

THE RIGHT TO REHABILITATION FOR CHILDREN

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**THE RIGHT TO REHABILITATION FOR
CHILDREN:**

**What are the challenges and impacts of implementing
the right to rehabilitation for child survivors of
torture using writing therapies in the UK?**

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Abstract

This research looks into the implementation of and barriers to securing the right to rehabilitation for child survivors of torture in the UK, through drawing together legal and psychosocial literature and by examining these in a case study on the impact of writing therapy at the Baobab Centre. The Baobab Centre is a non-residential community centre which offers a range of therapies and advocacy services to young people who have been subject to organised violence and torture. One of the rehabilitation sessions offered to young people is bibliotherapy, a pilot project using literature and expressive writing to help begin the process of understanding the traumas they have suffered.

New definitions and standards in the legal framework have been put forward by the UN Committee on the Convention Against Torture in the form of a draft General Comment on Article 14 on the right to rehabilitation and reparations for torture survivors. This study looks at the challenges and opportunities this General Comment could create for child survivors of torture in International Human Rights Law, UK domestic law and finds that it reflects trauma treatment ethics. It is seen how some of the legal barriers to attaining the right to rehabilitation are reflected in and perpetuated by health, immigration and social services in the UK. The cumulative impact of these barriers on the right to rehabilitation is assessed alongside the positive impacts of bibliotherapy, which shows how human rights principles can be implemented at the service delivery level through a creative therapy. This study contributes to the legal understanding of rehabilitation, and fills a research gap by looking at the impact of bibliotherapy on child survivors of torture.

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Declaration form

The work I have submitted is my own effort. I certify that all the material in the Dissertation which is not my own work, has been identified and acknowledged. No materials are included for which a degree has been previously conferred upon me.

Laila Sumpton

DATE: 03/09/2012

Introduction

This human rights research looks at the challenges and impacts of implementing the Right to Rehabilitation (RTR) for child survivors of torture in the UK and draws together the legal and psychosocial literature on the right to rehabilitation. The complications and barriers to achieving the RTR are explored both through the legal challenges and challenges in implementing rights through therapy specific to children. These standards and challenges are then tested through a case study on the impact of psychotherapy and creative therapies at the Baobab Centre, which is a non-residential community centre providing rehabilitation and advocacy services to young survivors of torture and organised violence. Particular attention is paid to the potential of bibliotherapy to implement the RTR for child survivors of torture, and some of the challenges in doing so.

The confusion between legal and medical definitions is raised throughout the research, as is the rights vs needs approach to rehabilitation. One area where this is particularly relevant is on the definition of a child, as although children are defined according to Article 1 of the Convention on the Rights of Children (CRC, 1989)¹ as under 18, the Baobab Centre treats chronological adults who are developmentally children due to the impacts of trauma. The definition of the RTR and what responsibilities this entails for duty bearers is still being further defined in International Human Rights Law (IHRL) and UK law, and the particular impact of the draft General Comment (GC) on the Convention Against Torture's (CAT, 1984) Article 14 on the RTR and reparations is used as the legal framework for the research (CAT, 2011). The nature and implementation of the RTR in International Human Rights Law (IHRL) and UK law is explored, looking particularly at the analysis and campaign work of the NGO Redress who are an expert in this field. The first two sections contribute to the academic debate on the right to rehabilitation, particularly for child survivors of torture, filling a gap in research on the legal ramifications of rehabilitation.

Within the field of writing therapies, bibliotherapy has been chosen to be investigated in the fourth section, following an assessment of challenges in therapy highlighted by ethical issues in trauma treatment. The impacts of bibliotherapy and the implementation of legal and trauma treatment standards are investigated by using a case study and data collection. This is a therapy that has had limited research from a human rights perspective and is used by a charity that specifically rehabilitates child survivors of torture, conflict and abuse, called the Baobab Centre (BC). Bibliotherapy is defined as “a program of activity based on the interactive processes of media and the people who experience it. Print or non-print material, either imaginative or informational is experienced and discussed with the aid of a facilitator” in Rubin (1978, 1). The bibliotherapy program run at the BC enables children to discuss a chosen piece of literature that relates to their own experience of conflict, abuse or torture. They then think about themselves through a character, and re-narrate their own life story in a way that can gradually help them understand what they have been through and go from being a victim, to a survivor. This research investigates the effectiveness and challenges of implementing rehabilitation through the work of the bibliotherapy at this organisation by using interviews with therapists and self-completed questionnaires from young survivors of torture and organised violence.

¹ All references to International Human Rights Treaty law is from: *Blackstone's International Human Rights Documents, 7th Edition*, ed Ghandi, Sandy. Oxford: Oxford University Press, 2010.

Methods and sources

A review of the legal and psychosocial literature including empirical studies relating to the implementation of the RTR has provided theories on the challenges, aims and impacts of bibliotherapy and also within rehabilitation. As no research on the use of bibliotherapy with child survivors of torture was found the legal and therapy standards found in the literature review were used to design interviews and questionnaires for BC staff and clients to assess the impact and challenges in the use of bibliotherapy.

Bibliographic

The authenticity, credibility, representativeness and meaning of all documents assessed was taken into consideration, to ensure that valid conclusions are made, and sources were cross-referenced if ambiguity was suspected. An awareness of bias and intent was maintained to ensure this was accounted for. Qualitative content analysis involved finding themes within documents that related the research questions and noting the prevalence of these themes (Bryman, 2012, 557). Legal literature was obtained from books and journals; utilising academic databases, as well as IHRL documents including treaties, General Comments (GC), special rapporteur reports and relevant jurisprudence from UK and European Court on Human Rights. For the second half of the research, books and journals on psychology and health care was used, as well as reports from relevant NGOs. Books on social research methods supported the methodology of the data collection.

Semi-structured interviews

Semi-structured interviews were needed to answer and shape the direction of the research regarding the implementation of relevant IHRL in the UK and the legal barriers to child survivors of torture. As reports and legal analysis from the NGO Redress were used to understand the RTR and the organisation has been closely involved with assessing the GC which forms the legal framework for this research, a staff member from Redress was interviewed. The second set of semi-structured interviews with the Director and bibliotherapy facilitator at the BC would be used to help answer and shape the direction of sections 3 and 4, which look at the challenges within therapy and bibliotherapy for child survivors of torture in the UK.

Informed consent was gained for the interviews with NGO staff, see Appendix II for the consent form used and Appendix I for the list of all interviews used. All interviews were recorded then transcribed, and the approach was primarily qualitative, as given the expertise of these professionals in their field the interviews provided rich and detailed answers that reflected the interviewee's views. A qualitative approach to interviews allowed for the flexibility necessary for this, so that the order of topics raised was reorganised, and the wording of questions changed as necessary. By ensuring that most questions were open, and were only closed for clarification purposes there was greater leeway for the interviewee to answer and truly share their world view on the implementation of rehabilitation.

Self-completed questionnaire

A questionnaire for self-completion was given on the impact of bibliotherapy for young people who had taken part in the sessions (Appendix III). The language used in both the 11 questions and instructions was clear, concise and easily understood, as was the presentation of the questions. A combination of closed and open questions were used so as to provide both quantitative and qualitative data, with a scale of 1-5 being given for some answers. Questionnaires were completed in

the presence of staff in the BC so that participants could be helped if needed. Staff from the BC were briefed on the questionnaire and instructed young people on how to fill it in, and were asked to collect questionnaires in numbered sealed envelopes- so that children would know that their answers would be truly anonymous and confidential. Previous to the questionnaire completion, children were asked to give their free and informed consent for their answers to be used, told what the research was for and told that they could withdraw their consent if they chose to do so (Appendix V). The researcher did not meet the children; so staff facilitated the completion of the questionnaire.

The 4 participants who completed the self-answered questionnaire and demographic information questions had the following features:

- They had given informed consent along with their guardian if under 18 for the use of their questionnaire answers and demographic information (See Appendix VI)
- They had a good level of English language so as to be able to complete the forms
- They had taken part in bibliotherapy sessions at the BC
- They were young people being treated using child psychotherapy methods for trauma caused by torture and organised violence
- They were either seeking asylum or had gained refugee status
- They were supported throughout the research by BC staff and had the research explained to them by staff

Feasibility and ethics

Participants

It is conceivable that it would be in the interest of BC staff to present positive pictures of their organisations and work in their interviews and to recruitment young people to take part in the research that might also be positive; which might bias the portrayal of impact. However, by taking this into consideration and making staff fully aware of my intentions and building up a good understanding with them, this was partially alleviated. Also, by having young people complete questionnaires provided another angle to the staff interviews, although this again could be subject to screening by staff.

Other biases that have impacted the validity of the research include the fact that the research was limited to English speakers as bibliotherapy is only accessible to young people with a good level of English language skills. If one of the positive impacts of the rehabilitation is the better integration of young people, then assessing the impact of bibliotherapy on English learners would have been useful, but this service is not offered. The young people who answered questionnaires, were in contact with the BC so as to give permission to take part- so the sample missed out young people that had stopped working with them for various reasons ranging from the conclusion of their treatment, to negative experiences, to possibly deportation. There is therefore a concern that more children who have had a positive relationship with the centre were part of the sample, but with this unavoidable bias being taken into consideration the information is put in context. With only 4 questionnaire respondents the data gives a brief glance into almost a quarter of the people who have taken part in this pilot project. The small number is understandable considering the fact that many young people being treated by the BC are going through difficult and unpredictable times, so being present and able to take part in project evaluation would only be possible for some clients.

Ethical issues

Harm to participants:

The British Sociology Association's Statement of Ethical Practice states that researchers should "anticipate and guard against consequences for research participants which can be predicted to be

harmful” and the Social Research Association states that research “should try to minimise disturbances both to subjects themselves and to the subjects relationships with their environment” (Bryman, 2012, 136). By asking the young people to reflect on the impact of the bibliotherapy in the questionnaire, this was not asking about their trauma, but their management of it. By checking the questionnaire content with staff at the BC first and using their expert advice, the questionnaire was created to ensure as far as possible that it would not cause distress.

Harm to researcher:

The risk of emotional harm through exposure to staff interviews and questionnaires on the topic of child torture rehabilitation is plausible, however, in my job of two years at Depaul UK where I write up case studies on child abuse and homelessness I have learnt how to take a professional approach towards distressing information. Self-awareness of my own limits and having colleagues to discuss arising issues helped mitigate this risk.

Confidentiality and informed consent:

Confidentiality for participants was ensured by not disclosing their names and gaining full informed consent for the use of information that they wrote and approved. A case study was given by staff in the interview, but the name was changed to protect the identity of the young person. It was crucial that all participants fully understood the reason and methodology of the research, and were given the chance to ask questions when they were asked for their informed consent. No children under 18 took part in the research so there was no need to contact legal guardians.

Deception:

The research was not represented other than what it was, and no covert observation was employed. With full consent, information about the research purposes and confidentiality procedures in place, deception did not harm the participants.

Other issues:

Other issues that could impact the research and feasibility include the researcher’s skill and background knowledge, as although trained in research and in understanding IHRL, the area of psychology and UK law is newer. However, the scope of the project is within the human rights field, and this is the area of training that has been undertaken. Positionality is another area to consider, as the topic is emotive and could potentially produce some distressing information about a very vulnerable and traumatised participant group. However, by ensuring that an appropriate academic distance is kept and that self-awareness is maintained, this issue was managed.

Section 1

What are the legal challenges in IHRL for the RTR for child survivors of torture?

The study explores the challenges of implementing the RTR for child survivors of torture in the UK, therefore in the first section the legal definition and meaning of IHRL that the UK is party to regarding torture, rehabilitation and child rights will be focussed upon.

Definition of torture

As this research focuses on child survivors of torture, the definition used combines CAT Article 14 and the CRC General Comment 13 (CRC,2011), as these represent the IHRL authorities on the topics. CAT Article 1, defines “torture” as the causing of “severe” physical or mental pain, which is intentionally inflicted or sanctioned by a public official so as to obtain information, intimidate, coerce, or punish for discriminatory reasons. The CRC GC 13 defines the torture of children as perpetrated by not just public officials, but “staff of residential and other institutions and persons who have power over children, including non-State actors” (2011, 10). It is conceivable that what constitutes “severe” mental or physical pain for an adult, may be different for a child- so GC 13 makes the definition relative to a child’s developmental state. Manfred Nowak, the Special Rapporteur of the Committee, discussed the contested issue of whether Article 14 of the CAT on the RTR should be applied to Article 16 on the prevention of cruel, inhumane and degrading treatment, when it says that it should be read with Articles 10, 11, 12 and 13 “in particular,” leaving Article 14 out, but not excluding it (Nowak, 2008, 385). According to Nowak, the boundaries between torture, inhumane, cruel and degrading treatment were not fully defined in the drafting of the Convention, and are still being re-defined in the literature and IHRL, as is the RTR.

The evolution of the RTR

Due to the severe levels of pain and suffering that defines torture the physical, psychological, social, cultural and economic impacts can be immense, and finding effective remedies that adequately redress these wrongs or even begin to can be incredibly difficult and challenged by limitations of political will and the implementation of legislation. This can lead to challenges for securing the RTR which includes the establishment of laws to protect a victim’s rights and legal mechanisms to help them achieve redress, and victims should be able to start these proceedings against the State, individual or legal entity responsible (Nowak, 2008, 482). Redress as defined in the UN Basic Principles and Guidelines on the Right to Remedy and Reparations for Victims of Gross Violations of International Human Rights Law (Basic Principles) includes restitution, compensation, rehabilitation and guarantee of non-repetition, and this research focusses on the RTR both as part of reparations and also as a right in itself (OHCHR, 2005). The latter approach to the RTR sees it as separate to the right to reparations owed by the perpetrator State. It encompasses the victim’s right to physical, mental, social and financial restoration and healing, due not to their general right to health but due to their status as a torture survivor. The duty bearer for this rehabilitation right would be the host or home state, in recognition of their obligations to prevent and condemn torture in CAT. It is debateable whether both rehabilitation rights in this sense and as a part of reparations are referenced in Article 14, which states that:

“Each State Party shall ensure in its legal system that the victim of an act of torture obtains redress and has an enforceable right to fair and adequate compensation, including the

means for as full rehabilitation as possible. In the event of the death of the victim as a result of an act of torture, his dependants shall be entitled to compensation.” (CAT, 1984)

Challenges to implementing the RTR in law can be seen in the slow evolution of IHRL norms for child rights, and now the right to reparation, of which rehabilitation is a part, is widely recognised in customary international law (Redress, 2001, 12). Prior to the 1984 CAT the right to redress and effective remedy for violations of the state’s responsibility to protect were enshrined in the Universal Declaration of Human Rights (UDHR, 1948, Article 8), the International Covenant on Civil and Political Rights (ICCPR, 1966, Articles 7, 2), the International Convention on the Eradication of Racial Discrimination (ICERD, 1965, Articles 6, 11, 14) and the European Convention on the Protection of Human Rights (ECHR, 1950, Article 13). Though in 2005 the Basic Principles clarified that rehabilitation was a key constituent of reparations, it is unclear whether this is now used to interpret these treaties that mention the right to reparations and remedies.

Mentions of rehabilitation in treaty law prior to the CAT were in reference to the social reintegration of offenders in the ICCPR (Article 10, 14) and the Convention on the Rights of Migrant Workers and Members of their Families (1990, Article 17, 18). This reading of rehabilitation incorporates the right to support for restoration of socio-economic status, in recognition of this being diminished by sentencing. Paragraph 12 of the GC includes “re-integrative and social services” in its holistic definition of rehabilitation, perhaps drawing on the meaning of rehabilitation in other treaties, The CAT gave the first example of rehabilitation being referred to in connection with reparation whereas CRC Article 39 referred to the “recovery” of child victims of violence, not reparations and rehabilitation. Rehabilitation is only mentioned in the CRC in the context of the right to health (Article 24) and the rights of disabled children (Article 23), but not in response to state violence. Usually the CRC is used in conjunction with other treaties so as to ensure that IHRL takes into consideration the specific rights of children- however because Article 39 seems to be weaker, by not referring to reparations, and the CAT does and applies to people of all ages; Article 14 will be the standard used for defining rehabilitation. From this potential barriers to the RTR have been identified in the wording of Article 39, which could have implications if implemented.

In 1993 the Vienna Declaration and Program of Action called for “further concrete action within the framework of the United Nations with a view to providing assistance to victims of torture and ensuring more effective remedies for their physical, psychological and social rehabilitation” and additional contributions to the UN Voluntary fund for Victims of Torture (Redress, 2009, 13). The NGO Redress concluded that a victim-centred approach to the RTR only began to rise up the international agenda after 2000 when the topic of reparations was the theme of the UN International Day of Support of Victims of Torture. In that year the Basic Principles were revised by M. Cherif Bassiouni of the CAT Committee, but changes did not incorporate a better definition of rehabilitation, though it was clarified that it was part of reparation (Redress, 2009, 20). The most holistic definition of rehabilitation is seen in Article 26 of the 2006 Convention on the Rights of People with Disabilities. This informed the 2011 GC on Article 14, which draws on the definition of rehabilitation as part of reparations as set out in the Basic Principles and outline a host state’s responsibilities for providing access to justice regardless of who may be the bearer of responsibility (OHCHR, 2005, Article 3c, 14). It also stressed that states should co-operate to enable this (OHCHR, 2005, Article 4). The result of which, if successfully proved under Article 15, would be reparations, possibly including rehabilitation. Interim measures are however stipulated in the Basic Principles for the care of victims during the process “regardless of whether the perpetrator has been charged” in Article 10. It seems that the CAT Committee is positioning the RTR as both a right in itself, and as part of reparation; therefore a host state to a survivor of torture would have responsibility to facilitate both suing the home state and claiming interim rehabilitation rights from the host state.

As the understanding of rehabilitation developed through treaty laws and regional laws, the work of the Committee and the campaigns and research of organisations like FFT and Redress, enabled the legal challenges posed by the RTR to become clearer. A conference in 2010 organised by Redress and the Essex Transitional Justice Network brought together academics, NGOs and psychologists who work in the field of rehabilitation to define the opportunities and challenges presented by rehabilitation as a form of reparation (Redress, 2010). They found that the definition, scope, duty bearers and beneficiaries of the RTR were unclear, especially if NGOs should provide the requisite services when states have the obligation to fulfil Article 14. The conference also highlighted the poor implementation of the Istanbul Protocol in domestic law and policies, which defines best practice guidelines on identifying victims of torture, and is crucial to improving accessibility of the RTR. Moreover, it was highlighted that reparations were just one way of achieving rehabilitation, and that the consideration of victim's needs is the primary concern, but stressed the need to raise awareness of survivor's rights and needs.

The draft GC on Article 14

The draft GC on Article 14 was put forward in response to the growing concern about the definition of the RTR, and the Committee clarified that rehabilitation needs to be accessible, effective, holistic, participatory and generally should have a victim-centred approach. Paragraph 10 of the GC expands upon the traditionally medical interpretation of rehabilitation and includes legal and social services. Article 14 obligates states to ensure "as full a rehabilitation as possible," and the GC stipulates that this should reflect state resources as well as the victim's own capacity for rehabilitation; it will be seen in section 3 if the latter differs for children. The GC also states that the aim of rehabilitation is the "restoration of dignity of the victim" And to enable the "maximum possible self-sufficiency and function for the individual concerned". When children are still reliant upon the support of a parent or guardian, it is assumed that the aim for "self-sufficiency" needs to be seen as eventual. Assessing the challenges of implementing the RTR for child survivors of torture the aims set out in the draft GC will be used as the main framework for assessing services, and it will be seen if these standards are appropriate to the needs of child survivors of torture.

According to paragraph 6 of the GC, "redress" in Article 14 encompasses all five forms of reparation "restitution, compensation, rehabilitation, satisfaction and guarantees of non-repetition" and should be read accordance with the Basic Principles. Another challenge to implementing the RTR is seen in the readiness of domestic courts and the ECHR to give reparations for state violations which include compensation but not rehabilitation (FFT, 2010). In *Guridi v Spain* (2005) the Committee found that providing only monetary compensation is inadequate (Nowak, 2008), which is pertinent when you consider that younger children are rarely in control of their finances... A challenge for children's right to reparations would be ensuring that the necessary advocacy support was provided so as to achieve their right to reparation. This might be separate to family members especially if they arrive in a host country as unaccompanied minors. With particular relevance to children the GC states that "the victim" may be interpreted as including dependents and family, and that all victims have the right to redress regardless of whether the perpetrator is apprehended. This clarification is relevant to child survivors of torture whether they are primary, secondary or tertiary victims of torture (Green, 2007, 268). FFT and Redress have commented upon the need to add clauses to the GC with regards to the specific needs of children for "specialist and multi-disciplinary service development and provision" (FFT, 2011, 5) (Redress, 2011, 17). It will be revealed in November 2012 whether the recommendations of Redress and FFT will be accepted, and the eventual form will have significant repercussions for child survivors.

Jurisdiction and the RTR

Does the state have an obligation to provide access to redress to citizens and non-citizens who have been tortured by other States? If so then this would mean that Article 14 called for civil universal jurisdiction. As this study focuses on children who have suffered torture outside the UK and are applying for refugee status; the extent to which the UK has responsibility for civil universal jurisdiction needs to be taken into consideration.

In the 1981 Working Group, Holland suggested that Article 14 should be applicable to torture “committed in any territory under it’s [the State’s] jurisdiction” (Nowak, 2008, 457, 492). The eradication of this in later drafts of the CAT could be seen to mean that the article has extraterritorial application according to both Nowak (2008) and Hall (2007). The Committee began to regularly comment and congratulate states on providing extraterritorial rehabilitation rights between 2005 and 2007 (Hall, 2007, 929), mentioning that that States must ensure victims are rehabilitated, regardless of whether they were “harmed in the territory of the State party or by nationals of the State party” which is “particularly important when a victim is unable to exercise his or her rights guaranteed under Article 14 in the territory where the violation took place” (CAT, 2011, 5). This appears to encompass the general RTR and the state’s responsibility to allow access to reparation mechanisms for the state responsible. If this were to be adopted with this clause and implemented by States, it could provide wider access to the right to rehabilitation, particularly for refugees. Paragraph 20 was endorsed by FFT because otherwise “many survivors of torture would be placed in the perverse situation of having to return to a risk of further torture in order to exercise their right to rehabilitation” (FFT, 2011, 8).

It remains to be seen whether or not reparations provided symbolically and in acknowledgement of the RTR by a host state are as meaningful as those provided by perpetrators in the home state: despite the fact that that in effect the results of each are the same . The United States is one of the few countries with domestic legislation that specifically implements Article 14, the Torture Victim Protection Act 1991 provides “a universal civil jurisdiction for torture committed abroad” (Hall, 2007, 935). The Committee asked Canada to implement Article 14 into domestic law after the Canadian court held that reparations could not be provided by the state for torture committed by public officials in other states in *Bouzari v Islamic Republic of Iran*- due to their State Immunity Act (Nowak, 2008, 493). The argument was also made that if criminal universal jurisdiction for perpetrators of torture is allowed, then civil universal jurisdiction for survivors should be allowed, Committee members added that disallowing this was “illogical” as the latter is “less intrusive” (Nowak, 2008, 495).

It will be seen if the GC could lessen barriers to the RTR for child survivors of torture through changing international norms on state immunity, ensuring that rehabilitation are included in reparations and widens the scope of rehabilitation and the state’s responsibility. Some of the challenges identified in IHRL that the UK is party to could either persist or be overcome through domestic implementation.

Section 2

How has IHRL relevant to child survivors of torture been implemented into UK law, and what challenges does this present?

This section looks at some of the barriers to the RTR in the UK relevant to BC clients, who are child survivors of torture and organised violence who have either gained refugee status or are seeking asylum. Bearing in mind the challenges in IHRL already discussed it will be seen how torture, reparations and child rights are defined in UK law to ascertain how these **affect the RTR**. The challenges posed by the asylum system and how the general RTR is attained will also be assessed. At the heart of the challenge of implementing legislation is whether or not rehabilitation is defined as a **right or a need**. Staff from Redress have stated that “there is obviously legislation in place about provision of services, but that is on a needs basis rather than rights.” There is nothing specific in UK law that states that there is “a right” to rehabilitation” (Appendix II).

Torture definition and reparations in the UK

Torture is prohibited in UK law under Section 134 of the Criminal Justice Act 1988², and the definition correlates with the CAT’s Article 1. Under UK law however the motivation that makes an action torture is not specified, only that it is done as part of a public officials’ duties, whether they are from the UK or not. The violation can be committed in the UK or elsewhere, but the nationality of the victim is not mentioned- so the question remains of whether a non-UK citizen tortured outside the UK by a non-UK public official would be able to prosecute from the UK using this law. The State Immunity Act 1978 blocks victims of any nationality from prosecuting state officials from other countries and gaining reparations from them which could include rehabilitation. The law was challenged in Jones vs Ministry of Interior case at the ECtHR involving a UK citizen who was tortured by public officials in Kuwait. However, the State Immunity Act 1978 was used to ensure that public officials from other States were immune from the jurisdiction of UK Courts (). The unaccepted Torture (Damages) Bill 2008, proposed that there should be an exception to the State Immunity Act 1978 to allow torture survivors in the UK to seek reparations against non-UK public officials (Redress pamphlet, 2007?). Paragraph 20 of the GC, stipulates the need for states to provide access to starting reparations procedures for all victims of torture regardless of where violations were committed, and where victims are from. If the provisions in the GC for civil universal jurisdiction were accepted, this would strengthen the campaign for the implementation of the Torture (Damages) Bill and potentially improve access to the RTR.

The UK’s Human Rights Act 1998 draws UK domestic law into line with the provisions of the ECHR- notably Article 13 on the right to effective remedies for violations of rights protected in the Convention including Article 3 on torture. Due to the State Immunity Act, the Human Rights Act does not affect the victim’s RTR as part of reparation when the perpetrator is a public official from outside the UK, which excludes the majority of claimants from seeking justice, presenting a serious challenge. This means that most survivors in the UK should only be able to attain their general RTR in recognition of their status as survivors of torture, but it seems that there is no law which provides this right- unlike in the US according to Redress staff (Appendix II). So it would appear that the UK provides rehabilitation services for torture survivors on a needs not rights basis, unless you consider

² All references from UK law were from All references to UK law from: The National Archives, <http://www.legislation.gov.uk/>

donations to the UN Voluntary Fund for Victims of Torture as fulfilling their obligations under Article 14 of the CAT. Other challenges to obtaining the RTR as part of reparations are seen in the ECtHR's tendency not to offer rehabilitation as part of reparations, preferring instead to offer compensation and restitution (Redress, 2009, 45). The Court could instead use the definition of rehabilitation in the GC as part of reparations to inform the Court's jurisprudence and promote the RTR.

Child rights and refugee status in the UK

As the practice of securing the RTR as part of reparations for child refugees in the UK has been shown to be limited, it will be investigated whether the general RTR is in UK law, and failing this what other means there are to ensure that children's rehabilitation needs are met. To interpret the rehabilitation rights of child survivors of torture, the CAT Article 14 can be read in conjunction with the CRC, which according to Article 2 is applicable to "each child within their jurisdiction", regardless of their national and legal status. The Children's Act 1989 seems to be the main legislation for implementing the CRC, and Article 17 interprets the CRC Article 2 by stating that "it shall be the general duty of every local authority...to safeguard and promote the welfare of children within their area who are in need." However, the Children's Commissioner reported that "many Local Authorities have stated that they do not have the resources to support this population [unaccompanied minors] leading some councils to practice a policy of evicting children when they reach 16" (2008, 30-32). This is despite UNHCR Refugee Child Guidelines discussing how holistic rehabilitation services need to be provided even if such services are not available to the general population (1994,). While legislation interprets some IHRL relevant to child survivors of torture, the lack of resources for implementation appears to present the main barrier.

If it can be proved that a child asylum seeker has suffered torture as defined in the CAT, then it will remain to be proven that they meet the definition of a refugee as defined in the 1951 Refugee Convention whereby "owing to a well-founded fear of persecution" due to "membership of a particular social group or political opinion" they are "unable or unwilling to avail himself of the protection of that country." BC staff said that the children they supported were often sent out of the country by their families without understanding or knowledge of the reasons or socio-political background to the "well-founded fear" criteria of the refugee definition (). When this difficulty is combined with the contradictory and inaccurate country information used by the UKBA and Home Office (Children's Commissioner, 2012), then legislation that could lead to refugee status and the chance to attain the RTR ends up failing to offer protection due to poor implementation. The RTR could be more accessible to child survivors of torture if it became more recognised in UK jurisprudence that children can be a "particular social group" and it has been established by critics that there are child specific forms of persecution which can amount to a "well-founded fear" (Ressler, Boothby and Steinbock in Van Bueren, 1998, 363). When this happens in the context of hostilities CRC GC 6 states that subjecting children to this through refoulement "constitutes a serious human rights violation and thereby persecution, and should lead to the granting of refugee status" (CRC,2005).

The right to seek asylum for torture survivors is reinforced by the CAT's Article 3 which prohibits "refoulement"- returning someone to a state "where there are substantial grounds for believing that he would be in danger of being subjected to torture" (CAT, 1984).. Merely seeking rehabilitation services after torture in a home state could leave open the risk of further torture, and FFT have argued that "denial of the RTR can amount to persecution giving rise to a claim for protection under Article 1a (2) of the UN Refugee Convention" (FFT, 2010, 26). However, for torture survivors to be a "particular social group" they would have had to have suffered persecution because of their "particular social group" in the first place. UK Home Office Guidelines state that "to attempt to return someone to a country where there is a complete absence of treatment, facilities or social support which could result in an imminent and lingering death and cause acute physical and mental

suffering would be very likely to engage our obligations under Article 3” of the ECHR (Immigration Directorate’s Instructions, 2006). For torture survivors there is no clarification here on whether they distinguish between treatment needed because of state violations, only the level of healthcare needed compared to home state facilities, potentially leading to a situation where their RTR in their home country could endanger them further.

One of the main challenges of implementing the RTR in the UK is being able to correctly assign this right to child refugees in need even if this is done informally and without specific laws for torture rehabilitation. This process is undermined while the Istanbul Protocol, CRC, Child Refugee Guidelines are not implemented through UK law and UKBA policy. The CRC’s Article 22 states that refugee and asylum seeking children are entitled to “appropriate protection and humanitarian assistance” and this protection and assistance needs to be carried out in line with Article 3 on the “best interests of the child”, but it is debateable whether “appropriate protection” entails the RTR. The implementation of Article 22 could be seen through section 4 of The Asylum Seekers (Reception Conditions) Regulations 2005 which makes specific recommendations for the consideration of the “special needs” of child refugees when providing support, but rehabilitation is not specifically included (). The Borders, Citizenship and Immigration Bill 2009 promised to promote the welfare of children seeking asylum, and again it was unclear if this is the legal basis for UKBA and Social Services to refer child survivors of torture to rehabilitation services or whether fulfilling the requirements of the Welfare Checklist in the Children’s Act 1989 was the more appropriate legislation.

Despite this immigration legislation mentioning the specific needs, but not rights, of child asylum seekers the Children’s Commissioner’s report criticised interview procedures conducted by UKBA staff which lead to children’s identity, welfare and reasons for asylum being incorrectly recorded(2012, 7-9), which undermined their efforts to seek asylum and their RTR in the UK. This was despite stipulations in the UKBA’s own policy document stating that “screening is not the place to explore the claim for asylum” (2012, 37). Children seeking asylum face delayed access to health care and inadequate legal support for their asylum claim assessment, and complications from using telephone translators lead to further inaccuracies in the process leading to more distress for the child (Children’s Commissioner, 2012). The UK eventually retracted its objection to the application of CRC Article 3 on the “best interests of the child” to matters of asylum and immigration for children in 2008 (UKBA, 2009), which if implemented through service procedures relevant to child asylum seekers could greatly reduce barriers to the RTR. Perhaps in response to this and Article 16 of the 1989 Children’s Act which states that delays in legal processes “prejudice the welfare of the child” and further pressure from the Children’s Commissioner’s report criticising the lengthy asylum process and delays in UKBA assessments (2012), such delays were ruled to be unlawful by the High Court (FFT, 2012). As legislation for child asylum seekers is spread between child specific and immigration specific laws, it is perhaps within the crossovers that some challenges arise, leading to difficulties in securing the RTR.

The general RTR in the UK

Article 39 in the CRC applies to child survivors of torture, stating that “appropriate measures” should be taken by the State to “promote physical and psychological recovery and social reintegration”. It will be seen whether “all appropriate measures” for recovery in Article 39 and “as full a rehabilitation as possible” under the CAT’s Article 14 has been implemented in the UK. Concerns raised by the CRC Committee in their 2008 response to the UK’s report about “inadequate monitoring” for looked after children (CRC, 2008), is relevant to unaccompanied minors supported by Social Services under their obligations in the Children’s Act 1989 and monitoring of rehabilitation services highlighted in the GC on Article 14. The Committee also highlighted the poor implementation of Articles 24 on the right to health and 39 by discussing concerns about the “impact of and general accessibility of mental health services on vulnerable groups of young people

such as refugees.” The UK legislation which could be used to address the Committee’s concerns might be the Health and Social Care Act 2003, which states in section 17 of chapter 43 that services for children in need should be monitored by The Commission for Social Care Inspection (CSCI) and The Commission for Healthcare Audit Inspection so that children in particular are safeguarded and their welfare and rights promoted (UK legislation, 2003). Organisations that fall under their inspection category include “independent clinics”- so it is unclear whether NGOs such as the BC would fall under this category. The need to monitor rights implementation could in fact undermine the RTR as government reviews would lessen the independence and confidentiality that make NGOs accessible to torture survivors.

With the CRC highlighting concerns about mental health services for children in general despite UK legislation such as the Mental Health Act 2007 (CRC, 2008), this presents extra challenges to securing the RTR for refugee children. According to the Children’s Legal Centre failed asylum seekers can only access limited National Health medical services including compulsory psychiatric services (The Children’s Legal Centre, 55). However the services available for young refugees include CAHMs who often have age requirements (56), and when young refugees who are technically adults need child psychotherapy support due to their developmental age. CAHMs is also a government run organisation and does not have the community support element that NGO specialist mental health services have. NGOs seem to be the most relevant service providers for the general RTR for young refugees and asylum seekers.

Interestingly there was no mention of the UK implementation of Article 14 in the UK’s 2008 CAT Committee Report, and it was surprising that the move to implement the Torture Damages Bill 2008 was not included either. As stated in the previous section, a way for States to fulfil their responsibilities under Article 14 to all torture survivors would be to support the UN Voluntary Fund for Torture Victims, which funds organisations such as the Refugee Council and FFT in the UK. However, challenges in IHRL implementation have been seen to undermine the RTR in terms of reparations and generally, with a needs rather than rights focus seeming dominant.

Section 3

What are the main substantive challenges that child survivors of torture face when seeking the right to rehabilitation?

The therapy methodology for implementing rehabilitation should ideally reflect the principles in IHRL that the UK is party to and seek to enable “as full a rehabilitation as possible” and be facilitated in line with Article 3 of the CRC on the “best interests of the child”. The particular impact and needs of child survivors of torture will be investigated by looking at psycho- social literature and using interviews with the BC staff. Substantive obligation is defined in the GC as “State Parties must ensure that a victim of torture or ill-treatment obtains full and effective redress and reparative measures including compensation and the means for as full rehabilitation as possible” (CAT, 2011, 1). As stated previously the State Immunity Act 1978 prevents torture survivors from seeking reparations from public officials from other states. Despite this, the general RTR exists through Local Authority responsibilities under the Children’s Act 1989 and health care legislation though it seems that the RTR is best met through services offered by specialist NGOs.

Challenges from the definition of torture

The difficulties of applying the CAT definition of torture persists in psycho-social literature (Hardi and Kroo, 2011, 133). The role or responsibility of the public official in torture is central in UK law but not in the World Medical Association’s definition (Basoglu, 1992 in Gorman, 2001, 443) and the law’s insistence on defining torture this way shows more of an attempt to prevent states from torturing than safeguarding all victims of torture in general. Rehabilitation professionals therefore are caught between two definitions, but ultimately treat symptoms of trauma regardless of whether the cause fits either definition or neither. BC staff stated that several of the 70 young people they have supported over one year had survived torture by state officials and militias, however, they use a “much broader definition of human rights abuses against children,” stating that “from a child psychotherapist’s point of view I don’t think there’s a difference internally whether it was a state official or not”³. This is consistent with the stance taken in CRC GC 13 despite this not being interpreted into UK law as far as can be seen.

The BC work with young refugees and asylum seekers some of whom are primary, secondary and tertiary survivors of torture (Green, 2007, 268) as well as those who have experienced cumulative violence through being child soldiers, “abandoned by the state”, trafficked, in conflict and severely abused by family members in their home countries. Implementing the RTR for therapists begins with signs of trauma which may or may not be connected to torture, whereas a State’s awarding of rehabilitation reparation or in recognition of torture according to Article 14 begins with evidence of torture. So the RTR begins with a general duty of care based on the right to health, and then this develops into something closer to reparations once the State or NGO acknowledges the torture. The need in the GC for rehabilitation to be “victim centred” was seen in case studies where therapists were able to successfully adjust the therapeutic frame after learning that patients had suffered torture perpetrated by public officials, so the power structure between patient and therapist was changed so as not to re-traumatise survivors (Fabri, 2001) (Tizon, 2001). This shows

³ All quotes from Baobab Centre Staff in section 3 were from the interview with the Clinical Director, Appendix II

why rehabilitation which is participatory and victim centred enables gradual empowerment after the disempowerment of torture.

Challenges within therapy and from the GC

The GC obliges States to provide information in their Committee reports on “methods available for assessing effectiveness of rehabilitation programs and services” under paragraph 40d, and NGOs would also be able to report on the challenges and impacts of their services. Ideally if the GC standards were followed, the States and NGOs responsible for providing services would need to ensure rehabilitation services were accessible, particularly to vulnerable groups such as refugees and children. Whether the UN Voluntary Fund for Victims of Torture has an existing monitoring procedure that could incorporate these standards and extend this evaluation tool to states would be another possible goal for the Committee. An aim could be to ultimately standardise services whilst ensuring they are victim centred and culturally relevant, which are challenges in themselves.

The European Association for Counselling has already attempted to unite service delivery in their charter stating that their main aim is to “respect for human rights and human differences” and to preserve the dignity of patients (Bond, 1999, 381) which is the aim of rehabilitation in the GC. However, there are different ethical stances and therapy practices within Western Europe. The UK and Netherlands’ therapy models towards are more victim centred and participatory approach, whereas the Swedish system placed social welfare over individual needs, and Italy and Greece placed the least importance on participation (Bond, 1999, 377-8). In Section 2 the participation and victim centred aims were seen in UK legislation, and in this section further challenges to implementation will be seen. The approach advocated in the GC and by some European healthcare models is important for refugee torture rehabilitation, as the therapeutic frame needs to be adjusted around their needs to avoid re-traumatisation, and support cultural transitions (Gorman, 2001, 449). Community building through rehabilitation and holistic participatory programs are essential because torture can be described as a “socially and politically constructed disaster” which destroys a survivor’s ideas about society (Lie et al, 2004, 345). Original interpretations in IHRL of rehabilitation focused on social integration; the GC highlights this again and it would be a challenging but important area for states and NGOs to evaluate in CAT reports. Especially considering that unaccompanied child survivors would need even more support to achieve this.

The BC is a non-residential community centre working “very closely on cultural transition” and they provide a community setting through regular group activities and encouraging the giving and accepting of support from the group. Their community meetings help young people learn to discuss issues and challenge authority without fear of punishment, before helping them take part in the wider community. Cultural barriers to rehabilitation from “treating the minority client in isolation is perhaps the most frequent cross-cultural psychotherapeutic error” (Elass, 1997 in Gorman, 2001, 445), however, community building to help refugee survivors get “social capital” relies in part on “the degree and kind of support they receive from the host culture” (Garland et al, 2002, 71); this would include NGO and state services. For example, a successful psycho-legal counselling program for torture survivors in India was undermined by the lack of community rehabilitation, legal education and reintegration of survivors and their families (2008, 333). As refugees are isolated from the gradual healing and understanding process that their communities might be going through in their home states, community building in a host country is both a challenge to and an impact of securing the RTR. The different policies and stances in European legislation and communities could either help or undermine this, which is why supportive spaces such as the BC are crucial to rehabilitation but are also limited by a lack of adaptation in healthcare and societies. The GC includes “medical, and psychological care as well as legal and social services” in rehabilitation which seems to reflect psycho-social literature that explains that torture causes “somatic, psychological, social, legal and spiritual” damage which “challenges five core adaptive systems ensuring safety,

attachment, justice, identity role, and existential meaning” (Silvoe 1999 in Hardi and Kroo, 2011, 134). BC staff stated that damage to these systems in children whilst they are still developing gives them a lower resilience and capacity for rehabilitation, increasing the amount of advocacy support they need for their accommodation, health, education and social needs amongst others. So it seems that training across relevant services would be needed to secure the holistic rehabilitation advocated in the GC and by the BC

The BC works with young parents as this is crucial to securing a child’s right to rehabilitation, Graessner (2001) stated that children can be “infected” by a parents torture experiences to become tertiary victims (Green,2007), and then fail to be “detoxified” by traumatised parents (Garland, 2002, 100). PTSD in Middle Eastern refugee children was seen to be caused by a combined exposure to trauma, the breakdown of family interactions of traumatised parents and a parent’s unemployment (Montgomery and Foldspang, 2006, 64). Therefore therapies which rehabilitate the whole family holistically and help with employability are preferable (Lie et al, 2004, 327). Studies showed that “the higher the level of exposure to traumatic events, the stronger the effect of family seemed to be” (Lie et al, 2004, 327) this shows how crucial the community support provided by the BC is for unaccompanied child survivors of torture. BC staff stated that they reinforce the strength of family even when they may have died or be in another country, this enables young people to find resilience in the positive memories of their families previous care and support of them. The need to implement support as soon as survivors are identified (Wenk-Ansohn, 2001, 69) using procedures such as the Istanbul Protocol, and reforms of UKBA’s child procedures could help prevent the “intergenerational and societal transmission of abuse” (Garland et al, 2002, 102).

Ethical issues

Ethical issues that could challenge the RTR particularly for child survivors of torture in the UK are outlined in the following six principles of trauma treatment; fidelity, nonmaleficence, beneficence, autonomy, justice and self-interest (Kinzie and Boehnlein, 1979, in Kinzie and Engdahl 313-4), which seem to reflect the standards in the GC. It will be seen how these principles are challenged and alleviated at the BC.

Firstly, the “fidelity” of the doctor-patient relationship needs to be based on trust and BC staff discussed how this was particularly challenging for isolated young people whose attachment adaptation systems were damaged leading them to have “difficulties in having relationships.” Adding that clients “come from cultures where talking about feelings to a stranger is not necessarily a familiar idea,” and that their trust with adults in a position of authority had been fundamentally broken, and clients worried that information shared in therapy would be used against them by perpetrators of violence in their home country (Baobab Centre, 2001). Examples were given of how the “therapeutic alliance” were put under pressure by the needs of some lawyers to quickly attain reports on the reasons and impacts of trauma for asylum cases, calling into concern the implementation of CRC Article 3. Challenges to fidelity have led some rehabilitation NGOs to cease offering support with asylum procedures to maintain trust with clients and their independence of government procedures and avoid “limited definitions of trauma and restrictive diagnostic schemes” (Graessner, 2001, 156). The impact on fidelity from government monitoring of Article 14 duties, and the extent to which this happens in the UK under the Health and Social Care Act 2003 where “independent clinics” come under the monitoring remit would be an area for further research.

Secondly, “nonmaleficence”, the ethic of “do no harm” entails the dangers of therapists failing to prevent countertransference, minimizing patient’s trauma, acting insensitively and pushing patients. The asylum process pressures that impact upon rehabilitation have been shown, but to assess nonmaleficence at the BC would require a longer term and more detailed study that did not rely only on staff interviews, which could be subject to bias. However, staff interviewed have shown the

participatory and victim centred nature of the BC, where clients play a significant role in managing the pace and scope of their treatment to mitigate nonmaleficence.. Due to the complexity and individuality of a patient's trauma and background, the potential of rehabilitation methods causing harm is real without the victim-centred approach, and even with it. Staff stated this is overcome through building up the therapeutic alliance, however, preventing harm through building resilience is challenged by numerous external factors that are outside the therapist's control. Case studies of young people who return to the BC after leaving treatment due to difficult psychotherapy sessions, or drug addiction issues shows the benefit of services felt by young people. Advocacy support is key to their work because of the stress and uncertainty of engaging with the asylum process, which has been seen to exacerbate trauma (Herlihy, 2004) (Brody, 1994 in Gorman 2001, 443). BC staff had particular concerns about child's rights legislation not being implemented through the training, availability and procedures followed by Social Services. They also saw the challenges presented in helping young people transition between child and adult health services when survivors were chronologically adults but developmentally children. Similar concerns about Social Services and health services were raised by the Children's Commissioner (2012). The GC called for "effective" rehabilitation services and improved monitoring, which may help better implement the RTR across services relevant to child survivors of torture.

Thirdly, "beneficence" is about the reduction of suffering, and provision of competent treatments which promote health based on sound scientific reasoning. BC staff stated that their rehabilitation aims centred around building resilience, promoting dignity and helping young people become part of a community whilst "managing affect, and managing behaviour- things like aggression, sadness, aloneness, hopefulness, hopelessness and managing fear levels." This area will be looked at in more detail through the provision of bibliotherapy. BC staff raised concerns about limited training opportunities for this within the UK and were concerned that creative writing sessions were therapeutic but not classed as therapy and were being lead by artists without sufficient training (Sumpton, 2012) , which goes back to the ethic of nonmaleficence. Bibliotherapy allows a survivor to use displacement to begin understanding and managing the trauma they have suffered, and BC staff based the scientific reasoning that "when somebody is traumatised and overwhelmed that they have breaks in their synapses and that the links between nerve cells...and that therapeutic work can re-establish links between brain cells" in their psychotherapy sessions.

Fourthly, "autonomy" within trauma treatment can be linked to the principle of participation emphasise in the GC which encourages survivors to be an active partner in the treatment program. Pardeck and Woo's 1995 study showed that 72% of children who stopped treatment in a psychiatric ward did so because their treatment was not explained to them adequately, and also criticised the restrictive and controlling hospital environment for children. BC staff ensured that participation is a main part of therapy by having clients review their rehabilitation every 6 months, take part in project evaluations and by encouraging them to choose what type of creative therapy they would like to participate in, rather than referring them to groups. BC staff also said that group participation is at a pace that suits the young person so that they first find "a language to express what has happened to them" in individual therapy then "share their experiences with others that have had similar experiences," with further opportunities of becoming mentors and organising activities and fundraisers available. Again assessing the full impact of these project areas has been limited by the scope and practicalities of the research.

Fifthly, the role of "justice" as a principle in trauma treatment can be explained as the acceptance of justified indignation against wrongs as well as enabling the patient's decision to protest injustice. However, the idea of "wrongs" is complicated by the fact that not only do survivors blame themselves, but BC staff would also need to help young people understand their roles as perpetrators of violence, in betrayal and as collaborators within a context where they are also often

seeking asylum (Baobab Centre, 2011). This is also complicated by the fact that BC staff need to help a young people understand the politics behind their violent experiences and the language of human rights abuses; it was unclear if clients were supported by the centre to raise awareness and campaign even though they cannot attain the right to reparations in the UK.

Studies show how reparations and testimony therapy can be beneficial to mental health and rehabilitation in general (Kroo and Hardi, 2011), that establishing the truth of violations can be more powerful for victims than justice (Weschler 1990). The other argument is that encouraging justice in treatment is a form of nonmaleficence and that reparations and politicisation were damaging forms of avoidance behaviour which can worsen trauma (Gurris, 2001, 35). The complex link between rehabilitation and reparation objectives are seen in psycho-legal counselling which aims to “achieve individual justice and not improve mental health.” It is positioned as a program that might be therapeutic if successful but is not therapy and involves empowerment through legal education, mediation and advocacy (Agger, 2008, 315). Agger states that justice is “understood in a wider meaning, which includes the survivor’s experience of having achieved justice by, for example, the perpetrator acknowledging the violations, and asking the survivor to forgive or the solidarity and acknowledgement received from persons of authority” (2008, 330). This would suggest that a sense of justice in treatment can be achieved by the acknowledgement of the therapist, and in their advocacy role throughout their asylum process

Sixthly, “self-interest” is the challenge in trauma treatment that the therapist meets their own needs throughout, as this could have a profound effect on all of the other principles. BC staff’s concerns about limited space, funds and staff for the increasing number of clients could have an impact on this. Again, with limited interviews and participant feedback, this was another substantive challenge to the RTR, with practical and personal implications, that was not investigated fully.

Barriers to rehabilitation in asylum

The psychological impacts of torture present major barriers to attaining asylum, and thus in some cases the right to rehabilitation. The UK Immigration and Nationality Directorate (1998) states that “discrepancies, exaggerated accounts, and the addition of new claims of mistreatment may affect credibility” (in Herlihy et al, 2004, 645) and it is conceivable that the impacts of torture on a young person’s account could undermine their right to rehabilitation. Studies have shown that survivors actively cover up their memories and instances of betrayal, guilt and shame linked to torture and instead express “themselves in agonizing psychosomatic symptoms” and that they “do not experience simple goal directed rage and aggressive feelings towards their torturers; instead they tend to lash out against themselves” (Gurris, 2001, 29).

Grasener (2001, 155-156) stated that intensive therapy should only be initiated for survivors with a confirmed refugee status, and that to do so would be harmful because the scope of trauma would be opened before a person was potentially deported and unable to continue rehabilitation. BC staff also discussed how the psychological impacts of trauma can increase after refugee status is confirmed, increasing a young person’s need for rehabilitation services, whereas Basoglu et al’s (2005) stated the opposite (in Hardi and Kroo, 2011, 139).

The standards for the RTR set in the GC seem to be reflected in the ethics of trauma treatment and in the understanding of rehabilitation that the BC operationalizes. However, limitations to securing the RTR through NGOs like the BC have been seen in the extreme nature of torture, limited support from national services and barriers from cultural difference.

Section 4

What are the challenges and impacts of using bibliotherapy in the rehabilitation of children generally, and at the BC?

The Human Rights Based Approach (HRBA) to rehabilitation

The HRBA advocates working in a non-discriminatory, participatory and accountable way (UNDG, 2003), with IHRL and the GC on Article 14 further validating this position, alongside the trauma treatment ethics examined in section 3. The potential for “nonmaleficence” highlighted by some psychologists with regards to bibliotherapy raises concerns about the effectiveness of it for rehabilitation and shows the importance of facilitating it within a HRBA. However, the aims of bibliotherapy according to Herman (1997, in Day, 2009, 84), Pardeck and Pardeck (1984, in Detrixhe, 2010) and Bryan (1939, in Rubin, 1978, 29) are all united in the need to promote a client’s empowerment, which is central to the GC.

Interviews with staff members and questionnaires for clients of the BC have been used to assess some of the challenges and impacts of using bibliotherapy in the rehabilitation of child survivors of torture in the UK. The need for research to add to the debate on the RTR and the effectiveness of bibliotherapy was highlighted by therapy professionals from several NGOs (Sumpton, 2012) and in the majority of literature researched; Pehrsson stated that “the majority of empirically based bibliotherapy studies focus on non-fiction practices that are disorder specific, often dealing with cognitive behavioural and self-help guides” (2005, 281). Bringing in the human rights standards for rehabilitation to the assessment of the effectiveness of bibliotherapy has not been seen in other research, which has primarily been from a psychology background.

Why bibliotherapy and expressive writing are used for torture survivor rehabilitation

Using the bibliotherapy definition as outlined in the introduction, the methodology utilised by the BC is composed of both expressive writing and bibliotherapy- the use of literature and writing to help children understand their trauma. The argument for the use of writing therapies with child survivors of torture comes from numerous psychosocial researchers who state that the “disclosure or translation of traumatic experiences into words as a testimony can have psychological benefits (Van de Veer, 1998; Smyth and Pennebaker, 1999 in Redress, 2009, 30). The “beneficence” reasoning behind both bibliotherapy and expressive writing lead the BC to use these forms of rehabilitation as a displacement tool to support psychotherapy and vice versa.

Story telling is central to psychotherapy, making bibliotherapy a perfect tool, and in Dwivedi and Gardner found that seeing life events in a narrative format was a natural understanding process (1997, 20). In section 3 it was also seen how essential it was for children to describe their reasons for seeking asylum in a coherent narrative, so in theory bibliotherapy could support both rehabilitation and a child’s claim for refugee status. The relevance of this creative approach to rehabilitation for child refugees and asylum seekers can be seen in the fact that their development gets “strained” whilst adapting to life in a host country and rapidly learning a language, leading to “a lack of creativity, risk taking and poor memory, so that making sense of situations, giving a context and a history with emotionally appropriate actions was rare” (Garland et al, 2002, 100). Bibliotherapy, like the GC, aims to promote “self-sufficiency” through teaching problem solving, making it particularly important for addressing some of the issues raised by Garland et al.

Aims of bibliotherapy

Some of the main aims of bibliotherapy that are particularly relevant to children are that its' use of stories (1) releases emotional pressures, (2) provides multiple solutions, (3) promotes smoother dialogue about concerns, (4) models capable decision-making strategies, (5) exposes children to divergent cultural views, (6) generates opportunities for children to investigate other interests, (7) produces fertile ground for self-reflection (Pardeck and Pardeck, 1998a; in Pehrsson, 2005, 276). When the GC including integration in its aims, group bibliotherapy is particularly relevant as it utilises "not only the (literary) material but the group itself to facilitate self-growth so the tension of the therapist-client relationship is further eased" (Rubin, 1978, 10).

The BC run individual and group bibliotherapy sessions and the "self-growth" aim is common to both and BC staff agreed that the GC aims generally correlated with their therapy aims in bibliotherapy sessions adding that "you are aiming at hope and resilience through a re-telling of a terrible story."⁴ The risks of maleficence and in pushing a participant to describe their trauma are real, and encouraged by the pressure to produce reports for asylum procedures. Despite this, these risks seemed to be mitigated by the victim-centred and participatory approach advocated by the GC and ethics of trauma treatment. Staff discussed the enjoyment that young people gained from stories, even though bibliotherapy presents some cultural and language barriers the facilitator saw that "great books have things to say that are eternal and everyone seems to recognise them as true" .

What is the impact of bibliotherapy?

Research into the impacts of writing about traumatic events shows the beneficence behind the BC's bibliotherapy methodology, which they adjusted for children who were survivors of torture and organised violence. Writing therapies reduced PTSD symptoms amongst traumatised adult survivors of organised violence (van Dijk, J.A et al. 2003) and Cienfuegos and Monelli (1983) noted the reduction of PTSD in 39 survivors of torture and mock execution (in Redress, 2009, 30). Best practice methodologies for using bibliotherapy with traumatised children is provided by therapists such as Jennings (2005), Kaywell (2004) and Shotton (2004) advocate its' positive impact. Furthermore, two empirical studies showed the effectiveness of bibliotherapy on children, one enabled the reduction of aggression in boys (Schechtman, 1999) and the other boosted the self-esteem of girls gaining treatment for obesity (Sauter, 2010, in Thomas, 2011). One of the concerns raised about bibliotherapy was that it was only effective on clients with low support needs (Schechtman, 1999, 40) (Lindman and Kling, in Detrixhe, 2010, 64). The participant group that this research focusses on have high support needs, including PTSD symptomology, so it will be seen to what extent bibliotherapy is effective, or at least appreciated by participants. Although, Lie et al warned against measuring trauma in children only through PTSD symptomology- and as rehabilitation should be holistic according to the GC and cover mental, physical, social and legal aspects, impact assessment would need to reflect this to be inline with GC standards. A study by Onyut et al (2005) showed the successful treatment of Somali children in a refugee camp in Kenya suffering from PTSD and depression through using f life story-telling and testimony writing in a process called KIDNET. This is a child focussed version of narrative exposure therapy, where participants are encouraged to fill in the gaps in their traumatic memories of events to habituate the trauma. Elements of KIDNET are used in the bibliotherapy treatment at The BC for child survivors of torture, who take part in expressive writing exercises and journal keeping. A method which Agger and Jensen (1996) saw to be universally successful in their experience of using this to support refugee survivors of organised violence (in Redress, 2009, 30).

⁴ All quotes from "BC staff" in this section are from the interview with the Baobab Centre Bibliotherapy Facilitator, Appendix II

It could be argued that testimony therapy is only universally successful if the client group is literate, and as many young refugees and asylum seekers either had their **education disrupted by war** or are still learning English, these variables mean that bibliotherapy is only appropriate for some clients. The of universality is also challenged by the fact that 33 different nationalities are represented amongst the young people supported by the BC, and staff said that therapy was more accessible to some due to a range of factors including cultural differences. This can affect the trauma treatment ethic of “fidelity” as one barrier seen by BC staff was the fact some of the young people “don’t listen to women in their culture”. However, through following the principles highlighted in the GC to make the bibliotherapy sessions participatory and victim-centred BC staff discussed how this could sometimes be overcome.

The impact of bibliotherapy at the BC

The impact of the BC’s bibliotherapy will be seen in how they help attained Pardeck and Pardeck’s (1998) six aims (in Pehrsson, 2005).

Yusuf, a 23 year old Eritrean seeking asylum in the UK had to flee after his father disappeared and then was killed, with BC staff saying that it was “because he was on the wrong side.” He asked to attend individual bibliotherapy sessions and the story chosen for him was about a young man who escapes prison and then is able to be accepted by society and lead a positive life which BC staff thought “*models capable decision-making strategies*” and eventually helped Yusuf learn how to trust, feel positive about the volunteering he was doing and learn when to seek help. Section 3 discussed literature about how trauma stops development and damages core adaptive functions, so by slowly showing examples of how characters overcome difficulty these functions are built up and “*provide[s] multiple solutions.*” Bibliotherapy “*promotes smoother dialogue about concerns*” and through using a book that discussed what different rooms meant to the character, staff were able to initiate a discussion about his room at present and at his home before he had to flee. He spoke for the first time about the intimidation and racism he was facing in his current accommodation and this was the conversation that lead him to seek help with resolving this.

Due to his experiences of trauma as a tertiary victim in his home country and in the course of travelling to the UK, he was less able to deal with this despite being 23 years old his development was uneven, leading him to act a lot younger than his chronological age. The discussion about his room in London helped “*releases emotional pressures*” and feeling of helplessness in his accommodation situation, and it then helped him discuss his homesickness, which staff used to help build up his resilience by reminding him of positive memories of his family. BC staff used the joint exploring of stories to promote the “fidelity” central to helping a young person explore their past and discuss worries about their present. This trust and confidence building in bibliotherapy “*generates opportunities for children to investigate other interests*” For Yusuf this meant looking into employment and education opportunities which were shown to be crucial to trauma recovery by Lie et al (2004). Staff said that the sessions helped him learn “that he can re-write himself as this confident man who can work for Oxfam. His life has taken on this new hope and this new direction.” BC staff said that “the book triggers writing which is admitting” and this is how bibliotherapy “*produces fertile ground for self-reflection.*”

Bibliotherapy also “*exposes children to divergent cultural views*” and this was particularly valuable for Yusuf for through a book set in South Africa he was able to examine issues of home and identity that he found too painful in a previous book set in his home country and exploring issues that were too closely linked to the reasons he had to flee. He stopped attending sessions for a while, but Yusuf decided to come back to bibliotherapy and the book was changed, BC staff said “he came back because he felt more confident after his psychotherapy.” Staff also said that sometimes it can work the other way as well with people leaving psychotherapy and using bibliotherapy to build up their confidence to return to it.

Whether or not the young people continue writing in their own time to help them understand their trauma and aid decision making is a key aim of the sessions, and shows the long term impacts of bibliotherapy, perhaps that it supports the GC aim of “maximum self-sufficiency.” The successful impact of the BC’s combination of expressive writing and bibliotherapy was stated by a young refugee who had survived extreme domestic abuse from her father who was also the community leader, the abuse had resulted in her being raped and then her baby being killed, she said that “writing helps me to stand outside myself, because I am not the girl, I am me looking at the girl through the writing.” BC staff said that several bibliotherapy participants like this client continue writing journals after stopping bibliotherapy sessions, and one questionnaire respondents stated that “I feel the need to write because writing gives me an inner strength that I like very much”. The willingness of some young people to continue writing over others may also be linked to the different ways people learn and process information, some young people may be more suited to kinaesthetic, visual or auditory processing. Other young people kept journals to help them understand their past “I write because I want to remember how it was before and try to compare the experience to now”.

Questionnaire respondents also valued insights into different cultures and periods of history in sessions where they read *Great Expectations* and *Jane Eyre*, the language used to describe sessions was positive and all expressed the value in improving their reading and writing skills and did not write any criticisms or suggestions. The four questionnaire respondents from Chad, Uganda and Eritrea were aged 23-29, but still receiving child psychotherapy due to their developmental age and all said that they felt significantly more positive about the future after attending the sessions. The small sample represents four young people who felt positively about bibliotherapy and elected to take part in the research, so some bias can be seen in the results. Also, the nature of the questionnaire which reviewed sessions lead by staff who are still working with the young people might have also made them wary of criticising the sessions, despite assurances of confidentiality. Those who did not enjoy the sessions moved to other therapy sessions and were not contactable for survey participation. As bibliotherapy participants are self-selecting anyway- it would be expected that most of the feedback would be similarly positive.

What are the risks and criticisms of bibliotherapy?

Writing based therapies using bibliotherapy, narrative exposure therapy or testimony therapy have been seen to be ineffective by some psychologists. However, there is also a consistent objection in the psychology literature about the lack of empirical research on the impacts of writing therapies in the treatment of trauma, so the basis of criticisms for bibliotherapy is often limited to individual studies with very different client groups. The use of fiction in bibliotherapy has been dismissed by post-structuralist critiques who hold that “narrative structures bear no reference to life itself”, and Freeman (1993) states that it is this premise that holds the entire integrity of the therapy together (Dwivedi and Gardener, 1997, 20). In Riordan and Wilson’s (1989) review of bibliotherapy research they found non-fiction to be far more useful in rehabilitation than fiction (Detrixhe, 2010, 60). Whilst Amstrader et al (2007) stated that Cognitive Behavioural Therapy provided the most effective and long term rehabilitation for PTSD patients than bibliotherapy (in Day, 09, 84).

The appropriateness of using fiction to help trauma sufferers understand their situation through a character’s experience, was questioned by Pardeck and Pardeck (1984), who stated that this could lead to clients over intellectualising their situation (Detrixhe, 2010, 68). However, with careful book selection and facilitation BC staff said that young people like Yusuf could gain a clearer understanding of their situation. They critiqued the practice of not over-intellectualising but oversimplifying young people’s issues through choosing unchallenging reading material, which is a point mentioned in the literature on “maleficence” in trauma treatment. Schechtman (1999, 40) also highlighted the dangers of poorly facilitated bibliotherapy that was not participatory, stating that it

could provoke anxiety and produce unclear advice. Whilst Hacking (1995) stated that bibliotherapy could not be empowering when the therapy entailed a patient and client dynamic where it was inevitable that a language and forced reading would be imposed (Dwivedi and Gardner, 1997, 37). Again, by ensuring the GC principles of participation and the trauma treatment ethic of “fidelity” such risks can be overcome, which has been shown in the BC methodology.

Instead of these risks BC staff identified challenges to rehabilitation when using bibliotherapy that were more practical and related to having to do group sessions rather than individual ones due to time and space, not having enough background information on young people’s histories before sessions leading to difficulties planning and making sessions victim-centred so as to avoid “nonmaleficence” from perhaps covering a topic that is too challenging. BC staff also discussed time pressures when helping young people admit their situation and then gain an insight into it because “I am expected to do this in one session, but actually you need eight sessions where you work through the problem slowly.” Space restrictions also meant that there was initially a mixed group for bibliotherapy, but eventually all of the female clients dropped out because they felt uncomfortable discussing their histories in a mixed group, so a separate group was set up for them.

Comparing the BC with other models

When assessing the success of bibliotherapy the individual’s preference towards reading and literature will have a huge impact. To explore their own story through displacement the young people need to use a tool that they feel comfortable and confident with, whether it is literature, music or art. The following studies by LeLievre (1998) and Salah (2001) show different approaches to selecting material to what is done at the BC with the first difference being a mono-cultural group, and the second being the use of religious material.

One of the difficulties at the BC’s group bibliotherapy sessions is choosing a reading material that will suit the needs of children from different cultural, national, religious and ethnic backgrounds whose traumatic experiences are often quite different. LeLievre’s study on using literature, music and film in the therapy of middle-aged Vietnam veterans suffering from PTSD, benefitted from the fact that clients shared similar traumatic experiences from the same war, and shared the same culture; making it easier to choose material that would be appropriate for everyone (1998, 74-98). Diversifying the therapy tools to use not just literature, but also film and music had a positive effect on the symptoms of the clients. The group also benefitted from having regular attendance, which is a particular challenge for the BC. LeLievre’s study also ran therapy sessions for the partners of clients separately (1998), which due to the resources restrictions at the BC would not be possible for young people with partners in the country. Another difference is that due to their age and being nationals in the country where they were receiving therapy, the clients had established support networks and a familiarity with services that could aid their rehabilitation. The BC clients however attend therapy with limitations in the areas, adding extra challenges to their RTR but these are mitigated to some extent by the BC advocacy support. Seeing that LeLievre’s patients did not have successful therapy directly after the war when the men were in their late teens, and still suffered with PTSD twenty years later really underlines the importance of working with traumatised young people as soon as possible.

Bibliotherapy seems to be more likely to be successful when the material is closely linked and meaningful to the client, and though this is difficult to achieve in a group of mixed backgrounds it is easier to be accurate with individual bibliotherapy. Ahmad Salah (2001) was able to successfully use religious proverbs and stories in a story-telling version of bibliotherapy which helped the young person who had been tortured begin to understand his traumatic story and learn how to deal with the pressures of going through the asylum process. As the client was religious each story told by the

therapist was held in great significance, however, the didactic nature of the morals of each story did not seem to allow the client to choose a way of understanding, but was told. One of the main aims of bibliotherapy is encouraging “decision making” skills and the GC discusses the need for “maximum self-sufficiency” in rehabilitation, so BC staff choose books that will facilitate these aims. Unlike with Salah’s use of parables where there is often one right way to act, one BC client said they valued the stories used because it was “very noble and open minded.” Problem solving essential to adapting to a new country and dealing with trauma is also encouraged by presenting stories that are different to the client’s background, unlike Salah’s choice of familiar stories from the Qur’an. BC clients enjoyed “understanding character’s different behaviours” and “how people lived in different times.” BC staff said that because young people have to go over their own stories of trauma many times through the asylum procedure and access to other services “what the point of using a book would then be, would be to show that other people have gone through it, and that’s very comforting, and have come out in a way that’s comforting.”.

One of the key traits in characters that bibliotherapy tries to demonstrate is resilience, however in a type of therapy called “back to the future” piloted by Palgi and Ben-Ezra (2010) they helped a young soldier suffering from Acute Stress Reactions find evidence of his own resilience by looking at his past and how he had acted in the traumatic incident. Literature was not used in this therapy, but a similar technique was used to help a client learn that they are capable of dealing with stress. Bibliotherapy unlike Palgi and Ben-Ezra’s model looks for examples of resilience in not just the client’s life, but in literature; which is especially useful if remembering a positive past that is now unobtainable is particularly painful. Four BC clients found examples of resilience, “different cultural views” and “decision making” in the books and valued how “the characters in the books overcame hardship” and said “what I liked about it was always a good conclusion.”

Displacement inherent in bibliotherapy particularly suits working with children at a pace that does not lead to maleficence, whereas Palgi’s and Ben-Ezra’s model was for an adult who had family in the country to support him (2010). Palgi and Ben-Ezra avoided colourful language because of the fear of re-traumatising the individual, whereas the bibliotherapy at the BC’s uses vivid literature to help young people understand their emotions, not avoid them. Though “back to the future” was successful in treating the young soldier’s condition, allowing him to return to work and still show no signs of the condition six months later- it seems clear that this method using direct analysis of trauma would not be suitable for the children and young people at the BC who use bibliotherapy to offset the intensity of individual psychotherapy sessions and help them explore their creativity as a means to developing problem solving skills.

As the bibliotherapy offered by the BC is in its pilot stages and the support received in the centre is holistic, covering advocacy, psychotherapy and creative therapies amongst others- it is hard to assess the particular impact of just bibliotherapy on rehabilitation; only what it brings to the other services offered for young people who request it. A review of primarily psychology and psychosocial literature on rehabilitation and the effectiveness of bibliotherapy and other writing therapies has shown the need for research into the specific impact of this upon the rehabilitation of child survivors of torture in the UK- as this group has to date not been represented.

Conclusion

This research has taken an intra-disciplinary approach bringing together two elements of the RTR for children- the health aspect and the legal/political aspect, as redress and specifically rehabilitation is both a civil and political right and an economic cultural and social right.

In assessing the challenges to implementing the RTR in IHRL the possible impacts of the draft GC were assessed and a recommendation would be for NGOs such as FFT and Redress, who supported the drafting process, to campaign for the strength of the GC to be maintained. If they also sought to raise support for the inclusion of paragraph 20 on civil universal jurisdiction; this would ensure that the campaign to strengthen the RTR in the UK through the Torture (Damages) Bill would be backed by the CAT Committee position. Research into how the GC would affect the jurisprudence of the ECtHR could be used to ensure wider access to the RTR.

Pending the acceptance and possible changes to the GC, it would be interesting to assess if the rehabilitation standards could be used by the UN Voluntary Fund for Victims of Torture in their potential global evaluation of how NGOs are implementing the RTR through their projects. If some standardised best practice methods for rehabilitation for vulnerable groups similar to the torture definition principles in the Istanbul Protocol could be generated by state and non-state rehabilitation services, this could help improve knowledge on what makes rehabilitation “accessible”, “effective” and facilitates “as full a rehabilitation as possible”. Further research is recommended for looking into the feasibility and impact on torture victims, and whether the UK could follow legislation examples from the US where a fund for torture survivors partly fulfils their obligations under Article 14 and from the Australian law which states that torture can be a civil offence.

Continuing the debate on the widening of the torture definition particularly with regards to the CRC GC 13 definition with academic, CRC and CAT Committee members, states and NGOs, this developing definition needs to lead to a better understanding of what the implications would be for legislation and service delivery. BC clients represented several young people who had been traumatised to the level of torture according to the CAT definition, but many more who had suffered trauma through other means were not represented. Though legally this puts the young people in different positions with regards to the asylum process, in a therapy sense this did not seem to alter the support they received. A conference from the NGO and state run rehabilitation services on the challenges between clinical and legal definitions may help support developments of best practice for young refugees.

Aside from the State Immunity Act, other challenges in UK legislation for the RTR for child survivors of torture were seen in the absence of legislation on the general right to rehabilitation for torture survivors, meaning that services available seem to be given on the basis of health needs not rights. Closer analysis into whether UK legislation, particularly the Children’s Act 1989, is adequately protecting the rehabilitation rights of asylum seeking and refugee children would be needed, following concerns raised about the policies and lack of implementation in UKBA, Social Services and the Health services in relation to this particularly vulnerable population. Better monitoring to thoroughly assess the needs and numbers of child survivors of torture and of organised violence in the UK needs to be addressed, and the impact of these services that secure their RTR would be possible with stronger legislation to support this them. The proposed GC would call for better monitoring and evaluation, and it would be hoped that the GC would also raise the importance of the RTR on the CAT Committee reports, which would add pressure to changes in the law and in service delivery.

Section 3 looked at the challenges on implementing the RTR through trauma therapy showing some divisions in the therapy and legal understandings of rehabilitation and torture, but ultimately that the GC reflects the main aims of rehabilitation NGOs like the BC. Further research into the potential strain on fidelity, which increased state monitoring, could help support the recommendations for evaluation stated in the GC. The centrality of promoting a therapeutic community of young people in the BC's work conflicted with the aim of the GC on "maximum self-sufficiency". Also a study by experts on whether the GC is in line with child refugee therapy needs would help moderate the parameters of evaluation specifically for children. As the GC states how crucial a holistic approach is when viewing the therapy in isolation, this was seen to be insufficient.

The challenges to a child survivor of torture's RTR when accessing services at the BC including bibliotherapy, seemed to stem from immigration procedures, as well as the difficulties from their trauma and the lack of children's guardians for young refugees and asylum centres. The BC highlighted the need to research Social Services, UKBA training and policy to assess the implementation of the CRC, and such concerns were also raised by the CRC Committee (2008) and Children's Commissioner (2012).

The last sections looked at the challenges of bibliotherapy, drawing together legal and therapy standards to see if this was a mode of therapy suitable to child survivors of torture. Practical restrictions at the BC in terms of time, space and funds for services, were seen to affect bibliotherapy sessions the most when the facilitator had limited information on the client's case history; bibliotherapy has the best impact when tailored specifically to the young person's story. Further challenges were seen in the therapies accessibility and appeal to participants, but considering how methodology reflected GC standards on rehabilitation and ethics on trauma treatments had only a few exceptions. The limited scope of the research meant that areas which were highlighted as challenging in the literature review such as "self-interest", resulted in bibliotherapy only being suitable for clients with low-support needs. In addition the reasons for young people not continuing with the therapy could be further investigated with more detailed interviews with staff and young people as well as focus groups. Despite this aptness of bibliotherapy and expressive writing both for rehabilitation, education, cultural awareness and supporting the confident narratives needed for the asylum process, was seen in the enthusiasm shown by the BC staff and the few young people that took part in the research. Investigating the potential for this to be extended to other young survivors, supported by other organisations through training and the creation of best practice resources would also be a positive step. However, raising the profile of bibliotherapy is crucial for this to be possible, and the literature review showed no examples of the use of bibliotherapy with young survivors of torture. The potential of bibliotherapy to be combined with English as a Second Language teaching for refugees is another area that would be interesting to investigate.

As long as the effects of torture continue to cause severe pain and suffering then torture effectively continues for the victim, so the state's obligations to prevent torture as enshrined in the CAT, and its effects are seen through the through RTR and by access to reparations. Truth-telling supported by story-telling is at the heart of the research on the RTR, both to encourage reparations and asylum claims and to support a young person's capacity to begin the healing process and understand what they have suffered.

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Appendix I

Semi-structured interviews

Job title and interviewee role	Main topics covered
International Legal Advisor Redress	<ul style="list-style-type: none">- CAT Article 14- CRC GC 13- Civil universal jurisdiction- State Immunity Act 1978- Torture and Rehabilitation definitions- ECtHR jurisprudence on rehabilitation
Clinical Director, The Baobab Centre	<ul style="list-style-type: none">- Rehabilitation definition- Impacts and challenges of working with young survivors of torture and organised violence- Challenges posed through asylum process and Social Services procedures- Definitions of torture- How the BC works
Bibliotherapy Facilitator, The Baobab Centre	<ul style="list-style-type: none">- Aims of bibliotherapy- Challenges and impacts of using bibliotherapy- Case study examples

Appendix II

Consent form for Babobab Centre Staff

My name is Laila Sumpton and I am a Masters student at the University of London. I am conducting research on bibliotherapy and the right to rehabilitation. I plan to write my Masters dissertation based in part on what you and others tell me in this interview.

If you agree to be interviewed, we will talk about the bibliotherapy organised by the Baobab Centre and how the right to rehabilitation can be implemented. As we talk, I will take written notes about our conversation as well as a recording so I can remember the most important parts after I leave.

Your participation in this interview is completely voluntary. If I ask a question that you do not want to answer, you do not have to answer. If, at any time, you want to stop the interview, you can tell me and we will stop. There is no problem if you choose not to participate or stop the interview. It is completely your choice.

Please certify that you have read and understood this statement and that you give consent to be interviewed.

Signature and Date

Printed Name

Appendix III

Bibliotherapy participant self-answered questionnaire

Participant number:

1. Write three words to describe the bibliotherapy sessions?

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2. What did you enjoy in the sessions?

.....

.....

.....

3. What was difficult in the sessions?

.....

.....

.....

4. On a scale of 1-5 circle how helpful have you found the bibliotherapy sessions?

1	2	3	4	5
Very unhelpful	Unhelpful	Okay	Helpful	Very helpful

5. Do you write about your experiences in your own time? Please circle Yes or No

a. If yes, why do you feel the need to write and what type of writing do you do? (e.g. journal, stories, poetry)?

.....

.....

.....

6. What literature used in the sessions did you like and what exactly did you like about it?

.....
.....

7. What literature used in the sessions did you dislike and what exactly did you dislike about it?

.....
.....

8. What would you like to change about the sessions and why?

.....
.....

9. On a scale of 1-5, circle the number that best describes your answer:

a. Before you started the sessions how did you feel about the future?

1	2	3	4	5
Very negative	Negative	Okay	Positive	Very positive

b. Now how do feel about the future?

1	2	3	4	5
Very negative	Negative	Okay	Positive	Very positive

10. What are your hopes for the future?

.....
.....
.....
.....

Appendix VI

Demographic questions to be filled out by Baobab Centre staff about participants who took part in the bibliotherapy sessions and also completed the self-answered questionnaire

1. Participant's number:			
2. Gender:	male	female	other
3. Present Age:			
4. Nationality:			
5. Ethnicity:			
6. Religion:			
7. Languages spoken:			
8. Level of English language skills:			
9. Reason for referral: survivor of torture, conflict, abuse, other- details:			
10. Date started bibliotherapy sessions:	/	/	
11. Number of sessions attended			
12. Has the participant ended their bibliotherapy sessions:	Yes	No	
13. If yes, what were their reasons for ending sessions:			
14. Where referred from:			
15. Current refugee/asylum status:			
16. Parent or guardian in the UK:	Yes	No	
17. What other therapies accessing through the Baobab Centre:			

Appendix V

Baobab Centre Consent form for bibliotherapy participants

What is the questionnaire for and who is doing the research?

My name is Laila Sumpton and I am a Masters student at the University of London. I am studying the work done by the Baobab Centre and I am interested in learning about what the young people supported by the Baobab Centre think about the bibliotherapy sessions run by Marion Bairaitser.

Do I have to answer these questions?

No, completing this questionnaire is voluntary. If you agree to complete these questions I plan to use your answers in my research.

Will my name be in the research?

No your name will not be given or used in any way. But, your answers will be used. Instead of writing your name at the top of the paper you will be given a number, so no one will know the name of the person who has given the answers. I will make every effort to protect your privacy at all times and I will not tell anyone that you answered the questionnaire.

What if I change my mind about being included in your research after I have answered the questions?

If at any point after answering these questions you decide you would not like your answers to be used in my research, you can tell Sheila and she will make sure that your answers are not included.

Permission for asking questions about me:

With your permission I would also like Marion and Sheila to provide answers to the following questions about you so that I can understand who The Baobab Centre works with. Your name would not be given here either, only your number.

18. Participant's number:
19. Gender:
20. Present Age:
21. Nationality:
22. Ethnicity:
23. Religion:
24. Languages spoken:
25. Level of English language skills:
26. Reason for referral:
27. Date started bibliotherapy sessions:
28. Number of sessions attended:
29. Has the participant ended their bibliotherapy sessions: yes/no

- 30. If yes, what were their reasons for ending sessions:
- 31. Where referred from:
- 32. Current refugee/asylum status:
- 33. Parent or guardian in the UK:
- 34. What other therapies accessing through the Baobab Centre:

Privacy

The information in the questionnaire and from the above questions will only be shared with my university.

If you have any questions about the research you can talk to Sheila or Marion who will tell me your concerns, and I will answer your questions as soon as possible.

If you have read and understood what is written here and give you consent please sign here:

- I give my consent for Laila Sumpton to use my questionnaire answers in her research

Signature Date _____

Printed Name _____

- I give my consent for Laila Sumpton to use the answers from the “questions about me” in her research

Signature Date _____

Printed Name _____