third countries. Some funds for rehabilitation were also available via the European Refugee Fund but, as these funds were monitored by Member States, many delays impacted the payments of the various instalments, creating liquidity crisis in NGOs which, structurally have extreme difficulties in creating sound reserves level.

As a consequence, rehabilitation centres within Europe have been struggling on a daily basis - for years - to be able to secure the funds enabling them to provide rehabilitation services free of charge to victims of torture who could otherwise not afford to pay for them.

Though all EU Member States are party to UNCAT where Article 14 places an absolute obligation on states to provide for as full rehabilitation as possible (i.e. not related to the available resources of the state or to the responsibility of the state as a perpetrator), this is far from being a reality.

In fact, due to the crisis, the rehabilitation centres for victims of torture in the EU are at an increased risk of not providing services to the victims. Severe problems were identified with the Member States' ability to identify victims of torture and very few Member States offer the instructed rehabilitation, many have no assistance to offer at all. **The prospective closure of the rehabilitation centres in the EU for lack of funding carries therefore a heavy human cost, borne by the victims of torture themselves.**

To compensate for this gap, the IRCT has advocated since 2010, along with the European Parliament, for the creation of a Pilot Project budget line (turning in 2014 into a Preparatory Action) to ensure that funds are available in the EU for the rehabilitation of victims of torture. The first call for proposals has been launched in October 2011 and resulted in 31 applications received from centres in 14 EU countries. The total of EU requested grants amounted to 6 million Euros, showing the great need for financial support among rehabilitation centres. Out of the 31 proposals, only 4 projects have been financed. The second call for proposal was launched in July 2012 with 25 applications submitted from various countries. As 2 million Euros were available in 2012 (compared to only 1 million in 2011), 7 projects have been selected. The funds needed to support all the projects which applied for

[11] European Instrument for Democracy and Human Rights

funding amounted to approximately 8 million Euros, **showing the relevance of the initiative and the needs to be covered**. In 2013, 25 applications were received, for a total amount of only 2 million Euros available. The volume of applications received since the beginning demonstrates the urgent need, in the European Union, for supporting the rehabilitation of torture victims. The preparatory action supported for the last for years by the European Parliament and managed by DG Home is therefore essential to prevent more physical and mental suffering of these survivors.

With the current negotiations over the Multi Annual Financial Framework 2014-2020 and the framework programs such as the one on Fundamental Rights or the Asylum and Migration Fund being renegotiated, **the IRCT calls upon the EU to keep a strong focus on, in parallel:**

- **its commitment to support financially the rehabilitation of torture victims** via the setting up of a formal budget line in the new MAFF;
- **its commitment to the upholding of high standards in the protection and rehabilitation of torture victims,** as enshrined in the Charter of Fundamental Rights, in the European Convention on Human Rights and in the UN CAT;
- furthering its commitments to the latter high standards by **initiating a feasibility study on the accession by the EU - as a legal entity – to UN CAT**;
- **further incite Member States to respect their international commitments by ensuring that rehabilitation services are appropriate, accessible and available on their territory, in particular via the funding of these services as enshrined into UN CAT Article 14**.