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Conceptualising Rehabilitation as Reparation for Torture Survivors: A Clinical Perspective

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'I used to be a strong man, healthy, I played sport for my country, I was strong, I could do so much. I could take care of my parents, my children and my wife. I was a man. I had a family. Now look at me, I am nothing, I have nothing, not my family, no home, I cannot work, I have no life. I am a shell, broken, empty… nothing. Sometimes I eat, I sit, wait…for what, I don't know. I don't want to see anyone, or go anywhere or do anything… the whole day, thinking, thinking, afraid, empty….lost. I don't sleep much, always scared. Then I wake, still scared. I have nightmares of the torture, I wait endlessly for the morning, exhausted, I am tired of living… and it goes like this, every day.

I have no life now. This is a life worse than an animal's, not the life of a man. I have no hope, hope is the privilege of being human – is it not? I am nothing, not even a human being'.

Survivor of torture[1]

Introduction

To feel that one is not *"even a human being"* is a common expression amongst torture survivors. What can restore a 'sense of being human' is not a mere existential or abstract question, it begs a consideration of what rehabilitation actually means. Whilst in international human rights law, the right to rehabilitation is recognised as a form of reparation for victims of human rights violations[2], in the general health field, the term rehabilitation has particular meanings and goals which are usually not explicitly connected to a human rights perspective. This article explores the concept of rehabilitation as reparation specifically for torture survivors, though this may have relevance to survivors of other gross human rights violations.

To date, the understanding of rehabilitation as a form of reparation has remained partial, disconnected between the legal and health and social care disciplines and largely monolithic. In a near vacuum of state provision of rehabilitation services for torture survivors, since the mid-1980s non-governmental organisations have provided rehabilitation services for torture survivors with at least 200 such centres globally, with many differences theoretically, ideologically and in services provided. Most centres explicitly acknowledge torture as a human rights violation, though to differing degrees embrace a human rights perspective in their service models, such that legal understandings of rehabilitation as reparation have little to no bearing on health understandings of rehabilitation practice. Numerous factors conspire to prevent the effective implementation of the right to rehabilitation as reparation, including inadequate or the absence of national legislation, mechanisms and a budget relevant to protecting this right, lack of training for lawyers, health professionals and decision-makers, absence of political will, lack of available services, specialist staff and protection for survivors, inaccessibility of services etc.. Additionally, inadequate conceptual clarity and integration between different disciplinary perspectives (particularly legal and health) has no doubt contributed to this disparate development of rehabilitation in practice, and likely hindered the effective implementation of the right to rehabilitation.

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Rehabilitation in international human rights law

The right to a remedy and reparation is well-established in international law[3], referring to the obligation of a wrongdoing party to redress the damage caused to the injured party.[4] The need to repair has been described as 'basically a requirement of justice to restore human dignity[5]', a task which is 'closely tied up with the social and international order in which human rights are to be realised (Article 28, UDHR)'[6] and which requires nations and communities to 'embrace the need to repair as a collective prescription[7]'. Whilst the right to redress and rehabilitation has been elaborated in various UN principles, resolutions and guidelines[8], the UN Basic Principles on Reparation[9] is the first international instrument to consolidate the right to reparation, expressly recognising rehabilitation as one of the forms of reparation, though failing to provide a working definition.[10] The UN Convention Against Torture (UNCAT) was the first human rights instrument to incorporate rehabilitation as a form of reparation in 1984, establishing in Article 14 that:

> Each State Party shall ensure in its legal system that the victim of an act of torture obtains redress and has an enforceable right to fair and adequate compensation, including the means for as full rehabilitation as possible. In the event of the death of the victim as a result of an act of torture, his dependants shall be entitled to compensation […].[11]

Rehabilitation is one of the five types of redress, the others being restitution, compensation, satisfaction and guarantees of non-repetition. To date, the scope, meaning and reach of the right to rehabilitation remains work in progress. The scoping of rehabilitation by international courts and treaty bodies has been limited[12]; and where the Committee of the Convention Against Torture has increasingly referred to the right to rehabilitation in its conclusions and recommendations, this has lacked consistency in its terminology, specificity and often included with other redress measures or subsumed in data collection requests . The differing legal and remedial powers of the different courts and treaty bodies, and related wording of relevant legal instruments, individual case circumstances or country situations may partly account for the differential practice in addressing rehabilitation.

The lack of clear standards for rehabilitation as benchmarks against which implementation can be assessed, has possibly also contributed to this ambiguity for practitioners and policy-makers on what constitutes rehabilitation, and when the obligation to ensure the means to 'as full rehabilitation as possible'[13] has been met. This ambiguity has been partly addressed by the development of the General Comment 3 by the CAT Committee[14] on Article 14, the right

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to reparation for torture survivors. As the first interpretative statement by a UN human rights treaty body, the Committee of the UN Convention against Torture, on the issue and content of the right to rehabilitation, the General Comment is a significant and landmark contribution to informing the Convention against Torture, other UN treaties and supranational human rights bodies more generally, as well as other supervisory or judicial bodies through which a torture survivor might seek a legal remedy.

The General Comment defines rehabilitation as

> the restoration of function or the acquisition of new skills required as a result of the changed circumstances of a victim arising from torture or ill-treatment. It seeks to enable the maximum possible self-sufficiency and function for the individual concerned, and may involve adjustments to the person's physical and social environment. Rehabilitation for victims should aim to restore, as far as possible, their independence; physical, mental, social and vocational ability; and full inclusion and participation in society.[15]

The right to rehabilitation as reparation extends beyond the provision of general clinical and social care and it is to be distinguished from the right to 'the highest attainable standard of health'[16] and the right to 'habilitation and rehabilitation' for persons with disabilities.[17] Nevertheless, some torture survivors could be recognised also as persons with disability and entitled to benefit from measures taken to achieve the highest attainable standard of health. The right to rehabilitation as a form of reparation under the UN Convention against Torture is however, not subject to progressive, but immediate realisation and the obligation to provide rehabilitation for victims 'may not be postponed'.[18]

Clinical interpretations of rehabilitation

In healthcare, rehabilitation as a concept took hold following the First and Second World Wars when it referred largely to the care provided to soldiers injured and disabled, to alleviate their suffering and facilitate a re-establishment of their lives and integration into society. Since then, the concept and practice of rehabilitation has evolved considerably in a broad range of health fields, for example, medicine, mental health, forensic psychology and psychiatry, neuropsychology, etc. and applied to a wide range of health difficulties, from physical disability, brain injury, heart conditions, neurodegenerative diseases, alcohol or other substance dependency and to criminal offending behaviour. Traditional understandings of rehabilitation in these fields have influenced, to some extent, current rehabilitation services for torture survivors.

Rehabilitation in medicine

In general medicine, rehabilitation is conceptualised as both treatment and as an outcome. Rehabilitation as treatment can be hospital/clinic or community-based and include medical

(including medication), physical, occupational and speech therapies, together with other specialist forms of healthcare, including psychological therapies to support those undergoing physical rehabilitation. Where there is a lack of access to specialist care, rehabilitation may take the form of 'self-help' and home-training (sometimes with professional guidance or support)[19]. In medicine, rehabilitation treatment seeks, as outcomes, the maximum possible self-sufficiency and restoration of function (physical, sensory, mental etc.) for the individual concerned, or the acquisition of new skills to cope in the aftermath of injury, illness, disability, surgery or disease. It also aims to facilitate social integration and participation, sometimes involving adjustments to the physical and social environment of the patient, including family members, as appropriate.

The World Health Organisation's early definition of health, as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'[20] has influenced various definitions of rehabilitation[21]. These were largely dominated by biological medicine, and less emphatic on social well-being and social medicine. The need for social and vocational rehabilitation[22], however, was acknowledged, specifically in relation to disability. This shift to highlighting the significance of the individual's social environment in rehabilitation, was evident in the WHO's position that 'rehabilitation aims not only at training disabled and handicapped persons to adapt to their environment, but also at intervening in their immediate environment and society as a whole in order to facilitate their social integration' and that it is necessary 'to reduce to a minimum all handicapping conditions in all aspects of their environment'.[23]

Currently, as expanded upon later, rehabilitation services for torture survivors vary tremendously in the weight given to the immediate and wider societal environment in their service design, rehabilitation interventions and activities.

Rehabilitation in psychology and mental health

The WHO has referred to psychosocial interventions and mental health treatment for mental, neurological and substance use disorders [24] but not explicitly to the term rehabilitation in relation to mental health. The term rehabilitation is inconsistently used in the field of psychological and mental health, but contested and its popularity waned. This is largely because of its origins in traditional medicine where rehabilitation refers to a specific period of intervention aimed at eliminating symptoms or objective indicators of illness and restoring health and functioning after an injury, disease or illness.

Traditional biomedical conceptions of mental health regard rehabilitation as a time-limited treatment or 'cure' of an apparently discrete pathology or of a problem seen to be arising from the genetics, brain disease or chemical imbalances of an individual, where treatment is usually in the form of pharmacological intervention and sometimes psychosocial

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interventions. Early writings in mental health also identify objectives as helping patients to optimise their social performance in as normal a social context as possible and facilitating optimal social adjustment, by considering the interaction between the individual and the environment[25], sometimes using the term psychosocial rehabilitation[26]. Current understandings in mental health also note the necessity of providing supportive environments in maximising social functioning[27] and fostering social inclusion[28].

The concept of rehabilitation in the psychological and mental health field has evolved in response to two parallel movements, both rejecting traditional notions of rehabilitation and the medicalisation of distress[29]. One is the movement challenging biomedical approaches to mental health problems, led by health professionals and academics, arguing against the reductionist approach which understands the problem within individual biology and genetics, instead of emphasising the multifactorial, complex psychological and social causes of distress and suffering[30]. The other is the mental health 'survivor movement', led by people with enduring mental health problems who use or have formerly used and 'survived' mental health services, which are criticised for their paternalistic approach and biomedical interventions, and because they can be experienced by survivors as coercive, oppressive, disempowering and abusive[31].

Within mental health, rehabilitation has been defined as

> a whole systems approach to recovery from mental illness that maximises an individual's quality of life and social inclusion by encouraging their skills, promoting independence and autonomy in order to give them hope for the future and leads to successful community living through appropriate support.[32]

This definition encapsulates the recovery approach in mental health[33], a contested concept[34] with no one definition[35], though commonly used in reference to the therapeutic process; the outcomes of that process (subjective and objective); and the philosophical approach of a service. It focuses on improving the quality of life of the individual concerned[36], enabling individuals to function in various areas of life, as well as possible, and sometimes despite their psychological and mental health problems, emphasising the 'continuous promotion of therapeutic optimism'[37].

What are now described as recovery-oriented mental health services, recognise the need for crisis and longer-term care, support and interventions aimed at understanding and addressing the social and psychological causes of distress. They adopt a multidisciplinary approach, using health and social care interventions to fulfil outcomes and goals identified by the individual, furthering autonomy and choice and promoting optimal social functioning, even where mental health problems and suffering persist. Overall, in mental health, recovery has displaced the term rehabilitation, emphasising that people affected by severe and enduring mental health problems can have positive, long-term prospects. Whilst there are cultural and regional variations in the conceptualisation and practices to facilitate recovery (sometimes referred to, and dismissed, as indigenous approaches) from psychological and mental health problems, these approaches remain largely subjugated within the dominant global health and global mental health discourses.[38]

Rehabilitation as reparation for survivors of torture

In terms of language, state health services, where available, rarely provide or refer to specialist services as rehabilitation for torture survivors. Some NGO-provided services, however, may describe themselves as specialist rehabilitation services or centres, although in practice not use the terms 'rehabilitation' or 'reparation' to refer to their work. Advocacy activities and legal support to access justice, offered by some NGOs to torture survivors, are described as 'prevention' or advocacy, but not explicitly framed as rehabilitation, unfortunately contributing to somewhat artificial distinctions between 'health protection' and 'legal protection'. In practice, there is still no single, agreed, interdisciplinary definition or approach to the rehabilitation of torture survivors. To better conceptualise rehabilitation as reparation for torture survivors, it is important first, to understand the impact of torture and what it is that rehabilitation should seek to 'repair'.

Understanding the impact of torture and implications for rehabilitation

Torture is not any one specific act, but the judicial interpretation of one or more acts and/or omissions based on a legal definition of torture.[39] Torture methods may be physical and/or psychological, including sexual, and the physical and mental pain and suffering they cause are often as intertwined as the methods. The impact of torture can be multidimensional, physical, psychological, social, interpersonal, functional and existential[40] and can be profound, long-term and severe, yet not always visible[41]. This creates many challenges for medical examinations[42] and for psychological assessments and documentation of torture[43]. Early identification of survivors, with an adequate health assessment and evaluation of the survivor's needs and strengths[44], by qualified health professionals[45], followed by early

intervention with access as soon as possible to services[46] can help prevent health problems becoming chronic or critical. In practice, rehabilitation for torture survivors is a complex, intricate, intensive and specialised endeavour, confounded by unique individual and familial histories and multiple external, environmental factors, such that rehabilitation cannot be equated with general health and social care.

Rehabilitation can rarely restore the torture survivor's health, well-being and life as it was prior to the experience of torture. Torture destroys the core of humanness – it ruptures the capacity to trust and to form relational bonds with other human beings, alienating survivors from others. For many survivors, rehabilitation is the antithesis to torture and its dehumanising, degrading, fragmenting and isolating effects. Rehabilitation, first and foremost, is about survivors being recognised and treated as human beings. It is about enabling survivors to form relational bonds with others, including family and community members again, to function and live as human beings, worthy of respect, dignity and inclusion – in services and society.

Chronic ill-health related to torture can profoundly affect daily life, at home, with peers and friends and at work or education with poor social functioning. This may lead to the inability to work or pursue any educational or vocational paths, sometimes leading to a breakdown in family functioning and poverty. At an interpersonal level, torture can lead to an impairment of trust, communication and the capacity to establish or maintain any kind of relationship with another person, including family members. This may be as a result of decreased perceptions of control and the denigration of individual and group identity[47]. The impact can be debilitating and severe, leading to family conflict, family breakdown, potential intimate partner violence and an adverse impact on parenting, which in turn can heighten the vulnerability of children in the family. Rehabilitation may never lead to well-being or effective social and family functioning. The multiple effects of torture on children can endure[48] and parental trauma may lead to intergenerational problems[49], affecting children later in their own adult relationships, families and future social functioning.

Torture can raise intense existential angst for many survivors, destroying their core beliefs in humanity and in themselves as human beings of worth and belonging to humanity. This in turn can be compounded by stigma, shame, social exclusion, social deprivation and further harm, leaving the survivor literally at the periphery of society: isolated, excluded and vulnerable to marginalisation, discrimination, exploitation and further harm; and unable to participate in social, community and political life[50]. At the community level, the rupturing of social bonds can be compounded by intense, pervasive and chronic fear with profound mistrust and mutual suspiciousness. This in turn can lead to fragmentation in society, marginalisation and a breakdown of social cohesion. Where survivors are unable to access appropriate rehabilitation, the experience of stigma and discrimination can prevent any integration into society. For some, the use of substances (alcohol, drugs etc.) or other means to cope can lead to further health problems, raising public health and other concerns.

Rarely a discrete, isolated experience torture can be multiple experiences, of varied duration, circumstances, context and combination, repeated over time, over different periods of detentions or of armed conflict and organised violence. The context of ongoing threats, intimidation, persecution, stigma against survivors and their families, poverty and impunity, all add to the continued and sometimes repeated and multiple harms and suffering endured by survivors and their families. Even where some torture survivors find ways to continue building trust, relationships and their lives, any threats and crises in their lives and social environment (e.g. social stigma, unemployment, loss of housing, food insecurity, xenophobia, discrimination), and future traumas, losses and events (such as a resurgence of civil unrest and conflict, racist violence in the country of asylum, death of family members etc.) may trigger repeated relapses. Rehabilitation, then, does not necessarily have an end point for survivors. 'Repair', in practice, usually means that rehabilitation can at best seek to minimise suffering and enable a 'good enough' outcome (for example, improving health, enabling dignity, self-value, social connectedness, social functioning and regaining a sense of purpose and to live with hope, beyond the devastating consequences of torture), not a permanent 'fix' to a pre-torture state of health and well-being (restitution to the *status quo ante*).

Given the different and specific social, economic, legal and political contexts in which survivors live, and their unique circumstances, experiences and histories of persecution and torture, as well as their own personal life histories, age, gender, cultural background, beliefs etc., the impact of torture is highly heterogeneous and unpredictable, and varies for each person, family and community. There is no one, single rehabilitation service or method or intervention which works for all survivors, in all contexts[51] but it is widely accepted that rehabilitation requires a holistic approach[52] specific to the needs of each survivor, with the provision of specialist services for torture survivors[53], which 'may include a wide range of inter-disciplinary measures, such as medical, physical and psychological rehabilitative services; re-integrative and social services; community and family-oriented assistance and services; vocational training; education etc'.[54] External factors can also prevent the effectiveness of rehabilitation on survivors (such as lack of income, impunity, ongoing conflict, lack of security, immigration detention, discrimination, homelessness etc.), such that the protection of other civil, political, social and economic rights of survivors are highly relevant, alongside rehabilitation.

Cross-cutting human rights principles such as non-discrimination[55], gender-sensitivity[56] and culture-sensitivity[57] are relevant to reparation measures, procedures and rehabilitation services and practices. Sexual torture can destroy the social fabric of families, communities and societies by deliberately violating social taboos, gender-based, cultural and religious norms, values and beliefs. Torture can also target particular beliefs and cultural, ethnic and other identities, with the impact mediated by meaning-making, which in turn is inevitably mediated by language and culture. Thus, rehabilitation is rarely the same for even the same

methods of torture, instead the cultural and gendered context of torture and of the survivor become crucial in rehabilitation.

Approaches to rehabilitation for torture survivors

Globally, the limited implementation of the state obligation to ensure the means to as full rehabilitation as possible for all survivors, in practice, has led to the proliferation of non-state rehabilitation services for survivors; and their diminishment in numbers, this volatility being related to increasingly scarce funding and in some areas, intimidation and reprisals from state authorities. Historically, these non-governmental organisations are run by a small number of staff, with differing backgrounds, often managing vast caseloads with basic facilities and minimal resources. These services, across regions, have adopted different approaches to rehabilitation. Approaches to rehabilitation refers to the broad aims, principles, values and theoretical preferences of a service, ultimately, which shape the overall service model: the design, content and delivery of service components, interventions and activities.

Notwithstanding these different approaches, there is broad consensus amongst specialist practitioners working with torture survivors that rehabilitation services need to be safe for survivors and for staff, appropriate, specialist and holistic. Holistic care for torture survivors refers to a philosophical stance to health and overall well-being, which recognises the inter-relatedness of physical, psychological, social and interpersonal well-being. The wide range of needs are recognised as requiring a wide range of specialist interdisciplinary care, though not necessarily within the same service. Whilst many domestic reparation programmes in states undergoing transitions include some elements of general psychosocial care and assistance, this often falls short of holistic and specialist rehabilitation.

The various components of rehabilitation services for torture survivors can include:
(a) Early identification, assessment of specific and multiple needs, and referring to services offering necessary and relevant specialised care.
(b) Psychological services: individual-based, family-based and group-based therapies; and documentation of the impact of torture.
(c) Medical services: Medical assessments and interventions, including physiotherapy, formal documentation of torture, and in some services, resources permitting, the provision of basic medical care and medication. The lack of necessary equipment, medication, resources and health personnel to offer medical investigations such as x-rays, scans, surgery etc. may lead to referrals to appropriate services, where they exist and are accessible.
(d) Community-based services: Community support and activities to promote social connectedness and a supportive environment, and to challenge stigma and discrimination against survivors.
(e) Social and welfare services: Facilitating access to food, adequate shelter, clothing, social support for survivors and their families.
(f) Legal services: Providing information, facilitating legal representation, assistance with family re-unification, support in accessing to justice and litigation.
(g) Education-related services: Facilitating access to schooling and integration into education, supporting educational and psychosocial development of children, support to school staff and facilitating native language education.

(h) Vocational services: Facilitating integration into work, livelihood-development to increase productive capacity and skills-building etc.
(i) Advocacy services: Facilitating individual-level advocacy, community awareness-raising and collective survivor-led advocacy.

Increasingly, despite acknowledging the need for holistic care, many rehabilitation services focus on only one component (e.g. psychological services or legal services). This lack of holistic rehabilitation service provision is due to a combination of multiple contextual and theoretical differences.

The variance and specificity of domestic legal, political and social contexts inevitably influence survivors' diverse experiences and the impact of torture on them, their families and communities. In some regions, ongoing violations may mean that services prioritise new torture survivors and their immediate social welfare and protection needs. Other services may focus only on refugee torture survivors, and on one component of rehabilitation (e.g. psychological support), whilst some services prioritise community-based support and social rehabilitation, where numbers of victims in local communities are high and specialist health professionals with relevant expertise are unavailable. Demands specific to the domestic and regional contexts can then drive rehabilitation approaches, further tempered by financial constraints and opportunities where funding can shrink dramatically and unexpectedly. The ideological and philosophical proclivities of service providers have further driven rehabilitation service designs and delivery[58]. Differences in the nature of services offered is also determined by who is able to access those services and their needs.

Rehabilitation services vary in their inclusion criteria, some operating narrow criteria based on their own definitions of survivors, for example, only accepting survivors with refugee status, excluding undocumented migrants or other asylum seekers, or including survivors of human trafficking, domestic violence, 'war trauma' or refugees who are not torture survivors. Some only accept survivors meeting a particular threshold of distress, denoted by a psychiatric diagnosis, such as post-traumatic stress disorder. In state reparation programmes, access to rehabilitation may be denied to some due to domestic definitions of victims and eligibility criteria. Access to rehabilitation services or state reparation programmes may be restricted to particular survivors or groups of survivors due to distance, lack of financial or physical means, availability of transport, disability or threats of further intimidation or harm etc..

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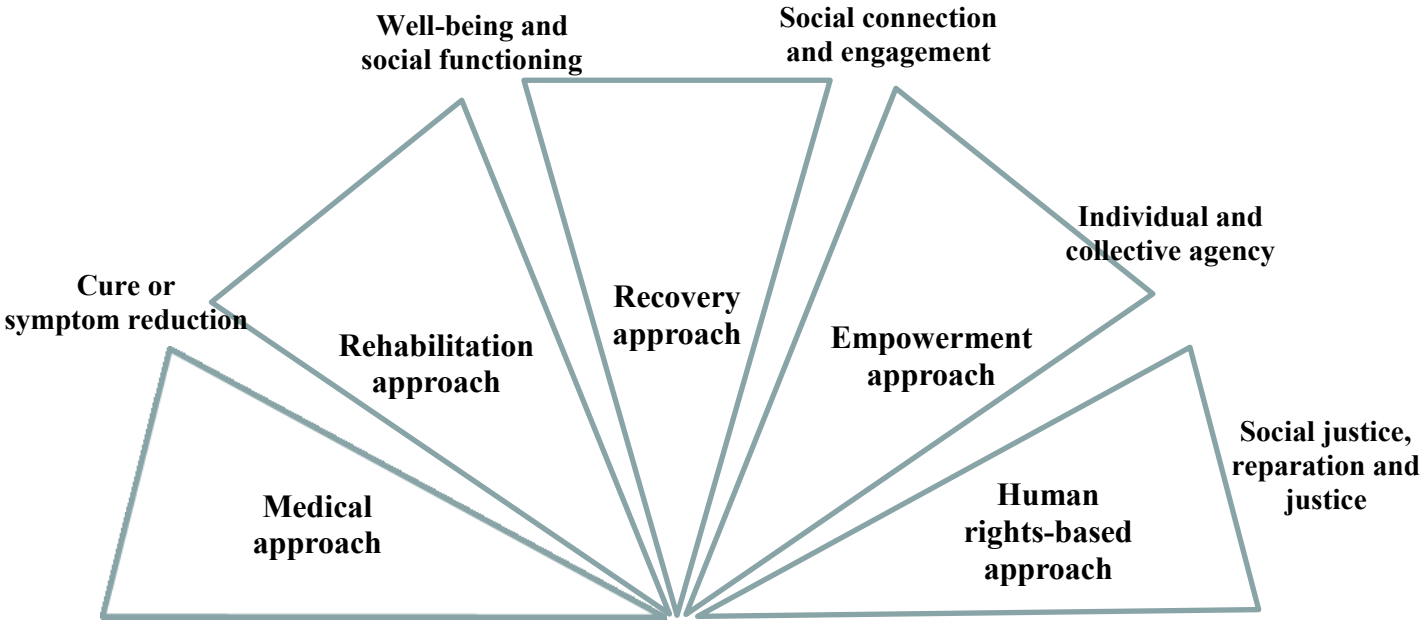

Figure 1. Approaches to rehabilitation for torture survivors

Theoretical differences in approaches to rehabilitation (figure 1) partly reflect historical developments in the health and social care fields. The historical dominance of the *biomedical approach* in general healthcare (often described as the medical model) is characterised by a focus not only on symptom-reduction and medical cure, but also on improving task-related functions, daily social functioning and self-sufficiency of individuals as goals[59]. Since the mid-1980s, the biomedical approach, has influenced many rehabilitations services for torture survivors (*rehabilitation approach*), though direct medical interventions remain limited, given limited resources and access to specialist staff, equipment and facilities.

The biopsychosocial model of health, in focussing on the interaction of multiple biological, psychological or social processes in health and illness[60] challenged the biomedical approach, its reductionism and narrow emphasis on biological factors and pharmacological and medical interventions. In mental health, the rejection of the biomedical model in favour of a biopsychosocial model, heralded the *recovery approach* which recognises the multiple influences on mental health, including biological, social and psychological factors. This approach acknowledges the resilience, resources and strengths of individuals and their families, and considers the survivor's full social, cultural and spiritual background and environment. Recovery is seen as a continual process of managing the impact of mental health difficulties on daily functioning and social integration; managing the impact of social stigma, the loss of hope, discrimination and disempowerment related to mental health problems; and a process of gaining a positive sense of self, new meaning and a sense of purpose in life – it is a process of fostering hope. Rehabilitation is then envisioned as a process of recovery, not a search or achievement of a final state of recovery.

Rehabilitation services for torture survivors may draw on aspects of the recovery approach, emphasising the need for both medical and psychological care to decrease symptoms, and improve social functioning in everyday life (e.g. family roles, daily tasks, education, work). However, ideologically, many recovery-oriented rehabilitation services for torture survivors still largely locate 'the problem' (and target of rehabilitation interventions) within individuals and commonly fail to explicitly conceptualise, or target in their approaches, the social and political causes of those needs. Thus, torture, poverty, homelessness, vagaries of the asylum system, continued persecution, deprivation and impunity may be acknowledged as relevant to the person's suffering, but not necessarily as a relevant focus for the service or health interventions. These services typically position themselves as specialised health or clinical services, with the recovery paradigm still encapsulated within a wider health (or illness), not human rights, framework.

Empowerment approaches[61], became particularly influential since the mid-1980s. These approaches, with their variations, emphasise the environmental influences of the social context on well-being. They explicitly foreground individual strengths, individual agency, survivor participation and social connection with others in similar situations, towards collective support and social action within communities. In general mental health services, empowerment approaches increasingly de-emphasise the role of specialist medical and psychological services and technologies (e.g. psychotherapy, psychotropic medication), which are seen as oppressive, serving the *status quo* and as stripping people with mental health problems of their sense of agency and personal and social resources. Health professionals are then positioned and engaged as partners, alongside those using mental health services, collaborating in different aspects of service delivery, rather than, as authoritative experts imposing their specialist knowledge. Some rehabilitation services for torture survivors and domestic reparation programmes may promote community engagement and support, in their community-based activities, important in addressing the profound sense of social dislocation and isolation engendered by the experience of torture and in assisting survivors with vocational and educational integration and livelihood development. Some draw on the language of empowerment without necessarily focussing on genuine and meaningful survivor participation or on enabling social activism. Empowerment approaches share one key goal with human rights-based approaches: the aim of increasing individual and collective agency of survivors.

A human rights-based approach to the rehabilitation of torture survivors can be described as the adoption of human rights as a conceptual and guiding framework; and the application of human rights principles in all aspects of rehabilitation assessments, interventions, documentation of torture and monitoring of patterns of torture, their impact and policy implications. Essentially, a human rights-based approach to rehabilitation recognises the interdependency of civil, political, social, economic and cultural rights, and the potential inter-linked impacts of violations on survivors *and* their family members. It places physical, psychological and social health firmly within the context of security, social justice, equity and non-discrimination and frames health not just as 'needs' but as rights to safety and physical and mental integrity; various protections, freedoms, reparation and justice. As such, a human rights-based approach to rehabilitation explicitly acknowledges, names and seeks to

address the multi-level causes of harm and distress: the practice of torture and other human rights violations; the lack of effective legislation, mechanisms and monitoring to end impunity; the lack of access to justice and redress; structural inequalities, social stigma and discrimination.

Non-governmental rehabilitation services drawing on a human rights-based approach often offer different combinations of specialist medical, psychological, social, welfare and legal support and interventions, for torture survivors and their families. They may also engage in prevention activities, including raising awareness of the public and policy and decision-makers of the prohibition of torture, the right to rehabilitation and the impact of torture and other social and political factors and injustices on survivors, their families and communities; advocating for primary prevention; supporting survivors to ensure protection from *refoulement* and further harm; and to seek reparation and justice. That said, not all survivors wish to pursue justice, or feel safe and emotionally robust enough to engage in the justice process. The extent to which seeking and achieving justice 'heals', and therefore whether it is an aspect of the rehabilitation process, is another matter, with limited and inconclusive evidence[62].

Generic psychosocial support, where included in state reparation programmes, may fall somewhere in-between biomedical and empowerment approaches, not necessarily explicitly adopting a human rights-based approach, despite such state programmes being established ostensibly as responses under human rights obligations. Where health rehabilitation is said to be available within state general health services, often these services are offered in silos and lack an integrative approach to the range of inter-related, complex needs of torture survivors. Medical and psychological interventions available within state healthcare are specialised, though not specialised in addressing the specific, complex, broad and potentially long-term nature of the impact of torture. In other words, they are rarely holistic and specialised for torture survivors.

A widening conceptual schism within NGO rehabilitation services, particularly in Europe and North America, has emerged in the last decade between what are considered prevention activities and legal support in the pursuit of justice for survivors, legal rehabilitation, the domain of lawyers; and clinical and health care interventions or 'treatments', the domain of healthcare practitioners. Social rehabilitation[63] and vocational/educational rehabilitation[64], practitioners, where available, are recognised for their contributions, but often seen as peripheral to psychological services. Although not entirely surprising (since the psychological impact of torture can impact on all spheres of daily life and social functioning within the family, home, education and work), the construction of the harm of torture as being exclusively or predominantly psychological trauma, and the centering of psychological services as constituting, on their own, 'rehabilitation' is a distinct and problematic trend. This is also evident in many state healthcare or reparation programmes, which focus on psychological 'trauma-focussed' services, effectively distant from integrative, holistic rehabilitation as reparation. In the service of evidence-based practice, the privileging of certain types of evidence of the effectiveness of certain psychological interventions, (which

draw on the biopsychosocial approach, though without the 'social') may partly account for this. Another factor precluding integrative rehabilitation, based on a human rights-based approach, within state health and social care systems, is that staff in these services may be prevented from engaging in activities deemed to not be strictly health interventions, and any criticisms of state policies or practices may lead to threats, surveillance, expulsion from one's job or harm.

One serious consequence of this trend is the transmutation from recognising torture survivors as victims of human rights violations to viewing them as a 'clinical group', defined not by the shared experiences of torture or their right to rehabilitation as reparation for human rights violations, but by the narrow lens of the psychological health impact of torture. Conflating torture with illness categories (e.g. post-traumatic stress *disorder*) locates the problem of torture within the individual[65]. Further, it obscures the nature of torture as a crime and as a brutal assault on the person and their family, and frames torture as a health problem, like any other, which needs to be 'treated', irrespective of the context or cause (whether ill-treatment, road traffic accident trauma, natural disaster, intimate partner violence, bullying etc.) In rejecting the psychologisation of torture and the exclusive focus on psychological symptoms[66], some argue that psychological interventions should be framed within a human rights-based approach; focusing on the causes: the nature and wide impacts of torture, as well as the specific personal, cultural, and political meanings this holds for each individual or family, within their social, economic and political contexts[67]. As such, psychological interventions in a human rights-based approach can indeed address particular health difficulties, but they should seek to enable the survivor to feel validated, absolved of any guilt (that they have something inherently wrong with them, that they are less than human, that they caused this harm and suffering to happen to them or that they are somehow emotionally or constitutionally weak and to blame). In a human rights-based approach to rehabilitation, torture should be explicitly acknowledged as a human rights violation, not as an illness or a disease; and rehabilitation as a contribution towards reparation, in recognition of a wrong-doing and harm inflicted upon them.

In summary, rehabilitation is an umbrella term for a range of specialist services, activities and interventions to support and enable torture survivors, their families and communities to move forward, beyond the experiences of torture. However, in practice, state rehabilitation services specialised for torture survivors are largely absent, and where state reparation programmes exist, there is partial coverage of rehabilitation. Overall, in NGO-provided services, there is a lack of consistency in the approach to rehabilitation and the content of rehabilitation components, with limited provision of comprehensive, integrated rehabilitation services. Social, legal, economic and political factors specific to each context no doubt contribute to the emergence of this diversity and inconsistency. Yet, the historical lack of a shared definition of rehabilitation which integrates legal and health understandings, has likely maintained these differences and hindered effective dialogue and collaboration between rehabilitation health and social care rehabilitation experts and lawyers, which in turn may have prevented more effective interdisciplinary efforts, with the participation of torture survivors, to ensure state implementation of the right to rehabilitation.

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Bridging legal and clinical perspectives on rehabilitation

Conceptual clarity on rehabilitation and congruence between legal and clinical understandings are perhaps the necessary starting blocks for strategies to ensure the effective implementation of the right to rehabilitation as a form of reparation. General Comment 3[68] has made an immense and significant contribution to international law in the articulation of rehabilitation as reparation, whilst attempting to navigate the theoretical tensions in service delivery models. For example, in defining rehabilitation, General Comment 3 leans on prevailing clinical discourses, leans on the traditional medical rehabilitation approach to define rehabilitation goals ('restoration of function or acquisition of new skills or the acquisition of new skills' and as 'self-sufficiency'[69]); whilst also drawing partly on the recovery approach in stating that 'rehabilitation for victims should aim to restore, as far as possible, their independence, physical, mental, social and vocational ability; and full inclusion and participation in society'[70].

The General Comment also draws on empowerment approaches by noting the importance of the discourse of survival and strengths of victims of torture[71], and the related language of victim and survivor as interchangeable, and as a choice of the person who has been tortured[72]. Not surprisingly, the General Comment exemplifies a human rights approach, underlining rehabilitation as a form of reparation[73] and emphasising a victim-centred approach throughout; stating that the 'victim's participation in the selection of the service provider is essential'[74].

On the whole, the General Comment reflects a range of approaches to rehabilitation, though only partially integrates these diverse approaches, thereby, at times reinforcing the prevailing conceptual ambiguities, contradictions and differences in rehabilitation practice.
The emphasis on the need for assessment by medical professionals[75] to access rehabilitation is at odds with an interdisciplinary, holistic conceptualisation of rehabilitation. Further, the link between activities involving 'adjustments to the person's physical and social environment'[76] (which in medical rehabilitation refers largely to adjustments in the immediate environment to facilitate social functioning, mobility etc.) and those activities and interventions which seek to also address the wider, social context in which rehabilitation takes place (to enable 'full inclusion and participation in society'[77]), is not made explicit. Beyond the conceptual ambiguities, the potential fluidity of the concept and practice of rehabilitation in response to theoretical and research advances and trends in the field, remains a challenge to effective implementation. The evolving interpretation of rehabilitation by international courts and treaty bodies could allow for this, though this does not circumvent the need for an integrative, interdisciplinary understanding of the right to rehabilitation.

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Conceptualising rehabilitation: towards an integrative understanding

Overall, a legal understanding of rehabilitation explicitly frames rehabilitation as a reparation measure, comprised of specialised services offering medical, psychological, social, educational and legal rehabilitation to survivors and their families. Health (clinical) and social care understandings frame rehabilitation in diverse ways, including as symptom reduction, alleviation or amelioration of health difficulties related to torture. Wider understandings of rehabilitation in the field include social welfare, educational and vocational support, social engagement, integration and community support and legal support and advocacy.

There are at least three areas with scope for further conceptual integration and research. The first area, beyond the scope of this article, is the relationship between different rehabilitation interventions; and research on which interventions (e.g. legal support, social welfare advice and enabling access to housing, food etc., psychological therapy etc.) are most effective, alone or in which combination. The second area of conceptual and research gaps is role of the social, political, legal and wider context in which rehabilitation takes place, in ensuring the means to as full rehabilitation as possible; and in facilitating maximum recovery. The availability of rehabilitation services does not mean that in practice survivors can meaningfully access or benefit from rehabilitation. Impunity, lack of access to justice, ongoing threats, political instability, conflict, social deprivation and insecurity, poverty, social stigma, marginalisation and discrimination can all severely hamper the provision, access to and the rehabilitation process and impact on survivors, rendering any rehabilitation measures potentially meaningless, ineffective and unsustainable. Assessing the impact of these extraneous contextual factors on rehabilitation provision and effectiveness would be the first step in identifying which factors need to be prioritised by states and targeted for improvement by ensuring appropriate state policies, mechanisms and processes, for example, to judicial reforms to end impunity and to ensure the safety of survivors; economic reforms and immediate and sustainable social welfare and protection for survivors and their families etc., alongside ensuring effective rehabilitation service provision.

The third area for further exploration and research is the relationship between rehabilitation and other reparation measures including restitution, compensation and satisfaction measures and the procedural right to justice. One question is whether the right to rehabilitation exists independently, and/or partly within the right to compensation, satisfaction and restitution[78]. The inclusion of rehabilitation within restitution is highly theoretical, since the extent to which rehabilitation can ever restore a victim's health or well-being to a pre-violation state is questionable. Where compensation includes monetary awards for non-pecuniary damage; and for treatment costs already incurred, or anticipated, rehabilitation can be said to partly exist within compensation measures. Satisfaction measures including the building of health facilities, or free healthcare, or the provision of health programmes for a community can legitimately be seen as encompassing rehabilitation, albeit partially, and not necessarily for each individual victim.

The specific relationship between reparation measures, in terms of what can be considered and experienced as rehabilitative for survivors, is another question with a dearth of empirical

evidence. Whilst this relationship and the related rehabilitative processes for survivors is a separate issue from what is considered an effective remedy, the question has implications for how meaningful and effective remedies are in achieving the goals they intend: reparation for survivors. Historically, international instruments have tended to be silent on the appropriate form and extent of remedies[79], particularly notable with regards to rehabilitation. Although the Principles of Reparation state that reparation should be 'full and effective', taking into account individual circumstances, and be 'appropriate and proportional to the gravity of the violation and the circumstances of each case'[80], like the General Comment, they do not explicitly point to the relationship between reparation measures in terms of potential rehabilitation.

In integrating legal and clinical perspectives, rehabilitation can be conceptualised as having distinct yet, at least six inter-related dimensions:

1. Rehabilitation as *measures* to ensure reparation
2. Rehabilitation *activities and interventions*
3. Rehabilitation *functions*
4. Rehabilitation as the individual, family, community and societal *processes of recovery*
5. Rehabilitation as the *environment or recovery context*
6. Rehabilitation *outcomes* of the above, at individual, familial, community and societal levels.

All *measures* to ensure restitution, compensation, satisfaction and to end impunity and ensure justice, alongside different types of rehabilitation *activities and interventions* (e.g. psychological, medical, social, legal), offered in combinations specific to the needs of the individual, family or community, are potential means to achieve positive rehabilitative outcomes. These measures, interventions and activities require key *functions* to be served. At an individual level, rehabilitative functions may include validation of humanity, restoration of dignity, affirmation of individual worth, affirmation of survivors as deserving of reparation, recognition of wrong-doing and resulting harm, re-directing blame away from the survivor to the state, amelioration of suffering, enabling individual health and well-being, enabling re-connection with life plan, enabling trust in society, enabling psychological closure and remembering the past but not being imprisoned by it or by its impact. At the societal level, rehabilitative functions can include public condemnation of wrong-doing and of those responsible, public acknowledgement of state responsibility, re-directing responsibility for reparation and societal change to state, affirming societal values and morality, ensuring positive response from society towards survivors, ensuring collective willingness to deal with the past and future, ensuring security and safety, correcting historical inequities, ensuring social inclusion of survivors, ensuring conditions for trust and social cohesion, enabling reconciliation, remembrance and closure, without forgetting, denial or silence. Broadening the conceptualisation of rehabilitation as a function enables practitioners, service providers and decision-makers to be alert to and exploit every avenue available (including non-treaty procedures, complaints mechanisms, criminal procedures etc.) with the potential to facilitate individual and/or social recovery.

The process by which these rehabilitative functions are achieved is referred to here as the *recovery process* for individual survivors, their families and for communities, heterogeneous processes specific to each case and its context. Individual recovery may depend on family recovery, which in turn can support community and societal recovery processes. Yet, risks to the recovery process can present in the lack of access to appropriate rehabilitation services, and in the lack of an appropriate recovery environment.

The *rehabilitation or recovery environment* refers to the elements and conditions in the wider context, conducive to, or in some cases, essential to the recovery process. The specific social, political, cultural, economic and legal contexts of the violations and the context in which reparation measures are made, can all shape, facilitate or impede recovery.
Key elements of the recovery environment[81] for torture survivors include security (physical security, no threats of refoulement and a guarantee of non-repetition)[82]; adequate welfare (housing, clothing, food); societal acknowledgement of wrongdoing, not denial or silence; societal support of survivors, rather than indifference, blame or hostility; availability of social support networks (e.g. family, friends, religious community); and justice (efforts at establishing truth and ensuring justice); absence of societal prejudice and discrimination (e.g. in accessing healthcare and justice).

The rehabilitation environment includes the immediate family environment and the community, material, social and wider context of survivors. The family context of the survivor, particularly when more than one member has been tortured or witnessed torture is crucial to the recovery and functioning of survivors and their whole family[83]. The community context can also be an obstacle or instrumental to the recovery process, for example where sexual torture can lead to shame, stigma and ostracisation of survivors by their community[84].

Rehabilitative outcomes refer to individual, family and societal recovery. Indicators of recovery vary according to health models of well-being, cultural understandings of justice and cultural, political, religious and gender differences in constructions of individual and social well-being. At the individual level, outcomes are typically defined by the particular approach to rehabilitation, though they include physical and psychological health outcomes, improved interpersonal and social health and relationships, effective social role-functioning, re-connecting with and social integration into a community or society, improved agency and activism, identity affirmation, personal development and finding meaning in experiences and suffering. Rehabilitative outcomes can vary for individuals, families and communities, and the cyclical recovery process necessitates a recognition of the idiosyncratic, multi-level and complex nature of recovery.

An integrative model of rehabilitation as reparation

Rehabilitation is defined here as a process of recovery which requires a range of reparation measures, rehabilitation services, interventions and activities to enable the torture survivor to survive harm and suffering endured; and to achieve various outcomes for the individual

survivor, their family and communities. It is a process which recognises and seeks to mobilise the strengths of the survivor, whilst recognising the importance of redress, justice and protection from harm, stigma and discrimination against victims, their families and communities to the recovery process. This definition promotes a 'whole systems human rights approach' to rehabilitation, one which integrates aspects of health and legal understandings of rehabilitation. Specifically, a whole systems human rights approach recognises that rehabilitation and process of recovery does not take place in a social, economic, political or legal vacuum. It recognises the importance of multiple and interlinked systems and contexts which interact, facilitate, influence or hinder the dynamics of recovery for individuals, their families and communities. These include the availability and quality of family and community networks of support; the material, economic, social, cultural and political contexts and systems in which survivors and their families live; and the legal system and context.

The model proposed (figure 2) resembles a revolving door, in recognition that the recovery process is not linear; and that for many survivors and their families the recovery process can be cyclical, ongoing**,** long-term and involve multiple entry and exit points. It is a process which requires different interventions, targeted at different levels (individual, family, community), provided simultaneously or sequentially at different times; and different remedial measures, for different survivors and communities and in different circumstances. The door to recovery may never be conclusively shut. Hence, relapse, or an interruption to the recovery process is always possible, necessitating re-entry into the recovery (rehabilitative) process. Some may not be able to access, or feel psychologically ready to engage in, rehabilitation services (e.g. where there exist obstacles to access or where other immediate basic needs and priorities dominate); or to engage in justice mechanisms, but may do so later. For some, despite access to rehabilitation services, health crises may be triggered by political changes, legal decisions, thwarting of the justice process, social stigma, victim-blaming, social exclusion, indifference or rejection, re-opening wounds and exacerbating suffering. Sometimes, satisfaction measures for a community may be realised long before individual survivors receive compensation, access rehabilitation services or justice. Further, not all reparation measures can be offered or always be ensured for all survivors and given harm from torture is rarely fully reparable, it may be "more appropriate to search for the best fitting measures in light of the harm suffered and the characteristics of the victimisation"[85]. Efforts to facilitate societal recovery (e.g. social reconciliation), or to ensure justice may precede measures, interventions or activities to enable individual recovery, yet their inter-relatedness is important.

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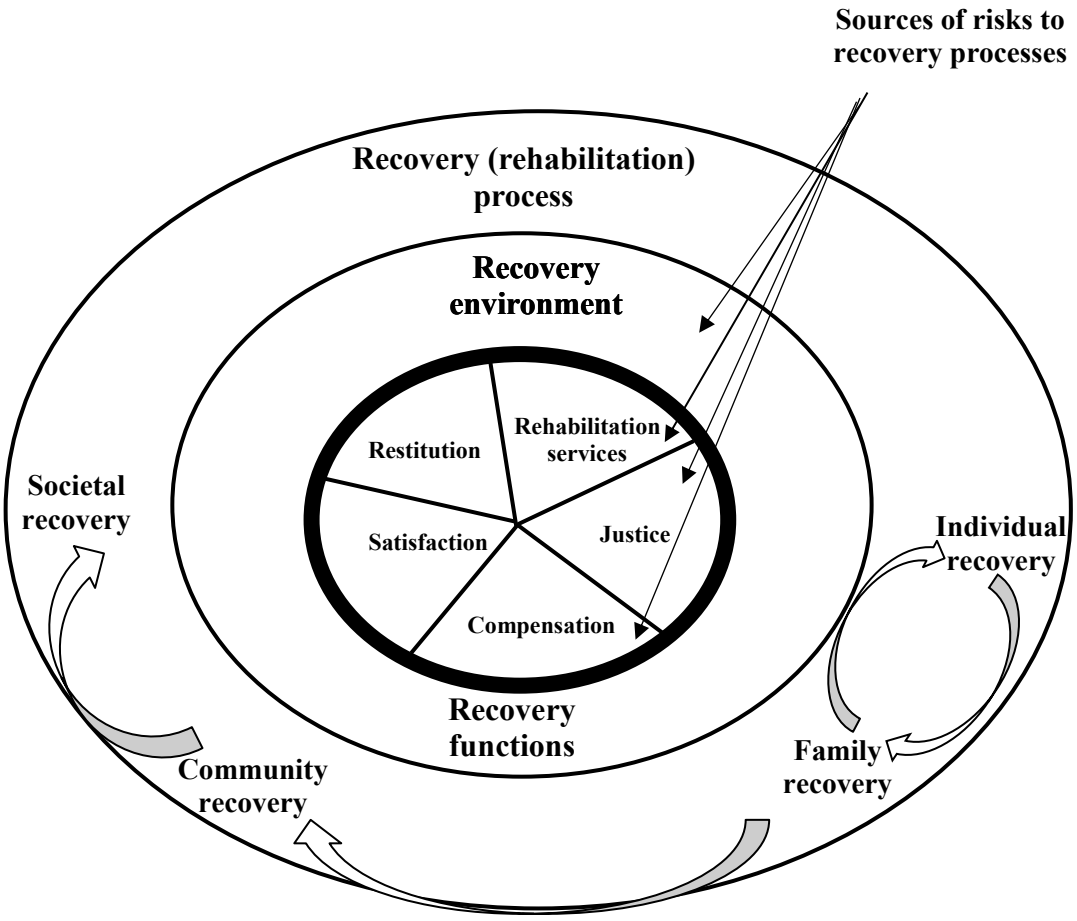

Figure 2. An integrative model of rehabilitation as reparation: a 'whole systems recovery approach'

Future research could help develop this conceptual model of rehabilitation by clarifying the nature and significance of the relationship between measures seeking social justice (e.g. addressing social inequalities and discrimination) and measures to ensure criminal accountability for torture, specifically in terms of their rehabilitative value for individual survivors, and for their families. The model proposed here does not adequately differentiate between the actual measures for reparation and justice, and the mechanisms and procedures necessary to access and ensure them. Future research could explore, in different contexts, the rehabilitative value of these different reparation measures and their related mechanisms; as well as the risks they pose in terms of causing harm or disrupting or hindering the recovery process, for survivors and their families.

Conclusions

In conclusion, inconsistent rehabilitation practices and the implementation of the right to rehabilitation can be improved, at the very least, by conceptual clarity and integration of health and legal understandings of rehabilitation. The call for concerted interdisciplinary

collaboration and dialogue, particularly between lawyers and clinicians, and for such conceptual integration however, is not intended as a feeble request to recast all reparation measures, or justice in the idea that they must heal victims[86]. Rather, it is an invitation to recognise justice and all reparation measures as potential routes to individual, family, community and social recovery. Theoretical differences between approaches to rehabilitation may not be reconciled, but systematic, empirical and interdisciplinary research exploring the 'revolving door' rehabilitation model; and survivors' experiences and views on reparation, offer a way forward. Such research, specifically, can address the questions of what 'works' best towards rehabilitation and recovery, in terms of different reparation measures, rehabilitation interventions and activities, in which combinations, for who, (individuals, families and communities), how, when and under which circumstances. The absence of evidence of the effectiveness (in achieving positive rehabilitative outcomes) of particular remedies or mechanisms, separately or in combination, to ensure reparation does not mean that the right to reparation is undermined. But interdisciplinary research may highlight opportunities to harness and maximise the potential for reparation and recovery, by examining different ways to enable survivors to 'feel human' again, to humanise, where torture has sought to dehumanise and brutalise individuals, families, communities and society.

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NOTES

1. Torture survivor formerly in psychological therapy with the author, as part of a rehabilitation programme. Both terms, victims and survivors, are used interchangeably in this paper. Although the term victim serves as a recognition of a violation, in the health fields, the term 'victim' is outdated and carries negative connotations, and the term 'survivor' is also criticised by some of those who use health services, in that it implies an end to their suffering and a denial of ongoing harm.
2. For example, Basic Principles and Guidelines on the Right to a Remedy and Reparations for victims of gross Violations of international human rights and humanitarian law. Adopted by General Assembly Resolution UN Doc. A/RES/60/147, 16 December 2005 (hereinafter: 'Basic Principles').
3. Mahmoud Cherif Bassiouni, "International Recognition of Victims' Rights," *Human Rights Law Review*, vol.6, no.2 (2006), pp. 203-279, at p.207. See also, UN Human Rights Council resolution on Torture and other cruel, inhuman or degrading treatment or punishment: rehabilitation of torture victims/survivors, A/HRC/22/L.11/Rev.1, 19 March 2013; UN Basic Principles and Guidelines on the Right to a Remedy and Reparation, above no.2.
4. Ibid. The principle of the right to remedy and redress was central to the 1928 decision of the Permanent Court of International Justice, in the Chorzow Factory Case. While the case is not a human rights one, it is highly relevant in terms of the principles it establishes regarding the right to reparation. See: *Factory at Chorzow (Germany v. Poland)*, 1928 P.C.I.J. (ser. A) No.17 (Sept. 13).
5. Theo van Boven, 'The need to repair. International Journal of Human Rights', vol.16, no.5, (2012):694.
6. Ibid.
7. Ibid., p.694-5.
8. See, Basic Principles (supra note 2); UN Human Rights Council resolution on Torture and other cruel, inhuman or degrading treatment or punishment: rehabilitation of torture victims, A/HRC/22/L.11/Rev.1, 19 March 2013; UN Office of the High Commissioner for Human Rights (OHCHR), Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ('Istanbul Protocol'), HR/P/PT/8/Rev.1, 2004.
9. Basic Principles, supra note 2.
10. For a fuller discussion, see Clara Sandoval, 'Rehabilitation as a form of reparation under international law'. (London: REDRESS, 2009).
11. United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984) (herein the 'UN Convention Against Torture' or 'UNCAT'), Article 14.
12. A full discussion of the jurisprudence is beyond the scope of this article, see REDRESS (supra note 10).
13. Supra note 11.
14. UN Committee Against Torture, General Comment no.3, 2012: Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment: implementation of Article 14 by States parties, 19 November 2012 (hereinafter: 'General Comment' or 'GC').
15. GC para.11. This definition is echoed elsewhere: UN Human Rights Council Resolution on Torture and other cruel, inhuman or degrading treatment or punishment: rehabilitation of torture victims, A/HRC/22/L.11/Rev.1, 19 March 2013; and the African Commission on Human and Peoples Rights, General Comment no.4, 2017, on the**:** The Right to Redress for Victims of Torture and Other Cruel, Inhuman or Degrading Punishment or Treatment (Article 5)**,** 23 February to 4 March 2017.
16. As enshrined in the International Covenant on Economic, Social and Cultural Rights, Article 12, and the UN Convention on the Rights of Persons with Disabilities, Article 25.
17. As enshrined in the UN Convention on the Rights of Persons with Disabilities, Article 26.
18. GC, para.12.

19. Einar Helander, 'The origins of community-based rehabilitation'. Asia Pacific Disability Rehabilitation Journal, vol.8, no.2, (2007): 3-32.
20. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19–22 June 1946; signed on 22 July 1946 (Official Records of the World Health Organization, no.2, p.100) and entered into force on 7 April 1948.
21. See WHO Expert Committee on Medical Rehabilitation, *Second Report,* Technical Report Series 419, (Geneva, 1969); WHO Expert Committee on Disability Prevention and Rehabilitation, Technical Report on Disability Prevention and Rehabilitation, 668, (Geneva, 1981); WHO, Meeting Report, Rehabilitation 2030: A call for action, (Geneva, 2017).
22. WHO 1981, ibid.
23. WHO Technical Reports Series, 668, WHO, Geneva, (1981): 9.
24. See WHO (2013) Comprehensive mental health action plan 2013-2020. Sixty sixth world health assembly, doc. A66/10. Rev.1; WHO (2016) mhGAP intervention guide for mental, neurological and substance use disorders in non-specialised health settings. Geneva, 2016; WHO (2015) Mental Health 2014 Atlas, Geneva.
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26. Ram Cnaan et al., 'Psychosocial rehabilitation: Toward a definition'. Journal of Psychosocial Rehabilitation, 11, (1988): 61-77.
27. Geoff Shepherd 'A personal history of rehabilitation (or Knowing me, Knowing you – Aha?)'. Clinical Psychology Forum, 82 (1995): 4-8.
28. Jed Boardman (ed.) Social inclusion and mental health. (London: Royal College of Psychiatrists, 2010).
29. Medicalisation is "defining the problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or use a medical intervention to 'treat it'" (Peter Conrad, 'Medicalization and Social Control'. Annual Review of Sociology, vol.18, no.1, (1992): 211).
30. For example, John Read and Jacqui Dillon, 'Models of Madness: Psychological, social and biological approaches to psychosis'. (London: Routledge, 2013); Jerry Tew, 'Social approaches to mental distress'. (Basingstoke: Palgrave Macmillan, 2011); Mark Rapley, Joanna Moncrieff and Jacqui Dillon, 'Demedicalising misery. Psychiatry, psychology and the human condition. (Basingstoke: Palgrave Macmillan, 2011); Lucy Johnstone, 'Users and abusers of psychiatry: A critical look at psychiatric practice'. (London: Routledge, 2009); Suman Fernando, 'Cultural diversity, mental health and psychiatry'. Hove: Brunner-Routledge, 2003); Mary Boyle, 'The problem with diagnosis'. Psychologist, vol.20, no.5, (2003): 290-292.
31. For example, see Marius Romme, Sandra Escher, Jacqui Dillon, Derk Corstens and Mervyn Morris, 'Living with voices: Fifty stories of recovery. (Ross-on-Wye: PCCS Books, 2009); Peter Campbell, 'Surviving the system'. In Thurstine Bassett and Theo Stickey (eds.) *Narratives of mental health survivors*. (Chichester: Wiley-Blackwell, 2010); Premila Trivedi, 'Racism, social exclusion and mental health: A Black User's Perspective', In *Racism and mental health, prejudice and suffering*, Kam Bhui (ed.) (London: Jessica Kingsley, 2002); Judy Turner-Crowson and Jan Wallcraft, 'The Recovery Vision for Mental Health Services and Research: A British Perspective. Psychiatric Rehabilitation Journal, vol.25, no.3 (2002): 245-254.
32. Helen Killapsy, Cressida Harden, Frank Holloway et al., 'What do mental health services do and what are they for? A national survey in England. Journal of Mental Health, vol.14, (2005): 157-165.
33. Frank Holloway, 'The forgotten need for rehabilitation in contemporary mental health services: A position statement from the Faculty of Rehabilitation and Social Psychiatry'. (London: Royal College of Psychiatrists, 2005): p.2.

34. For a detailed analysis of the recovery approach see David Pilgrim and Ann McCrainie, 'Recovery and mental health: A critical sociological account'. (London: Palgrave Macmillan, 2013).
35. Marianne Farkas, 'The Vision of Recovery Today: What it is and what it means for services'. *World Psychiatry*, vol.6, no.2, (2007): 68-74.
36. Royal College of Psychiatrists, 'Rehabilitation and Recovery Now'. Council Report CR121. (London: Royal College of Psychiatrists, 2004): p.5.
37. Paul Wolfson and Debbie Mountain, 'What people want from rehabilitation services'. Faculty of Rehabilitation and Social Psychiatry. (London: Royal College of Psychiatrists, UK, 2008).
38. Suman Fernando, 'Mental health worldwide: Culture, globalization and development'. (Basingstoke: Palgrave Macmillan, 2014).
39. See Article 1 of the UN Convention against Torture: "*For the purposes of this Convention, the term 'torture' means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity*."
40. For reviews, see: Roger Gurr and Jose Quiroga, 'Approaches to torture rehabilitation'. Torture, 11, 1, (2001):1-35; Jose Quiroga and James Jaranson, 'Politically-motivated torture and its survivors: A desk study review of the literature'. Torture, vol.15, no.s 2-3, (2005): 1-112.
41. Uwe Jacobs, 'Psycho-political challenges in the forensic documentation of torture: The role of psychological evidence', Torture, vol.10, no.3, (2000): 68-71.
42. Michael Peel and Vincent Iacopino (eds.) The medical documentation of torture. (Cambridge: Cambridge University Press, 2009); Duncan Forrest, 'Examination for the late physical after effects of torture'. Journal of Clinical Forensic Medicine, vol.6, (1999): 4-13.
43. See: The Istanbul Protocol, above note. 8; Nimisha Patel, 'Psychological Assessment and Documentation of Torture in Detention'. In *Monitoring and Documenting Conditions of Detention, Custody, Torture and Ill-Treatment: a practical guide,* Joe Beynon and Jason Payne-James (eds.). (London: Taylor-Francis, 2017).
44. GC, para.13.
45. GC, para.15.
46. GC, para.15.
47. Angela Nickerson, Richard Bryant, Laina Rosebrock and Brett Litz, 'The Mechanisms of Psychosocial Injury Following Human Rights Violations, Mass Trauma, and Torture'. Clinical Psychology Science and Practice, 21, (2014):172-191.
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50. Cindy Sousa, 'Political violence, collective functioning and health: A review of the literature'. Medicine, Conflict and Survival, 2013 vol.29, no.3, (2013): 169–197.
51. Nimisha Patel, Amanda Williams and Blerina Kellezi, 'Reviewing outcomes of psychological interventions with torture survivors: Conceptual, methodological and ethical issues'. Torture, vol.26, no.1, (2016): 2-16.
52. GC, paras.11 and 13.
53. GC, para.13.
54. GC, para.13. Specialist services refers to the specialised awareness, knowledge, understanding and skills specifically related to assessing and addressing the torture survivor's needs.
55. GC, para.32.

56. GC, paras.33 and 39.
57. GC, para.32.
58. Supra note 51; Edith Montgomery and Nimisha Patel, 'Torture rehabilitation: reflections on treatment outcome studies'. Torture, vol.21, no.2, (2011): 141-5.
59. WHO, supra note 21.
60. David Pilgrim, 'The Biopsychosocial Model in Health Research'. Journal of Critical Realism, vol.14, no.2, (2015):164-180.
61. Douglas Perkins and Marc Zimmerman, 'Empowerment theory, research, and application'. *American Journal of Community Psychology,* vol.23, no.5 (1995): 569-579.
62. For further discussion, see: Nimisha Patel, 'Justice and Reparation for torture survivors'. Journal of Critical Psychology, Counselling and Psychotherapy, vol.11, no.3, (2011): 135-147; Yael Danieli, 'Massive trauma and the healing role of reparative justice'. Journal of Traumatic Stress, vol.22, no.5, (2009): 351-357; Camelia Doru and Nimisha Patel, 'Justice and impunity: Implications for the rehabilitation process of torture survivors in Romania', paper presented to the IRCT X International Scientific Symposium: Delivering on the Promise of the Right to Rehabilitation, Mexico City, Mexico, 14 to 16 March 2016; Camelia Doru, 'From healing the wounds to correcting injustice: The road to national reconciliation'. Paper presented to the International Seminar on National Reconciliation, 26 September 2008, Bucharest, Romania.
63. Social rehabilitation, a term used in international law but no longer common in healthcare, refers to interventions aimed at facilitating social functioning, interpersonal relationships and social reintegration following illness, injury or disability.
64. Refers to interventions aimed at supporting survivors to commence or resume education, work, livelihood-building initiatives etc. See Basic Principles (supra note 2); and WHO definitions of rehabilitation (supra note 21).
65. Nimisha Patel, 'The psychologisation of torture'. In Mark Rapley, Joanna Moncrieff and Jacqui Dillon (eds.) De-Medicalising Misery: Psychiatry, psychology and the human condition. (London: Palgrave Macmillan, 2011).
66. Ibid. Main criticisms of such approaches are that they neglect the wide-ranging effects of torture, beyond individual trauma reactions which are often characterised as having psychiatric disease or disorder status (e.g. as 'post-traumatic stress disorder') of universal applicability, whilst de-politicising the context of torture, pathologising and psychologizing torture. For critiques see Derek Summerfield, 'Addressing human response to war and atrocity: Major challenges in research and practices and the limitations of Western psychiatric models'. In *Beyond trauma: Cultural and societal dynamics*, Rolf Kleber, Charles Figley and Berthold Gersons (eds.), (New York: Plenum, 1995); Patel, 2011 (supra note. 65).
67. Ibid; Nimisha Patel, 'The Prevention of Torture: Role of Clinical Psychology'. International Journal of Critical Psychology, Counselling and Psychotherapy, vol. 7, no.4, (2007): 229-246.; Richard Blackwell, 'Counselling and psychotherapy with refugees'. (London: Jessica Kingsley, 2005).
68. Supra note 14.
69. GC, para.11.
70. Ibid.
71. GC, para.3.
72. GC, paras.11 and 13.
73. GC, para.6 and 11..
74. GC, para.15
75. Ibid.
76. GC, para.11.
77. Ibid.
78. Dinah Shelton, 'Remedies in International Human Rights Law'. (Oxford: Oxford University Press, 2005), p.275.
79. Nigel Rodley, 'The treatment of prisoners under international law'. (Oxford: Oxford University Press, 1999), 97-98.

80. Principle 18, Principles on Reparation. The Joinet Principles on victims' rights with regards to combating impunity are relevant to understanding what "full" and "effective" may mean. The right to reparation, contained in several principles, includes reparation procedures (principle 34) specifying that "victims shall have access to a readily available, prompt and effective remedy" and "be afforded protection against intimidation and reprisals" (Joinet, L., 'Question of the Impunity of Perpetrators of Human Rights Violations (Civil and Political)'. Revised Final report, UN Doc. E/CN.4/Sub.2/1997/20/Rev.1).
81. Convention on the Rights of the Child 1989 is the only instrument which explicitly refers to the importance of the environment, stating that psychological and physical recovery and social integration 'shall take place in an environment which fosters the health, self-respect and dignity of the child' (Article 39).
82. The importance of security and safety are acknowledged several times in the Principles on Reparation (Principles 10, 12, 22).
83. Jocelyn Avigad and Zohreh Rahimi, 'Impact of Rape on the Family'. In M. Peel (ed.) Rape as a method of torture. (London: Medical Foundation, 2004).
84. Libby Tata Arcel, 'Torture, cruel, inhuman, and degrading treatment of women: psychological consequences'. Psyke & Logos, vol.22, (2001): 322-351; Nimisha Patel and Aruna Mahtani, 'Psychological approaches to working with rape'. In M. Peel (ed.) Rape as a method of torture. (London: Medical Foundation, 2004).
85. Heidi Rombouts, Pietro Sardaro and Stef Vandeginste, 'The right to reparation for victims of gross and systematic violations of human rights'. In K. de Feyter, S. Parmientier, M. Bossuyt and P. Lemmens (eds.), 'Out of the Ashes: Reparation for victims of gross and systematic human rights violations'. (Intersentia: Antwerpen-Oxford, 2005), para.146.
86. Martha Minow, 'Between vengeance and forgiveness: Facing history after Genocide and Mass Violence'. (Boston, MA: Beacon Press, 1998), p.63.