

Current migration situation in the EU: Torture, trauma and its possible impact on drug use

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The prohibition of torture and inhuman or degrading treatment or punishment is a cornerstone of the international and European human rights protection regimes. Nevertheless, a significant number of migrants and asylum applicants experience or witness physical and psychological violence, inhuman or degrading treatment, or are victims of other violent crimes. Most of these cases involve their countries of origin, but incidents do also occur both in transit countries and in the European Union (EU). These experiences can trigger or intensify trauma and undermine mental health. This report looks at the prevalence of torture and trauma among arrivals, as well as its impact in terms of drug use. It also discusses the support available to victims.

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Thematic focus: Torture, trauma and its possible impact on drug use

Many individuals who flee war and armed conflict, and particularly those fleeing persecution, are likely to have experienced trauma. This may include torture and inhuman or degrading treatment. They may also have family members or friends who experienced such trauma. Such experiences can occur in people's country of origin. They can also take place while people are in transit and trying to enter the EU, as well as upon arrival in the EU. One way of coping with trauma can be the use of drugs (both licit and illicit), which is explored in the last section of this report.

From a fundamental rights perspective, the prohibition of torture and inhuman or degrading treatment or punishment is an absolute, non-derogable right under international human rights law, as stipulated by the 1948 Universal Declaration of Human Rights (Article 5), the 1966 Covenant on Civil and Political Rights (Article 7), more specifically in the 1984 Convention against Torture (Articles 1 and 16); and, on a regional level, by the 1950 European Convention on Human Rights (ECHR) (Article 3).¹

Torture is not allowed under any circumstance – including war, public emergencies or terrorist threats –

and irrespective of the victim's conduct, however undesirable or dangerous.² Both international law and the ECHR not only prohibit torture, but also other forms of ill-treatment. The European Court of Human Rights (ECtHR) has drawn distinctions between prohibited acts, essentially using a "threshold of severity" test. Inhuman treatment is defined as at least such treatment as deliberately causes severe suffering, mental or physical, which in the particular situation is unjustifiable. The severity of pain and suffering forms the basis for distinguishing between inhuman and degrading treatment in accordance with ECtHR case law,³ which establishes that degrading treatment must include at least some form of "gross humiliation".

As for the perpetrators, not only state officials per se qualify and trigger state responsibility, but so do "other persons acting in an official capacity". The ECtHR added to this the positive duty of states to provide protection against ill-treatment, even where such treatment results from the conduct of non-state actors. (For example, a state was held responsible for acts committed by a husband against his wife because state officials were aware of these acts but did nothing to prevent them.)⁴

MAIN FINDINGS

- Limited data are available on victims of torture among applicants for international protection, with Greece the only EU Member State to regularly collect this information. Similarly, data on traumatised applicants are sketchy and information on suicide attempts incomplete.
- Findings point to limited formal screening procedures to identify asylum seekers who are victims of torture or experienced severe trauma. Identification heavily relies on the expertise and knowledge of individual staff. Tools are increasingly being developed to facilitate identification by non-experts.
- In most EU Member States, there is no evidence that would suggest recurrent violence or excessive use of force by state officials or entities working on their behalf. Information collected by FRA mostly focuses on individual and localised incidents. At the same time, serious incidents are more frequently reported along the external borders of the Schengen area.
- Training, monitoring bodies and complaint mechanisms exist in all EU Member States, but their effectiveness in preventing ill-treatment varies from one Member State to another.
- A recurrent issue restraining victims' access to support services is the limited number of specialised medical staff who can provide psychological or psychiatric support. The lack of staff often leads to long waiting periods. Starting therapy when asylum applicants are homeless or the conditions in a reception facility are not adequate to sustain the therapy poses another challenge.
- Limited information on the link between trauma and drug use has emerged. Drug use among asylum applicants particularly affects adolescents and young men, and has so far been given little attention.

Under primary EU law, according to Article 4 of the Charter of Fundamental Rights of the European Union ('EU Charter'), "no one shall be subjected to torture or to inhuman or degrading treatment or punishment". In light of Article 52 (3) of the EU Charter, its meaning and scope correspond to Article 3 of the ECHR.

If left untreated, the trauma caused by torture rarely diminishes over time. Such trauma may cause panic attacks, mistrust, flashbacks, chronic depression and paranoia, which can make it extremely difficult for a person to function in society, as a recent study by The International Rehabilitation Council for Torture Victims covering eight EU Member States highlights. The trauma may also have a knock-on effect on other family members, affecting children's education and ability to integrate into society.⁵

Data on victims of torture

It is difficult to produce accurately official data on the extent and nature of people's experiences of torture, given that victims find it hard to report to the authorities and the opportunities for reporting are inadequate. Data from non-governmental organisations (NGOs) can complement official data – where this exists – but it is also highly reliant on the ability and opportunities for victims to report. Some of the reasons victims do not report can include the following:

- victims are unable to disclose ill-treatment, immediately upon arrival or shortly after, as they are often not provided with the psychological support that they may be in need of;
- screenings can take place at a time and in an environment that does not encourage disclosure of abuse, for example, due to lack of confidentiality in crowded facilities;
- screenings are often carried out by state agents, including members of the border guard or police force. As torture can be perpetrated by law enforcement officials, this does not encourage trust in these authority figures, and victims are unlikely to disclose abuse.

In addition, rape and other forms of sexual assault, which may constitute torture or inhuman and degrading treatment, may not be disclosed by those who have experienced this. In some Member States, it may be overlooked in screening procedures or, when recognised, categorised as 'violence against women' and not considered as torture/inhuman and degrading treatment.

Given the above challenges when trying to identify accurate reporting of incidents of torture, posttraumatic stress disorder (PTSD) and related abuse, the following figures – as reported to the EU Agency for Fundamental Rights – have to be interpreted cautiously. It is likely that the data referred to in this focus is under-counting the true extent of these human rights abuses. NGOs, such as International Rehabilitation Council for Torture Victims, confirmed these difficulties.

According to data sourced from the Greek Asylum Service, in 2016, out of 51,091 asylum applications, 577 applicants were registered as victims of torture, rape or other sexual violence or abuse; these included 387 men and 190 women. Some 250 victims (43.32 %) were Syrians, 94 (16.29 %) were Iraqis and 48 (8.31 %) were Afghans.⁶

- **Aside from Greece, none of the other 13 Member States covered in this report collect official data on the number of victims of torture among asylum applicants.**

In Slovakia, although statistics on victims among asylum seekers are not available,⁷ the Border and Alien Police collects some figures from the border and from immigration detention facilities. However, no victim of torture was reported in 2016.⁸

In Bulgaria, Denmark and Sweden, non-governmental organisations (NGOs) provided unofficial estimates on victims of torture identified among asylum applicants in 2016. In Bulgaria, three victims were tortured in their countries of origin and two or three persons were subjected to sexual violence and exploitation by smugglers. In addition, about 10-15 cases of domestic violence were identified, some of which led to suicide

attempts.⁹ In Denmark, public authorities referred eight asylum applicants to specific torture screenings in 2016.¹⁰ Of the 1,500 asylum seekers examined during 2016 by the Crisis and Trauma Unit in the Region of Västra Götaland in Sweden, about half indicated that their human rights were violated in ways that could amount to torture, degrading or inhuman treatment.¹¹

According to a Swedish Red Cross study from 2016,¹² the prevalence of torture among samples of forced migrants varied from 1 % to 76 % and was heavily dependent on the background of the group sampled, the context in the country of origin and the instrument used to detect torture in the country of asylum.

Exploring the identification and rehabilitation of torture victims

In August 2016, FRA's monthly migration report focused on [migrants with disabilities](#). The report includes a section on victims of torture. It explores the situation concerning the identification and rehabilitation of torture victims in seven EU Member States.

Data on traumatised persons

As with victims of torture, the EU Member States covered do not collect statistics on how many asylum seekers or migrants are severely traumatised or suffer from posttraumatic stress disorder (PTSD). Existing data mainly originate from civil society organisations and their collection is not systematic.

Where data exist, they may be linked to specific projects or research. In Slovakia, for example, within the framework of a specific project – the STEP 3 project – NGOs identified six persons with psychiatric disorders and one with PTSD between 1 December 2016 and 30 January 2017.¹³ In Germany, research carried out by the Technische Universität München in 2015 concluded that more than one third of Syrian refugee children in a Bavarian reception centre suffered from psychological disorders.¹⁴ In Sweden, one in three newly resettled Syrian refugees displays clear

symptoms of depression and anxiety; 30 % of them show symptoms corresponding to PTSD.¹⁵

Other data cover only a specific timeframe. In eastern Germany, between March 2014 and October 2015, PTSD was diagnosed in 35.42 % of the persons supported by the specialised centres in four federal states and depression was diagnosed in 27.08 % of cases.¹⁶ In Bulgaria, between April and September 2016, the Nadja Centre provided consultations to 250-300 persons, out of whom 20-30 were diagnosed with PTSD.¹⁷ The Austrian Network for Intercultural Psychotherapy and Extreme Traumatization (*Netzwerk für Psychotherapie und Extremtraumatisierung*, NIPE) reports that its 10 member organisations treated 2,550 asylum seekers between July 2015 and July 2016.

Some collected information covers only a specific region. In Italy, for example, between October 2014 and December 2015, the NGO 'Doctors without Borders Italy' carried out interviews in special reception centres (*Centri di Accoglienza Straordinaria*, CAS) in the area of Ragusa (Sicily), as well as in Rome, Milan and Trapani (Sicily). According to their report, out of the 387 interviewees, 189 persons (48.8 %) were victims of traumatic experiences before their journey to Italy and 319 (82.4 %) during the journey. Of the 387 patients interviewed, 27 % showed symptoms corresponding to anxiety and PTSD, and 19 % showed symptoms of depression. The most frequent traumatic experiences before the journey included witnessing the kidnapping or detention of a family member (28 %), conflicts between families (31 %) and fear for their own lives (7 %). The most frequent traumatic experiences registered during the journey included: detention (35 %), armed conflict (12 %), forced labour and exploitation (5 %), torture (9 %), sexual violence (4 %), and a constant feeling of their own lives being at risk (10 %).¹⁸

Recording suicide attempts

FRA was able to collect some official data on suicides and other forms of self-harm among asylum seekers in Denmark, Finland, Hungary, the Netherlands and Poland. As illustrated in

Table 1, data differ significantly in terms of what is recorded.

- Of the 120 suicide attempts and incidents of suicidal behaviour among asylum seekers recorded in Denmark in 2016, 29 involved children.¹⁹

Table 1: Official statistics on suicide attempts and other forms of self-harm among asylum seekers in five EU Member States

	Time period	Suicides	Suicide attempts	Self-harm	Verbal suicide threats
Denmark	Jan-Dec 2016	3	120*	n.a.	n.a.
Finland	Oct 2015-Sept 2016	5	15-20	n.a.	n.a.
Hungary	Jan-Dec 2016	0	11	75	n.a.
The Netherlands	Jan-June 2016	n.a.	n.a.	648	484
Poland**	Jan-Dec 2016	n.a.	2	6	n.a.

Notes: *Figure on suicide attempts in Denmark covers both suicide attempts and suicidal behaviour.

**Figures on Poland cover both asylum seekers and migrants.

n.a. = not available

Source: FRA, 2017

Suicides and suicide attempts among asylum seekers or refugees in 2016 were also registered by unofficial sources in Bulgaria,²⁰ Germany,²¹ Greece,²² Slovakia²³ and Sweden. In Sweden, these include unaccompanied children.²⁴

Organisations in Greece²⁵ and Italy²⁶ identify the long waiting time for the outcome of the asylum procedure or the rejection of an application and the consequent deportation as reasons for suicide attempts. Trauma can also be worsened due to poor reception conditions, frequent transfers of asylum seekers from one reception facility to another, or due to the geographical isolation of reception centres (for example, in Italy²⁷ and Bulgaria²⁸). Authorities in Bulgaria²⁹ and Hungary³⁰ noted that some suicide attempts may be aimed at attracting attention.

Identification

The Reception Conditions Directive (2013/33/EU) obliges EU Member States to take into account the specific situation of vulnerable persons. One category of vulnerable persons listed in Article 21 of the directive consists of victims of "torture, rape or other serious forms of psychological, physical or sexual violence". Article 22 of the directive requires EU Member States to assess whether vulnerable persons have special reception needs. Such needs must be addressed, including if they emerge at a later stage. The situation of persons with special reception needs must be monitored appropriately.

The Asylum Procedures Directive (2013/32/EU) contains a similar duty. Its Article 24 obliges EU Member States

to assess, within a reasonable time after the submission of an asylum application, whether applicants are in need of special procedural guarantees. If so, adequate support must be provided to the applicant.

Findings point to limited formal screening procedures to identify asylum seekers who are victims of torture or experienced severe trauma. Victims of torture and traumatised applicants are mostly identified during health screenings and/or during the registration or eligibility interview. The effectiveness of screening mechanisms rests on the obligation to systematically apply them, which is a major concern as most efforts of identification appear to be ad-hoc or depending on some form of self-identification (for example in Greece³¹ and Hungary³²). Other stakeholders contacted for this report underlined that identification is primarily based on obvious signs of physical abuse and psychological distress (Austria,³³ Greece³⁴).

- **Existing medical checks for applicants for international protection are not adequate for ensuring the systematic identification of victims of torture or traumatised people.**

In Austria, for example, health checks for new arrivals do not include a psychological screening.³⁵ In France, only unaccompanied children are systematically screened.³⁶ In Finland, not all asylum seekers undergo basic medical checks.³⁷ Where an asylum applicant reports severe human rights violations and comes from a country where torture is documented, there is not necessarily a follow up.³⁸ In Greece, not all new arrivals to hotspots undergo psychosocial assessments and medical screening, despite the legal provisions in place.³⁹

The Danish NGO Dignity is implementing a new measure for the early identification of torture victims, which targets newly arrived and possibly traumatised asylum seekers and refugees, in four municipalities. The Red Cross and the social services in these municipalities refer such persons for a clinical assessment. Following this, their state of health is stabilised through work in small groups and

through individual sessions, if necessary. Where appropriate, asylum seekers and refugees receive individual treatment specifically targeting PTSD symptoms.⁴⁰

Training

In the absence of official screening, identifying persons who experienced torture or are traumatised relies heavily on the expertise and knowledge of individual staff.

Article 4 (3) of the Asylum Procedures Directive and Article 25 (2) of the Reception Conditions Directive require EU Member States to ensure that staff working with or interviewing victims of torture receive adequate training.

In spite of training efforts, staff working with asylum applicants often lack the necessary knowledge, skills and experience to identify victims of torture – as reported by stakeholders interviewed in Denmark,⁴¹ Finland,⁴² Italy,⁴³ and Spain.⁴⁴ The knowledge of individual staff may also vary among different reception centres or units, as reported, for example, in Finland.⁴⁵

- **The Istanbul Protocol: Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment provides useful guidelines for assessments of persons who allege torture and ill-treatment, for investigating cases of alleged torture, and for reporting findings to the judiciary or other investigative bodies.⁴⁶ The manual is a frequently used training tool. For example, in Spain, it forms part of the training for all personnel entitled to use force.⁴⁷**

In contrast, in 2016, the United Nations (UN) Committee against Torture noted its concern about the manual's absence from trainings for police staff, or for civilian and medical personnel who participate in the care and treatment of individuals who are arrested, detained or imprisoned in France.⁴⁸ At the same time, eligibility officers at the French Office for the Protection of Refugees and Stateless Persons (*Office français de*

protection des réfugiés et apatrides, OFPRA), as well as section heads, receive targeted training delivered by mental health specialists.⁴⁹

To facilitate the identification of torture victims, in Poland, the authorities included relevant provisions in the contract with the private entity providing medical care to asylum seekers, obliging their medical personnel to take part in the identification procedure. The Head of the Office for Foreigners also adopted special procedure No. 1/2015, which contains concrete steps for the identification and support of victims of torture by the employees of the Social Assistance Department.⁵⁰

Tools

Some tools to support identification are available. In 2016, the European Asylum Support Office (EASO) developed the 'identification of persons with special needs tool' (IPSN Tool).⁵¹ The tool is currently available in 19 EU languages. During February and March 2017, Sweden will test the integration of the tool in national procedures to facilitate the identification of persons belonging to vulnerable groups. The tool will be used when an application is submitted, but identification efforts may continue throughout the asylum process.⁵² In June 2017, the Danish Red Cross will introduce a new questionnaire to specifically identify victims of torture;⁵³ the validity of the questionnaire will be tested via a cooperative effort between the Danish Red Cross and the NGO Dignity.

Some countries use special questionnaires to identify victims of torture and other abuse, such as the PROTECT questionnaire⁵⁴ (Bulgaria,⁵⁵ Hungary,⁵⁶ Spain,⁵⁷ and, in the frame of a 2014-2015 project, France⁵⁸). This questionnaire was developed as part of a project to identify specific categories of vulnerable persons, such as persons who have been subjected to torture, rape or other forms of severe psychological, physical or sexual violence. It intends to ensure that such people receive the necessary treatment for the damages caused by those acts. The questionnaire consists of 10 questions on

psychological vulnerability and on the most important psychological problems resulting from severe trauma.

In Sweden, the Migration Agency developed an internal 'Manual on migration cases' (*Handbok i migrationsärenden*), which includes sections specially focusing on asylum seekers and torture/PTSD.⁵⁹ For example, the manual points out that agency officials must bear in mind that asylum applicants who have been subjected to torture may give conflicting and/or imprecise answers in eligibility interviews, or may need more time to be able to speak about traumatising experiences. Furthermore, the manual states that officials processing cases involving torture must ensure that the applicant feels safe during the asylum interview.⁶⁰

Violence and excessive use of force in the EU

This section looks at allegations of violence and excessive use of force in the EU. It describes select incidents reported by various sources to illustrate that traumatic experiences may not only occur in the country of origin or in transit, but also once a person has arrived in the EU. This section does not analyse whether the incidents reach the threshold required by Article 3 of the ECHR. The section only covers conduct by authorities and not other violent experiences that may have a traumatising effect, such as racist attacks. It also does not deal with conditions in detention facilities.

In most EU Member States, there is no evidence that would suggest that violence or excessive use of force by state officials or entities working on their behalf regularly occurs. Information collected by FRA mostly focuses on individual and localised incidents. For example, in Germany, the trial of security guards accused of severely mistreating and humiliating asylum applicants in North Rhine-Westphalia starts in February 2017.⁶¹ In France, in early January 2017, Doctors without Borders (*Médecins Sans Frontières*) reported incidents in certain areas of Paris involving the police confiscating the blankets of

migrants sleeping outside, which led to cases of hypothermia.⁶²

Meanwhile, serious incidents are reported more frequently along the external borders of the Schengen area. Allegations of ill-treatment and excessive use of force have emerged, for example, from Hungary, Bulgaria, Greece, Italy and Spain. Although not covered by this data collection, recent reports also concern Croatia.⁶³

As highlighted by FRA in past months, in Hungary, reports of violence, excessive use of force and humiliating practices increased significantly after the adoption of a new law in July 2016. This law allows the police to transfer migrants who entered the country in an irregular manner to the outer side of the border fence with Serbia, if they were apprehended within 8 km from the border.⁶⁴ Reported practices include the use of unleashed dogs, the use of pepper spray, beatings, yelling at people, and, most recently, taking away warm clothing and making people kneel.⁶⁵ Civil society representatives noted that in most cases the authorities deny the occurrence of such incidents and are unwilling to investigate them.⁶⁶

Several incidents are also reported from Bulgaria and Greece. In Bulgaria, in October 2015, an Afghan asylum seeker was shot dead by Bulgarian police after crossing the Bulgarian-Turkish border.⁶⁷ Last year, the media also reported on several vigilante groups detaining and abusing asylum seekers and migrants close to the Bulgarian-Turkish border. This includes the group 'Vasil Levski', a union of former police and military force trainees.⁶⁸ Some of the perpetrators are now under investigation.⁶⁹

In June 2016, 12 unaccompanied children of Pakistani nationality were reportedly abused by police officers in Lesvos. Some of them had nosebleeds, abrasions on the wrists due to handcuffing, and other wounds on various parts of their bodies.⁷⁰ On 24 November 2016, the police station on the island of Samos was accused of holding a 25-year-old refugee from Iraq under inhumane conditions at the police station for nineteen days.⁷¹ In

September 2016, Amnesty International reported that five Syrian refugee children were allegedly ill-treated by Greek police for carrying plastic toy guns.⁷²

Excessive use of force and violence by the police and state security bodies has also been reported in Spain, particularly concerning people who climb the fences in Ceuta and Melilla.⁷³ On 21 October 2016, *SOS Racismo* together with the Coordinator for the Prevention of Torture (*Coordinadora para la Prevención de la Tortura*) asked for an investigation of various claims of maltreatment of immigrants by the police in the Aliens Detention centre (CIE) in Aluche.⁷⁴ *Convivir Sin Racismo* also denounced physical and verbal maltreatment in the Aliens Detention Centre in Sangonera, including frequent beatings in places not covered by security cameras.⁷⁵ Official complaints in these cases are few in number and have not been investigated sufficiently.⁷⁶

Excessive use of force to take fingerprints was brought to FRA's attention from hotspots in Italy in the course of 2015 and early 2016.⁷⁷ More recently, Amnesty International reported similar concerns, mainly in locations outside the hotspots.⁷⁸

Finally, the UN Committee against Torture made a number of critical observations at the time of the seventh periodic report on France, stating that it was "worried by the allegations of violence against applicants for asylum and migrants, as well as their situation in Calais and that region."⁷⁹ A recently published report by the NGO ANAFÉ contains allegations of ill-treatment at airport holding centres.⁸⁰

Preventive measures

Under Article 2 (1) of the UN Convention against Torture, which is binding for all EU Member States, each State Party must "take effective legislative, administrative, judicial or other measures to prevent acts of torture in any territory under its jurisdiction". Similarly, Articles 1 and 3 of the ECHR place a number of positive obligations on European states, designed to prevent torture and other forms of ill-treatment. In cases involving degrading

or inhuman treatment by private individuals rather than a state official, the ECtHR highlighted the responsibility imposed on states to put in place preventive measures that protect individuals under their jurisdiction from torture and inhuman or degrading treatment or punishment, whatever the source of that ill-treatment might be.⁸¹ These measures should provide effective protection, in particular for children and other vulnerable persons, and include reasonable steps to prevent ill-treatment of which the authorities had or ought to have had knowledge.⁸²

Legislation in all EU Member States contains safeguards to ensure that force is only used when necessary and proportionate. These safeguards are also applicable in the context of border management or initial registration and reception of asylum seekers. In the Netherlands, for example, according to the Ministry of Security and Justice, the use of force by state actors must always be limited to a minimum. It must always be proportionate and justifiable, in line with the 'violence instruction' (*geweldsinstructie*)⁸³ of the services. However, legislation alone – even if accompanied by concrete guidance – is not sufficient to prevent abuse. As described above under 'identification', staff need to be adequately trained to enable them to handle difficult situations. Moreover, effective monitoring and complaint mechanisms must be in place.

Monitoring bodies

Monitoring mechanisms help ensure that Member States comply with their obligations to prevent torture, abuse or any other form of excessive violence. All signatory States to the United Nations Convention against Torture must submit regular reports to the UN Committee against Torture, which issues Concluding Observations.⁸⁴ They cover positive aspects, remarks and recommendations for each State to ensure the fulfilment of its obligations, including prevention. In addition, specially created monitoring bodies undertake field visits: at the European level, the Committee for the Prevention of Torture of the Council of Europe (CPT), as set up by the European Convention

for the Prevention of Torture,⁸⁵ organises periodic visits to places where people are deprived of their liberty or freedom and issues reports containing recommendations. Places visited include, among others, immigration detention centres, psychiatric hospitals or social care facilities.

Table 2 provides an overview of the work of these two Committees in the EU Member States covered by this report during the past year. Between 1 January 2016 and 31 January 2017, the CPT visited four EU Member States and the UN Committee reviewed reports by three EU Member States.

Issues raised by these monitoring bodies include, for instance, the use of force, safeguards against ill-treatment and the conditions of detention. For example, in its report to the Government of the Netherlands, the CPT remarked on the conditions of the penitentiary psychiatric centres, where immigration detainees may also be kept, and invited the government to increase the role of the Ministry of Health.⁸⁶ Similarly, the CPT observed the treatment of foreign nationals during a joint removal operation between Spain and Germany, as coordinated by Frontex, in which individuals were transferred from Spain to Colombia. It noted that it did not observe any instances of ill-treatment of the returnees but recommended that returnees are informed several days in advance of their impending return flight.⁸⁷

Such supra-national bodies are complemented by National Preventive Mechanisms set up under the Optional Protocol to the UN Convention against Torture (OPCAT).⁸⁸ The Protocol requires each signatory State to "maintain, designate or establish, one or several independent national preventive mechanisms for the prevention of torture at the domestic level".⁸⁹

- **As shown in Table 3, all EU Member States covered in this report, except for Slovakia, have National Preventive Mechanisms that were set up under Optional Protocol to the UN Convention against Torture (OPCAT).**

Table 2: CPT Visits and Concluding Observations of the UN Committee against Torture between 1 January 2016 and 31 January 2017, 14 EU Member States

	Country visits by the Committee for the Prevention of Torture	Concluding Observations by the UN Committee against Torture
Austria	NO	NO
Bulgaria	NO	NO
Denmark	NO	CAT/C/DNK/CO/6-7
Finland	NO	CAT/C/FIN/CO/7
France	NO	CAT/C/FRA/CO/7
Germany	NO	NO
Greece	13 – 18 April 2016 ; 19 – 25 July 2016	NO
Hungary	NO	NO
Italy	8 – 21 April 2016	NO
The Netherlands	2 – 13 May 2016	NO
Poland	NO	NO
Slovakia	NO	NO
Spain	17 – 19 February 2016 ; 27 September – 10 October 2016	NO
Sweden	NO	NO

Source: FRA, 2017

In Italy, the Authority for the Protection of People who are Detained or Deprived of their Personal Freedom (*Garante nazionale per i diritti delle persone detenute o private della libertà personale*) carries out such monitoring tasks. In January 2016, it examined all the Italian hotspots and identification and expulsion centres (*Centri di Identificazione ed Espulsione* – CIEs) to assess the adequacy of reception conditions and the respect of migrants’ fundamental rights. The ensuing report did not outline episodes of extreme abuse or violence.⁹⁰

National preventive mechanisms may be complemented by other monitoring bodies. In Finland, the Parliamentary Ombudsman (*Eduskunnan oikeusasiamies/Riksdagens justitieombudsman*) carried out six inspection visits at reception centres in 2016. Reception centres for unaccompanied children were also inspected.⁹¹ His work is complemented by the Non-Discrimination Ombudsman (*Yhdenvertaisuusvaltuutettu / Diskrimineringsombudsmannen*) and by internal monitoring mechanisms within the Finnish Immigration Service (*Maahanmuuttovirasto/Migrationsverket*).

Table 3: National Preventive Mechanisms set up under Article 17 of OPCAT, 14 EU Member States

Member State	National Preventive Mechanism
Austria	Austrian Ombudsman Board (<i>Volksanwaltschaft</i>)
Bulgaria	The Ombudsman of the Republic of Bulgaria (ORB)
Denmark	Danish Parliamentary Ombudsman (<i>Folketingets Ombudsmand</i>)
Finland	Parliamentary Ombudsman
France	Contrôle général des lieux de privation de liberté
Germany	National Agency for the Prevention of Torture
Greece	Greek Ombudsman
Hungary	Commissioner for Fundamental Rights
Italy	National Guarantor for the Rights of Persons Detained and Deprived of their Liberty
The Netherlands	Inspectorate for Security and Justice (Coordinating institution of six different entities)
Poland	Commissioner for Human Rights
Slovakia	OPCAT not signed
Spain	Ombudsman (<i>Defensor del Pueblo</i>)
Sweden	Chancellor of Justice Parliamentary Ombudsmen (<i>Riksdagens ombudsmän</i>)

Source: FRA, 2017

These preventative measures are not always considered to be effective. For example, according to the NGO Rights International Spain, an independent oversight mechanism with powers to supervise police actions is lacking in Spain.⁹² Similarly, the Dutch section of Amnesty International notes that the office of the Inspectorate of Security and Justice is not sufficiently independent or transparent.⁹³ Concerning Finland, in January 2017, the UN Committee against Torture noted that “while the Parliamentary Ombudsman has been entrusted with the task of serving as the national preventive mechanism, insufficient financial or human resources have been allocated to the Ombudsman and [...] the mechanism may not have the human resources necessary to carry out its mandate”.⁹⁴

Complaint mechanisms

Criminal law avenues are not easily accessible to victims who do not speak the host country language and who may not have easy access to legal support. For example, civil society representatives in France noted that the normal legal avenues are in practice not very effective: complaints are often dismissed with no further action.⁹⁵ This situation can be mitigated by setting up effective complaint mechanisms and complaints boxes in reception facilities.

Complaint mechanisms can be internal to the police or the immigration service (for example, in Denmark or Hungary).⁹⁶ Such internal mechanisms, though important, should also be complemented by the possibility to complain to independent bodies.

In Finland,⁹⁷ Denmark,⁹⁸ and Spain,⁹⁹ for example, the Parliamentary Ombudsmen can be approached.

Follow up to incidents

Ensuring follow up to individual incidents with effective investigation is important to convey a zero-tolerance approach to ill-treatment. However, this does not appear to happen regularly. In Hungary, for example, the NGO MigSzol notes that reported instances of violence do not lead to investigations or, if they do, the investigations generally conclude that officials committed no violence.¹⁰⁰

As the following example shows, incidents can also be effectively followed up with new policy measures.

Responding to excessive violence in Germany

In Germany, security men were accused of severely mistreating asylum applicants in North Rhine-Westphalia. Following the incident, the Ministry of the Interior together with non-governmental organisations took the following measures:

- A supra-regional coordination centre (*überregionale Koordinationsstelle*) was established to follow up and address specific allegations and to detect structural deficiencies;
- a roundtable hosted by the Ministry of the Interior was made responsible for monitoring and addressing structural deficiencies;
- mobile control groups were set up to check refugee accommodation facilities on a regular basis, and standards for security companies guarding reception facilities were improved.

Sources: DW, [German police raid security firm accused of abusing asylum seekers](#); German Institute for Human Rights, [‘Entwicklung der Menschenrechtssituation in Deutschland Januar 2015 – Juni 2016’](#), p. 72; Germany, [Response of the North Rhine-Westphalian government](#)

Support to victims of torture and traumatised persons

The Victims’ Rights Directive (2012/29/EU)¹⁰¹ provides for a comprehensive set of rights for victims of crime, which aim to guarantee that they receive appropriate information, protection and support.¹⁰² Article 9 (1) of the directive requires Member States to provide victim support services. These include, among others, “information, advice, and support relevant to the rights of victims” and “emotional and, where available, psychological support”.

Article 25 (1) of the Reception Conditions Directive (2013/32/EU)¹⁰³ obliges Member States to “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”.

General Comment No. 3 of the Committee against Torture stipulates that victims of torture have a right to full rehabilitation, which includes medical and psychological care as well as legal and social services. To fulfil this obligation, each State Party should adopt a long-term and integrated approach and ensure that specialised services for victims of torture or ill-treatment are available, appropriate and promptly accessible.¹⁰⁴

Victims of torture and traumatised persons require different forms of support. Depending on the case, this can include, among others, special accommodation arrangements, psychosocial counselling, specialised healthcare, legal support and information, and interpretation to be able to effectively access existing services.

Facilities

Accommodation needs may be covered either by placing the asylum applicant in a specialised care facility or by making other arrangements within existing reception centres. For example, specialised care facilities can be provided by the state in Austria¹⁰⁵ or Germany.¹⁰⁶

- **Specialised care facilities for victims of torture or severely traumatised asylum applicants are limited. Even where these exist, the facilities often do not adequately cover the needs of victims of torture and traumatised persons.**

As an illustration, the German Federal Association of Psychosocial Centres for Refugees and Victims of Torture (*Arbeitsgemeinschaft Psychosozialer Zentren für Flüchtlinge und Folteropfer*, BAFF) reports that places in facilities for particularly vulnerable persons, including those specially designed for traumatised refugees, are far below current needs. There are numerous inquiries from staff in hospitals, psychiatric institutes and counselling centres who want to accommodate their clients and patients in these facilities but do not succeed.¹⁰⁷ In Greece, UNHCR highlighted the lack of emergency accommodation for extremely vulnerable people, such as shipwreck survivors and survivors of sexual gender-based violence.¹⁰⁸

Specialised psychological and medical care

The majority of EU Member States provides for some kind of psychological care for victims of torture or otherwise traumatised persons. This is often done in cooperation with NGOs – in Hungary, for example, through the Cordelia Foundation.¹⁰⁹

Cooperating to support victims of torture and trauma in Hungary

In Hungary, the Cordelia Foundation cooperates with the national authorities by providing support to victims of torture and trauma. On a regular basis – in most cases daily – the Foundation’s staff members visit the reception and detention centres and assist torture victims, severely traumatised asylum seekers and refugees. Cordelia installed complaint boxes in the open refugee camps and the asylum detention centres so that refugees and asylum seekers can submit their complaints in writing. The Foundation always reports incidents of violence or abuse to the heads of reception centres, and since the authorities have very good relations with

the Foundation, they are open to listening to the Foundation’s recommendations in terms of preventive measures and policy changes. According to the Immigration and Asylum Office, all indications from Cordelia staff members of potential incidents of abuse or violence are investigated.

Sources: Hungary, Cordelia Foundation; Immigration and Asylum Office

Deficiencies are reported in several Member States regarding the access, availability and quality of psychological care. If specialised care is unavailable, victims of torture or traumatised persons are directed to the psychological care available to all asylum seekers in reception centres. However, numerous centres are under-resourced and cannot meet the demands for rehabilitation.

- **The limited number of specialised medical staff who can provide psychological or psychiatric support is a recurrent issue.**

For example, in Spain, there is usually one psychologist in every reception centre for asylum seekers. In some Spanish reception centres, the number of asylum seekers can be as high as 120.¹¹⁰ The number of persons in need of psychotherapy is estimated to be much higher than what can actually be provided, especially in bigger cities. For example, in Austria, one organisation in Vienna currently has 400 persons in need of assistance on its waiting list.¹¹¹ The shortage of psychologists due to lack of funding was also mentioned in Bulgaria.¹¹² In Greece, the availability of psychological and psychiatric care is limited, especially in remote areas and on the islands: asylum seekers and immigrants in need of psychiatric care are referred to the local hospitals, where capacity is limited. In Samos, for example, there is only one psychiatrist for the whole island.

- **Starting longer-term therapy for people who are homeless or when conditions in the reception facility are not adequate to sustain such therapy poses another challenge.**

In the Netherlands, one of the main problems in providing psychological care is the frequent

relocation of asylum seekers between the different centres.¹¹³ *Médecins du Monde*, which provides psychosocial and health care services in the Moria hotspots in Lesbos, Greece underlined that the facility is not adequate for vulnerable people who need therapeutic care as it cannot be successfully provided as long as patients stay there.¹¹⁴ As reported by Human Rights Watch, a psychologist from the medical organisation WAHA underlined that the “basic rule in psychology is that the patient must change the environment around him and oblige himself to change his way of thinking. Here it is very difficult. I can’t make refugees accept the life under sun, rain, hot, cold...”¹¹⁵ MSF made similar conclusions.¹¹⁶ Some centres for torture victims – for example, in Sweden¹¹⁷ – do not treat asylum seekers because long-term treatment should be provided only to persons with permanent residence.

The lack of sufficient resources can lead to long waiting periods. As an illustration, in Austria, the waiting time for therapy is between two and six months.¹¹⁸ In Germany, access to the national healthcare system is limited for the first 15 months, except for treatment for acute illness and pain.¹¹⁹ Therefore, victims of torture rely on the 34 external psychological centres that deal with this demand.

- **The German Federal Association of Psychosocial Centres for Refugees and Victims of Torture indicated that about 5,600 asylum seekers had to wait for more than a year to receive treatment or get an appointment with a specialist.**¹²⁰

Issues of access can also vary within a country from region to region. In Finland, Amnesty International underlined that services for torture victims should be available in all parts of the country, so as to make treatment and rehabilitation services accessible to all victims.¹²¹ In France, the association *Parcours d’exil* stresses that the supply of care is inadequate compared to the demand, with a significant lack of resources and poor distribution of care organisations across the country. For example, services are

available in Paris and Lyon, but not in the Calais area or in other regions.¹²²

Information and interpretation

The manner in which victims of torture or traumatised persons are informed about their options also varies. In some Member States, such as Austria, asylum seekers are informed about available support and services at the initial stages of their application,¹²³ whereas in others – for example, Hungary¹²⁴ – this mainly occurs through leaflets, with lists of services available at the reception centres. In some Member States, it is mainly NGOs which inform the victims of torture of their support options, as is the case, for example, in Slovakia.¹²⁵

Language barriers can often prevent victims from receiving necessary care. Information regarding access to care is in principle given to victims in a language which they understand or through interpreters – for example, in Slovakia, Austria, and Hungary.¹²⁶ The quality of the information may depend on the availability of qualified interpreters. For example, in Sweden, due to the long distances and the lack of availability of interpreters for all languages, interpretations are likely to be carried out over the phone.¹²⁷ In Bulgaria, the Nadia Centre reported that a number of newly appointed interpreters and social mediators lack the necessary knowledge and skills to deal with such delicate situations and may actually hamper the proper provision of psychological care.¹²⁸

Coping with trauma and torture – drug dependence

FRA also explored to what extent victims of torture or severely traumatised persons display signs of drug dependence. Limited information on the link between trauma and drug use emerged. Drug problems among asylum applicants and migrants have been given little attention so far. However, it affects a number of young people, including children, and creates safety risks for others in reception facilities.

Data availability and extent of problem

- **There are no official or unofficial data on the number of victims of torture or severely traumatised persons with signs of drug dependence in any of the 14 Member States covered by FRA's research.**

In France, some partial information exists for specific care centres or regions, but is only available to doctors.¹²⁹

Statistics on drug use based on nationality are available in Poland.¹³⁰ In Slovakia, the Border and Alien Police has data on foreigners in detention centres and drug use; numbers remain low (five persons with drug addictions in 2014, 26 in 2015 and 13 in 2016). The trend is different in other EU Member States. In Denmark, the Men's Home (*Mændenes Hjem*) – an organisation that provides drop-in-centres and shelters for homeless people and people who use drugs in Copenhagen – observed an increase in the number of foreigners and asylum seekers among drug users. A rough estimate – without data being systematically collected – suggests that the numbers doubled in 2016 in comparison with previous periods; however, the estimated numbers are relatively low.¹³¹ Similarly, in Germany, the Federal Criminal Police Office (*Bundeskriminalamt*) reports that the number of drug consumption instances (including cannabis) with involvement of immigrants increased from approximately 5,000 cases in 2014 to some 8,000 cases in 2015. However, it is not known how many of these offences related to asylum applicants or refugees.¹³²

In 2016, three cases of illicit drug dependence were identified in Bulgaria¹³³ and a number of cases were identified in Hungary, which variously relate to asylum applicants/migrants.¹³⁴ If the drug at issue is listed as an illegal substance under Hungarian law, the affected person is reported to the police.¹³⁵

Causes of substance dependence and use

In all of the above cases, it cannot be determined whether, or to what extent, the reported dependencies or use were linked to previous trauma or torture.

The development of mental health conditions and drug use is not only related to traumatic experiences asylum seekers had in their country of origin, but also depends on their situation after arrival.¹³⁶ The Ministry of Health in Germany refers to reports noting that drug dependence is often developed after some time in the country. Use of addictive substances, aggression and suicidal tendencies are typical symptoms of the attempt to cope with a feeling of hopelessness.¹³⁷ Civil society organisations in Austria and in the Netherlands note that the uncertainty concerning the outcome of the asylum procedure and/or family reunification, the waiting times, and concerns about family members left behind cause further stress.¹³⁸ Professionals in the Netherlands further suggest that factors within the general population of asylum seekers, such as group pressure, poverty and isolation, also influence drug use by asylum seekers. Trauma can be an aspect that influences drug use, but this differs from person to person, and in some cases those with trauma-related issues can be more resistant to the 'temptations' of drug use.¹³⁹

A number of foreigners in Bulgaria already suffered from dependencies upon arrival. Young Afghans already used hashish in their own country and drug dealers have been noticed around reception centres since 2013, aiming to exploit their drug problem, often offering low quality drugs.¹⁴⁰

Demographics

Among asylum seekers, drug dependence predominantly affects young men under 30 years of age, and to a lesser extent women.¹⁴¹ In Greece, it also affects unaccompanied boys.¹⁴²

There are no aggregated national data that would allow identifying clearly the country of origin of asylum applicants or migrants in an irregular situation who are using drugs. However, social or medical staff have observed certain trends: Afghan men under 20 years of age have been the most common group with drug dependence problems in Bulgaria.¹⁴³ In France, doctors working in care centres specialised in the treatment of

migrants and refugees noted that young adults from North Africa, in particular Egypt, or from Eastern Europe have drug-related problems.¹⁴⁴ In the Netherlands, individuals of Eritrean origin were observed to be especially prone to alcohol use.¹⁴⁵

Health checks

For its data collection, FRA asked whether initial or subsequent health checks include specific screening for drug dependence. In the overwhelming majority of Member States, this is not the case.¹⁴⁶ However, drug dependence is one of the issues asked about at the initial health check in Finland¹⁴⁷ and in subsequent health interviews in Sweden, where the initial medical screenings focus only on detecting diseases.¹⁴⁸ The new screening procedure in reception facilities to be initiated in Denmark by the Danish Red Cross in June 2017 will also include questions on drug use.¹⁴⁹

As illustrated by responses received from Bulgaria and Slovakia, where no specific screening occurs, the testing of drug use may be performed if a person is suspected of taking drugs or if a person him-/herself confirms drug use.¹⁵⁰ If drug dependence is detected, the migration office in Slovakia is required to ensure that the psychiatric 'ambulance' or psychiatric hospital provides appropriate medical treatment.¹⁵¹ Drug dependence may also be detected when, during health checks, doctors ask applicants what regular medicine they take, as was noted with respect to Hungary.¹⁵²

Types of substances

In Austria, alcohol is the predominant substance that is misused.¹⁵³ Alcohol is also often used in Germany.¹⁵⁴ Concerning illicit drugs, although no reliable information emerged, stakeholders point to cannabis consumption (not necessarily dependence),¹⁵⁵ and psychotropic drugs such as heroin.¹⁵⁶ In Denmark, cocaine was also mentioned.¹⁵⁷

Selected measures taken

In a number of EU Member States, drug users are being informed about the dangers of drug dependence – as, for example, in Greece¹⁵⁸ –

and staff receive training (for example, in France¹⁵⁹). Particular attention is often given to adolescents. For example, unaccompanied children in Sweden receive training regarding alcohol, narcotics, drugs and tobacco.¹⁶⁰ The NGO Condrops in Bavaria (Germany) provides assistance and counselling to unaccompanied children and adolescent refugees.¹⁶¹ The drug emergency service in Berlin (*Drogennotdienst*) offers information and counselling to refugees in various languages.¹⁶²

Drug dependence and the general use of licit and illicit substances affects everyday life in accommodation facilities and often fosters conflict – as was noted, for example, in Germany.¹⁶³ Where possible, affected persons are oriented to care centres¹⁶⁴ or special asylum accommodation in cases where drug use results in behavioural changes.¹⁶⁵ Drug dependence issues in the Netherlands are addressed on an individual level within the regular addiction care framework, which includes specialised rehabilitation clinics, ambulant care, and general practitioner care.¹⁶⁶

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October 1991; *Soering v. the United Kingdom*, No. 14038/88, 7 July 1989.

3 ECtHR, "The Greek case", *Denmark v. Greece*, Communication 3321/67; *Ireland v. United
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BAfF assumes, that the proportion of torture affected persons is significantly higher than 44 %.
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Further information:

After one year of regular reporting, the EU Agency for Fundamental Rights changed the format and Member State coverage of its regular overviews of migration-related fundamental rights concerns. Current reports cover up to 14 EU Member States and are shorter, including main findings for the Member States covered together with a thematic focus section. References to EU Member States are included when specific findings support a better understanding of the challenges which affect several Member States or the EU as a whole.

For the February 2017 Monthly data collection on the migration situation in the EU – Highlights, see: <http://fra.europa.eu/en/theme/asylum-migration-borders/overviews/february-2017>.

For all previous monthly and weekly reports in 2015 and 2016, see: <http://fra.europa.eu/en/theme/asylum-migration-borders/overviews>

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