"A random system": The organisation and practice of torture rehabilitation services in Norway

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Key points of interest

- Rehabilitation services in Norway for torture victims with a refugee background are fragmented, and the resulting practice is highly person dependent.

Abstract

Introduction: This article addresses the provision of rehabilitation services for torture victims with a refugee background in Norway. It engages the topic from the outset of relevant rehabilitation rights and duties, presenting the organisation of rehabilitation services within the Norwegian health care system, and exploring the challenges and opportunities professionals see and experience as they seek to provide adequate treatment and rehabilitation for torture victims.

Methods and material: Qualitative interviews with 46 experts and practitioners that contribute to or otherwise focus on treatment and rehabilitation for torture victims in Norway, conducted between March and August 2019 and an email-based educational programme survey.. *Results and discussion:* Rehabilitation services for torture victims suffer from the absence of a systematic approach to identification and documentation of torture injuries. Moreover, the quality of rehabilitation services suffers from a lack of coordination and inclusion of actors that can contribute to comprehensive rehabilitation processes. Students of relevant professions, such as medicine, psychology, nursing, law, and policing, are to a large extent not exposed to knowledge about torture injuries and rehabilitation for torture victims during their professional studies.

Conclusion: Rehabilitation services for torture victims in Norway are fragmented, and the resulting practice is highly person dependent. Three recommendations are proposed in order to ensure minimum standards in rehabilitation services for this group: 1) developing and implementing a national plan of action on torture rehabilitation; 2) knowledge and capacity-building within relevant educational programmes, the national health services and

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other relevant public sector services; and 3) strengthening and institutionalising interdisciplinary communities of practice with specialised expertise on the topic at all relevant levels.

Keywords: Norway, professional practice, public health services, refugee background, rehabilitation.

Introduction

Torture leads to multifaceted rehabilitation needs across physical, mental, social, legal, welfare-related, and spiritual aspects of life (Patel, Kellenzi & Williams, 2014). The injuries affect both the person subjected to torture and the next of kin. It follows that rehabilitation must be coordinated between different service providers, which for torture victims with a refugee background may include health, care, social and other welfare services, as well as the immigration authorities and the reception system. It may, as such, encompass public and private institutions, as well as charities and non-governmental organisations (NGOs). This article starts from a well-founded concern that individuals who have been subjected to and survived torture before arriving in Norway do not receive the rehabilitation that they need and have a right to. Practitioners and experts have long expressed concern over the quality and extent of rehabilitation services for this group (Dyresen, 2017; Halvorsen, 2012; Lie, Sveaass & Hauff, 2014; Norwegian Psychiatric Society, 2014; RVTS, 2014; Sveaass, 2013; Varvin, 2015). Norwegian legislation does not provide torture victims with explicit rights to rehabilitation. The health regulations allow for individual assessment of each patient's needs (Ministry of Health and Care Services, 2000). However, Norwegian health regulations shall be in line with international obligations, and when examining the rights and duties for rehabilitation following torture in a Norwegian legal context, different international human rights treaties are relevant. The UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984), hereafter UNCAT, Article 14 makes it clear that rehabilitation shall be ensured:

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

The wording of UNCAT does not, however, provide many holding points to *what* "full rehabilitation" entails or *how much* rehabilitation should be offered, nor does it clarify which state holds the responsibility when the victim no longer resides in the country where torture was inflicted. The commentaries by the Committee Against Torture (2012) are therefore very useful in their guidance to address such uncertainties, even if non-binding. The Committee has made clear that persons subjected to torture shall be helped to regain their previous functions, or alternatively, receive help to acquire new needed functions, and be rehabilitated as far as possible from their personal preconditions (p. 3) – not limited by the state's available resources (Sveaass, Gaer & Grossman, 2018). The Committee Against Torture (2012, p. 3) further advocates for a long-term and integrated rehabilitation approach that takes account of the torture victim's individual situation. Specialised services must be made available, including a procedure for evaluating individual needs according to the *Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (OHCHR, 2004), hereafter the Istanbul Protocol. States must enact legislation providing the right and

access to rehabilitation (Committee Against Torture, 2012, p. 5). Access must be granted as soon as possible after assessment by qualified medical personnel and rehabilitation must be available to everyone (p. 7). Emphasis is placed on ensuring access to asylum seekers and refugees (p. 3). The Committee Against Torture (2012, p. 8) also point out that police and prison staff, health personnel, lawyers and professionals working with immigrants, must be trained to use the Istanbul Protocol. They further maintain that rehabilitation does not only apply to individuals who have been tortured, but also to individuals who have been subjected to inhuman or degrading treatment (p. 1).

For torture victims with a refugee background, rehabilitation entails healing in exile. Flight, exile, and post-migration difficulties can complicate this process. Challenges that follow exile – such as finding one's place in a new society and the transnational space, are factors that impact on wellbeing (Quiroga & Jaranson, 2005), in addition to uncertainties and restrictions that follow from insecure and temporary legal statuses. Conditions in countries of origin and concern for significant others elsewhere also have an effect (Patel, Kellenzi & Williams, 2014). Even if exile entails new possibilities, and the absence of war and persecution, it does not necessarily translate into a sense of safety – pointing to the important difference between *being* safe and *feeling* safe. Exile often involves several losses such as loved ones, community, roles, self-worth, social networks, and life projects (Varvin, 2003). Exile can furthermore include experiences of isolation, discrimination, and the loss of income and can therefore lead to poverty, and even destitution, in the absence of adequate reception and welfare provisions (Jaranson & Quiroga, 2011). Moreover, a climate of mistrust, and the suspicion and ambivalence that refugees can face in the societies where they seek refuge, may heavily impact their rehabilitation process:

Many survivors relate that the worst was that they were not supported by those they had counted on. A refugee who experiences suspicion, an unfriendly bureaucracy, rejection of their asylum application, rejection on their housing application, rejection on economic support, rejection on their application for benefits, racism, xenophobia, can acquire a new trauma, one that fundamentally impacts trust, and that can lead to bitterness. Several have said that: it is worse than prison and the torture (Varvin, 2003, p. 25).

Accordingly, experiences from flight and exile, as well as integration, inclusion and treatment in the new country, and what future prospects allow for, affect the impact of torture injuries in a context of migration and displacement. For migrants with an irregular legal status, access to public services is limited. In response to a lack of accessible health care services, the Church City Mission and the Red Cross run health care centres for undocumented migrants in Oslo (2009-) and Bergen (2013-). From the beginning, the centres were established as a temporary solution to humanitarian needs, with the explicit ambition to become superfluous once public authorities secured necessary and predictable health care services for persons with an irregular legal status. The centres are still in operation, and the health professionals and social workers who volunteer their time and knowledge at these centres meet migrants who have survived torture and who are in need of comprehensive rehabilitation (Church City Mission & Oslo Red Cross, 2020).

It is from this outset that the Norwegian Red Cross decided to examine the status and quality of rehabilitation services for torture victims in Norway (see also Norwegian Red Cross, 2020). As part of this project, this article

looks at the provision of rehabilitation services within the Norwegian national health system – addressing both the organisation of services, knowledge in relevant professions, and practitioners' experiences of providing help, treatment and rehabilitation, and what, according to them, is needed to secure adequate rehabilitation services for torture victims.

Methods and material

This article combines intakes from a literature and grey literature review; a brief, email-based educational programme survey; and qualitative interviews with a diverse group of experts and practitioners whose work addresses torture injuries. We contacted all educational institutions in Norway offering professional studies in medicine, psychology, nursing, law, and policing (see table 1 for a complete overview), with two questions: *if* 'torture' is covered as a topic within the relevant programmes during the academic year 2018/2019, and if so, *how* the topic is integrated in the curriculum and teaching. We contacted the departmental administrations of each given programme (a total of 25 programmes at 16 institutions), which either responded directly or referred us to relevant staff members. We received no response from three institutions and obtained an incomplete answer from one department.

The primary contribution of this article is, however, based on the qualitative interviews we conducted with professionals whose work concerns torture victims either clinically or in research, academia, care work, reception and refugee integration work, and capacity-building. The recruitment process for these interviews started with preliminary talks with publicly known experts and scholars who introduced and shared an overview of relevant professionals. We further contacted the Directorate of Health, the National Institute of Health, the Norwegian Centre for Violence and Traumatic Stress Studies (NKVTS) and the five Regional Resource Centres about Violence, Traumatic Stress and Suicide Prevention (RVTS), who also shared information about relevant professionals.[1] We aimed for a strategic sample to include professionals with considerable experience with and knowledge about "refugee health," including torture rehabilitation. As we started interviewing, we were introduced to participants' networks and colleagues – and benefitted greatly from this snowballing element. All in all, we invited 57 professionals to take part – and as we concluded the interviews in August 2019, we had interviewed 46 of them. The strategic sampling approach has given insight into the field of torture rehabilitation from across Norway's four health regions (South-East, West, Mid-Norway and North). The lowest number of participants from one single region was 6 and the highest was 21. Note, however, that the number of participants from each region does not reflect the population size of the relevant region, or the number of practitioners that operate there. In total, we interviewed 28 women and 18 men, and their individual professional experience focusing on refugee health spanned from around one year to more than 40 years. Half of the participants had worked within this field for around 20 years or more.

We did not limit our interviews to any one profession, service provision or specific part of the rehabilitation process, as we have sought

1 The Directorate of Health hosts a professional council for immigrant health, the National Institute of Health has a dedicated unit working on migration health, and NKVTS and RVTS have refugee health and forced migration as part of their focus areas, and the RVTSs are, furthermore, mandated by the Directorate of Health to include torture among their many specified topics.

to explore the breadth of professionals' experiences with treatment and rehabilitation of torture injuries for this study. That said, most interviewees are health care providers. 43 of the 46 participants have a clinical background: 35 work within specialised health care services, and seven work on primary health care services, both within NGOs, and the private and public sectors. Several participants are also affiliated with universities, refugee reception structures and humanitarian organisations. While some exclusively focus on the arrival and/or settlement phases (10 out of the 46 participants) – most work with refugee health at all stages, spanning the arrival, settlement and subsequent stay in the country. Accordingly, their patients/clients have different legal statuses – from persons with an irregular legal status to those who are Norwegian citizens. Half of the participants work primarily or exclusively with issues to do with refugee and migration health, whereas the other half work on various topics yet still have extensive experience on this. By profession, the participants are trained psychologists (16 out of the 46), nurses (7), medical doctors (6), psychiatrists (5), social workers (4), physiotherapists (3), dentists (2), an occupational therapy nurse, a child welfare worker, and a lawyer. Many have completed specialisations. It is important to emphasise again here that the selection of participants for this study has been strategic in that we have prioritised professionals with considerable experience on refugee health. We have therefore not interviewed general practitioners (GP) as such, albeit they are important first line responders within the national health care system – and key gatekeepers for access to rehabilitation services for torture victims through referrals.

Most of the interviews (27) were conducted one-to-one, by the first author. She also conducted three group interviews (two with two participants and one with three), and three focus groups with four participants each. For all interviews, we used a topical interview guide as a point of departure, covering eight themes: (1) experience; (2) identification of torture injuries; (3) documentation of torture injuries and competency; (4) interdisciplinary treatment and rehabilitation; (5) rehabilitation services and perceived availability; (6) relevance of exile and background; (7) socio-economic issues and social rehabilitation; and (8) quality of services, including also a specific focus on being a practitioner in this field. Each interview covered all eight themes, but depending on participants' knowledge and respective emphasis, they varied in terms of which topics were covered most into-depth. We asked participants to share both their professional experience and their assessment of the general state of rehabilitation services for torture victims. Participants were not presented with a definition of "rehabilitation" but spoke to the spectre of services as regards torture injuries – from housing and help with specific ailments to understandings of what constitutes comprehensive rehabilitation.

All focus group interviews, one group interview and 17 one-to-one interviews were recorded and later transcribed verbatim and analysed in NVivo. We specifically looked for similarities in perspectives, positions, and experiences that spanned different background variables (e.g., participants' professions and geographic locations). Participants whose quotes are used are referred to by profession (and number where necessary to differentiate between them). All quotes have been translated into English.

Findings and discussion

Describing the services available for people subjected to torture, one participant stated, "The so-called Norwegian model [is not] a

model. The Norwegian system is a random system" (Psychologist 1). This echoed in the accounts of many participants. In the following, we will present an overview of the organisation of services. The overview builds on grey literature and information gathered from institutions of higher education providing professional studies in medicine, psychology, nursing, law and policing. We then explore the participants' experiences and reflections on providing help, treatment and rehabilitation to torture victims with a particular focus on identification and documentation of torture injuries and the importance of interdisciplinary communities of practice. We proceed by exploring their reflections on the crucial components for adequate rehabilitation. Our findings are then discussed in relation to each other in the conclusion, where we also suggest measures to ensure that Norwegian authorities meet rehabilitation needs resulting from torture injuries.

Organisation of services and inclusion in educational programmes

Norwegian authorities have a proclaimed goal of equal and adequate health and care services for the whole population (Ministry of Health and Care Services, 2013). This implies that provisions should be equally good and adapted to each patient regardless of background. Yet, the rehabilitation services available to torture victims with a refugee background are affected by general challenges that immigrants face in accessing health, care, and welfare services. Adequate translation and interpretation services for those who need it are preconditions for equal and adequate services (Alpers, 2017; Directorate of Health, 2011). Issues and challenges associated with language and interpretation services were raised in 25 interviews, including the three focus groups. While participants discussed several issues pertaining to language, such as the benefits and drawbacks of face-to-face versus remote interpretation (by video or telephone), how to facilitate good collaboration between interpreters, themselves and their patients/clients, the implications of which language is used (the mother tongue or another language), and the importance of also offering peer support to interpreters, many focused in-depth on halting language services and a hesitant public sector that sometimes lacks even basic skills in working with interpreters. For instance, one nurse working within the general health care services explained the situation as follows, "What I perceive as very basic knowledge about using an interpreter is not always known. [Service providers] therefore have reservations about using interpreters and experience unnecessary barriers. […] Many [professionals] are poorly trained and find it difficult." A survey among interpreters in the national interpreter register shows that interpreters with formal qualifications were used in only four out of 10 interpretation assignments within the public sector in 2017 (Directorate of Integration and Diversity, 2018). Moreover, while family members should not be used as interpreters by public services and authorities (Directorate of Health, 2011), it is not uncommon that both adult and minor family members have this function (see, e.g., Faryabi, 2017). It places an unduly burden on family members and can hinder what can be communicated. Furthermore, using children as interpreters is prohibited by law (Ministry of Justice and Public Security, 2016, § 11 e). Participants also described concern over general system competency and cultural competency, which are further important aspects in the provision of rehabilitation – and which may hinder both identification of torture injuries and a proper understanding of their impact in the patients'/clients' lives (Alpers, 2017; OHCHR, 2004; Quiroga & Jaranson, 2005).

The national health care service is the main provider of rehabilitation services for torture victims in Norway. In practice, this implies that those with a right to a GP, must seek referral to the specialised health care services from there. It also means that they are liable for a user fee until they have paid the annual maximum fee (NOK 2,460 in 2020) and receive an exemption card for such expenses. Several participants noted that treatment related expenses pose a barrier for patients with limited funds and income. This contrasts with the situation at specialised centres elsewhere that provide services free of charge for torture victims (e.g., Freedom from Torture in the UK), traumatised refugees (e.g., DIGNITY in Denmark[2]), and for persons with a refugee background more broadly (e.g., the Swedish Red Cross) (Norwegian Red Cross, 2020). We identified a few places in Norway where referrals could be made by others than the GP, including possibilities for self-referral, and where consultation was free of charge. However, these represented the exception rather than the norm. Several participants also pointed out that costs for transportation in order to access services represents an additional barrier.

While no specialised centres for torture rehabilitation exist in Norway, a specialised dental service includes torture victims: facilitated dental health provision for persons subjected to torture, assault and with odontophobia (TOO) (Directorate of Health, 2010). This service is limited to persons with a valid residence permit, and torture injured patients represent a very small share of patients; two percent according to information we received from the Directorate of Health (e-mail, August 2019). Yearly, this amounted to 18–22 patients in 2016 to 2018. Regardless of this low number, research shows that it is common with torture to the face, the mouth, and the teeth (Høyvik, Lie & Willumsen, 2019).

In order to gain insight into how knowledge about torture is ensured in relevant disciplines and professions, we examined *if* and *how* the topic is included in selected educational programmes during the academic year 2018/2019. We contacted all Norwegian educational institutions offering professional studies in medicine, psychology, nursing, law, and policing. We found that lectures addressing the topic are overwhelmingly absent. For professional studies in medicine given at four universities, knowledge about torture as a separate topic is part of the mandatory instruction at one institution (University of Bergen) and the non-mandatory instruction at another (The Arctic University of Norway). It is not part of the curriculum in any of the professional studies in psychology. Furthermore, only one nursing degree granting institution includes the topic as part of the mandatory training (Oslo Metropolitan University). Both for professional studies in law and policing education, the focus is limited to establishing the prohibition of torture. This was also reflected in participants' experiences. Among the seven participants who discussed whether the topic had been covered during their studies, only one had experienced this, in the 1990s.

Identifying torture injuries and the importance of interdisciplinary communities of practice

Identification, examination, and documentation of torture injuries are important steps for treatment and rehabilitation. Research and clinical practice highlight many challenges in identifying persons who have been tortured. This is further complicated by one of this article's main findings: the absence of a systematic approach to identification and

2 With the limitation that they have been granted permission to stay in Denmark.

documentation, and an unclear division of responsibilities. There are several points during the asylum and settlement processes where public service providers and asylum seekers and refugees interact, both formally and informally. The issue at stake is therefore not an absence of opportunities in which experiences of torture can surface (Brekke, Sveaass & Vevstad, 2010; Jakobsen et al., 2007; NOU, 2011). For instance, the Directorate of Health (2015) has developed the *National guidelines for the healthcare services for asylum seekers, refugees and family reunited persons IS-1022*, hereafter IS-1022, where both torture victims and the Istanbul Protocol (OHCHR, 2004) are referred to explicitly, and which recommends offering a general health examination by the local health authority (physician or nurse) three months after arrival (Directorate of Health, 2015). For the examination, a form including two questions about identifying torture is recommended: *Have you witnessed torture? Have you been subjected to torture?* (Directorate of Health, 2017). Our participants

Table 1. Overview of torture as topic in selected educational programmes.

Degree	Educational institution	Mandatory	Other**
Medicine	University of Oslo (UiO), The Arctic University of Norway (UiT)	No	Yes
	University of Bergen (UiB), Norwegian University of Science and Technology (NTNU)*	Yes	
Psychology	UiO, UiT, NTNU	No	No
	UiB	Incomplete	Incomplete
Law	UiO, UiT	Yes	Yes
	UiB	Yes	
Nursing	Oslo Metropolitan University	Yes	
	UiT, NTNU, University of Agder, University of Stavanger, Molde University College, Østfold University College, University of South-Eastern Norway, Western Norway University of Applied Sciences	No	No
	Inland Norway University of Applied Sciences	No	Yes
	VID Specialized University, Nord University, Lovisenberg Diaconal University College	No reply	No reply
Policing	The Norwegian Police University College	Yes	

** Guest lectures, part of non-mandatory lectures or similar.

* Not as own topic but included in lectures about trauma and abuse.

highlight some actors as particularly important for identifying torture injuries following arrival and settlement: health and social workers, teachers, reception centre staff, the immigration authorities[3] (especially during the asylum interview) and NGOs.

While identification was discussed in all interviews, the issue of *when* torture injuries are usually identified was raised in nine, including the three focus group discussions. Several of these participants spoke about how, unless torture injuries are identified early, it can be delayed for years and even decades. Some spoke about torture victims who had been in Norway for years before anyone had asked whether they had been tortured:

I have met people who have been here a long time without having their torture injuries identified. Symptoms, you treat the symptom […] and then we never ask the question. There are extreme examples with people who have become extremely disabled due to torture, but where no one ever asked the question of what caused it or why it is this way. Where the patient themselves, due to brain damage, was unable to communicate it or where they did not know that what they had been subjected to is called torture according to the law (Psychologist 2).

Unless identification efforts are institutionalised and followed in a systematic manner, torture injuries can remain unidentified, leaving people without adequate services or support, as suggested by another participant:

I sometimes get patients who have been in Norway for 20 years and have never been in contact with the needed health service. They have tried to stay at home, tried to hold down a job, became disabled at some point but never received support for their mental health needs (Psychologist 3).

While acknowledging how difficult it can be to identify torture injuries, participants spoke of how certain forms are easier to identify than others. Acts of torture that do not leave visible marks are more difficult to identify than physical injuries, although the marks are not always identified as related to torture. Seeing different symptoms in relation to one another can itself be challenging (Høyvik & Woldstad, 2018). Furthermore, torture victims can be afraid or hesitant to reveal their experiences to service providers, as torture is often committed by professional representatives of public organs, within institutions, and can include health professionals being present. Torture victims may have suffered cognitive damage, loss of consciousness, dissociative amnesia, numbness, or alienation due to the injuries inflicted (Høyvik & Woldstad, 2018; Quiroga & Jaranson, 2005). They may also worry about issues of confidentiality, the presence of interpreters and concern regarding access to treatment and rehabilitation. Trust is generally both a precondition and a challenge – and it can take time to build a sense of safety, a safe space where trust allows for sharing. Sexualised forms of torture are described as particularly difficult to talk about regardless of the victim's gender. Having been forced to commit torture is also a form of torture that the participants emphasised as particularly difficult. In addition, they spoke of patients/clients with survival guilt who had witnessed the torture of others that they could not or dared not intervene on behalf of. Intense feelings of stigma, shame and guilt were also raised as barriers that prohibit some from ever talking about what they have been subjected to. Torture victims may also refrain from sharing their experiences out of concern for others' wellbeing:

3 Fafo Institute for Labour and Social Studies is undertaking a study (September 2020–February 2021) for the Norwegian Directorate of Immigration on torture victims in the asylum process. For more information, see (in Norwegian): https://www.fafo.no/prosjekter/aktive-prosjekter/item/utredning-om-torturutsatte-i-asylprosedyren

Many of my patients were very much in doubt whether I could bear to listen to what they had been subjected to […] Would I be able to listen and to carry the burden of knowing about it? If they told me, would I break into pieces? They did not want to expose me to the strain of listening to what they had been subjected to (Psychologist 4).

At the system level, identification is challenged by a lack of guidelines for *how* it should be done, *who* should do it, *what* it should entail and, furthermore, by whether there should be a general screening or not (Sveaass & Lie, 2020). It also relates to insufficient knowledge about the topic within the national health service and a concern that deliberate identification is unethical if one has nothing to offer at the other end. Our participants emphasised that torture as a topic can be experienced as difficult, causing some professionals to refrain. A precondition for identification therefore appears to be that service providers are confident about the topic and, moreover, that they can offer or refer patients/clients to adequate services.

The Istanbul Protocol represents the international minimum standards for examining and documenting torture and other inhuman treatment (OHCHR, 2004). There is no Norwegian edition nor summary of the Protocol. Our study points to a lack of systematic implementation of the Istanbul Protocol in the national health services and an absence of professionals who can undertake an examination and provide documentation according to it. As noted by others (Lie et al., 2015; RVTS, 2014), a lack of tariffs for reimbursement for documentation also represents a hampering factor. The IS-1022 states that "Health certificates [documentation and preceding examination] in immigration and asylum cases are necessary in order to safeguard the rule of law, both when applying for protection and for facilitation of the stay in the country" (Directorate of Health, 2015, section 3.2, para. 1). To this, we can add the importance of professional documentation of torture injuries and subsequent rehabilitation. As explained by one participant, *"Norway is not fulfilling its obligations to torture victims as I have seen them formulated in UN statements. Full rehabilitation shall be offered. Nor do we know the Istanbul Protocol properly" (Psychiatrist 1)*.

Participants also described the important role played by accessible, institutionalised and interdisciplinary, communities of practice for the provision of adequate treatment and rehabilitation services. Research participants shared a need for and emphasised the meaning of such communities. Some highlighted a need for a national reference centre to lean on; others underscored the value of established, specialised peer groups or teams at the institution where they work. For all, the value of such communities lies in common dedication and the opportunity to reflect on practice, develop skills, peer consultation and support, and debrief challenging treatment and rehabilitation processes. An emphasis was also placed on institutional frameworks that value their expertise and assessment and allow for flexibility in their practice as to respond to complex needs and patients'/clients' life situations. We found several communities of practice and networks in our mapping of services with particular knowledge about refugee health. However, rather than a result of a national systematic and equal service, they were often local, and in some instances, regional solutions initiated by dedicated professionals both within private practices, the national health care service, and NGOs. One psychologist shared their experience of being part of such a group of practitioners:

I know what to do, but that is because I have had the opportunity and time, and have been offered guidance and was told what to read and what to look into; and I have also been given time to put all this into a clinical setting. It would not have been like this if I had just tumbled across the

topic [torture injuries and rehabilitation]. I have been given the opportunity to acquire the necessary competency (Psychologist 2).

A psychiatrist also raised the importance and implications of feeling competent:

If you know that you can do something, then it is much easier to handle challenging situations. If you do not have any methods or means, then it is much easier to feel helpless, and then you can get burned out (Psychiatrist 2).

A satisfactory rehabilitation service for torture injuries, accordingly, also relates to the presence of adequate support structures for those who provide interpretation, help, treatment, and rehabilitation. In the other Scandinavian countries, where there are established centres providing specialised rehabilitation for this group, the importance of such peer support systems is well acknowledged, and a key component of the centres' infrastructure (Norwegian Red Cross, 2020).

Practitioners' reflections on adequate rehabilitation

We have established that UNCAT's (1984) Article 14 states that torture victims shall have "as full rehabilitation as possible" and that the Committee Against Torture (2012) recommends what such rehabilitation should entail and where the responsibility lies. As part of our research, we also asked the participants what they see as important components for adequate rehabilitation. Combined, their experiences speak to three interrelated factors that should be present to secure satisfactory rehabilitation processes for torture victims:

1. An interdisciplinary and comprehensive approach (identification, documentation, treatment and rehabilitation, individual and family perspective, advocacy, capacity-building, etc.) that includes user involvement.
2. Coordinated and systematic interventions across service providers (physical, mental, legal and social) and consideration of the role of different institutions (private, public and NGOs).
3. Ensuring systemic, cultural, and language competency.

According to the participants, torture tends to have cross-cutting implications in torture victims' lives and for their next of kin. Rehabilitation should therefore be coordinated between relevant services and consider both an individual perspective, a family perspective, living conditions and overall quality of life. Hence, rehabilitation should also include a community and societal perspective. In the provision of services, it is important to remember that ideas about illness, social skills and quality of life can differ between those providing and those receiving help (Jaranson & Quiroga, 2011). Torture rehabilitation emerges as a field of practice that stretches across administrative authorities, social, care and health services, and the life cycle. Overall, and importantly, there has been little focus on how children of torture victims cope and manage in the Norwegian context (RVTS, 2014), although emergent research highlights how parental suffering and trauma among adult refugees impacts on children's daily life and development in diverse ways (Johansen & Varvin, 2019). It is also important to keep in mind that people of all ages are subjected to and are witnesses to torture.

It is a cause for great concern that several participants in our study describe institutional frameworks that either directly hinder adequate responses to the needs of torture victims or make the needed response more challenging to carry out. Several participants pointed out how patients/clients with traumas originating from torture with need for mental healthcare

in particular, experience challenges in accessing the needed services, and that increasingly, these focus on short treatment plans and increased production figures – into which comprehensive rehabilitation programmes do not necessarily fit:

The rehabilitation situation for this group of patients within the mental health services is unsatisfactory. You do the minimum effort if you do anything at all. It is very difficult to refer these patients to mental health services. Most of them must make do with the primary health care service. They take the great majority of these patients (Psychiatrist 3).

Participants spoke to the necessity of service provisions that respond to complex needs and allow for a holistic approach and sufficient time; an approach that minimises patient/client drop-out. Several participants emphasised the importance of responding to basic needs first. They offered examples of torture victims who were lacking the very essentials, such as food or electricity. These participants described the importance of a comprehensive understanding of rehabilitation needs to include the spectre of help, treatment, and rehabilitation, ranging from food, housing, and translation of documents to surgery and different therapeutic interventions. As pointed out by one participant, *One of the first things you should do when providing treatment, is to ensure that you are helping people in a way so that they feel an actual improvement of their situation* (Psychologist 1).

Two functions were repeatedly described as particularly important, but more or less absent in the rehabilitation provisions: a dedicated case manager to coordinate the process and a social worker to facilitate and translate the various regulations and rights in terms of social welfare and work programmes in line with social rehabilitation. Many participants pointed out how rehabilitation services are fragmented and emphasised the importance of not operating in silos independent of one another when several professionals are involved. Coordination and collaboration are therefore of paramount importance. Social worker competency was the professional capacity most asked for in interviews for this study. Social rehabilitation concerns living conditions and general life conditions. As described by one participant,

Many torture victims I have met, have been given social benefits, and have placed themselves in a small flat, and are sitting there in the dark by themselves. There is quite a bit of social rehabilitation required in order to have a dignified life (Psychiatrist 1).

Social rehabilitation entails rehabilitation back into society (Quiroga & Jaranson, 2005). Having someone in charge of social and broader welfare-related issues becomes particularly important in relation to administrative authorities, such as the Norwegian Labour and Welfare Administration (NAV). As highlighted by participants, who were often asked for help with interpretation and translation during therapy sessions and medical appointments, internet-based services and decision letters in Norwegian can be impossible to comprehend for several reasons, including language skills and illiteracy, digital or otherwise. Several participants within the specialised health care service had taken the coordination and social worker roles upon themselves. This involves assisting patients in navigating available services and acknowledging the patient's broader circumstances and needs. It was clear that helping patients with practical matters was an important component of treatment and in establishing a therapeutic alliance. This is crucial as effective treatment in a therapeutic setting depends on trust and an alliance between the professional and the patient. At the same time, some expressed that it was outside their expertise, that it

was time-consuming and left little room for traditional and equally important therapeutic interventions; highlighting the importance of the involvement and support also of other professionals to respond adequately to their patients' rehabilitation needs.

Conclusion

This article shows that torture victims with a refugee background are far from secured access to adequate rehabilitation services in Norway. This results from several interrelated issues. It pertains to general challenges, such as ensuring adequate and equal access to health and care services for all regardless of background, but also more specific challenges relating to having been subjected to torture and other grave human rights violations. These issues concern different systemic levels and authorities but are all crucial for a satisfactory rehabilitation service. In our research, we met highly competent professionals, many of whom have stretched far beyond what can be expected in their jobs, to address the needs of torture victims who they meet in their professional capacity. There are many other professionals like them out there. Rather than shying away from a task too tall to handle, they develop skills and expertise through perseverance, personal initiatives, networks, and profound dedication to help those who have trusted them with their experiences. Some have employers who acknowledge the value of their dedication and allow time and resources to respond to complex needs. However, their work and prioritisation of a group of patients/clients with particular vulnerabilities, and what can be comprehensive rehabilitation needs, are more often person-dependent than the result of institutional or national priorities. Importantly, several participants pointed out that their efforts where done despite of the organisation of rehabilitation services, rather than because of it.

Given the general lack of coordination, institutional priorities, frameworks, and inclusion of actors that would contribute towards a comprehensive rehabilitation process, the rehabilitation services for torture victims are fragmented across the country. Practitioners who strive to ensure local rehabilitation services describe a powerlessness when faced with a system that does not facilitate satisfactory rehabilitation. We have also found preliminary evidence that service providers may lack sufficient knowledge about the topic and that students of relevant professions, such as medicine, psychology, nursing, law, and policing, are to a large extent not exposed to the subject as part of their training, particularly as concerns rehabilitation. Accordingly, services are likely to continue to be characterised by insufficient knowledge about 'torture' as a topic and unfamiliarity with international protocols for identification and examination – as encapsulated in the Istanbul Protocol (OHCHR, 2004). While the Istanbul Protocol is importantly referred to in IS-1022 (Directorate of Health, 2015), the guideline is non-mandatory, and professionals may be unfamiliar with it. This again affects the quality of services. As the organisation of practice stands today, a national systematic approach is missing, and identification and documentation of torture injuries therefore appears arbitrary. Given that persons subjected to torture often struggle with mistrust of public authorities, feelings of shame and even denial, both knowledge about torture and a systematic approach is necessary. Importantly, without knowledge about torture injuries, it becomes extremely challenging to undertake good identification – a precondition for full rehabilitation to take place at all. To this end, there is an urgent need for further research that investigates GPs' knowledge about and practice pertaining to identification, referrals, and rehabilitation.

Finally, our findings suggest that torture victims with a refugee background experience the same barriers that immigrants more generally share in accessing public health, care and welfare services, such as issues pertaining to a public sector that still needs more competence in terms of serving an increasingly diverse population. This is manifested for instance through issues arising from language, including the usage of interpreters without formal qualifications, and different understandings of health, systemic knowledge and health literacy. There is therefore also an urgent need to continue to follow-up and address identified challenges (Directorate of Health, 2018) as to achieve the Norwegian authorities' goal of equal and adequate health and care services for the whole population (Ministry of Health and Care Services, 2013).

To secure rehabilitation for torture victims in Norway, the shortcomings of the current rehabilitation "model" needs to be addressed. Based on the experiences accounted for by the professionals we interviewed for this study, we make three recommendations to ensure that the authorities meet the current rehabilitation gaps.[4] First and foremost, we recommend that

1. *Norwegian authorities develop and implement a national plan of action on torture rehabilitation*. A national plan of action would provide the framework for a systematic, equal, accessible and comprehensive rehabilitation service to people who have survived torture – rather than the current fragmented services and the resulting highly person dependent practice.
2. *A focus on knowledge and capacity-building within relevant educational programmes, the national health services and other relevant public sector services.* All participants highlighted the importance of both general knowledge and expertise, among a wide group of professionals. Few participants had themselves been exposed to the topic of torture as part of their studies and raised the importance of this topic within educational programmes in medicine, nursing, physiotherapists, psychologist, occupational therapists, dentists, interpreters, social workers, lawyers, and the police. In addition, they emphasised the importance of frameworks on identifying, documenting, treating and rehabilitating torture injuries and of strengthening competence within existent service provisions (as would be ensured by a national plan of action).
3. S*trengthening and institutionalising interdisciplinary communities of practice with specialised expertise on the topic at all relevant levels.* Torture injuries may require rehabilitation across physical, mental, legal legal, social and spiritual aspects of life. This necessarily includes different services and administrative authorities. It can be extremely challenging both for the person requiring different services and the professional trying to provide and coordinate these. Accessible and interdisciplinary communities of practice are therefore of great importance, as highlighted by a

4 Upon completing the study, we presented these recommendations in a series of consultations with about 30 individuals from relevant public, private and humanitarian institutions, including some whom had partaken in the study and the rest being first invited to comment on our findings. Chatham House Rules applied. In these consultations, there was broad consensus for the need to include the topic of torture in educational programmes and capacity-building, and for a national plan of action. The significance of communities of practice was also broadly recognised, albeit with different weightings in terms of how these should or could be institutionalised and made available to relevant stakeholders. We suggest this recommendation in particular as a topic for further research and discussion.

majority of our participants. In response to this finding, we suggest that specialised and interdisciplinary competency about torture rehabilitation, as regards all levels of service, should be strengthened and gathered in one or more institutionalised communities of practice that supports existent and decentralised services.

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