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REPORT OF THE TASK FORCE COORDINATION COMMITTEE THE GOVERNOR'S TASK FORCE ON THE FEASIBILITY OF A MINNESOTA CENTER FOR VICTIMS OF TORTURE

April 1985

I. INTRODUCTION

The Coordination Committee was charged by the Task Force with making recommendations on the feasibility, scope, location, budget, and funding of the proposed center for victims of torture.

The committee was chaired by Sam Heins, and included Msgr. Jerome Boxleitner (for Archbishop John Roach), Mr. Steven Dunham, Mayor Donald Fraser, Dr. W. Eugene Mayberry, Reverend Bryan Peterson, Dean Robert Stein, and Professor David Weissbrodt.

II. RECOMMENDATIONS

The committee recommends:

1) A Minnesota Center for Victims of Torture be established;

2) The Center have both treatment and research as its major functions, with a strong educational component as well;

3) The Center be an independent, nonprofit corporation but be affiliated with one or more major medical and educational institutions;

4) The Center utilize the staff and resources of these institutions for most specialized treatment functions;

5) The Center be located in a major metropolitan area which can offer sizeable medical, educational, and social resources;

6) The Center treat approximately 100 patients a year;

7) The Center seek a private sector endowment of between $10 million and $12 million to finance its operations.

III. NEEDS ASSESSMENT

No definitive estimates on the number of worldwide torture victims exist. Amnesty International estimates that more than one third of the world's governments are responsible for the torture of prisoners. Between January, 1980 and mid-1983, Amnesty International interceded on behalf of 2,687 individuals in danger of torture in 45 countries. This figure includes only those who are able to make their situation known outside of their country, probably a small percentage of the actual number. Time magazine reports that the number affected runs

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into the tens of thousands annually, with perhaps 1,000 survivors reaching Western Europe, the United States or Canada annually.

The Denmark Center for the Rehabilitation of Torture Victims treats up to 70 people a year. These patients are taken from the population of established refugees in Denmark. That country admits 500 refugees a year. By contrast, the United States received 72,000 legally acceptable refugees in 1984, while another 180,000 persons have applied for refugee status. While the Danish refugee population almost certainly has a different composition than the American refugee population, it cannot be doubted that the number of victims of torture currently residing in the United States is significantly larger than the number being treated in Denmark. The Toronto center works with about 250 victims a year. Again, the Canadian refugee population is likely to be significantly smaller than that in the U.S.

According to the Minnesota Department of Human Services, approximately 26,200 refugees were residing in Minnesota in June, 1984. 25,000 of these were from Southeast Asia, with the remaining 1,200 from Poland, Rumania, Ethiopia, and Afghanistan. Most of these people reside in the Twin Cities and Rochester areas. No estimates are available on the number of torture victims residing in the state, although some cases are known to medical and human services personnel.

The treatment of victims of torture is specialized; standard medical practice is not always adequate. Amnesty International reports in Torture in the Eighties "The immediate and long-term effects of such intense physical and psychological abuse are oppressive. ... Clearly, there is a great need for medical treatment both immediately after torture and over a longer period, including psychiatric treatment in many cases. ... Torture victims often need social, medical and psychological help after release. Systematic examinations of torture victims conducted by Amnesty International's Danish Medical Group, established in 1974, show that practically all victims suffer from multiple mental and physical sequelae (after-effects) to torture." The report also points out that trauma is not always limited to victims; their families often exhibit psychosomatic symptoms as well. However, there is no consensus about what constitutes effective treatment. There exists a need for research into the effective treatment of torture in addition to the simple provision of medical services. Effective research in this field would provide benefits well beyond the help provided to those few actually treated at a center. (Note: I hope that material from the medical and legal committees can be used to supplement this section.)

The committee believes that the existence of a center can be justified solely on humanitarian grounds. In addition, a center would be in keeping with the fundamental values of the American People. Finally, a center would keep the problem of torture in the public eye, and thus deal not only with its treatment but its prevention.

While there do exist doctors who treat torture victims in various countries in South America, they face significant political and practical impediments which prevent them from establishing a publicly visible torture rehabilitation center. It should not be the intend of a U.S. center to bring victims who can be treated in their own countries. However, a U.S. center can treat those victims who currently reside in the United States or in a country where treatment facilities are not available.

It is clear to the committee that the need for treatment, research and education on torture exists. It remains to be determined whether Minnesota is a suitable location for this activity. The committee attempted to identify reasons for and against a Minnesota location.

There are several reasons why a center for treatment of torture victims should <u>not</u> be located in Minnesota:

1) There is at present little money available for this activity.

2) The center would provide little direct benefit to Minnesota residents with the exception of those who have been victims of torture.

3) Other parts of the country have a larger and more diverse refugee population. Minnesota is relatively distant from many of these population centers.

4) The center will provide relatively few jobs and contribute only a little to the state's economy.

5) As persons residing in other parts of the country or abroad come to Minnesota for treatment, they may add to the burden on state and local social services.

6) The medical services required, while in many ways unique, are not likely to need the "state of the art" resources of facilities such as those found at the University of Minnesota or the Mayo Clinic.

7) Unless a truly first class facility can be developed it is better not to try at all. A mediocre facility will only duplicate resources available elsewhere while doing a disservice to victims by raising expectations.

Why, then, should a center be established in Minnesota?

1) Minnesota has a worldwide reputation for excellence in medical, legal, and social services. While "high-technology" medical expertise may not always be required, a concentration of skilled and concerned individuals in many diverse fields is necessary for successful operation.

2) There is a need for a center that is not now being met anywhere else in the United States.

3) Toronto and Copenhagen are not necessarily the most "logical" locations for treatment centers in terms of concentrations of refugees and proximity to major population centers. The centers were developed there solely because of the existence of a group of concerned and committed individuals. This condition also exists in Minnesota. Minnesota has a tradition of cultural exchange and involvement in the world community. This tradition would be enhanced by the development of a center.

4) While Minnesota's refugee population may not be as large as that of New York, California, or Florida, it is one of the largest in the country and may be the largest on a per capita basis. As such the services required by patients and their families may very likely already exist.

5) Despite the size of Minnesota's refugee population there is relatively little controversy over immigration matters when compared with the rest of the country. A center located in Minnesota is likely not to be as politically volatile as a center located in an area with a larger refugee population or one in a border area.

6) It is unlikely that those treated at a center would require public support for long periods of time. The burden on Minnesota taxpayers will be minimal.

7) The establishment of a center would bring increased national and international recognition to the state.

It is the view of the committee that the need for a center on treatment, research, and education relating to victims of torture is clear and that such a center should be established in Minnesota. The overriding factors in this recommendation are humanitarian considerations and the fact that there is no such center elsewhere in the United States nor is there likely to be one in the near future. It is not the desire of the committee that this center be the only one in the United States. Rather, we hope that this center will serve as an example to others, and that treatment, research, and educational programs of this center will benefit not only those in Minnesota, but victims and potential victims worldwide.

(Note: The final task force report should include appendices describing the Toronto and Copenhagen centers and descriptions of existing Minnesota refugee services.)

IV. OPTIONS

Five options exist for continued activity on behalf of torture victims in Minnesota. They are:

1) Continuation of an ad hoc group of interested parties

2) Sponsorship of a symposium on the treatment of torture victims
3) Establishment of a referral center for victims
4) Establishment of a treatment center
5) Establishment of an educational and research center.

These five options are not mutually exclusive. Minnesota activities could involve a combination of any or all of these five. In the view of the committee, however, the most appropriate action would be the establishment of a treatment, research, and educational center with some elements of a referral center.

The continuation of an ad hoc group was seen as serving little purpose. It would have the advantage of requiring little in the way of financial resources. However, it would be extremely difficult to ensure continuity and focus. Sponsoring a symposium would provide the issue greater visibility than the continuation of an ad hoc group and could provide an important educational forum. However, conferences on the treatment of torture victims are relatively frequent. A conference took place in Racine, Wisconsin in late 1983. There is an annual conference in Denmark, and one is planned for Buenos Aires this summer. Publication of the proceedings of these conferences as such has been difficult as many participants feel that any publicity would endanger treatment efforts particularly by doctors in Third World countries. However, a conference designed to train Minnesotans in treatment methods will be an important step in the establishment of a treatment center. (See the report of the Conference Committee.)

A referral center would provide a more stable, continuous, and active resource than the options outlined in the previous paragraph. It could be local, regional, or nationwide in scope. Such a center would provide no direct treatment but instead put victims in touch with physicians, therapists, and others with an interest in working on the problem. A referral center would be less expensive than a treatment center and could cover a wide range of services. However, the committee feels that a referral center would lack the capacity to follow up on the results of treatment, would experience problems due to a heavy reliance on volunteer labor and services, and lack sufficient quality control, particularly if conducted on a regional or national level.

A treatment center would have fewer problems with quality control or follow-up. It would, however, be the most expensive option. The committee believes that we should not provide a service unless we can be confident that this service can be performed well and can serve as a means to enhance the treatment of torture victims both by the acquisition of knowledge and by serving as an example to other communities. It is our view that a referral center cannot achieve these goals, leaving some provision of direct treatment as the recommended option.

V. STRUCTURE

It would not be possible or desirable to perform all treatment or provide all services directly under the auspices of a Minnesota center. Certainly not every medical specialty could be represented on the center's staff. We envision a small medical staff which would make frequent referrals to members of various specialties. Services would largely be provided on an outpatient basis, with patients and their families living in the community. The in-house medical staff would perform basic diagnosis and treatment and ensure continuity and coordination of treatment. The center would also include researchers whose purpose would be to evaluate and follow up on treatment and to help educate others. Similarly the center would rely heavily on the existing social service network to aid in housing, employment, assimilation of families, and provision of basic living necessities, but would have at least one social worker on the staff to coordinate and follow up on referrals.

The educational and research function would also be served by such a center. Indeed, the committee feels that these functions are as important as the treatment function. A Minnesota center would not be able to treat all of the victims that reach the U.S., let alone those seeking treatment worldwide. The dissemination of knowledge acquired at the center therefore becomes extremely important. In addition, there is considerable controversy about what type of treatment is most appropriate; relatively little is known in this area. The research function thus takes on added importance. Finally, the presence of such a center can serve to enhance awareness of the international problem of torture, and thus may eventually aid in the most desirable result, its prevention.

In the view of the committee the proposed center would best function as an independent nonprofit, tax-exempt corporation affiliated with one or more major institutions. The corporation would be governed by a board of directors with day-to-day operations under the supervision of an executive director. The board of directors would be comprised of between 25 and 30 members and would include representation from the state's medical, legal, spiritual, business, and academic communities. Organizations which currently provide social services to refugees and others would also be included as perhaps would be representatives of national and international human rights organization and state government as well as concerned citizens. The size of the board would probably necessitate the formation of an executive committee chosen from within the board's membership.

VI. WHO WOULD BE TREATED?

The center would treat only victims of torture by foreign governments, defining torture in accordance with the definition adopted by the United Nations in 1975 and reaffirmed in 1984. The definition reads:

> "1. ... torture means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted by or at the instigation of a public official on a

person for such purposes as obtaining from him or a third person information or confession, punishing him for an act he has committed, or intimidating him or other persons. It does not include pain or suffering arising only from , inherent in or incidental to, lawful sanctions to the extent consistent with the Standard Minimum Rules for the Treatment of Prisoners.

"2. Torture constitutes an aggravated and deliberate form of cruel, inhuman or degrading treatment or punishment."

The limitation of treatment to victims of torture by foreign governments is due to a desire to keep the center removed as much as possible from the American political system and because treatment and referral systems for victims of abuse within the United States already exist. Moreover, the expertise gained at the center will ultimately aid all victims of abuse, domestic or foreign, by governments or by individuals. However, we expect that many individuals claiming to be victims of abuse within the United States will contact the center, requiring that the center have both a strong screening mechanism and a working knowledge of alternative resources.

Several other questions exist regarding admissions to the center. The first involves victims of torture not by governments but by terrorist groups or by organizations claiming to be governments but not universally recognized as such. The committee has not yet resolved this issue. A second issue involves persons in the United States without adequate documentation. The subcommittee recommends that admission to the center not depend on immigration status. Victims would almost certainly qualify as individuals with a well-founded fear of persecution and thus would qualify as refugees. The center will assist in referring victims to lawyers who will help them obtain appropriate immigration status.

The committee envisions the treatment of approximately 100 individuals a year. The first patients would be those already residing in Minnesota, with additional patients coming first from the Midwestern region and finally from the rest of the nation.

VII. LOCATION

The committee has outlined six criteria for the selection of a site for the center:

1) The center should be close to affiliated institutions in order to take full advantage of their resources.

2) The center itself should be in a freestanding location in order to maintain an independent identity.

3) The center should be located in a community which can provide adequate support services and opportunities for victims and their families and which can minimize the difficulties of integrating victims and families into society.

4) The center should present a non-threatening physical appearance in order to minimize the trauma of those tortured in an institutional setting.

5) The community and affiliated institutions should possess the resources necessary to attract top scholars in the field.

6) The community should include an adequate number of persons with the language skills needed to serve as interpreters.

It is the view of the committee that these criteria could best be met in a major metropolitan area which contains a major medical institution and which already has a substantial refugee population. Minneapolis, St. Paul, and Rochester would appear to be the communities in Minnesota best fitting the above list. The committee feels that the use of a state hospital campus or other similar facility would be inappropriate because these institutions are located in smaller cities which lack the needed community services and because the appearance of these facilities may well be threatening to patients.

VIII. BUDGET

The committee anticipates that $300,000 would be needed to cover initial expenses. The bulk of this amount would go towards the purchase and renovation of a building, which would cost about $250,000. An old house located near an affiliated institution would be a likely location. The remainder would go towards the purchase of office and medical equipment and supplies.

The committee also anticipates an annual operating budget of $635,000, broken down as follows.

PROPOSED BUDGET
MINNESOTA CENTER FOR TREATMENT OF VICTIMS OF TORTURE

Staff: (salaries and benefits)	
Executive Director	$ 75,000
Secretary	$ 20,000
Intake Worker	$ 30,000
Social Worker	$ 30,000
Physician Services	$120,000
2 Part-Time Researchers	$ 75,000
Translators (part-time)	$ 50,000
	$400,000
Other:	
Supplies	$50,000
Support for victims	$15,000
Training	$40,000
Other treatment-related expenses	$130,000
	$235,000
TOTAL	$635,000

This budget does not include services which would be provided by persons not directly affiliated with the center or treatment funded by insurance or government assistance programs.

IX. FUNDING

The committee feels that the center would best be served by obtaining an endowment of between $10 million and $12 million. This amount should be sufficient to provide the operating budget outlined above, maintain this operating budget for the foreseeable future, and provide for some limited expansion of services beyond the levels envisioned in this report.

The most practical way to seek funding at this level is to obtain a single large donation from a foundation or individual. The task force should immediately begin to make contacts with potential donors.

As an alternative to a large endowment, it has been suggested that some donors would prefer to commit a fixed amount, perhaps equal to the proposed operating budget, for a fixed period, for example ten years. We feel that this would be an acceptable alternative, though not as desirable as an endowment.

Large amounts of direct federal funding for this project are both unlikely and undesirable. It is undesirable because of the need to avoid even the perception of tying the center to U.S. foreign policy. However, individuals being treated at the center may well be eligible for a number of federal and state programs, particularly medicaid. In addition, researchers affiliated with the center may well use federal agencies as a source for research grants.

X. SCHEDULE

The committee estimates that the center would receive its first patients in the spring of 1986. The schedule leading up to this opening reads as follows:

May 1985
- Report presented to Governor Perpich
- Center files for incorporation and tax-exempt status.

July 1985
- Incorporation complete
- Board of Directors established
- Formal proposal prepared for funding purposes

Summer and Fall 1985
- Proposals made to potential funding sources

January 1986
- Tax exempt status granted
- Initial staff hired, operations begin

April 1986
Conference /training session held

May or June 1986
First patients admitted