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Good Practices and Current Challenges in the Rehabilitation of Torture Survivors

Discussion Paper

Regional meeting on Rehabilitation for Victims of Torture for countries in the OSCE region
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Introduction

1. This paper summarises some of the key issues and developments related to the implementation of the right to rehabilitation for survivors of torture and ill-treatment, and is intended to inform discussions at a regional meeting on rehabilitation for victims of torture for countries in the OSCE region. The event is being hosted by the Government of Denmark as part of core group of the Convention against Torture Initiative (CTI) and held in partnership with the German Chairmanship of the OSCE and DIGNITY – Danish Institute against Torture, on 23-24 June 2016 in Copenhagen, Denmark.

2. The discussion paper, commissioned by the CTI, has been authored by Nimisha Patel, Professor of Clinical Psychology, University of East London and Director of the International Centre for Health and Human Rights, UK and Therese Rytter, Director of Legal and Advocacy Department and Elna Søndergaard, Senior Legal Advisor, DIGNITY. *

Section 1: How many survivors of torture and ill-treatment are there?

3. The numbers of survivors in countries of the OSCE region vary and are extremely difficult to estimate for a number of reasons. Statistics are rarely collected on this population by States, not least because of the complexities involved in identifying survivors; absence of effective mechanisms to screen, assess and document torture and ill-treatment; and difficulties in establishing trust, fears of stigma, shame and negative repercussions and challenges in ensuring the security of survivors if they come forward and disclose torture or ill-treatment.

4. Estimates of the number of torture survivors often rely on figures based on survivors who are seen at specialist services, which are likely to be a significant underestimation given the many barriers which prevent survivors from accessing rehabilitation services. The International Rehabilitation Council for Torture Victims (IRCT) estimates around 400,000 torture survivors live in the European Union alone[1], with similar earlier estimates in the USA[2].

5. With the caveat of difficulties in establishing accurate statistics, it is highly likely that the scale and complexity of the challenges in addressing the rights and the needs of all survivors are both serious and substantial.

Section 2: What is the right to rehabilitation for torture survivors?

6. The right to reparation for torture victims is firmly grounded in international law. The United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT) enshrines the right to rehabilitation, as a form of reparation, in Article 14:

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

* The discussion paper was also reviewed by Dr. Alice Edwards, Head of the CTI Secretariat. The content does not necessarily reflect the CTI's core group's views.

[1] International Rehabilitation Council for Torture victims. 26 June - International Day against Torture. The fight against torture: a key priority for the EU. http://europa.eu/rapid/pressReleasesAction.do?reference=MEMO/07/254. Accessed 25 February 2010. These figures do not account for recent Syrian refugees.

[2] Jaranson J.M. (1995). Government-sanctioned torture: status of the rehabilitation movement. Transcultural Psychiatric Research Review, 32, 253–86; and CVT http://www.cvt.org/where-we-work/united-states.

means for as full rehabilitation as possible. In the event of the death of the victim as a result of an act of torture, his dependants shall be entitled to compensation […].

7. While Article 14 speaks of 'redress', the contemporary terminology refers to a procedural right to a remedy and a substantive right to adequate rehabilitation.[3] Rehabilitation is one of the five types of redress; the others being restitution,[4] compensation,[5] satisfaction[6] and guarantees of non-repetition.[7] This is also reflected in the General Comment no. 3 of the UN Committee against Torture concerning the implementation of Article 14 by States parties.[8] The right to redress and rehabilitation has been elaborated in various UN resolutions, guidelines and principles.[9]

8. The right to rehabilitation as a form of reparation for torture victims is to be distinguished from the right to 'the highest attainable standard of health'[10] and the right to 'habilitation and rehabilitation' for persons with disabilities[11], although some torture victims could be recognised also as persons with disability, while torture survivors are also entitled to benefit from measures taken to achieve the highest attainable standard of health. A distinguishing feature, however, is that the right to rehabilitation, as a form of reparation under the UNCAT, is not subject to progressive, but immediate realisation. In other words, the obligation to provide rehabilitation "may not be postponed".[12]

9. At the European level, the right to 'rehabilitation' has not yet found its way into any treaty, although the European Convention of Human Rights provides for an 'effective remedy' (Articles 3 and 13) and 'reparation' (Article 41), but in its jurisprudence this has so far been limited to compensation and restitution. The Council of Europe Convention on the Compensation of Victims of Violent Crime, to which 26 countries are party, establishes a right to compensation, which shall cover 'medical and hospitalization expenses' (Article 4). The right of torture survivors to redress and rehabilitation has also been reiterated by the Commissioner for Human Rights of the Council of Europe in his most recent human rights comment.[13] At the European Union level,

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[3] As laid down in the UN Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and International Humanitarian Law, UNGA resolution 60/147 of 16 December 2005 ('UN Basic Principles and Guidelines on the Right to a Remedy and Reparation').
[4] Restitution refers the restoration of the victim to the original situation before the violation (principle 19).
[5] Compensation refers to measures provided for any economically assessable damage (principle 20).
[6] Satisfaction includes a broad range of measures, from those aiming at cessation of violations to truth seeking, etc. (principle 22).
[7] Guarantees of non-repetition comprise broad structural measures of a policy nature, e.g. institutional reforms aiming (principle 23).
[8] CAT, General Comment 3, Implementation of Article 14 by the States parties, CAT/C/GC/3, 19 November 2012.
[9] See, UN Human Rights Council resolution on Torture and other cruel, inhuman or degrading treatment or punishment: rehabilitation of torture victims, A/HRC/22/L.11/Rev.1, 19 March 2013; UN Basic Principles and Guidelines on the Right to a Remedy and Reparation, above n. 3; UN Office of the High Commissioner for Human Rights (OHCHR), Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ('Istanbul Protocol'), HR/P/PT/8/Rev.1, 2004.
[10] As enshrined in the International Covenant on Economic, Social and Cultural Rights, Article 12, and the UN Convention on the Rights of Persons with Disabilities, Article 25.
[11] As enshrined in the UN Convention on the Rights of Persons with Disabilities, Article 26.
[12] CAT, General Comment N°3 (2012), para. 12.
[13] Council of Europe, Commissioner for Human Rights, Human Rights Comment, 7 June 2016, http://www.coe.int/da/web/commissioner/-/torture-survivors-have-the-right-to-redress-and-rehabilitation

the EU Charter of Fundamental Rights articulates the right to an 'effective remedy' (Articles 4 and 47).

10. In its General Comment no. 3 on the implementation of Article 14 by the States parties, the Committee against Torture affirms that the provision of means for as full rehabilitation as possible should be holistic and include medical and psychological care as well as legal and social services. The overall aim is to ensure the restoration of function or the acquisition of new skills required by the changed circumstances of a victim in the aftermath of torture or ill-treatment.[14] As a result, the Committee has held that States parties shall ensure that effective rehabilitation services and programmes are set-up in the State, access to such rehabilitation should not depend on the victims pursuing legal remedies, and that the right applies to all victims without discrimination and regardless the victim's status.[15]

Section 3: What is rehabilitation for torture survivors?

11. For victims and survivors[16] of torture or ill-treatment, access to safe, meaningful and appropriate rehabilitation can be fundamental to their well-being and recovery. To understand the purpose of rehabilitation, it is important first to understand the nature and impact of torture and the needs of survivors.

3.1 Understanding the impact of torture

12. *Torture is not any one specific act, but the judicial interpretation of one or more acts and/or omissions based on a legal definition of torture.*[17] *Torture methods may be physical and/or psychological, including sexual, and the physical and mental pain and suffering they cause are often as intertwined as the methods.*

13. The impact of torture can be profound, long-term and severe, yet not always visible[18]. This creates many challenges not only for medical examinations, but also for psychological assessments and documentation of torture[19]. The impact of torture can be physical, psychological, social, functional and existential[20]. Torture can lead to a multitude of physical

[14] CAT, General Comment N°3 (2012), paras. 11-14.
[15] CAT, General Comment N°3 (2012), paras. 15 and 32.
[16] Both terms may be used interchangeably, and the UN Committee against Torture states that the "term 'survivors' may, in some cases, be preferred by persons who have suffered harm. The Committee uses the legal term 'victims' without prejudice to other terms which may be preferable in specific contexts."(CAT, General Comment N°3 (2012), para. 3).
[17] See Article 1 of the UN Convention against Torture: "*For the purposes of this Convention, the term 'torture' means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is 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*."
[18] Jacobs, U. (2000). Psycho-political challenges in the forensic documentation of torture: The role of psychological evidence. Torture, 10, 3, 68-71.
[19] See The Istanbul Protocol, above n. 9; Patel, N. (2015) Psychological assessment and documentation of torture. Encyclopaedia of Forensic and Legal Medicine, second edition. London: Elsevier.
[20] For reviews, see: Gurr, R. & Quiroga, J. (2001). Approaches to torture rehabilitation. Torture, 11, 1, 1-35; Quiroga, J. & Jaranson, J.M. (2005). Politically-motivated torture and its survivors: A desk study review of the literature. Torture, 15, 2-3, 1-112.

injuries, disability, ill-health and chronic pain, as well as impacting on the psychological health of individuals.

14. Torture can also negatively impact on the interpersonal relationships of survivors, often with an impairment of trust, communication and the basic capacity to establish or maintain any kind of relationship with another person. Torture can thus severely impact on couple and family relationships, leading to family conflict, potential domestic violence and an adverse impact on parenting, which in turn can heighten the vulnerability and safety of children in the family. The effects may be family breakdown, and for children, there may be enduring and severe intergenerational problems which can affect their own adult relationships, families and future social functioning. Torture can also profoundly affect daily life, with poor social functioning, both at home, with peers and friends and at work or education, with further consequences in terms of inability to support the family, or oneself.

15. Torture ruptures social bonds, alienating survivors from others, increasing their isolation, despair and ill-health, which can lead to chronic ill-health, poor social functioning, inability to work or pursue any educational or vocational paths. This can leave the survivor quite simply isolated, alienated, suspended and vulnerable to marginalisation, discrimination, exploitation and other harm.

16. At the community level, the rupturing of social bonds is compounded by intense, pervasive and chronic fear with profound mistrust and mutual suspiciousness. This in turn can lead to fragmentation in society, marginalisation and a breakdown of social cohesion. Where survivors are unable to access appropriate rehabilitation, they are likely to remain socially excluded and the experience of stigma and discrimination can prevent any integration into society. For some, the use of substances (alcohol, drugs etc.) or other means to cope can lead to further health problems, raising public health and other concerns and potentially, leading to social problems related to substance misuse.

17. Further, torture is rarely one discrete isolated experience, rather, torture can be multiple experiences, of varied duration, circumstances, context and combination, repeated over time, over different periods of detentions or of armed conflict and organised violence. Given the range of experiences of survivors, their unique context and own personal life histories and experiences, their age, sex/gender, cultural background, beliefs etc., the impact of torture can vary for each person, family and community.

3.2 Understanding 'rehabilitation'

18. The right to rehabilitation is defined in General Comment 3 as "the restoration of function or the acquisition of new skills required as a result of the changed circumstances of a victim arising from torture or ill-treatment. It seeks to enable the maximum possible self-sufficiency and function for the individual concerned, and may involve adjustments to the person's physical and social environment. Rehabilitation for victims should aim to restore, as far as possible, their independence; physical, mental, social and vocational ability; and full inclusion and participation in society"[21].

[21] CAT, General Comment N°3 (2012), para. 11. For a fuller discussion of the right to rehabilitation, see: REDRESS (2009) Rehabilitation as a form of reparation under international law. London: REDRESS http://www.redress.org/downloads/publications/The%20right%20to%20rehabilitation.pdf; and Smith, E.,

19. To understand what rehabilitation is it is important to consider that:

(a) Most survivors do not immediately or easily disclose torture, for reasons of fear, physical and psychological debility and mistrust. Rehabilitation requires the early identification of survivors, with an assessment and evaluation of the survivor's needs and strengths[22], by qualified health professionals[23], followed by early intervention with access as soon as possible to services[24]. The expedience of this process is crucial to minimise health problems and poor social functioning becoming chronic, more serious or critical.

(b) The impact of torture can be enduring, debilitating and so severe that 'rehabilitation' may never lead to full recovery or restoration of health and well-being[25], but there is a State obligation to take an integrated long-term approach[26] to provide the means to as full rehabilitation as possible[27].

(c) Given the impact of torture is multidimensional, affecting many aspects of health, well-being and social functioning, no one method, intervention or rehabilitation activity can meaningfully address the full range of needs of survivors and their families. Hence, addressing the impact of torture requires a holistic approach[28] with specialist services for torture survivors[29], which "may include a wide range of inter-disciplinary measures, such as medical, physical and psychological rehabilitative services; re-integrative and social services; community and family-oriented assistance and services; vocational training; education etc."[30].

(d) Torture impacts on each individual in unique ways, dependent on their age, sex/gender, culture, beliefs, personal history and their specific experiences of torture. As such, there is no one, single rehabilitation service or method or intervention which works for all survivors, in all contexts. Rehabilitation should be offered on the basis of an early assessment and evaluation of the needs, strengths and unique experiences of the survivor and take into account the survivor's culture, personality, history and background[31].

(e) There are many external factors which mediate the effectiveness and impact of rehabilitation on survivors, such that changes to the external environment will be

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Patel, N. and MacMillan, L. (2010) A remedy for torture survivors in international law: Interpreting rehabilitation. Discussion Paper. London: Medical Foundation for the care of victims of torture https://www.freedomfromtorture.org/sites/default/files/documents/MF%20Rehabilitation%202010%20Final.pdf; Patel, N. *(forthcoming)* Clinical perspectives on the right to rehabilitation. In Sandoval, C. and McGregor, L. (eds.) 'Rehabilitating Victims in Processes of Transition: The Law and Practice of Rehabilitation as a Form of Reparation'. Oxford: OUP.

[22] CAT, General Comment N°3 (2012), para. 13.

[23] CAT, General Comment N°3 (2012), para. 15.

[24] CAT, General Comment N°3 (2012), para. 15.

[25] CAT, General Comment N°3 (2012), para. 12.

[26] CAT General Comment N°3 (2012), para. 13.

[27] CAT General Comment N°3 (2012), para. 12.

[28] CAT, General Comment N°3 (2012), paras. 11 and 13.

[29] CAT, General Comment N°3 (2012), para. 13.

[30] CAT, General Comment N°3 (2012), para. 13. Specialist services refers to the specialised awareness, knowledge, understanding and skills specifically related to assessing the torture survivor's needs, and evaluating what services, and additional support they need to enable them to benefit from available services.

[31] CAT, General Comment N°3 (2012), para. 15.

necessary, including addressing barriers to accessing rehabilitation; impunity; lack of access to justice; lack of security, adequate housing, food and other basic needs.

(f) Torture can be sexual and gender-based, with some methods of torture and ill-treatment, including rape and other forms of sexual torture, intended to destroy the social fabric of families, communities and societies by violating social taboos, gender-based, cultural and religious norms, values and beliefs. Rehabilitation should be gender-sensitive[32] and culture-sensitive[33], addressing the complexity of the needs of individuals and their families; and be provided in their relevant language[34].

(g) Torture destroys the human capacity to trust others and raises intense existential angst for many survivors who are made to feel dehumanised and alienated from humanity. This in turn can be compounded by stigma, shame and social exclusion, leaving the survivor at the periphery of society and excluded from many services. Rehabilitation needs to take a victim-centred approach [35] and the "victim's participation in the selection of the service provider is essential"[36].

3.3 Why provide rehabilitation?

20. Notwithstanding the legal obligations to ensure the means to provide for full rehabilitation as possible, there are good policy reasons to do so as well as serious consequences of non-provision to consider. The health and well-being of survivors can help sustain positive family life, supportive parenting and good social functioning whereby survivors can fulfil their family, social and work roles, which in turn can minimise the poor mental health of survivors and family members. This can enhance the psychological, social, educational and childhood development of children of survivors, minimising the long-term effects of torture and/or living with a parent who is a survivor. Rehabilitation can thereby enable and empower children and adults to continue educational and vocational pursuits, becoming productive members of society. Rehabilitation can also facilitate social inclusion and integration, contributing to social cohesion and to the overall welfare of society.

21. Rehabilitation can also increase survivors' family members' labour productivity, which can lead to higher family income in the long-term[37]. Hence, the absence or delay in provision of multidisciplinary rehabilitative services could (a) prove costlier to society, even after taking the cost of rehabilitation into account[38]; (b) increase chronicity of torture-related health problems, adding strain to existing health and social care services, creating public health challenges, increasing costs and diverting resources of mainstream services; (c) increase the likelihood that survivors present to services only in crisis when health problems become very serious, severe, chronic and intractable; and (d) increase the risk of serious health and protection concerns (e.g. suicide, self-harm, violence to others, child-protection issues), which can lead to further serious complications, harm or death.

[32] CAT, General Comment N°3 (2012), paras. 33 and 39.
[33] CAT, General Comment N°3 (2012), para. 32.
[34] CAT, General Comment N°3 (2012), para. 15.
[35] HRC res A/HRC/22/L.11/Rev.1, para. 9; HRC res A/HRC/22/L.11/Rev.1, paras. 11 and 12.
[36] CAT, General Comment N°3 (2012), para. 15.
[37] Preliminary findings from a health economic study conducted by DIGNITY - Danish Institute against Torture.
[38] Ibid.

3.4 Rehabilitation services and models

22. Rehabilitation services and models vary from one country or context to the next. Services have evolved in the last three decades in response to several main factors:

    (a) Developments in the fields of health and social care.

    (b) Increasingly complex contexts and needs of survivors with diverse experiences of genocide, repressive regimes, survivors from former labour and concentration camps, the rise in non-international armed conflicts and the associated violence of non-state actors and other similar situations.

    (c) Professional trainings, theoretical preferences and philosophical positions of service providers have informed different approaches to rehabilitation service delivery[39].

    (d) Funding availability and sources.

23. Rehabilitation within broader reparation programmes, has evolved differently in transitional societies, each dependent on the unique country context. Whilst many reparation programmes include some element of psychosocial care and assistance, this often falls short of holistic and specialist rehabilitation.

24. Rehabilitation service models have also developed in diverse ways in non-transitional contexts. Some services focus only on one specific aspect of the impact of torture, such as psychological trauma of individual survivors, with less emphasis on the need for medical, social, vocational or legal rehabilitation. Other services prioritise community-based services to address the needs of individuals and their communities, particularly where whole communities or large segments of society are affected. Other services provide integrated, 'one-stop-shop' services where specialist services are offered under one roof. Some services integrate both rehabilitation and other activities towards redress and prevention, including survivors as advocates and in their own pursuit of justice. Services also vary in their referral pathways to and from other relevant agencies or government departments and/or in the availability and effectiveness of mechanisms and procedures for the early identification of survivors. The extent to which services can be said to satisfy key standards of rehabilitation is highly variable and more research is required.

25. The nature of funding can also influence service design, model and delivery. Based on available funding, rehabilitation programmes have covered all the various aspects of rehabilitation, or are limited in scope. Funding may also influence the way in which governments deliver rehabilitation, whether directly or through private entities. Some sources of external funding have been established, such as the UN Voluntary Fund for the Support for Victims of Torture[40], though these are not yet adequately funded, and are intended to complement rather than replace government allocation of resources. The majority of current rehabilitation services are provided by independent NGOs. According to the IRCT, in the OSCE region, there are some 28 NGO-run rehabilitation centres in the 57 OSCE participating States. Of these, some operate as hybrid models such that the NGO may be part-funded by the State. Very few exist in or are

[39] Patel, N., Williams, AC de C. and Kellezi, B. (2016) Reviewing outcomes of psychological interventions with torture survivors: Conceptual, methodological and ethical issues. Torture, vol.26, no.1, 2-16; Montgomery E. and Patel N. (2011) Torture rehabilitation: reflections on treatment outcome studies. Torture, 21, no. 2, 141-5.
[40] http://www.ohchr.org/EN/Issues/Torture/UNVFT/Pages/WhattheFunddoes.aspx

integrated within national health and social care services, and many of these regularly deal with other, sometimes related populations, such as refugees[41].

3.5 Rehabilitation components

26. The components of rehabilitation services vary according to the country context, service model and specific needs and contexts of survivors. Rehabilitation components may include a range of therapies and support activities, offered sequentially or simultaneously, depending on need, availability and the socio-economic, political and legal context within which rehabilitation services are provided.

Components of rehabilitation services	
Early identification, assessment, evaluation services	Identifying needs; documenting impact of torture; ensuring referral to or the direct provision of specialised care and other services
Psychological services	Providing individual-based, family-based, group-based therapies and activities; and community-based support
Medical services	Providing or facilitating access to medical services and other physical and complementary therapies
Social welfare services	Facilitating access to food, adequate shelter, clothing, social welfare for survivor and family
Legal services	Providing information, facilitating legal representation, assisting with family re-unification, supporting access to justice and litigation
Education-related services	Facilitating access to schooling, facilitating integration into education, supporting educational and psychosocial development of children, supporting school staff and facilitating native language education
Vocational services	Facilitating integration into work, livelihood-development to increase productive capacity and skills-building etc.

[41] Whilst traditionally, rehabilitation services have been predominantly provided by NGOs not States, General Comment 3 is clear that "the obligation in Article 14 to provide for the means for as full rehabilitation as possible can be fulfilled through the direct provision of rehabilitative services by the State, or through the funding of private medical, legal and other facilities, including those administered by non-governmental organizations (NGOs)" (CAT, General Comment N°3 (2012), para. 15).

Section 4: Ensuring and providing rehabilitation services: Current challenges

Some of the current challenges to implementing rehabilitation are outlined below:

4.1 Developing optimal service models and appropriate methods

27. The term 'optimal service models' refers to the most appropriate model of service design and delivery for the given population and context, to achieve the best rehabilitation outcomes for survivors. One of the challenges of designing optimal models for rehabilitation services or programmes is how to ensure that the design and delivery of rehabilitation services are relevant to the specific country context and as well as the specific needs of survivors[42].

28. 'Methods' of rehabilitation refers to the range of interventions offered within rehabilitation services. A significant, related challenge to establishing appropriate methods for rehabilitation relates to the paucity of evidence. Whilst there is increasing research, it is often lacking in cultural validity and applicability. Further, existing evidence focuses only on one dimension of the impact of torture (e.g. psychological) and neglects to address the full and wide range of needs of torture survivors. There remain numerous conceptual, methodological and ethical shortcomings of existing research[43] and there is a need for further, more rigorous, culturally-valid and ethical research. Other barriers to ensuring adequate and appropriate rehabilitation may be broader in scope and relate to the lack of security and basic welfare provision, the persistence of impunity, ongoing risks exploitation and harm, poverty, discrimination and marginalisation.

29. Although there remains debate regarding what works best, there is a broad consensus, based on extensive practice-based evidence, amongst practitioners specialising in the care of torture survivors, on key aspects of rehabilitation services[44]. As reflected in General Comment no. 3, there is consensus that interventions should be: (a) specific to the full range of needs of the survivor(s); (b) culture- and gender-sensitive; (c) flexible; (d) interdisciplinary and holistic; (e) empowering and facilitating survivors' strengths, well-being and social functioning; and (f) uphold the dignity of survivors and most importantly, ensure the security and safety of survivors and their family members.

30. Areas of ambiguity and different views amongst specialist practitioners centre on whether rehabilitation can be short-term and applied in a uniform way to all survivors; whether single-domain interventions (e.g. those which only target specific psychological trauma symptoms) are sufficient to constitute rehabilitation; whether certain interventions or services delivered in isolation (e.g. social rehabilitation, or medical care) can be considered rehabilitation as a form of reparation; and whether standard, generic healthcare as such provided by some State health

[42] For one example of guidance on establishing rehabilitation services, see IRCT (2013) Rehabilitation of Torture Survivors: A Resource kit for Service Providers. Copenhagen: IRCT.

[43] For a fuller discussion see: Jaranson J.M., and Quiroga J. (2011) Evaluating the services of torture rehabilitation programmes: History and recommendations. Torture, 21, no. 2, 98–140; Montgomery E. and Patel N. (2011) Torture rehabilitation: reflections on treatment outcome studies. Torture, 21, no. 2, 141-5; Patel, N., Williams, AC de C. and Kellezi, B. (2016) Reviewing outcomes of psychological interventions with torture survivors: Conceptual, methodological and ethical issues. Torture, vol.26, no.1, 2-16.

[44] For examples of different services and guidance on good practice, see: Bittenbinder, E. (ed.) (2010). Good Practice in the care of victims of torture. Karlesruhe: von Loeper Literaturverlag; and Bittenbinder, E. (ed.) (2012). Beyond statistics: Sharing, learning and developing good practice in the care of victims of torture. Karlesruhe: von Loeper Literaturverlag.

and social care services can meet the standards for rehabilitation as envisaged in international law.

31. Good practice in establishing optimal rehabilitation service models and methods would take a long-term integrated approach[45], with country-specific analysis of the:

(a) Existing policies, infrastructures and State financing for the provision of health and social care, legal, educational and other support and access criteria and mechanisms;

(b) Security situation and the cultural, social, political context, and geographic location(s) within which services are to be provided;

(c) Potential barriers to the provision of effective rehabilitation services and programmes;

(d) Diversity of torture survivors, including age, sex/gender, cultural and linguistic backgrounds and their needs;

(e) Existence of organisations providing specialist care for survivors of torture and ill-treatment;

(f) Availability of suitably qualified staff (including medical, psychological, social welfare and legal professionals as well as interpreters, where necessary); and qualified professionals with specific expertise in providing specialist care to torture survivors;

(g) Access to medical or other technologies relevant to rehabilitation of torture survivors;

(h) Availability of appropriate interventions and methods.

4.2 Addressing the specific needs of torture survivors in different country contexts

32. Addressing the specific needs of torture survivors with special and additional needs (e.g. children, unaccompanied minors, survivors of sexual violence, survivors with complex and serious mental health problems, older adults, people with learning or physical disabilities) raises some challenges. These relate to how best to identify those survivors who are particularly vulnerable and have special needs; how to ensure prompt access to a range of services and to engage necessary protection measures; and how to facilitate multi-agency, coordinated support to minimise people falling through the net and to prevent further harm.

33. In certain situations, for example, in transitional justice societies, where torture survivors are still living in the place where they were tortured, or when their perpetrators remain at large and/or in positions of authority and influence, there are many factors which may impede access to rehabilitation services. Fear of reprisals or adverse consequences of coming forward, particularly where there is impunity, compounded by fear of exposure to stigma, shame and further injustices or incarceration may lead survivors to be afraid of, and even discouraged by others to disclose torture or other special needs, in order to ensure their protection.

34. In a context where there is large-scale victimization or large-scale movements of people, as in the current refugee and migrant movements in Europe, there are specific challenges which coalesce around questions of how to establish who is particularly vulnerable and who has special needs amongst the thousands on the move; how to ensure timely access to appropriate care[46];

[45] CAT, General Comment N°3 (2012), para. 13.

[46] There exist comprehensive guidelines on the provision of care in emergency settings, notably: UNHCR (2013) Operational Guidance on Mental health and Psychosocial support programming for refugee operations. Geneva: UNHCR, available at http://www.unhcr.org/525f94479.html; Inter-Agency Standing Committee (IASC)

how to ensure that care provided to all torture survivors, as well as others with special needs, is sufficient to constitute rehabilitation; and how to ensure that care provided is not only an emergency response with basic humanitarian assistance[47]. A related challenge is how States can ensure the provision of a humanitarian (health and social care) response to all refugees, particularly those vulnerable on health grounds; whilst not neglecting the obligation to also provide appropriate and holistic rehabilitation for torture survivors amongst them.

35. Some good practice by States includes:

(a) The recognition that the treatment of asylum seekers and refugees in emergencies and during the asylum determination process must be humane and not further dehumanise and re-traumatise them. This is essential since people on the move and in transition are likely to have experienced extreme hardship and traumatic experiences (e.g. losses, exploitation, witnessing the death or harm to others) and many may have also experienced torture and ill-treatment, though not yet disclosed this.

(b) The recognition that some torture survivors (including those amongst asylum seekers and refugees, and those in transitional justice societies) are particularly vulnerable and have special needs (as outlined above).

(c) Early identification of torture survivors, including those with special needs which involves a proper assessment conducted by appropriately qualified, experienced and licensed health professionals (not lay persons) who are trained and experienced in recognising and assessing physical, psychological and other indications of torture and vulnerability, and facilitating disclosure of torture[48].

(d) Particular attention and early identification of child survivors of torture, as well as children living with or looked after by family members or other adults who may be torture survivors, which includes assessment by appropriately qualified and licensed health professionals (not lay persons). This includes early identification of unaccompanied minors, who may be at risk of exploitation and other harm, and whose protection, psychological, medical and educational needs will need to be addressed.

(e) Early identification of survivors of sexual violence where there may be resultant life-threatening sexual health problems, pregnancy or other complications to consider.

(f) Clear referral pathways and mechanisms for torture survivors so that identified survivors are referred promptly to and able to access appropriate rehabilitation services.

(2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, available at: http://goo.gl/vYJtl4. These guidelines however, are limited to mental health and psychosocial care, and do not address the need or provision of longer term, comprehensive rehabilitation services (not only as an emergency response) for torture survivors.

[47] See CAT, General Comment N°3 (2012), para. 37.

[48] See the Istanbul Protocol, above n. 9; de Donato, M. (2012) Maieutics Handbook: Elaborating a common interdisciplinary working methodology (legal-psychological) to guarantee the recognition of the proper international protection status to victims of torture and violence. Rome: CIR. For the identification and facilitation of disclosure of rape, sexual and other torture see Patel, N. and Cohen, J. (2015) Identification and Health Assessment of Rape and other Sexual violence or Torture: A Handbook for Clinicians. London: ICHHR. For training material for supporting survivors of gender-based violence in war and armed conflict, see: HHRI (2014). Mental health and gender-based violence: helping survivors of sexual violence in conflict - a training manual. Oslo: Health and Human Rights Info.

(g) The monitoring of the reception of refugees by the host community and proactive measures to ensure their safety, protection from xenophobia, racist abuse and violence or harassment and re-victimisation.

4.3 Legal challenges to ensuring rehabilitation

36. There are a number of legal challenges to ensuring rehabilitation, which may depend upon the specific circumstances of the case, the national legal framework and on what legal basis the victim is pursuing his or her right to rehabilitation (see section 2).

37. The UN Committee against Torture has stressed in its General Comment no. 3 and in Concluding Observations that access to rehabilitation programmes "[…] should not depend on the victim pursuing judicial remedies"49, yet many jurisdictions require it.

38. In those situations, seeking a legal remedy may be the only option in order to access rehabilitation. The psychological implications of having to engage in legal proceedings can be severe for victims of torture who are often particularly vulnerable and have special needs. The complexity of legal proceedings, the lack of jurisdiction in national law for the State to prosecute (e.g. if the national law does not recognize the passive personality principle) or the lack of a victims' fund in criminal proceedings are all barriers to rehabilitation. Pursuing civil remedies may be equally complex, not least in some jurisdictions where the criminal case must conclude prior to any civil proceeding being activated. In addition, victims might face the legal obstacle of not being entitled to state-sponsored legal aid, which can have knock-on effects in terms of limiting access to justice and basic social welfare, adding immense strain and exacerbating health problems.

39. Even in successful proceedings, the award may be limited to that of monetary compensation to cover past medical expenses and eventual future expenses[50]. This may not be provided with the purpose of or be adequate to cover the cost of rehabilitative support and hence not fulfil the requirement in Article 14 of the UNCAT according to which rehabilitation service should be allocated in addition to compensation ("including the means for as full rehabilitation as possible").

40. As international law on reparation understands that victims include immediate families and others, including persons who have intervened on their behalf,[51] it is important that national laws and practices recognize and operationalize this understanding.

41. Although tying the provision of rehabilitation to a prior court remedy has the potential to deny rehabilitation to many survivors, access to legal services and the pursuit of justice are important components of rehabilitation in their own right. Pursuing justice can be an important part of an individual's own rehabilitation – giving them recognition and acknowledgement for wrongs

[49] CAT, General Comment N°3 (2012), para. 15.

[50] For relevant jurisprudence, see REDRESS (2009) Rehabilitation as a form of Reparation under International Law; and Medical Foundation (2010) A Remedy for Torture Survivors in International Law: Interpreting Rehabilitation – A Discussion Paper. London (both at supra note 21).

[51] Basic Guidelines (supra note 3.), para. 8: "victims are persons who individually or collectively suffered harm, including physical or mental injury, emotional suffering, economic loss or substantial impairment of their fundamental rights, through acts or omissions that constitute gross violations of international human rights law, or serious violations of international humanitarian law. Where appropriate, and in accordance with domestic law, the term 'victim' also includes the immediate family or dependants of the direct victim and persons who have suffered harm in intervening to assist victims in distress or to prevent victimization".

done[52]. They need to be supported through legal proceedings, in a way that minimizes the potential negative consequences of proceedings on them. A well-functioning criminal justice system is best supported by rehabilitation services for its victims, including before and during the court proceedings.

4.4 Accountability and monitoring and evaluation of rehabilitation services

42. As with all good public policy oversight, appropriate monitoring and evaluation of rehabilitation is key. One of the main difficulties of assessing the effective implementation of rehabilitation is the lack of clear indicators for the well-established standards (see box below and section 3.2), precluding both the measurement of the quality of rehabilitation services; and the effective reporting and accountability of service providers[53].

The Right to Rehabilitation: Summary of Standards

- Available, readily accessible, adequate, appropriate rehabilitation
- Holistic approach, with range of interdisciplinary services
- Specialist services for torture survivors
- Provided on the basis of a needs assessment and evaluation by qualified, independent health professionals
- More than initial care in the aftermath of torture
- Non-discriminatory and culture- and gender-sensitive
- Available in relevant languages of victims
- Victim-centred: tailored to address the victim's needs, preferences for rehabilitation service and their culture, personality, history and background
- Provided in a way that guarantees the safety and personal integrity of the victims and their families
- Provided without a requirement for the victim to pursue judicial remedies; and without reprisals or intimidation

43. The Committee against Torture has asked States to:

(a) Establish "a system to oversee, monitor, evaluate, and report on their provision of redress measures and necessary rehabilitation services to victims of torture or ill-treatment"[54]; and

(b) Include in their reports to the Committee "data disaggregated by age, gender, nationality, and other key factors regarding redress measures afforded to victims of torture or ill-treatment[55];

[52] For fuller discussion of these issues, see: Mendlehoff, D. (2009) Trauma and vengeance: Assessing the psychological and emotional effects of post-conflict justice. Human Rights Quarterly, vol. 31, 592-623; Sveaass, N. & Lavik, N.J. (2000) Psychological aspects of human rights violations: The importance of justice and reconciliation. Nordic Journal of International Law, vol. 69, 35-52; Patel, N. (2011) Justice and Reparation for torture survivors. Journal of Critical Psychology, Counselling and Psychotherapy, vol.11, no.3, 135-147.

[53] The International Centre for Health and Human Rights, UK has recently completed its work on developing indicators for the right to rehabilitation, which can be adjusted to each country context (forthcoming publications).

[54] CAT, General Comment N°3 (2012), para. 45.

[55] CAT, General Comment N°3 (2012), para. 45.

"the rehabilitation facilities available to victims of torture or ill-treatment and the accessibility thereof, as well as the budget allocation for rehabilitation programmes and the number of victims who have received rehabilitative services appropriate to their needs"; and the "methods available for assessing the effectiveness of rehabilitation programmes and services, including the application of appropriate indicators and benchmarks, and the result of such assessment"[56].

44. Good practice by States would include:

(a) Ensuring that indicators and benchmarks for rehabilitation used are clarified for the unique, overall context and the cultural context of the country;

(b) Ensuring all rehabilitation service providers (including NGOs and private providers) have in place appropriate strategies and systems to ensure effective monitoring and evaluation in accordance to the standards established in General Comment no. 3;

(c) Ensuring effective systems to collect monitoring and evaluation data from service providers, to be able to demonstrate that services satisfy the legal standards for establishing the needs of torture survivors, while observing data protection principles; for providing rehabilitation; and to ensure that services can and do report on the nature and quality of rehabilitation provided to whom[57].

[56] CAT, General Comment N°3 (2012), para. 46.
[57] Patel, N. and Williams, A. (2014) Monitoring and Evaluation for Torture Rehabilitation Services: A Handbook for Service Providers. London: ICHHR.

Section 5: Summary of key discussion points

Key questions for discussion at the OSCE Region meeting	See Programme Sessions	See Discussion Paper
What are State obligations for the provision of rehabilitation? • What is the right to rehabilitation for torture victims? • Why provide rehabilitation from a pragmatic perspective? • What are the consequences of non-provision?	1, 2	Sections 2, 4.4
What is rehabilitation for survivors of torture and ill-treatment? • What are the needs of torture victims? • Why is rehabilitation important for survivors? • What are the different rehabilitation service models?	1	Section 3
What are good practices around legislative guarantees for rehabilitation and access to legal and administrative proceedings? • What are good practices in providing legal aid to victims of torture? • What are the challenges and legal obstacles survivors face to access rehabilitation services? • What are the implications of some jurisdictions requiring that rehabilitation is contingent on obtaining a legal remedy? • What is the possible impact on survivors of engaging in complex legal proceedings in order to access rehabilitation?	3	Section 4.3
What are good practices and challenges in rehabilitation service provision? • What is the importance of early identification and (early) referral to rehabilitation services? • Which rehabilitation service model is currently applied in your country and why? • Has a mechanism for accountability, monitoring and evaluation been established? What are the lessons learned?	1, 4, 5, 6	Sections 3, 4.1, 4.2