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

May, 1985

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I. INTRODUCTION

On January 18, 1985 Governor Rudy Perpich of Minnesota appointed a task force to examine the feasibility of a Minnesota center for victims of torture. The Task Force was charged with investigating the feasibility of a center, how it might be funded, where it might be housed and what services it might offer. The following report presents the conclusions of the task force.

The Task Force consisted of 25 distinguished Minnesotans representing the state's legal, medical, behavioral science and religious communities, state and local government, and concerned citizens. The Task Force was co-chaired by Dr. W. Eugene Mayberry, chairman of the Board of Governors of the Mayo Clinic, and Robert Stein, dean of the University of Minnesota Law School. A complete list of the members of the Task Force is found in Appendix A.

II. RECOMMENDATIONS

The Task Force concludes that:

1) A need exists for the provision of medical, legal, family and social services to the victims of torture;

2) The need for these services is not now being met in the United States;

3) Minnesota meets the criteria necessary for the success of such a center;

4) There is a need for continued research into the effective treatment of victims of torture.

The Task Force therefore recommends that:

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 affiliated with one or more major medical and educational institutions;

4) The Center treat victims of torture by foreign governments, with an initial goal of treating 100 persons per year;

5) Medical services be provided which take a comprehensive approach to the treatment of both victims and their families;

6) Legal and social services needed by victims be provided through existing service delivery systems;

7) The Center be located in the Twin Cities area;

8) The Center seek initial funding of $500,000 and an annual operating budget of $600,000;

9) The Center maintain this operating budget by seeking an endowment of $12,000,000 from private sources;

10) The Center plan to admit the first patients in late spring 1986.

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

Some estimate of the demand for treatment can be ascertained by examining the experience in other countries. 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 has admitted 500 refugees a year, though this number was recently increased to 2,000. By contrast, the United States received 72,000 legally acceptable refugees in 1984, while another 180,000 persons have applied for political asylum status. Although 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 Canadian Center for Investigation and Prevention of Torture in Toronto has referred with about 200 victims to treatment in its first year of operation. Again, the Canadian refugee population is likely to be significantly smaller than that in the U.S. (Descriptions of the Copenhagen and Toronto Centers are found in Appendix B.)

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, Afghanistan, and Ethiopia. Most of these people reside in the Twin Cities and Rochester areas. In addition, some U.S. citizens who have suffered torture by foreign governments reside in Minnesota. 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.

A. Medical Services

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. In addition, the experience of concentration camp survivors shows that torture victims may suffer from long-term disabilities and the inability to work if they do not receive treatment.

The need for specialized treatment for victims of torture manifests itself in several ways. First, a holistic approach to treatment is required. Such an approach involves coordinated attention to physical, psychological, spiritual, and social parameters and recognizes that the individual victim is embedded in a familial, cultural and social matrix as well. The experience with prisoners of war from Vietnam, the American hostages held in Iran, and victims of the French-Indochina war and the Yom Kippur war underscores the need for a strong commitment to the involvement of family members in the long-term treatment and rehabilitation process. Second, the medical care must be conducted in such a way as to provide the credibility and trust needed to permit effective psychological intervention. Third, those involved in treatment delivery must recognize that their efforts may remind patients of their torture experience and thus evoke considerable discomfort in the victim. Therefore effort must be given to explaining treatment to the victim and the family so as to minimize the unpleasantness. Finally, treatment must encourage the "normalization" of victims.

There is no universally recognized approach to treating victims of torture. There do, however, exist a range of options. It is recognized both from studies from the Second World War and the more recent Danish-Canadian reports that head trauma is common in victims of torture. Individuals suffering from organic brain syndrome require specific rehabilitative and treatment programs directed to their brain injury. For those victims free from brain injury other numerous medical and psychological symptoms need to be addressed. Studies conducted as an outgrowth of the Vietnam experience have led to several approaches concerning post-traumatic stress disorders and "coping". From the Danish experience with victims of political torture comes a conceptual model with emphasis on allowing people to discuss their feelings and responses, with medical personnel providing understanding and reassurance.

In addition, the approaches now in use have yet to undergo systematic assessment of their effectiveness in follow-up studies. Therefore, a significant need exists for research programs designed to determine the optimal treatment of victims of torture and their families. Such a program would provide benefits well beyond the help provided to those few actually treated at a center.

B. Legal and Social Services

Victims of torture will frequently require legal and social services in addition to medical treatment. Unlike medical services, social and legal needs will in many cases be similar to those required by immigrants and refugees who have not been tortured. These needs in many cases will arise from language and cultural differences and can include income maintenance, employment, language instruction, and housing. Clients of a center and their families will have difficulty with many day to day legal aspects of our society. Typical legal services will often involve interactions with government agencies and departments, and may involve immigration law.

C. Conclusion

The Task Force 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 doctors exist who treat torture victims in countriew where torture is occurring, particularly in South America, they face significant political and practical impediments which prevent them from establishing a publicly visible torture rehabilitation effort. It should not be the intent of a U.S. center to bring in victims who can be treated in their own countries. A U.S. center can, however, treat those victims who currently reside in the United States or in a country where treatment facilities are not available.

D. Suitability of Minnesota

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

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

1) Little money is presently 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) The most necessary condition for the success of a center is the presence of a group of concerned and committed individuals. 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 such a group. This condition also exists in Minnesota. Minnesota has a strong 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 many of the legal and social services required by patients and their families may 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 not likely 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 Task Force 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 persons victimized by torture and potential victims nationally and worldwide.

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 Task Force, 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. Although it would have the advantage of requiring little in the way of financial resources, 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. Conferences on the treatment of torture victims are relatively frequent, however. 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. This is not to say, however,

that a conference would serve no purpose in Minnesota. A conference designed to train Minnesotans in treatment methods will be an important step in the establishment of a treatment center.

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. We believe, however, 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. We strongly believe that Minnesota should provide this service only if we are confident that it 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

In the view of the Task Force 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, religious, business, social service, and academic communities. The board might also include representatives of national and international human rights organization, state government, and 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 add to the body of existing knowledge and ultimately aid all victims of abuse, domestic or foreign, by governments or by individuals. We also expect that many victims of non-governmental 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 Task Force believes that these persons would likely be eligible for treatment. A second issue involves persons in the United States without adequate documentation. The Task Force recommends that admission to the Center not depend on immigration status. Victims of torture would almost certainly qualify as "individuals with a well-founded fear of persecution" and thus would qualify as refugees. The Center will assist in arranging legal services to help victims and their families obtain appropriate immigration status.

Screening of eligible patients will be difficult. The Task Force believe that the determination of eligibility (e.g. evaluation to establish that an individual has been the victim of torture) should be performed at a different site and with personnel not associated with the treatment program. This approach will permit the program to focus its energies and resources on treatment itself. Possible screening methods include referral of a professional or referral from a group such as Amnesty International.

Initially the Task Force envisions the treatment of approximately 100 individuals a year, with possible expansion as resources and demand allow. 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. SERVICES PROVIDED

A. Medical Services

The optimal medical program would be provided by an outpatient treatment program located at a freestanding urban facility with proximity and ties to major medical instiutions such as University Hospitals or St. Paul-Ramsey Medical Center. Under this plan the medical centers could provide needed medical consultation and support. They could also provide sites for hospitialization in the few cases where this is deemed necessary. The freestanding facility is desirable because many victims of political torture are reluctant to be treated in "institutional settings." In many cases of recent torture, physicians have been active participants. Hence, a freestanding facility, without formal trappings, might help to minimize apprehensions based on the nature and circumstances of the torture experience. Such a setting may, however, make evaluation and treatment more difficult. This difficulty may be overcome, in part, by having a staff person, volunteer, "friend", or clergy member accompany patients on their visits to medical facilities. Also, the medical procedure should be fully explained to the patient and his or her family and clergy. Affiliated treatment facilities might in part also be redesigned to appear less institutional. This problem, however, is recurrent, reflecting an inherent tension between the need for initial systematic evaluation and careful followup measures on one hand and the need for a more humanistic, less formal approach on the other.

Staff for medical treatment would include a small first-line staff with other persons available for consultative activities. The first-line staff would include a physician (not a psychiatrist), a social worker, a psychiatrist or psychologist, interpreters, and a network of clergy. Second-line staff would include a physiotherapist, a neurologist, and a physical and medical rehabilitation (PMR) physician, with a dentist, otolaryngologist, ophthalmologist and an orthopedist available for consultative activities. Selection of all personnel should be predicated on strong interest in and dedication to working in this area. It is also important that some staff be committed to research.

The Task Force emphasizes the important role that clergy may serve in the treatment program. Many victims are more willing to work with clergy than with other mental health professionals. Clergy are already involved in a wide range of human rights activities in the community. In addition, many victims undergo a spiritual crisis as the result of their experience which must be addressed as part of a complete treatment program.

B. Legal Services

The focus of legal services offered through the Center will be meeting the needs for legal assistance which relate to the clients' needs for food, shelter, and health care. Language and cultural barriers will result in many difficulties with the day-to-day legal aspects of our society. These needs require both a teaching role and the more typical provision of legal services. These services are likely to be heavily oriented towards administrative law and government proceedings.

The Task Force recommends that existing volunteer lawyers programs be used to provide legal services to those clients of the Center that are not able to pay. For those clients able to pay, existing legal referral services should be adequate. In particular, Hennepin County Legal Advice Clinic and the volunteer lawyer programs of Ramsey and Olmsted Counties are willing and able to work with clients of the Center. Additionally, the Committee on Legal Assistance to the Disadvantaged of the Minnesota State Bar may be of assistance. Other assistance may be available through law students, the Minnesota Justice Foundation, and non-lawyers, including lay volunteers.

Non-lawyers may prove particularly useful. Lay persons can be very effective in fact-gathering and documentation for immigration proceedings and in helping victims understand the legal system of the United States. In these cases it would be desirable to use persons familiar with the language and culture of the victim rather than persons familiar with the intricacies of the law. Training will likely be required for both volunteer lawyers and non-lawyers.

When dealing with a large number of citizens of foreign countries some questions of immigration status will inevitably arise. These questions can involve both the status of the victim and that of his or her family and could affect either entrance to the United States or the right to remain. While there are few Minnesota lawyers who specialize in immigration law, these persons are likely to volunteer. In addition, the Legal Advice Clinic of Hennepin County is willing to sponsor training sessions in response to demonstrated needs and has already received inquiries from lawyers wishing to volunteer time for clients of the Center. Meeting immigration law needs could be difficult, however, if the demand for these services exceeds our expectations.

C. Social Services

Clients of the Center and their families may well have significant need for social services in addition to legal and medical services. Some will need housing, others employment or temporary income maintenance. Other needs include education (including English as a second language), food, health care for families and basic help in becoming accustomed to a strange culture.

Fortunately Minnesota, with its sizeable refugee population, is well experienced in meeting these needs. It is the view of the Task Force that the relatively small number of persons brought into the area by the Center would not place an undue burden on existing refugee services. However, a social worker employed by the Center may be needed to put clients in touch with the proper programs. This individual could also help identify appropriate providers of legal services. A partial list of services and programs for refugees is found in Appendix C.

D. Research and Education

The Task Force strongly recommends that research and education be considered essential roles of the Center and assume equal importance with treatment. The Needs Assessment section of this report discussed the importance of research in the medical sector. In addition to research on the effectiveness of medical treatment, research should also be conducted on the long-term consequences of torture upon the psychiatric and physical health status of the victims and upon the interpersonal relationships of the victims and their families. The Center should therefore employ at least two researchers, initially on a part-time basis. These persons would concentrate in the medical and psychological areas. In addition, research efforts could be supplemented by persons affiliated with existing academic institutions and funded through traditional means of obtaining research support.

Documentation would also be a major theme. A Minnesota Center would not only be important in the immediate care of individuals who experience extreme trauma, but is likely to be viewed as a central repository of legal, psychiatric, family, organizational, and planning information associated with victims of torture. The Center should therefore be able to disseminate this information in a clear and succinct form to enable other individuals, clinicians, scholars, and legal specialists to pursue their own line of research on related topics. Sufficient safeguards should be in place, however, to assure the privacy and safety of clients and their families and to maintain the effectiveness of treatment and screening methods. This documentation, research, and education will enable the Center to be of benefit to many more than those few who can be treated at a Minnesota Center. In addition to research conducted under the auspices of the Center, documentation will help further research efforts elsewhere. We will be dependent upon other scholars, political scientists, human rights specialists, and medical practitioners throughout the world to pursue related research and to share their findings with the Center. This ongoing dialogue among interested and committed individuals would be enhanced with the Center's efforts in the formulation and development of a data repository and clearinghouse.

The educational function of the Center will also be served by the conference outlined in the section on training below.

E. Coordination of Services

The variety of needs and services that a patient will require and the previous experiences that many have had with bureaucracies and medical personnel could make treatment and finding the ability to meet basic needs a frightening and difficult experience. We therefore recommend that an "ombudsman" be assigned to each family to coordinate services and serve as the primary contact with the Center and associated organizations. This person could be a paid social worker or a volunteer. It would be desirable, though not always possible, for this person to speak the language of the patient.

VIII. TRAINING

The extensive use of volunteers envisioned by the Task Force will obviously necessitate training. This need has been addressed in the section on legal services but will apply to medical and social services as well.

To partially fulfill this need the Task Force recommends that a a conference/training session be held in Minnesota several months before the opening of the Center. This session would involve two days of training for prospective staff, volunteers, and others who wish to learn about the medical legal, and other tasks and services which the Center will be undertaking. In addition, a one day conference designed to give national and international visibility to the Center as a place for the treatment of torture victims, for research, and for education about torture would help fulfill the Center's educational role.

The Center would invite to the training session as participants and/or observers those doctors, nurses, psychologists, social workers, refugee resettlement personnel, representatives of social service organizations, immigration lawyers, physiotherapists, clergy, translators, and others who may be working in the Center, volunteering their services to the Center, referring potential clients to the Center, or otherwise be cooperating with the Center.

The training session would include presentations on such topics as the diagnosis of the physical and psychological consequences of torture, medical treatment, psychological counseling, dental care, physiotherapy, follow-up assessment to determine whether treatment had long-term beneficial results, the special problems of certain categories of torture victims and their families (women, children, teenagers, etc.), the social needs of torture victims and their families, and the legal problems of torture victims. The training session might also include a discussion among those engaged in the treatment of the victims of rape, child abuse, and spousal abuse, as well as victims of concentration camps, prisoner of war camps, and similar experiences to learn whether their treatment modes might be useful for torture victims and to assess the degree of commonality or difference among these sorts of traumatic stress situations.

The one day conference would be open to the public and would include a keynote address by the U.N. Special Rapporteur on Torture. There would be four panel discussions or presentations by: (1) victims of torture, (2) those who have been involved in the medical treatment of torture victims, (3) those who have worked to prevent torture, and (4) those who have studied the phenomenon of torture, possibly including a former torturer.

(1) The victims would be selected so as to demonstrate the worldwide scope of the problem in such countries as Argentina (under the previous government), Iran, South Africa, and the Soviet Union.

(2) Representatives of the torture treatment centers in Copenhagen, Toronto, and South America would be invited to speak about their work and the progress they have made in helping victims.

(3) Representatives of Amnesty International, the International Commission of Jurists, the International Committee of the Red Cross, the U.N. Trust Fund for Torture Victims, and other organizations would be invited to discuss the techniques they use to prevent or work against torture throughout the world.

(4) The last panel of the conference would focus upon the torturer and the sorts of training which might be provided to military, police, and others, so as to make it less likely that torture will occur.

If the Center is to open for the care of patients in late Spring 1986, the best time for the conference/training session would be early Spring, for example, early in April 1986. In order to assure the success of the conference/training session, resource people should be invited by October 1985.

Ideally, the initial staff of the Center should organize the conference, but the Center will probably not have funding or staff until early in 1986, which would be too late to begin planning for the conference.

In May 1985 the Amnesty International USA (AIUSA) staff will begin planning their program for 1986. The conference/training session could be proposed at that time with the hope that Amnesty International staff in Chicago and New York could help identify and arrange speakers for these sessions.

A third alternative would be to find some local organization which might be interested in organizing the conference, such as the American Lutheran Church, other religious organizations, or the Minnesota Lawyers International Human Rights Committee. More discussion will be required in order for this alternative to be seriously considered.

IX. LOCATION

The Task Force 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 Task Force 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 and St. Paul would appear to be the communities in Minnesota best fitting the above list with a location near the University of Minnesota being one desirable site. Rochester also appears to meet many of the criteria outlined above. The Task Force believe 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.

X. BUDGET

The Task Force anticipates that $500,000 would be needed to cover initial expenses. The majority 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. $200,000 would be needed to finance the conference/training session. This figure is based on the assumption that about 25 guests would be invited from abroad and 25 would be invited from within the United States. The remaining participants would pay their own way or come from the local area. A much more modest training session with four international guests and ten national travelers could

be arranged for about $15,000. The remaining startup costs would result from the purchase of office and medical equipment and supplies.

The Task Force 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.

XI. FUNDING

We believe 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. Work should immediately begin to make contacts with potential donors.

As an alternative to a large endowment, it is possible 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.

XII. SCHEDULE

The Task Force estimates that the Center would receive its first patients in the spring of 1986. The schedule leading up to this opening would be:

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

APPENDIX A.

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

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APPENDIX B.

EXISTING CENTERS FOR TREATMENT OF THE VICTIMS OF TORTURE

I. Copenhagen

The International Rehabilitation and Research Centre for Torture Victims (RCT) was founded in 1982 for the purpose of treating torture victims and their families. It is a private foundation, financed by private individuals, organizations, and national and international funds. Their 1984 budget was $476,000. The staff includes about 15 full and part-time employees.

RCT treats approximately 50 to 75 victims per year, most of them from Latin America, Africa, or the Middle East. Treatment is almost exclusively on an outpatient basis and is conducted by a team consisting of a physician, a social worker, a physical therapist, a nurse, and a psychologist. RCT does not treat Danish citizens and accepts only citizens of foreign countries who have been granted political asylum by the Danish government.

Treatment is based upon the philosophy that torture victims are "normal" people who have experienced a "normal reaction" to an extremely abnormal situation. Torture victims are not looked upon as patients with psychiatric illness, and traditional psychiatric approaches are seldom felt to be indicated. The Center does not use standard psychological tests, psychiatric diagnoses, and pharmacotherapy.

Every attempt is made to treat patients in an environment which is the opposite of the prison/torture environment. The physical facility is small and home-like. Personnel do not wear hospital uniforms, and every attempt is made to keep the surroundings quiet. The basic physical examination of victims is kept at a minimum. Treatment is explained in great detail and the victims are told, "You must talk and if you will talk about your experiences, we can help you". Therapy sessions with the psychologist are held twice weekly and last about one and one-half hours each. Most victims are treated for six months, although at least one individual has been in treatment for two years. There is an extensive use of team conferences to make intake decisions, formulate treatment plans, discuss problem patients, and determine when an individual can be discharged.

RCT operates on a budget of $456,000 per year. This does not include many indirect costs such as those associated with the physical facility. Similarly, it does not include an additional $100,000 for inpatient treatment since this is picked up by the Danish health system. It also does not cover the cost of dental treatment. The direct costs average between $6,000 and $10,000 per patient per year. It should be kept in mind, however,that the U.S. dollar is considerably overvalued with respect to the Danish Kroner. Comparable U.S. expenditures would be much higher.

The RCT treats only those victims who have become established as refugees in Denmark and does not consider those who have entered Denmark in the hope of obtaining refugee status. They prefer the more established refugees because the Center can legitimately reassure the refugees that they will not be subjected to ill-treatment again. The RCT relies upon about 15 doctors within the Danish Medical Group of Amnesty International to give assessments of whether applicants for refugee status have been tortured. Hence, the RCT does not get involved in such politically sensitive assessments but instead restricts itself to treatment and research. However, Danish immigration procedures are much less time consuming than those in the U.S. Most applicants for refugee status are processed within six months in Denmark while in the U.S. a similar determination can take years.

Four members of the Task Force (Mr. Heins, Dr. Mayberry, Dr. Vanselow, and Prof. Weissbrodt) visited the Copenhagen Center In January 1985. These members concluded that while the treatment provided at the RCT is admirable and apparently successful in obtaining good results it is a relatively new enterprise, its methods have not been subjected to rigorous scientific scrutiny, and there is no record or reliable prediction of the long-term effectiveness of treatment. Further, most accounts of their work are anecdotal and subjective. Hence, much as the RCT is admired it should not be simply emulated. The optimal treatment for torture victims may be more or less complicated and sophisticated than that provided at RCT. For example, an interdisciplinary team of human services and health related professionals under the leadership of medical personnel may be appropriate. If so, treatment could be provided at considerably less cost than that associated with the extensive use of medical doctors as in the Danish model.

B. Toronto

The Canadian Center for Investigation and Prevention of Torture (CIPT) is a non-profit institution incorporated in March 1983 in Ontario, Canada. Located in Toronto, the CIPT has three major activities: treatment of victims of torture, research into the needs of torture victims, and education of professionals and the public. Financial support for the CIPT comes from the UN Voluntary Fund for Victims of Torture; from the Canadian federal, provincial, and municipal government; and from churches, trade unions, and from various foundations. They have an annual budget of about $100,000 and a staff of two.

The CIPT serves as a referral center for torture victims and their families. Torture victims are referred to the CIPT by lawyers, doctors, and others. The CIPT then assists victims and their families in locating medical assistance, finding employment, and getting settled in Canada. The referral network includes a group of 35 family physicians and 11 psychiatrists who undertake the actual care of torture victims. The CIPT has also allocated a small fund for providing financial assistance to torture victims to cover small items such as paying for a telephone or a drivers's license.

The doctors instrumental in establishing the CIPT saw more than 700 torture victims between 1978 and the formation of the CIPT in October 1983. During its first twelve months of operation (October 1983 through October 1984) the CIPT referred 202 survivors of torture and violent persecution and their families from 30 countries for medical help. The CIPT treates only refugees who have been subjected to torture. Canada has admitted about 350,000 refugees since World War II. During the past ten years Canada has received about 11,000 South and Central Americans from such countries as Argentina, Chile, El Salvador, Guatemala, Guyana, and Honduras. Canada has also received refugees from other parts of the world, including Afghanistan, Sri Lanka, and Uganda.

The CIPT has engaged in a number of educational activities including presentations to regional, provincial, national, and international meetings of nurses, physicians, medical students, and other health care workers. They also plan to organize several seminars for physicians and other professionals working with survivors of torture. Early in 1984 the CIPT developed a selection process and training program for community workers. At least 15 volunteers have now completed the CIPT training sequence and are involved in Integrated Support Teams to assist torture victims, provide short term intervention, and assist with refugee documentation. The CIPT has also assisted groups or organizations working with torture victims in Edmonton, Ottawa, Montreal, Toronto, Winnipeg, and Windsor, as well as Johannesburg, Montevideo, Stockholm, and West Berlin.

The doctors instrumental in creating the CIPT and the Executive Director of the CIPT have been associated with the Canadian Section of Amnesty International and with the Canadian Medical Group of Amensty International. The research program of the CIPT is part of the work of the Canadian chapter of Anti-Torture Research, an independent bio-medical society established in Denmark to sponsor research into the problems associated with torture and its prevention. In April 1985 an oarganization of volunteers and lay workers was formed to be associated with the CIPT and to assist in the training and use of volunteers in working with torture victims.

Members of the Task Force have corresponded with the Executive Director of the CIPT and with one of the principal physicians working with the CIPT. A visit to the CIPT has been scheduled for June 1985.

APPENDIX C.

A PARTIAL LIST OF SOCIAL PROGRAMS AND SERVICES DEALING WITH REFUGEES IN MINNESOTA

1. Catholic Charities

Catholic Charities has been involved in refugee resettlement since World War II. Its Migration and Refugee Services Office has resettled over 8,000 refugees since 1975. Services include various kinds of counseling and referrals, aid in family reunification, and immigration processing. The Office provides sponsorship through church groups, families, and volunteers who meet the basic needs of shelter, food, and clothing. Volunteers also serve as English tutors and home visitors.

The aim of the program is to enable refugees to become self-sufficient. To this end, Catholic Charities provides employment assistance through Project R.I.S.E. (Refugees in Search of Employment), a national model. The agency also contracts for a pre-employment case management program. it seves welfare clients deemed ready for work helping to remove obstacles to employment.

During fiscal year 1984, Catholic Charities resettled 458 persons, 409 of whom were from Southeast Asia. Catholic Charities offices in St. Cloud and Rochester have active resettlement programs similar to the one in the St. Paul and Minneapolis Archdiocese.

2. Community University Health Care

Community University Health Care, located in south Minneapolis, was started four years ago to meet the psychological needs of refugees. The clinic has five bilingual case workers who deal primarily with Southeast Asian refugees, with one case worker presently being trained to work with Ethiopian refugees.

Many clients are referred from Hennepin County Medical Center, but others arrive through word of mouth. Although there are some documented cases of diagnoses such as schizophrenia, the majority of people are seen for depression, social readjustment and post-traumatic stress syndrome. During the fourth quarter of 1984 over 700 registered clients were seen, 620 for social adjustment. In addition, another 500 clients were "unregistered" and seen for consultation.

3. Lutheran Social Services

Lutheran Social Services has served over 7,000 refugees since 1975. It provides sponsorship programs and offer counseling and/or referral services for people who need mental health, marriage, or other counseling. Several branch offices throughout Minnesota provide services to refugees including immigration and advocacy work, aid in family reunification, and sponsor large-scale immigration hearings. Lutheran Social Services also offers employment and job development services. It currently contract for preemployment management, working with welfare clients deemed ready for employment and removing obstacles to employment such as day care and transportation. Lutheran Social Services is also working with the American Refugee Committee on a program training volunteers from several large corporations to work with refugees.

4. Minnesota Department of Human Services

The Refugee Resettlement Office of the Department of Human Services administers federally funded programs directed at refugees. Eighty-five percent of the money appropriated for this purpose goes to "learning the English language" with the remaining 15 percent designated for resettlement programs. This money must be used during the first three years of a refugee's resettlement. As with all federal social service programs, the continued funding of these efforts is uncertain.

The Department also sponsors the State Refugee Advisory Council, a committee which covers a broad range of topics concerning refugees.

5. Our Lady of Guadalupe Area Project

Our Lady of Guadalupe Area Project began 25 years ago and functions mainly as an educational center. They operate an alternative high school with between 40 and 50 students, many of whom speak Spanish as a second language. During the evening the Project sponsors English as a second language classes. Most students in these classes are Mexican, with current enrollment between 15 and 20.

The Project also acts as a general referral center to those in need and sometimes distributes food to the needy.

6. St. Paul - Ramsey Medical Center

The International Clinic of the St. Paul-Ramsey Medical Center provides medical services to refugees, currently handling about 1,100 patient visits per year with a staff of three part-time medical personnel (a physician, a

psychiatrist, and a nurse), one part-time social worker, and four part-time interpreters. Over 90 percent of the patients are from Southeast Asia.

The International Clinic functions as any other clinic in the medical Center, billing services to medical assistance, social security, private insurance, or self pay. Many patients eventually "graduate" to regular clinics at the medical Center or elsewhere in the community.

7. Social Adjustment Mental Health Center

The Social Adjustment Project for Refugees is part of the Wilder Foundation. The Center currently serves 400 clients, most of whom are Southeast Asian. Funding is currently provided by the federal government, though the Wilder Foundation will have to match funds beginning in December, 1985.

The Center provides mental health services through a staff of bilingual case workers, a social worker, a psychologist and a psychiatrist. Patients are generally referred by community physicians. The most common reasons for referrals are domestic abuse, post-traumatic stress, and depression.