A Remedy for Torture Survivors in International Law: Interpreting Rehabilitation

Discussion Paper

www.torturecare.org.uk

© Medical Foundation for the Care of Victims of Torture
Registered charity number 1000340
Published December, 2010

Written by:
Ellie Smith.
Nimisha Patel
Leanne MacMillan

For further information or to discuss this paper please contact Leanne MacMillan, Director of Policy & External Affairs, Medical Foundation at lmacmillan@torturecare.org.uk

Table of Contents

INTRODUCTION **5**

PART I

Developing the theory in international law: Interpreting "as full rehabilitation as possible'' **6**

Lessons from the Inter-American Court 10

Rehabilitation: a clinical interpretation 12

Nature of the State obligation: what is meant by "as full rehabilitation as possible" 13

Interpretation by comparison: the right to health 15

The context of rehabilitation 17

Conclusion to Part I 18

PART II

Rehabilitation: Applying international standards to European and domestic provisions **19**

The European Court of Human Rights (ECHR), UK judicial and Home Office approaches 20

Difficulties in approach and assessment 22

The current approach of the courts to cases involving torture survivors 22

Threshold of Article 3 25

Advancing a claim under refugee law: return to a State where rehabilitation for torture will not be provided amounts to persecution 26

Assessing adequacy of rehabilitation in the Receiving State 27

Conclusion to Part II 29

Biographies 31

Bibliography 32

“For most victims, the experience of their ordeal will remain present for the rest of their lives, if not physically then at least mentally. Often, the psychological impact of torture amounts to what has been described as a “disintegration of the personality”. The harm inflicted may be so profound that it shatters the very identity of a person, the ability to feel any joy or hope, to engage with his or her environment, or to find any meaning in life … The impact of the abuse is rarely limited to the person directly targeted but also victimizes their families and even their communities. The victims’ inability to resume their work further adds to their social seclusion and financial strain. In general, experiences of torture cannot be entirely “left behind”, let alone forgotten”

– Manfred Nowak, Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment[1].

Introduction

The Medical Foundation for the Care of Victims of Torture decided to examine the right to rehabilitation for two very practical reasons.

First, the Medical Foundation’s vision is of a world in which torture and organised violence are vanquished. Accountability and the provision of a formal legal remedy for those who have been tortured are key aspects in the fight against torture, and rehabilitation is essential to the ultimate reparative aim of returning a victim of torture to the position they were in prior to their abuse. However, rehabilitation in the context of torture is not defined in international law, and is rarely awarded as an aspect of a legal remedy for torture. In addition, no definition of rehabilitation has been advanced by the Committee against Torture. Arguably, a definition is needed to inform its own practice and to guide other bodies through which a torture survivor might seek a legal remedy. Most importantly, survivors themselves deserve to understand what the content of the right is that they seek to rely upon.

Second, in its work with survivors of torture who have sought refuge in the United Kingdom, the Medical Foundation witnesses a growing problem: survivors of torture fail to gain protection either as refugees or through some form of humanitarian or subsidiary protection. While it may have been acknowledged that they had survived torture, in the absence of any fear of torture in the future, they are deemed to have no further claim to remain in the UK. As a result, many are returned to countries still in early post-conflict phases of establishing basic healthcare and legal systems, where there is scant, if any, provision for healthcare, let alone the form of rehabilitation that is needed by those who have survived torture. While this approach may be in keeping with current understandings of the non-refoulement provisions of the UN Refugee Convention and the UN Convention against Torture, it fails to consider any claim that a survivor of torture might have in relation to any right to rehabilitation.

[1] Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, A/65/273, 10 August 2010.

The result of this, in effect, is that two groups of torture survivors in exile have emerged: those who are granted asylum and as a result are able to access some of the care and treatment that they need from the UK state, and those whose therapeutic needs as torture survivors are equally meritorious, but who are returned to their countries of origin, where they have little hope of ever gaining access to any form of rehabilitation. In fact, the legacy of the torture they have endured and the lack of access to rehabilitation may constitute a new or continuing violation of their human rights.

The challenge is to ensure that the right to rehabilitation is given meaning, so that it can address the current situation of survivors who increasingly are not afforded protection in the countries to which they flee. If survivors of torture are entitled to a remedy from the State responsible for the abuse, then failing meaningful access to that remedy, it may be argued that a survivor seeking asylum in another country should not be returned to that State if they will not be given access to the means for as full rehabilitation as possible.

In order to render the right to rehabilitation meaningful, there needs to be a coherent basis on which to articulate and measure it, and this requires an interdisciplinary approach which embraces both a clinical and legal understanding. This report explores how remedies in international law are understood, with specific focus on the right to rehabilitation.

A definition of the clinical component of the term "rehabilitation" is proposed, based upon the understandings of expert clinicians at the Medical Foundation who work with survivors of torture. Resulting State obligations under the right are considered through a comparative legal analysis of international instruments and practice. The practical application of the right is considered in the context of seeking a legal remedy for torture. The findings are then applied to the issue of the proposed removal of a torture survivor from a Host State to the State responsible for the torture in circumstances where clinical care and support on return would be inadequate or non-existent. Finally, a tool is set out to measure the adequacy of rehabilitative services and State compliance with its obligations under the right to rehabilitation.

Part I – Developing the theory in international law: Interpreting "as full rehabilitation as possible"

The right to rehabilitation as a remedy is contained in Article 14(1) of the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984) (the "UN Convention against Torture"):

"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." *[emphasis added].*

It is clear from the wording of Article 14(1) that rehabilitation is an aspect of a victim's remedy for torture. Support and confirmation of this are found in the UN's Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law (the "UN Basic Principles"),[2] which indicate that rehabilitation is a distinct component of reparations for survivors of abuses.

Article 18 provides:

"...victims of gross violations of international human rights law and serious violations of international humanitarian law should...be provided with full and effective reparation...which include the following forms: restitution, compensation, *rehabilitation*, satisfaction and guarantees of non-repetition". *[emphasis added].*

Further support can be found in the Statute of the International Criminal Court, Article 75(1) which provides that:

"The Court shall establish principles relating to reparations to, or in respect of, victims, including restitution, compensation *and rehabilitation*". *[emphasis added].*

The right to a remedy is recognised in both international[3] and regional[4] human rights conventions. International humanitarian law expressly provides for a judicial remedy for "grave breaches", which includes torture.[5]

---

[2] Adopted by General Assembly Resolution 60/147,16th December 2005.

[3] See, for example, Article 2(3)(a) of the International Covenant on Civil and Political Rights (1966), which requires State Parties "To ensure that any persons whose rights or freedoms as herein recognized are violated shall have an effective remedy, notwithstanding that the violation has been committed by persons acting in an official capacity." In addition, the right to a remedy in respect of both general and specific breaches of Human Rights Conventions can be found in the International Covenant on Civil and Political Rights (art 9(5) and 14(6)), the International Convention on the Elimination of All Forms of Racial Discrimination (art 6), the Convention of the Rights of the Child (art. 39), the Convention against Torture and other Cruel Inhuman and Degrading Treatment, (art. 14); the Inter-American Convention on Human Rights (arts 68 and 63(1)), the African Charter on Human and Peoples' Rights (art. 21(2)).

[4] See, for example, Article 13 of the European Convention on Human Rights and Fundamental Freedoms (1950) (the "European Convention"), which provides "Everyone whose rights and freedoms as set forth in this Convention are violated shall have an effective remedy before a national authority notwithstanding that the violation had been committed by persons acting in an official capacity". Article 5(5) of the Convention also contains a specific and express right to a remedy in respect of incidences of deprivation of liberty in breach of the provisions of Article 5. Similarly, Article 25(1) of the Inter-American Convention on Human Rights, 1969 (the "Inter-American Convention) provides "Everyone has the right to simple and prompt recourse, or any other effective recourse, to a competent court or tribunal for protection against acts that violate his fundamental rights recognized by…this Convention…".

[5] The Geneva Conventions (1949) require signatory States to effectively investigate and prosecute allegations of grave breaches. See Articles 49 & 50 of the Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field; Articles 50 & 51 of the Convention for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea; Articles 129 & 130 of the Convention Relative to the Treatment of Prisoners of War; Articles 146 & 147 of the Convention Relative to the Protection of Civilian Persons in Times of War. The 1977 Additional Protocol I expressly provides for the payment of compensation to victims of abuses.

The right to a remedy for grave human rights abuses, including torture, is reflected in international criminal law instruments such as the Statute of the International Criminal Court[6] and the Rules of Procedure and Evidence for the International Criminal Tribunals for both Rwanda[7] and the Former Yugoslavia.[8]

In addition to its elucidation in treaty form, the right to a remedy can also be found in a number of international declaratory provisions,[9] in the judgments of international[10] and regional tribunals[11] and in the work of leading academics and experts.[12] The right to a remedy for the breach of human rights standards is therefore well established and widely accepted. It forms a part of customary international law, and, as such, is binding on all States irrespective of their treaty obligations.

There is little in the way of guidance on how the right to rehabilitation should be interpreted in practice, and the need to develop this standard is clear.

Although it refers to rehabilitation, the UN Convention against Torture does not define the term. The practice of the UN Convention's treaty body, the Committee against Torture, provides little further in the way of clarification. While this Committee has indicated that clinical rehabilitation forms a part of any "full rehabilitation",[13] it has not elaborated further on how the term should be understood. Where it has specifically identified the need to provide medical and psychological treatment to survivors of torture, this has not been in the express context of "rehabilitation".[14]

[6] Article 75.
[7] U.N. Doc. ITR/3/REV.1 (1995), adopted 29th June, 1995; Rule 106.
[8] U.N. Doc IT/32/Rev.40, adopted 11th February 1994, Rule 106.
[9] Universal Declaration of Human Rights (art. 8); Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power, Adopted by General Assembly resolution 40/34 of 29 November 1985; Declaration on the Protection of all Persons from Enforced Disappearance (art 19), General Assembly Resolution 47/133 of 18 December 1992; Principles on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions (Principle 20), recommended by Economic and Social Council Resolution 1989/65 of 24 May 1989; and the Declaration on the Elimination of Violence against Women.
[10] See, for example the judgment of the Permanent Court of International Justice, *Factory at Chorzow (Germany v. Poland) (Merits)*, (1928) PCIJ, Series A., No. 17; the decision of the Human Rights Committee in the case of *Hugo Rodriguez v. Uruguay*, Comm. no. 322/1988, Views of 19th July, 1994, U.N. Doc. CCPR/C/51/D/322/1988 (1994); the UN Committee Against Torture, Concluding Observations on Turkey (CAT/C/CR/30/5), on Peru (CAT/C/PER/CO/4(2006)), and on Georgia (CAT/C/GEO/CO/3 (2006)).
[11] See, for example, the decision of the Inter-American Court of Human Rights, in the case of *Velasquez Rodriguez*, Serial C, No. 4 (1989), at para. 174; the European Court of Human Rights in *Kudla v. Poland*, App. No. 30210/96; (2002) EHRR 11, para. 152.
[12] See, for example, the International Law Commission's Draft Articles on Responsibility of States for internationally wrongful acts (2001), (art. 31).
[13] See, for example, the Committee's consideration of Guatemala's initial report, 1995, CAT/C/SR.232, at para. 22, which also refers to redress as a form of "moral rehabilitation". The Committee also makes express reference to the need to provide medical rehabilitation to the family members of disappeared or tortured individuals.
[14] See, for example, Concluding Observations on Turkey, CAT/C/CR/30/5, para 123.

In their Annotations to the Convention,[15] Burgers and Danelius, both of whom were actively involved in the drafting of the Convention, provide further, but limited insight and guidance, indicating only that rehabilitation would include “medical or psychological treatment [and] special mechanical aids”.

A definition of “rehabilitation” is not yielded from the Convention’s text, the application of its provisions by its treaty body, or from expert Annotations to the Convention. But, guidance can be found in other international instruments which refer to “rehabilitation” and which have similar objects and purposes as the UN Convention against Torture.

The right to rehabilitation is contained in the Statute of the International Criminal Court. Again, however, the term is not defined in the Statute, and has not yet been considered by the Court itself in its early case law.

The UN Basic Principles,[16] which describe “rehabilitation” in broad, holistic terms, note that: “Rehabilitation should include medical and psychological care as well as legal and social services”.[17] The description is likely to resonate with those who provide rehabilitation services to survivors of torture, and is useful as it indicates that while rehabilitation may have medical and psychological components, a survivor of torture will have other rehabilitative needs. These include the need for social rehabilitation through reintegration and support, as well as legal rehabilitation through, for example, the pursuit of justice and the restitution of property. To this extent, the UN Basic Principles reflect and expand upon the limited guidance on the meaning of rehabilitation provided to date by the UN Committee against Torture. These social, legal, judicial and restitutive aspects of rehabilitation can contribute to, and are often complementary to, the effectiveness of any clinical rehabilitation programme.

While the detailed consideration of non-clinical aspects of “rehabilitation”, together with other reparative forms, are beyond the scope of this paper, the interdependence of the various aspects of reparation and their impact upon clinical rehabilitation are discussed in more detail below.[18]

[15] In Burgers, J. Herman and Danelius, Hans, The United Convention Against Torture: A Handbook on the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1988. Herman Burgers served as Chairman-rapporteur of the 1982 – 1984 sessions of the Working Group established to draft the Convention, while Hans Danelius wrote the initial drafts of the Convention and was an active participant in all sessions of the Working Group.
[16] UN Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law (the “UN Basic Principles”), adopted by General Assembly resolution 60/147, 16th December 2005.
[17] Article 21.
[18] Vienna Convention on the Law of Treaties, 1969, Article 31(1).

Lessons from the Inter-American Court

Although, the Inter-American Court of Human Rights (the "IACtHR") has, to date, not sought to define rehabilitation in the course of its practice, its more recent jurisprudence recognises that, in order to provide an adequate remedy, a range of reparative measures must be considered. It has awarded reparations that can be considered rehabilitative in nature, if not expressly in name, including measures that contain both clinical and non-clinical aspects of rehabilitation.

The earlier practice of the IACtHR had been to award compensation for moral damages,[19] and subsequently as reimbursement of medical fees already paid by a Claimant.[20] Notably, however, the recognition in any reparations award of the anticipated costs of *future* medical care and treatment was not consistently addressed by the Court, and its inclusion depended instead upon whether a specific request had been made by the Claimant[s].[21] Even at this stage, the Court acknowledged in its practice that therapeutic care was required not only by the individual victim[22] but also by their next of kin.[23]

The case of the *Street Children v. Guatemala,*[24] which involved the kidnap, torture and death of four street children and the murder of a fifth, marked a shift in the Court's approach. In that case, the IACtHR awarded other reparative measures to the families of the deceased, including commemorative reparation measures. Most notably, in his separate opinion, Judge Cancado Trindade drew attention to the interdependence of reparative measures, including rehabilitation.[25]

Since its decision in the *Street Children* case, the approach of the IACtHR to the award of measures that have a clinical, rehabilitative element has continued to evolve, albeit inconsistently. The practice of the Court has largely been either to award a fixed, monetary sum to fund future medical expenses,[26] or to order the free provision by the State of remedial therapeutic care and support.[27]

---

[19] *Velazquez Rodriguez v. Honduras*, 21st July, 1989.
[20] See, for example, *Castillo Paez v. Peru*, 27th November, 1998, *Suarez Rosero v. Ecuador*, 20th January, 1999.
[21] As in, for example, *Blake v. Guatemala*, 22nd January, 1999.
[22] As in the case of *Suarez Rosero v. Ecuador*, 20th January, 1999, which involved torture and inhuman treatment.
[23] This was the case, for example, in *Castillo Paez v. Peru*, 27th November, 1998, which was a disappearance case. See also *Velazquez Rodriguez v. Honduras*, 21st July, 1989.
[24] Villagrán Morales and Others v. Guatemala, 19th November, 1999.
[25] See paras 3 - 5 of his Separate Opinion.
[26] Such as in the cases of *Molina Theissen v. Guatemala*, 3rd July, 2004; *Tibi v. Ecuador*, 7th September, 2004.
[27] See, for example, the cases of *Barrios Altos v. Peru*, 30th November, 2001; *Cantoral Benavides v. Peru*, 3rd December, 2001; *19 Tradesmen v. Colombia*, 5th July, 2004; *Juvenile Re-Education Centre v. Paraguay*, 2nd September, 2004; *De La Cruz Flores v. Peru*, 18th November, 2004; *Plan de Sanchez v. Guatemala*, 19th November, 2004.

In all but one case, where a State has been ordered by the Court to pay a fixed monetary sum to a survivor or their family, this has been specifically requested by the Claimants and has been supported by clinical evidence.[28]

In a number of cases where the IACtHR has ordered a State to provide free therapeutic care to survivors and/or their families, it has identified the need to ensure that services are tailored to the individual's circumstances and needs,[29] and has, in several instances, imposed an obligation on the abusing State to establish a Committee for the specific purpose of assessing clinical need.[30] In addition, the compulsory nature of the State obligation to provide access to rehabilitative care is emphasised in the Court's judgment in the case of the *19 Tradesmen v. Colombia*,[31] where it noted that:

"…psychological treatment *must* be provided that takes into account the particular circumstances and needs of each of the next of kin, so they can be provided with collective, family or individual treatment, as agreed with each of them and following individual assessment".[32] *[emphasis added].*

The recognition by the Court of an obligation on an abusive State in respect of the recovery and rehabilitation of a survivor or their family is welcome. In addition, its acknowledgement of the need to provide rehabilitative care to the families of those directly affected by abusive State practices, as well as to the individual, the need to assess and evaluate clinical needs on an individual basis and involve individuals in the development of a tailored treatment model are all positive.

However, where the Court has included either the provision of free medical treatment or a monetary sum as an aspect of its award against a State, it has done so without any clear conceptualisation of what rehabilitation might properly constitute and without any obvious assessment of whether services in the territory of the abusing State exist, or whether those services are available, accessible or otherwise appropriate. Notably, while in the case of *Plan de Sanchez v. Guatemala*,[33] the IACtHR specified that medical treatment should be adequate, it did so in the absence of any consideration of what adequate services might comprise in practice. Further, while in a number of cases the IACtHR has advocated the establishment of a Committee to evaluate clinical need, there is little in the way of ongoing monitoring of treatment or assessment of compliance with obligations on the part of the State involved.

[28] With the exception of *Bulacio v. Argentina*, 18th September, 2003, in which compensation was awarded to the next of kin of a minor who was beaten in police custody and who later dies of his injuries. As sum was included to cover their future medical expenses. Although the award was not expressly requested by the Claimants', there was evidence before the Court documenting their consequent suffering.

[29] See, for example, *Juvenile Re-Education Centre v. Paraguay*, 2nd September; *19 Tradesmen v. Colombia*, 5th July, 2004.

[30] As in *Juvenile Re-Education Centre v. Paraguay*, 2nd September; *Plan de Sanchez v. Guatemala*, 19th November, 2004.

[31] *19 Tradesmen v. Colombia*, 5th July, 2004, Series C No. 109, paras. 275-278

[32] At para 278.

[33] *Plan de Sanchez v. Guatemala*, 19th November, 2004.

In particular, there is no indication of any specific prioritisation of treatment of the individual within the healthcare system of a State which, as discussed below, must be one significant aspect of considering rehabilitation within the legal context of the right to a remedy, as opposed to viewing the concept within the remit of the right to the highest attainable standard of health.

In the absence of any further interpretation, international law provides that a term be construed “in good faith in accordance with the ordinary meaning to be given to the terms of the treaty in their context and in the light of its object and purpose”.[34] We have therefore interpreted clinical aspects of “rehabilitation” in accordance with common clinical understandings of the term rehabilitation, as understood by clinicians working with torture survivors.

Rehabilitation: a clinical interpretation[35]

This section examines current clinical conceptualisations of "rehabilitation" in the field of torture.

In general medicine, rehabilitation is conceptualised as an outcome, referring to the restoration of function or the acquisition of new skills in the aftermath of injury, illness, surgery or disease. It seeks to enable the maximum possible self-sufficiency and function for the individual concerned, and may involve adjustments to the patient’s physical and social environment. Treatment might include medical, physical, occupational and speech therapies, together with other specialist forms of healthcare. The success of rehabilitative efforts can be assessed by reference to the quality of life of the patients, as indicated by the patients themselves.[36]

The approach to medical rehabilitation when working with survivors of torture is in line with this conceptualisation, except that, for many torture survivors, a full restoration of function is not possible, and rehabilitative measures will aim to ensure optimum functioning, wherever possible.

Rehabilitation in the area of mental health refers both to the services offered and to the underlying principles adopted to address ongoing and severe mental health difficulties. The term “rehabilitation” has traditionally been used to refer to an outcome, emphasising the ameliorative goal of enabling individuals “to function in important areas of life as satisfactorily as possible and if necessary, despite the basic problem”.[37]

The concept of rehabilitation has been further developed and refined within the mental health ‘survivor movement’, driven by survivors and service users, emphasising the ongoing and continual process of recovery.

---

[34] Vienna Convention on the Law of Treaties, 1969, Article 31(1).
[35] Based on Patel, N, *Reparations for Survivors of Torture: Towards an integrative framework for understanding “Rehabilitation”*, unpublished Master’s thesis, University of Essex, (2007).
[36] Fuhrer (2000)
[37] Bledin (2007)

In this context rehabilitation is seen as clinicians enabling the patients to overcome the stigma attached to mental health difficulties and their loss of hope, as well as difficulties associated with discrimination and disempowerment, and to regain a positive sense of self, regardless of enduring symptoms.

This understanding has lead to the development of the ‘recovery model’, which seeks to improve the holistic quality of life of the individual concerned,[38] considering the resilience and strengths of individuals and their families, and which requires an assessment of needs, which in turn considers the survivor’s full social, cultural and spiritual environment.

Rehabilitative work is aimed at the fulfilment of outcomes and goals identified by the individual, hence furthering autonomy and choice, and maintaining optimism for recovery (understood as leading to well-being and the ability to resume social roles) even where mental health problems persist. Focus is placed on the need to provide supportive environments to maximise function.[39]

These principles of rehabilitation in mental health have largely been recognised by practitioners working with survivors of torture and applied to torture-related psychological health difficulties.

For torture survivors in particular, current clinical approaches are based on the understanding that rehabilitation needs to: (a) include multidisciplinary services to address the holistic and diverse needs of torture survivors and their families; (b) consider the importance of safety and stability in the current environment; and (c) to address the potentially long-term impact of torture, and its consequences for the victims’ social functioning, in terms of their social, familial and employment responsibilities.

Nature of the State obligation: what is meant by “as full rehabilitation as possible”

The right to rehabilitation contained in Article 14 of the UN Convention against Torture is qualified by the words “as full…as possible”. The words relate to the ambit of the provision, and provide guidance as to the nature of the obligations imposed on the State by the right to rehabilitation.

Delegates engaged in the drafting of the UN Convention against Torture expressed concern that “rehabilitation” was too vague a term. Rather than seek to define it, however, delegates chose to qualify it by the addition of the phrase “as full…as possible”.

[38] Royal College of Psychiatrists (2004), p.5.
[39] Shepherd (1995).

In their Annotations to Article 14, Burgers and Danelius provide some guidance as to how delegates intended the term to be construed, indicating that rehabilitative treatment, including the provision of mechanical aids, should be provided "so far as they are available". This in turn suggests that the qualifying phrase relates to the existence, accessibility and availability of services and equipment in the State rather than to the extent or degree to which a survivor is able to make a recovery. As a result, the nature of the obligation imposed on the State in terms of physical provision and support is relative, and its practical content will therefore vary as between States, depending upon such factors as the availability of resources and facilities.

While the inclusion of a relative component is not uncommon in relation to economic, social and cultural rights, which are subject to progressive implementation, assessment of State compliance with their obligations under the UN Convention against Torture does not generally measure the implementation of rights in this way.

In addition, the Annotations to the Convention produced by Burgers and Danelius indicate that "where there is a need for medical or psychological treatment or for special mechanical aids, such treatment or such aids *shall* be provided so far as they are available" *[emphasis added].*[40] This indicates an intention on the part of the drafters, that where rehabilitative services exist and there is capacity, the State *must* provide them. It may also be argued that a State is unable to evade its duty to provide rehabilitative care simply by failing to operate or otherwise offer available and appropriate rehabilitation services for individuals it has tortured, reflecting an intended obligation to *actively provide* these services as far as possible. [41]

Support for this interpretation can be found in General Comment 14 of the Committee on Economic, Social and Cultural Rights, which draws a distinction for the purpose of assessing a State's obligations under the right to health between unwillingness and inability to provide medical services. As a result, the relative qualification in the phrase should be read as incorporating only a limited degree of permissible flexibility on the part of the State.

The UN Convention against Torture provides no further guidance as to the nature and extent of the obligations imposed by the right to rehabilitation under Article 14. Further and recent guidance is available through the analysis of how relevant international human rights and State obligations have been interpreted and applied.[42]

[40] Burgers, J. Herman and Danelius, Hans, *The United Convention against Torture: A Handbook on the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, 1988.

[41] Support for this interpretation can be found in General Comment 14 of the Committee on Economic, Social and Cultural Rights, which draws a distinction for the purpose of assessing a State's obligations under the right to health between unwillingness and inability to provide medical services of a certain type. Twenty-second session, 25th – April – 12th May 2000, Geneva, at para 47.

[42] Reading across other provisions in international human rights law is accepted as an interpretation approach.

Interpretation by comparison: the right to health

Corollary State obligations arising under the right to the highest attainable standard of health[43] are particularly pertinent in the assessment of the nature and content of the clinical component of rehabilitation under Article 14. There are differences as well as similarities between the rights, and both of these are useful in informing the interpretation of the right to rehabilitation, as well as the nature of State obligations arising under it.

Article 12(1) of the International Covenant on Economic, Social and Cultural Rights (1966) provides:

“The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”.

Like the right to “as full rehabilitation as possible”, the right to health includes aspects which are relative in nature: the right takes into account both the State’s available resources and the biological and socio-economic conditions affecting the individual. Genetic factors, the proclivity of individuals to ill-health and their lifestyle choices are all factors which impact upon the level of health enjoyed. As a result, the right to health cannot be understood as the right to be healthy, but rather, the right to enjoy a variety of facilities, services and conditions conducive to the realization of the highest attainable standard of health on a non-discriminatory basis.[44] In this respect, the right to health is comparable to the right to “as full rehabilitation as possible”, the qualifying, relative terminology applying to the availability and accessibility of services rather than to the degree of recovery.

A significant difference between the two rights, however, is that the right to rehabilitation arises in response to harm directly inflicted by the State,[45] while the legal obligations imposed on the State under the right to health arise in response to harm for which the State is not directly responsible, i.e. naturally occurring illness. As a consequence of the lack of any direct State responsibility for harm suffered under the right to health, the fact and degree of direct and active State provision of treatment required can be affected by factors including the predisposition of individuals to ill-health, their adoption of a risky or unhealthy lifestyle and a lack of sufficient resources.

Conversely, direct State responsibility for the harm suffered must surely impact upon the degree of State action required under the right to rehabilitation in the provision of rehabilitative care.

[43] For convenience, the right is hereafter referred to as the right to health.
[44] See General Comment 14 of the Committee on Economic, Social and Cultural Rights, para. 9.
[45] Including instances of State responsibility to act in respect of private acts of abuse, arising as a result of its positive obligation to protect human rights.

Support for this argument can be found by analogy in the judgements of the European Court of Human Rights and the UK House of Lords, respectively, in which they acknowledge that, in cases where return is considered in the absence of adequate medical facilities in the Receiving State, the threshold of Article 3 will be particularly high where the harm which requires treatment was not directly inflicted by the State, and where there is a lack of State resources to provide the necessary care. These cases are discussed in more detail below. It must also follow, therefore, that a State's margin of discretion under the right to rehabilitation is significantly less than that enjoyed under the right to health given that it is responsible for the harm.

The degree of State compliance with its obligations under the right to health can be evaluated and an assessment must incorporate consideration of whether failure to provide services is due to an inability or an unwillingness on the part of the State.[46]

Although the potential provision of services may be limited by economic factors and the availability of resources, a State must take all possible and necessary steps to ensure the realisation of the right, over time, through the preparation and implementation of a national public health strategy and action plan. This, in turn, should contain deliberate, concrete and targeted steps towards the full realisation of the right.[47] It must be subject to periodic participatory review through a transparent process, and include a means of monitoring and measuring progress.

Where a State has not been able to comply fully with its obligations, it must be able to justify its use of resources and to establish that they have been distributed in an appropriate manner, on the basis of genuine health need and without discrimination. The plan must pay particular attention to the healthcare needs of vulnerable or marginalised groups within the State. In addition, it should address the core obligation to ensure that medical services are culturally appropriate, and that staff are trained in the specific needs of vulnerable or marginalised groups,[48] including training in issues of health and human rights.[49]

An assessment of a State's fulfilment of its obligations under the right to rehabilitation could be approached in a similar manner to how we assess the delivery of a right to health.

There are a number of factors which can be adopted from the right to health approach which apply in particular to torture survivors and which strongly support prioritisation in the allocation and provision of healthcare services and support. Notably, survivors may be vulnerable in terms of their health and well-being as a result of their torture, while many may come from marginalised minority groups, or will suffer further marginalisation as a result of their torture (for example, in the case of rape or other forms of sexual torture). In terms of who is targeted or otherwise vulnerable to abuse, torture itself is often an extreme form of discrimination.

[46] See General Comment 14, para 47.
[47] See General Comment 14, para 30.
[48] See General Comment 14, para 37.
[49] General Comment 14, para 44(e)

Where clinical rehabilitative care is not provided or is otherwise inaccessible to a survivor of torture, however, the nature and degree of State obligation will differ due to the respective natures of the two rights. Whilst the right to health is a progressive right, which requires the realisation and development of healthcare provision and systems over a period of time, the right to rehabilitation, as a civil and political right, is immediately realisable. In addition, the right to a remedy presupposes the existence of a remedy that is effective, accessible and realisable.[50] As a result, where rehabilitation services are not provided, obligations under Article 14 must require a more immediate and proactive State response than under the right to health.

The context of rehabilitation

As already indicated, the notion of rehabilitation encompasses both clinical and non-clinical elements, and will also include, for example, social, cultural and legal aspects of rehabilitation. While the focus of this paper is on the clinical component, reference to non-clinical forms of rehabilitation is made here to the extent they impact upon clinical rehabilitation.

The pursuit and achievement of legal justice and reparations can play a significant role in the recovery process of torture survivors. In particular, the prospect and process of seeking justice, as well as its practical realisation, can all be of positive rehabilitative value to survivors of torture.

In addition, the successful pursuit of justice and reparations may also help in the individual's reintegration and reaffiliation, and could involve not only the punishment of perpetrators, an award of damages and the return of property, but also an acknowledgement that the abuse happened and was unacceptable, going some way to restoring the dignity of the survivors in their own eyes and in the eyes of their communities.[51]

For survivors of torture who have sought asylum in another country and been denied protection, the context of rehabilitation upon return will be significantly different, as they struggle to re-establish themselves in communities and families that may have been significantly altered while they were in exile. Within return contexts, the survivor may have no access to any rehabilitation services, and clinical experience indicates that many will have left behind some level of professional, familial and social support in the host country.

---

[50] This is made explicit in a number of cases. See, for example, Article 2 ICCPR, which requires States Parties to develop judicial remedies in the event of a breach, ensure that the determination of any complaint shall be by a competent authority and see that the remedy is enforced once granted; Article 25(2)(b)&(c) IACHR obliges States Parties to "develop the possibilities of judicial remedy" and to "ensure that the competent authorities shall enforce such remedies when granted".

[51] Notably, the reporting of torture in many States may lead to the stigmatisation and marginalisation of the survivor, particularly although not exclusively in the cases of sexual violence. This in turn will engender State obligations in relation to access to justice. It is beyond the scope of this paper to consider the full extent of these obligations in detail here. For further guidance on this, see *Justice Denied: The experiences of 100 torture surviving women of seeking justice and rehabilitation*, Medical Foundation, 2009.

While there may be no violation of the principle of *non refoulement*, there will be ongoing concerns about the conditions under which, and to which, a survivor is repatriated.

Conclusion to Part I

Despite being a well-established principle of international law, treaties provide little guidance on how "rehabilitation" should be interpreted. However, the clinical component of rehabilitation can be analysed and defined by reference to clinical interpretations, as understood by experts working to rehabilitate survivors of torture.[52]

Broadly speaking, human rights approaches to rehabilitation aim to alleviate suffering of individuals and their families, restore health or, where unrealistic, to enable survivors to manage their health difficulties and the emotional impact of torture; and to address the effects of torture within their social, cultural and historical context, on individuals, relatives and community - aiming to validate survivors' dignity and challenge injustice.[53] It will be a key challenge to find ways for a State that tortures its citizens to provide clinical rehabilitative services in keeping with its obligations.

The right to a remedy also includes the pursuit of legal actions against perpetrators, the restoration of property and the reintegration of the victim into society. These all reflect additional reparative obligations on the State which have value in themselves and also can have a positive benefit on the context and environment in which therapeutic, rehabilitative work is conducted, as well as rehabilitative benefits *per se*.

In the context both of those seeking a legal remedy against a torturing State and of those who have sought asylum but who are at risk of return, the assessment of whether a Receiving State fulfils its obligation to provide as full rehabilitation as possible is an objective exercise that is ultimately rendered extremely difficult due to the paucity of available information relating to clinical provision for torture survivors. As with similar assessments under the right to health, those seized of making determinations can do so on the basis of the circumstances of each State, its available resources and the individual rehabilitative/clinical needs of the torture survivor.

It should be noted, however, that while the term permits a degree of relativity where resources are limited, the margin of discretion enjoyed by the State in the allocation of those resources must be narrow, and where resources permit, the State will not enjoy any margin of discretion in the provision of rehabilitative services.

Simply put, a State cannot torture its citizens and then fail to provide them with rehabilitation on the basis of inadequate resources.

---

[52] Emphasis has been placed here on the interpretation of clinical aspects of rehabilitation. It should be borne in mind, however, that the term also encompasses legal and social rehabilitation.
[53] Patel, N, *Reparations for Survivors of Torture: Towards an integrative framework for understanding "Rehabilitation"*, unpublished Master's thesis, University of Essex, 2007.

Part II - Rehabilitation: Applying international standards to European and domestic provisions

As a State Party to the UN Convention against Torture, the UK has accepted legal obligations including under Article 14. These obligations not only exist at the international level, but also impose strong imperatives at the domestic level: international law requires States to perform their obligations under a treaty in good faith, and domestic law cannot be invoked as justification for failure to perform international obligations under a treaty.[54] As a result, national provisions should, wherever possible, be construed consistently with a State's international commitments and obligations.

European case law substantially guided the development of the definition of torture contained in the UN Convention against Torture. The close relationship between the UN and European monitoring and enforcement bodies that subsequently emerged produced ostensibly parallel interpretations. As a result, case law and interpretations from these respective systems strongly guide each other.

Article 3 of the European Convention on Human Rights[55] (the "European Convention") provides:

"No one shall be subjected to torture or to inhuman or degrading treatment or punishment".

Article 13 of the European Convention provides:

"Everyone whose rights and freedoms as set forth in this Convention are violated shall have an effective remedy before a national authority...".

In addition to being expressly provided by Article 13, the right to a remedy is also implicit in Article 3 of the European Convention. This obliges States to take remedial action in relation to acts of torture and other abusive practices for which they are directly or indirectly responsible (the latter as a result of its positive obligation to protect individuals from ill-treatment perpetrated by private actors).

Neither Article 13 nor Article 3 of the European Convention provides guidance on what was intended in terms of a remedy. International law, however, and in particular, the codifying provisions of the UN Basic Principles, are clear that a remedy for torture or other gross violation of human rights would include rehabilitation.

[54] Vienna Convention on the Law of Treaties, 1969, articles 26 – 27.
[55] Convention for the Protection of Human Rights and Fundamental Freedoms (1950).

The UK and European application of the right to rehabilitation in relation to torture is significant for two reasons:

- it enables survivors of torture to pursue rehabilitative remedies against perpetrator States within Europe; and
- it may impact the proposed return of a torture survivor from a European Host State to the Receiving State responsible for torture in instances where rehabilitative care will not be provided, will be inaccessible or will be otherwise inadequate in the Receiving State.

The first of these scenarios was considered in Part I of this paper. In particular, the extent of a State's compliance with its obligations under the right to rehabilitation can be assessed in accordance with the principles set out there. In the case of the second scenario, obligations will arise for both the Host and Receiving (abusing) State. Again, the obligations of the Receiving State to provide rehabilitative care have already been considered in Part I, and compliance with them can be monitored and assessed. Obligations of the Host State are considered here, and are examined in the context of actions brought under the provisions of the European Convention.

The European Court of Human Rights (ECHR), UK judicial and Home Office approaches

Express reference is made here to United Kingdom domestic jurisprudence and practice in order to assess UK obligations when faced with the proposed removal of a torture survivor, in circumstances where there are no, or inadequate, medical and therapeutic rehabilitative services available in the Receiving State. It should be noted that the principle applies equally to all States Parties to the European Convention.

The question of whether individuals should be returned to a State where they will receive no or inadequate medical care is typically pleaded under Articles 3 and/or 8 of the European Convention.

Because the issues applicable to the examination under Article 8 are essentially subsumed by those under Article 3, reference is therefore made here to Article 3 only. In many cases both Articles 3 and 8 will have been pleaded.[56]

[56] The right to respect for private life under Article 8 ECHR includes the right to physical and moral integrity. Unlike Article 3, Article 8 is a relative provision subject to considerations of proportionality, thereby permitting the State to interfere with that right in limited circumstances. The threshold for medical-based Article 8 claims is thought to be the same as for those brought under Article 3, and the factors identified by the European Court in the consideration of Article 3 claims will also apply to Article 8 cases. The European Court recently concluded in the case of *N v. UK* that where removal did not breach Article 3, it was not necessary to examine the complaint under Article 8. See also the judgment of the House of Lords in *Razgar*, noting "it is not easy to think of a foreign healthcare case which would fail under Article 3 but succeed under Article 8". It is beyond the scope of this paper to provide a critique of the *N* judgment. However, while the Court might decline to consider an application under one article where it has already succeeded under another, it is unusual for it to do so where an application has failed under another article.

The European Court of Human Rights has indicated, through its case law, that the threshold of Article 3 will be very high in a situation where an individual requiring clinical care will receive no or inadequate treatment in the Receiving State. As a result, the circumstances in which removal can successfully be resisted will be exceptional.

The Court has identified a number of factors that will be relevant to the consideration of whether this high threshold has been breached. Notably, where removal has been successfully resisted, individual factors were not of themselves determinative, but rather had a cumulative bearing on the assessment of adversity facing the Applicant if returned to their country of origin. These factors include the severity and stage of the illness reached (typically, whether it was at a terminal stage), the availability and accessibility of medical care in the Receiving State, the presence there of family or other forms of social support such that the Applicant would not be deprived of the ability to die in dignity, and the assumption of care by the Host State[57] in advance of intended removal.

This issue was considered in 2005 by the UK House of Lords in the case of *N*,[58] where it held that the test of whether removal would breach the threshold of Article 3 ECHR was:

"...whether the applicant's illness has reached such a critical stage (i.e. he is dying) that it would be inhuman treatment to deprive him of the care which he is currently receiving and send him home to an early death unless there is care there to enable him to meet that fate with dignity".[59]

This position is reflected in UK Home Office guidance to its caseworkers, which provides:

"…the circumstances in which an individual can resist removal on Article 3 related medical grounds will be exceptional…However to attempt to return someone to a country where there is a complete absence of treatment, facilities or social support which could result in an imminent and lingering death and cause acute physical and mental suffering would be very likely to engage our obligations under Article 3, where the UK is treated as having accepted responsibility for care."[60]

---

[57] See, for example, *D v. UK* (1997) 24 EHRR 423; *BB v. France*, 9th March 1998, RJD 1998-VI, p.2596; *Karara v. Finland*, Application No. 40900/98, 29th May, 1998; *MM v. Switzerland*, Application No. 43348/98, 14th September 1998; *SCC v. Sweden*, Application No. 46553/00, 15th February 2000; *Henao v. Netherlands*, Application No. 13669/03, 24th June 2003; *Amegnigan v. Netherlands*, Application No. 25629/04, *N v. UK* Application No. 26565/07, 27th May 2008. Since the case of *D*, the Court has not found that removal of an applicant would breach the standards of Article 3 on the grounds of their ill-health. Although the circumstances of *B.B.* were similar to those of *D*, the French government gave an undertaking not to deport, and the case was therefore struck from the Court's list before any judgment could be given.

[58] *N(FC) v. SSHD* [2005] UKHL 31.

[59] per Baroness Hale. The Court's judgment has since been considered and approved by the European Court (by majority), in *N v. UK* Application No. 26565/07, 27th May 2008.

[60] UK Home Office, Immigration directorate instructions, Chapter 1 Section 10, Human Rights, December 2006.

Difficulties in approach and assessment

This case law indicates that the current threshold at both the European and United Kingdom levels is extremely high for medical cases where those who are ill resist returning to a State where they will not have adequate or any care.

However, cases involving the threat of removal of a torture survivor to a perpetrator State in circumstances where rehabilitative care is absent or otherwise unavailable to the survivor can be distinguished from those concerning individuals suffering from naturally occurring illness or disability. As a result, the current approach of the courts to medical cases involving a lack of facilities in the Receiving State is not suited to cases concerning survivors of torture who have consequent rehabilitation needs.

The following section includes an analysis of the current approach to medical cases, indicating how cases involving torture survivors are clearly differentiated from the approach taken, and suggests an alternative and more appropriate approach to assessing their claims. It goes on to consider how the distinction between medical cases involving individuals suffering from naturally occurring illness or disability and those of torture survivors impacts upon the threshold for establishing a breach of Article 3 in such cases.

The current approach of the courts to cases involving torture survivors

Many of the cases decided to date by the European Court on the issue of return in the absence of adequate medical care are not those of survivors of torture, and the focus in the decisions is very much on the provision of access to medical care rather than to rehabilitation. Despite this, the Court has taken the same approach to cases involving torture survivors as it does to more general medical cases. The return of a torture survivor to the very State where they were tortured, in circumstances in which the State cannot or will not fulfil its obligation to provide rehabilitation for that torture are, however, materially different.

More recent case law of the European Court of Human Rights and the UK's domestic courts shows some acknowledgement of a distinction between cases concerning needs arising from naturally occurring illness, disability or infection and those resulting from torture.

In its judgment in *Bensaid v. UK*,[61] for example, the Court stated that:

"The Court accepts the seriousness of the applicant's medical condition. Having regard however to the high threshold set by Article 3, particularly ***where the case does not concern the direct responsibility of the Contracting State for the infliction of harm*****,** the Court does not find that there is a sufficiently real risk that the applicant's removal in these circumstances would be contrary to the standards of Article 3." *[emphasis added]*[62]*,*

*a*nd in *N v. UK*,[63] in justifying the high threshold of Article 3 in such cases, noted that:

"…it should maintain the high threshold…given that in such cases ***the alleged future harm would emanate not from the intentional acts or omissions of public authorities or non-State bodies,*** but instead from a naturally occurring illness and the lack of sufficient resources to deal with it in the receiving country".[64] *[emphasis added].*

In its Asylum Policy Instruction on the European Convention, the Home Office provides:

"Where an applicant's suffering on return will not result from deliberately inflicted harm, the threshold set by Article 3 is particularly high".[65]

The courts have therefore recognised that there is a distinction to be made between cases concerning harm that is beyond the control of the State and that perpetrated by the State. Despite recognising this distinction, however, Courts have, to date, failed to explore the full implication of the distinction they have made, and, in particular, how their own approach to the determination of such cases should differ as a result, noting only that the distinction would impact upon the threshold required before the proscription contained in Article 3 might be engaged.

In assessing the adequacy and availability of medical care in the Receiving State, European and UK courts take into account the existence, accessibility and standard of treatment options, as well as prevailing financial, geographic and staffing limitations in the Receiving State, and in doing so recognise some of the practical difficulties inherent in the realisation of a progressive right, such as the right to health.

[61] *Bensaid v. UK*, (2001) 33 EHRR 10, 6 February 2001.
[62] At para 40.
[63] No. 26565/07, 27th May 2008.
[64] Para 43.
[65] Para 7.2, *Medical claims*.

In conducting its assessment, the Court affords the applicant the same priority as any other member of the population of the Receiving State.[66] While not making any express reference to, or determination of whether return would result in a breach of the applicant's right to health in the Receiving State, the Court's approach essentially amounts to an abridged assessment of possible breach of that right and, where the potential consequences of that breach are considered "exceptional", they are deemed to breach the very high threshold of Article 3 established in such cases.

However, in medical cases involving the proposed removal of a torture survivor the right in respect of which protection is sought, and against which breach is assessed, is the survivor's right to a remedy, and not their right to health. As a result, rather than asking itself whether medical facilities in the Receiving State are adequate to meet the needs of the returnee, the Court should ask whether there are existing rehabilitative facilities and services in the Receiving State which are available and sufficient to meet the torture survivor's right to "the means for as full rehabilitation as possible". This assessment must necessarily take into account the specific prioritisation of resources that a torture survivor should be afforded under the right to rehabilitation and the very limited degree of flexibility afforded to the Receiving State in that regard.

Courts must also consider the context in which rehabilitative care would take place in the Receiving State, with particular reference to the interdependence and positive therapeutic benefits of other reparative measures, together with the need for security in the recovery environment.[67] Factors which relate to the recovery environment in the Receiving State, such as ongoing violence, perpetrator impunity, a lack of housing or the means to make a living and social ostracism will also impact upon treatment needs in the Receiving State, and consideration must therefore also be given to the security of the recovery environment and the ability of the individual to return in safety and dignity to the extent that these factors impact upon the torture survivors' condition and their rehabilitation.

It is important to recall that many who have been tortured and who flee are seeking safety from States where there is ongoing repression, conflict or mass human rights violations. Many other Receiving States are emerging from serious and long-standing periods of crisis, while many more are developing States or otherwise subject to high levels of intervention from external actors at the global or regional level. These are not situations where there is emphasis on the provision of a wide spectrum of public services such as those in the areas of health or legal and social services.

[66] And in fact, a full determination of whether the right to health would be breached in the Receiving State would most likely afford the applicant a degree of prioritisation over others as result of States' obligation to provide specifically for those who have been discriminated against and/or are from a Minority group. Torture is very often an extreme expression of discrimination.

[67] See Patel, N, *Reparation for Survivors of Torture: Towards an integrative framework for understanding "Rehabilitation"*, unpublished Master's thesis, University of Essex, 2007. The notion of recovery environment here refers to the wider environment (including the legal, political, social, welfare, family and community contexts) and the therapeutic milieu in which rehabilitation takes place.

It is therefore important to look objectively at whether there is even a basis upon which to expect that a survivor might be able to access any rehabilitative support or services if returned. If the answer to this is "no", then they should not be returned.

A review of potential countries of return reveals that there are a few with fledgling rehabilitation services, and many with no public health sector services with a specific emphasis on torture survivors. Targeted international funding in the area of rehabilitation has been diminishing not growing, even though the tendency for returning survivors who have sought protection outside of their countries of origin seems to be increasing. The harsh circumstances faced by individuals in need of rehabilitation are familiar terrain for those who work with survivors and it is clear that there needs to be greater scrutiny when making decisions about the return of survivors.

The question of return in the case of a survivor of torture itself raises clinical concerns that differentiate these cases from those concerning naturally arising illness or disability over and above the simple cessation of treatment in the UK. In many cases, the fact of return to the country, or even city or geographical area in which the torture took place is in itself highly traumatic, thereby antithetical to and an obstacle to rehabilitation. As a result, the court's assessment must also take into account rehabilitation needs occasioned by the fact of return. The Court will also need to consider the impact of both the trauma suffered by survivors who return, and on their ability to access rehabilitative care.[68] Notably, where the lack of clinical provision is a result of the Receiving State's breach of its obligation to provide rehabilitation, the deprivation of a remedy will in turn compound the harm suffered.

If returned to the perpetrator State, expert medical evidence should be used to assist the court's assessment of the individual's health and prospect for recovery. This evidence should in turn encompass not only current treatment needs but also those occasioned by the fact of return to the torturing State, including both those generated by the trauma of return and those resulting from the environment and context in which treatment would be taking place.

Threshold of Article 3

The distinction between cases concerning individuals suffering from naturally occurring illness or disability and those who have rehabilitative needs as a result of torture also impacts upon the level of the threshold applicable before Article 3 might be considered to have been breached.

[68] The Court of Appeal recognised this issue in the case of *Y&Z (Sri Lanka) v. The Secretary of State for the Home Department*, [2009] EWCA Civ 362, where Lord Justice Sedley observed "although some psychiatric care is available in Sri Lanka, these two appellants are so traumatised by their experiences, and so subjectively terrified at the prospect of return to the scene of their torment, that they will not be capable of seeking the treatment they need. Assuming that they come unscathed through interrogation at the airport, with no family left in Sri Lanka and no home to travel to, the chances of their finding a secure base from which to seek the palliative and therapeutic care that will keep them from taking their own lives are on any admissible view of the evidence remote" [para 61].

In justifying the exceptionally high threshold of Article 3 in these cases, domestic and European courts refer to:

(a) The fact that the case is "foreign";
(b) The fact that the alleged ill-treatment is neither the direct nor indirect responsibility of the national authority in the Receiving State; and
(c) The fact that the European Convention had been designed to protect civil and political rights, and not economic, social and cultural rights, such as the right to health.[69]

Where the need for rehabilitation results from torture for which the State is directly or indirectly responsible, (b) does not apply, and the resulting threshold must therefore be lowered. In addition, while the right to health is economic, social and cultural in nature, the right to a remedy is a civil and political right, and as a result, (c) is also inapplicable, as justification for the exceptionally high threshold. It is therefore reasonable to assume that the threshold of Article 3 will be lower in cases involving the proposed return of torture survivors in circumstances where they face no or inadequate access to rehabilitative treatment and care.

Advancing a claim under refugee law: return to a State where rehabilitation for torture will not be provided may amount to persecution

One of the interests of the Medical Foundation is to develop arguments that will ensure that those survivors of torture who have no future risk of being tortured, are nonetheless able to sustain a claim for protection under the UN Refugee Convention on the basis that they will not have access to rehabilitation as a survivor of torture if returned to the country they fled. There are of course difficulties in framing this argument and success will depend on whether it can be established that the denial of the right to rehabilitation can amount to persecution giving rise to a claim for protection under Article 1a(2) of the UN Refugee Convention and for a Convention-based reason that it is persecution:

"… for reasons of race, religion, nationality, membership of a particular social group or political opinion…".

For those seeking to ensure the protection and rehabilitation of torture survivors in countries of asylum, individual cases should be brought forward to explore whether international refugee law provides a path to a survivor securing rehabilitation. For example, it might be fruitful to explore a claim to protection under refugee law on the grounds that there would be a denial of the right to rehabilitation due to some form of discrimination that was so serious as to be persecution; or, on the basis of a person being a member of a particular social group – i.e. torture survivors who are not granted access to any or adequate rehabilitation.

[69] See ECtHR in *N v. UK*, No. 26565/07, 27th May 2008.

The nexus to persecution for a Convention based reason may be difficult to establish in relation to article 14. While it may be possible to show that a person has been targeted for torture for a Convention reason, it may not follow that they would equally be denied access to rehabilitation on the same basis. A case example helps to illustrate the point where there may be some prospect for establishing the basis for a claim: An MDC activist had been tortured by Zanu-PF forces in Zimbabwe but, having sought asylum in the UK, the decision-maker did not believe he faced any real risk of future abuse if returned, even though it was accepted that he had been tortured. Conceptualizing the denial of a right to rehabilitation as the basis of a claim to protection might be sustainable under the UN Refugee Convention if in Zimbabwe medical treatment was systematically denied to anyone who did not carry a Zanu-PF membership card, and access to rehabilitative care denied on the basis of his political allegiances – i.e. for a Convention reason.

It is clear that this approach needs further development, as there is currently little available guidance in the area.[70] Interesting arguments are being developed around the use of economic, social and cultural rights as a basis for an asylum claim given a deprivation.[71] Using the clinical criteria outlined below as the basis for measuring if rehabilitation is adequate and accessible in a country of return may present a step forward in establishing, within the asylum context, that the denial of a right to rehabilitation can form part of the basis of a claim.

Assessing adequacy of rehabilitation in the Receiving State

It is important not to underestimate the challenge in obtaining even the most basic information on health or rehabilitation provision available in countries of return. One need only look at the top countries currently of interest in terms of return: many are emerging from conflict, most have serious phases of post-conflict rebuilding to achieve, and many are States shored-up by UN or regional entities and are under strict development agendas. Many do not have a national public health plan that includes reference to torture survivors' rehabilitation.

In all instances, obtaining precise data on rehabilitation services is challenging, and very little information is available in the public sphere. There is an urgent need for States to report on this issue. As things currently stand, decision-makers will be hard pressed to make informed determinations in this area in the current vacuum of relevant information.

With this limitation in mind, it is nonetheless possible to set out a framework for assessing adequacy of available services, in the interest both of considering a State's ability to provide appropriate services to a returning torture survivor and of giving some guidance on what data is needed.

[70] The MF is developing its thinking in this area, looking for appropriate cases and will publish a paper on this in mid 2011.
[71] M. Foster, *International Refugee Law and Socio-Economic Rights: Refuge from Deprivation,* 2009.

In assessing the adequacy of treatment in the Receiving State, regard should be given to current clinical practice and understandings of what constitutes appropriate and adequate rehabilitation to enable as full rehabilitation as possible. This section outlines key dimensions of rehabilitation and of adequacy in terms of minimum criteria, as commonly interpreted by experts in clinical practice with torture survivors.

Rehabilitation in clinical understandings is used to refer to rehabilitative *services and context*, the *process* of recovery for individual victims and their families, as well as the *outcome and indicators* of rehabilitation, or recovery. For the purposes of defining adequacy of rehabilitation, the focus here will be only on the constituent components of rehabilitative services and relevant minimum criteria with respect to service design and context.

Three key minimum criteria of 'adequate rehabilitation' services need to be met, and all three need to be present before services can be deemed adequate. All three criteria are interdependent, interrelated and indivisible. In many cases the establishment of any single criterion will be contingent on the presence of other criteria.

- **Criterion 1** - Rehabilitation services **appropriate** for torture survivors.

Appropriateness refers to the standard by which rehabilitation services are able to address the clinical and holistic, rehabilitative needs of torture survivors, arising from their experiences of torture, and where relevant, the related rehabilitation needs of their families. The mere availability of general healthcare will not satisfy the criterion of 'appropriate' services for torture survivors unless the services fulfil the minimum criteria of 2 and 3 below. For example, in cases where general medical and psychiatric services exist in the country to which a torture survivor is returned, it is unlikely that the rehabilitation needs of torture survivors will be met unless those services are accessible, safe and stable.

- **Criterion 2** - Rehabilitation services to be **accessible** to torture survivors.

For rehabilitation services to be considered adequate they would need to be accessible to torture survivors in practice.

Geographical limitations can impede access to available services, which themselves may be inadequately resourced and staffed, such that the likelihood of torture survivors being able to access care, even with the specific prioritisation to be offered to them by virtue of the State's narrow margin of discretion is low. Accessibility in this regard requires that torture survivors, without discrimination, can be seen promptly and their rehabilitation needs assessed and identified as early as possible upon return. In health terms, early assessment and identification requires identification of those torture survivors whose clinical needs are urgent, and of those who are particularly vulnerable, including young people, the elderly, those with severe mental or psychological health problems and those with physical disabilities, illnesses and acute injuries, requiring further prioritisation within the already narrow margin for discretion.

- **Criterion 3** - The environmental context in which rehabilitative services are offered to be **safe and stable.**

Environmental factors and lack of security or stability that impede or prevent access will render available services inadequate. For example, in the context of ongoing political instability, torture survivors may not feel safe to approach and access rehabilitation services where there remain concerns about the possible consequences, in terms of discrimination, further reprisals or breach of confidentiality by staff providing rehabilitation services.

Clinically, the criterion of safety is by necessity subjective, with the effectiveness of the rehabilitative process being dependent on the extent to which the torture survivor feels safe and is assured of the safe and stable context of rehabilitation.

Similarly, in a context where societal attitudes to returning torture survivors entail hostility, disbelief, blame, stigma or shaming (for example, with rape victims, or those with severe mental health problems), rehabilitation services cannot be deemed to be meaningfully accessible or adequate if torture survivors are unable to integrate and their experiences of injustice are not acknowledged officially nor their dignity publicly validated, such that they are hindered or feel unsafe to approach rehabilitation services.

In the case of geographical limitations, the availability of rehabilitation services in one area does not fulfil the criterion of safety if the geographical area is perceived as unsafe, or the route to access this area entails risks to the safety of the torture survivor. Further, if the geographical, political, staffing or financial limitations or the absence of adequate housing are likely to result in rehabilitation services being unstable, or not being reliably accessed at repeated appointments during the period of the rehabilitation programme, the accessibility criterion cannot be seen to have been met.

Conclusion to Part II

The cases of torture survivors faced with return to the State responsible for their torture, in circumstances where appropriate clinical facilities are inadequate or absent, are clearly different in nature to those concerning individuals suffering naturally occurring illness or disability. The right at issue is the right to a remedy, rather than the right to health, and this right engenders different obligations for the Receiving State in terms of treatment provision and prioritisation. In addition, the fact of direct State responsibility for harm suffered lowers the threshold of article 3 in the assessment of potential harm suffered on return, while any assessment must also encompass additional harm and consequent treatment needs generated by the fact of return itself. There is a need to further explore the protective ambit of international refugee law in reliance on the right to rehabilitation.

Generally, it is clear that efforts to develop the content of the right to rehabilitation can benefit greatly from emerging clinical understanding and articulation of indicators that can inform legal understandings. The three criteria put forward in this paper set out that in order that services in the Receiving State might be considered sufficient for return, they must be practically accessible, adequate in terms of content and reflective of key operation standards, including being non-discriminatory.

Biographies of contributors

Ellie Smith

Ellie Smith is a Human Rights Lawyer and Researcher with expertise in the international law of torture, and with specialism in reparations and justice for torture survivors and the application of international human rights standards into regional and domestic practice. She spent eight years with the Medical Foundation as Human Rights Research Officer. She is currently Visiting Research Fellow in the Centre on Human Rights and Conflict, Department of Law, and Honorary Lecturer in Psychology at the University of East London, and works as an Independent Consultant and Researcher in the law of torture.

Nimisha Patel

Dr Nimisha Patel is a Lead Consultant Clinical Psychologist and Head of Audit and Evaluation Research at the Medical Foundation. She is also a Reader in Clinical Psychology, University of East London. She has lectured extensively and published in the area of the rehabilitation of survivors of torture.

Leanne MacMillan

Leanne MacMillan is the Director of Policy and External Affairs at the Medical Foundation where she leads an interdisciplinary team that combines policy, advocacy, research, legal casework, campaigning and capacity building. She is an elected member of the Council of the International Rehabilitation Council for Torture Victims, regularly lectures on the prevention of torture, gender and torture, and human rights documentation in clinical contexts. She is a lawyer and has been an activist in human rights for over two decades, has conducted research in over 20 countries and has represented human rights organisations at the UN, EU and other regional fora.

Bibliography

Treaties

Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field, 1949.

Convention for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea, 1949.

Convention Relative to the Treatment of Prisoners of War, 1949.

Convention Relative to the Protection of Civilian Persons in Times of War, 1949.

Convention for the Protection of Human Rights and Fundamental Freedoms, 1950.

Convention Relating to the Status of Refugees, 1951.

International Covenant on Civil and Political Rights, 1966.

International Covenant on Economic, Social and Cultural Rights, 1966.

International Convention on the Elimination of All Forms of Racial Discrimination, 1966.

Inter-American Convention on Human Rights, 1969.

Vienna Convention on the Law of Treaties, 1969.

Additional Protocol I to the Geneva Conventions, 1977.

African Charter on Human and Peoples' Rights, 1981.

United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1984.

Convention of the Rights of the Child, 1989.

Declarations and other instruments

Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law (the "UN Basic Principles"), adopted by General Assembly resolution 60/147, 16th December 2005.

Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power, Adopted by General Assembly resolution 40/34 of 29 November 1985.

Declaration on the Protection of all Persons from Enforced Disappearance, General Assembly resolution 47/133 of 18 December 1992.

International Law Commission, *Draft Articles on Responsibility of States for internationally wrongful acts* (2001).

Principles on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions, Economic and Social Council resolution 1989/65 of 24 May 1989.

Rules of Procedure and Evidence for the International Criminal Tribunal for Rwanda, U.N. Doc. ITR/3/REV.1 (1995), adopted 29th June, 1995.

Rules of Procedure and Evidence for the International Criminal Tribunal for the Former Yugoslavia, U.N. Doc IT/32/Rev.40, adopted 11th February 1994.

Rome Statute of the International Criminal Court, UN.doc.A/CONF.183/9.

UN Committee against Torture, *Concluding Observations on Peru*, (CAT/C/PER/CO/4(2006)).

UN Committee against Torture, *Concluding Observations on Georgia*, (CAT/C/GEO/CO/3 (2006)).

UN Committee against Torture, *Consideration of Guatemala's initial report*, (CAT/C/SR.232 (1995)).

Universal Declaration of Human Rights, 1948.

Books, Reports and Articles

American Psychiatric Association. *Diagnostic Statistical Manual-R*. APA, Washington, 1981.

Burgers, J. Herman and Danelius, Hans, *The United Convention against Torture: A Handbook on the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, 1988.

Foster, Michelle, *International Refugee Law and Socio-Economic Rights: Refuge from Deprivation,* Cambridge University Press, 2009.

Giller, I. & Bracken, P. & Kabaganda, S. *Uganda: war, women and rape*. Lancet, 337:604, 1991.

Hannah, J., Winning Human Rights Cases – Specific Articles of the ECHR and how to use them, (undated).

Home Office, *European Convention on Human Rights*, API, October 2006.

Home Office, *Applications raising article 3 medical grounds*, APU Notice, 20th Oct 2003.

Home Office, Immigration Directorates' Instructions, Chapter 1, Section 10, February 2007.

Medical Foundation for the Care of Victims of Torture, *Rape as a Method of Torture*, 2004

Medical Foundation for the Care of Victims of Torture*, Justice Denied: The experiences of 100 torture surviving women of seeking justice and rehabilitation*, 2009.

Nowak, M., *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, 15th January 2008, A/HRC/7/3

Patel, N., *Reparation for Survivors of Torture: Towards an integrative framework for understanding 'Rehabilitation'*, unpublished Masters thesis, 2007.

Pirouet, L. *Suicide and Attempted Suicide among Asylum Seekers Detained in the UK by the Immigration Authorities. Paper presented to the Institute for the Study and Treatment of Delinquency, Canterbury, 1991.*

Redress, *Rehabilitation as a Form of Reparation under International Law*, December 2009.

Save the Children, *Asylum and Immigration Implications for HIV/AIDS Diagnosis*, (undated).

Turner, S. & Gorst-Unsworth, C. *The psychological sequelae of torture: a descriptive model.* British Journal of Psychiatry, 157, 475-480, 1990.

Vinar, M. *Pedro or the demolition: a psychoanalytic look at torture.* British Journal of Psychotherapy, 5:353-363, 1991.

Cases

International:

Factory at Chorzow (Germany v. Poland) (Merits), (1928) PCIJ, Series A., No. 17.

Hugo Rodriguez v. Uruguay, HR Comm. no. 322/1988, Views of 19th July, 1994, U.N. Doc. CCPR/C/51/D/322/1988 (1994)

Inter-American Court

Velasquez Rodriguez, Serial C, No. 4 (1989), 174.

Castillo Paez v. Peru, 27th November, 1998.

Suarez Rosero v. Ecuador, 20th January, 1999.

Blake v. Guatemala, 22nd January, 1999.

Villagrán Morales and Others v. Guatemala, 19th November, 1999.

Barrios Altos v. Peru, 30th November, 2001.

Cantoral Benavides v. Peru, 3rd December, 2001.

Bulacio v. Argentina, 18th September, 2003.

Molina Theissen v. Guatemala, 3rd July, 2004.

19 Tradesmen v. Colombia, 5th July, 2004.

Juvenile Re-Education Centre v. Paraguay, 2nd September, 2004.

Tibi v. Ecuador, 7th September, 2004.

De La Cruz Flores v. Peru, 18th November, 2004.

Plan de Sanchez v. Guatemala, 19th November, 2004.

European Court of Human Rights

D v. UK (1997) 24 EHRR 423.

BB v. France, 9th March 1998, RJD 1998-VI, p.2596.

Karara v. Finland, Application No. 40900/98, 29th May, 1998.

MM v. Switzerland, Application No. 43348/98, 14th September 1998.

SCC v. Sweden, Application No. 46553/00, 15th February 2000.

Bensaid v. UK, (2001) 33 EHRR 10, 6 February 2001.

Kudla v. Poland, App. No. 30210/96; (2002) EHRR 11.

Henao v. Netherlands, Application No. 13669/03, 24th June 2003.

Amegnigan v. Netherlands, Application No. 25629/04.

N v. UK Application No. 26565/07, 27th May 2008.

United Kingdom

R v. SSHD ex p. Razgar, [2004] UKHL 27.

N(FC) v. SSHD [2005] UKHL 31.

Y&Z (Sri Lanka) v. SSHD [2009] EWCA Civ 362.