



International
Rehabilitation
Council for
Torture Victims



CONFERENCE REPORT

The Right to Rehabilitation for Torture Victims



Beirut, Lebanon – 27/28 June 2013

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The International Rehabilitation Council for Torture Victims (IRCT) is an independent, international health-based human rights organisation, which promotes and supports the rehabilitation of torture victims, promotes access to justice and works for the prevention of torture worldwide. The vision of the IRCT is a world without torture.

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Introduction

The International Rehabilitation Council for Torture Victims (IRCT) and Restart Center for Rehabilitation of Victims of Violence and Torture (Restart) hosted a two-day conference on the right to rehabilitation for torture victims. Over 100 participants, including health and legal representatives from IRCT's global network of torture rehabilitation centres from 44 countries, academic experts, government representatives, intergovernmental organisations and civil society, attended the conference. The main objective of the conference was twofold: firstly, to explore the ways in which rehabilitation is provided to torture victims; secondly, to consider how states can be encouraged to strengthen their implementation efforts in ensuring provision of holistic and victim-centred rehabilitation services. The interlinked themes provided a platform to share examples of models for the delivery and funding of rehabilitation and explore ways in which rehabilitation providers and other key stakeholders

can assess and evaluate the services provided in their national context. The conference also provided an important platform to address the immediate situation in the Middle East, which is facing particular challenges with regard to the provision of rehabilitation services to torture victims, many of whom are refugees from the Syrian crisis.

This report outlines the key themes discussed at the conference, including different models for delivery of rehabilitation and the challenges faced by IRCT member centres on the ground, in the context of the Committee against Torture's General Comment No. 3 in 2012¹ on Article 14 of the UN Convention against Torture.

1. General Comment No. 3 (2012): Implementation of article 14 by State Parties, CAT/C/GC/3, 13 December 2012.

Main objectives of the conference:

1

Explore the ways in which rehabilitation is provided to torture victims.

2

Consider how states can be encouraged to strengthen their implementation efforts in ensuring provision of holistic and victim-centred rehabilitation services.



The conference in context: Article 14 and the right to rehabilitation

The right to rehabilitation for torture victims is included as a means of redress and reparation guaranteed by Article 14 of the Convention against Torture (UNCAT). One of the key issues for the right to rehabilitation is the identification of the role of the state in its obligations to ensure access and funding for rehabilitation services. The General Comment on Article 14, which was published by the Committee against Torture in December 2012, clarifies the obligations of State Parties, in relation to redress, compensation and rehabilitation for torture victims. While the Committee has provided its expert opinion on the extent of the legal obligations contained in the Convention, the IRCT encourages further discussion on the practical implications of implementing the health component of the right to rehabilitation in line with the legal obligations laid out in the General Comment.

The IRCT regards the General Comment as a significant step towards recognising the obligation for states to provide the means for “as full rehabilitation as possible”, and confirming that rehabilitation must be holistic, which takes into account the strength and resilience of the victim. The General Comment makes clear that the obligations on State Parties refer to the need to restore and repair the harm suffered by the victim and their dependents, recognising that the victim’s life may never be fully recovered and that the obligation does not depend on the available resources of the state.

However, the IRCT also recognises that the reality is that rehabilitation services are not readily available in all countries. Additionally, many governments lack specific programmes or health budget lines to provide or ensure the provision of rehabilitation services to torture victims. Therefore, the conference was intended to encourage further discussion and collaboration between key stakeholders from government, civil society, survivors’ groups, academia and donor organisations on how rehabilitation for torture victims can be effectively delivered and can contribute to the fight against torture, using the General Comment as a framework.

A legal perspective on General Comment No. 3

Dr Lutz Oette, REDRESS, UK

Dr Lutz Oette opened this session with an introduction on the scope of the right to rehabilitation as reflected in General Comment No. 3 and within the

context of the right to reparation as established by Article 14 of UNCAT and the International Covenant on Civil and Political Rights (ICCPR). He highlighted that the General Comment is an important step in developing the legal concept of the right to rehabilitation, particularly as the right to rehabilitation, as part of reparation, has to some extent been neglected. The neglect is, in part, due to the dichotomy between the legal and medical understanding of what constitutes rehabilitation. For the first time, a treaty body has developed the legal concept of the right to rehabilitation with input from non-governmental organisations, including the IRCT.

In particular, the General Comment clarifies that rehabilitation should take a holistic approach with the ultimate goal to enable the victim to be self-sufficient, independent and able to function as part of society. Significantly, the scope of the intended beneficiaries (rights-holders) of Article 14 is widened to include the family of victims and human rights defenders. The scope is also not limited to the territory concerned; it should be applicable to all victims irrespective of where the torture took place.

However, the question remains: how far does the responsibility of the state go? A further key question is: how should the right to rehabilitation be implemented in practice?

More research, Dr Oette suggested, is needed into how domestic laws reflect the right to rehabilitation, and how we determine who has access to services. The General Comment suggests a wide range of interdisciplinary measures, with implementation taking a victim-centred approach. However, this needs more discussion, in particular in the context of gender-based violence, refugees and exiles.

Dr Oette explained that the means by which rehabilitation is provided — either through direct provision by the state, by private facilities including NGOs or a combination — will have important implications for funding. There is a clear obligation for the state to pay for the provision of services, but what does this mean in practice, and what effect will this have on the independence of services? In addition, how do the obligations placed on a state to pay for rehabilitation relate to its obligation to pay compensation? He suggested that states should provide services alongside direct compensation.



Finally, he emphasised the significance of the General Comment as an advocacy tool, for example:

- As a relevant component of policy, legislative or institutional reform, thereby ensuring its implementation at the national level
- Using paragraphs 45 and 46 of the General Comment as a non-exhaustive checklist of issues that the Committee against Torture and the Special Rapporteur should in future report at the international level
- Raising awareness through the media of the importance of the right to rehabilitation
- Developing capacity of legal and health professionals to understand the scope of the right to rehabilitation, through collaborating on training and research projects
- Conducting litigation with collaboration between rehabilitation centres, lawyers and other NGOs

A clinical perspective on General Comment No.3

Dr Nimisha Patel, International Centre for Health and Human Rights and the University of East London, UK

Dr Nimisha Patel reflected on what constitutes rehabilitation from a clinical perspective. She referred to the definition given in the General Comment but also emphasised that, from a practitioner's view, the definition goes further. For example, in practice the outcomes of rehabilitation are far wider than defined by the General Comment. From a clinical perspective, the outcomes include the individual, family and community; rehabilitation may rebuild the physical, psychological, interpersonal and social functioning, as well as address an existential meaning, i.e. the victim making sense of their suffering and wanting a sense of justice.

One important question she underlined is to consider what changes are needed in the torture victim's environment to facilitate a full rehabilitation. Again, while the General Comment defines rehabilitation as services, in practice the services will vary greatly in terms of the components, activities, availability of professionals and the local needs in each context. Dr Patel reflected that in its functioning as a form of reparation, rehabilitation may include any range of measures (e.g. clinical, social, legal, educational, vocational, prevention activities, community development, etc.). There is no single intervention that is guaranteed to work for everyone in any given context. With this in mind, the relationship between rehabilitation services and other measures, including compensation, need to be looked at together.

Rehabilitation is not merely an end point, she said, but a process of recovery that could draw on different approaches to rehabilitation: medical, psychological, empowerment and justice. She proposed defining rehabilitation as a combination of these various approaches, involving a range of services, activities and measures to enable victims to survive the harm endured. Regarding the reference to "victim-centred rehabilitation" in the General Comment, she stressed that victims (survivors) should be able to speak out and should not be seen as passive in the rehabilitation process. As such, victims' views are important, not only when tailoring the rehabilitation programme, but also when evaluating services, planning and designing programmes and conducting advocacy and research. She highlighted the importance of seeing victims as experts in their own right, many of whom are willing to be involved in a more active way in raising awareness of torture rehabilitation.

A key question asked by Dr Patel in her presentation was, how do we implement "as full rehabilitation as possible", and how do we know when services provided meet the obligations laid out in the General Comment? Her view was that there is a need to inte-

grate survivors' views with clinical experience and align these to the legal standards. The importance of building core standards and benchmarks, not just aspirations, is evident. But what should those standards be? Dr Patel introduced her on-going research on Victim-Centred Standards for Rehabilitation, in which she seeks to establish a framework to analyse the existing rehabilitation provision in a state in order to facilitate planning, designing and delivery and evaluation of rehabilitation service provision. Her framework adopts six independent and inter-related standards, including appropriateness and safety, both of which are mentioned in the General Comment framework.

Finally, it is important to locate the victim's experience in their particular context. Rehabilitation has to make sense to victims and be meaningful to them. The General Comment as a legal definition should be seen not as constraining but as an open-ended, on-going process. It should pave the way for greater collaboration between legal and health professionals.

Where does the right to rehabilitation fit in to the global perspective on health systems?

Public health systems: Holding governments accountable – establishing standards, measuring implementation

Dr Paul Bolton (Johns Hopkins Bloomberg School of Public Health, USA)

Dr Paul Bolton spoke about the methods and challenges of establishing standards and measuring implementation in public health systems, with particular reference to cases where he has worked with torture victims. Reflecting on the challenges to implementing standard measures linked to the General Comment framework, he underlined the importance of allowing survivors to participate in the process and taking into account the personality, background and history of the survivor. Thus, although the basic symptoms of torture victims may be similar at the global level, the problems faced by victims will vary from region to region. The diversity of reactions to torture creates



The theme of the conference was so relevant to everybody working in the field of rehabilitation of torture victims, especially for the people who are willing to open new rehabilitation centres. Every presenter had her/his unique experience that we should all know about.

Raghdha Sleit, El Nadeem, Egypt

challenges to drawing up an agreed list of standard measures and instruments, but underlines the need to carry out basic qualitative research beforehand. Such research would consist of listing all commonly mentioned problems from sample interviews with torture victims and then prioritising these based on frequency and severity. For example, if torture victims identify economic problems as a primary complaint, perhaps mental health rehabilitation should not be given priority. In this way, he viewed holistic treatment as being a particular package of programmes that are put together in a region to meet the specific priorities of the local people.

In terms of monitoring and evaluation of programmes, Dr Bolton reflected that the purpose of monitoring is to identify problems as they occur so that they can be addressed immediately. Evaluation is determining if there is a change in the indicator between the beginning and end of the programme. Indicators that can be used to establish effective implementation may include:

- Fidelity monitoring: evaluating whether the intervention provided is of good quality;
- Availability and access: indicators could include distance, time taken to travel to a centre, travel and opportunity costs (e.g. attending treatment during working hours impacts on the costs to the individual in loss of working hours);
- Uptake: the appropriateness of services can be defined by how many people who know about the services actually access them;
- Survivor compliance or cooperation: how many of those who start treatment complete it;
- Feasibility and cost: who (e.g. the state?) will pay for the services and is the funder able and willing to pay for the duration necessary;
- And effectiveness: what would happen to the survivor in the absence of services, i.e. the services are effective if the survivor would be worse off without them. Alternatively, if the intervention does harm or causes the survivor's condition to worsen, it should be avoided.

For example, the outcome of effectiveness in relation to the framework of the General Comment would be the restoration of dignity to the survivor, in terms of the survivor's individual role and roles in relation to his/her family and society. As this will vary according to the society, there is no single instrument to measure the individual's restoration. However, by conducting basic qualitative research through open-ended questions, researchers can determine which indicators could be used to monitor the effectiveness of the services offered.

Dr Bolton noted it is hard to hold states accountable but suggested that treating the state as a partner

whose priorities also need to be met could be one way of overcoming this obstacle. In this way, services would address the priority problems of the survivors, instead of just on problems due to torture. Where possible, survivors should access the services alongside other beneficiaries.

He gave the example of Iraq, where most torture victims receive mental health and counselling services integrated into the physical health system, which is accessed by all. The advantages of this approach are several-fold:

- The government is often more supportive;
- There is more anonymity, which appeals to clients;
- Reach and access are enhanced through integration; and
- Torture survivors who need specialist care can still access it through a referral system to torture and trauma centres.

He also cited the apprenticeship model of training and supervision — a process of continuous learning with on-going supervision and on-the-job training — as a method for expanding access to quality treatment in low-resource countries. This model allows non-professionals to learn to provide treatment while assuring survivors get quality care.

In the open discussion following Dr Bolton's presentation, it was noted that assessment of torture treatment services in asylum-receiving countries may be based on different needs of the victims than in countries where torture takes place. Torture victims not present in their home country will have different priorities and concerns, e.g. accessing the asylum system, finding their family and finding work. Therefore, interventions and instruments to measure outcomes need to be adapted to reflect this population. It was noted that there is a need to carry out more research, including by the service providers themselves, on the quality and effectiveness of the services provided. Governments and donors are also requesting this information.

Public health systems: accessing health systems and health financing

Prof. Martin McKee (London School of Hygiene and Tropical Medicine, UK)

Prof. Martin McKee spoke about access to health systems and health financing in the context of the right to health. Prof McKee pointed out that a key difference from the right to rehabilitation is that the right to health does not include a right to redress and therefore does not provide an automatic legal entitlement; it is subject to progressive realisation and to resource availability.

He outlined the challenges of achieving universal

health coverage, namely the time countries take to implement it, the lack of legislation or the political will. In the context of achieving the right to health, cross-national analysis showed that key factors for success were the ability to raise tax, the existence of democratic systems and having a legal mandate. In terms of funding, the tax system is the best way to collect money.

Research has shown that to achieve universal health coverage, in addition to increased tax collection, there should be institutional and political support and a shared national identity making society more willing to invest in the collective good. Furthermore, a more divided society was less likely to promote universal health coverage.

A rights-based health system should include the incorporation of human rights treaties, advocacy, functioning courts and an independent judiciary to ensure the implementation of laws, monitoring of implementation and strategic litigation. Health systems should be participative, with community engagement essential to achieving this. A health system should function with transparency, respect for

cultural differences and ensure equality in accessing it. In addition, independent monitoring, accountability, shadow reports and strategic litigation are necessary to ensure standards are maintained.

Prof McKee gave the example of the UK in which the government has moved towards contracting out parts of the health service to private companies. This can have a negative effect on the state's accountability to maintaining an appropriate standard of service and can also prevent NGOs that are unable to function as competitively as large corporations from being involved in providing these services where the state seeks to avoid responsibility. Many of the challenges faced when implementing the right to health could be relevant to the implementation of the right to rehabilitation, particularly in the areas of funding and state accountability.

In the open discussion following Prof McKee's presentation, it was noted that NGOs are bridging the gap by providing the majority of torture rehabilitation services. However, NGOs will still be held accountable, particularly in terms of accessing funding, and therefore it is important to measure and evaluate the effectiveness of services provided.



Prof. Martin McKee from the London School of Hygiene & Tropical Medicine reflected on the accessing of health systems and health financing in the context of the right to health.

The right to rehabilitation in country contexts

Leanne MacMillan (Head of Membership, IRCT) introduced the learning objectives for the session and highlighted the importance of further developing the scope of the right to rehabilitation across all disciplines. The workshop sessions aimed to highlight the range of challenges faced in delivering rehabilitation within the framework foreseen by the General Comment through case studies on rehabilitation in different country contexts across four themes. Presenting case studies on how services are provided in the national context was intended to allow participants the opportunity to critically analyse and identify good practices and successful interventions that could be replicated in other regions or national contexts.

The various ways to deliver and fund rehabilitation services is a first step to agreeing on the indicators

and benchmarks based on the key principles outlined in the General Comment: that services are patient-centred (includes non-discriminatory, culturally sensitive, participatory); available (through either direct provision by the state or the funding of private medical, legal and other facilities, or a combination); appropriate (holistic, victim-centred, with the assessment and evaluation of victims' needs based on the Istanbul Protocol); and accessible (includes delivery in a context of confidence and trust, secure environment, non-discriminatory, independent of other judicial remedies).

The session highlighted the challenges of working towards the implementation of a right given the range of contexts within which rehabilitation services are provided.

Thematic groups:

1

State-led vs NGO-led rehabilitation

– Uruguay, Netherlands, Burundi

2

Refugees and Resettlement

– Lebanon, USA, Australia

3

Rehabilitation in transitional justice societies

– Peru, South Africa

4

Working in challenging environments

– Egypt, Russian Federation, Ecuador

State-led vs NGO-led rehabilitation – Uruguay, Netherlands, Burundi

Miguel Scapusio (Servicio Paz y Justicia, Uruguay) gave an overview of the context of rehabilitation in Uruguay, where torture survivors from the military dictatorship (1973-1985) have faced a long history of impunity, stigmatisation and absence of reparation from the state. Only in 2006 did the government pass legislation granting reparations to people imprisoned during the dictatorship; and in 2008 a presidential decree assured health assistance — provided by the state — to victims and their families. Uruguay’s rehabilitation policies, he said, have serious shortcomings given that there is no concrete rehabilitation programme taking into account the victims’ individual needs. There is an absence of real public policies to deal with the historical context in which torture occurred. He reflected that rehabilitation cannot, in the context of Uruguay, be separated from the reparation process. There is a need to move forward in terms of truth, justice and memory, and he does not believe that rehabilitation should be separated from these other elements of reparation.

Boris Drozdek (Psychotrauma Centrum Zuid, Netherlands) outlined the challenges faced in the Netherlands, which has a semi state-led system for the rehabilitation of torture victims. Asylum-seekers and refugees make up the main category of torture victims and many challenges in providing full rehabilitation are caused by the shortfalls in the asylum procedure. For example, the delays in processing applications, the prohibition of work and the limited access to the community all lead to social marginalisation of victims and restricted access to medical services. He mentioned the Committee against Torture recently highlighted that the eight-day asylum procedure for some applicants means that initial health checks are insufficient for determining torture *sequelae*. In addition the Committee found that there is a lack of proper implementation of the standards in the Istanbul Protocol, in particular, a denial of the causality between torture and mental health problems, and no transfer of medical data upon release from immigration detention, which impedes continuity of appropriate care.

One positive step taken recently to improve the system is that the three specialised centres were given a *carte blanche* to reorganise the system by which mental health services are provided to asylum-seekers. The new system envisages that the most specialised centres will provide treatment for acute cases and will also provide consultations and training



The discussion was very relevant and timely. The Right to rehabilitation is not well explored in the country. [...] There is this closed discussion on who has the better rehabilitation program.

Rosal Revaldo, Medical Action Group, Philippines

on how to screen torture victims to the regional mental health institutions and reception centres. The system seeks to improve knowledge sharing between the different types of health services and encourage a greater focus on community care in the reception centres so that torture victims are more empowered during the recovery process.

Mathieu Shalif (Solidarité d’Action pour la Paix/Grand Lacs, Burundi) reflected on the challenges faced in providing and funding rehabilitation services in a country that has suffered years of conflict and in which the army and security forces have used torture as a tool of repression. He explained that SAP-GL was established in 1999 with the help of the Jesuit Refugee Services (JRS) to advocate against torture and help and support torture victims. It now has around 20 volunteer lawyers, social workers, nurses, psychologists and one physician and supports over 100 torture victims, mainly women and children. The centre works in a very challenging environment: Burundi sees very high numbers of refugees — many from the Democratic Republic of the Congo — transiting the country. Many of these refugees have suffered torture, trauma or sexual violence. It has also undergone periods of transition, from civil war to a democratically elected president, which led to political violence and on-going fighting. The centre has been attacked in the past by pro-government militia, and so staff and clients are in a highly stressful and insecure environment.

SAP-GL works to identify victims of torture, to gather information on their behalf and assess their needs. It provides counselling, psychosocial assistance and medical treatment in its clinic. It also provides support in vocational or technical training, basic micro-business skill training (in income-generating activities) to aid the empowerment of victims. Its main centre is in Bujumbura, with “antennae” centres in the more rural areas of Burundi. Its recent accomplishments include establishing a medical centre,

opening a sewing workshop for women and providing assistance to women and girls in the Bujumbura and Kayanza provinces. Mr Shalif highlighted the importance of giving the community an opportunity to express its needs and opinions, particularly in situations where many communities feel unable to speak out due to the repressive environment.

General discussion

The group discussed the challenges in state- and NGO-led rehabilitation. Although the main aim may be ultimately to get the state to take responsibility for the rehabilitation of torture victims, in practice implementation is difficult. In addition, certain models, e.g. the Netherlands model, would be difficult to implement in countries where torture happens within the state. While there are different approaches to

providing rehabilitation services between democracies and regimes, how to structure rehabilitation is not only a political question but also needs to be looked at in terms of capacity, including the numbers of torture victims, available funding and other resources. The importance of cooperation was emphasized, both at a national and regional level. Making efforts to introduce the work of the rehabilitation centres can pay off if the state starts to understand the work and show support. The centre in Cameroon noted that inviting government officials to some of its training events and seminars has encouraged the government to support their work and participate in the discussion, so they understand the benefits and need for torture rehabilitation. The involvement of international organisations (e.g. the IRCT) and coalition groups can also help to promote the work of rehabilitation services where it is difficult for the centres themselves to openly criticize the government.



Boris Drozdek (Psychotrauma Centrum Zuid, Netherlands) outlined the challenges faced in the Netherlands, which has a semi state-led system for the rehabilitation of torture victims. Asylum-seekers and refugees make up the main category of torture victims and many challenges in providing full rehabilitation are caused by the shortfalls in the asylum procedure.

Uruguay

Netherlands

Burundi

	Uruguay	Netherlands	Burundi
Availability	<p>Health assistance restricted to state services</p> <p>Limited services — initially only one state-run rehabilitation centre in Montevideo</p> <p>Serious challenges regarding location, bureaucracy and financial resources</p>	<p>Inadequate identification and referrals</p> <p>Medical screening conducted within asylum reception centres</p> <p>Asylum-seekers have access to basic medical services, but limited opportunities for psychosocial rehabilitation in reception centres</p> <p>Staff in reception centres lack knowledge of torture <i>sequelae</i> and tend to distrust “trauma narratives” — can compromise the screening and recognition</p> <p>Few referrals are made by reception centres to one of the three specialised centres, which generally handle more acute cases</p> <p>No opportunities for empowerment</p>	<p>Lack of availability of services in the more rural and isolated regions</p> <p>Funding shortages — SAP-GL cannot establish centres in all regions</p> <p>Rehabilitation entirely NGO-led</p> <p>No government policy or funding for rehabilitation</p>
Appropriateness	<p>Lack of training and knowledge of torture <i>sequelae</i></p> <p>Lack of sensitivity amongst professionals working with survivors</p> <p>Victims have no control over their referral for treatment to specialised services — this is organised by the state</p> <p>Lack of trust of state services — victims often consult NGOs to check the reliability of state services</p> <p>Lack of good quality psychiatric, psychological and psychosocial assistance. A Mental Health Programme never materialised, due largely to a lack of political will, budgetary and regulatory issues</p> <p>Mental health services are not prioritised</p>	<p>Holistic rehabilitation only present at the top level of services, i.e. the three specialised centres</p> <p>Compartmentalising services can paralyse the holistic rehabilitation process at other levels</p> <p>Medical professionals often not independent (e.g. medical staff at reception centres or detention centres are state employees)</p> <p>The victim’s individual needs are often not properly evaluated</p>	<p>SAP-GL provides a holistic approach</p> <p>Care providers consider victims’ individual needs</p> <p>SAP-GL raises awareness to encourage communities to change their attitudes towards torture victims, to avoid stigmatisation, marginalisation and to encourage cooperation within communities to ensure a support network is available</p>
Accessibility	<p>No discrimination accessing state services</p> <p>Victims can access a Citizen Service Office that provides information on medical care provided by the state, part of the Integrated National Health System</p> <p>However, system faces a high level of bureaucracy, a dependency on decisions made based on political incentive, delays from a lack of staff and space</p>	<p>Environment is open and safe, but often inaccessible</p> <p>State agents disable the recovery environment and the legal system works against full access to specialised rehabilitation centres</p>	<p>Family and community networks important as a basis for educating communities on the effects of torture</p> <p>Knowledge spread through existing community structures, e.g. churches and hospitals</p> <p>Counselling empowers victims and communities</p> <p>Orientation activities and judicial assistance also encourage community involvement</p> <p>Widespread poverty impedes access to all services, e.g. legal</p> <p>Security and safety concerns for victims and human rights defenders; high level of impunity</p>



Mathieu Shalif (Solidarité d'Action pour la Paix/Grand Lacs, Burundi) reflected on the challenges faced in providing and funding rehabilitation services in a country that has suffered years of conflict and in which the army and security forces have used torture as a tool of repression.

Eliane Arida (Restart Center, Lebanon) introduced the work of Restart in Lebanon. They currently face major challenges in helping the increasing numbers of refugees in Lebanon. The organisation at present has three projects relating to refugees. The first, a psychological rehabilitation programme, treats 1,400 victims of torture, which includes holistic services for non-Palestinian refugees. In addition, they run a community-based programme that has assisted more than 100 victims between December 2012 and May 2013. The programme reaches out mostly to Syrian refugees, who are torture victims and in detention. The third project provides mental health services, in collaboration with UNHCR, to refugees and asylum-seekers from Syria. Providing services to refugees can create particular challenges as many refugees are not registered, thus making referrals difficult and hampering treatment.

Sana Hamzeh (Restart Center, Lebanon) introduced family therapy as one of the many forms of therapy used by Restart and, as such, an example of how they have adapted forms of therapy to meet the specific needs of the patient, i.e. taking a patient-centred approach. Family therapy, Ms Hamzeh explained, is often used with refugees and families of torture victims as regular therapy has been found to have a limited impact on these groups. The aim of the therapy is to allow the family to restart its life together and to support each other under the new and unfamiliar conditions faced by refugees. There are challenges in using this therapy, such as high costs, duration, the lack of trained therapists and gaining trust with the family.

Dr Karen Hanscom (Advocates for Survivors of Torture and Trauma, USA) reflected on the different structures in the USA for treating asylum-seekers and refugees who are torture victims. Refugees resettled in the USA have access to benefits – education, settlement services, financial assistance and access to employment. They are able to become a permanent resident after one year and a US citizen after five years. However, few receive specialised torture treatment. On the other hand, asylum-seekers have no rights and many who arrive without a visa are placed in detention, where they have no access to legal support, medical assistance, etc. The 24 rehabilitation centres in the USA work with asylum-seekers or refugees and have a capacity to serve up to 6,000, although it is estimated that there are around 400,000 torture victims in the USA. The centres are united through membership in the National Consortium of Torture Treatment

Programs (NCTTP).

Bernadette McGrath (Survivors of Torture and Trauma Assistance and Rehabilitation Service Inc., Australia) highlighted the stark contrast in the Australian approach to rehabilitation from the USA, in terms of the elements in the General Comment. She pointed out that as Australia is geographically isolated from the rest of the world, it developed a service model with unique features. The Forum of Australian Services for Survivors of Torture and Trauma (FASTT) is a network of agencies that respond to the needs of survivors of torture and trauma. There are eight agencies located in each capital city. The network builds and shares expertise and resources, provides input to government policy and programmes, collects, collates and analyses national data, strengthens and develops fundraising, negotiation and project management of the centres. As such, it provides a coherent voice in the field of torture rehabilitation and the development of National Minimum Standards for the Provision of Services to Survivors of Torture and Trauma. At present, FASTT funding is set at 4.6 million AUD (3.1 million EUR) and is divided between the eight agencies proportionally. Larger agencies voluntarily subsidise the smaller agencies. There is a concern that the recent change in government could lead to a potential loss of funding, alongside the increasing numbers of asylum-seekers.

General discussion

The general discussion outlined some of the common challenges faced by the three case studies in the work they carry out with refugees and asylum-seekers. It was agreed that refugees often focus on the issue of resettlement, and it may take some time for them to see the positive aspects of rehabilitation. In all three countries, the issue of lengthy detention for asylum-seekers is a concern, particularly as this often hinders their access to rehabilitation services. In Australia, FASTT agencies have access to detention centres, but in the USA it is harder to gain access. In Australia, the ability of centres to work independently when they are funded mainly by the state was raised. To overcome this, Australia recently passed legislation that prevents funds from being withdrawn in the event that an organisation speaks out against the government. It was suggested that improving communication and sharing experiences between countries dealing with refugees seeking resettlement and those working with resettled refugees would be beneficial to understanding the various challenges in providing rehabilitation services.

Lebanon

USA

Australia

Availability

Centres work on various levels, e.g. community-based refugee programmes, programmes with specialised international agencies, such as UNHCR, and in places of detention

Thirty-four centres, across 15 states and Washington, D.C., provide rehabilitation as part of the National Consortium of Torture Treatment Programs (NCTTP)

Of these, 24 centres have a comprehensive torture treatment programme; five centres offer legal or other support

Funds available through the Torture Victim Relief Act, distributed by the Office of Refugee Resettlement. Also limited federal funding, funding from UNVFVT, state grants, foundations, corporations and individual donations

Historical and cultural expectations that the state must take responsibility for the provision of services

Universal availability of good basic health and social services

Support to survivors of torture or trauma provided by the FASTT network of rehabilitation centres, funded by the Department of Health and Ageing

Centres aim to provide long-term counselling and other support to high-need torture and trauma survivors and assist them to access mainstream services

Appropriateness

Treatment tailored according to individual's needs, e.g. family therapy used for many refugees

Refugees often see resettlement as the only solution, which can affect their response to certain kinds of therapy

Refugees face additional pressures, which can hamper rehabilitation, e.g. feelings of injustice, hopelessness, guilt, separation from family

National data is systematically collected across centres in the NCTTP

More research planned to study effectiveness of treatment methods for best practice development

Centres provide case management with ASTT using a strength-based model that aims to empower the victim to realise his/her own needs

Focus on psychological and social rehabilitation as part of the resettlement process. Less work on legal redress or reparations

Holistic services, including psychosocial counselling, advocacy, empowerment and recovery, psychiatric/GP clinics, child and youth programmes, complementary therapies, training of other service providers and capacity building in communities.

Most victims are not in first country of asylum (in contrast to Lebanon) meaning trauma is often not at the acute stage

Open-ended services recognise that symptoms of torture may reappear and full rehabilitation can be a lengthy process

Accessibility

Challenge of accessing unregistered refugees who need urgent treatment

A growing number of refugees places pressure on the ability of services to provide support to all who need it

There is a severe difference between availability of social services (food, housing, medical care) for asylum-seekers compared to refugees

Torture treatment services are limited

All centres experience long waiting lists

Few asylum-seekers in detention have access to legal support and even less have access or support from rehabilitation centres

Medical care in detention is lacking

Safe environment for victims and staff

Challenges associated with treating refugees or asylum-seekers, e.g. loss of identity, separation from family, cultural and linguistic barriers

Distinction between conditions faced by refugees and asylum-seekers, many of whom are detained. Safety issues around working with detained asylum-seekers and challenges with working in a non-therapeutic environment

Increased demand means long waiting lists to access services

Dr Lutz Oette (REDRESS) introduced the workshop noting that there has been very little focus on rehabilitation in transitional justice processes in international discussion, but that rehabilitation has much to contribute. In the context of transitional justice societies, rehabilitation needs to be considered in the immediate phase as well as from a long-term perspective. Dr Oette gave an overview of the challenges to rehabilitation in Chile, citing it as an experimental model in which a small team of health professionals trained others to provide services.

However, in terms of accessibility there were particular challenges — only 18% of those registered actually had effective access to rehabilitation services, and it took more than 20 years to have permanent staff and geographical coverage. In addition, a lack of information about the programme meant many victims trusted private rehabilitation services more than those within the state system. In terms of appropriateness, there was a lack of integration and holistic approach in the programmes. However, with time the system has experienced a degree of stability and professionalism, and state-run services have worked more closely with NGOs. In transitional justice societies, there may also be the question of accessibility of rehabilitation services to exiled nationals. In Chile, REDRESS is involved in a case before the Inter-American Court of Human Rights that considers whether exiles should be entitled to benefit from state-run rehabilitation programmes.²

Juana Luisa Lloret de Fernández (Centro de Atención Psicosocial, Peru) spoke about collective reparations in the context of Peru, where the Truth and Reconciliation Commission established a number of initiatives to seek reparations for victims of the armed conflict. The state created a high-level multi-sectorial commission to design, implement and supervise reparation policies, and the Integral Reparations Plan (IRP) was adopted in 2005 to provide holistic attention to victims of the armed conflict. A Unique Registry of Victims (URV) was set up to recognise the collective or individual harm to victims, without discrimination. Programmes for health reparation, educational reparation and collective reparation were established as part of the IRP. The collective reparations programme aimed at strengthening communal relations as those most affected by the conflict were the poor, rural and indigenous communities.

2. García Lucero et al. v. Chile, Case no. 12.519.

Sharon Vermaak (The Trauma Centre for Survivors of Violence and Torture, South Africa) spoke about rehabilitation in post-apartheid South Africa. She highlighted the different groups of victims — apartheid-era victims that appeared before the Truth and Reconciliation Commission, who still use rehabilitation services; apartheid-era victims, who start to need rehabilitation years after the torture took place; and second-generation apartheid-era victims. In addition, present-day victims include refugees and asylum-seekers, victims of hate crimes, alleged criminals, suspects, protesters, communities in conflict with the law and victims of organised crime. Perpetrators of torture are both state and non-state actors. In general, the government needs to honour the Convention against Torture both procedurally and substantively; as long as Article 14 is not part of the legislative framework, rehabilitation services will remain poor and under-resourced. In addition, training and capacity development of medical, legal and mental health professionals on torture is essential, and there is a need for more research into the links between torture victims and organised crime and prisons.

General discussion

The need to include rehabilitation as part of the transitional justice process, the problems with cut-off dates (or closed lists) for victims to claim reparations, and recognising the needs of second and third-generation victims were some of the common threads of rehabilitation in transitional justice societies. The examples given showed the various challenges of providing collective versus individual reparations, with rehabilitation as one component. In Peru, collective reparations have been used to further political interests, and local authorities have failed to inform local communities of their rights in some cases. With collective reparations, some victims may feel they are not adequately recognised if funds are allocated to the whole population and not to individual victims. It was agreed that a truth and reconciliation commission is an important part of the process, but that, in the case of South Africa, its success was limited in encouraging the government to take responsibility for rehabilitation services. In transitional justice societies, there is the likelihood that violence becomes normalised and perpetrators can become victims, or vice-versa. This can foster discrimination in accessing rehabilitation services.

Peru

South Africa

Availability	Peru	South Africa
Appropriateness	<p>Focus on physical and mental health</p> <p>Services meant to be available to all victims, but in reality they are insufficient to meet the needs of victims</p> <p>Victims often given a diagnosis but then have no access to treatment or medicine</p>	<p>General medical services under pressure due to a lack of mental health professionals and knowledge of torture symptoms</p> <p>High risk of secondary victimisation, particularly among present-day victims</p> <p>Rehabilitation services offer holistic programmes, including community healing interventions, memorialisation programmes, advocacy, skill-based programmes, clinical counselling</p> <p>Access to social and legal services through a referral system with other NGOs</p> <p>Length and type of treatment is based on the victim's needs. Socio-economic needs are often a priority due to the lack of compensation available</p>
Accessibility	<p>Ability to access the holistic health system dependent on the socio-economic level of victims</p> <p>Holistic rehabilitation still not offered to many internally displaced victims</p> <p>Discrimination exists — some victims are perceived as “terrorists” and are discriminated against in the registration process</p> <p>Female victims in rural areas do not have access to services, and rape victims are not given access to female medical staff. Lack of women's participation in the process</p>	<p>Discrimination between apartheid victims on the closed list and apartheid victims not on the closed list, who have difficulties accessing rehabilitation services</p> <p>Regional disparity exists — not all provinces have access to specialised torture rehabilitation services</p> <p>Secondary victimisation prevents some victims, particularly refugees, from seeking help</p> <p>Lack of trust of the police due to intimidation and police brutality means that incidents of present-day torture often go unreported</p> <p>Lack of security makes many present-day victims reluctant to access mental health services</p>

4

Working in challenging environments – Egypt, Russian Federation, Ecuador

Raghda Sleit (El Nadeem Center, Egypt) introduced the work of El Nadeem, which is the only rehabilitation centre for torture victims in Egypt. The centre relies on funding from private donors and is supported by volunteer staff.

Faridun Zavurbekov (Interregional Non-governmental Organization Committee Against Torture, Russian Federation) introduced the work of CAT, which has provided legal support and rehabilitation services to victims of torture since 2000. The centre has set up mobile groups in order to be able to react promptly to allegations of human rights violations in any region of the country. It then endeavours to organise an independent investigation into the incident and represents the victim at court and before investigation bodies, as well as providing access to medical and psychological treatment and counselling.

Yadira Narvaez (Fundación para la Rehabilitación Integral de Víctimas de Violencia, Ecuador) introduced the many challenges faced in providing rehabilitation services to torture victims in Ecuador. The country has a high number of refugees, torture occurs for more than half of persons in detention, and there are high numbers of enforced disappearances. Only 0.8% of torture victims have received care directly from the state. Many torture victims are reluctant to accept assistance from the state as the state is generally the perpetrator of acts of torture. There are many NGOs, around 12,000 working in the health field, but only two centres provide torture rehabilitation services. PRIVA has been advocating for a holistic penal code, which will recognise holistic rehabilitation as an element of full reparation. It has entered into dialogue with state institutions to encourage torture victims' rehabilitation to be included as a part of public health policy. PRIVA seeks to influence university institutions to play a role in developing tools to evaluate victims' needs in order to generate changes to public health policy. In this way knowledge is spread amongst legal and health professionals, and PRIVA is able to build on its limited capacity.

General discussion

Working in an environment in which the state authorities are not supportive of the work carried out by rehabilitation centres was the common theme in this workshop. Various countries, including Pakistan and Sri Lanka gave examples of similar ways of working to those illustrated in the three case studies. In some

cases, trying to engage with the state authorities, particularly by offering training for police, judiciary, etc., can enable a more conducive working environment and build trust. It was also noted that breaking down the stigma attached to torture is important to encourage victims to rely on family support and seek help from available services.



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The most important aspect of the workshop was learning about different contextual problems which will allow us to develop strategies, especially to influence governmental institutions.

Yadira Narvaez, PRIVA, Ecuador

Egypt

Russian Federation

Ecuador

Availability

Rehabilitation services provided in an environment in which the state policy of systematic torture and impunity continues

Lack of political will to address previous or current torture, and the spread of violence and political animosity threaten to increase society's tolerance of torture

National legislation has not been changed — state agents who commit torture continue to be protected from criminal prosecution

Funding of services is entirely from private sources

No domestic regulations that establish procedures for providing rehabilitation

The Code of Criminal Procedure, which allows redress for those who are unlawfully prosecuted, does not recognise torture victims as eligible for rehabilitation

State does not implement or finance rehabilitation services, and the notion of "torture victim" is not recognised in the state healthcare system

Very few torture victims receive care directly from the state

Only two centres provide rehabilitation services for torture victims

Centres have limited financial and staffing resources

Some dialogue with state institutions is possible, e.g. lobbying and advocacy work

Appropriateness

Holistic rehabilitation, including psychological and psychopharmacological therapy, referrals to doctors and other medical professionals, forensic evaluations of torture, legal support, support to families of victims, campaigning and helping victims and their families to tell their story through the media

Services provided according to victim's needs

Referrals to lawyers and the public health system as required

Many victims prioritise redress through justice over rehabilitation, so providing legal support is an important service

Helping victims to access other services reduces the stigma attached to seeking mental health support

Free medical assistance for Russian citizens — any victim can rely on free basic somatic treatment

Istanbul Protocol not implemented — healthcare professionals in state hospitals and clinics lack skills to diagnose and document torture-related injuries. This hampers investigation and treatment programmes for the victim

More specialised and long-term treatment is not available free-of-charge

NGOs fill the gap in the state healthcare system by providing medical, psychological and social rehabilitation through private donors and the UNVFVT. The treatment is tailored to the victim's needs

Services focus on rehabilitation, prevention, documentation and investigation of torture

Services include psychological treatment and social assistance, encouraging the victim to restore links with his/her family and social network to aid the recovery process

Many victims receive treatment in public hospitals where injuries are not documented properly, making it harder to prosecute

Accessibility

No discrimination in treatment offered by the centre

Women can access specialised services for torture and other related violence; the centre takes referrals from refugee organisations

Raising awareness of the centre's services is a challenge, thus the centre has set up a hotline

Some field visits carried out to regions where torture has occurred, or if the victims are unable to travel to the centre

Prohibited from accessing prisons or detention centres

Victims fear reprisals, threats, arrests if they report torture and difficult to build trust

High risk of retraumatisation — victims often return to the environment where the torture took place, making full rehabilitation difficult

Difficult to access social support for victims who have lost their job, housing and enable those to meet basic needs

Staff work in an insecure environment having faced personal attacks and attacks on the premises

The centre provides a range of services: medical/psychological treatment and counselling, legal support (court representation and investigatory work)

Protection gaps exist for victims not covered by medical insurance — the person is unable to access the state healthcare system. This mainly affects migrants, refugees, relocated persons or undocumented persons

Safety and security of victims is not guaranteed. National law provides for the protection of witnesses and victims in criminal proceedings, but protection measures are rarely taken in relation to torture victims, even when there is irrefutable proof of intimidation

Confidentiality of victims and families is not ensured, and they become easy targets for intimidation by state agents

Human rights defenders work in a vulnerable situation with no protection offered by the state

Estimated 70% of torture is committed on persons deprived of their liberty

Often victims are not aware of their rights and think torture is normal punishment (particularly in detention or police settings)

Victims often fail to seek assistance from doctors, psychologists and social workers

Stigma attached to seeking psychological help; offering multidisciplinary services can alleviate this obstacle

Centre works in an insecure environment — threats have been made against staff and the internet has been hacked. A forensic doctor was killed

Region in focus: the Middle East

Ninette Kelley (UN Refugee Agency) said that the Syrian refugee crisis in the region has reached emergency levels. According to her:

- Approximately 500,000 registered Syrian refugees in Lebanon as of 27 June 2013 (see illustration); forecast to rise to 1 million by the end of 2013³
- Around 25% of refugees are women and over 52% are children, the majority of which are deeply traumatised
- Massive strain placed on public health systems in Lebanon and Jordan
- In Lebanon, over 150,000 refugees have been identified as having psychosocial needs, many addressed through community centres, agencies providing counselling (including Restart Center) and other services and community outreach volunteers
- Challenges – to increase technical capacity, e.g. specialised services for children, and service delivery; strengthen coordination mechanisms.

Dr Manal Tahtamouni (Institute for Family Health/ Noor Al Hussein Foundation, Jordan) spoke about the work of the Institute with Iraqi and Syrian refugees:

- Jordan has received around 32,000 Iraqi refugees and will have an estimated 1.3 million Syrian refugees by the end of 2013
- There is no state recognition of psychosocial-services for torture cases, and it is not considered a state priority, including for other groups like refugees
- The centre works in cooperation with UNHCR in refugee camps, screening refugees, providing basic and specialised counselling services to vulnerable groups especially on child protection, gender-based violence and war-related trauma, in addition to training of local partners in community-based organisations and volunteers to provide primary psychosocial assistance
- Training on torture is absent from medical and psychological curriculum, and there is a lack of knowledge or understanding of rehabilitation and documentation
- Access to rehabilitation is sensitive and taboo.

3. At the time of publication, the estimated number of Syrian refugees in Lebanon is 780,000 (including those awaiting registration). Source: UNHCR, Inter-Agency Regional Response for Syrian Refugees, Egypt, Iraq, Jordan, Lebanon, Turkey, 3-9 October 2013. Available at: <http://reliefweb.int>.

There is a need to change the mentality of the victims themselves, victims' families and care providers.

Dr Alissar Rady (World Health Organization) spoke about the organisation's programmes addressing torture perpetrated against persons with psychosocial disabilities, including the Mental Health Gap Action Programme (mhGAP), the regional strategy for mental health, the global action plan for mental health (May 2013).

Lebanon close-up

The session benefitted from three panellists from the Lebanese government, who offered an overview of the state's role in rehabilitation and torture prevention. **Dr Chauki al Haj (Ministry of Public Health)** recognised that although Lebanon ratified the UNCAT and OPCAT, there is clearly a need to implement Article 14 of the UNCAT fully. In reality, the main challenge for his ministry is the financial aspect. As **Judge Raja Abinader (Directorate of Prisons)** explained, the focus of the Ministry of Justice is on the prevention of torture, particularly through strengthening the role of the National Preventative Mechanism. He also reflected on the need to clearly define torture in the Penal Code so that it is made a criminal offence. He noted the need to provide prisoners with medical records. The Ministry of Justice is working with the Ministry of Social Affairs to provide every prisoner with a social file to screen their social needs.

Lieutenant Ziad Kaed Bey (Ministry of Interior) spoke on behalf of the Internal Security Forces explaining that a Human Rights Department was established in 2008. In 2010 a Committee against Torture was also established to create a complaints mechanism. Training and education on human rights is offered as a part of the induction process in the police and security forces. Cooperation with civil society organisations, including Restart, has improved, but there is still a need to gain public confidence.

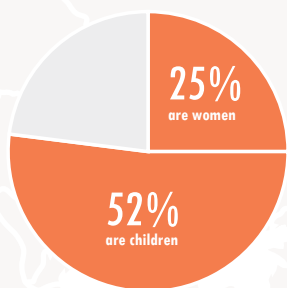
Wadih Al-Asmar (Centre Nassim, Lebanon) said that in practice there is very little implementation of either the UNCAT or OPCAT in Lebanon, and the state's primary report on implementation of UNCAT is still pending. However, in the last two to three years, some progress has been made in that the state has admitted that torture is taking place, although in reality there is an absence of protection. As a result, civil society is substituting the work that the state should carry out. However, this is not a viable long-term solution; the state needs to acknowledge viola-

tions carried out and provide a comprehensive plan for reparation, rehabilitation and justice. However, he felt that the lack of political will meant that there is a lot of talk but little action on the part of the state.

Suzanne Jabbour (Restart) summed up the challenges faced in Lebanon: the gap between law and practice,

the need for the government to fully commit, a lack of resources to finance rehabilitation. In addition, the need to protect victims is essential if they are to provide evidence of torture. There is also a need for civil society organisations to coordinate their work.

500,000
registered Syrian
refugees in Lebanon
as of June 2013



1,000,000
forecasted by the
end of 2013

Massive strain
placed on public health systems in
Lebanon and Jordan

150,000
refugees with
psychosocial needs

“ ”

Suzanne Jabbour from Restart summed up the challenges faced in Lebanon: the gap between law and practice, the need for the government to fully commit, a lack of resources to finance rehabilitation.

Reflections: Where are we now as a movement?

Mr Craig Higson-Smith (Center for Victims of Torture, USA), Dr Nimisha Patel, Dr Lutz Oette and Dr Paul Bolton reflected on the key findings from each of the parallel workshops, providing an overview of where we are as a movement with reference to the key elements in the right to rehabilitation framework. Mr Higson-Smith set out a sliding scale of possible benchmark indicators according to the degree of torture taking place in a country.

What are other stakeholders doing to implement the right to rehabilitation?

Mr Rauno Merisaari (Ministry of Foreign Affairs, Finland) gave an overview of the challenges his government faces in supporting the rehabilitation of torture victims. In Finland, two rehabilitation centres, supported with funding from the Ministry of Social Care and Health, offer support to asylum-seekers. The Finnish government gives small grants to local

Context	State systematically and actively uses torture to control population and those supporting torture victims: the question of state-led versus NGO-led services is meaningless	State agencies use torture to extract confessions, to control prisoners, patients, etc., but not in systematic fashion: NGOs leading state through policy and legislative development, awareness campaigns, training of personnel, etc.	States undergoing transitional justice processes: state-led initiatives for reform and rehabilitation. Important opportunity for civil society but should not be naïve	State actively supports the rehabilitation of torture victims: state-led initiatives in partnership with NGOs. However, important rights may be eroded over time
Availability	Minimum availability of services	Limited availability of services	Greatly increased availability of rehabilitation initiatives, at least for a limited time. Importance of legislation including rehabilitation measures	Yes, but problems with adequate identification and referrals
Appropriateness	Often strong community-based systems emerge to protect and support people. But no referral possibilities for more severe cases and no possibilities for satisfaction or guarantees of non-repetition	NGO services may be appropriate but limited. Services through state agencies are limited in quality and quantity, offered to general population, may focus on medical rehabilitation and have limited access to community structures and processes. Few possibilities for satisfaction or guarantees of non-repetition	Potential for highly appropriate rehabilitation, including opportunities for compensation, satisfaction, changes to social/political factors that enabled torture	Comprehensive, but only at top levels, medicalization of problems. Working with refugee populations so little opportunity for social change, satisfaction, etc.
Accessibility	Very low, unsafe, long distances	Issues around safety in state facilities, language, minority groups may find it difficult to access services	Increased accessibility although some groups may be disadvantaged e.g. through inclusion/exclusion criteria or discrimination	Open, safe but sometimes unreachable. State agents may disable recovery environment

organisations in other countries to support rehabilitation and torture prevention work. He noted the importance of ensuring non-discrimination towards women, children and minorities in the provision of rehabilitation services. Mr Merisaari also agreed that one of the main challenges is to ensure that states are held accountable for providing as full rehabilitation as possible. He further highlighted the importance of advocating for a greater ratification and implementation of UNCAT and OPCAT. In Finland, he noted the need to ensure the sustainability and quality of services with more tailored services to meet the needs of the victims. He outlined the importance of multi-stakeholder cooperation and the need for support from civil society organisations, even in cases where the state may meet all its obligations under Article 14.

Dr Abdel Salam Sidahmed (Office of the High Commissioner for Human Rights, Lebanon) outlined the organisation's supporting role to the UN Committee against Torture. He noted that the visits conducted by the Subcommittee on Prevention of Torture (SPT) are carried out with the agreement of states, and as such they are usually able to access places of detention and enjoy a degree of cooperation from the state. In addition, the work of OHCHR's field offices ensures collaboration with governments and civil society organisations at the national level. OHCHR provides technical support and help to governments when reporting to the Committee, and in relation to other human rights concerns, e.g. the conduct and training of police and security forces. He welcomed the General Comment on Article 14 as a landmark development, particularly as an encouragement to states to consider the issue of redress more seriously. He considered that the victim-centred approach to rehabilitation, which focuses on enabling the individual to reassert their position in society and rebuild their life, is a particularly positive aspect of the right to rehabilitation. He also noted that the General Comment was followed by a resolution of the Human Rights Council (HRC) in March 2013,⁴ which emphasises that states should take persistent steps towards the eradication of torture. Both the General Comment and the Resolution are significant steps to strengthen the mechanisms to hold states accountable and to give civil society a greater voice in the dialogue.

María Sánchez Gil-Cepeda (EU Delegation to the Lebanese Republic) reflected on the multidisciplinary approach that the EU Delegation follows in order to encourage dialogue. She reflected on the importance of interacting with government, civil society organisations and other stakeholders. In addition to showing commitment, an open dialogue must be maintained

between the EU Delegation and the state in order to understand the challenges faced. She underlined the importance of civil society involvement in providing input to reports sent by the EU Delegation to its counterparts in Brussels. She stressed the importance of the UN treaty bodies in the role they play highlighting individual cases. She outlined the funding support given through the European Instrument for Democracy and Human Rights (EIDHR) process, including to rehabilitation work. Finally, she emphasised the fundamental role that civil society plays in the provision of rehabilitation services and advocacy and lobbying; the state cannot replace this role, but it is vital that there are strong state institutions in order to make collaboration between the state and civil society work.

Astrid Melchner (UN Voluntary Fund for Victims of Torture) outlined the work of the UNVFVT highlighting its victim-centred approach to funding. UNVFVT distributes assistance through a variety of non-governmental channels, taking into account the cultural and political context. Its assistance is victim-centred, can be accessed by victims' families and is offered independent of the need to pursue judicial remedies. Moreover, the fund recognises that a long-term, tailored and specialised response is necessary. Aside from being the only financial international tool exclusively dedicated to the rehabilitation of torture victims, the fund is also global, predictable and non-politically motivated, making it a unique mechanism. In 2013, it is expected that the fund will have helped a total of 57,000 victims with grants totalling more than 7 million USD (approximately 5.1 million EUR). The UNVFVT provided input to the drafting of the General Comment, and believes it will help to take forward the imperative of assisting victims. Ms Melchner also highlighted the HRC Resolution of March 2013 as a landmark resolution supported by 66 states. She hopes that the momentum created by these two important developments will make governments realise how critical civil society organisations are in this field and provide a useful strategic tool for NGOs. She highlighted that while many organisations may seek to maintain their independence, often partnership and cooperation with state institutions will enable capacity development and reinforcement of services. She reflected on the reporting processes, both to the Committee and in the UN's Universal Periodic Review (UPR) process, as one form of partnership or cooperation envisaged by the General Comment. Finally, she reflected that the fund is part of a partnership as it supports non-governmental channels of assistance but receives contributions from State Parties. However, she highlighted a major challenge faced by the fund is that, in the past five years, it has lost some 30 percent of its contributions (11.6 million USD (approximately 8.5 million EUR) in 2008, but

4. UN Human Rights Council, 22nd session, Torture and other cruel, inhuman or degrading treatment or punishment: rehabilitation of torture victims, A/HRC/22/L.11/Rev.1, 19 March 2013.

only 8.2 million USD (approximately 6 million EUR) in 2012), and its donor base has shrunk from 38 to 22 donors. The support of states is vital to fuel the fund, and she underlined the importance of advocating to governments of the importance of maintaining their contributions.

Dr Mechthild Wenk-Ansohn (Berlin Center for the Treatment of Torture Victims, Germany) spoke about the importance of the General Comment as an invitation to bring in the knowledge of specialist rehabilitation centres in defining the right to rehabilitation framework. She identified the need to enhance mechanisms so that access to treatment is guaranteed for all. In addition, raising awareness and ensuring improved methods for recognising victims of torture through screening are essential to ensuring accessibility. Linked to this is the need to train professionals in primary healthcare system to recognise the signs and symptoms of torture. One issue that was raised in the parallel workshops was how to encourage more medical professionals to specialise in this area of work. Dr Wenk-Ansohn highlighted the importance of offering training on forensic documentation of torture and other related issues, in combination with training on general violence so as to attract more interest from medical and health professionals. Rehabilitation centres should be at the forefront of sharing this knowledge and expertise and promoting training in this area of work. In terms of providing appropriate treatment, Dr Wenk-Ansohn highlighted the need to take a multidisciplinary approach and to offer a combination of support services involving psychological, social and family interventions, as well as access to education and help with employment. Specialised services should be linked to the public health system to encourage sharing of knowledge and increased cooperation.

In terms of funding, she recognised the current challenges faced by rehabilitation centres, particularly with the decrease in European Union funding, but also the difficulties of encouraging states where torture is practiced to fund rehabilitation. In terms of tools

to use, she highlighted the reporting mechanism, particularly to the Committee, and gave the example of the Parallel Report produced by bzfo and other civil society organisations on the treatment of detained persons awaiting deportation in Germany. In addition, she highlighted the significance of lobbying at the national and international levels and the importance of cooperation, for example through coalitions to achieve more weight and coordinate at a strategic level.

Finally, **Dr Nimisha Patel** summed up the challenges faced in implementing the right to rehabilitation from the clinical perspective. She emphasised the need to implement ethical interventions in which survivors are involved in the process and that provide a common conceptual understanding of rehabilitation. In terms of rehabilitation as a form of reparation for a wrong committed she highlighted the clinical ethical imperative to provide a humanitarian response (as an addition to the legal obligation). Working towards implementation, service providers need to be able to define their working models and justify these in terms of the local context and needs. The designing and delivery of services is a continuous process of evaluation and review, with the need to question and adapt. The planning and development of a workforce is an essential element of this process, thus a need to identify the necessary skills and training to meet the required standards. The training needs to maintain a specialised and effective workforce and the cost of delivery of services need to be reviewed in relation to financing, in particular given the current challenges with reduced funding from sources such as the UNVFVT. In relation to accountability, Dr Patel encouraged the movement to see the General Comment and other legal instruments as tools that can be used to hold states accountable through reporting mechanisms and shadow reports. Related to this is the importance of data collection that can demonstrate why rehabilitation is needed and how it works. She pointed out that our greatest accountability is to the victims themselves and in meeting our commitment to torture survivors, the ability to work and collaborate across all disciplines is vital.

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The conference provided us with the **tools, arguments and rationale** that we can use in our own countries to promote rehabilitation of torture survivors.

Karen Hanscom, Advocates for Survivors of Torture and Trauma, USA

“ ”

It was a meeting where it was possible to **exchange opinions with other centres**, both in the same region and from remote areas. That has enriched us, to observe other forms of work. It is a continuous learning.

Juana Luisa Lloret, Centro de Atención Psicosocial, Peru



Mr Pradeep Agrawal, Society for Social Research, Art and Culture, India, addresses the panelists in the last session of the conference.

“ ”

I found more insight on the role and the need to bring government on board in the rehabilitation process.

Fred Muzira, African Centre for Treatment and Rehabilitation of Torture Victims, Uganda

“ ”

The conference was a nice podium for professionals engaged in rehabilitation to exchange experiences and opinions and inspire each other with regard to options necessary to continue their work. What lacks, in my opinion, is spreading experiences and our message to a broader audience of professionals not directly involved with rehabilitation of torture survivors.

Boris Drozdek, Psychotrauma Centrum Zuid, Netherlands

Next steps

Since rehabilitation is at the core of the IRCT's work, the members that were able to participate in this global conference offered the essential expertise needed to contribute to the discussion on how rehabilitation services should be provided within the framework laid out by the UN Committee against Torture in General Comment No. 3. The torture rehabilitation movement is in a unique position to hold states accountable to their obligations and ensure the delivery of proper support, according to the needs of torture survivors. The parallel workshops in which very different countries were juxtaposed within four thematic areas highlight the complexity of the rehabilitation movement and the context within which IRCT's membership works. As demonstrated in the workshops and in the follow up discussion, there

are many different models of rehabilitation services existing across our global network, depending on a multitude of factors including the political and legal system, security situation, and the economic, cultural and social framework. Measuring the effectiveness that rehabilitation services have with regard to supporting torture survivors and holding states accountable to support rehabilitation services either directly or indirectly is very much a developing aspect of our work.

The conclusions drawn from this conference should be taken into consideration by the torture rehabilitation movement when it further develops its work to promote the right to rehabilitation. The main issues can be summarised as follows:

Context (e.g. political, historical, cultural) within which rehabilitation services are provided is vital to understanding the needs of survivors, the capacity to deliver and the most appropriate service model. There is no 'one size fits all' rehabilitation model – variations will exist. However, in any model a victim-centred approach is essential. According to the environment within which rehabilitation services are delivered, different approaches may be taken, for example:

- Transitional justice societies –
 - Other elements of redress tend to be given a greater focus than the individual's clinical rehabilitation;
 - Civil society organisations play a vital role in raising awareness and advocating for the inclusion of individual rehabilitation measures as an integral part of the transitional justice process;
 - Rehabilitation may take on an individual or collective nature depending on the historical context.
- Refugee-receiving countries –
 - Asylum-seekers are at risk of being returned to the place where torture was committed, increasing the risk of re-traumatisation;
 - Refugees may not consider rehabilitation as a priority. Their main concerns may focus on resettlement, finding a job and housing, tracing family, etc.;
 - The specific needs of refugees and asylum-seekers must be reflected in the holistic rehabilitation offered.

State responsibility for the provision and funding of services – the right to rehabilitation obligates states to either provide rehabilitation directly through state services, or fund services provided by non-state medical, legal and other facilities, including those administered by NGOs.⁵ The degree to which a state accepts responsibility will also impact on the availability, appropriateness and accessibility of services, as illustrated in the diagram on p.20.

5. UN CAT, General Comment no.3 (2012), CAT/C/GC/3, 13 December 2013, paragraph 15.

Links to national health systems – states can use the current resources and expertise they have at their disposal as a base to build on, by encouraging links to national health systems, either as implementing actors, partners or through referrals (to and from specialised rehabilitation centres)

Links to national education system – states can integrate education related to assessment (e.g. Istanbul Protocol) and rehabilitation of torture victims as a permanent subject in all relevant fields: justice systems such as police, prison, lawyers and judicial staff, as well as in the basic curricula of health professionals such as psychologists, nurses, social workers, health officers, medical doctors.

Multi-faceted services – to reflect the real needs of survivors of torture. They encourage survivors to access services (e.g. mental health) that alone may carry a significant stigma. In addition, the ability to access justice and to enjoy economic, social and cultural rights should be seen as an important part of providing a multi-faceted service to survivors of torture. In addition, the community provides support to victims, avoiding stigmatisation and encouraging victim participation in the rehabilitation dialogue.

Safe and secure environment – for survivors of torture to access rehabilitation services and for health and legal professionals to carry out the work. States have a responsibility to ensure providers of rehabilitation services do not face reprisals or intimidation. Priority should be placed on creating a context of confidence and trust in which assistance is provided and in which confidentiality is maintained.⁶ A lack of security causes additional stress for staff, particularly if there are no procedures in place. Rehabilitation centres need to address staff burnout, for example through care for caregivers programmes.

The following tools are available for promoting the right to rehabilitation:

General Comment No. 3 on Article 14 of the UNCAT – a legal tool that enables both State Parties and civil society organisations to promote the right to rehabilitation, for example:

- Using paragraphs 45 and 46 of the General Comment as a guideline for information that should be included in reports to the Committee on the implementation of the right to rehabilitation (by states and civil society organisations);
- Rehabilitation centres can refer to the information outlined in paragraphs 11-15 and 46 as a minimum standard of required information in state reports on rehabilitation services and in the reports civil society organisations provide to the Committee against Torture and other monitoring mechanisms.

Human Rights Council Resolution on torture⁷ – a political tool that recognises the importance of rehabilitation as a component that is required in order to provide an effective remedy to redress torture and cruel, inhuman, or degrading treatment or punishment:

- It calls on states to ensure that appropriate rehabilitation is promptly available to all victims without discrimination;
- It emphasises that a state's role is to provide rehabilitation either directly by the public health system or through funding private rehabilitation services.

6. UN CAT, General Comment no.3 (2012), CAT/C/GC/3, 13 December 2013, paragraphs 13 and 15.

7. UN Human Rights Council Resolution, A/HRC/22/L.11/Rev.1, 19 March 2013.

Data collection – a key tool to enable the mapping of rehabilitation services:

- By identifying existing rehabilitation services in the country against torture victims' needs;
- Evaluating how victims' needs are provided for by NGO-led rehabilitation services and how this complies with the General Comment framework;
- Evaluating what services the state provides, including in terms of general mental health services;
- Evaluating other available resources or partners that could provide resources, e.g. private hospitals, specialist medical centres, etc.;
- Establishing or strengthening systems to ensure confidentiality of torture victims.

Following IRCT's strategic framework, we are working on the right to rehabilitation in the following ways:

1 Strengthening capacity

Raising awareness is an important first stage to achieving the implementation of the right to rehabilitation. For example through:

- Informing victims of torture, health and legal professionals and other key stakeholders of states' obligations and victims' rights under Article 14 of the UNCAT;
- Capacity development (provided to state agencies, medical/legal professionals, via university curriculum);
- Peer supervisory networks (internal and external), particularly of health and legal professionals, social workers, other professionals in contact with survivors of torture.

Collecting data – states and rehabilitation service providers should carry out systematic data collecting on rehabilitation, in order to provide disaggregated overviews of compensation and rehabilitation provided to torture victims.

Accessing funding – Article 14 places an absolute obligation on states to provide for as full rehabilitation as possible (i.e. not related to the available resources of the state or to the responsibility of the state as a perpetrator). However, the IRCT recognises that until this is achieved, other funding sources need to be accessed, for example:

- Partnerships between rehabilitation centres, IRCT and other stakeholders should be encouraged to strengthen collaboration and access more funding opportunities;
- Lobbying at the national and international level is required to encourage states to donate to the UNVFVT.

2 Influencing policy

Creating the policy and legal framework to operate rehabilitation services, for example through:

- Lobbying and advocacy at national, regional and international levels, to ensure that -
 - Domestic law provides for all five forms of reparation;
 - National courts order these reparations;
 - Rehabilitation is made available at the earliest point in time, based on a health assessment and not a judicial decision;
 - States take responsibility for providing specific funding for torture victims.

3

Sharing knowledge

Promoting education and research — Ensuring rehabilitation of torture victims and torture prevention is included in standard medical and legal schools' curriculums and research programmes of academic institutions;

Training relevant stakeholders — At a local level this can be a way of overcoming barriers to collaboration between stakeholders, e.g. training police, prison officials or judiciary as a first step to encouraging state involvement at a national level on further justice reforms;

Promoting multidisciplinary and multi-stakeholder collaboration – between the state, civil society organisations, victims of torture as advocates in their own right, actors working in public health in general, academic institutions and professional associations, for example:

- To encourage empowerment of victims of torture;
- To encourage capacity development;
- To hold states accountable for the provision of rehabilitation services;
- To strengthen the evaluation process of any rehabilitation services provided (by state or NGO-led);
- To implement the right to rehabilitation more widely;
- Using coalitions to strengthen collaboration on national, regional and global levels. In countries where states actively participate in torture, international collaboration is all the more essential.

Conclusion

The UN Committee against Torture's General Comment No. 3 lays out a framework indicating that services have to be available, appropriate and accessible in order to fully realise the right to as full rehabilitation as possible. The expert opinion confirms that State Parties to the UNCAT may be held accountable in meeting this obligation. The global conference organised by IRCT and Restart has paved the way for identifying the key challenges currently faced by torture victims in enjoying the right to rehabilitation by encouraging discussion and an exchange of ideas on how this work should be taken forward. The key recommendations that came out of the conference, which are summarised above, should shape the future work of the torture rehabilitation movement in order for the implementation of the right to rehabilitation to become a reality.

The IRCT and Restart would like to thank all the speakers who presented at the conference, encouraging a stimulating and thought-provoking discussion. Our thanks also go to the IRCT member centres who presented workshops to give an invaluable insight into the many challenges of providing rehabilitation services. Finally, we extend our gratitude to the Restart staff who worked with the IRCT Secretariat to make the conference a great success.

Speakers

Judge Raja Abinader	Ministry of Justice, Lebanon
Wadih Al-Asmar	Centre Nassim at Lebanese Centre for Human Rights, Lebanon
Eliane Arida	Restart Center for Rehabilitation of Victims of Violence and Torture, Lebanon
Ziad Kaed Bey	Ministry of Interior, Lebanon
Dr Paul Bolton	Johns Hopkins Bloomberg School of Public Health, USA
Boris Drozdek	Psychological Centre South Netherlands (RvA NL), Netherlands
Elsa Fenet	EU Delegation to the Lebanese Republic, Lebanon
Juana Luisa Lloret Fernández	Centro de Atención Psicosocial (CAPS), Peru
Dr Chauki Al Haj	Ministry of Public Health, Lebanon
Sana Hamzeh	Restart Center, Lebanon
Dr Karen Hanscom	Advocates for Survivors of Torture and Trauma (ASTT), USA
Craig Higson-Smith	Center for Victims of Torture (CVT), USA
Suzanne Jabbour	Restart Center, Lebanon
Ninette Kelley	UN Refugee Agency (UNHCR), Lebanon
Bernadette McGrath	Survivors of Torture and Trauma Assistance and Rehabilitation Service Inc. (SSTARS), Australia
Prof Martin McKee	London School of Hygiene and Tropical Medicine, UK
Astrid Melchner	UN Voluntary Fund for Victims of Torture (UNVFVT), Switzerland
Rauno Merisaari	Ministry of Foreign Affairs, Finland
Yadira Narváez	Fundación para la Rehabilitación Integral de Víctimas de Violencia (PRIVA), Ecuador
Dr Lutz Oette	REDRESS, UK
Dr Nimisha Patel	International Centre for Health and Human Rights and the University of East London, UK
Dr Alissar Rady	World Health Organization (WHO), Lebanon
María Sánchez Gil-Cepeda	EU Delegation to the Lebanese Republic, Lebanon
Miguel Scapusio	Servicio Paz y Justicia (SERPAJ), Uruguay
Mathieu Shalif	Solidarité d'Action pour la Paix/Grand Lacs (SAP/GL), Burundi
Dr Abdel Salam Sidahmed	Office of the High Commissioner for Human Rights (OHCHR), Lebanon
Raghda Sleit	El Nadeem Center for Psychological Management and Rehabilitation of Victims of Violence, Egypt
Dr Manal Tahtamouni	Institute for Family Health/Noor Al Hussein Foundation (IFH/NHF), Jordan
Sharon Vermaak	The Trauma Centre for Survivors of Violence and Torture (TCSVT), South Africa
Dr Mechthild Wenk-Ansohn	Berlin Center for the Treatment of Torture Victims (bzfo), Germany
Faridun Zavurbekov	Interregional Non-governmental Organisation Committee Against Torture (CAT), Russian Federation

How to support the IRCT

We need your support to fight torture and to help torture survivors rebuild their lives. By donating even a small sum, you can assist us to put an end to torture and to ensure that torture survivors and their families receive much-needed treatment and other services. Donations can be made in the following currencies: Danish Kroner (DKK), Euros (EUR) and U.S. Dollars (USD).

By credit card

Please visit www.irct.org to make a donation using a credit card. All transactions are guaranteed safe and secure using the latest encryption to protect your personal information.

By cheque

Cheques made payable to the International Rehabilitation Council for Torture Victims (IRCT) should be sent to:

International Rehabilitation Council for Torture Victims
Copenhagen Europe Center
Vesterbrogade 149, building 4, 3rd floor
1620 Copenhagen V
Denmark

By bank transfer

Danske Bank
Holmens Kanal Branch
Holmens Kanal 2
1090 Copenhagen K
Denmark
SWIFT code: DABADKKK

Danish Kroner (DKK) account

Registration No.	4183
Account No.	4310-821152
IBAN	DK90 3000 4310 8211 52

Euros (EUR) account

Registration No.	4183
Account No.	3001-957171
IBAN	DK69 3000 3001 9571 71

U.S. Dollars (USD) account

Registration No.	4183
Account No.	4310-005029
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The International Rehabilitation Council for Torture Victims (IRCT) is an independent, international health-based human rights organisation, which promotes and supports the rehabilitation of torture victims, promotes access to justice and works for the prevention of torture worldwide. The vision of the IRCT is a world without torture.

Restart Center for Rehabilitation of Victims of Violence and Torture is a non-governmental organization (NGO) active in the field of rehabilitation of victims of torture and violence. Restart was established in 1996. It has been an IRCT member centre since 2003 and is a founding member of the Network in the Middle East and North Africa (AMAN). Restart's Executive Director is Ms Suzanne Jabbour. Drawn by a human rights-oriented approach, Restart's vision builds on the concept of dignity and integrity of each individual. Restart delivers its commitments in the field through a participatory strategy that is applied by a multidisciplinary team of experts and includes awareness-raising campaigns, lobbying, providing comprehensive rehabilitation services as well as social reintegration support in order to help alleviate the human suffering of torture survivors at the individual, family and community level.