INSTITUTE FOR ADVANCEMENT OF JUSTICE & HUMAN RIGHTS

Companion Guide to the IAJ Psychological Investigation Standard

Forensic Investigator Licensing, the Duty to Document, and the Treaty-Equivalence Question

A Definitive Guide for Forensic Psychologists, Treating Psychologists, and Other Care Providers Encountering Torture and CIDT

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Executive Summary

This Guide is a companion to the IAJ Psychological Investigation Standard (IPIS). It addresses one question: when, where, and on what authority may a forensic psychologist or treating clinician document, evaluate, and report on alleged torture or cruel, inhuman, or degrading treatment (CIDT)? The answer is structured around five themes, three audience tracks, and one structural argument about U.S. compliance with the Convention against Torture. The full Guide develops each. This Executive Summary states the conclusions and points the reader to where the full treatment appears.

The Controlling Sentence

The treaty-based duty to document torture and CIDT operates through lawful professional practice, not around it. Professional authority permits the work; the treaty-based duty motivates and structures it; Istanbul Protocol methodology disciplines it. Three cooperating layers, all required, none in tension.

The five themes

Theme A — Licensing regulates the practitioner; receiving forums regulate the report. A license is an affirmative grant of authority to its holder. It does not, by itself, dictate which evidence a court or treaty body may receive. Receiving forums apply their own evidentiary rules. Many U.S. jurisdictions define the practice of psychology broadly enough to include forensic, legal, governmental, and human-rights assessments; a New Jersey-licensed forensic psychologist conducting an Istanbul Protocol evaluation is performing activity that lies squarely within the scope her license already authorizes. *(Part I, Theme A.)*

Theme B — Forensic evaluation is a distinct regulated posture, not treatment. Clinical and forensic practice are two postures within the regulated practice of psychology, governed by the same licensing boards and disciplined by the same codes (plus, for forensic work, the APA Specialty Guidelines for Forensic Psychology, 68 Am. Psychologist 7 (2013) (extended through Dec. 31, 2026), and Istanbul Protocol 2022 ed. ¶¶ 201, 666 on forensic independence from the alleged perpetrators and the institutions associated with them). The forensic posture is regulated practice, not unregulated activity. The protective purposes of cross-border telehealth provisions are generally tied to the therapeutic posture, and the cross-border reach of any particular statute is a jurisdiction-specific question. *(Part I, Theme B.)*

Theme C — Two duties, two regimes, one report. Every clinician or medico-legal expert working on a torture or CIDT case operates under both a professional-authority duty (defined by the license, appointment, or recognized expert status under which the person works) and a treaty-based duty to document (defined by UNCAT Articles 12, 13, and 16 and the Istanbul Protocol). They cooperate; they are not in tension. Duty strengthens the justification for the work; it does not replace the professional authority that permits it. *(Part I, Theme C.)*

Theme D — The ethics of non-refusal, properly scoped. Professional ethics frameworks generally prohibit abandonment and strongly disfavor suppression and avoidant silence. A clinician may not refuse merely because torture documentation is inconvenient, uncomfortable, institutionally disfavored, or likely to produce legal involvement. But the duty to document does not require every clinician to personally undertake every case; it is fulfilled through competent action — which may mean referral, consultation, scope-limited documentation, supervised assistance, preservation of records, or protected reporting where personal undertaking is not appropriate. The ethical breach lies in abandonment, suppression, or avoidant silence — not in responsible referral or honest acknowledgment of competence limits. *(Part I, Theme D.)*

Theme E — The structural equivalence argument. When the United States ratified UNCAT, Congress represented that existing federal and state laws already provided equivalent mechanisms for prevention, investigation, prosecution, and remedy. That representation is the equivalence promise. The principal federal torture statute (18 U.S.C. §2340A) is extraterritorial only; there is no federal mandated-reporter regime for torture or CIDT against competent adults; state mandated-reporter statutes are structured around child abuse, elder abuse, and vulnerable-adult categories that do not capture torture as such; misprision of felony (18 U.S.C. §4) is too narrow and too contested to substitute. The IAJ position is that the U.S. has not delivered the equivalence Congress promised, and the individual clinician's documentation is one of the few mechanisms by which the gap becomes visible on the international plane. The structural argument is a critique of the State's architecture; it is not authorization for clinicians to operate outside professional regulation. Where a clinician is prevented by a specific binding legal bar from rendering documentation that the situation otherwise calls for, the Bar-Documentation Duty (Theme E.5) applies: the bar itself becomes the object of documentation, and is reported or preserved through lawful protected channels — direct, anonymized, aggregate, delayed, privileged, or preserved for later disclosure if the restriction is lifted — so that the equivalence gap is recorded rather than erased by silent retreat. The duty is no silent withdrawal, not unlawful disclosure. Theme E.6 supplies the structural reason E.5 matters: silent declination is not Article 1 acquiescence by the clinician, but it may function as the case-level mechanism through which State acquiescence and regulatory non-equivalence become effective. A clinician may be required to comply with a binding bar; a clinician is not required to convert that compliance into silence. There is no silent declination and surrender of a torture or CIDT victim to fate. *(Part I, Themes E.1–E.6; full treatment Part IV.)*

The three audience tracks

Track 1 — Forensic Psychologists. Medico-legal evidence is the work product. The cross-jurisdictional paradigm — a forensic psychologist licensed in one place, evaluating a survivor in another, for a forum in a third — is supported by the framework: license at practitioner location, forensic posture not engaging the protective purpose of cross-border telehealth rules, receiving forum applying methodology-based rather than licensure-based criteria — subject to the twelve inquiries and counsel review where any concrete jurisdictional issue remains. Includes a 10-step intake decision tree. *(Part III, Track 1.)*

Track 2 — Treating Psychologists and Care Providers. The witness obligation arises from clinical encounter, not from forensic engagement. Contemporaneous documentation in the clinical record is the most defensible documentation. Treating-provider authority — the deference accorded under ADA Title I caselaw and EEOC accommodation guidance to a treating clinician's medical judgment, extended by the IAJ to torture documentation — does not require forensic credentials. Treatment and documentation are both required; one does not discharge the other. Includes a 10-step intake decision tree. *(Part III, Track 2.)*

Track 3 — Cross-Jurisdictional and International Experts. IFEG members, UN Committee Against Torture members, SPT members, Special Procedures mandate-holders, and analogously credentialed experts work across jurisdictions because the work is structurally international. The credentialing system is built to match. Article 20 — the UN Committee Against Torture's confidential inquiry procedure into systematic practice — has no domestic admissibility gate but applies an international credibility threshold ("reliable information" containing "well-founded indications"). The methodological burden is the entire burden. Includes a 10-step intake decision tree. *(Part III, Track 3.)*

As used in this Guide, 'witness' means a professional documentation-and-preservation responsibility within role. It does not mean compelled testimony, subpoena status, or disclosure outside consent, privilege, confidentiality, or law. The full working definition appears in Part I, Theme D.

The twelve intake inquiries

Before accepting or beginning any forensic evaluation involving a cross-jurisdictional element, the clinician runs through twelve inquiries: (1) own licensure status and scope; (2) survivor's location; (3) receiving forum or mechanism; (4) forensic versus treating posture; (5) remote modality and its limits; (6) requesting party and their interests; (7) Supervisory Falsification Pass arrangements; (8) treating-provider involvement; (9) mandated-reporter duties; (10) reprisal risk and digital security; (11) informed consent free of compulsion; and (12) counsel consultation on any unresolved legal question. The full cautionary explanations for each inquiry appear in Part II.C; the decision trees in each audience track operationalize them.

The IAJ does not give legal advice

The IAJ is an educational and investigative institute. It develops standards, methodology, and analytical frameworks. The Guide describes what the requirements should look like when considered from the international plane (UNCAT, the Istanbul Protocol) and from the equivalence promise Congress made at ratification. It identifies the inquiries a clinician should make. It does not give legal advice and does not represent individuals before any forum. Clinicians facing concrete licensing, criminal, regulatory, or evidentiary questions about a specific case should obtain advice from counsel admitted to practice in the relevant jurisdiction.

How to read the rest of this Guide

Readers who want the controlling principles should read Part I in full. Readers who want operational guidance — what is allowed, what is not, what to ask at intake — should read Part II. Readers in a specific role should read the corresponding track in Part III and use that track's decision tree at intake. Readers engaged with the structural argument about U.S. UNCAT compliance should read Part IV. Part V addresses supervision, hostile subpoenas, conflict settings, and self-care. Part VI restates the ultimate principle. Every reader should read at least the Executive Summary and the Front Matter; every clinician who will rely on the Guide in practice should also read Part II.C (the twelve inquiries) and Part I, Theme D (the scope of non-refusal).

Front Matter and Reading Notes

A. What this Guide is and is not

This Guide is a companion to, not a replacement for, IPIS. It addresses one focused question that recurs in every torture and CIDT investigation: when, where, and on what authority may a forensic psychologist or treating clinician document, evaluate, and report on alleged torture or cruel, inhuman, or degrading treatment (CIDT)? The Guide consolidates three converging answers — the principle that licensing regulates the practitioner while receiving forums regulate the report; the recognition that forensic evaluation is a distinct regulated posture, not treatment; and the dual-duty regime under domestic licensure plus treaty obligation — and adds two further questions that follow inevitably from them: what professional ethics require of a clinician who is asked to look away, and whether the federal architecture for investigating torture and CIDT is consistent with the equivalence Congress promised to the international community when the United States ratified the Convention against Torture.

IAJ DOES NOT GIVE LEGAL ADVICE

The IAJ is an educational and investigative institute. It develops standards, methodology, and analytical frameworks. It does not give legal advice and it does not represent individuals before any forum.

Nothing in this Guide is legal advice. The Guide describes what the requirements should look like when considered from the international plane (UNCAT, the Istanbul Protocol, jus cogens, and the customary law of human rights) and from the equivalence promise Congress made to the international community at ratification. It then sets out the inquiries a clinician should make so that licensed counsel can render advice on application in any particular case.

Clinicians facing concrete licensing, criminal, regulatory, or evidentiary questions about a specific case should obtain advice from counsel admitted to practice in the relevant jurisdiction. The IAJ assists with methodology and documentation; it does not substitute for counsel.

B. How the Guide is organized

The Guide is built around five integrated themes and three audience tracks. The themes are addressed first as a unified framework so that every reader sees the whole picture, then again, separately, for each audience so that each reader receives the maximum depth their role requires. The five themes are:

1. Theme A — Licensing regulates the practitioner; receiving forums regulate the report. A clinician's home-jurisdiction license is the affirmative authorization that matters; licensing statutes police who is competent to practice, while receiving forums (courts, tribunals, treaty bodies) apply their own evidentiary rules to determine what evidence they may receive.

2. Theme B — Forensic evaluation is a distinct regulated posture, not treatment. The activity that licensing boards regulate (treatment, therapy, diagnosis for care) is one regulated posture; forensic documentation for legal, human rights, and treaty-body purposes is another regulated posture, governed by the same boards plus forensic-specialty obligations. The distinction is between two postures of regulated practice, not a claim that forensic work escapes regulation.
3. Theme C — Two duties, two regimes, one report. Every clinician or medico-legal expert working on a torture or CIDT case operates under both a professional-authority duty (defined by the license, appointment, or recognized expert status under which the person works) and a treaty-based duty to document torture and CIDT. The two regimes reinforce each other where they overlap. The treaty-based duty strengthens the justification for the work; it does not replace the professional authority that permits it.
4. Theme D — The ethics of non-refusal, properly scoped. Professional ethics frameworks generally prohibit abandonment and strongly disfavor suppression and avoidant silence; they do not require every clinician to personally undertake every case. The duty is fulfilled through competent action, which may include referral, consultation, scope-limited documentation, supervised assistance, or protected reporting where personal undertaking is not appropriate. The ethical breach lies in looking away, not in honest acknowledgment of competence limits.
5. Theme E — The structural argument. The federal architecture for investigating torture and CIDT — including the criminal statutes that might be triggered by official conduct, the absence of a generalized federal mandatory-reporting duty for clinicians who learn of torture or CIDT, and the patchwork of state mandated-reporter regimes — is examined to ask whether the United States has, in fact, delivered the equivalence Congress promised at ratification. The IAJ's view is that it has not. This is a critique of the State's architecture, not an authorization for clinicians to operate outside professional regulation.

C. Audience tracks

After the unified treatment, the Guide is sectioned to address each audience fully:

- Track 1 — Forensic Psychologists: clinicians whose primary work product is medico-legal evidence.
- Track 2 — Treating Psychologists and Care Providers: clinicians whose primary work is care, but who encounter torture and CIDT and acquire a non-discretionary witness obligation.
- Track 3 — Cross-Jurisdictional Experts: U.S. and foreign experts (including members of the IFEG, former UN Committee Against Torture members, UN Subcommittee on Prevention of Torture members, and Special Procedures mandate-holders) who contribute to evaluations of survivors located outside their licensing jurisdiction or who contribute to information submitted to international mechanisms.

D. Decision tree plus narrative

Each audience track ends with a decision tree the clinician can run through before accepting or beginning an evaluation, followed by a narrative discussion of the cautionary considerations that the tree alone cannot capture. The trees are designed to be photocopied and used at intake; the narratives are designed to be read in full at least once and then consulted when an unusual case arises.

E. Calibration

This Guide is written at the calibration of IPIS: lawyerly, candid about contested questions, and explicit where reasonable people disagree. Earlier IAJ documents asserted broader categorical conclusions about licensing scope; the Standard reframes those conclusions as jurisdiction-specific legal questions to which a strong principled answer can be given but for which independent verification by counsel remains necessary. The Guide preserves that calibration throughout.

F. Cross-references and status

Citations in this Guide point to IPIS as the principal companion, to the IAJ jus cogens Synthesis Memorandum for the treaty-law structure, to the IAJ Disability Harmonization Thesis for the remedies-and-equivalence analysis, and to the Texas Supreme Court amicus IAJ-AMI-20260217-001-LEG for the equivalence promise as applied to U.S. proceedings. Where this Guide uses defined terms from IPIS (Level 1–4, SFP, CIRF, Dual-Track Rule, Forum Nullus, Aggravated Suppression, Forensic Probability, Forensic Integrity Attestation, Template A), the Standard definitions control.

The overarching frame of this Guide is that professional authority (licensure or its recognized equivalent), the treaty-based duty to document, and Istanbul Protocol methodology are three cooperating layers — all required, none in tension. The duty operates through lawful professional practice, not around it. Where a state psychology practice act defines the practice of psychology broadly enough to include forensic, legal, governmental, and human-rights assessments — and several do, including New Jersey's N.J.S.A. 45:14B-2 — the defensible posture is that forensic torture documentation falls inside the regulated practice, performed by a licensed practitioner in a forensic rather than therapeutic posture and within the scope the license already grants. This affirms the practitioner's authority rather than disclaiming the practice.

Status: this Guide is a publication candidate. The Istanbul Protocol 2022 paragraph numbers cited in this Guide have been verified against the official OHCHR PDF (Professional Training Series No. 8/Rev. 2, May 2022). Final release remains subject to legal review by IAJ counsel admitted to practice in the relevant jurisdictions, and to primary-source verification of the remaining authorities cited or relied on in the Guide — the federal and state statutes, the professional ethics codes, the APA Specialty Guidelines, the ADA/EEOC treating-provider authority, PSYPACT status, the Article 20 working-methods materials, and the UK authority.

Part I — The Overarching Explanation

Five propositions, taken together, resolve the licensing question for a clinician asked to document torture or CIDT. They are stated first in compressed form so the reader can hold the entire argument in view, and then expanded over the rest of Part I.

The Corrected Frame: Three Cooperating Layers

The question this Guide answers is not 'licensure versus duty.' That frame sets up a false conflict and concedes ground that need not be conceded.

The correct frame is that three layers cooperate to authorize and discipline the work:

1. PROFESSIONAL AUTHORITY — the practitioner is licensed in good standing in her jurisdiction (or, for some internationally credentialed experts, holds an appointment, mandate, or recognized expert status), and the work she performs falls within the scope that authority grants.

2. DUTY — the treaty-based and ethical duty to document torture and CIDT motivates and structures the work, and explains why declining the work based merely on convenience, discomfort, institutional pressure, or unexamined jurisdictional anxiety is not an available ethical response. (An actual legal bar — a licensing prohibition, a board rule, a court order, a privilege restriction, or a genuine foreign-law problem — remains a valid reason to decline, refer, or limit personal undertaking; where personal undertaking is foreclosed, the Bar-Documentation Duty (Theme E.5) applies — document and report the operation of the bar itself; silent retreat is not an available ethical response. See Theme D, Theme E.5, and Inquiry 12.)

3. METHODOLOGY — the Istanbul Protocol and IPIS supply the discipline that makes the work usable as evidence on the international plane and admissible (where the rules permit) on the domestic plane.

All three are required. None is in tension with the others. The duty does not displace professional authority; it operates through it. Professional authority does not constrain the duty; it permits the practitioner to fulfill it.

The Five Propositions

1. Licensing regulates the practitioner; receiving forums regulate the report. The license is an affirmative grant of authority to its holder; it does not, by itself, dictate which evidence a court or treaty body may receive. Receiving forums apply their own evidentiary rules. (Theme A)

2. Forensic evaluation is a distinct posture within the regulated practice of psychology, not an activity outside it. The forensic-versus-clinical distinction is real and decisive, but it is a distinction between two postures of regulated practice, not a claim that forensic work escapes regulation. (Theme B)

3. Every clinician or medico-legal expert operates under two simultaneous duties — a professional-authority duty (under license, appointment, or recognized expert status) and a treaty-based duty to document — and they cooperate rather than conflict. The duty strengthens the justification for the work; it does not replace the professional authority that permits it. (Theme C)

4. When torture is credibly alleged or clinically indicated, professional ethics across helping-profession frameworks strongly disfavor abandonment, suppression, and avoidant silence. The duty to document within role is heightened, not relaxed, by difficulty. (Theme D)

5. The combination produces a structural conclusion: the United States, by promising equivalence at ratification and then failing to provide effective domestic mechanisms for investigation and prosecution of torture and CIDT, has not delivered what Congress promised. The duty to document falls on the individual clinician precisely because the equivalence machinery has not been built. This is a structural argument about the architecture, not a claim that individual clinicians may operate outside professional regulation. (Theme E)

Theme A — Licensing Regulates the Practitioner; Receiving Forums Regulate the Report

State and national psychology licensing statutes are grants of authority issued to a person. They authorize a clinician, identified by name and credentialed by a board, to practice within a defined scope. Two structural points follow.

First, a license is an affirmative grant. It tells the practitioner what she may do; the question for any particular task is whether the task falls within the scope the license grants. For forensic torture documentation, the analysis is usually affirmative: psychology practice acts in many U.S. jurisdictions define the regulated activity broadly enough to include forensic, legal, and governmental assessments. New Jersey's statute, N.J.S.A. 45:14B-2 (defining 'practice of psychology') and N.J.S.A. 45:14B-6 (scope of activities), is illustrative: the New Jersey practice act defines psychology to encompass psychological assessment and related professional psychological services and does not, by its terms, exclude forensic, legal, governmental, or human-rights assessment from the scope of the regulated practice. A New Jersey-licensed forensic psychologist conducting an Istanbul Protocol evaluation is performing activity that lies squarely within the scope the license already authorizes. The defensible position is not that the work falls outside the practice of psychology; it is that the work falls inside the practice of psychology, performed by a licensed practitioner in a forensic posture, within the scope the license already grants.

Second, where a state's licensing statute reaches across borders at all — for example, through a telehealth provision that defines practice as occurring where the recipient is located — it does so for a specific protective purpose: to ensure that a resident patient receiving ongoing care has a locally-accountable provider and a local board to complain to. The protective purpose engages the therapeutic relationship. A purpose-based reading of those statutes does not extend them

automatically to a one-off forensic examination conducted for a court or treaty body, in which there is no patient and no care, unless the text of the jurisdiction's statute, regulation, board guidance, or temporary-practice rule expressly says otherwise. This is not a claim that the forensic activity escapes regulation; it is an argument that the cross-border reach of the regulating statute does not, by its own purpose and absent express extension, capture this kind of work. The IAJ supplies the principled default; counsel verifies the statutory exception in any specific case.

Receiving forums — domestic courts, immigration tribunals, foreign tribunals, and UN treaty bodies — apply their own rules to determine what evidence they may receive. They ask whether the evidence is relevant, reliable, methodologically sound, and produced by a qualified expert. A practitioner's license is relevant to that inquiry as one indicium of qualification. It is not, by itself, a precondition to receipt. International human rights mechanisms in particular assess Istanbul Protocol methodology and demonstrated expertise; they do not ask which state's license the clinician holds.

Theme B — Forensic Evaluation Is a Distinct Posture Within Regulated Practice

This is the foundational distinction in the IAJ Standard. Version 2 of this Guide restates the distinction more carefully than earlier formulations did. The point is not that forensic evaluation escapes the regulated practice of psychology; it is that forensic and clinical practice are two distinct postures within the regulated practice, governed by different ethical priorities, owing duties to different parties, and producing different work products.

Element	Clinical Posture	Forensic Posture
Purpose	Care, treatment, diagnosis for the patient's benefit	Documentation for a legal, human rights, or treaty-body proceeding
Relationship	Therapeutic — clinician owes a duty of care to the patient	Examination — clinician owes a duty of objectivity to the legal or international system
Primary beneficiary	The patient	The forum that receives the evidence; the historical record
Ethics governance	State licensing boards and professional codes (treatment focus)	Same boards and codes (forensic specialty guidelines); plus Istanbul Protocol; plus IP ¶¶ 201, 666 forensic independence
Confidentiality posture	Strong therapeutic confidentiality	Limited — the work product is created to be transmitted
Outcome	A treatment plan or ongoing care	A written report and, if called, testimony

Two consequences follow.

First, the forensic posture is a regulated activity, supervised by the same licensing boards and disciplined by the same professional codes that govern clinical practice (and, for forensic-specific obligations, by the APA Specialty Guidelines for Forensic Psychology, 68 Am. Psychologist 7 (2013) (extended through Dec. 31, 2026), and by Istanbul Protocol 2022 ed. ¶¶ 201, 666 on forensic independence from the alleged perpetrators and the institutions associated with them). Out-of-state psychologists, out-of-state psychiatrists, out-of-state trauma experts, and international experts are routinely brought into jurisdictions to conduct forensic evaluations, including torture documentation. They do so as licensed practitioners operating in the forensic posture, not as practitioners operating outside professional regulation.

Second, the protective purpose of any cross-jurisdictional reach in a state's licensing statute is generally tied to the therapeutic posture — to ensuring that resident patients receiving ongoing care have local accountability. Whether and how the same statute reaches the forensic posture is a jurisdiction-specific question. The IAJ does not assume a blanket answer either way.

Important caveat (IPIS calibration)
The posture distinction is real, broadly recognized, and decisive in many jurisdictions. Where a state psychology practice act defines the regulated activity broadly enough to include forensic assessment as well as clinical care (and many do), the practitioner remains inside the regulated practice; the question becomes whether her license, which authorizes her to practice psychology, encompasses the forensic work. Where it does, the license ordinarily encompasses the work, subject to jurisdiction-specific restrictions. Where it does not — for example, where a state-specific carve-out narrows the scope — the practitioner should ask counsel whether any compact pathway, temporary-practice provision, or forensic-specific exception applies. The IAJ does not assume a blanket exemption from any state licensure regime; it does assert that forensic torture documentation by a licensed practitioner, operating in the forensic posture and applying Istanbul Protocol methodology, is regulated forensic practice, not unregulated activity.

Theme C — Two Duties, Two Regimes, One Report

Every clinician or medico-legal expert working on a torture or CIDT case is subject to two simultaneous duties. They are not in conflict; they are in cooperation.

The Professional-Authority Duty (Licensure or Equivalent)

The first duty is owed to the body that authorized the person to perform the work — most commonly the state or national board that issued the clinician's license, but for some internationally credentialed experts the source of authority is an appointment, mandate, or institutionally-recognized expert status rather than a domestic license. The duty requires the practitioner to remain within scope of practice, maintain competence, observe applicable telehealth and cross-jurisdictional rules where they exist, and uphold the relevant ethics code.

The duty is local in source: it is defined by the law or institutional framework that supplied the authority.

The Treaty-Based Duty to Document

The second duty is owed to the international legal order and is rooted in the Convention against Torture (UNCAT) and the Istanbul Protocol. UNCAT Articles 12 and 13 require effective and impartial investigation of any act of torture or CIDT, wherever it occurs in the territory of a State Party. Article 16 extends the same obligations to CIDT. The Istanbul Protocol, endorsed by the UN General Assembly and treated by the UK Supreme Court in KV (Sri Lanka) v Secretary of State for the Home Department [2019] UKSC 10, [21]–[22] (Lord Wilson) as authoritative ("equally authoritative" to the Tribunal's Practice Direction), supplies the methodology by which that investigation is performed. The Istanbul Protocol (2022 ed., HR/P/PT/8/Rev.2, ¶¶ 148, 631) is explicit: clinicians who encounter survivors of torture or CIDT have a duty to investigate and document according to its standards, and that duty supersedes limitations that may be imposed by statutory considerations (¶ 631 verbatim). The duty does not depend on credential level, licensure status, specialty, or the clinician's comfort with legal proceedings.

How the two duties interlock

In the ordinary case, the duties cooperate. The licensure duty supplies the affirmative authority to practice and the discipline of professional accountability. The treaty-based duty supplies the methodology, the purpose, and the obligation to act. A clinician who fulfills both is doing nothing the licensing board could reasonably object to — and is doing what the international order requires.

A formulation worth memorizing

Duty strengthens the justification for the work; it does not replace the professional authority that permits it. The international duty to document torture and CIDT is a reason to act and a discipline that shapes how the work is done. It is not an exemption from professional regulation. The clinician who tries to invoke the international duty as a substitute for the authority to practice is making a losing argument; the clinician who invokes it as the reason she is exercising her existing professional authority — and as the methodology she follows in doing so — is making a winning one.

Where the duties appear to diverge — for example, where a hostile court or licensing board threatens action against a clinician for documenting torture — the IAJ position is that the apparent divergence is itself diagnostic of a system that is not delivering the equivalence Congress promised. The clinician's response is not to choose between the duties but to document the conflict using the IAJ Clinician's Incident Report Form (IPIS Appendix H, the CIRF) and continue to fulfill both. A licensing board may discipline a licensee for departures from competence, methodology, consent, confidentiality, scope of practice, or applicable cross-jurisdictional rules. But where a clinician documents torture or CIDT through regulated forensic practice within

licensed scope, the mere fact of fulfilling the international duty to document should not itself supply a legitimate disciplinary basis.

Theme D — The Ethics of Non-Refusal

Professional ethics frameworks generally disfavor a clinician's looking away when torture or CIDT is credibly alleged or clinically indicated. The frameworks differ in language but converge in substance: abandonment, suppression, and avoidant silence are the breaches they guard against.

Framework	Operative provision	Effect when torture is alleged
APA Ethical Principles (2017)	§6.01 (documentation); §3.04 (avoiding harm)	Failure to document harms the patient by depriving them of evidence; documentation is required.
NASW Code of Ethics	§3.04 (records); §6.01 (social welfare and human rights)	Documentation simultaneously satisfies record-keeping and human-rights-advocacy duties.
ACA Code of Ethics	§A.1.a (primary responsibility — dignity and welfare)	Documenting respects dignity by validating experience and promotes welfare by creating evidence for remedy.
AAMFT Code of Ethics	§3.6 (accurate documentation)	Accurate records include reports of torture and observed effects.
Istanbul Protocol ¶¶ 148, 201, 624, 631, 666, 673	Duty to document and report; independence from the alleged perpetrators (¶ 201); independence from State employers and military chain of command (¶ 624); independence of State-employed clinicians from law enforcement, prosecution and military authority (¶ 666); access to non-governmental independent clinicians (¶ 673)	Direct, on-point, and methodologically prescriptive.

The Abandonment Prohibition

Refusing to document torture or CIDT because of fear of legal involvement effectively abandons the patient to undocumented suffering. Professional ethics frameworks generally prohibit abandonment. The clinician who declines to document on unexamined jurisdictional or licensing concerns, where competent documentation is within reach, is in a worse ethical position than the clinician who documents and accepts the inconvenience that may follow.

The Scope of Non-Refusal — A Necessary Guardrail

The Abandonment Prohibition does not mean every clinician must personally undertake every torture or CIDT evaluation. The duty is fulfilled through competent action, which sometimes means referral, consultation, scope-limited documentation, supervised assistance, preservation of records for a properly qualified colleague, or protected reporting through an appropriate pathway.

A clinician may responsibly decline to be the primary evaluator where competence is lacking, where an unavoidable role conflict exists, where informed consent cannot be obtained, where documentation cannot be conducted without unacceptable reprisal risk, where language or cultural competence is insufficient, where impairment or capacity limits the clinician's functioning, or where a specific legal restriction prevents personal undertaking.

Where the reason for not personally undertaking is a specific binding legal restriction (a licensing prohibition, a board rule, a court order, a privilege restriction, a foreign-law problem) rather than competence or capacity, the Bar-Documentation Duty (Theme E.5) applies. The bar itself becomes the object of documentation and reporting through professional and international channels. Silent retreat is not an available ethical response even where personal undertaking is foreclosed. Compliance with the bar is a separate matter from acknowledgment of the bar; the clinician complies and reports.

The ethical breach lies in abandonment, suppression, or avoidant silence — not in responsible referral, role-limited documentation, or honest acknowledgment of the limits of one's competence. The duty is to ensure that competent witness occurs; it is not a duty to personally perform every possible witness function. Every framework that prohibits abandonment also requires competence and informed-consent practice. The two requirements operate together.

What the Guide Means by Witness

The Guide uses the word 'witness' throughout in a specific and limited sense. It is a borrowing from the Istanbul Protocol and from IPIS §1.1, and it does not carry the legal-procedural meaning of a person under subpoena, on the stand, or compelled to testify.

By 'witness' the Guide means: a professional custodian of facts observed in the clinical encounter and of accounts received from the patient, with a corresponding responsibility to record, preserve, and (where appropriate, lawful, and consented) transmit what was observed and reported, in keeping with the Istanbul Protocol's documentation standards and the clinician's licensed role.

The witness obligation is therefore a documentation-and-preservation responsibility within professional role. It is not a legal duty to testify, a duty to undertake every case personally, or a duty to disclose without regard to confidentiality, privilege, or consent. What the responsibility requires in any given case — personal evaluation, referral, consultation, contemporaneous documentation, preservation of records for a properly qualified colleague,

> supervised participation, protected reporting where a pathway exists, or some combination — is a matter of competent professional judgment exercised within scope.

The IAJ position, drawn directly from IPIS §1.1 and Section 12, is that every care provider who encounters credible allegations or clinical indicators of torture or CIDT acquires this documentation-and-preservation responsibility, and that the responsibility cannot be declined wholesale merely because the subject matter is difficult, institutionally disfavored, or legally inconvenient. The responsibility arises from the encounter itself. The licensing question is downstream of the responsibility; the scope-of-action question is part of fulfilling it.

Theme E — The Structural Argument: Reporting Duties, Federal Statutes, and the Equivalence Question

E.1 The architecture as Congress described it

When the United States ratified UNCAT in 1994, the Senate attached Reservations, Understandings, and Declarations (RUDs). One declaration stated that Articles 1–16 are not self-executing. The justification offered to the international community for the absence of a comprehensive domestic implementing statute was that existing federal and state laws already provided equivalent mechanisms for prevention, investigation, prosecution, and remedy. See S. Exec. Rep. No. 101-30 (1990) (Senate Foreign Relations Committee report on UNCAT). Congress represented to the world that the U.S. constitutional and statutory architecture was equivalent or greater protection. That representation is the equivalence promise.

E.2 What an equivalence regime would require

To satisfy what Congress represented, the domestic architecture would have to deliver, at a minimum:

6. Effective criminalization of torture and CIDT wherever they occur in U.S. territory, with prosecutorial pathways that do not depend on the willingness of the alleged perpetrator's institution to cooperate.
7. Mandatory investigation by competent independent authorities whenever a credible allegation arises, consistent with UNCAT Articles 12 and 13.
8. A complaint pathway for victims that does not require attorney representation, that protects against reprisal, and that produces meaningful investigation rather than referral back to the institution alleged to have caused the harm.
9. A reporting framework for clinicians and other professionals who acquire knowledge of torture or CIDT, comparable in structure and reliability to the mandated-reporter regimes that exist for child abuse and elder abuse.
10. Protection for clinicians who document and report, including independence from the courts, prosecutors, and police whose conduct is being investigated (Istanbul Protocol 2022 ed. ¶¶ 201, 666; see also ¶ 679 (whistleblower protections)).

E.3 What the domestic architecture actually provides

The federal architecture as it currently stands diverges from the equivalence model in several material respects. The Guide identifies the divergences without offering legal advice on how they would be litigated in any particular case.

(a) The principal federal torture statute is extraterritorial only

18 U.S.C. §2340A criminalizes torture committed outside the United States. By its own terms it does not reach domestic conduct. Adversarial arguments have read §2340A's extraterritorial scope as evidence that Congress understood UNCAT to reach only extraterritorial conduct. The IAJ position — set out in the jus cogens Synthesis Memorandum, Dimension IV.D — is that this reading is unjustified: §2340A fills a jurisdictional gap for overseas acts, while domestic torture was assumed by Congress to be addressed by other federal and state criminal law. The practical effect, however, is that there is no single federal criminal statute that punishes torture as such when committed inside the United States.

(b) Domestic torture is addressed, if at all, by adjacent statutes

Conduct that would qualify as torture or CIDT inside the United States is reached, if at all, by:

- 18 U.S.C. §242 (criminal deprivation of rights under color of law) — willful violation of constitutional rights by state actors;
- 18 U.S.C. §241 (conspiracy against rights) — including reach to purely private actor conspiracies;
- 42 U.S.C. §1983 — civil rights claims for constitutional violations under color of state law;
- The Eighth and Fourteenth Amendment 'deliberate indifference' framework (Estelle v. Gamble, 429 U.S. 97, 104 (1976));
- The Americans with Disabilities Act and the Rehabilitation Act for disability-based institutional harm.

None of these is denominated a torture statute. Each requires its own predicates. None requires a clinician who learns of torture or CIDT to report it; each provides a vehicle that someone else — typically a prosecutor or a civil plaintiff — may use after the fact.

(c) There is no generalized federal mandatory-reporting duty for clinicians who learn of torture or CIDT

U.S. mandated-reporter regimes are state-by-state and category-specific. Every state has a child-abuse mandated-reporter statute that obligates clinicians to report suspected child abuse to a designated authority. Most states have elder-abuse or vulnerable-adult mandated-reporter statutes. Several states have separate firearm-injury or domestic-violence reporting duties. None of these regimes is structured to capture torture or CIDT as such. A clinician who learns that a public official has tortured an adult — outside the child-abuse, elder-abuse, and vulnerable-adult frames — generally has no statutory recipient to whom a report is owed.

This is the most direct equivalence gap. The Istanbul Protocol's clinician duty to document and report (2022 ed. ¶ 631) presupposes a domestic infrastructure that receives and acts on the report. The U.S. architecture provides such infrastructure for some categories of harm and not for torture and CIDT in their own right. The clinician who attempts to comply with the international duty finds no domestic mailbox for the report.

(d) Misprision of felony — a statutory backstop with very limited reach

18 U.S.C. §4 (misprision of felony) provides that one who has knowledge of the actual commission of a federal felony and conceals it, while failing to make it known as soon as possible to a federal authority, may be punished. Federal courts have read §4 narrowly to require active concealment rather than mere silence (see Branzburg v. Hayes, 408 U.S. 665, 696 & n.36 (1972) (treating concealment of felony as historically disfavored and reproducing the §4 text); see also United States v. Ciambrone, 750 F.2d 1416, 1417–18 (9th Cir. 1984) (requiring an affirmative act of concealment in addition to failure to disclose)), and §4's application to professionals operating under confidentiality duties is contested. Misprision is therefore not a workable substitute for a properly designed clinician-reporting regime, but its existence on the books underscores Congress's recognition, in principle, that knowledge of federal felonies carries reporting consequences. Where the underlying conduct does constitute a federal felony — for example, a §242 violation committed under color of law — the absence of any clinician-specific reporting pathway is the more striking by contrast.

Confidentiality, Privilege, and HIPAA — A Necessary Caveat

Nothing in this analysis overrides confidentiality, privilege, HIPAA, state psychotherapist-patient privilege, informed-consent requirements, or jurisdiction-specific exceptions to confidentiality. The structural point made in this Part is that the United States has not created a general torture/CIDT reporting pathway comparable to the child-abuse or elder-abuse reporting frameworks.

Whether disclosure of a particular patient's torture or CIDT history is permitted or required in a particular case remains a jurisdiction-specific legal question. The clinician's documentation duty under the Istanbul Protocol applies to what is recorded; the transmission and disclosure of that record are governed by the patient's informed consent and by the confidentiality and privilege rules of the jurisdiction in which the clinician practices.

Where a mandated-reporter statute is engaged (child abuse, elder abuse, vulnerable adult, or category-specific reporting), the statute supplies its own confidentiality exception. Where no mandated-reporter statute applies, disclosure proceeds — if at all — on the basis of informed consent or another recognized confidentiality exception. The IAJ does not give legal advice on which confidentiality exception applies in any particular case; counsel does.

(e) State-licensing board ethics codes versus the international duty

State-licensing board ethics codes incorporate, by reference or by inference, the duty to document accurately and the duty to avoid abandonment. Several state codes also reach the duty to report

harms. None of the codes is drafted in language that obviously captures torture or CIDT inflicted by public officials. The clinician operating in good faith therefore receives no clear domestic instruction comparable to the international instruction the Istanbul Protocol provides.

E.4 The structural conclusion

Taking these strands together: Congress promised equivalence at ratification. The principal federal torture statute reaches only extraterritorial conduct. There is no federal mandatory-reporting duty for clinicians who learn of torture or CIDT. Mandated-reporter regimes are state-by-state and structured around child abuse, elder abuse, and vulnerable-adult categories, none of which fully captures torture or CIDT by public officials. Misprision of felony exists but is too narrow and too contested to be a workable substitute. The result is that the clinician who fulfills the international duty to document, and the survivor who relies on that documentation, operate in a domestic infrastructure that has not been built to the equivalence specification.

The IAJ Position

The IAJ's position — set out in IPIS and in the jus cogens Synthesis Memorandum — is that the absence of an effective domestic investigation-and-prosecution architecture for torture and CIDT is itself a breach of the equivalence promise made at ratification, and is documentable on the international plane regardless of whether any domestic forum is willing to adjudicate it.

The clinician's documentation, fulfilling the international duty, becomes both substantive evidence in the particular case and pattern evidence of the equivalence failure. The two functions are inseparable. This is why IPIS instructs every IAJ report to be prepared first on the international (Istanbul Protocol) plane and then translated for domestic presentation under the RUDs — the Dual-Track Rule. The international plane is the plane on which the equivalence promise is measured.

E.5 The Bar-Documentation Duty: where the bar appears, the bar is documented

The structural conclusion has an immediate operational corollary that this Guide names the Bar-Documentation Duty. Where a specific domestic legal barrier — a licensing prohibition, a board rule, a court order, a privilege or confidentiality restriction, a foreign-law problem, or any other binding legal constraint — prevents a clinician from rendering the torture/CIDT documentation that the situation otherwise calls for, the clinician's residual duty is not silent retreat. It is to document and report the operation of the barrier itself, because the operation of the barrier is precisely an instance of the equivalence gap that this Guide identifies and that UNCAT Article 20, the Committee Against Torture's periodic-reporting mechanism, and the Special Procedures of the UN human rights system are competent to examine when the obstruction appears as part of a systematic pattern.

Silent retreat — declining the work and saying nothing further — extinguishes evidence of the very equivalence gap the Convention's mechanisms were designed to address. The clinician who

is blocked but reports the blocking contributes evidence to the structural record; the clinician who is blocked and remains silent erases it. Where personal undertaking of the evaluation is foreclosed, the Bar-Documentation Duty replaces it as the operative ethical obligation, and is fulfilled in four steps.

The Bar-Documentation Duty — Four Steps

1. Document the bar. Record, with the same methodological discipline the Istanbul Protocol applies to torture documentation, what the bar is, when and how it activated, what documentation would have been preserved absent the bar, what the clinician was prepared to do, and what specific aspect of the equivalence gap the bar instantiates. Use the IPIS Clinician's Incident Report Form (CIRF, Appendix H) and IPIS §9.4 Aggravated Suppression categories where the bar arose from process pressure.

2. Preserve permissible evidence. Within the constraints the bar imposes, preserve such observations, clinical impressions, and contemporaneous records as may lawfully be preserved, in a form that does not breach the bar but is available to a future inquiry that the bar does not reach. Where consent is available, ensure the survivor is offered the option of contemporaneous preservation independently of any compelled or prohibited disclosure.

3. Report through lawful protected channels. Transmit the documented account of the bar through whatever lawful, consented, protected, anonymized, aggregate, delayed, or later-reviewable channel remains available. Channels include the IAJ (where consent, confidentiality, privilege, safety, and applicable law permit; IAJ maintains pattern data on equivalence-gap incidents and contributes such data to international mechanisms, but is one lawful option among many, not a mandatory recipient); the UN Committee Against Torture (through CAT periodic-reporting submissions, NGO shadow reports, and contributions to any Article 20 cohort the Committee may be developing); the UN Special Rapporteur on Torture (through the Special Procedures communications mechanism); the Subcommittee on Prevention of Torture and applicable National Preventive Mechanisms (under OPCAT); and reputable NGO partners (IRCT, IFEG, REDRESS, OMCT, and equivalents).

4. Do not silently retreat. The clinician complies with the bar. The clinician does not validate the bar by silence. The duty is no silent withdrawal — it is not a duty of unlawful disclosure. Compliance with a restriction is one act; allowing the event to vanish from the record is a different and unnecessary act. The clinician complies; the bar's operation is preserved in the record at whatever level of generality lawful channels will receive; both facts contribute to the structural argument over time.

Scope and Safety Constraints on the Bar-Documentation Duty

The Bar-Documentation Duty operates within the same confidentiality, privilege, and reprisal-risk constraints that govern the underlying clinical work. Where the bar itself is sealed or confidential (for example, where a court order prohibits even acknowledging the existence of the order), the clinician documents at the highest level of generality permitted — 'a binding

restriction I cannot describe in detail prevented documentation in this matter' — and reports to channels that can receive such information lawfully. Where even generalized external reporting may itself violate the restriction, the clinician should preserve a privileged or protected internal record for later lawful disclosure if and when the restriction is lifted, modified, or reviewed by a competent authority. The duty here is no silent erasure of the event — not unlawful disclosure.

Reprisal-risk considerations under Istanbul Protocol 2022 ed. ¶¶ 176–179 (criteria for any breach of confidentiality, including the ¶ 178(c) requirement that the risk of reprisals to the alleged victim be 'deemed to be low by both the clinician and the alleged victim'), ¶ 612 (risks where examination is conducted outside ordinary clinical facilities), and ¶ 679 (whistleblower protections for clinicians who document and report) apply equally to the Bar-Documentation Duty. Where reporting would create imminent danger to the survivor, the clinician, or third parties, the clinician calibrates modality and timing consistent with safety — anonymized aggregate reporting, delayed reporting, reporting through a protected channel, or privileged internal preservation for later lawful disclosure — but does not abandon the duty.

The IAJ does not give legal advice on whether a particular bar applies in a particular case, or on whether a particular form of bar-documentation may itself be lawful. Counsel admitted in the relevant jurisdiction answers those questions. What the Guide supplies is the principle: the bar itself is part of the record, not an end of it.

The Bar-Documentation Duty closes the logical gap that the Scope of Non-Refusal callout in Theme D opens. Theme D acknowledges that the duty of non-refusal does not require every clinician to personally undertake every case; competent referral, scope-limited documentation, and protected reporting are all available. The Bar-Documentation Duty specifies what 'protected reporting' looks like when the constraint is not lack of competence or capacity but lack of permission — when the State or another binding authority has prevented the work that the clinician was prepared to do. In such cases, the Guide's instruction is unambiguous: document the bar, preserve what can be preserved, report or preserve through lawful protected channels, and do not silently retreat.

The Bar-Documentation Duty — Final Formulation

A genuine legal bar may prevent personal undertaking of the evaluation. It does not authorize silent retreat. The clinician must document the bar, preserve what may lawfully be preserved, and report or preserve the barrier through lawful, protected, consented, anonymized, delayed, or later-reviewable channels — so that the equivalence gap is not erased.

E.6 The acquiescence question: does silent declination make State non-equivalence effective?

The Bar-Documentation Duty rests on a deeper structural question, and the question deserves to be put plainly because it shapes every step of the analysis that precedes it. UNCAT Article 1

defines torture as severe pain or suffering inflicted 'by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity.' The Committee Against Torture has developed the concept of 'acquiescence' to include State failure to prevent, investigate, document, prosecute, and remedy torture and CIDT — and, importantly, State failure to do so where the State's own architecture obstructs investigation and documentation. See CAT General Comment No. 2 on Implementation of Article 2 by States Parties, U.N. Doc. CAT/C/GC/2 (24 January 2008), ¶¶ 17–19 (treating the failure of States to exercise due diligence to prevent, investigate, prosecute, and punish acts of torture by non-State actors as conduct that 'enables non-State actors to commit acts impermissible under the Convention with impunity' and constitutes a form of acquiescence).

The clinician, considered individually, is not a 'public official' within the meaning of Article 1. The State acquiesces; the clinician does not. But where the State's acquiescence operates through structural barriers that prevent clinician documentation — licensing rules with chilling reach, sealed restrictions, court orders, board interpretations that punish good-faith documentation, jurisdiction-of-evaluee complications, foreign-law problems — silent retreat by the blocked clinician may function as the case-level mechanism through which the State's acquiescence becomes effective. The State sets the architecture of obstruction; silent withdrawal allows that architecture to operate in the particular case without leaving a record. The survivor's torture goes undocumented; the equivalence gap goes unrecorded. State acquiescence and regulatory non-equivalence may become effective in the individual case through individual silence — unless silence is replaced by documented compliance and lawful reporting or preservation of the bar's operation.

The Question the Profession Must Answer

Does silent declination — the silent decision to walk away from a torture or CIDT survivor because a domestic legal bar happened to operate that day, with no documentation, no preservation, and no report — make State acquiescence and regulatory non-equivalence effective in the case at hand?

The IAJ position is that silent declination is not Article 1 acquiescence by the clinician. The clinician is not a 'public official' within Article 1, and the State, not the clinician, is the one whose acquiescence Article 1 reaches. Silent declination may, however, function as the case-level mechanism through which State acquiescence and regulatory non-equivalence become effective. The State creates or maintains the architecture of obstruction; silent withdrawal allows that architecture to operate without leaving a record of its operation. The Bar-Documentation Duty (Theme E.5) is the clinician's lawful method for refusing that evidentiary erasure.

Compliance with a binding bar is one act; silent erasure of the survivor's case is a different, and avoidable, act. The first is sometimes required by law. The second is never required by law. The Bar-Documentation Duty is the framework's instruction on how to do the first without doing the second.

Stated as the proposition the Guide commits to: there is no silent declination and surrender of a torture or CIDT victim to fate. The bar may compel withdrawal from the evaluation; it does not compel silence about the withdrawal.

The controlling sentence

A clinician may be required to comply with a binding bar. A clinician is not required to convert that compliance into silence.

A note on what this principle is and is not

This is not a blame principle. It is an anti-erasure principle. Its purpose is not to accuse clinicians who confront real legal constraints — clinicians may be afraid, unrepresented, medically compromised, economically vulnerable, or facing sealed orders, board rules, privilege restrictions, or foreign-law constraints they cannot fully resolve in the moment. Its purpose is to identify the lawful residual act still available when personal undertaking is blocked: document, preserve, report through whatever lawful channel remains, or preserve for later lawful disclosure. The Bar-Documentation Duty supplies that residual act. The Guide intends to give blocked clinicians a method, not a charge.

This question is uncomfortable and is meant to be — but uncomfortable about the State's architecture, not about the individual clinician's character. The Guide does not assert that any individual clinician's silent retreat in any particular case is morally or legally indistinguishable from State acquiescence; that is too strong, and the doctrinal point about Article 1's 'public official' element forecloses the strongest version of the claim. What the Guide does assert is that a structural mechanism by which State acquiescence may become effective is — case by case — silent clinician retreat in the face of bars the State has erected. The choice to break that mechanism, by documenting and reporting the bar through lawful channels, is available to the individual clinician in essentially every case. The Bar-Documentation Duty is the operational name for breaking the mechanism. E.6 is the structural reason E.5 matters; E.5 is the operative duty E.6 explains.

The IAJ does not offer legal advice on whether any particular clinician, in any particular case, is exposed to liability for documenting or for failing to document. It offers the framework. Counsel applies it.

Part II — What Is Allowed, What Is Not, and the Inquiries to Make

This Part organizes the operational consequences of Part I into a structure the clinician can use. It addresses three questions in turn: what is allowed in the ordinary course; what is not allowed; and what inquiries the clinician should make at intake, with cautionary explanations for each.

A. What Is Allowed

The following actions are ordinarily within a licensed clinician's professional role, subject to the clinician's license, competence, supervision status, applicable mandatory-reporting rules, confidentiality and consent obligations, cross-jurisdictional restrictions, IPIS Level Designations for who may sign which report, and the inquiries set out in Section C below. They describe the affirmative scope the framework recognizes; they are not a representation that any clinician, anywhere, may perform every listed item without those qualifications attaching.

11. Documenting that a patient reported torture or CIDT and what the patient said, including direct quotation where appropriate. (See IPIS §1.1 and §10.1 Step 1.)
12. Documenting the clinician's own observations — affect, behavior, physical findings within scope, cognitive presentation, functional impact.
13. Diagnosing torture-related conditions, where the clinician's license and training authorize diagnosis, using DSM-5 or ICD criteria. (Care providers whose license does not authorize independent diagnosis document observations and refer the diagnostic question to a qualified colleague.)
14. Forming and recording a clinical impression of the consistency between the reported history and the documented presentation, framed in Istanbul Protocol consistency language (2022 ed. ¶ 380, with explanation at ¶¶ 381–383; psychological-evidence application at ¶¶ 540–545) rather than as a credibility/truthfulness determination.
15. Conducting a remote evaluation by secure video where in-person evaluation is not feasible, with the modality and its limitations transparently documented in the report.
16. Producing a written report and, if called, providing testimony, subject to the ethics-of-non-refusal as scoped in Theme D and IPIS Forensic Independence framework (Appendix F).
17. Filing a Clinician's Incident Report Form (CIRF — IPIS Appendix H) where institutional, supervisory, or judicial obstruction is encountered.
18. Contributing the evaluation to information packages submitted to UN treaty bodies, Special Procedures, the IFEG, IRCT, Physicians for Human Rights, and analogous bodies, consistent with the survivor's informed consent, applicable confidentiality and privilege rules, and digital-security protocols (IPIS §5.4 and following).

B. What Is Not Allowed

The following are categorically outside the framework. They are not gray areas; they are exclusions.

19. Independently authoring or signing an Istanbul Protocol-compliant forensic report while unlicensed or pre-licensed (AMFTs, MFT interns, psychology trainees, and students may assist under supervision but may not author, sign, conduct independent psychological testing, render diagnostic conclusions, or provide forensic opinions as the evaluator). (See IPIS Part E.)
20. Conducting a forensic evaluation as if it were clinical care, or providing care under the pretext of a forensic evaluation. The two activities are distinct in purpose, scope, and ethical posture, and conflation produces both forensic and clinical harm.
21. Holding oneself out as a 'Level 4 Expert' without the IPIS external credential minimum (doctoral-level, board-certified or forensic fellowship-trained, with international law competence). IAJ Level designations are internal workflow roles and do not supersede state licensure requirements.
22. Conducting or reporting on a coerced evaluation — one where the subject has not given meaningful informed consent — as if it were voluntary. IPIS §171 (after Istanbul Protocol 2022 ed. ¶ 171) requires the autonomy of subjects who refuse consent to be respected unconditionally; coerced evaluations may themselves constitute CIDT and must be documented as such in the CIRF.
23. Suppressing, softening, or omitting documentation of torture or CIDT in response to institutional, supervisory, employer, or judicial pressure. IPIS §9.4 treats this as both an ethics violation and, where the pressure is exerted through process, a documentable instance of the equivalence failure described in Part I, Theme E.
24. Using forensic skills to facilitate or 'clean up' torture — for example, failing to document a biological assault to protect the reputation of a tribunal, agency, or judiciary. IPIS expressly identifies this as complicity.
25. Disclosing findings beyond the consented scope. In conflict settings or where reprisal risk exists, findings may be shared only with the survivor's full and informed consent and only via the IAJ Digital Security Protocol.

C. Inquiries to Make at Intake — With Cautionary Explanations

Before accepting or beginning a forensic evaluation that involves any cross-jurisdictional element, the clinician should run through the following inquiries. The decision tree in each audience track distills them; the cautionary explanations here flag the issues the tree alone cannot capture.

Inquiry 1 — Where am I licensed, and is my license in good standing?

Cautionary explanation. The license is the practitioner's affirmative authorization to practice. If it is restricted, suspended, on probation, or limited in scope, the clinician must determine whether the restrictions reach the proposed work. A clinician practicing under supervision may participate

in evaluations only in the supervised-assistant role described in IPIS Part E.1, with the supervisor as the author and signatory of the report.

Inquiry 2 — Where is the survivor physically located at the time of evaluation?

Cautionary explanation. This is the question that most often triggers a perceived jurisdictional problem. Apply Theme A: licensing regulates the practitioner; the regulated act occurs where the practitioner is. Then apply Theme B: forensic evaluation is a distinct regulated posture, not treatment; therefore the 'client location' rule developed for telehealth treatment does not engage in the same way as for a therapeutic relationship. Then verify: does the survivor's jurisdiction have a psychology practice act that — as a matter of its own text and purpose — reaches forensic torture documentation conducted by an out-of-jurisdiction expert? Many will not, particularly where the work is remote, forensic, non-treatment, and prepared for a receiving forum or mechanism rather than for local clinical care; but the answer depends on the text and purpose of the jurisdiction's statute, regulation, board guidance, temporary-practice rule, and any applicable telehealth rule. Where the question is unclear, document the inquiry, obtain counsel's input where available, and proceed unless an actual prohibition (not an inferred concern) is identified.

Inquiry 3 — What forum or mechanism will receive the report?

Cautionary explanation. The receiving forum's or mechanism's own rules are what gate admissibility, not the licensing statutes of any state. A U.S. federal court applies Daubert/Rule 702; a U.S. state court applies its analogue; a UK immigration tribunal applies the Tribunal Procedure Rules and Practice Direction with reference to the Istanbul Protocol (KV (Sri Lanka) [2019] UKSC 10); a UN treaty body applies its own working methods. Each is a reliability gate, not a licensing gate. Where the report is intended for a UN mechanism — for example, an Article 20 confidential inquiry, a Special Procedures communication, or NGO shadow reporting — there is no domestic admissibility gate; there is, however, an international credibility threshold. UNCAT Article 20 is triggered only when the Committee receives 'reliable information' containing 'well-founded indications' that torture is being systematically practiced. The threshold is not adversarial and not formal, but it is real, and methodology bears the load of meeting it.

Inquiry 4 — Is this evaluation forensic, treating, or both?

Cautionary explanation. The two postures are distinct and should be kept distinct. A clinician who has a treatment relationship with the survivor and is asked to provide a forensic opinion should consider whether dual relationships are workable, whether the treating-provider authority (drawing on the deference accorded under ADA Title I caselaw and EEOC accommodation guidance to a treating clinician's medical judgment, and extended by the IAJ to torture documentation) is the appropriate vehicle, and whether a separate forensic evaluator should be engaged. The treating-provider documentary authority does not require forensic specialty credentials, but it also does not substitute for a properly framed forensic report when one is needed.

Inquiry 5 — Is the modality remote, and what does that imply?

Cautionary explanation. Remote evaluation of asylum seekers and torture survivors is an accepted and validated practice. The Istanbul Protocol does not prohibit it. The clinician must document the modality, note what could and could not be observed (physical findings in particular may be limited), and explain why the opinion is nonetheless reliable. Remote modality is a transparency issue, not a licensing issue.

Inquiry 6 — Who is the requesting party, and what are their interests?

Cautionary explanation. The clinician's duty of objectivity and impartiality (Istanbul Protocol 2022 ed. ¶ 269 (Chapter IV: "All clinical evaluations of cases in which torture or ill-treatment is alleged or suspected should be conducted with objectivity and impartiality")) runs to the receiving forum, not to the requesting party. A request from counsel, an NGO, an academic, or the IAJ does not subordinate the clinician's judgment to the requester's case theory. The Forensic Independence template (IPIS Appendix F) and the Forensic Integrity Attestation (IPIS Appendix G) are the standard responses to attempts at undue influence.

Inquiry 7 — Is there a Supervisory Falsification Pass requirement, and how will it be met?

Cautionary explanation. IPIS requires a Supervisory Falsification Pass (SFP) on every IAJ report before finalization, performed by a Level 4 Expert who did not conduct the primary evaluation. The SFP's jurisdictional scope is addressed at IPIS Part D/SFP §; the IPIS position is that the SFP is a document-review process in which the reviewer has no contact with the subject, no therapeutic relationship, no diagnostic role for treatment purposes, and no clinical-care function, and that the protective purposes of state therapeutic-practice regulation are accordingly not engaged in the same way as for the primary evaluation.

Two distinct questions about the SFP reviewer must be kept separate. The first is methodological and subject-matter qualification: can the reviewer competently apply the Istanbul Protocol and IPIS to a report of this kind? Credentials issued by the IAJ, the UN Committee Against Torture, the UN Subcommittee on Prevention of Torture, the IFEG, Special Procedures appointments, or equivalent international bodies may establish this qualification. The second is professional licensure or recognized expert status authorizing the reviewer to render the kind of conclusions the review entails. Where the SFP requires the reviewer to render psychological, psychiatric, diagnostic, or forensic conclusions in their own right (rather than confining the review to methodological auditing of another evaluator's work), the reviewer must hold an underlying professional credential, licensure, appointment, or recognized expert status that authorizes those conclusions in some jurisdiction with proper authority. IAJ, IFEG, CAT, SPT, or equivalent international credentials may establish methodological or subject-matter qualification; they do not themselves substitute for a professional license where the reviewer's work would otherwise constitute regulated psychological or medical practice.

In practical terms: the clinician should confirm before final report issuance both who will perform the SFP and that the reviewer's combination of professional credential plus methodological qualification matches the kind of review the case requires. Whether any particular state's statute reaches document-review work by an out-of-state reviewer is a jurisdiction-specific question on which the IAJ does not give legal advice.

Inquiry 8 — Is there a treating provider, and is their authority being honored?

Cautionary explanation. The Treating Provider Principle — a term used by the IAJ to describe the deference accorded to a treating clinician's medical judgment under disability-discrimination jurisprudence and EEOC reasonable-accommodation guidance, and extended by the IAJ to torture and CIDT documentation — recognizes that treating providers possess authoritative knowledge of their patients' conditions. The underlying concept (deference to a treating provider's medical judgment in disability assessment) is grounded in ADA Title I caselaw and EEOC guidance; the IAJ extends it to forensic torture documentation. A forensic evaluator who proceeds without consideration of a treating provider's documented findings risks both forensic error and ethical breach. The treating provider's authority does not require forensic credentials.

Inquiry 9 — Are mandated-reporter duties engaged?

Cautionary explanation. The clinician must check the mandated-reporter statutes of the jurisdiction where the clinician practices, and — if different — where the survivor is located. Child-abuse mandated-reporter statutes are universal and may be engaged if a minor was the subject of, or witness to, the torture or CIDT. Elder-abuse and vulnerable-adult statutes may be engaged in some states. As Part I Theme E sets out, no general U.S. clinician mandated-reporting duty for torture or CIDT exists. Where a state statute does engage, compliance is mandatory and is independent of the international duty to document.

Inquiry 10 — Is reprisal risk material, and what protections apply?

Cautionary explanation. The Istanbul Protocol (2022 ed. ¶¶ 176–179 on the criteria governing any breach of confidentiality where torture is alleged and reprisal risk is in play, including the requirement that the risk of reprisals to the alleged victim be "deemed to be low by both the clinician and the alleged victim" before disclosure is even considered (¶ 178(c)); ¶ 612 on the heightened risks (security, privacy, reprisals, pressure) where the clinical examination is conducted outside ordinary clinical facilities; ¶ 679 on whistleblower protections for clinicians who document and report) and the IAJ digital security protocols require the clinician to consider whether documentation could place the survivor, the clinician, or third parties at reprisal risk. Where risk is material, the clinician should adjust the modality of documentation, the scope of disclosure, and the storage of the record accordingly. Reprisal risk does not extinguish the duty to document; it shapes how the duty is fulfilled.

Inquiry 11 — Is the proposed evaluation voluntary, and how is consent being obtained?

Cautionary explanation. IPIS, after Istanbul Protocol 2022 §171, requires informed consent to be obtained free of compulsion. Court-ordered evaluations without meaningful procedural safeguards may themselves constitute CIDT. The clinician who is aware that the subject has been compelled to undergo evaluation must document that fact in the CIRF as a potential CIDT indicator and must not present a coerced evaluation as voluntary.

Inquiry 12 — Have I consulted counsel where appropriate?

Cautionary explanation. The IAJ does not give legal advice. Where the clinician's inquiries identify any genuine question of law — a state psychology practice act with unusual reach, a state mandated-reporter duty whose scope is unclear, a court order that appears to require disclosure of confidential clinical records — the clinician should consult counsel admitted to practice in the relevant jurisdiction before proceeding. The Guide identifies the questions; counsel answers them. Where counsel identifies a binding restriction that prevents personal undertaking, the work does not end; it shifts to the Bar-Documentation Duty (Theme E.5). The bar itself is documented and reported through professional and international channels. The clinician complies with the bar; the clinician does not validate the bar by silence.

Part III — Audience Tracks

Each of the following sections addresses one audience fully. Readers may proceed directly to the section that applies to them, but every reader benefits from at least skimming the other two: forensic and treating practice intersect more often than either group typically expects.

Track 1 — Forensic Psychologists

1.1 The forensic psychologist's situation

The forensic psychologist's work product is medico-legal evidence. The license authorizes practice within a defined scope; the forensic role requires objectivity, methodology, and the production of a report that will be examined under the receiving forum's evidentiary rules. For torture and CIDT cases the framework is Istanbul Protocol-driven, with the Dual-Track Rule supplying the structure for translating between the international (substantive) and the domestic (procedural) planes.

1.2 What the forensic psychologist may do

Beyond the items listed in Part II.A, which apply to all clinicians, the licensed forensic psychologist may:

- Author and sign the primary Istanbul Protocol-compliant forensic report (IPIS Level 3 or Level 4, depending on case complexity);
- Conduct full psychological assessment with standardized instruments selected for cultural validity and Istanbul Protocol compatibility;
- Render attribution and consistency opinions in IP terminology, framed under the IAJ Clinical Attribution Framework / Forensic Probability Standard described in IPIS;
- Perform an SFP review on another evaluator's report, where the reviewer holds Level 4 methodological credentials, has the professional authority required for the type of conclusions rendered, and did not participate in the primary evaluation (subject to the SFP credentialing and professional-authority requirements in Inquiry 7);
- Testify, subject to the Forensic Independence framework (IPIS Appendix F) and the principles of evaluator-independence-from-the-alleged-perpetrators set out in IP ¶¶ 201, 666;
- Decline to render opinions that exceed methodological reach — refusing to opine where the data does not support an opinion is itself an exercise of forensic competence, not a refusal to document.

1.3 What the forensic psychologist may not do

In addition to the categorical exclusions in Part II.B:

- Render a 'credibility' determination in the colloquial truthfulness sense. IPIS confines credibility to the IP consistency framework; framing the question as truth-versus-lie

exposes the evaluator to cross-examination as a de facto human polygraph and is methodologically unsupported.

- Allow the requesting party's case theory to dictate methodology or conclusions. The duty of objectivity runs to the receiving forum.
- Offer legal conclusions about whether torture 'occurred' as a legal matter — the IP framework provides clinical descriptors that allow adjudicators to determine whether the legal threshold is met.
- Submit a final report without the SFP attached or incorporated by reference, except under the Tiered SFP for routine Template A cases as described in IPIS.

1.4 Cross-jurisdictional forensic evaluation: the practical case

The paradigm case is the one set out in the IAJ documents and developed in the conversation that informs this Guide: a forensic psychologist licensed in one jurisdiction (for example, New Jersey) evaluates a survivor located in another jurisdiction (for example, the United Kingdom) for a forum located somewhere else (for example, a UK asylum tribunal or a UN treaty body).

Applying the framework:

26. The license authorizes the regulated work, performed at the practitioner's location. (Theme A.)
27. The forensic-clinical distinction means no treatment relationship arises with the survivor in their location, and the protective purpose of any client-location telehealth rule there is not engaged. (Theme B.)
28. The receiving forum applies its own evidentiary rules. UK tribunals apply the Tribunal Procedure Rules with Istanbul Protocol reference per KV (Sri Lanka); UN treaty bodies apply their own working methods; U.S. federal courts apply Daubert and FRE 702. None requires a license in the receiving forum's jurisdiction. (Theme C.)
29. Professional ethics strongly disfavor declining the evaluation based on unexamined jurisdictional anxiety where competent documentation is within reach; an actual legal bar is a different matter and may warrant declining, referral, or a limited role. (Theme D.)
30. The structural conclusion — that the United States has not built the equivalence machinery Congress promised — makes the individual evaluator's documentation more important, not less. The international plane is where the equivalence promise is measured, and Istanbul Protocol-compliant documentation feeds directly into it. (Theme E.)

The forensic psychologist in this paradigm case should document the licensing analysis in a Forensic Independence statement attached to the report (drawing on IPIS Appendix F), should be transparent about the modality (Inquiry 5), and should make the report self-explanatory on its face: a reader unfamiliar with the framework should be able to see from the report itself why the cross-jurisdictional posture is consistent with the Istanbul Protocol and the licensing law.

1.5 Forensic Psychologist Decision Tree

This tree is designed to be completed at intake and retained in the case file. A 'No' at any step requires the clinician to stop, address the issue, and document the resolution before proceeding.

Step	Question	If YES proceed; if NO action
1	Is my license in good standing, with no restrictions that reach the proposed work?	If NO: do not proceed; refer to a colleague whose license is unrestricted, or operate as supervised assistant only.
2	Is the proposed work forensic (documentation for a legal/treaty-body purpose), not clinical care?	If NO and a treatment relationship is intended: see Track 2. If both are intended: separate the roles or engage a separate forensic evaluator.
3	Have I identified the survivor's location and the receiving forum?	If NO: complete the intake and identify both before proceeding.
4	Does the survivor's jurisdiction have a psychology practice act whose text and purpose reach forensic torture documentation by an out-of-jurisdiction expert?	If YES or UNCLEAR: consult counsel; consider compact pathways or temporary-practice provisions; document the analysis.
5	Does the receiving forum admit out-of-jurisdiction forensic experts on the basis of methodology and qualification rather than local licensure?	If NO (a rare case): consult counsel about admissibility; consider whether the report can serve other purposes (international submission, treating-provider support, NGO peer review) even if not directly admissible.
6	Have I obtained informed consent, free of compulsion, with the modality and limitations disclosed?	If NO: do not proceed; coerced evaluation may itself constitute CIDT (IPIS §171).
7	Is reprisal risk addressed? Are digital security protocols in place?	If NO: implement before proceeding; adjust scope of disclosure accordingly.
8	Is an SFP reviewer identified, and is the path to SFP completion clear?	If NO: arrange before final report issuance (Central SFP Panel for cross-jurisdictional cases).
9	Are mandated-reporter duties in the practitioner's jurisdiction engaged? In the survivor's jurisdiction?	If YES: comply with the relevant statute in addition to the international duty to document.
10	Have I consulted counsel on any unresolved legal question?	If NO and any legal question remains: do so before proceeding.

1.6 Narrative discussion for forensic psychologists

The forensic psychologist working in this area faces three practical pressures the tree alone does not capture.

The first is the temptation to over-claim. Cross-jurisdictional torture work is well-founded but contested, and the contest is won by accuracy rather than by assertion. A report that confidently claims 'forensic evaluation is never the practice of psychology' will be undermined the first time it meets a state psychology practice act that defines practice broadly. A report that explains why, in the specific case, the regulated act occurred at the practitioner's location, why the protective purpose of any client-location rule is not engaged by the forensic posture, and why the receiving forum applies methodological rather than licensing criteria, will survive scrutiny. Calibration is forensic competence.

The second is the temptation to under-claim. Some forensic psychologists, faced with hostile cross-examination or a regulatory inquiry, retreat to a defensive posture and frame their work as merely 'expressing opinions' that the receiving forum is free to disregard. This understates the methodology and the discipline involved, and feeds the structural problem identified in Part I, Theme E. The clinician's documentation, properly framed, is evidence of clinical reality and of methodological rigor; it deserves to be presented as such.

The third is the temptation to treat the structural argument as a license for shortcuts. The equivalence failure identified in Part I, Theme E does not relax the methodological requirements; it makes them more important. The international plane on which the equivalence promise is measured is also the plane on which methodological deficiencies are most visible. The clinician who cuts corners because the U.S. domestic architecture is broken provides ammunition to those who would use the methodological deficiency to argue that the documentation cannot be relied on.

The disciplined posture is to document fully, frame accurately, and let the receiving forum decide. The forensic psychologist's job is to make that decision possible.

Track 2 — Treating Psychologists and Care Providers

2.1 The treating clinician's situation

The treating psychologist or care provider operates inside a clinical relationship: there is a patient, there is care, there is a duty of care that runs to the patient. Treating clinicians encounter torture and CIDT in three principal scenarios: a new patient discloses past torture; a current patient discloses torture that is ongoing (institutional, custodial, or otherwise); or the clinician's own observations indicate torture or CIDT that the patient has not yet named. Each scenario generates the witness obligation described in IPIS Section 12 and Part I Theme D of this Guide.

2.2 What the treating clinician may do

Beyond the items in Part II.A:

- Document contemporaneously, in the patient's clinical record, every disclosure of torture or CIDT, every observation consistent with such disclosure, and every clinical impression formed.

- Diagnose within scope of practice (PTSD, complex PTSD, depressive disorders, dissociative presentations, somatic presentations including those reflecting Distress-Induced Harm under the IPIS framework).
- Treat. Treatment is not the same as forensic documentation, but it is not in tension with it. The treating clinician continues to care for the patient while documenting accurately.
- Invoke the Treating Provider Principle as extended by the IAJ (drawing on ADA Title I caselaw and EEOC reasonable-accommodation guidance on deference to treating providers): the treating clinician's longitudinal observation, baseline documentation, and ongoing clinical relationship confer documentary authority that does not depend on forensic specialty credentials.
- Record observations and diagnoses in a manner that makes them available, with the patient's consent, for submission to forensic reviewers, NGOs, treaty bodies, or counsel. Documentation is not the same thing as transmission; the patient's informed consent governs the latter.
- Refer to a forensic evaluator where a forensic report is needed in a particular forum and the treating clinician is not the right person to produce it. Referral does not extinguish the treating clinician's documentation duty.

2.3 What the treating clinician may not do

In addition to the categorical exclusions in Part II.B:

- Decline to document because the patient may litigate or because the records may be subpoenaed. The fear of future legal involvement does not supersede the documentation duty (IPIS §2.4).
- Soften, omit, or euphemize torture or CIDT in the clinical record to spare an institution, a court, an agency, or a colleague. IPIS expressly identifies this as complicity.
- Substitute treatment for documentation. Both are required; one does not discharge the other.
- Hold oneself out as a forensic evaluator if the treating posture is the actual one — the dual relationship creates evidentiary and ethical problems that are best avoided by clear role separation.
- Permit a supervisor to direct non-documentation. IPIS §9.4 requires the supervisee to document anyway, to document the supervisory direction itself, and to file the CIRF where appropriate.

2.4 The treating clinician across jurisdictions

Treating clinicians more often operate locally than forensic evaluators do, but cross-jurisdictional questions arise: a patient relocates; a patient is in detention in another state or country; a telehealth treatment relationship is established across state lines. The Guide's framework applies.

Telehealth treatment regimes — including the PSYPACT compact, enacted in 43 jurisdictions as of February 2026 (41 states, the District of Columbia, and the Commonwealth of the Northern Mariana Islands) — exist precisely to manage cross-jurisdictional treatment. They do not bear on the forensic documentation duty in the same way. A treating clinician operating across state lines under a recognized telehealth pathway documents torture or CIDT in the same way as a treating clinician operating locally. The documentation duty is intrinsic to the treatment relationship; the telehealth pathway authorizes the treatment relationship, not the documentation duty separately.

2.5 Treating Clinician Decision Tree

Step	Question	If YES proceed; if NO action
1	Has the patient disclosed torture or CIDT, or do my observations indicate it?	If YES: the witness obligation has arisen. Do not decline it on credential or jurisdictional grounds.
2	Am I licensed in good standing in the jurisdiction where I am providing care (or under a compact/telehealth pathway that authorizes the care)?	If NO: address the underlying treatment authority question; this is a treatment-licensure issue, not a documentation issue.
3	Am I documenting contemporaneously, in the clinical record, what the patient said and what I observed?	If NO: begin immediately. Contemporaneous documentation is the most defensible documentation.
4	Am I diagnosing within my scope of practice?	If NO: refer or consult. Diagnose only within scope; document observations regardless of diagnostic capacity.
5	Is the torture or CIDT ongoing?	If YES: the documentation duty is heightened (IPIS §6.2); treatment may be impossible until the harm stops, and documentation may itself function as the only available intervention.
6	Are mandated-reporter duties engaged (child abuse, elder abuse, vulnerable adult)?	If YES: comply with the statute; the international documentation duty operates independently of, and in addition to, the statutory duty.
7	Is the patient asking for the documentation to be transmitted (to counsel, an NGO, a tribunal, a treaty body)?	If YES: obtain informed consent for the specific transmission; observe digital-security protocols; do not transmit beyond the consented scope.
8	Is institutional, supervisory, employer, or judicial pressure being applied to soften or suppress documentation?	If YES: continue to document accurately; document the pressure itself; file the CIRF (IPIS Appendix H); consult counsel.

Step	Question	If YES proceed; if NO action
9	Should a forensic evaluation be performed (in addition to my treating documentation) for a specific forum?	If YES: refer to a qualified forensic evaluator; share treating records with the patient's consent; remain in the treating role.
10	Have I consulted counsel on any unresolved legal question?	If NO and any legal question remains: do so.

2.6 Narrative discussion for treating clinicians

Three patterns recur in the treating context.

The first is the temptation to defer documentation until the clinician feels more certain. Trauma disclosures are often partial, fragmentary, or revised over time. Some clinicians wait until the picture is clearer before recording anything. This is a mistake. Contemporaneous documentation — even of fragmentary disclosure — is the strongest record. The clinician documents what was disclosed and when, observed and when, and lets the record develop as the clinical picture develops. IPIS §10.1 Step 1 is explicit on this point.

The second is the perceived tension between treatment and documentation. Some clinicians worry that documenting torture will damage the therapeutic alliance, especially if the patient does not want litigation. The IAJ position is that documentation respects the patient's experience and supports future options without forcing any particular use. The patient's informed consent governs what happens with the record. The therapeutic alliance is supported, not damaged, by accurate witness.

The third is the temptation to defer to a forensic specialist as the 'real' documenter. Treating clinicians sometimes assume that their documentation does not 'count' because they are not forensic-credentialed. The Istanbul Protocol and the Treating Provider Principle as extended by the IAJ are emphatic to the contrary. Treating documentation has independent evidentiary value, often greater than a one-off forensic evaluation because of the longitudinal observation and contemporaneous record. The treating clinician's record is not a draft awaiting forensic ratification; it is its own evidence.

Where a forensic report is also needed, refer. Where it is not, the treating record stands on its own.

Track 3 — Cross-Jurisdictional and International Experts

3.1 The cross-jurisdictional expert's situation

This Track addresses two related populations: U.S.-licensed clinicians whose work routinely crosses state lines, and internationally credentialed experts — IFEG members, current and former UN Committee Against Torture members, UN Subcommittee on Prevention of Torture (SPT) members, UN Special Procedures mandate-holders, Physicians for Human Rights appointed

experts, and analogously credentialed individuals — who contribute to evaluations and to information packages submitted to international mechanisms. The Guide's framework supports both populations on the same principled basis: licensing regulates the practitioner; forensic evaluation is not clinical practice; treaty-based duties run in parallel with licensure duties; ethics forbid refusal; and the equivalence failure makes individual documentation more important, not less.

3.2 The basis on which IFEG and analogous experts operate

Members of the IFEG (Independent Forensic Expert Group, convened by the IRCT), of the UN Committee Against Torture, of the SPT, and of the Special Procedures system are credentialed by international institutions rather than by any single national licensing authority. They typically also hold national professional licenses in their countries of training and practice. The combination — international credentialing plus national licensure — is the standard pattern.

These experts work across jurisdictions because the work is international by definition. The Convention against Torture creates international obligations on every State Party; the Istanbul Protocol supplies the methodology; the treaty bodies and Special Procedures are themselves international. Asking an IFEG member to obtain a license in every jurisdiction in which a survivor might be located would be incoherent: the work is structurally cross-jurisdictional and the credentialing system is built to match.

The principled basis for cross-jurisdictional operation is the same as for any forensic evaluator: licensing regulates the practitioner at her location; forensic documentation for an international mechanism is not the regulated practice of clinical psychology in any other jurisdiction; the receiving body (the treaty body, the Special Procedure, the international tribunal) applies its own working methods, which assess methodology and qualification rather than licensure.

3.3 What the cross-jurisdictional expert may do

- Conduct primary forensic evaluations of survivors located outside the expert's licensing jurisdiction, applying the Istanbul Protocol and the IPIS framework, subject to the expert's own license in good standing in the jurisdiction where the work is performed.
- Perform SFP reviews on IAJ reports from any jurisdiction, consistent with IPIS's position that the SFP — being document review — does not engage in-state clinical practice in the same way as a primary evaluation, subject to the credential-versus-licensure distinction set out in Inquiry 7.
- Contribute to information packages submitted to UN treaty bodies, including under UNCAT Article 20 (confidential inquiry into systematic practice) and Special Procedures communications.
- Aggregate evaluations across cases to demonstrate pattern, where multiple survivors of similar conduct are documented.
- Serve as Level 4 reviewers on cases for which their international credentialing satisfies the IPIS Level 4 methodological qualification standard, provided that the reviewer also

holds an underlying professional credential, licensure, appointment, or recognized expert status authorizing the kind of conclusions the review entails. International credentials establish methodological qualification; they do not, by themselves, substitute for professional licensure where the work would otherwise constitute regulated psychological or medical practice.

3.4 What the cross-jurisdictional expert may not do

- Substitute international credentialing for treatment authority or for licensure. International credentials may qualify the expert for forensic human-rights work and may support recognition by a receiving forum or mechanism; authorization for any particular act of regulated practice comes from the underlying license, appointment, tribunal acceptance, or recognized expert status. International credentials sit on top of that authorization; they do not replace it, and they do not, by themselves, authorize the practice of clinical psychology in jurisdictions where the expert is not licensed.
- Operate without local counsel awareness in jurisdictions where adversarial challenge is likely. The Guide does not require local counsel for every cross-jurisdictional evaluation; it does require that counsel be consulted where any genuine legal question arises.
- Treat aggregation as a substitute for methodological rigor. A pattern argument is only as strong as each evaluation that constitutes the pattern. IPIS's methodological discipline applies to every contributing evaluation.

3.5 Article 20 and analogous mechanisms

Scope Caveat — Article 20 Procedure

This Guide addresses licensing, the duty to document, and the methodology that disciplines the documentation. It does not purport to be a full procedural manual for Article 20 submissions. The Committee Against Torture's working methods on Article 20 — confidentiality regime, source protection, State-party opt-out under Article 28, cooperation expectations during inquiry, treatment of summary accounts in the Committee's annual report, follow-up procedure, and the interface with Special Procedures — have specific contours that bear on how a submission should be assembled and presented. The IAJ should maintain a separate Article 20 procedure companion addressing these elements. Clinicians and counsel contemplating an actual Article 20 submission should consult that procedure companion in addition to this Guide.

The IAJ's primary international forum, beyond domestic courts and asylum tribunals, is the UN Committee Against Torture's Article 20 confidential inquiry procedure. Article 20 is triggered by reliable information indicating that torture is being systematically practiced in the territory of a State Party. The mechanism is systemic rather than individual, inquisitorial rather than adversarial, and information-receiving rather than gate-keeping. NGOs and other credible bodies

submit information; the Committee weighs it; designated members may conduct a confidential inquiry, with the State's consent for any visit.

For cross-jurisdictional experts, three features of Article 20 matter:

31. There is no domestic admissibility gate. The Committee does not apply Daubert, Rule 702, or any state-level admissibility rule. It applies methodological and qualification criteria internal to its own working methods.
32. There is, however, an international credibility threshold. Article 20 is triggered only by 'reliable information' containing 'well-founded indications' that torture is being systematically practiced. The threshold is non-adversarial but real; meeting it is a function of methodological rigor, cohort consistency, and transparent documentation.
33. The methodological burden is the entire burden. Article 20 submissions are made credible by Istanbul Protocol-grade methodology applied across a cohort of evaluations sufficient to demonstrate pattern.
34. The State whose practices are at issue may have opted out under Article 28; this should be verified before any Article 20 submission is mooted. As of the latest OHCHR list, States that have opted out include China, Israel, Pakistan, Saudi Arabia, Syria, the UAE, and others; the United States has not opted out of Article 20, and Article 20 inquiries against the United States are accordingly available in principle.

Where the United States is the State concerned, the IAJ position — set out in v97 and the jus cogens Synthesis Memorandum— is that domestic remedies for systemic torture by public officials are sufficiently fragmented, institution-dependent, and non-equivalent that the international plane may be the only structurally independent and treaty-congruent pathway capable of addressing the pattern as such; Article 20 is therefore a natural mechanism for systemic presentation. The equivalence failure described in Part I Theme E is what makes Article 20 the operative mechanism for the pattern question, even where individual domestic remedies remain theoretically available for individual claims.

3.6 Cross-Jurisdictional Expert Decision Tree

Step	Question	If YES proceed; if NO action
1	Do I hold international credentials (IFEG, UNCAT, SPT, Special Procedures, PHR, or equivalent) or a national license in good standing?	If NO: this Track does not apply; obtain credentialing or operate under supervision per v97 Part E.
2	Is the work forensic documentation for an international mechanism, a domestic court applying international methodology, or an asylum/refugee forum?	If NO: re-examine whether the work falls under Track 1 or Track 2.
3	Have I confirmed that the receiving body assesses on methodology and qualification rather than local licensure?	If NO: confirm before proceeding; document the inquiry.

Step	Question	If YES proceed; if NO action
4	Have I verified the survivor's location and obtained informed consent free of compulsion?	If NO: complete before proceeding.
5	Is the State concerned a party to UNCAT, and (for Article 20 work) has it opted out under Article 28?	If opted out: alternative mechanisms (Special Procedures, regional bodies) may apply. If party and not opted out: Article 20 is available.
6	Is the methodology of each contributing evaluation consistent with v97 and the Istanbul Protocol 2022?	If NO: do not aggregate; standardize first.
7	Are reprisal risks for survivor, clinician, and third parties addressed, and digital-security protocols applied?	If NO: implement before any data transmission.
8	Is the SFP completed (or arranged) for every contributing report?	If NO: arrange via the IAJ Central SFP Panel.
9	Is local counsel aware of the work in jurisdictions where adversarial challenge is foreseeable?	If NO and challenge is foreseeable: engage counsel.
10	Has the equivalence failure analysis been documented where the U.S. is the State concerned?	If NO and the U.S. is concerned: incorporate the Dual-Track analysis and the jus cogens Synthesis Memorandum framework into the submission.

3.7 Narrative discussion for cross-jurisdictional experts

Three observations track the work of IFEG members and analogously credentialed experts across many cases.

First, the international plane is the right plane on which to do this work, and the framework should be presented as such. International experts who frame their reports as if they were domestic court-experts — apologetically explaining their qualifications to a hostile audience — concede ground that need not be conceded. The work is grounded in international law; the methodology is the Istanbul Protocol; the receiving forum (where international) is governed by international working methods. The framing should reflect the actual ground on which the work stands.

Second, aggregation is where the equivalence failure becomes visible. A single forensic evaluation, however rigorous, does not demonstrate that a State has failed to implement UNCAT. A cohort of evaluations, methodologically consistent and substantively similar across cases, does. The cross-jurisdictional expert who participates in cohort work is participating in the demonstration of pattern that the equivalence promise was designed to make unnecessary and that the equivalence failure has made necessary.

Third, the work has a temporal dimension. Treaty-body inquiries are slow; equivalence failures persist while inquiries are pending; survivors continue to be harmed. The cross-jurisdictional expert's contribution is to the historical record as much as to any immediate forum. Each evaluation, properly preserved, contributes to a body of evidence that may be useful in proceedings not yet contemplated. The Istanbul Protocol's discipline — accurate, contemporaneous, methodologically rigorous — is what makes the contribution durable.

Part IV — The Structural Argument: Equivalence and the Duty to Document

Part I Theme E summarized the structural argument. Part IV develops it in the depth the question deserves. The Guide does not give legal advice on whether the argument would prevail in any particular forum; it sets out the analysis and the inquiries that follow from it.

4.1 The equivalence promise and its content

When the United States ratified UNCAT, the Senate's view was, in substance, that existing federal and state laws provided the necessary mechanisms for the prevention of torture and CIDT and that no comprehensive new implementing statute was therefore required. See S. Exec. Rep. No. 101-30 (1990) (Senate Foreign Relations Committee report on the Convention against Torture). That representation was made to the international community and accepted by other States Parties as the basis for entering treaty relations with the United States. It is the equivalence promise.

Under the Vienna Convention on the Law of Treaties, States Parties act in reliance on each other's representations at ratification. The equivalence promise is not a unilateral domestic constitutional arrangement; it is a representation that operates on the international plane. The IAJ–IRCT Synthesis Memorandum v9, Dimension IV, sets out the framework for treating the equivalence promise as a measurable international-law commitment.

4.2 The categories of equivalence the promise covers

To deliver equivalence, the domestic architecture must — at minimum — match UNCAT's principal substantive and procedural obligations:

35. Prohibition (Articles 1, 2, 16): domestic law must prohibit torture and CIDT throughout territory under U.S. jurisdiction without derogation.
36. Criminalization (Article 4): acts of torture must be offenses under domestic criminal law.
37. Jurisdiction (Article 5): the State must establish jurisdiction over torture offenses wherever committed by its nationals or against them, and wherever the alleged offender is present in its territory.
38. Investigation (Articles 12, 16): prompt and impartial investigation must follow any credible allegation.
39. Complaint (Articles 13, 16): individuals must have the right to complain to competent authorities and to have their cases promptly and impartially examined, with protection against ill-treatment as a consequence of the complaint.
40. Remedy and compensation (Article 14): victims must have the right to redress and to fair and adequate compensation.
41. Non-use of statements obtained by torture (Article 15): no statement made as a result of torture may be invoked as evidence in any proceedings.

4.3 The categories where equivalence is most contested

Several of the equivalence categories are addressed by U.S. constitutional law (notably the Fifth, Eighth, and Fourteenth Amendments) and by adjacent statutes (notably 18 U.S.C. §§241–242, 42 U.S.C. §1983, and the ADA/Rehabilitation Act). Others are not addressed at all, or are addressed in a manner that the IAJ — and the international community — regards as inadequate.

4.3.1 Criminalization of domestic torture as such

As noted in Part I Theme E, 18 U.S.C. §2340A criminalizes torture only when committed outside the United States. The U.S. Senate's understanding at ratification was that domestic torture was already addressed by existing law. The international community — including States Parties that have formally objected to the U.S. RUDs and the UN Committee Against Torture in its 2006 and 2014 concluding observations on the U.S. — has not accepted that the existing law is equivalent. The Netherlands objected at ratification that the U.S. Article 16 reservation is 'incompatible with the object and purpose of the Convention.' Finland filed a parallel objection. The Committee Against Torture has urged withdrawal of the RUDs and alignment of domestic law with UNCAT's absolute prohibitions.

The IAJ position is that the objections and the Committee's concluding observations are themselves part of the international record of equivalence failure, and that this record is admissible on the international plane regardless of any domestic forum's view.

4.3.2 Mandatory investigation under Articles 12 and 13

UNCAT Articles 12 and 13 require mandatory and impartial investigation of credible allegations of torture and CIDT, and an effective right to complain. The equivalent domestic mechanism would be a prosecutorial or independent-investigator pathway that triggers automatically on credible allegation. The U.S. domestic architecture provides civil-rights statutes that allow victims (or, more accurately, plaintiffs) to bring claims, and criminal statutes that may be invoked by the U.S. Department of Justice. Neither is mandatory in the Article 12 sense; the criminal statutes depend on prosecutorial discretion, and the civil statutes depend on the victim's ability to retain counsel and to navigate the courts that may themselves be implicated in the conduct.

Where a clinician documents torture or CIDT inflicted by a public official inside the United States, there is, in many cases, no automatic recipient of the report comparable to the recipient designated by a child-abuse mandated-reporter statute. The clinician's documentation goes into the patient's clinical record; from there, it may or may not reach a forum that will act on it. This is the central structural problem and the most visible equivalence failure.

4.3.3 Clinician reporting duties for torture and CIDT

U.S. mandated-reporter law is built around vulnerable-population statutes (child abuse, elder abuse, vulnerable adult) and category-specific statutes (gunshot wounds, certain communicable diseases). None of these directly captures torture or CIDT by public officials when the victim is a competent adult.

Reporting category	Federal or state	Captures torture/CIDT?
Child abuse and neglect	All 50 states have statutes (and 34 U.S.C. §20341 for federal lands); recipients vary (CPS, law enforcement)	Only where minor is victim or witness; not the general category
Elder abuse / vulnerable adult	Most states	Only where victim falls within statutory definition; not the general category
Gunshot / serious knife wounds	Many states	Incidental capture only; not the category itself
Certain communicable diseases	All states (varies)	Not applicable
Torture or CIDT as such	No federal statute; no state statute denominated this way	No

The structural conclusion is that a clinician who learns of torture or CIDT inflicted on a competent adult by a public official in the United States generally has no statutory recipient to whom a mandated report is owed. The Istanbul Protocol's clinician duty to document and report (2022 ed. ¶ 631) operates in a vacuum at the domestic level: the duty exists, but the recipient does not.

4.3.4 18 U.S.C. §4 — Misprision of felony

Misprision of felony provides that 'whoever, having knowledge of the actual commission of a felony cognizable by a court of the United States, conceals and does not as soon as possible make known the same to some judge or other person in civil or military authority under the United States,' shall be punished. Federal courts have read the statute narrowly to require an affirmative act of concealment in addition to silence (see Branzburg v. Hayes, 408 U.S. 665, 696 & n.36 (1972); United States v. Ciambrone, 750 F.2d 1416, 1417–18 (9th Cir. 1984)). It is therefore not a workable substitute for a properly designed clinician-reporting regime. Its existence on the books does demonstrate that Congress, in principle, recognizes that knowledge of federal felonies generates reporting consequences.

Where the underlying conduct does constitute a federal felony — for example, a willful violation of constitutional rights by a state actor under 18 U.S.C. §242, or a conspiracy under 18 U.S.C. §241 — a clinician who learns of the conduct and takes no affirmative step to conceal it likely does not commit misprision by remaining silent. Nor does the statute create an affirmative reporting pathway: it punishes concealment, not non-reporting. The Guide notes its existence to frame the equivalence question more sharply: Congress has recognized that knowledge of federal felonies matters, but has not built the infrastructure that would make a clinician's knowledge of torture or CIDT operate as a trigger for investigation.

4.4 Can the structural argument be developed into a clinician's duty under federal law?

The user-question to which this Part is responsive asks whether the federal statutes — and the absence of a federal mandated-reporter regime for torture and CIDT — can be developed into a clinician's duty grounded in federal law, and whether the failure to provide such a regime is itself a breach by the regulatory authorities and the State of the obligation to deliver UNCAT equivalence and to ensure domestic investigation.

The IAJ's analytical answer is structured in three parts.

4.4.1 The duty as it exists today

At present, the clinician's duty to document torture and CIDT is grounded in:

42. Professional ethics codes (APA, NASW, ACA, AAMFT, and analogous frameworks). These are codified ethical obligations enforced by licensing boards and professional associations. They are binding on the licensee within the framework's reach. They do not create a federal cause of action.
43. The Istanbul Protocol (2022 ed., HR/P/PT/8/Rev.2), particularly ¶¶ 148, 201, 269, 380, 624, 631, 666, and 673. The Protocol is endorsed by the UN General Assembly and is treated as authoritative by U.S. and foreign courts where international human rights documentation is at issue. It is not domestically enforceable as such (the United States has no statute incorporating the Protocol), but it informs the standard of care.
44. UNCAT Articles 12, 13, and 16 (operating on the international plane). These create State Party obligations; they are not directly enforceable in U.S. courts because of the non-self-executing declaration.
45. State mandated-reporter statutes (where the survivor falls within a protected category).
46. The treating-provider authority drawing on ADA Title I caselaw and EEOC reasonable-accommodation guidance on deference to a treating clinician's medical judgment, and extended by the IAJ to torture and CIDT documentation.
47. The federal civil rights statutes (18 U.S.C. §§241–242, 42 U.S.C. §1983), which do not create a clinician reporting duty but do create vehicles for after-the-fact prosecution and civil claims.

4.4.2 The duty as it should be on the international plane

On the international plane, a State that has ratified UNCAT and represented to the international community that its domestic mechanisms are equivalent has, at minimum, an obligation to build a functioning architecture that:

48. Captures clinician knowledge of torture and CIDT and routes it to a competent independent investigatory authority;
49. Protects clinicians who report and survivors who disclose;
50. Provides for impartial investigation in every case where credible allegation arises;

51. Provides remedy and compensation as a matter of right rather than as a matter of prosecutorial or judicial discretion.

The structural conclusion is that the U.S. has not built this architecture and has not, therefore, delivered the equivalence Congress represented. The clinician's documentation may be one of the only professionally structured contemporaneous records of the failure as it manifests in individual cases.

4.4.3 The duty as it should be developed under U.S. law

Whether the structural argument can be developed into a clinician's duty grounded in federal law is a legal question on which the IAJ does not opine. The analytical inquiries that follow from the framework, however, are these:

52. Could Congress, consistent with its existing constitutional authority, enact a federal mandated-reporter statute that captures clinician knowledge of torture and CIDT? The answer appears to be yes: Congress has enacted comparable federal statutes in adjacent areas (e.g., the Child Abuse Prevention and Treatment Act framework, certain federal-employee reporting duties).
53. Has Congress, in light of the equivalence promise, an international-law obligation to do so? The IAJ position, after the jus cogens Synthesis Memorandum and the equivalence-objection record from States Parties and the Committee Against Torture, is that the equivalence promise carries a programmatic obligation to build the architecture necessary to deliver what was promised, and that the absence of a clinician-reporting framework for torture and CIDT is among the visible gaps.
54. Until Congress acts, what is the clinician's posture? The IAJ position is that the absence of a domestic recipient does not extinguish the international duty to document; the clinician documents to the IAJ, to NGOs operating under Istanbul Protocol standards, to the patient's chosen counsel, and — through the IAJ and analogous bodies — to international mechanisms. Where a specific domestic legal bar prevents the clinician from rendering documentation that the situation otherwise calls for, the Bar-Documentation Duty articulated in Part I, Theme E.5 applies: the bar itself becomes the object of documentation and reporting, so that the equivalence gap is recorded rather than erased by silence. The CIRF is the in-house IAJ instrument for capturing institutional obstruction and operates as the standard intake instrument for Bar-Documentation Duty reports; the SFP is the in-house instrument for methodological discipline; the Article 20 pathway is the international forum of last resort.

Summary of the Structural Argument

1. Congress promised equivalence at ratification.

2. Equivalence requires, at minimum, mandatory investigation, effective complaint pathways, clinician reporting infrastructure, and meaningful remedies.

3. The U.S. domestic architecture does not, today, deliver these requirements for torture and CIDT inflicted on competent adults by public officials inside the United States.

4. The absence of a clinician mandated-reporting framework for torture and CIDT is one visible component of the equivalence gap.

5. The individual clinician's duty to document, anchored in professional ethics and the Istanbul Protocol, is therefore not optional but heightened: it is one of the only mechanisms by which the gap can be made visible on the international plane.

6. Whether and how this conclusion produces an enforceable federal duty is a legal question for counsel and ultimately for Congress. The IAJ records it as the framework requires it to be.

4.5 What the structural argument does not say

The structural argument set out in this Part is at risk of one specific misreading, and the Guide addresses it directly here so the misreading cannot take root.

The structural argument is about the architecture of U.S. compliance with UNCAT — the absence of federal criminal torture jurisdiction inside the United States, the absence of a clinician mandated-reporter regime for torture and CIDT, the absence of an automatic investigation pathway under Articles 12 and 13, and the gap between what Congress promised at ratification and what the domestic system actually delivers. It is a critique of the State's architecture, not an authorization for individual clinicians to operate outside professional regulation.

Specifically, the structural argument does not say, and should never be read to say:

- That the international duty to document exempts a clinician from licensure. It does not. The duty operates through the clinician's licensed authority; the licensed authority is what makes the documentation usable as evidence and protects the clinician from disciplinary risk.
- That the equivalence failure permits clinicians to practice across state lines without regard to state psychology practice acts. It does not. Cross-jurisdictional forensic work proceeds on the principled basis set out in Part I — the practitioner is licensed where she works, the protective purpose of cross-border statutes is generally tied to the therapeutic posture, and the receiving forum applies its own evidentiary rules. The equivalence failure does not add a new pathway around licensure; it explains why the licensed work matters.
- That clinicians may dispense with informed consent, confidentiality protocols, methodological discipline, or competence requirements because the international duty is heightened. It does not. The heightened duty heightens the methodological obligations rather than relaxing them.
- That the IAJ provides legal advice on whether the structural argument would prevail in any particular forum, or that individual clinicians should rely on the structural argument without counsel. The IAJ does not give legal advice. The argument is recorded as an analytical

framework; its legal application in any case requires counsel admitted in the relevant jurisdiction.

The structural argument and the licensure framework operate together. The structural argument explains why the work matters; the licensure framework explains how the clinician may lawfully do it; the Istanbul Protocol and v97 explain the discipline that makes the work credible. None of the three displaces the others.

Part V — Additional Operational Issues

5.1 Supervision and the supervised practitioner

The interaction between licensing, supervision, and the duty to document recurs at intake. The Guide's position, drawn from v97 Part E and §6.3, is as follows.

Unlicensed and pre-licensed practitioners (AMFTs, MFT interns, psychology trainees, students) may not author or sign Istanbul Protocol-compliant reports, may not conduct psychological testing independently, may not provide diagnostic conclusions on their own authority, and may not provide forensic opinions or testify as the evaluator. They may assist under supervision in interview, history-gathering, supportive services, and data collection.

The supervisor is the author and signatory of the report. The supervisor's authority is what makes the supervised assistant's work usable. The Forensic Integrity Attestation (v97 Appendix G) is the formal instrument by which the supervisor certifies the work and accepts professional responsibility for it.

Where a supervisor directs non-documentation or suppresses documentation, the supervisee is ethically obligated to document anyway, to document the supervisory direction itself, to seek guidance from a licensing board or ethics committee, and to file the CIRF. v97 §9.4 is explicit on this point.

5.2 The hostile subpoena and the retaliatory professional complaint

Clinicians who document torture and CIDT sometimes face hostile subpoenas seeking the underlying clinical records, or retaliatory professional complaints filed with licensing boards by parties whose conduct is the subject of the documentation.

v97 Appendix F provides the IAJ Legal Objection Template, designed to be served in response to a hostile subpoena. The Template asserts forensic independence under IP ¶¶ 201, 666, protection from reprisals under IP standards, the non-clinical practice status of the forensic evaluation, and the ethical duty to witness. It does not eliminate the legal question — counsel must answer that — but it provides the analytical posture from which counsel can work.

Retaliatory complaints to licensing boards should be defended on the same analytical basis: the licensing board's protective jurisdiction is over clinical practice; the conduct complained of (forensic documentation of torture by a public official) is not the practice the board regulates; and the documentation duty arises under international law and professional ethics rather than as an exercise of clinical discretion.

5.3 Conflict settings and digital security

Where documentation could place the survivor, the clinician, or third parties at reprisal risk — including in conflict settings, custodial settings, or settings involving organized institutional pressure — v97 §5.4 and following set out digital-security protocols. The clinician should limit

disclosure to the consented scope, store records under the IAJ secure-access protocol where applicable, and consider de-identification or pseudonymization where the operational risk warrants.

Reprisal risk shapes the form of documentation; it does not extinguish the duty to document.

5.4 Self-care and vicarious trauma

v97 Appendix T sets out the IAJ Clinician's Self-Care Protocol for Vicarious Trauma. The Guide notes its existence here for completeness: clinician wellbeing is part of forensic rigor, not a separate concern. Fatigue, moral injury, hypervigilance, rescue impulses, and emotional numbing all degrade the quality of forensic and clinical work. Self-monitoring, structured breaks, workload pacing, and referral when the clinician's functioning is materially compromised are part of the evaluation protocol.

Part VI — Summary and the Ultimate Principle

The Ultimate Principle

The torturer's goal is silence. The clinician's duty is witness. The clinician fulfills that duty as a licensed practitioner, operating in the forensic posture within her licensed scope, applying Istanbul Protocol methodology, and observing the consent, confidentiality, competence, and forensic-independence requirements that disciplined professional practice demands.

Witness is not a single act and does not always mean disclosure. It means accurate documentation, contemporaneous preservation, competent assessment within scope, consultation where the clinician's competence has limits, protected reporting where a pathway exists, and referral where personal performance is not appropriate — all within lawful and ethical limits. The duty is to ensure that competent witness occurs; it is not a duty to undertake every possible witness function personally.

Licensing, the international duty, and methodology are three cooperating layers — none in tension with the others, all required together. The structural argument explains why this work matters at scale: the United States has not delivered the equivalence Congress promised, and individual documentation by individual clinicians is one of the few mechanisms by which that gap becomes visible on the international plane. The IAJ does not give legal advice. It supplies the framework, and the framework supplies the discipline.

End of Companion Guide.

Forensic Investigator Licensing, the Duty to Document, and the Treaty-Equivalence Question

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