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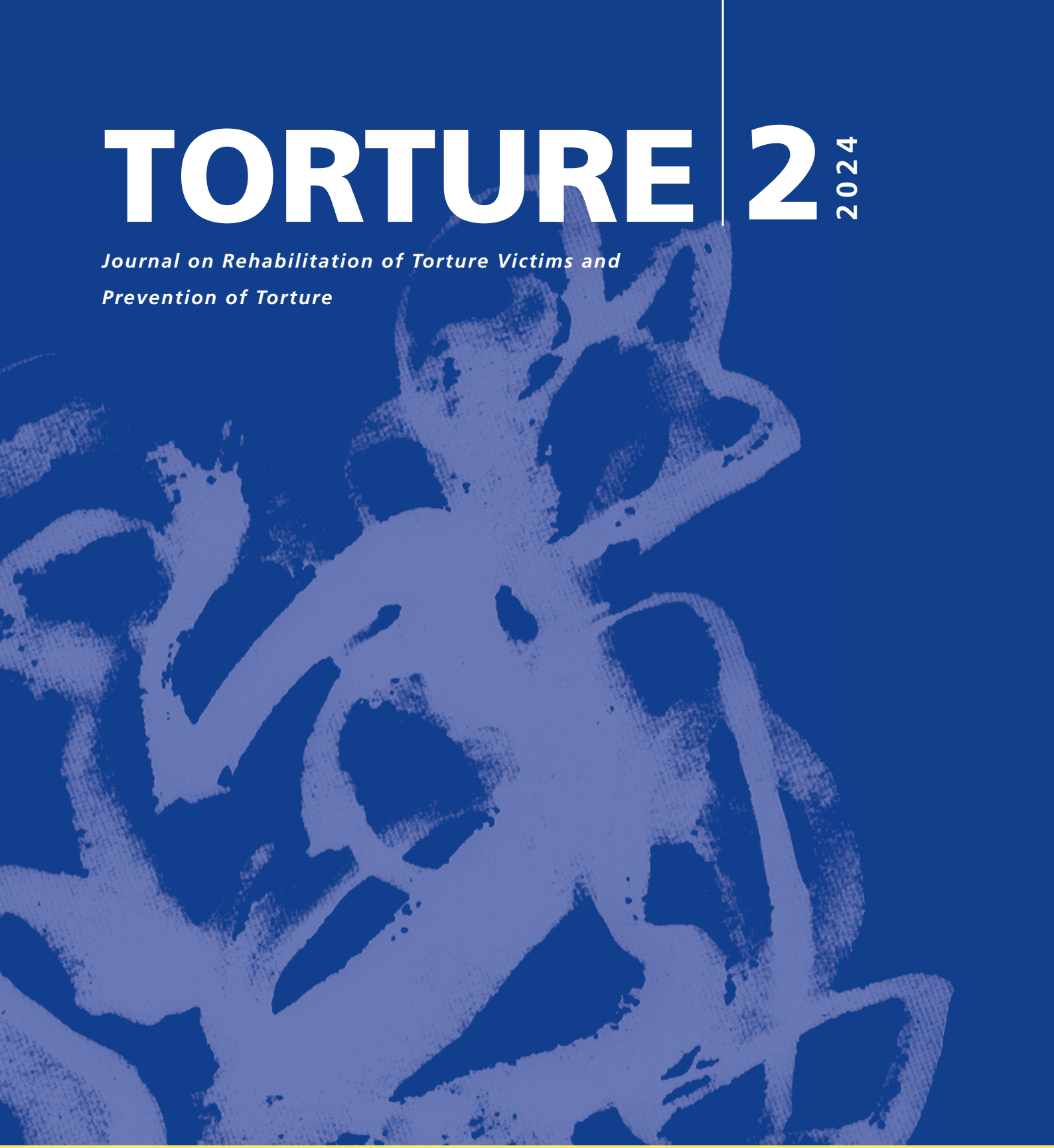

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https://doi.org/10.7146/torture.v34i2.149090 *Editorial*

Cross-cultural assessments of torture survivors based on the Istanbul Protocol

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Abstract

The text provides an overview of the key considerations for conducting a cross-cultural assessment of a torture survivor. The first part introduces essential concepts in anthropology, medicine, cross-cultural psychology and psychiatry. The second part reviews the most relevant elements concerning a forensic report of a survivor. The text has particular focus on cultural considerations regarding the ethical aspects of the Istanbul Protocol. It also addresses aspects related to the encounter with the survivor and the interview, medical aspects including the physical examination with a focus on transcultural ideas on pain and suffering, and the psychological and psychometric assessment. It also briefly discusses aspects related to consistency and credibility analysis. In the last section, the text provides a global perspective and a checklist of cultural considerations following the outline of the Istanbul Protocol.

An evaluation of a torture survivor would require a cross-cultural perspective when there is a difference between the cultural, linguistic or ethnic background of the survivor and the institution or the person that requires it.

The Istanbul Protocol, in its 2022 revised version, offers some indications on how to take cultural aspects into account in the assessment of torture survivors (see annex 1).

In this editorial, we will try to further elaborate on transcultural aspects of forensic assessments and provide suggestions and guidelines in the framework of the Istanbul Protocol.[1]. The first part of the editorial will review basic anthropological concepts, while the second will focus on specific aspects of the assessment.

Anthropological expertise versus transcultural assessment. Generally speaking, the expert will face two different types of reports (Kirmayer et al., 2007):

1. Those of a more anthropological nature attempt to explain the cultural context in which the events take place and the particular significance they may have in the light of that context. The aim is to understand how the cultural context determines the account of events, including likely causal explanations (IIDH, 2010; Meger, 2010). Table 1 reflects three examples of this type of report. In all them, the anthropological expertise helped the Court to understand the role of culture and context in the framing of rights violations
2. Expert reports of a more clinical nature, related to cross-cultural medicine and psychology, that aim to explain the individual, family and community impacts of torture in the light of the person's worldview including psychosocial, anthropological and cultural perspectives. Table 2 provides four examples. In all these cases the expert report assessed the specific impacts of torture from the light of the identity and cultural background of the victims.

1 The terms cross-cultural and transcultural are often used interchangeably, but they have distinct meanings, especially in fields like psychology, anthropology, and healthcare. Cross-cultural refers to the comparison or interaction between two or more different cultures. It focuses on identifying and understanding the differences and similarities across cultures. Transcultural refers to going beyond individual cultures to find commonalities and shared experiences. It aims to integrate aspects from multiple cultures, transcending boundaries to create a new, inclusive understanding

Table 1.

Case	Relevance of forensic report – expert witness from a cross-cultural perspective
Yakye Axa Indigenous Community v. Paraguay Interamerican Court of Human Rights (2005)	The Yakye Axa community, part of the Enxet-Lengua people, traditionally inhabited the Chaco region in Paraguay. Over time, their lands were sold to private owners, leading to their displacement and severe living conditions. – An anthropological report showed the community's historical connection to their ancestral lands – A cross-cultural assessment showed the suffering of the community and the impact of displacement on cultural and social life. The Court ruled against the State, among other HR violations, regarding the Right to Life (Article 4) due to the community's precarious living conditions and the inaction of the State[2].
Similar cases in the IACHRT: Xucuru Indigenous People and their Members vs. Brasil (2018); Mayagna Awas Tingni Community v. Nicaragua (2001), Saramaka People v. Suriname Maya Indigenous Communities of the Toledo District v. Belize	
"Street Children" (Villagrán-Morales et al.) v. Guatemala (1999)[3]	The case concerned the kidnapping, torture and murder of four street children in Guatemala City by individuals or groups operating outside the control of the state. Expert reports and expert witnesses provided information on the situation of street children in Guatemala, including marginalisation, stigma, vulnerability to abuse and exploitation. The Court condemned the state for lack of protection of the tortured and murdered children.
Royal Commission into Aboriginal Deaths in Custody (1987-1991)[4]	The Commission made an inquest on the disproportionate number of suicides of Aboriginal people in Australian police stations and prisons. The findings of the expert reports showed the psychological impact of cultural dislocation, racism, and the lack of consideration for the distinctive needs of Aboriginal inmates.

Table 2. *Relevance of forensic report – expert witness from a cross-cultural perspective*

Case	
Prosecutor v. Thomas Lubanga Dyilo (2012) International Criminal Court[5]	Thomas Lubanga Dyilo, a Congolese army leader, was charged with enlisting and conscripting children under the age of 15 and using them in the Patriotic Force for the Liberation of Congo (FPLC). – Many of the witnesses were former child soldiers who testified about their recruitment, training, and participation in hostilities. While the defence often challenged the credibility of witnesses, particularly those who were former child soldiers, the prosecution called upon expert witnesses, including psychologists and child protection specialists, to provide context and explain the psychological impact of the crimes on the child soldiers, supporting the credibility of the statements – There was also a discussion on whether the minors had voluntarily joined the Army. The psychological expert reports discussed the consideration of age, family, community and cultural norms to show the unvoluntary nature of their involvement. The Court ruled the minors suffered cruel and inhumane treatment.

2 https://corteidh.or.cr/docs/casos/articulos/seriec_125_ing.pdf
3 https://corteidh.or.cr/docs/casos/articulos/seriec_77_ing.pdf
4 http://www.austlii.edu.au/au/other/IndigLRes/rciadic
5 'Lubanga (ICC-01/04-01/06) Decision of the Trial Chamber I; 14 March 2012', 2012, pp. 1–624. https://www.icc-cpi.int/sites/default/files/CourtRecords/CR2012_03942.PDF

Case	
Prosecutor v. Bosco Ntaganda International Criminal Court[6]	Bosco Ntaganda was charged with war crimes in the ICC including rape, murder, and torture committed by his troops in the Central African Republic (CAR). – The transcultural forensic reports documented the systematic use of rape and sexual violence as a weapon of war in Congo, the profound trauma inflicted on the victims, many of whom were stigmatized and ostracized in their communities due to the sexual violence they endured. – Expert reports also were essential in determining individual and collective reparation measures
Lonkos and Mapuche Communities v. Chile (2008) Inter-American Court of Human Rights (IACtHR) (Vargas-Forman et al., 2022; Vargas, 2017)	The Court analysed the application of Chile's Anti-Terrorism Law against Mapuche leaders and activists who were advocating for territorial rights. – The forensic reports considered the cultural significance of the Mapuche people's connection to their land and the right to recover their ancestral lands, the role of the Longkos and Machis (traditional healers) within the community and the psychosocial impact of detention on them when being condemned in high security prisons far from the land. The State was condemned to overturn the convictions and ordered individual and collective reparation measures that took into account the cultural elements of trauma.
Ines Fernández vs Mexico[7]. Inter-American Court of Human Rights (IACtHR)	Mrs. Fernández Ortega was an Indigenous Me'phaa woman, resident in Barranca Tecoani, Guerrero state. At the time of the events, on 22 March 2002, she was raped at home in front of her four children by a group of approximately eleven Mexican soldiers, dressed in uniforms and carrying weapons, to obtain information on the whereabouts of her husband. – An expert report, with a psychoasocial and transcultural perspective, assessed the personal and family impact that Mrs. Fernández Ortega and her children suffered as a result of the rape and the years of impunity – A second report assessed the impact that the torture had on the Me'phaa Indigenous community, especially the women and the social fabric.
Similar case: Rosenda Cantú vs Mexico.	

Some basic concepts of Ethnomedicine and Ethnopsychology.

We will here very briefly go through basic concepts in anthropological medicine, relevant to writing forensic reports.

An ethnic group can be defined as a collective of individuals who share a common cultural tradition, symbolised by an identifying name and a collective consciousness of belonging to that group. It is estimated that there are currently approximately 15,000 ethnic groups worldwide, with some comprising only a few surviving individuals.

Ethnicities are *dynamic and heterogeneous structures* that are in constant interaction with the surrounding populations, with frequent insertions, borrowings or exchanges among cultures. It is therefore important to avoid a rigid or essentialist view of cultures and to refrain from assuming the existence of cultural archetypes. For instance, there may be greater similarities between a young Guaraní and a young Mapuche internally displaced in town, than between a young and an older traditional Guaraní person. Furthermore, due to globalization, a significant proportion of survivors can navigate multiple cultural contexts with relative ease.

Cultural relativism posits that all cultural norms are inherently valid and deserving of respect. Nevertheless, in instances where these practices conflict with fundamental human rights, the latter must prevail. Female genital mutilation provides an illustrative example of this tension between cultural norms and the protection of human rights. Nevertheless, the question of where the boundary of what are considered fundamental human rights lies is open to debate, particularly from those who argue that the Universal Declaration of Human Rights was drafted from the perspective of Global North, with markedly individualistic societies (Ramcharan, 1998).

Etic and Emic

The study of culture can be roughly approached from two perspectives: the *emic approach,* which involves the description and

6 https://www.icc-cpi.int/sites/default/files/CourtRecords/CR2019_03568.PDF

7 https://corteidh.or.cr/docs/casos/articulos/seriec_215_esp.pdf

analysis of a culture from the perspective of those who belong to it, and the *etic approach*, related to the description and analysis of a culture from the perspective of an external observer.

To illustrate, in the context of the impact of traumatic events, *susto* can be conceptualised as an ethnic-illness endemic to certain Latin American cultures, that appears mostly in children. It is typically described as a critical bodily response of physical and psychological collapse in response to situations of alarm or crisis. However, it is important to note that there are variations in the descriptions, causal attributions and treatments applied to *susto* by the family or healers in different countries and cultural settings. By contrast, from an etic perspective, *susto* would be labelled, according to Western psychiatric classifications, as an adjustment or an anxiety disorder. The emic approach is more closely aligned with the subjective and experiential perspective of the survivor. In contrast, the etic perspective facilitates the establishment of a shared forensic language, which is crucial in an expert process. Indeed, anthropological expert opinions aim to establish a connection between the two perspectives (Harris, 1976).

Key concepts in cross-cultural psychology relevant to forensic assessment

Self and identity. The concept of person and self is understood differently in Western and non-Western cultures. There are alternative ways of defining what constitutes correct or "normal" behaviour. Furthermore, in collectivistic societies there are interpersonal constructions of personality that extend beyond Western individual traits. A significant number of clinical diagnoses lack adequate cultural translation and personality disorders is one of them (Sökefeld, 1999). Consequently, it is imperative to exercise particular caution when analysing allegedly personality traits or making personality diagnoses in the context of cross-cultural assessments.

Cultural determination of emotions. Although there is a set of emotions that are considered universal (the usual agreement is happiness, sadness, anxiety, anger and disgust), the context in which these emotions are considered normative or expressed varies across culture (Leff, 1988). An understanding of the cultural context in which emotions are experienced is thus required (Kirmayer et al., 2018). The interpersonal emotions of guilt and shame serve to exemplify this cultural dependence, with notable discrepancies observed between, for instance, African, European, and Asian cultures regarding the origins, bodily symptoms, triggering situations, cognitions and behaviours linked to guilt (Leff, 1988).

Cultural analysis of pain. There is no evidence to suggest that cultural differences exist in the perception of physical or psychological pain. However, there are discrepancies in the interpretation of pain (and suffering as its subjective dimension) and in the manner in which its expression is deemed socially acceptable (Alexander et al., 2007). It is contrary to the available evidence to assume that there are cultural contexts in which individuals who suffer ill-treatment or torture are more resilient to (and therefore feel less) physical or psychological pain.

Grief and Bereavement. It is particularly important to consider the impact of culture on forensic reports in the context of bereavement and mourning. In Western societies, the individual is typically regarded as either dead or alive in the biological sense. In contrast, traditional cultures often conceptualise a series of transitional phases between life and death, during which the person is perceived to remain present and interact with the living. This includes, for instance, expressing opinions and engaging in activities that continue to affect friends and loved ones. Consequently, there are numerous avenues of symbolic communication with relatives through pain, dreams or rituals. Accordingly, in Western societies, rituals are directed towards the bereaved and the suffering they are enduring, whereas in traditional societies, rituals are communal social acts that support the deceased and help them on their journey towards other dimensions of life in these different states of transition. The focus is on helping those who leave and not those who remain.

Health and disease

The concept of health and illness varies considerably between different ethnomedicines. There are significant differences in the way disease, its causes and, consequently, the best treatment are conceived.

A dualistic view of mind and body and the significance of disease. The concept of mental illness is linked to a dichotomous view of body and mind that is not shared by all cultures. A holistic view of the human being will only consider illness - which encompasses, in its wholeness, the body and the mind. Bodily pains can be an embodied memory of traumas, losses and crises. (Raingruber & Kent, 2003). In the case of torture victims, physical symptoms, particularly chronic pain, will often be forms of bodily metaphors for the traumatic experiences the person has endured. (Theidon, 2004).

Relationship between body and symptoms. While Western cultures tend to express distress using emotions and cognitions, non-Western cultures tend to have a holistic view of mind and body and express distress through somatic symptoms. Sometimes this is wrongly labelled by Western experts as *alexithymia* or inability to put words to emotions. This can be a Western-colonizing view of misinterpreting body-mind unity. This view can lead to errors by not properly exploring mental

health issues or trauma when they are primarily presented as physical complaints.

Illness

In the Western conception, psychological disturbances are understood to result from a disruption in the individual's functioning, which may be attributed to either biological alterations (i.e. lack of serotonin) or a lack of emotional or cognitive resources (coping mechanisms to navigate the external environment). In contrast, traditional cultures tend to view illness as originating from external agents, whether physical, natural or supernatural, that *penetrate* the body and disrupt its equilibrium. This force is a personification of the illness that has entered the body and which the therapist must therefore expel. In order to extract the disease, a variety of therapeutic techniques are employed, with the central focus being on symbolic healing processes of a secular or religious nature, as described in numerous texts on medical anthropology (Levi-Strauss, 1964). Symbolic healing is combined with a number of other traditional therapeutic elements, including meditation, phytotherapy, ecstasy and catharsis, the use of metaphors and counselling guidelines, the recontextualisation of the problem in accordance with culture, the resignification of the person's role, the restructuring of the family or social environment, and ceremonies that restore balance and reconnection with the environment, social elements, or natural or supernatural forces.

These therapeutic manoeuvres have a biological basis insofar as, through the manipulation of symbols and other techniques, they are able to generate biological changes in the person (Dow, 1982). The physiological bases of these changes are gradually becoming better known with the study of interoceptive receptors and the bi-directional connection between the central brain and these peripheral receptors (Khalsa et al., 2018; Tsakiris & Preester, 2019). These processes are not dissimilar to the biological changes observed in the standard Western psychotherapies (Davies, 2018).

Traditional medicine practitioners can discern these interconnections and offer culturally congruent coping strategies that are beyond those of a Western-trained therapist.. Therefore, collaboration and communication between different medical systems are vital for the benefit of the patient. The input of a traditional healer can be invaluable in providing an outside perspective to offer contrasting views and an alternative perspective when preparing a forensic report..

Culture-bound syndromes and Idioms of Distress in the assessment of torture survivors

Are there non-culture-bound syndromes?

Western classifications have traditionally included a category of the so-called culture-bound syndromes (CBS). The supposition that CBS exist is merely an ethnocentric conceptual distortion and, with time, the concept has declined. There are numerous medical systems globally, each with its own diseases classification system. Regardless of the specific taxonomy employed, culture is a pertinent factor in all of them. Koro and Dhat can be considered culture-bound syndromes in the same way that anorexia, alcoholism or depression are (Leff, 1988). Western classifications tended to group some folkloric syndromes under the label of CBS, collecting some of them from among the hundreds of diagnoses that exist in the different ethnomedical systems and cultures around the world. However, the emphasis in CBS was placed on the anecdotal rather than on the cultural understanding of the symptoms and syndromes. The majority of the so-called culture-bound syndromes (CBS) are somatic, dissociative, or psychotic reactions to overwhelming anxiety and stress. These syndromes possess an inner logic that can be discerned through a process of assessment and dialogue, which is what is relevant in the expert assessment.

It is important to distinguish between the so-called CBS and idioms or cultural concepts of distress.

Cultural concepts of distress

The term cultural concepts of distress (known in the past as *idioms of distress*) is used to describe words or expressions that capture physical or psychological discomfort from a cultural perspective (Kaiser & Weaver, 2022). Such expressions may correspond from simple colloquialisms to symptoms, signs, or even nosological entities. For a cultural concept of distress to be considered a syndrome, it must manifest within a specific cultural context, possess a name that is recognised by local healers, and be accompanied by an aetiological and therapeutic hypothesis that is grounded in that culture.

To list even an approximate list of *Cultural Concepts of distress* that have been used concerning survivors of torture can be an endless task (Simons & Hughes, 2012). Over the last 30 years, more than 100 papers have been published with different proposals for specific terms and symptoms that would reflect psychological or psychosomatic reactions about experiences of war, violence, conflict or torture in almost every geographical location where extreme violence has occurred. Just as an example, there are around ten papers, one review and two chapters that describe cultural concepts of distress for Cambodia survi-

vors, suggesting terms which are, by the way, not always coincident in their meaning and context of application (Kidron & Kirmayer, 2019).

Cultural concepts of distress are not diagnoses. In a way of speaking, "being stressed" is a cultural concept of distress in Western cultures that may or might not correspond to multiple (or any) diagnoses. The cultural concepts of distress that people use in their language bring us closer to the reality in their words and narrative (Kidron & Kirmayer, 2019).

We might find, just to mention some, the *baksbat* (Broken Courage) in Cambodia (Chhim, 2013), *tension* (tension), *bi-shi sinta* (excessive thinking), *feshar* (pressure), *gum zai nofara* (unable to sleep), and *shoit-shoit lagon* (feeling restless and/or trapped) among Rohinya refugees (Trang et al., 2024). *Hozun* and *majnun* have been described Among Darfur refugees (Rasmussen et al., 2011); *child witchcraft* (as a metaphor for family psychosocial and trauma suffering) has been described in Sierra Leone torture survivors (Yoder et al., 2021), *pinsamientuwan* (repetitive thoughts, worries), *ñakary* (collective suffering and distress, collective punishment) or *llaki* (sorrow, embodied grief) among quechua people in Perú (Pedersen et al., 2008, 2010), *reflechi twòp* (thinking too much) in Haiti (Kaiser et al., 2014), although similar cultural concepts around thinking too much are described in many cultures (Kaiser et al., 2015); *huzun*i (deep sadness), *msongo wa mawazo* (stress, too many thoughts), and *hofu* (fear) in refugees from Congo (Greene et al., 2023), *Sakit Hati* (chronic mental distress related to resentment and anger amongst refugees exposed to persecution) in West Papua (Rees & Silove, 2011). In Nepal, Kohrt & Hruschka (2010) described up to sixteen cultural concepts of distress related to trauma and torture.

Some studies show that CCD might be more useful in forensic assessments than Western categories. Chhim (2014) showed, while doing forensic expert reports for the Extraordinary Chambers in the Courts of Cambodia (ECCC), that *Baksbat* (Broken Courage) could capture more trauma symptoms among Khemer Rouge survivors and provide unique information beyond that described by PTSD. More important than a catalogue of terms is the availability of methodologies that help us to understand and properly describe the experiences of severe suffering of survivors in specific cultural contexts (Rechtman, 2000).

The Mapuche people have a complex ethnomedical system with a classification of diseases transmitted orally that combines the physical, psychological, psychosocial and spiritual, with specific treatments attached to each one (Pérez-Sales et al., 2000). Among the Mandinka, Fox (2003) identified four post-trauma syndromes: two were disorders of the heart, one affected the mind, and the last affected the brain. These syndromes operate cumulatively: If the heart problems are severe, this leads to dysfunction in the mind and, ultimately, the brain. At each stage, Mandinka healers had specific treatments. In both cases, there is a medical system that provides a theoretical framework to understand the diagnosis of torture survivors from within the culture.

Williams (2021) has shown how in most contexts torture survivors navigate both systems and often hybridisation between the emic and etic occurs. In his study, in Uganda, the psychiatric notions of suffering brought into the region by humanitarian intervention programs interacted with local concepts of suffering (based on conceptions of the spirit) and people proved a mixture of Western concepts with traditional meanings and causal explanations.

Trauma is a universal experience, but not a universal entity, it is a social construct. Culture shapes the way that torture and trauma are perceived and responded (Nicolas et al., 2014). Forensic experts should, as much as possible, avoid limiting their work to fit the survivor in pre-fixed categories, but try to gain deeper insight into local perceptions of trauma-related distress. and how symptoms are understood, interpreted, expressed and coped with (Bovey et al., 2024).

Although there has been much debate about the cross-cultural validity of the PTSD concept (Marsella, 2005), there is now sufficient accumulated evidence to show its biological basis, shared traits across cultures and usefulness (Hinton & Lewis-Fernández, 2011). Its use not only allows for a common forensic language, but also for comparison of impacts between people from different cultural backgrounds and types of violence, something that would be impossible to address from an emic perspective alone. Preliminary data also partly supports the transcultural validity of Complex PTSD (Heim et al., 2022). Annex 2 shows a selection of comparative epidemiological data on PTSD in the general population and in survivors of war and torture in different countries and cultural settings, showing the usefulness of its use as a shared global concept from an etic perspective.

Interviewing survivors- Some cross-cultural elements

In cross-cultural assessment, some particularly elements require consideration. These include, among others:

– The use of *Western terms* for which a translation is assumed to exist. In some cultures, there are no terms that are equivalent to some folk Western expressions like anxiety or depression. There are, in some cultural settings, certain particular ways of asking about psychological distress. Common questions in Latin America or Africa might be: *How is your heart*

doing? How are you thinking? The interviewer might have answers such as*: My heart is weak or my thoughts do not rest; I keep having brain pain; Since I got out of prison, I have a burning heat that goes up and down my body*, or *At night I feel ants walking inside my body*... As most people are nowadays bicultural, anxiety and depression will likely be understood by all survivors, but it is good practice to be aware how is the usual way to ask.

- Individualistic or Western cultures are more inclined to make *intimate or personal disclosures*. This may result in the forensic expert perceiving individuals from collectivist cultures as lacking trustworthiness, sincerity, or a capacity to convey their thoughts with clarity. Consequently, they may be regarded as exhibiting inconsistency or a lack of credibility (Jubany, 2017).
- Additionally, cultural differences exist concerning the *types of questions or situations that are perceived as embarrassing*. In a Western setting, it may be perceived as socially inappropriate to make out-of-context comments. In traditional cultures, the act of interrupting another individual without allowing them to conclude their utterance or raising one's voice to engage in discourse with new arguments may be perceived as a breach of cultural norms.
- From a Western perspective, the *concept of truth or falsehood* is dichotomous. In collectivist cultures, by contrast, there may be a socially tolerated use of white lies for the sake of maintaining balance in the dialogue or for the well-being of the group.
- There are differences in the *sense of humour* and very rational cultures find it more difficult to find absurd ideas amusing and humour or jokes might not be understood or even misunderstood.
- Finally, in collectivist cultures there is flexible *use of time* to meet the obligations of social reciprocity, whereas in individualistic cultures time is seen as a scarce resource to be rationed and controlled.

The Istanbul Protocol : transcultural perspectives

The Istanbul Protocol (UNHR, 2022) provides advice on cross-cultural aspects of assessing torture survivors. In Annex 1 we have collected the paragraphs where this is reflected, and the advice provided on them. There are aspects related to the interview, use of translators and formulation of diagnosis among others. We will consider here some aspects which are not fully developped and complement the information provided there.

Ethical aspects

The Istanbul Protocol sets out very strict ethical requirements for a report to be compliant with it. Some of these ethical requirements may demand a cross-cultural perspective. Table 3 summarizes these aspects.

Physical examination: cultural norms.

Different cross-cultural elements are of relevance in the medical examination:

There are important cultural differences in patients' expectations of the physician's physical examination. For some people, the fact that the doctor is close to the body, examines, touches and explores gives them confidence and indicates that the doctor has done his or her job properly. For others it may be seen as unnecessary and invasive and that the doctor should trust their account. It is important to ask questions in advance in the informed consent process and to take cultural preferences into account when organising the examination. (Costanzo & Verghese, 2018). It is also important when deciding whether a family member or other trusted person should be present at the physical examination of the person. In Arab cultural settings the husband may want to be present at his wife's examination and it is important, if the examiner is a man, to be able to have female health workers present at the examination in his place.

History taking

The medical examination is based on a thorough medical history similar to what would be done with any other patient seen for the first time in primary care. This includes an anamnesis and a systematic examination by apparatus, including not only the external observation of lesions but also a cardiological, respiratory, abdominal, musculoskeletal and sensory organ examination.

Some notions of tropical medicine will be helpful for patients coming from areas where there are uncommon infectious diseases, especially if the survivor was held in overcrowded prisons or unhealthy premises. Dietary conditions should also be explored.

A cross-cultural perspective will allow a targeted examination with a special emphasis on detecting the methods of torture prevalent in a certain area. Thus, for example, falanga requires a specific physical examination of the sole of the foot and alterations in mobility and standing which are not routinely done. Knowing that falanga is a widely used method of torture in, for instance, Sudan, Egypt or Syria will allow for specific questioning and examination of survivors from these countries. The use of sexual torture with the insertion of objects via the anus against Sahrawi militants by the Moroccan police allows for targeted anamnesis and eventual examination. There

***Table 3**. Transcultural view of ethical aspects in a forensic assessment compliant with the Istanbul Protocol.*

Informed consent	***Individual or collective decision.*** In some cultures, consent might be influenced by family, community or even religious authorities. It is essential to strike a careful balance between respecting individual autonomy and cultural norms, on the one hand, and the flexibility that others might be involved in the process, on the other. ***Language***. The informed consent document should be written in the language that the individual understands best. This entails the utilisation of straightforward and unambiguous terminology, devoid of legal or medical jargon that could prove confusing or intimidating. ***Non-verbal communication*** may be employed to ascertain whether the individual is comprehending the information provided and genuinely consenting to the proposed course of action. It is important to ensure that the individual is indeed understanding the information presented and that the consent is truly informed. ***Power balance***. Some individuals may be more vulnerable to power imbalance, particularly if the subject is from a marginalised or oppressed group. From a reparative perspective, the consent process should be designed to empower the individual and to ensure that they feel in control of their decision to participate. This would entail giving the person a clear right to refuse or withdraw consent at any point. ***Confidentiality Concerns***: In small communities and in contexts where local disputes and conflicts are prevalent, concerns about confidentiality may be particularly pronounced. It is of the utmost importance to address these concerns and to elucidate the manner in which the information will be safeguarded, with a view to preventing any potential harm. ***Culturally Appropriate Documentation***: Furthermore, the method of documenting consent must be culturally appropriate. A verbal agreement may be regarded as more binding than a written one. The process should respect these preferences while also meeting the legal and ethical standards that apply in this context.
Confidentiality and privacy	***Expectations around privacy and confidentiality***. In some cultures, the concept of privacy is highly valued and strictly maintained, whereas in others, the notion of privacy may extend to the community or family unit, rather than being confined to the individual. There is a risk that the forensic expert may breach the collective expectations of communal privacy. The justification for privacy can be based on legal grounds. In some cases, a participatory approach may prove an effective means of circumventing an otherwise challenging situation. One potential solution is to conduct the interview in a manner that allows for a distinction between collective and private aspects. This could entail addressing certain topics, such as the account of events, in a collective manner, while other aspects, such as medical and psychological exploration, are conducted privately.
Security	***Legal Awareness***: It is important to be aware of the local laws and regulations regarding the documentation and reporting of violence. For instance, reflecting sexual violence can have unexpected negative consequences in countries where there are homophobic laws or abortion is legally penalised. ***Global context but also local context.*** In small communities where there is a delicate balance between different ethnic groups or families in conflict, the act of visiting or interviewing residents in a particular house is not neutral. It is necessary to consider the roles and power balance within the community when determining how to conduct the assessment. It is particularly important to avoid singling out individuals in leadership roles, especially empowered women or families who may be at the centre of threats. ***Community Relations and risk of reprisals***: The possibility of backlash or reprisals may be greater in closely-knit communities where speaking out can affect not only the individual but also the wider family or community. Some members of the community might be fearful or vulnerable by others reporting.

are repeated reports of torture against sexual organs in China that will not be reported unless specifically asked.

Knowledge of cultural practices can also help to make a differential diagnosis in cases where some cultural practices can be confused with torture. Thus, for example, Einterz (2018) reported the need to make a differential diagnosis in Central African cultures between skin lesions caused by torture and skin lesions caused by ritual scarification. In children who have studied in Koranic schools in North Africa or Afghanistan are common marks and scars on legs and arms as a result of beating with sticks by teachers.

Biological markers

Biological parameters should be assessed with caution. For example, in certain malaria endemic areas there may be normative baseline levels of haemoglobin in the blood that would be considered indicative of anaemia in other settings. There are some analytical parameters that can be influenced by the area from which the person comes.

Also to consider that, in pharmacological torture, there are differences in the impact of drugs in different geographical areas due to differences in liver metabolisation (Lin & Lin, 2015). The effect of psychotropic drugs may be different from that expected in the assessor's usual environments.

Pain screening

The most important symptom in the medical examination of torture victims is pain. Up to 60% of survivors present with chronic forms of pain associated with torture. (Baird et al., 2017; de C Williams & Baird, 2016)

It is important to understand the difference between pain (as a neurological manifestation of damage) and suffering (as a subjective expression of pain) (Bustan et al., 2015). It is paramount to understand cultural variations in the expression of suffering, social norms and expected behaviour in interpreting the signs of examination (Abd-Elsayed, 2019; Lasch, 2000) and the connections between traumatic events, culture and pain.

Neurological manifestations

Differential diagnosis between some somatic conditions with conversive and dissociative symptoms and underlying neurological disorders can sometimes be challenging. This is especially complex in the case of pseudo-crises. An adequate anamnesis, a cultural understanding of the symptoms, the existence of a cultural perception of the disease and the performance of some complementary tests (such as an EEG or a sleep study) may help in the differential diagnosis (Moreno & Peel, 2004).

Psychological examination: etic and emic

In an expert assessment, the clinician should include an assessment from both the emic and etic perspectives. Regarding the etic approach, the interview corresponds to the standard criteria as developed in the Istanbul Protocol (chapter 4 to 6).
Table 4 summarises the steps for an emic assessment of the survivor.

Cultural formulation interviews.

Different models try to provide guidelines on how to conduct the psychiatric interview. The DSM-5 Cultural Formulation Interview (CFI) includes questions that explore the individual's cultural identity, cultural explanations of the illness, cultural factors related to the psychosocial environment and levels of functioning, and cultural elements of the clinician-patient relationship (Lewis-Fernández et al., 2020)

Kleinman (1988) has developed an extensive and very detailed model on how to explore mental health issues in different cultures. It has four sections that include asking patients about their understanding of the cause, course, and treatment of their illness, as well as their expectations for care.

Transcultural view of psychometric tools. Questionnaires adapted to culture and context

A psychometric analysis is essential when trying to objectify the consequences of ill-treatment or torture. But this entails additional challenges. In the case of large population studies, the development of ad-hoc instruments adapted to the context and culture may be considered. In most cases, however, the forensic expert will have to resort to previously developed and cross-culturally validated instruments. Table 5 provides a list of tools that have been validated in a wide range of cultures

In circumstances where some forensic assessments are required from the same population, an alternative route may be considered. This involves the development of a psychometric instrument based on local cultural concepts of distress. A variety of methodologies have been proposed (Bachem et al., 2024; Bolton et al., 2013; Fabian et al., 2018; Weaver et al., 2022) although all of them require a considerable amount of time (Patel & Hall, 2021)

Credibility analysis

There are some transcultural aspects of credibility in torture survivors, which a forensic expert must be aware:

– **Stereotyping and Bias**: Evaluators may unconsciously apply cultural stereotypes or biases when assessing the credibility of symptoms. For example, certain cultural groups might be un-

***Table 4**. Emic assessment*

1. Description of the symptoms elicited by torture in the person's own words. Clarification of symptoms and expressions
2. Consideration of whether the symptoms could correspond to some cultural concepts of distress according to what exists in the cultural environment to which the person belongs. Try to clarify when this is used and what situations produce it.
3. Whether the person suffered from these symptoms or syndrome earlier in life, and what treatment was prescribed from within the culture. If, at that time, they were brought by themselves or the family to a traditional healer and what kind of treatment they received.
4. Causal attribution of these cultural symptoms. Reasons for the symptoms to appear concerning torture and likely explanations, especially (a) if they can be attributed to some kind of transgression, harm or external influence other than torture. (b) why torture would produce these symptoms
5. Exploration of illness behaviours and the functional and life impact of the symptoms

***Table 5**. Psychotic Tools with a Transcultural Perspective.*

	Posttraumatic Stress Disorder
Harvard Trauma Questionnaire (HTQ) (Berthold et al., 2019; Shoeb et al., 2007)	The HTQ has been translated into over 30 languages and validated and used in around 50 countries. It includes both a trauma event checklist and symptom questions based on DSM criteria. It has been regularly updated to new DSM versions. Transcultural studies have shown very slight differences between the cut-off scores of the English version (2.5) and those in other cultures (Ocuppied Palestine (2,3); Iraq (2.2); Bosnia (2.6).
Postraumatic Stress Disorder Checklist- Civilian version (PCL-C) / PCL-5 (for DSM-V) (Blanchard et al., 1996; Weathers et al., 1991)	The PCL-C has been translated to around 30 languages and used in a similar number of countries. Although based on DSM diagnostics, some of the versions include adjusting the language and slightly modifying items to fit cultural norms and experiences of trauma. Most of the studies just translate the questionnaire but still use the English scores (cut-off 33). In some of the studies, cut-off scores were recalibrated (i.e. China, Japan, Brazil, Mexico) although the results always ranged quite close to the English original validation (range of cut—off scores 30 to 38)
Other alternative PTSD tools translated and/or validated to more than 20 languages around the world	Impact of Event Scale-Revised (IES-R) Clinician-Administered PTSD Scale (CAPS) Trauma History Questionnaire (THQ) Davidson Trauma Scale (DTS) Child PTSD Symptom Scale (CPSS)
	Depression
Tools translated or validated in more than 20 languages around the world	Beck Depression Inventory (BDI) Patient Health Questionnaire-9 (PHQ-9): Center for Epidemiologic Studies Depression Scale (CES-D):
Quality of Life	WHOQOL-BREF (World Health Organization Quality of Life – BREF. assess quality of life across four domains: physical health, psychological health, social relationships, and environment. Specifically designed for cross-cultural use and has been validated in multiple countries and languages (WHO, 1996) SF-36 (Short Form Health Survey) EQ-5D (EuroQol-5 Dimension)

fairly perceived as being untruthful or unreliable, which can influence the assessment process.

- **Cultural Norms Regarding Emotion**: In some cultures, showing emotions like fear, sadness, or anger might be proscribed, which can lead to underreporting or minimization of symptoms. This might be misinterpreted as a lack of credibility due to a supposed dissonance between the account of events and the emotions attached to it. People from cultures with high expression of emotions tend to be considered more credible than those from cultures which are more contained. The same can be applied to non-verbal communication. For instance, avoiding eye contact is usually considered in Western culture as a sign of lack of credibility, while in many cultures might be a sign of respect.
- **Structure of memory and sense of time**. While some cultures tend to recount events in a linear way, others tend to recall key events, without a clear timeline. (Jobson & O'Kearney, 2006). The difficulties in organizing information in time may make the narrative lacking credibility. Furthermore, some cultures emphasize a tendency to suppress traumatic memories while others tend to share and keep them structured in a collective narrative. This will influence the way events are latter reminded.
- **Help-seeking behaviour**. Certain cultures tend to keep traumatic events in private. The forensic expert might be surprised that heavily traumatic experiences have never been shared and find it a sign of lack of credibility.

A short form of a culturally sensitive format for a transcultural forensic report according to the IP

Table 6 summarizes the main points to take into account for doing a cross-cultural assessment of a torture survivor based on the Istanbul Protocol Context

***Table 6**. Points to take account for cross-cultural assesment of a torture survivor.*

Ethical aspects	– Informed consent – individual or collective decision – Language – Non-verbal communication – Attention to power unbalance – confidentiality concerns – culturally appropriate documentation – Confidentiality and privacy. – negotiations of expectations – Security – Legal awareness – Attention to local context – Community relations and risks of reprisals.
Time and space	– Consideration of distance, position of chairs – Careful consideration of interviewing style: open questions, avoiding interruptions or being too directive
Use of translators	– Avoid family members – Discuss beforehand expectations, ethical aspects and ways to talk to survivors (see IP guidance)
Istanbul Protocol	
Psychosocial History	– Focus on community and family – Take into account family in an anthropological wide sense and not in a restricted biological sense. – Expect a non-western sense of time – Likely the survivor normalizing or minimizing attachment problems or vulnerabilities in infancy – Role of ancestors
Account of events	– Attention to verbal and non-verbal expressions of distress. – Expressions of emotions do not need to be culturally congruent with the examinator's expectations, Avoid judging an apparent lack of emotions. Ask beforehand to cultural mediators
History taking	– Anamnesis including cultural concepts of disease and cultural conceptions of health and illness – After the usual interview, consider questions related to an emic perspective (see table 4) – Systematic examination with consideration of prevalent diseases in the geographical area of the survivor – Cultural sensitivity to interrogation about sensitive matters. No answer does not mean it did not happen.
Medical Examination	– Cultural norms and expectations regarding physical examination, including physical contact and persons present in the room (see table on ethical aspects) – Special attention to exploring signs or marks of torture methods prevalent in the area. – Knowledge of religious or cultural practices likely associated with marks or bodily deformities

Psychological examination	– Cultural relativity of symptoms, including hearing voices, visual hallucinations or other classic Western psychotic symptoms – Special attention to pain and suffering as expressions of distress and, the relationship of pain (localization, intensity, triggers, cognitions) to trauma, crisis and loss. – Combine Western Diagnosis (etic) with Cultural conceptions of distress (emic) if they are relevant to the survivor. Try to link both in a map of causal relationships. – Attention to dreams – Use of cross-cultural tested tools. Avoid any intelligence, personality or projective tests. – Careful consideration of neuropsychological tests
Consistence analysis	– Include cultural considerations in deciding the level of consistency
Credibility analysis	– Attention to stereotypes and personal bias – Do not base credibility on emotions unless having experience with the expression of emotions in that cultural environment – Inconsistency in details is a rule and not an exception. Expect that the overall account of events is credible based on the internal coherence, sources of triangulation and analysis of impacts. – Difficulties in organising information in a time-line is not a sign of lack of credibility – Help-seeking behaviour and coping strategies should be according to the culture and not to Western expectations.
Conclusions	– Include cultural aspects in the causal analysis linking events, torture, impacts and sequels. – Include family and community considerations when relevant – Include culture on the analysing impact on life projects and well-being – If the expert proposes reparation measures, discuss with the survivor symbolic and community reparations, besides individual ones.

In this issue

This issue includes a special section with contributions that explore the integration of livelihoods in the rehabilitation of torture survivors. Starting with a paper from *Tania Herbert* examining the intersect between livelihoods loss and torture, the importance of documenting livelihoods losses in torture assessments and the integration of livelihoods into rehabilitation programs. It provides a foundational framework for treatment centres to consider the integration of socio-economic support into rehabilitation programmes, in addition to psychological and medical care, to address the full impact of torture. The author advocates for a survivor-centered, evidence-based approach to restore sustainable livelihoods as part of comprehensive treatment efforts.

Berta Soley and Skyla Parks present a paper which examines the short-term outcomes of five projects that integrate livelihoods support with mental health and psychosocial treatment for survivors of torture. These projects, conducted by IRCT member centers in Uganda, India, Lebanon, Nepal, and Palestine, aimed to enhance rehabilitation outcomes by addressing both socio-economic and psychological needs. The study's preliminary results suggest that integrating livelihoods into rehabilitation improved participants' well-being, social relationships, and community integration. However, limitations such as small sample sizes and short project durations make the results preliminary, highlighting the need for further research.

This is followed by a contribution by *Khanal and colleagues*, from one of the centres included in the study by Soley and Parks, assessing the outcomes of integrating livelihood support into mental health and psychosocial support (MHPSS) programs for survivors of torture in western Nepal. Results show reductions in anxiety, depression, and PTSD, as well as increased self-confidence, social trust, and economic resilience. The study emphasizes the importance of a holistic approach to rehabilitation, integrating livelihood support to enhance the well-being and social reintegration of torture survivors.

Likewise, *Ayesha Mushtaq* explores the integration of livelihood support with MHPSS in the rehabilitation of torture survivors in low- and middle-income countries (LMICs). Using a cross-sectional study, it highlights the negative cycle of poverty and mental health faced by survivors, with 92% of respondents confirming a strong link between the two. The integration of livelihood support is found to improve mental health outcomes, economic stability, and social reintegration. The study further recommends enhancing coordination, securing sustainable funding, and implementing holistic rehabilitation programs to address survivors' needs comprehensively.

The special section concludes with the contribution from *Andreea Lachsz*, which studies the incarcerated populations in Australia and the US, highlighting how many come from marginalized communities with histories of trauma, arguing that imprisonment adds to this trauma and calls for a shift in the criminal legal system from focusing on reducing reoffending to promoting healing. The author also advocates for stronger international legal protections and more research into the effectiveness of prison labour in supporting post-release livelihoods.

This issue also includes a research paper from *Nielsen and colleagues* that assesses the effectiveness of sleep-enhancing treatments, Imagery Rehearsal Therapy (IRT) and mianserin in trauma-affected refugees with PTSD. The study finds that IRT improved well-being six months post-treatment, but neither IRT nor mianserin showed significant benefits in sleep quality or other outcomes compared to TAU.

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Annex 1. Transcultural aspects in the 2022 updated version of the Istanbul Protocol. Where and how is transculturality taken into account

The revised version of the Istanbul Protocol has included some general considerations on transcultural aspects on forensic asssment of torture survivors.

Legal investigation of torture (#210)
The authorities investigating should have cultural competence related to the alleged victim

Use of translators (219, 296-298)
- Avoid family members, specially children; Prefer trained interpreters, previoulsy working in team with the clinician; Avoid co.detainees (#219)
- Rules regarding the use of interpreters
- Brief interpreters before the interview
  - Discuss confidentiality and ethical aspects.
  - Introduce some of the specific language used
  - Interpreters should (a) speak directly to victims and witnesses; (b) only use direct speech ("can you please describe what happened" not "the investigator is asking what happened"); (c) use active listening techniques (posture, nodding and respectful eye contact); (d) be able to control their emotional responses and show empathy and sensitivity; and (e) not editorialize, that is interpret exactly what is said and nothing more (f) help in gaining undertanding of body language, facial expression, silence, tone of voice anbd gestures.

General considerations for interviews (#294-295; 341)
- Clinicians who conduct evaluations of victims of alleged torture should have (...) cultural humility
- The clinician should attempt to understand mental suffering in the context of the interviewee's own experience, circumstances, beliefs and cultural norms
- Idioms of distress can be culturally specific or language-bound methods to express a feeling or experienceCulture and language can also influence how a specific illness, symptom or experience is conceptualized and describedAwareness and constant learning of idioms of distress and culture specific conceptualizations of pain and illness are of paramount importance for conducting the interview and formulating the clinical impression and conclusion
- Interviewers should also be aware of the sociocultural dynamics of their own identity and how implicit and explicit perceptions of power, ethnicity, nationality, gender, age, sexual orientation and socioeconomic status may impact the interview
- Interviewers should make sure to conduct themselves in a manner that does not offend cultural or religious sensibilitiesA lack of such awareness risks alienating the individual and/or causing them to feel uneasy, leading to a less effective interview
- It is important to remember that different cultures have different concepts of what is normal behaviour in an interview

Sexual and Gender Violence (#282, 600)
- Both sexual and gender-based torture are reliant on the power dynamics involved and can change based on the social, cultural and religious contextEven if no explicit sexual assault is alleged, many forms of torture have sexual or gendered aspects that must be considered in the evaluation
- Be familiar with the specific social, cultural, and political factors that may have influenced the physical and mental health of lesbian, gay, bisexual, transgender and intersex persons

Psychological evaluation (#493, #539)
- Cross-cultural research reveals that phenomenological or descriptive methods are the most useful approaches when attempting to evaluate psychological or psychiatric disorders What is considered disordered behaviour or a disease in one culture may not be viewed as pathological in another.
- Psychologial tests of personality and neuropsychological assessment lack crosscultural validity

Cross-cultural validity of Western diagnosis (#494)
- The diagnosis of PTSD has been applied to an increasingly broad array of individuals suffering from the impact of widely varying types of violenceHowever, the utility of this diagnosis has been questioned on many grounds, including its universal applicabilityNevertheless, evidence suggests that there are high rates of PTSD and depressive symptoms among traumatized refugee populations from many different ethnic and cultural backgrounds

Cultural relevance of symptoms (#497-498, 509)
- Western cultures suffer from an undue medicalization of psychological processesThe idea that mental suffering represents a disorder that resides in an individual and features a set of

typical symptoms may be unacceptable to many members of non-Western societies As much as possible, the evaluating clinician should attempt to relate to mental suffering in the context of the individual's beliefs and cultural norms

– The expression of distress may be nuanced or mediated by culture and social context, for example according to the experience of shame, fear of reprisals and fear of further stigma or ostracization within the family or community The psychological assessment should aim to reach an understanding of the multiple short- and long-term psychological, psychosomatic and psychosocial reactions beyond and not limited to a possible psychiatric classification
– Misinterpretation of psychotic symptomsCultural and linguistic differences, as well as flashbacks and anxieties, may cause misinterpretation of psychotic symptomsBefore diagnosing someone as psychotic(suffering from a mental disorder characterized by a distorted perception or processing of reality), the symptoms must be evaluated within the individual's unique cultural contextPsychotic reactions may be brief or prolonged, and the symptoms may occur while the person is detained and tortured or afterwards.

Interpretaton of findings (#525)

– The assessment of psychological status and the formulation of a clinical diagnosis should always be made with an awareness of the cultural context.
– Are the psychological findings expected or typical reactions to extreme stress within the cultural and social context of the individual?

Annex 2. Usefulness of the Etic perspective

***Table 1**. Epidemiological studies - Prevalence of PTSD in survivors of political violence including torture (%: Prevalence of PTSD)*

General Population		**Disasters**	
Brazil[1]	1.5%	India[2] (Mass disasters)	20%
South Africa[3]	2.3%	Nepal[4] (Earthquake)	9.5%
Mexico[5]	3.4%	Haiti[6] (Earthquake)	25%.
Bangladesh[7]	6.2%		
Philippines[8]	6.7%		
Rusia[9]	7-10%		
Pakistan[10]	13-50%		
General Population in areas of political violence, low-intensity armed conflict or social unrest		**Survivors of torture and political violence**	
Laos[11]	6%	Cambodia[12](survivors of genocide)	8-12%
Peru[13]	8%.	Kenya[14](political conflict)	12%.
Colombia[15]	10%.	Myanmar[16](internally displaced)	18%
Nigeria[17]	10%.	Rwanda[18] (10yrs after genocide).	24.8%
Zimbabwe[19]	15%.		
Ethiopia[20]	16%		
Sri-Lanka[21]	28%		
General Population in areas of War or On-Going political conflict			
Israel[22]	8% (higher close to border)		
Occupied Palestine[23],[24]	*Previous to Gaza bombings* 20-30% Adults; 25-40% Children and adolescents *During on-going bombings* 35% Adults; 45% Children and Adolescents		
Ukraine[25]	30%-40% ((higher close to border)		
Venezuela[26]	20-30% (Economic hardship -political instability		
Afghanistan[27]	35-45% - Adults; 50% Children and adolescents.		

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Torture, livelihoods and rehabilitation

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Key Points of Interest:

- Torture and livelihoods are intrinsically linked
- There are numerous challenges for torture treatment agencies in integrating livelihoods into programming
- Following principles of care for torture survivors, livelihoods can be included as part of holistic rehabilitation.

Abstract

The understanding of torture has evolved to encompass a complex interplay of factors including poverty, politics, health and psychosocial factors which increase vulnerability to torture. In response to this evolving understanding, rehabilitation efforts for torture survivors have expanded beyond medical and psychological care to encompass broader socio-economic dimensions, including livelihoods support. Livelihoods are not only a means of making a living, but also a source of purpose and identity. This article explores the intersect between livelihoods loss and torture, exploring where livelihoods loss co-occurs with torture, is a consequence of torture, or may be an act of torture in itself. The importance of documenting livelihoods losses in torture assessment and the integration of livelihoods into rehabilitation programs is considered. Although research in this area is sparse, existing evidence suggests that combining livelihoods rehabilitation with psychological and physical interventions, alongside long-term support are important components. For livelihood restoration to be effectively integrated, it must be survivor-centred, holistic, evidence-based and focused on safety. While the field is to date underexplored, this article provides a foundational framework for torture treatment centres and stakeholders to consider the role of livelihoods in both conceptualising and treating survivors of torture.

Introduction

Torture is held as exceptional and at the pinnacle of human rights abuse – but it is also accepted that torture is widespread and occurs across most regions of the world (Hamad, Patel & de C Williams, 2019; Milewski et al., 2023; Nowak, 2010). Torture also intersects with myriad other human rights abuses and a lack of attainment of basic human rights. Poverty, politics, activism, detention, and particular backgrounds and geography are all known as risk factors which come together in many and varied ways to increase vulnerability to torture. Torture has been described not only in terms of acts against individuals, but rather as overlapping forms of violence from many sources, and torture is deeply engrained in broader patterns of violence (Jensen & Kelly, 2022; Kimari, 2022).

As our understanding of torture adapts and changes, so must our responses to it. Rehabilitation is also no longer viewed as exclusively providing medical care or psychological care, or improving access to justice processes despite the disturbingly low number of investigations and successful prosecutions (Edwards, 2023). Torture rehabilitation is increasingly recognised as a response that also takes place in the same country or region where the torture occurred, rather than being confined to a post-conflict state or refugee resettlement. This shift acknowledges that many torture survivors are unable to flee the country where they were subjected to torture.

Rehabilitation is evolving to meet the range of complex needs of torture survivors and is based in the reality that the majority of torture survivors continue to exist in the same

structures and with the same vulnerabilities that were risk factors to begin with. One important aspect of rehabilitation is the role of livelihoods, both in the experience of torture and the rehabilitation following torture. Livelihood programs have been defined as seeking to "...increase the capacity of households and individuals to provide for themselves by protecting or enhancing their income, skills, and access in ways that support their own priorities and goals" (Jacobson & Fratzke, 2016, p. 4), and may refer to a wide range of educational, asset-based, or employment based activities that may range from one-off actions to activities spanning years.

The IRCT Strategy 2022-2025 recognises the goal of better livelihoods, and that supporting the establishment of survivor-led initiatives for stable income not only sets a strong foundation for healing, but also empowers individuals, ultimately aiding in their recovery from the trauma of torture.

Engagement or re-engagement in livelihoods is frequently an aim of survivors. Chambers and Conway (1991) present a frequently utilised definition, where a "livelihood comprises the capabilities, assets (stores, resources, claims and access) and activities required for a means of living" and has qualities of sustainability, namely the ability to cope with stress and shocks, be maintained over time, provide opportunities for the next generation, and contribute to other livelihoods long and short term (p. 6). However, just as rehabilitation encompasses more than health, livelihoods are more than simple economics and are "...even more as a way to give meaning to life."(de Haan, 2017, p. 3). Whilst the term livelihoods has these distinctive features, there are also strong relationships with other descriptors of a means of living, such as economic agency, employment, or financial stability. It is also distinct from other activities which may provide meaning but do not generally create, or have potential to create, a means of living, such as many social, creative or sports activities.

Article 14 of the Convention against Torture states 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". Rehabilitation seeks to restore what has been lost, acknowledging that a return to life before torture may not always be achievable. Instead, the aim of rehabilitation may be based on attaining the highest possible quality of life, often within individual or systemic constraints.

However, centres providing torture rehabilitation have highlighted a key limitation in realising this, agreeing that the difficulties in meeting basic needs severely hampers the delivery of as full rehabilitation as possible (IRCT, 2022a).

The concept of quality of life for torture survivors extends beyond physical and mental health, encompassing other social determinants of health including economic security, employment and education as articulated in IRCT Global Standards on Rehabilitation of Torture Victims (paragraph 15). This is consistent with the definition of rehabilitation, defined in the Convention against Torture's General Comment number 3 (article 14) 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" and as seeking to maximise self-sufficiency and function and to restore "their independence; physical, mental, social and vocational ability; and full inclusion and participation in society." (Committee against Torture, 2012, p. 3).

Considering these definitions, addressing livelihoods can be considered as an important, or even crucial component of torture rehabilitation, in terms of the role it can play in realising independence, physical and mental health, and inclusion in society.

To date, there has been limited attention to the intersection between livelihoods and torture, particularly in considering this in the context of the global south. This paper considers this intersection, particularly in considering loss of livelihoods for those who experience torture. It examines the role of torture treatment agencies in addressing livelihoods loss, proposing ways to integrate livelihoods into rehabilitation. Specifically, it emphasises the restoration of livelihoods as a crucial consideration in recovery. In exploring these areas, learnings from multiple disciplines are utilised, including development and poverty, psychology and health, psychosocial approaches and law, as well as knowledge from the professional experience of the author. The breadth of the topic is certainly a limitation, in that no area is exhaustively covered nor all viewpoints and empirical studies included. However, this article presents as a starting point in bringing these areas together for consideration for torture treatment centres and other interested readers to begin to discuss and integrate livelihoods into torture conceptualisation and treatment.

Loss of Livelihoods and Torture

Livelihoods can be lost or impacted by the taking away of resources, the taking away of capabilities, or the taking away of opportunities and access. The following list (whilst by no means comprehensive) details such losses:

- Loss of property including land, businesses, homes, livestock and goods. Property can be destroyed, stolen, acquired or owners can be denied access
- Loss of physical or mental capacity required for work

- Deprivation of liberty (particularly where extended) which involves the removal from most livelihood activities, and raises additional challenges on return to activities when and if released
- Refusal of licenses, registration, or any other permissions required to engage in livelihood activities (eg to run businesses, build, trade or utilise natural resources)
- The killing, disappearance, imprisonment or severe injury of a providing family member to the detriment of remaining family members
- Threats or acts of violence against people if or when they engage in work and other livelihood activities
- Inability to attain or maintain employment due to having been tortured and/or in line with the reasons for the torture (eg activism, political party membership, cultural background, status of relatives). This can include a lack of access to government employment, and can also include fear to employ such persons, as it may draw attention or repercussions for the employer
- Introduction of a societal stigma which impacts employability or engagement in activities, such as for those with a history of imprisonment, of having experienced sexual torture, of living with a disability, or generally having a reduced social capital

Most losses will not occur in isolation, and multiple livelihood impacts can occur at the same time. Impacts can also be compounding, such as where a lack of livelihoods limits capacity to access medical care, and health and social consequences limit job opportunities which create further financial impacts (Aon, 2015). These complexities are not only at an individual level. This list of livelihood losses emphasises the systemic nature of that loss – that it is often not individual factors, but rather the instruments of society or authorities that make a return to livelihoods difficult or impossible.

Losses from torture may also go beyond what is tangible, including human rights-based concepts captured in instruments such as the Convention against Torture and the Universal Declaration of Human Rights (UNGA, 1948). The loss of dignity and worth, the affront to the human spirit, and the loss of role, of place, of hope and of future are often of equal, and sometimes more importance than the more concrete list above. Loss can be even more profound where livelihoods are collective and deeply embedded in history and cultural identity.

Empirical and philosophical works have explored the nature of meaning and purpose in life, and the importance to well-being. George and Park (2013) summarised meaning as the sense of comprehension, significance and experiencing of life as making sense, and purpose as a sense of having core goals, direction, and enthusiasm for the future. Unsurprisingly, suffering has been demonstrated to impact life meaning (Edwards & Van Tongeren, 2019), and traumatic loss, such as through the refugee experience rips away much of what may have formerly given life meaning and purpose (Matos, Indart, Park & Leal, 2018).

The following sections explore how loss of livelihoods can be conceptualised within a torture framework, considering the possibilities of this loss as a consequence of torture, as co-occurring with torture, and whether livelihoods loss could be considered as an act of torture in itself. Whilst distinct categories are presented, it is acknowledged that overlaps may exist.

Livelihoods Loss Co-occurring with Torture

The co-occurrence of livelihoods loss and torture is mutually reinforcing: changes in capacity to work and loss of engagement in employment structures are common, and are often part of the objective of those who torture in breaking down and depleting the person. The disproportionate vulnerability of people in poverty to torture has been declared in the London Declaration on Poverty and Torture (IRCT, 2011), and an increasing focus on this nexus has been recognised in empirical research, in shifting approaches by human rights organisations, and in UN bodies such as the Subcommittee on Prevention of Torture (Oette, 2021). Whilst torture can impact people across divides, a clear link has been established between torture and poverty. Poverty has been determined as the leading risk factor for torture, and IRCT's Global Impact Data found that 40-50% of survivors receiving treatment live in poverty (IRCT, 2023; 2022a). The same structures which have been causal in poverty are often the same structures that allow torture to occur with impunity, and the already existing powerlessness of a person marginalised by poverty is exacerbated where torture occurs (Oette, 2021).

Asset loss, such as theft or destruction of property may occur at the same time as other acts of torture, and part of psychological impact can include being told of or witnessing assets being removed or destroyed, or being subjected to physical acts of torture at the same time as theft and destruction.

In addition to acts of torture, abuse of police power, lack of State protection, and violence against women and children are all intrinsically linked to extreme poverty (Alston, 2017). Within these vulnerabilities, the loss of livelihoods or the inability to secure them at all is a frequent co-occurrence.

Thus, in country contexts of conflict or authoritarian states, there is frequently a cluster of rights abuses which can co-occur: poverty, loss or lack of livelihoods, torture and other protection risks. Decisions for people in such situations may mean livelihoods are pursued only at a great risk to safety (Jasper, 2010).

Livelihoods Loss as a Consequence of Torture

Where physical or psychological harm results in lasting impacts, it is likely that there will also be impacts to livelihoods. Physical injuries may limit employment or work capacity, including for home-based income such as subsistent farming.

Psychological injury may result in mental health conditions or symptoms which limit livelihood engagement. For example, depressive symptoms may reduce motivation and life meaning, or PTSD may result in fear and avoidance which make moving around physical spaces difficult.

The change in social status for the person who experiences torture may also lead to them being ostracised and excluded from employment opportunities or community activities. This may be due to the stigma of trauma, or buy-in to structural causes of torture such as support for torturing governments, or excluding people belonging to marginalised groups. Employers or community members may also shun tortured individuals, in fear that they may be similarly targeted if they are seen as being supportive.

This loss can be further compounded where it is as the result of reprisals. Reporting torture can lead to further rights violations, including the direct loss of livelihoods, or of stigmatisation and community alienation, both of which can further reduce access to livelihoods (Tegal & Piyadasa, 2022; Towers, 2022). For those who do engage in legal action against perpetrators, there can be heavy financial costs (Tegal & Piyadasa, 2022), and the time and finances involved in seeking justice can be a livelihood loss in and of themselves.

If we consider this in addition to the co-occurrence between torture and livelihoods loss, a torture consequence is to add to the already vulnerable situations that many may already be in, and increasing issues of poverty, marginalisation and stigmatisation. This speaks to the creation of a torturing environment, where the environment has been intentionally created to attack basic needs, safety and individual and collective identity (Pérez-Sales et al., 2021). Integral to this is the economic marginalisation and discrimination heightening the vulnerability to torture (Oette, 2021).

Livelihoods Loss as an Act of Torture

Given these linkages between torture and livelihoods, it is worth consideration as to whether livelihoods loss could be considered an act of torture in itself.

To explore this, we can first return to the CAT torture definition, whereby torture is considered as any act causing severe physical or mental pain or suffering, intentionally inflicted for a purpose and in an official capacity.

Livelihood loss could be considered against the benchmark for severe pain and suffering, particularly where it is extreme and creates a risk of further harm. The material loss itself can be considered, but more so the meaning behind that loss. For example, loss of livestock or crops may be financial, as well as loss of family heritage, family role, status, pride, and future. As with other forms of mental suffering, severe suffering typically involves high perceived uncontrollability and stressfulness (Başoğlu, Livanou & Crnobarić, 2007). It also considers the cumulative impact of co-occurring violations (Başoğlu et al., 2007), may be accompanied by symptoms of mental health conditions (most notably PTSD and Depression symptoms), and should be understood within the cultural and localised context. Livelihood loss may also be part of building a larger picture of torture, where it may be any combination of physical, psychological, and livelihood impact (amongst others) which, when taken together, meet the threshold for suffering as being severe.

For a loss of livelihoods to be considered an act of torture in itself, it would also be inflicted by a public official with intentionality, where a person or persons are targeted for that act resulting in livelihoods loss. It would further be for a purpose, including such examples as retaliation, punishment or discouragement from engaging in political membership, for the purpose of 'breaking' the person through loss of identify or sense of self.

Evidence of livelihoods loss has the potential to contribute to a case of establishing torture and ill-treatment. This can subsequently contribute to forensic assessments, ideally to trigger the obligation of the State to investigate, as well as having the potential to influence areas such as securing rights and reparations, addressing impunity and substantiating asylum claims (Huminuik, 2016).

Guidelines for Including Loss of Livelihoods in Establishing a Case of Torture

The importance of documenting torture, and the frustrations of attaining evidence of torture has been recognised (Méndez, 2014). Medical and psychological evidence may be difficult to determine due to sophisticated methods of torture and difficulties in seeking health care. Some of these same complexities also exist in gathering livelihoods evidence, particularly in understanding the meaning of livelihoods for each individual and how this is impacted. However, there is also potential for assessment of livelihoods as part of an act of torture to be an additional source of forensic evidence contributing to establishing a case of torture.

Here, centres that provide torture treatment have a special role to play in establishing all causal/ contributing considerations, acts of, and impacts from torture. Guidelines already exist for establishing physical and psychological injury as an act of torture, through the Istanbul Protocol Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OHCHR, 2022), which particularly focuses on the physical presentation following torture. Currently, no such guidelines exist for loss of livelihoods, though it is common practice for torture treatment centres to make some record of this, as demonstrated through the data collated annually by the IRCT (IRCT 2022a). Livelihoods loss documentation should not be considered as an area to document in isolation, but rather as part of a holistic assessment of torture and its impacts.

Collection of livelihood specific information is in line with Istanbul Protocol recommendations, which encourages collection of data on "Immediate and long-term mental harm suffered, functional limitations and the socioeconomic impact of the alleged torture or ill-treatment on the person and the person's family" (OHCHR, 2022 p. 54). As with the Istanbul Protocol, the collection of livelihoods data aims to assess the consistency between the individual account of torture, and the findings of the assessment to establish a probable relationship.

Establishing a complete and comprehensive picture of livelihoods loss would be highly complex (noting that the Istanbul Protocol numbers 212 pages and is the result of years of consultation and expert contribution), and likely beyond the scope and capacity of many, if not all, torture treatment centres. However this cannot be an excuse not to encompass this in assessment and practice. Whilst aspiring to a more complete assessment instrument, instituting basic data collection around livelihoods should be a standard area of assessment to ensure a deeper exploration of both losses and their consequences. Assessment of the more practical elements exist in the development field, such as the post-disaster Livelihood Assessment Tool-kit (FAO & ILO, 2009). Whilst in no way designed for a cohort of torture survivors, this does provide a series of interrelated tools in assessing livelihoods assets and capabilities and how these can be assessed at different time points, including the development of a baseline, initial impact assessment, and more thorough livelihood assessment to inform livelihood strategy formulation. This may act as a complimentary document where organisations are developing capacity building skills in assessment and program design.

Data collection needs will be necessarily influenced by country, cultural and political contexts. Decisions as to what is important in livelihoods assessment should include the context knowledge of each centre or documenting worker, but also be informed by available literature and by client contribution. However, some areas to consider for inclusion in an assessment framework are outlined below.

- Determining the livelihoods loss as part of or as a consequence of torture
  - Tangible losses
    - Loss of assets
    - Loss of capacity (physical, mental, social, occupational function)
    - Loss of access and opportunities (eg to assets, jobs, spaces, licenses, services)
  - Losses in terms of psychological wellbeing and any other pain and suffering expressed due to livelihoods loss
  - Loss of meaning and purpose (since the torture event/s)
    - Challenges in understanding or making sense of torture events or life more generally
    - Loss of goals, life direction, other future plans and hope for the future
- Determining the state of livelihoods prior to act/s of torture (ie for any loss, determining at time at which that loss occurred, noting that some losses may be pre-existing, relate to previous acts of torture or may be anticipated for the future)
- Determining the cause of the livelihood loss (particularly establishing if the loss was intentionally inflicted and with a purpose)

Whilst these are areas for consideration, it must be also considered that the experience for the torture victim may not be easily quantifiable (Patel & Williams, 2019), and this may particularly be the case in working to understand losses, especially in terms of meaning and purpose. An openness to hear the livelihoods impacts without categorisation is just as important as covering the above topic areas for assessment.

Understanding that one has experienced torture as per the legal definition and having this documentation are indeed important in establishing and understanding this violation of an inalienable human right. However, for the survivor, this may not be viewed as overly relevant to their current and ongoing struggles. Whilst establishing the contribution of livelihoods loss to acts of torture is important in a legal sense, it is also a fact that legal cases against torture internationally are rarely successful (Jensen and Kelly, 2022).

It is in the rehabilitation provision where the survivor is most likely to see the value of services, and to experience restoration of what has been lost.

Considering Rehabilitation of Livelihoods

In all, there can be little doubt as to the link between torture and livelihoods, nor to the importance of livelihoods in consideration of as full rehabilitation as possible.

The IRCT 2022 annual report found that of the 61,823 torture survivors reported to be treated by member organisations, 35% received some form of livelihoods support (an increase from 21% in 2021). This certainly speaks to both the recognition of the importance of this support in rehabilitation efforts, as well as the increasing integration into programming. This is further detailed in the 2023 annual report, identifying 11 member organisations implementing livelihoods support programs with positive impacts.

This also reflects the voices of survivors and those who provide care for them. Economic problems are often expressed as the problem most at the forefront for torture survivors (Aon, 2015) and, put simply, more secure livelihoods are what survivors want and ask for. In providing victim-centred care, this is an important consideration and likely reflects decision making by IRCT member centres in livelihoods inclusion. Livelihoods-based programs and activities may also present an opportunity as an entry point or to increase program retention. Livelihoods based programming may have better retention than programs with an initial focus on psychological care, where retention rates are often poor (Higson-Smith, 2018; Patel & Williams 2019). This may assist in meeting challenges in engaging survivors, developing trust and relationships and increasing overall service engagement.

However, IRCT data does not currently detail all forms of livelihoods support provided by member centres, and compared to studies and reports on mental health programs, there are very few publications reporting torture rehabilitation programs and their impacts in relation to livelihood supports.

Livelihood programming is a large and complex area of study and practice, generally sitting within aid and development sectors. When pertaining to refugees, the United Nations High Commissioner for Refugees (UNHCR) typically designs and implements programs (Jacobson & Fratzke, 2016). However, torture treatment centres are not generally aiming to implement large-scale programs, and generally have neither the knowledge base nor the financial base to consider this.

Instead, it is proposed that livelihoods rehabilitation should be considered as an individualised approach directly related to the torture experience. A comprehensive livelihoods rehabilitation program can be considered one which:

1. Identifies a livelihoods loss which is linked to torture
2. Identifies how that loss is restored through livelihoods rehabilitation programs
3. Provides or restores required assets, capabilities and supports
4. Leads to the provision of an independent means of living
5. Is sustainable over time, even when support is withdrawn
6. Provides a sense of meaning and purpose to the individual

To consider livelihoods in rehabilitation, it is rarely a case of simply replacing the lost job or land, but rather working with the survivor to understand all conceptualisations of the loss and how recovery from that may look. As noted by Etzold, "People's livelihoods are not static, but rather unfold dynamically over time as people take on and change positions in social fields" (2016, p. 45).

Contributions to Livelihoods Rehabilitation

A comprehensive livelihoods rehabilitation program may not be possible or preferable for all treatment programs. This, however, does not mean that there cannot be other contributions from centres in integrating livelihoods within torture support in a way which is consistent with these ideals.

Complementary livelihoods activities which are not able or aiming to meet the proposed criteria to be considered rehabilitation can still be highly useful in the application of holistic care. Craft, market and other small-scale programs may not always be long term or sustainable, but may provide useful contributions to psychosocial rehabilitation, such as increasing activity levels, engaging in physical activity, as distraction or grounding strategies, or increasing social connectivity. Skills training in technical areas including economics and technology may not lead to enterprises or job opportunities, but they may act to increase interest in a range of areas, be useful in other areas of day-to-day functioning or increase points of entry into other programs or trainings. For example, a small qualitative study of a skills development program of refugee women in Jordon found that barriers to employment were not overcome, but the program did contribute to wellbeing, personal development and social cohesion (Thorne, 2020).

The loss of livelihoods assets may also be addressed directly, particularly where this ensures survival or reduces pressures or risks. Such contributions can be highly varied but may include cash or replacement of items required to engage in livelihoods. As well as providing for needs of living, such contributions may also increase dignity, build rapport, and increase options and opportunity for recipients.

Rehabilitation programs can contribute to large-scale livelihoods initiatives by providing insights on identifying torture survivors and enhancing trauma-based approaches specific to torture. Collaborations may also allow for larger agencies to provide general livelihoods programs but with contribution

from torture treatment agencies integrated in such ways that programs can then be considered as torture rehabilitation. Building partnership with like-minded or complimentary services for cross-referrals and program collaborations may offer greater potential to allow different organisations or actors to focus on what they do best.

Torture treatment centres can also act as advocates for livelihoods programs in their own countries, highlighting the link between torture and livelihoods and principles for best practice, legal action or activism, as well as compelling agencies to include the voices of torture survivors in program design and implementation.

It is vital that centres implementing livelihoods activities know what they are implementing, why and how, and that these decisions have been made with consideration for any risks.

Considerations for Livelihoods Rehabilitation

Integrating livelihoods rehabilitation into torture rehabilitation programs is not without risks, or areas for further consideration. Whilst not exhaustive, some of these areas for consideration are explored here. The capacity and capability of existing programs to include livelihoods rehabilitation programs may be a major limiting factor. Torture treatment centres supply a variety of services, and some may have specific expertise in areas such as medical or psychological treatment. There may be a range of practical barriers to increasing organisational capacity to address livelihoods including a lack of interest from organisations or staff, or a lack of available expertise to supply this service.

There are also risks of diverting time and funding from other needed rehabilitation services in medical, psychological and legal frameworks. Torture treatment centres are frequently already stretched thin, and may be limited in their ability to further expand services. If programs are not well considered and implemented, there is a risk that programs which aim to become holistic are instead piecemeal, or start to move away from the global goals of rehabilitation. There is also a risk that 'everything' becomes rehabilitation- where the multiple, complex needs of the person are all considered as needing to be addressing. Whilst the interconnectedness of the torture and the human experience are not denied, an all-inclusive model risks losing what makes torture rehabilitation centres special: the recognition of the inalienable right to live free from torture and to receive rehabilitation as part of reparations if that right is breached.

Client preferences are also a risk area for consideration. Whilst it is vital to promote the agency of torture victims in their choices regarding rehabilitation, there may be a risk associated with offering livelihoods rehabilitation, in that victims may wish to engage only in this area of programming, even where physical and psychological support needs are indicated. This can be common in torture treatment centres, where participants may not wish to pursue mental health treatment due to fear or retriggering, cultural reasons, or needs which are seen as more vital or immediate. This has organisational risks with the potential to reshape services away from other care needs. There may be greater complexities to explaining the service to people in poverty who do not meet the criteria of torture survivors, and at its most extreme, there may be a risk of fabrication or exaggeration of experiences to be able to access services which have the potential to alleviate poverty. Similarly, there are additional complexities in program evaluation where livelihoods rehabilitation is included. Programming with economic outcomes is likely to be reviewed favourably by clients due to gratitude in an environment of limited resources or fear of discontinuation of services, and clients may be less likely to scrutinise or give unfavourable feedback.

As outcomes for such programs have not as yet been empirically established, there is the discomfort of engaging in work which does not have a research basis. The link between livelihoods for people in poverty and mental health has certainly been demonstrated (Schininá et al., 2016; Renzaho et al., 2020), but the link between livelihoods rehabilitation and torture has not to the same level, and programs may have unanticipated or counter-productive outcomes. Whilst there are other areas of research and knowledge that can be borrowed from to build best practice, it should also not be assumed that the context and needs are the same for torture survivors as for those who have suffered other human rights violations, or even from one torture survivor to the next.

Risks to client safety must also be considered. The purpose of torture is often to dissuade dissent and political participation, or to ensure that individuals or groups remain marginalised. Where survivors increase their economic stability, recover assets or return to previous roles, this may draw attention of perpetrating authorities. Survivors have been shown to be targeted due to their involvement in activism (Hapal, Gante, Ibarra & Rombaon, 2022; Higgins-Smith, 2017; Kimari, 2022; Wangari & Priyanthi, 2022), and resuming such activities may also increase risk.

What Might Livelihoods Rehabilitation Look Like?

Livelihoods rehabilitation would ideally incorporate in full the 6 components outlined above (establishing links to torture; establishing links to restoration; providing assets and capabilities; leading to independent living; sustainable over time; providing a sense of meaning). Rehabilitation may also be in part, where there has been consideration of the links to torture and resto-

ration and then a considered decision as to what is achievable, logical and ethical. For example, a displaced family may not be able to achieve sustainable livelihoods, but the gain from daily routine and short-term economic relief means an activity is worthwhile. Another survivor may be unlikely to achieve independent living due to resulting disabilities, however a long-term low-income activity may give a sense of life purpose and meaning.

Some guidance can be taken from the diverse literature on the topic, though the majority of research from both the global north and south is focused on refugee and displaced populations, rather than torture survivors specifically.

Where employment is the outcome goal, one review by Lai and colleagues (2022) found that across 72 quantitative papers on the topic an overall positive impact on mental health for employment for resettled refugees in western nations, with not only the increased economic stability recognised, but also the productivity from meaningful work engagement. However, within the small set of four identified studies of people who experienced torture that were identified in this paper, the authors' review findings suggested that employment did not impact mental health, and that torture impacts are not mitigated solely by employment, though it was noted that further studies are needed in this area (Lai et al., 2022). Additional research studies found a lack of occupation to be a predictor of mental health concerns for torture survivors (Carlsson, Mortensen & Kastrup, 2006), and economic problems being the biggest concern as well the biggest barrier to seeking medical care (Aon, 2015).

Within papers focused on program evaluations, there are some more positive findings. Where training and support has been over years and led directly into apprenticeships or employment, positive outcomes have been shown, such as long term evaluations in Jordon and Palestine (Jabbar & Zaza, 2016; Hilal, 2012). Though not specific to torture, Kumar and Willman (2016) reviewed program outcomes for 12 programs for people in fragile and conflict-affected locations in Africa and Occupied Palestinian Territories. They considered programs that provided psychosocial support, livelihoods support or both. Findings suggested that asset building and longer-term livelihood support were important in contributing to a psychosocial well-being, as well as providing some evidence that psychosocial support alone can have a positive influence on securing livelihoods. Receiving psychological care and physical therapy were also linked to some improvement on employment and income outcomes in a pilot study in Kosovo (Wang et al., 2016).

In considering the wide range of livelihoods losses that are possible, an equally non-exhaustive list of possible livelihoods rehabilitation programs can also be formulated:

- Direct provision of access to jobs or education training required to obtain work. Training may range from brief up-skilling through to formal qualifications
- Provision of assets required to restore previous livelihoods. This could include access to capital, land, work and business spaces, and goods such as seeds, livestock or saleable items.
- Provision of assets required to adopt new livelihoods
- Provision of training and support for small business or micro enterprises
- Provision of programs that directly link physical and or psychological rehabilitation to livelihoods, where there are specific barriers which are causing ongoing difficulties in engaging in livelihoods
- Programs which identify specific vulnerable populations and provide opportunities, such as survivors or sexual torture, people with disabilities, people released from detention, or families where the person in the provider role is not longer present or able to work
- Advocacy or justice processes which address systemic barriers such as exclusion from licenses and registrations

The impacts on local environment and economy must be key considerations, as must equitable access, particularly for women, people with disabilities and other groups who may be discriminated against, marginalised or vulnerable. In line with ensuring sustainability, provision of any assets, capabilities and supports must include a period of maintenance and review.

The IRCT Standards on Rehabilitation were adopted in 2020 and represent a set of internationally agreed best-practice standards for rehabilitation. Relying on these standards, some of the goals for livelihoods rehabilitation integration are further explored below.

Survivor contribution

Survivor contribution to design and delivery of programs is vital, and the linchpin of a victim-centred approach. Contribution from victims is best achieved through survivor engagement, defined by Einolf and colleagues as "the meaningful involvement of torture survivors in the direction of treatment centres, advocacy work, and the design, implementation and evaluation of programs" (p. 46). The need for increased inclusion of client voices has been often recognised as a severe limitation of current torture rehabilitation programming (Einolf et al., 2023; Higson-Smith, 2017). Where survivor engagement is lacking, this heightens the risk of programming which is unsuccessful or does not otherwise meet the needs and expectations of clients, and may create further disempowerment. Programs where training and development areas are predetermined and which neglect to consider the differences between individuals are less

likely to result in meaningful change (Dagar, 2024; Lumley-Sapanski, 2019). The lack of inclusion of survivor-focused problem conceptualisation is a pressing limitation in current research on treatment outcomes for torture survivors (Hamid et al., 2019).

As noted by Patel, Kellezi and Williams (2014), "We have much to learn from consultation with torture survivors, both treated and untreated" (p. 21). This view has a particular resonance with working on improved recognition and responses to livelihoods loss, as we seek means to increase the limited knowledge base.

Holistic

The need for rehabilitation which considers the whole person is well recognised. In terms of livelihoods rehabilitation, this not only includes development of a means of living, but also rehabilitation of physical and psychological injury which may impact ability to engage in livelihoods activities. Both treatment and assessment which is considered overly westernised and medicalised has been critiqued (Hamid et al 2019; Lordos et al., 2021; Patel et al., 2014). As aptly stated by Lordos and colleagues (2021), "It is reasonable to assume that efforts to restore mental health in affected communities through a purely biomedical approach would likely fall short of the objective due to not addressing the social determinants of psychological distress, such as extreme poverty social isolation, and ongoing community polarization" (p. 107). Just as poverty and torture risk are linked, economic empowerment and psychosocial well-being have been demonstrated to have an impact on one another (Kumar & Willman, 2016).

The need for holistic care justifies the inclusion of livelihoods programming. However, it must also be ensured that any programs with livelihoods are also formulated and implemented with a whole-of-person approach. As such, it should be clear to both the organisation and the individuals as to how livelihoods fit in with their overall care, and how other forms of support are necessary to their livelihoods journey.

Evidence based

Whilst acknowledging that the evidence base is currently scant, organisations should be aiming to build an evidence base for the adopted methodologies within their organisation, their region and internationally. Ideally this would also include seeking opportunities to develop research for publication or seeking means to capacity build to enable this. However, empirical research is not the only evidence form of value. Evidence may also be established from a number of sources, including feedback from staff and survivors, field experts (primarily within/ from the country of concern) and program evaluations. Wangari and Priyanthi (2022) highlight the fact that there is not always a clear distinction between human right defenders and survivors, and speak of the role of these survivor-experts in strategy development. Expert and well-considered contributions allow organisations to comfortably commence or continue with livelihoods projects, whilst still keeping a broad goal of contributing to an increased academic research base.

A base of high-quality quantitative research is currently sorely lacking. Cochrane reviews of treatment for torture survivors have found that only psychological studies have met criteria for inclusion in their meta-analyses with only a small number considering other impacts such as quality of life (Patel et al., 2014; Hamid et al., 2019). However, such research methodologies may not be the best way to establish understanding and it should not be assumed that this is the only 'good' research approach (Patel & Williams, 2019).

Within a research base, it is important that the meaning and purpose elements are always considered alongside other wellbeing measures, as the intrinsic nature of torture is to break down life meaning and to incapacitate the victim to live a full life. To not consider the impact on meaning and purpose by both the act of torture and the rehabilitation program does not respect this fundamental understanding of torture. In this, qualitative research has an important complimentary role, as do research approaches which are more community-based and participatory (Salo & Bray, 2016).

Suggested areas for further research and consideration are included below:

- Development of assessment tools within torture assessment for establishing loss of livelihoods and the impact
- Consideration of the different categories of the torture/ livelihood loss link, and the application of this to rehabilitative livelihoods treatment (particularly where the loss can be considered as the act of torture itself), including whether and how this should influence the centre's treatment approach
- Development of a more robust understanding between the differences and similarities between livelihoods loss and rehabilitation for those who are located in the global south versus those who have accessed resettlement in the global north. This development is particularly needed for those who are unable to flee across borders, which is already a severely under researched area in the field of torture care.
- Further exploration of livelihoods development as a preventative mechanism for torture should be developed, given the established link between torture and poverty
- IRCT is well placed to continue to expand the development of livelihoods impact and rehabilitation in seeking additional

information from member centres on livelihoods assessments, approaches and programs.

Safety-focused

Identifying and managing possible safety risks to engagement in livelihoods rehabilitation including protection of asset and considering of risks of further targeting is a vital consideration. Some risks around livelihoods are explored earlier in this paper, being risks of capacity, a limited research basis and client safety.

As such, organisational development and program design should consider these and any other possible risks at all points. Integrating livelihoods loss into documentation, planning, and evaluation and research is an important first step. Supporting victims to document livelihoods as part of the usual process of assessment builds a strong understand of how specifically torture and livelihoods link in each country context.

The organisational capacity risk should also be included in strategic planning and programming. Organisations could consider a livelihoods strategy plan where livelihood activities and programs are explained, justified, and linked to broader organisational goals. In this, bodies such as the IRCT have an important role in promoting relevant materials and expertise to allow organisations to access or develop appropriate trainings and integrate knowledge into existing or new practices.

Conclusion

The loss of livelihoods resulting from torture is a multifaceted issue with profound implications for survivor well-being and recovery. Livelihoods loss can stem from physical harm, psychological trauma, social stigma, and systemic marginalisation, exacerbating the already vulnerable situations of torture survivors. Whilst the link between torture and livelihoods is present in both practice and literature, there have been limited writings into what this link actually is, and where livelihoods fit in the sequalae of torture. Livelihoods loss may co-occur with torture, or may be a more direct consequence or indeed an act of torture in itself where the torture definition parameters are met, contributing to the ever-evolving understanding of torture.

A holistic approach to rehabilitation that addresses not only physical and psychological wounds, but also loss of livelihoods, is a well-established understanding. However, an understanding of what entails livelihoods rehabilitation is well behind these other rehabilitation areas. The proposed framework considers the different facets of rehabilitation in recognising links and making meaningful and lasting change. It is equally recognised that there are a wide range of possible contributions that torture treatment centres can provide to livelihoods development, even where they may not have the capacity for a full livelihoods rehabilitation program. There may be risks to providing livelihoods rehabilitation or other livelihoods activities, particularly given the dearth of specific literature, however the very nature of torture rehabilitation means the risk exists, as does the need. And torture treatment takes this on with courage.

Torture and the rehabilitation from torture remain complex and evolving. Adding livelihoods rehabilitation conceptualisation certainly does not simplify this, but it represents the reality of the survivor experience and is an important area of work to respond to the expressed needs and indeed the reported actions of torture treatment centres for the survivors who access their services. Moving forward, further research, collaboration, and advocacy efforts are needed to address the gaps in knowledge and practice and ensure that livelihoods support is embedded as a cornerstone of comprehensive torture rehabilitation programs.

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Small funding can make a big difference: short-term outcomes of five projects linking livelihoods with mental health and well-being in torture-survivors.

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Abstract

This paper examines the short-term outcomes of five livelihood projects implemented by IRCT member centers in Uganda, India, Lebanon, Nepal, and Palestine. These projects aim to support the rehabilitation of survivors of torture (SOT) by combining mental health and psychosocial support (MHPSS) with livelihood interventions such as vocational training, farming, and small business development. Although the study's methodological limitations (such as small sample sizes, short project durations and lack of experimental groups), the findings suggest that integrating livelihood support with psychosocial treatment improves survivors' well-being, social relationships, and community integration. The paper concludes that, while preliminary results are promising, further research and longer-term studies are needed to fully assess the impact of livelihood support on the rehabilitation of SOT.

Keywords: psychosocial counselling, mental health and psychosocial support, MHPSS, livelihoods, socioeconomic support, survivors, torture, rehabilitation.

Introduction

Half of all survivors of torture (SOT) worldwide live in poverty. When treating SOT, rehabilitation and mental health treatment cannot be expected to work independent from supplemental support (specifically livelihoods) ensuring that individuals' most basic needs are met (Mukwege and Berg, 2016; Patel, 2019).
It is said that rehabilitating SOT without livelihoods support is comparable to a car without wheels. Or, a SOT may attend weekly sessions for counselling to no avail as they return to a home without sufficient food for the family— another stressor deterring focus from rehabilitation.

There is scarce literature regarding the impact of providing livelihoods support together with psychosocial counselling, and no previous systematic review has been conducted (Patel, 2019; Patel et al, 2014).

This brief scoping review includes papers covering topics such as the two-way relationships between livelihoods and mental well-being (and the study of their interaction), known mental health benefits of integrating livelihoods into rehabilitation (social, self-esteem/confidence, purpose in life, hope, and distraction from challenges), and cautionary tales against unmindful projects. Yet, it does not address the rich literature on the relationship between poverty and mental health and the social determinants of health.

Papers fall into the following two categories: establishing a relationship between livelihoods and well-being and the analysis of livelihoods intervention programs. Only one the papers focuses specifically on SOT (Carlsson et al., 2009).

Mental health and psychosocial support (MHPSS) integration into existing livelihoods programs is expected to improve the initial program's outcomes (Schininá et al., 2016). Moreo-

ver, the reverse effect is expected— livelihoods integration can improve MHPSS— and generates a mutually beneficial relationship (Schininá et al., 2016).

It is well established that livelihood-related stressors such as separation from one's family or precarious housing and accommodations, or an uncertain legal status can all contribute to the overall distress of SOT (Walther et al.,2020). Further studies into mechanisms by which poverty can contribute to mental ill-health expose uncertainty, challenging sleep environments, and exposure to pollutants and extreme temperatures, in addition to trauma, violence, and shame and guilt (Ridley et al., 2020). Just as examples, Veronesse (2022) showed that young Nigerian internally displaced persons (IDPs) in the Diffa camp had a negative psychological functioning as a result of insecurity steaming from deteriorating living conditions and humanitarian migrants in Australia in unaffordable housing were found to be 60% more likely to suffer from serious mental health issues than their peers in affordable housing (Martino et al., 2022). Further, food insecurity and poor mental health share a positive, significant association (Cole & Tembo, 2011).

As previously mentioned, there is a bidirectional relationship between livelihoods and mental well-being. Investigation of mechanisms by which mental-ill health can contribute to poverty include differential cognitive functions, economic preferences, productivity, and health expenditures (Ridley et al., 2020).

Early on in the research process, a study identifying a lack of sufficient social contacts as a significant predictor of emotional distress in male tortured refugees appeared. Potentially even more notable, though, is that this study found past traumatic events to have nearly no importance in predicting health-related Quality of Life (QoL), emphasizing the need for social and community engagement (Carlsson et al., 2009). In a livelihood skills development program for refugee women in rural Jordan (Thorne, 2020), all interviewed participants cited making friends as a primary goal for joining this particular program. Three months into the program, it was confirmed that most of these women were able to enhance their social capabilities (Thorne, 2020). This is consistent with findings from a study about a vocational training program for women refugees at the Zaatari camp in Jordan, where many participants emphasized the relationships they were able to build over the duration of the training, further boosting their self-confidence (Jabbar & Zaza, 2015) in addition to interviews with refugee women in Australia (Ziersch et al., 2023). However, these results vary against a finding from the UPLIFT program (project aiming to improve the QoL for young girls in Makindye and Nakawa, Uganda) having null or negative effects on participants' social relationships (Renzaho et al., 2020).

Other studies explore how livelihoods support may manifest into positive well-being results. In a series of interviews with Great Lakes African and Iraqi refugees, nearly all interviewees mentioned "productivity", or employment, as a way to promote healing from their trauma. Work was the topic brought up the most when discussing recovery, and many discussed how working helps reestablish a sense of normalcy and promotes taking care of one's needs (Hess et al., 2018). Results of the aforementioned UPLIFT program showed improvements of 10.7% in autonomy, 5.7% in personal growth, 5.4% in self-acceptance, and 5.3% in purpose in life (Renzaho et al., 2020). These studies substantiate the present literature that finds employment, vocational training, establishing and maintaining a business, learning skills useful in the home, and being able to contribute to both individual and family needs as boosters of confidence, hope, and self-esteem (Hilal, 2012; Jabbar & Zaza, 2015; Renzaho et al., 2020; Thorne, 2020). Moreover, interviews with 16 women with refugee backgrounds in Australia revealed the value many participants attach to distractions, in this case distractions from resettlement challenges (Ziersch et al., 2023). This can be upheld through previously mentioned interviews with Great Lakes African and Iraqi refugees, many of whom discussed how "productivity" provides a welcome relief from constant reliving of traumatic memories (Hess et al., 2018).

Despite the undeniable benefits of properly planned and implemented programs, attention should be called on the barriers faced by persons like refugees to finding and maintaining sufficient employment (Hess et al., 2018). In the Ziersch et alt, (2023) study in Australia, nearly all of the 16 interviewed refugee women were engaged in precarious employment in addition to being subject to poor working conditions, exploitation, and labour violations ultimately leading to poorer mental health (Ziersch et al., 2023). In other words, vocational training or even employment alone cannot be assumed to be enough, especially in the context of a larger goal of integrating both livelihood support and rehabilitation as a means to improve both areas. Additionally, a small loans intervention program in South Africa, part of a larger review, was found to be associated with an increase in stress levels among participants (Lund et al., 2011) and conditional cash grants was found to be harmful for adolescent girls despite being beneficial for boys in the same context (Zaneva et al., 2022), exposing the need to carefully consider the specific needs, differences, and values of the demographic being served.

The 2022 Livelihoods projects carried out by IRCT member centres contributes to available data testing hypothesis that

combining livelihoods support with psychosocial treatment can enhance rehabilitation outcomes for SOT.

IRCT project on livelihood programmes for torture survivors.

The IRCT's Strategy 2022-2025 establishes a clear two-pronged approach to fighting torture through an emphasis on Healing and Justice. In contribution to the theme of Healing, the 2022 Livelihoods Projects directly responds to reports from member centres by formally recognising that psychosocial and medical treatments cannot be fully effective when survivors of torture (SOT) have not had their basic needs met ("Rehabilitation without livelihoods is like a car without wheels"). Five IRCT' member centres ACTV Uganda, PVCHR India, Restart Lebanon, TPO Nepal, and TRC Palestine— were provided grants to implement proposed projects intended to serve each centre's unique observed needs.

This paper analyse whether short-term outcomes of the five 2022 Livelihoods Projects support the hypothesis that an integrated rehabilitation approach combining livelihoods support with psychosocial treatment may enhance the rehabilitation outcomes for SOT. The quantitative and qualitative data informing this paper were gathered from the IRCT's documentation of the 2022 projects, which included financial reports, narrative reports, and concept notes submitted by the centres as well as IRCT-hosted webinars where centres presented their projects. All five centres were contacted for interviews, further information, or both. Zoom interviews were conducted with PVCHR India and TPO Nepal, and email exchanges with TRC Palestine and Restart Lebanon were used to supplement the information submitted in their reports. ACTV Uganda was not able to be reached for an interview or further information.

Nonetheless, it is to be noted that the paper provides early insights into short-term (six months) results, which are to be followed by data on longer-term outcomes. Moreover, control groups were only facilitated in the Restart Lebanon and TRC Palestine projects, whereas the other projects (ACTV Uganda, TPO Nepal and PVCHR India) only draw on the results obtained from integrating livelihoods support into their existing rehabilitation programmes, without comparing it to rehabilitation outcomes when socioeconomic support is not provided. These limitations make the results of this compilation of studies only a first attempt of what should be a priority line.

Projects and data

TPO Nepal engaged 46 participants (adding to their existing cohort of 30 participants) in a 2-day workshop involving baseline evaluations and preparations, as well as a 3-day consultant workshop to develop their business plans. These involved goat farming, pig farming, buffalo farming, and vermicompost businesses, amongst others. Participants were supported with necessary materials such as groceries, a tempo battery, and the establishment of a shed. Each participant additionally met with a counsellor three times, on average, for psychosocial support. TPO's report mentioned that counsellors also provided technical guidance, though it is unclear what this entailed.

Both a pre-test and post-test involving questions regarding participants' current health conditions, whether they share feelings/problems with others, changes in familial and community support/trust, changes in sufficiency and attainment of basic needs, and current economic activity (occupation) were conducted. Further questions regarding program impacts on ability to manage daily expenses, economic trust by community members, self-confidence levels, and economic and social relationship levels were facilitated once in a post-test (data available on request).

Their initial results suggest improvements in physical health conditions given the respondents' increased access to medical treatment provided by TPO. Improvements are also noticed in their capacity to share feelings and speak about their problems, increased self-confidence and strengthened community integration .

Positive outcomes are also noticed on the sufficiency of basic needs and livelihood component, showing improvements in their ability to manage daily expenses, economic trust from the community and socioeconomic relationships, suggesting that this program had a positive impact on participants' socioeconomic situation. Per contra, marginal changes were noted in family and community support, as well as family and community allowance for SOT to participate in cultural and religious activities .

However, without a control group with whom to compare these findings, these results are only preliminary.

PVCHR India hosted 15 capacity building workshops on goat rearing, kitchen gardening, nutritional values, marketing, and resource mapping, followed by the distribution of seeds and plants to 2,261 families as well as goats to 27 families, in addition to facilitating dialogues ahead of livelihood distributions, and offering psychosocial support.

Psychosocial support was provided to 30 female SOT, including testimonial and brief narrative therapy, culminating in an honour ceremony. In the folk school dialogues, 1,234 individuals from 22 villages participated. Many SOT did not think of livelihoods as a viable option for them, thus, these folk school dia-

logue discussions around livelihoods, preparing land for kitchen gardening, and taking care of plants helped prepare participants in advance of seeds and plants distribution. This livelihoods initiative has benefited approximately 3,500 families in Anei. From the seeds distribution, by the end of the year, 2,523 tones of vegetables were sold at the market earning INR 26,775.

PVCHR provided data from surveying 25 SOT before and after receiving livelihoods support through the WHO-5 Well-Being Index. Respondents were asked to identify themselves on a range from at no time, some of the time, less than half of the time, more than half of the time, most of the time, and all of time regarding whether them feeling cheerful, relaxed, active and vigorous, waking up feeling fresh and rested, and their daily life being filled with things that interest them.

The results show a notable improvement in their feelings of cheerfulness, relaxation, as well as feeling active and rigorous, waking up feeling fresh and rested, and increased interest in daily life. Positive changes were also noted in their feeling of equal opportunities to find work and their household economic contribution (data available on request).

Again, their results should be considered preliminary due to the small sample size and lack of control group. .

Moreover, the same respondents were given a "Participation Scale" survey both before and after participation in the program that collected data on livelihood outcomes relative to respondents' peers. Results are shown in the following tables.

TRC Palestine identified 68 ex-detainee women in high need of support and provided all 68 with psychosocial support services. 40 of these women were randomly selected and then further divided in 2 groups of 20— the first group would receive just MHPSS services (control group) while the second group would receive both MHPSS services and vocational training in beauty salon work, embroidery, or handcrafts (experimental group).

TRC's report states that the 20 women in the experimental group were identified as in particular need of further livelihoods support through selection criteria such as unemployment status, education level and income.

The results showed maked improvement in all areas of the WHO Well-being Index. Likewise, findings indicate reduced levels of distress, increased self-esteem , and strengthened family integration and social relationships, although as there were positive results in both groups, not all differences reached statistical significance (data available on request)

Restart Lebanon established a workshop, or the Atelier, to train a cohort of 6 SOT in professional plumbing. The group completed 120 hours of training, 1 month of supervised training, and were provided with hand tools necessary to work independently as plumbers. By the end of this program, the participants were able to install appliances, water pipes, and drainage and water disposal systems in addition to repairing water facilities and equipment.

Restart conducted a Resilience Test on two groups: the experimental group composed by the 6 individuals who received MHPSS support and benefited from the training, and a control group composed of 5 persons who were only provided with MHPSS support. Restart additionally conducted a pre- and post- test with the 6 participants of the experimental group asking 5 questions relating to confidence, success, and development of skills like social or communication skills. These questions were answered by "yes", "no", or "maybe".

In the Resilience Test, the largest difference between both the experimental and control groups were in regard to whether they engage with school and community activities, followed by forming and maintaining positive relationships.

Smaller differences, but still remarkable, were found regarding respondents' level of self-confidence, their ability to address conflicts non-aggressively, their ability to perform daily activities, their capacity to handle traumatic flashbacks, and their hope for future, which were larger in the experimental group. There were small changes -although not reaching statistical significance due to small sample size- in the areas of remaining positive during setbacks, asking for support or help, adapting to adversity, and the capacity to let go of negative thoughts.

In the pre- and post- tests (n=6) respondents spend used significatly more the day in a useful way after participating in the program, considered that had develop social skills, improved upon their technical skills, and believed their relational skills improved.

ACTV Uganda trained and provided equipment to cohorts in professional tailoring training, small-scale businesses, agro-business, and village savings and loan associations (VSLA). ACTV's first activity included training 8 male and 2 female SOT for 6 months in professional tailoring skills to work with children's, women's, and men's clothing in addition to wedding gowns, evening wear, and cushions, amongst others. As this project had been conducted once before, ACTV was able to apply lessons learned from the prior cohort like conducting an orientation workshop establishing expectations for participants.

Their second activity aimed to support 3 male and 2 female SOT in establishing small-scale businesses involving making

chili, selling goat meat, and selling fish at stalls. Each SOT participated in selecting their business venture and made their final decision based on skills, the market, and available resources. Another activity involved training 9 male and 6 female SOT in farming through a local agriculturalist with knowledge of modern, mechanized farming techniques as well as providing the following: a pair of oxen, ox plows, seeds (soya beans, sunflower, maize), insecticides, and pesticides. A land use agreement was signed prior to using land offered by 4 members of this cohort, opening 11 acres for farming (first in the community). The project is underdevelopment with data until now.

ACTV also supported a group of 15 SOT, in VSLA management skills through a social support group. After identifying specific objectives the group wished to achieve (each group member saving UGX400,000 within the year, fostering an environment that enhances healing, and initiating a group investment), participants were trained in the VSLA approach in addition to being provided with a VSLA kit. By December 2022, the group had saved UGX 652,000, profited a net UGX 40,000 from their chapati stall and had plans to initiate a second-hand clothing business.

Participants of the tailoring program reported increased hope. A set of qualitative interviews (available on request) reflected this. It is important to remar how survivors found specially relevant the social benefits ("I am a better person now; I can relate better and socialize with other people. Due to torture, this is something I had stopped doing." (Survivor 3)). The business support project also yielded benefits. The report describes the wife of a program participant shared that her husband used to ask for "poison so that he could die and stop living a stressful life," but after the program "no longer asks for poison, we can get food and rent for the house." (Survivor 4). Participants of the farming training and equipment program were the first to open up such an area of land for these modern methods of farming, instilling their newfound value to the community. ACTV reported that participants experienced an increase of self-esteem from these learned farming skills, with community members even approaching participants for assistance in these farming methods. This qualitative data is an early glance into the perception of SOT of the impact of this integrated approach, while awaiting future quantitative reports.

Interpretation of findings

The five projects analysed aimed at providing some form of livelihood support, together with psychosocial counselling, to test the overall impact in the mental health and overall wellbeing of SOT. The livelihood initiatives adopted were appropriate to the context and local market demand: business plans, farming (goat, pig, buffalo) and vermicompost (Nepal); seeds and plants distribution, workshops on goat rearing, kitchen gardening, nutritional values, marketing and resource mapping, dialogues on different aspects of livelihoods (India); plumbing workshop (Lebanon); and training in professional tailoring, small-scale businesses, agro-business and VSLA (Uganda). Even though

Table 1*. Positive outcomesof integrating livelihoods support into rehabilitation through different components.*

	Positive improvement:
TPO Nepal	Changes in physical health, sharing feelings and problems, family and community support, sufficiency of basic needs Marginal changes: changes in family & community allowance to participate in religious & cultural activities
PVCHR India	Changes to feeling equal opportunities to find work, household economic contributions, feeling cheerful, feeling relaxed, feeling active/vigorous, waking up fresh and restored, interest in daily life,
TRC Palestine	Feeling feeling relaxed, feeling active/vigorous, waking up fresh and restored, interest in daily life, self-esteem, family integration and social relationships.
RESTART Lebanon	Self-confidence, hope for future, addressing conflicts non-aggressively, managing traumatic flashbacks, expressing feelings and concerns and able to perform daily activities
ACTV Uganda	Self-confidence, hopes for future, family relationships and community integration. (qualitative testimonies)

the livelihood support looked different in these contexts, they all supported SOT in establishing income generating-activities and/or equipped them with employability skills to improve their socioeconomic situation to ultimately test whether this integrated intervention would enhance SOT's rehabilitation outcomes, as compared to when only providing MHPSS.)

There are some limitations to this set of studies from SOT grassroot organisations: (a) control groups were only established in two of the five projects: TRC Palestine and Restart Lebanon,,(b) the samples size in some of the projects (Restart Lebanon and PVCHR India) being too small and (c) the timeframe of the projects being short to obtain definitive results on the impact of this integrated approach beyond 6 months

Table 1 summarices the main positive outcomesof integrating livelihoods support into rehabilitation through different components.

Common indicators used by the five centres included social relationships, community integration, and family integration while additional indicators included self-esteem and those measured by the WHO-5. The improved social relationships experienced by participants across the 5 countries are consistent with the identified literature regarding the criticality of social relationships and integration with the family and community to one's mental health.

The quantitative data reported by the five centers generally shows improvements, with some stagnant results, across indicators measured. There are no results that have shown a negative impact of livelihoods integration. It was probably due to small sample sizes, which are expected and essentially inevitable in the first year of such kind of projects, that many results were not able to show to what extent various aspects of SOT's well-being improved. Additionally, as each project was implemented in a window of about six months, there leaves an opportunity to gather more solid results as well as longer-term monitoring should future projects be granted a longer project timeline.

Taking into account the limitations of these series of small studies , the current data suggests that an integrated approach that encompasses rehabilitation and livelihoods support has a positive impact on, at least, social relationships, family and community integration, and can positively impact self-confidence and self-esteem. Some of the data also suggest that it can decrease trauma-related symptoms, such as managing traumatic flashbacks, negative thoughts, etc.

Conclusion

This paper aimed to determine whether the qualitative and quantitative data collected by the 2022 projects implemented through TPO Nepal, PVCHR India, TRC Palestine, Restart Lebanon, and ACTV Uganda were consistent with the hypothesis that integrating livelihoods support with existing rehabilitation treatments will strengthen beneficial outcomes for SOT. A thorough analysis of all five centres' projects finds preliminary evidence of positive improvement in the well-being of SOT through the integrated livelihoods approach, while awaiting for further studies with refined data collection methods, bigger samples and longer project duration, to achieve more solid conclusions on the extent to what this integrated approach enhances the rehabilitation outcomes of SOT

Nevertheless, the results are encouraging. All five projects suggest some form of improvement in social relationships or integration, oftentimes manifesting in the form of further integration with the larger community.

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Outcomes of integrating livelihood into mental health and psychosocial support program among survivors of torture: A mixed-method study from western Nepal

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Key points of interest

- Livelihood support is one of the major contributors for improving mental health and psychosocial well-being.
- Livelihood support helps to improve social relations and trust in the community. Improved economic capabilities and functioning via livelihood support enhances self-confidence and generates feelings of purpose and resilience among survivors of torture.

Abstract

Introduction: From 1996 to 2006, Nepal experienced a decade-long armed conflict that adversely impacted survivors of torture. The conflict posed threats to various facets of their lives, such as mental health, socio-economic status, human rights, and the process of reintegration into their original communities. This study was done with the survivors of torture from the armed conflict. *Objective:* This study aims to generate evidence on the impact of livelihood support (supporting individuals with earning their livelihood through business development, farming/animal husbandry and micro-entrepreneurship) upon mental health and psychosocial wellbeing as well as social empowerment of survivors of torture. *Results:* In total, 44 out of 46 torture survivors reported improvement in their mental health and psychosocial well-being after the livelihood intervention was instituted. Significant reduction in the severity of symptoms of depression (21.7% to 2.3%; P<0.001), anxiety (15.2% to 6.8%; P<0.001), and post-traumatic stress disorder (44.4% to 4.5%; P<0.01) was observed with medium to high effect size. Similarly, improvement in social relationship, economic status, and autonomy (increase in self-confidence and motivation) were noticed post-intervention. *Discussion and conclusion:* Our study concludes that the livelihood intervention has significantly contributed to economic uplift, improved mental health, psychosocial well-being, social empowerment and quality of life among the survivors of torture. The data provide preliminary evidence of positive outcomes from integrating a livelihood program into an MHPSS (Mental Health and Psychosocial Support) program. Although the lack of a control group prevents us from isolating the specific impacts of the livelihood program, our qualitative data indicate that the intervention is well-received, culturally relevant, and promising. The study has yielded certain recommendations for further research.

Keywords: Conflict, survivors of torture, livelihood, mental health and psychosocial support (MHPSS) and social relations.

Introduction

Nepal is a lower-middle income country situated in South Asia between India and China and has an area of 147,181 square kilometers and a population of approximately 30 million. Nepal emerged from a decade-long Maoist conflict between 1996 to 2006 claiming the lives of more than 16,000, while many more were subjected to torture, intimidation, extortion, and abduction. Nepal had the highest number of forced "disappearances" in the world in 2003 (Singh et al., 2005). The armed conflict between the Communist Party of Nepal (Maoists) and the Government of Nepal ended with a comprehensive peace agreement in 2006. The armed conflict led to social disruption, loss of lives and property, economic loss and had a significant impact on the livelihood and mental health of Nepalese population.

War has a catastrophic effect on the health and well-being of nations. War destroys communities and families and often disrupts the social and economic development of nations. The effects of war include long-term physical and psychological harm to children and adults, as well as reduction in material and human capital. (Murthy et al., 2006)

Available evidence shows that survivors of torture are highly vulnerable to developing mental health conditions and psychological distress such as depression, anxiety, post-traumatic stress disorder, palpitations, panic attacks, physical & chronic pain and suicidal ideation (Shrestha et al., 1998; Steel et al., 2009; Hassan et al., 2016). Besides the direct effects of emotional and physical trauma, torture survivors often report substantial financial and social problems (Weiss et al., 2016). Meanwhile, the interventions that focus on healing the effects of war have been shown to have limited impact as long as people continue to face daily stressors related to poverty, job insecurity, and housing, among others (Kienzler & Sapkota, 2020).

The World Health Organization (WHO) highlighted the importance of dealing with psychological trauma in World Health Assembly in 2005 and urged member states "to strengthen action to protect children from and in armed conflict" and the resolution of the WHO Executive Board in January 2005 urged "support for implementation of programmes to repair the psychological damage of war, conflict and natural disasters"(WHO 2005).

There is a dearth of evidence on the impact of livelihood interventions upon survivors of torture. There are different support programs for survivors of torture such as livelihood support or other necessary support program for survivors depending upon their local context and need (Liebling et al., 2020). An example from Uganda in which the government made provision for engaging refugees in socio-economic activities by providing 'livelihoods training including forestry' can be considered (Liebling et al., 2020).

Available evidence demonstrates that a context-specific intervention that adheres to the principle of holistic support, emphasizing overall well-being, social relations, and other determinants of mental health and human rights is required for torture survivors (Kienzler & Sapkota, 2020). The evidence on the effects of integrating livelihood into MHPSS programs for survivors of torture following the armed conflict is scanty. So, our study aimed to generate evidence on the impact of combined livelihood and MHPSS intervention on mental health and psychosocial wellbeing as well as social empowerment of survivors of torture. Our research question was: *Does livelihood intervention integrated with MHPSS program contribute to improving the mental health and wellbeing, social empowerment and economic upliftment and overall quality of life of survivors of torture?*

Methodology

This assessment was conducted as a part of the livelihood project being implemented by Transcultural Psychosocial Organization Nepal (TPO Nepal)) under the support of the International Rehabilitation Council for Torture Victims (IRCT) between 2021-2023. The survivors of torture in this study had been receiving individual psychosocial counselling support, group intervention support and medical treatment support. Therefore, the study aimed to explore how integrating livelihood support affects the mental health and well-being of torture survivors.

The livelihood project integration had comprehensive steps and approaches taken by doctors, psychiatrists, psychosocial counsellors and researchers:

1. Step 1: Identification and assessment of torture survivors in need of livelihood support

   Researchers and community-based psychosocial counsellors conducted one-on-one interviews to collect and review the current economic and social status of survivors of torture.

2. Step 2: Income generating activities (IGA) workshop

   A 2-day workshop was conducted with survivors of torture to brainstorm on business plans for income generation. During the workshop, the survivors actively participated as co-creators of their business plans, bringing forth their own concepts for potential enterprises. This collaborative process facilitated informed decision-making regarding their engagement in the livelihood program.
3. Step 3: Business development plan workshop

   Following the initial workshop, a subsequent business development plan workshop was conducted to further develop the survivors' business ideas. The primary activity of this phase was the creation of individual business plans, facilitated by expert consultation. TPO Nepal recruited a consultant to lead a 3-day workshop, during which each participant worked closely with the consultant to refine and formalize their business concepts. This hands-on approach ensured that each survivor of torture developed a viable and tailored business plan, laying a strong foundation for their future livelihood endeavors.
4. Step 4: Skill development training

   Building on the foundation of individualized business plans, the next step involved comprehensive skill development training aimed at expanding the survivors' business competencies and ensuring the sustainability of their livelihood activities. This phase involved mobilizing consultant who delivered targeted training sessions. These sessions were designed to equip the participants with essential business skills, such as financial management, marketing strategies, and operational efficiency. By enhancing their capabilities through these trainings, the survivors were better prepared to implement and sustain their business ventures, thereby promoting long-term economic stability and resilience.
5. Step 5: Providing essential items

   Following the skill development training, the project proceeded to provide essential items necessary for the initiation of the livelihood programs. This activity involved offering in-kind support tailored to each survivor's business development plan. The support included essential items such as inventory for grocery and cafe or maintenance costs for operational facilities like sheds. Additionally, to ensure the continued motivation and well-being of the participants, a full-time psychosocial counselor was deployed to provide regular follow-up and psychosocial counseling. This continuous support aimed to address any emerging challenges and foster a supportive environment, enhancing the likelihood of success and sustainability of the livelihood activities.

Setting

The study was conducted in Dang, Banke and Bardiya districts of Lumbini Province and Kailali and Kanchanpur districts of Sudurpaschim Province of Nepal. While Banke, Bardiya and Kailali predominantly harbour people from the marginalized communities (*Tharus*), Dang and Kanchanpur constitute of mixed communites including Brahmin, Chhetri and Janajati. These districts were selected as they were the most affected by the armed conflict. Bardiya recorded the highest number of survivors of torture in the country. Agriculture is the mainstay of livelihood in this region.

Design

The study utilized a mixed-methods approach. The quantitative assessment involved baseline and end line surveys using a structured questionnaire while the qualitative assessment involved interviews with survivors of torture.

Population and sample recruitment

The participants for the quantitative assessment were adult male and female survivors of torture from the armed conflict in the five aforementioned districts. Torture was inflicted among the survivors from both the state and rebelling parties. Sample recruitment was done purposively by using the following inclusion criteria:

– age over 18 years,
– history of directly being affected by the conflict,
– residence in the aforementioned districts and
– willing to participate in our study.

A total of 46 survivors of torture (43 female and 3 male) from Lumbini and Sudurpaschchim Provinces of Nepal were enrolled. Two of the participants from the baseline dropped out at the endline following their labour migration to India. The baseline and endline surveys and interviews were conducted face-to-face. An informed consent was taken from all respondents before the survey and interview. The survey and interviews were conducted in Nepali language.

All the survivors of torture who participated in the survey and interview had been receiving mental health and psychosocial support in the form of either individual psychosocial counselling or psychiatric consultation or group intervention.

Instruments

We used the following tools for measurement of mental health in the surveys: Beck's Depression Inventory (BDI), Beck's Anxiety Inventory (BAI), and Post-traumatic Stress Disorder (PTSD) Checklist-Civilian Version (PCL-C). All of these tools have been validated in Nepal.

BDI and BAI both constitute of 21 items and are used to assess depression and anxiety symptoms over the prior 2 weeks. Items are scored over a likert scale ranging from 0–3. The total score ranges from 0 to 62. Scales were validated for use in Nepal (Kohrt et al., 2002; Kohrt et al., 2003) with clinical DSM-IV diagnoses of major depressive disorder or generalized anxiety disorder: area under the curve (AUC) 0.92 (95% CI 0.88–0.96) for the BDI and 0.85 (95% CI 0.79–0.91) for the BAI; internal reliability (Cronbach alpha), BDI $\alpha = 0.90$ and BAI $\alpha = 0.90$. Based on the clinical validation of the BDI in Nepal, a score of 20 or higher suggests moderate depression symptoms with the need for mental health intervention (sensitivity 0.73, specificity 0.91) (Kohrt et al., 2002). 21 On the BAI, a score of 17 or higher indicates moderate anxiety symptoms with need for intervention (sensitivity 0.77, specificity 0.81) (Kohrt et al., 20023). These cut-off scores reflect symptom burden at the level requiring intervention. The cut-offs do not however indicate diagnoses of major depressive disorder or generalized anxiety disorder. Test–retest reliability Spearman–Brown coefficients for the BDI were 0.84 and for the BAI were 0.88.

Post-traumatic stress disorder (PTSD) Checklist-Civilian Version (PCL-C) is a 17-item self-report rating scale for assessing PTSD symptoms and severity within the past week (Weathers et al., 1993). The English-language measure has good psychometric properties in Western populations (Weathers et al., 1993). This tool has been validated in Nepal (Thapa, SB and Hauf, E., 2005) and has sound psychometric properties. The validated Nepali version performs similarly (Tol et al., 2007) with a cut-off score of 50 or above indicating need for intervention. Internal reliability was 0.83 and test–retest reliability was 0.82.

The surveys took between 45-60 minutes each. The qualitative interviews were conducted using a structured Key Informant Interview (KII) Guide. The interviews with survivors lasted between 30-40 minutes.

Social and economic impacts of the intervention were assessed using the locally developed qualitative and quantitative questionnaires. The qualitative questionnaires included open-ended questions aimed at understanding the survivors' feelings regarding several key areas:

- Economic and social relationships: This category explored the level of trust and quality of interactions (e.g., talking nicely) with other people.
- Self-confidence: This focused on the survivors' feelings of self-efficacy, such as their belief in their ability to accomplish tasks (e.g., feeling "I can do something").
- Economic trust: This examined the trust other people had in the survivors, including their willingness to extend loans.
- Everyday expenditure: This covered the survivors' ability to manage daily expenses, such as purchasing food, medicine, medical check-ups, and financing children's education.
- Inclusion in cultural and religious activities: This assessed the extent to which survivors were included in such activities by their family and community.
- Discrimination by family and community: This included discrimination due to being a survivor, as well as discrimination based on gender, caste, or other factors.
- Support by family and community: This investigated the level of support provided by family and community members.
- Trust by family and community: This measured the trust placed in the survivors by their family and community.
- Social network: This explored the survivors' social connections and support systems.

Table 1. *Testimonies of torture survivors regarding their mental health and psychosocial wellbeing*

Age, Gender, Torture, Year	Testimony
41, female, physical, mental, sexual and gender-based violence, 2002	"On 31 August, 2002, state force knocked on my door at 12 am midnight asking for my son who was convicted of being an alleged Maoist. My father-in-law was severely beaten. They grabbed and pulled my hair, took me to another room and raped me. They stepped and hit me with the boot and barrel of the gun. This severely affected me mentally".
42, female, physical, mental, sexual and gender-based violence, 2001	"I was taken under custody allegedly working for the Maoists. I was physically and mentally assaulted for 3 days. I was shifted to another prison for 1 year and 3 months. During those time they put blinds around my eyes and tortured me".
39, female, physical and mental	"My sister-in-law was shot dead in our house in my presence. I was physically assaulted, with fractured hands and one of my ear drums have ruptured".

Data collection and analysis

Data collection for baseline was done between 13th to 18th July, 2022 and the endline between 5th to 9th December, 2022. Baseline data was collected in July 2022 and endline was conducted in December 2022. The quantitative data was analyzed using SPSS whereas the qualitative data was analysed using a thematic approach. A paired-sample t-test was conducted to assess the impact of integrating a livelihood program with mental health and psychosocial support on survivors of torture, focusing on three key issues: anxiety, depression, and PTSD. Cohen's d was calculated for each variable to report the effect size (Cohen, 1988). Qualitative analysis involved detailed coding of the responses, which allowed us to systematically identify, organize, and understand patterns and themes within the data. This thematic approach of thorough review of interview transcripts followed with initial coding, searching for themes and reviewing them allowed the study to capture the nuanced and multifaceted nature of the social and economic impacts experienced by the participants, providing a rich and in-depth understanding of their experiences.

Results

Overall the integrated livelihood and MHPSS support demonstrated improvements in mental health outcomes, social relationships and empowerment, economic capabilities and resilience. The results have been illustrated subsequently.

Methods of torture among survivors

Table 1 quotes serve as examples of the forms of ill-treatment endured by the survivors.

MHPSS outcomes

Overall, mental health and psychosocial wellbeing of all the survivors of torture had improved at the endline. The survivors mentioned that receiving the group intervention and counselling had been a great help and supported them in managing the stress. They stated that the emotional support helped in boosting their self-confidence and also guided them in applying suitable coping mechanisms during periods of stress. Most of the respondents mentioned that the reason behind their mental health condition having improved as compared to before was receiving livelihood support and MHPSS services together. This was in-

Table 2*. Prevalence of psychosocial and mental health problems(anxiety, depression and/or PTSD)*

Category	Base line (N)	%	End line (N)	%	P value (paired t- test)
Anxiety					
No	39	84.8	41	93.2	<0.001
Anxiety (≥ 17.5)	7	15.2	3	6.8	
Total	46	100.0	44	100.0	
Depression					
No	36	78.3	43	97.7	<0.001
Depression (score ≥ 24.5)	10	21.7	1	2.3	
Total	46	100.0	44	100.0	
PTSD					
No	25	55.6	42	45.5	<0.01
PTSD (score ≥ 50)	20	44.4	2	4.5	
Total	45	100.0	44	100.0	
Co-morbidity status					
None	9	20.0	40	90.9	<0.001
Any one	20	44.4	3	6.8	
Any two	9	20.0	0	-	
All three	7	15.6	1	2.3	
Total	45	100.0	44	100.0	

ferred from the interviews with them. These findings have been supported by qualitative interviews.

> Nowadays, I do not think about negative things and don't have negative thoughts. Before, thoughts used to come frequently regarding what would happen in future, and I used to get worried. However, after talking to the counsellor, my condition has improved. Now I feel the energy in my body. Whenever I have stress, I think that I am not alone and there are others like me which gives me hope, and I feel ok. (55 years, F, Bardiya)

Outcomes on mental health and psychosocial status were measured using the validated tools-BDI, BAI and PCL-C. The prevalence of anxiety had significantly decreased from 15.2% to 6.8% at the endline (P<0.001) with medium effects size based on Cohen´s convention. Similarly, around 21.7% of respondents had depression at the baseline which significantly dropped to 2.3% at the endline (p<0.001) with high effect size. Approx. 44.4% had post-traumatic stress disorder which significantly reduced to 4.5% after the intervention with medium effect size. Meanwhile, 44.4 % met the cut-off for at least one of these mental health conditions (either anxiety or depression or PTSD) at the baseline which reduced to 6.8% after the intervention. Likewise, 15.6% had met the cut-off score for comorbidity of all three conditions at the baseline which dropped to 2% at the endline. While 20% had two comorbid conditions at the baseline, none was identified with two comorbid conditions at the end line. The improvement of comorbidity status during this period was also statistically significant (p<0.001).

All the respondents emphasized that the psychosocial counselling and training programs helped them in effectively managing their stress, anxiety, and depression. Overall, the mental health condition of all the service users had improved. All the individuals mentioned that receiving the group intervention and counselling had been of great help and support in managing their levels of stress. They felt that the counsellors provided them with emotional support, which had helped them boost up their self-confidence.

The end-line assessment identified that self-confidence had increased among all respondents after receiving the IGA/ livelihood support along with MHPSS. This had positively impacted the mental health and wellbeing of survivors. They said they felt they could also do something to sustain their living since they no more had any stress and uncertainty of future after receiving livelihood support. A 46-year-old female from Banke stated,

> My self-confidence has increased a lot. I also got the tent for keeping the goat as I wanted. Now I feel that I can manage and sustain my life with this goat.

Many other females responded similarly, saying that the IGA and mental health support has contributed a lot to increasing their self-confidence. A 39-year-old male from Banke stated, "*The psychosocial support and group healing intervention has increased my self-confidence and helped me and my family mentally*".

Some expressed how their strong confidence after the livelihood support and good social relationships improved their mental health. They felt that people in the community were treating them better which made them feel more confident and emotionally resilient. A female from Banke, age 39, mentioned that the support of goat farming had kept her very busy, which helped her ward off any other stressor(s).

Social and economic empowerment

Qualitative data

Socio-economic empowerment was measured both qualitatively and quantitatively. The majority of the respondents found their socio-economic condition to be better. They said that their social relationships in the community had become stronger, and their neighbours started helping them with their daily chores, trusting them and providing loans. They highlighted that enrolling in the counselling and livelihood support program changed the perspectives of their neighbours, who used to discriminate and exclude them before.

This discrimination manifested before in several ways including a lack of trust on survivors, exclusion from social and community events, and denial to provide informal loans (a common practice in Nepalese culture where neighbors lend money without documentation).

Prior to receiving livelihood support, many survivors faced significant challenges in managing their daily expenses. The provision of targeted livelihood support has markedly improved their financial situation enabling them to cover basic needs more effectively. For some, this support had resulted in substantial financial empowerment thereby allowing them to earn more than they previously could. Additionally, access to microloans has been facilitated, fostering trust within their communities. This economic resilience and empowerment has also contributed to their psychological well-being and alleviating stress. The integration of livelihood support has thus had a profound impact on the everyday lives of survivors of torture, promoting both economic stability and psychosocial well-being.

Several participants expressed that they had experienced discrimination but after the livelihood intervention they informed that the discrimination had decreased. Economic empowerment led to reduction of discrimination and increased trust. A significant factor contributing to the decrease in discrimination is the support provided to torture survivors by the organization. The community observed that these survivors received assistance from NGOs. The association of torture survivors with the organization and support network appears to have shifted community members' perspectives toward the survivors. One female from Kailali, age 41, said,

> It is better than before. Before, the community people did not trust me and used to discriminate against me, but now is not the case.

Others highlighted how they had received a loan from the group and short-term petty cash loans from neighbours due to the good social relationships they had developed in the community following the intervention.

The community members viewed their social status as more trustworthy due to their affiliation with an organization. One of the respondents from Banke mentioned that her family and neighbours now respect and trust her more because she received assistance to buy the battery for her TukTuk[1]. Other respondents from Dang, Banke, Bardiya, Kailali and Kanchanpur mentioned the same thing, namely that their neighbours and community had started trusting them and inviting them to various social events such as wedding ceremonies, festivals, and other gatherings. This trust was also developed with the local cooperatives where the torture survivors were able to get some financial support as a loan for a brief period.

Likewise, the majority of the individuals reported improvement in their economic condition compared to before. Most individuals highlighted how the livelihood support had benefited them in managing their everyday livelihood, finances, household expenses and materials for children. Many of the individuals were involved in goat and pig husbandry which generated profit after sale. Most individuals had their primary source of income through agriculture, livestock (goat and pig husbandry), labour works and other businesses respectively.

The majority of the survivors of torture had taken a significant leap of faith and hope when offered assistance with their livelihoods because this gave them some form of financial support and kept them busy. The end-line assessment found that the majority of the respondents felt that they received much or some support from their family and community members. Most of the support was related to providing help with everyday chores, medical treatment support, household support and other everyday activities.

Before receiving the support, it had been difficult for them to manage their daily expenses. After receiving the livelihood support, they reported being able to manage their basic expenses. Some have earned even more and felt the financial empowerment in their life. Many survivors were able to take the loan and build the trust in the community after receiving the livelihood support. They felt economic resiliency, empowerment and being busy helped them in managing their stress. Livelihood integration had a significant impact in the everyday livelihood of survivors of torture.

Majority of the individuals linked their economic condition to support from livelihood. They said that the livelihood support had provided them with some financial independence and some sort of help in managing everyday household expenses for oil, food and basic needs (copy, pencil, bag and clothes) for their children. A female from Bardiya, age 29, mentioned

> The condition is better. I sold two pigs for Rs 18,000 each. I also have 2 small baby pigs, which I bought for Rs 5000 and Rs 3500. The money that I received from selling the pigs helped me provide education for my daughter, food for my household and other small expenses. Furthermore, my husband is also doing labour work in India, and he sends Rs 10 to 15 thousand every month.

At the endline, majority of the survivors reported that it was easier for them to manage their everyday expenses especially medical expenses, stationery items for their children, running hotels, daily household expenses, educating their children, paying back their loan instalments, and buying compost. A 46-year-old female from Banke mentioned

> Livelihood support has given me some reason to live. It made my life very easy. It gave me a goat, and now I feel happy. After receiving the support, livelihood and earning have been easier.

Similarly, another female from Banke mentioned

> with the support, change has happened. They gave me Rs.14000 worth of Nepali Pote, and I sold it for Rs. 28000.

1 A "tuk-tuk" is a three-wheeled motorized vehicle used as a taxi or mode of transportation in certain countries. It's known for its compact size, distinctive sound, and offers a convenient way to navigate urban traffic.

Few of them mentioned that their economic relationship with the people in the community has become better, and they both lend money to each other, while others mentioned that even though the people in the community have started treating them nicely, they had not been supporting them in economic matters. One female from Bardiya, aged 50, mentioned

> The relationship has become better to some extent. But in terms of money, they trust me only for a day or two and don't lend me money for a long time. Since I don't have a husband, they don't trust me in financial matters.

One of the major outcomes observed in the intervention was economic empowerment. Providing torture survivors with livelihood opportunities, such as vocational training, assistance with battery replacement for their auto businesses, or other small business support, significantly contributed to their economic empowerment. Interviews with torture survivors and psychosocial counselors in the field revealed that the survivors had regained a sense of self-sufficiency and financial independence. This financial autonomy was highlighted as being crucial for their overall well-being.

Another significant improvement was observed in the survivors' psychological well-being. The sense of economic stability and the ability to support themselves and their families positively impacted their mental health. Survivors reported a reduction in feelings of helplessness and dependency, which had often been pervasive since the aftermath of their torture experiences.

Furthermore, access to livelihood opportunities had a profound impact on social reintegration and rehabilitation within the community. Many respondents noted that the support and opportunities they received helped build their credibility. Community members began to trust them more which facilitated their social reintegration. One respondent mentioned that becoming productive members of society made it easier to rebuild social connections and overcome the stigma often attached to victims of torture. This newfound trust made it easier for them to request help and loans from community members and neighbours, who previously did not trust them and often discriminated against them.

Additionally, survivors noted that their views, opinions, and conversations which were previously ignored, were now being considered. Their financial support and affiliation with a recognized non-governmental organization enhanced their credibility, leading to greater inclusion and invitations to community and social events. This shift in community perception played a crucial role in their social reintegration and overall sense of belongingness.

Table 3*. Livelihood intervention impact (endline data)*

Ease to manage daily Expenses	Yes
N(%)	40 (90.9%)
Increased economic trust by others in the community	Yes
N(%)	41(93.2%)
Increase in self-confidence	Yes
N(%)	44(100%)
Improved economic as well as social relationships	Yes
N(%)	41(93.2%)

Quantitative data

The results from the quantitative assessment show improvement in monthly earnings, spending capacities and expand business model that they opted.

Discussion and conclusion

This assessment took an attempt to determine the outcomes of integrating livelihood support into ongoing MHPSS program for survivors of torture. The study has several strengths. First, this study is unique in its nature in the sense that it has evaluated the multi-faceted outcomes of integrating economic intervention into ongoing MHPSS program. Second, the study has used scientific and validated measurement tools to determine the changes in mental health outcomes over time. Third, the study has used mixed methods approach to triangulate the findings from the study. Fourth, the study was done with survivors of torture and would probably be the first of its kind with those beneficiaries to estimate multi-dimensional impacts of livelihood intervention jointly delivered with MHPSS.

The findings from the study indicate that engaging survivors of torture in livelihood activities has contributed to economic uplift of the beneficiaries. This finding is consistent with the findings from various other studies conducted with victims of torture in fragile and conflict affected settings and low-middle income countries. These studies have demonstrated an improvement in income and reduction of poverty following economic/livelihood intervention (Blattman & Annan, 2011; Koyabu, 2014; World Bank, 2015).

Our study has shown improvement in psychosocial wellbeing of the beneficiaries following the livelihood intervention. Poverty has been identified as a mediator of the relationship between armed conflict and psychological wellbeing and mental health (Miller & Rasmussen, 2010). In a systemic review of

the psychological health of conflict-affected populations in low- and middle-income countries (LMICs), poor income and assets and unemployment were associated with poorer mental health and psychological wellbeing, and insecure financial conditions of unemployment contributed to poorer psychological wellbeing (Roberts & Browne, 2011). Similarly, a meta-analysis of 56 research studies on mental health amongst refugee people (including internally displaced, asylum seeking and stateless people) using a worldwide study sample demonstrated that economic opportunity had a linear relationship with improved mental health (Porter & Haslam, 2005). Integration of livelihood support into MHPSS programs demonstrated a positive impact, easing the management of daily expenses and reducing anxiety and depression among survivors, consistent with findings by Liebling et al. (2020). Consistent with these literature, livelihood interventions delivered to the victims of torture in our study have been found to have a positive impact on psychological wellbeing (El-Namrouty et al., 2013; Ziveri et al., 2019).

The paper by Lordos et al., 2021 highlights Rwanda's experiences of profound impact of violent conflict and genocide on mental health, social cohesion, and sustainable livelihoods, reflecting challenges that can be shared globally. Countries grappling with similar histories can draw valuable lessons from Rwanda's decades-long journey toward multisystemic recovery and resilience. The approach advocates for integrating local innovations with international practices, guided by scholarly reflection and evidence-based strategies.

Additionally, this study has also shown social empowerment among the beneficiaries after enrollment into the livelihood intervention. Social empowerment has been defined in a diverse manner across different settings (Kuttab, 2010). Social empowerment in our study has been conceptualized in the form of self-reliance, ability to regain social trust and harmony, establishment of social networks and connections, improved decision making capacity and enhanced capacity to voice one's opinion. Recipients of livelihood support in our study reported strengthened social relationships and economic trust within the community, emphasizing how financial stability fosters strong social and economic bonds for torture survivors.

The concept of trust, especially how affiliation with an organization enhances trust among survivors of torture, is indeed intriguing and merits further exploration in academic discussion. As observed in the context of this intervention, survivors highlighted that their association with a recognized non-governmental organization (NGO) significantly boosted their credibility within the community.

Moreover, exploring the community dynamics of these relationships is essential. The community's reception of survivors, influenced by their association with supportive organizations, shapes their opportunities for social engagement and acceptance. Future discussions could delve deeper into how these organizational ties impact social cohesion and community acceptance, drawing parallels with similar contexts where organizational affiliations have played pivotal roles in enhancing social relations among vulnerable groups.

Earning income through livelihood support not only provided essential financial assistance but also contributed to better mental health and psychosocial well-being through strengthened relationships with family and the community. The cumulative effect enhances overall well-being, resilience, self-esteem, and self-confidence in dealing with traumatic events. This finding from our study is consistent with a study on the impact of livelihood on psychosocial wellbeing and social empowerment in an ongoing conflict setting (Hammad & Tribe, 2020).

Continued mental health and psychosocial support were identified as beneficial for survivors' societal reintegration, addressing individual trauma experiences and improving interpersonal skills and community relationships. The study highlighted the significant positive impact of livelihood interventions on socio-economic empowerment, alleviating severe poverty and unemployment among survivors. The reduction of poverty through livelihood interventions contributed to improved mental health outcomes and social empowerment, as suggested by Kienzler and Sapkota (2020). Livelihood support increased self-confidence and resilience among survivors, aligning with findings from Weiss et al. (2016) and Kienzler & Sapkota (2020).

Our data show preliminary evidence suggesting positive results from integrating a livelihoods program into an MHPSS (Mental Health and Psychosocial Support) program. Although the lack of a control group makes it impossible to determine the specific impacts of the livelihoods program, our qualitative data indicate that the intervention is well-received, culturally relevant, and promising. Overall, our study suggests that the livelihood intervention has contributed to economic uplift, improved mental health and psychosocial well-being, and social empowerment among the beneficiaries enrolled in the intervention. The study highlights the potential of locally led livelihood interventions in alleviating the suffering of victims of torture.

The livelihood intervention should be developed using a co-creation approach, engaging the beneficiaries and considering the real needs and scope of market. This approach would help ensure the sustainability of the intervention and maintain the production-sale cycle. To support an efficient produc-

tion-sale cycle, a series of workshops were conducted in close consultation with survivors of torture and contextualized to the setting.

Social empowerment and resilience have often been defined using Western concepts, which might not always be applicable to the local context. Defining these domains with local understandings could better capture and visualize relevant outcomes of the livelihood intervention across the beneficiaries' lives. While the intervention has shown positive psychological, economic, and social outcomes, the presence of a control group for comparison could have strengthened the evaluation. Integrating livelihood intervention with mental health and psychosocial support programs is highly commendable where this study being one of a kind has also yielded certain recommendations for future improvements.

Limitations

There are some limitations to the study. First, the study was conducted among a small sample of survivors of torture in selected districts of Lumbini and Sudurpashchim Provinces of Nepal. So, the findings of the study may not be generalizable. However, this study has accessed a hard-to-reach community and contributed to an under-researched area in Nepal. Second, the study utilized a local semi-structured questionnaire for evaluating the economic impacts of the livelihood intervention. A more rigorous and elaborative method incorporating prior status of beneficiaries, income, source of income and whether the beneficiaries relied on our livelihood support would have been better. This would have further contributed to a broader scenario of economic impacts. Third, the improved outcomes of the study could partially be attributed to the psychosocial counselling and medical treatment support received by the survivors while receiving livelihood support as well and may not be solely due to livelihood intervention. Meanwhile, participation of the survivors in the training, affiliation with an organization and acquisition of appropriate skills could have led to improved outcomes at the endline. It is however difficult to delineate the effects of each individual component on improvement in outcomes. Fourth, a comparison between the specific intervention arms is lacking thereby limiting the understanding of impact of each intervention. Therefore, a randomized controlled trial consisting of 2 arms (MHPSS only and MHPSS + livelihood) or 3 arms (MHPSS only, MHPSS + livelihood and control arm) is recommended in future to further understand the outcomes of each specific intervention.

Project documentary: https://www.youtube.com/watch?v=at_0K88yBfs

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https://doi.org/10.7146/torture.v34i2.146559 *Special Section*

Integration of livelihood support with MHPSS in rehabilitation of torture survivors in LMICs: Addressing poverty and mental health dynamics

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Key points of interest

- Torture survivors experience significant psychological and economic consequences.
- Poor economic condition and mental health interact in a negative cycle in torture survivors.

Abstract

Introduction: The integration of livelihood support with mental health and psychosocial support (MHPSS) seems crucial for the rehabilitation of torture survivors in low- and middle-income countries (LMICs). This study aimed to explore the intersectionality of poverty and mental health, and the integration of livelihood support within MHPSS frameworks related to the rehabilitation of torture survivors in LMICs. *Method:* A cross-sectional study was conducted using a semi-structured questionnaire distributed to members of the International Rehabilitation Council for Torture Victims (IRCT) in LMICs (n=25). The questionnaire explored the perception of IRCT centres in LMIC countries regarding the extent to which poverty contributes to poor mental health outcomes among torture survivors and the effectiveness of integrating livelihood support into MHPSS interventions. *Results*: The study highlighted the significant economic challenges faced by torture survivors, indicating a high prevalence of extreme poverty among this group. The study found that 92% of respondents believed that poverty and mental health outcomes of torture survivors are strongly linked. Economic and social inequalities were identified as key determinants of mental health, emphasizing the need to address these inequalities in rehabilitation programs for torture survivors. *Discussion:* The study underscores the critical connection between poverty, mental health, and the experience of torture. In the view of most IRCT centres, the integration of livelihood support with MHPSS is essential for addressing economic disparities and promoting long-term resilience among survivors. The results highlight the need to conduct long-term longitudinal studies that provide support to this perception. The study recommends enhancing coordination among stakeholders, addressing cultural and social barriers, securing sustainable funding, and developing strategies to integrate livelihood support with MHPSS for torture survivors. According to participants, rehabilitation programmes should include economic empowerment, mental health support, and social integration, to contribute to a holistic recovery, long-term resilience, and overall well-being.

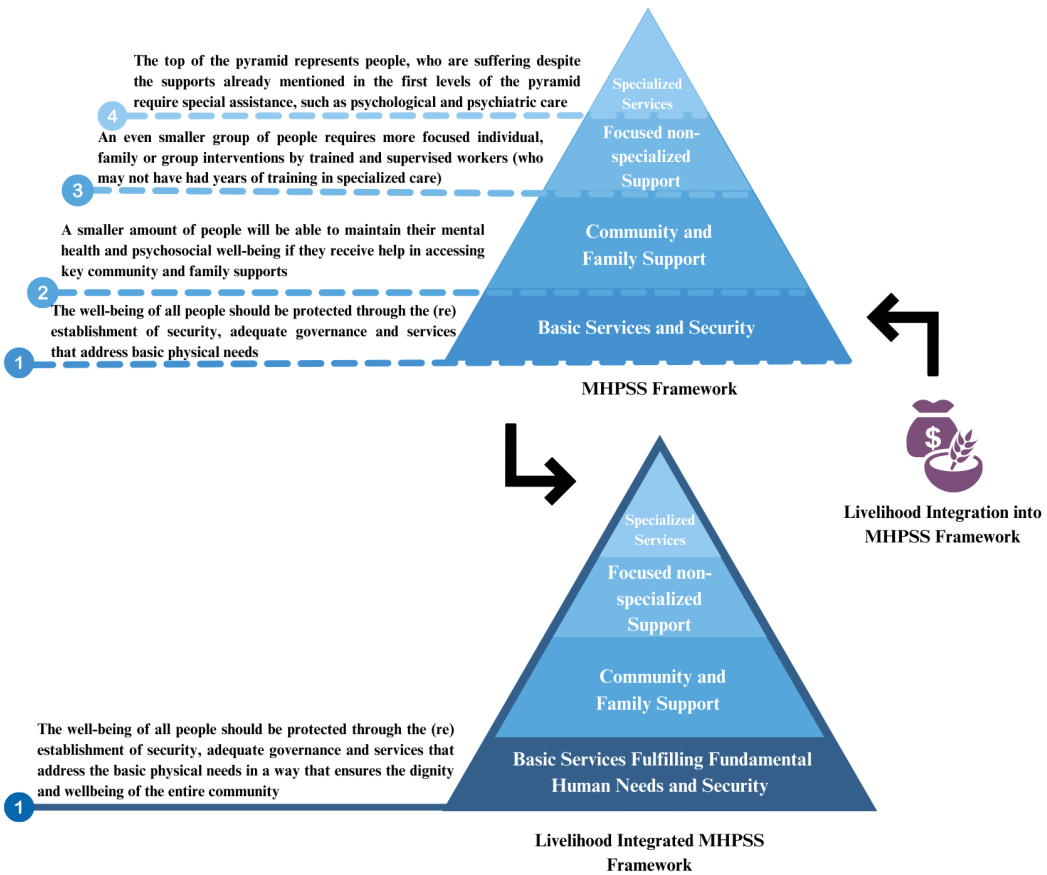
Keywords: Integration of livelihood support, mental health and psychosocial support, rehabilitation, torture survivors, economic

Background

Torture represents a severe infringement of human rights and persists as a prevalent practice across the globe (Amnesty International., 2023). The hardships and violence experienced by individuals during a humanitarian crisis can have a negative impact on their mental, physical, and spiritual health, as well as their ability to take advantage of economic opportunities (IOM Iraq., 2021). An exposure to torture during these crises — such as armed conflict and forced displacement — cause significant acute and long-term health consequences for millions of individuals, primarily affecting those in low and middle-income countries (LMICs) (Kohrt al., 2019). Growing international evidence shows that poor economic condition and mental health interact in a negative cycle all over the world in general and particularly in LMICs (Lund et al., 2011). However, little is known about the interventions that are being implemented to break this cycle and which are examples of good practice and elements of success from evidence-based studies.

MHPSS is increasingly recognized as a critical component of effective humanitarian response (Nemiro et al., 2022). However, historically, MHPSS research has focused largely on identifying the rates of post-traumatic stress disorder (PTSD) and major depression (Moore et al. 2020) while non-specific forms of psychological distress and psychosocial problems that are associated with several economic and social limitations (McVeigh et al., 2006), have been less well-addressed, despite being the target of most MHPSS programs in emergencies (Nemiro et al., 2022, Tol et al., 2011). Livelihoods are the capabilities, assets and activities required for individuals to earn money and secure a means of living (Islam et al., 2016). Combining livelihood support with psychosocial support can be effective for the rehabilitation of torture survivors in conflict-affected coun-

Figure 1. *Livelihood Integrated MHPSS Framework*



tries (IOM Iraq., 2021, Kumar et al., 2016) but this approach is not widely implemented. There are resources available for implementing psychosocial support in these settings, but it does not address the need of integrating livelihood with psychosocial support or how to integrate the two (IOM Iraq., 2021) specially in LMICs. Literature reveals that livelihoods are one of the backbones of the person's dignity both during a crisis and in ordinary situations. Psychosocial and medical services can have positive lasting effect if basic human needs are covered in parallel to these (Hassan et al., 2016). That is why it is a shared responsibility to provide the necessary resources along with MHPSS to guarantee a dignified life to the people in situation of vulnerability (UNHCR., 2015) The Inter-Agency Standing Committee (IASC) Guidelines in Mental Health and Psychosocial Support in Emergency Settings emphasize the significance of meeting basic needs and restoring social supports as fundamental for the recovery of individuals affected by crises claiming the natural healing of the majority of individuals affected by crises over time, once basic safety and survival needs are met, and community/family supports are restored (IASC., 2007, Schafer et al., 2014). Although IASC framework was designed for humanitarian settings, we suggest that it can be applied to the rehabilitation domain due to various cultural and contextual similarities (Einolf et al., 2023) and integration of livelihoods into MHPSS could lead to strengthening the fundamental of IASC MHPSS pyramid (Figure 1). While many humanitarian aid agencies support IASC guidelines, the evidence base for the effectiveness of such interventions/integrated approach in improving wellbeing and psychosocial health is limited (Tol et al., 2011). Likewise, implementing measurement models for these programs remains a persistent challenge due to the lack of funding, among other reasons.

The study aimed to explore the perception of IRCT centres in LMIC countries regarding the impacts of socioeconomic status on mental health in rehabilitation of torture survivors through a survey (see Annex 1). Central to this, are two research questions: firstly, the extent to which poverty contributes to poor mental health outcomes among torture survivors in LMICs, and secondly, the perception of the effectiveness of integrating livelihood support into MHPSS interventions during the rehabilitation of torture survivors.

Method

We employed a cross-sectional design, utilizing a semi-structured questionnaire (Annex 1) distributed to IRCT members in LMICs through a secure online survey platform, ensuring ease of access, anonymity, and efficient data collection.

Sample: A total of 25 members responded to the survey, representing a diverse range of geographical locations, cultural backgrounds, experiences[1] and perspectives.

Analysis. We used the Tableau software program for the description of results. Sample size did not allow for complex analysis.

Results

Integrating livelihoods into rehabilitation: what do we mean? Why?

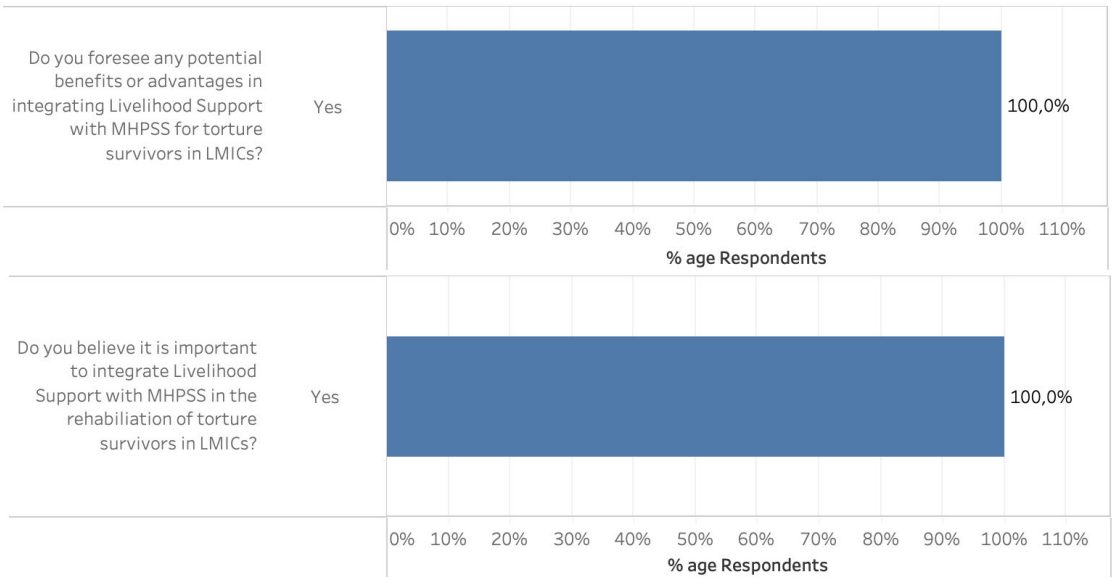
The integrated approach is expected not only to improve the mental health outcomes of torture survivors, but it is believed that its potential benefits also entail holistic recovery, long term resilience and overall well-being, enabling them to develop their full psychosocial potential and effectively enhance their rehabilitation (Figure 2). Through this approach, beneficiaries are expected to realize their capabilities, manage life's stress contribute to their community, and support their families with a stable income, purpose, and healthy emotional well-being.

Poverty and Mental Health Dynamics:

A majority (92%) of respondents believed that poverty and mental health outcomes of torture survivors are strongly linked. Economic and social inequalities were identified as key determinants of mental disorders in the country by 19 (90.48%).

1 Centro de Atención Psicosocial (CAPS, Peru), Counselling Services Unit (CSU, Zimbabwe), Federation Des Femmes Pour Le Developpement Integral Au Congo (FEDICONGO, Democratic Republic of Congo), Friends of Victims of Humans Rights Violations (AVVDH, Pakistan), Human Development Organisation (HDO, Pakistan), Human Rights Development Centre (HRDC, Bangladesh), Independent Medico Legal Unit (IMLU, Kenya), Instituto de Terapia e Investigación sobre las secuelas de la tortura y violencia de Estado (ITEI, Bolivia), International Medical Rehabilitation Center for Victims of Wars and Totalitarian Regimes (IRC, Ukraine), Liberia Association of Psychosocial Services (LAPS, Liberia), Medical Action Group (MAG, Philippines), Mwatikho Torture Survivors Foundation (MATESOF, Kenya), Regroupement Des Mamans De Kamituga (REMAK, Democratic Republic of Congo), Rescue Alternatives Liberia (RAL, Liberia), Restart Centre for Rehabilitation of Victims of Violence and Torture (RESTART, Lebanon), Society for Social Research Art and Culture (SOSRAC, India), Struggle for Change (SACH, Pakistan), The Tunisian Rehabilitation Institute for Survivors of Torture Survivors (NEBRAS, Tunisia), Trauma Centre Cameroon (TCC, Cameroon), Tree of Life (ToL, Zimbabwe), Vasavya Rehabilitation Centre for Torture Victims (VRCT, India), Women and Children Protection (WCP, Democratic Republic of Congo).

***Figure 2**: Potential Benefits and Advantages in Integrating Livelihood Support with MHPSS*



Potential Benefits and Advantages in Integrating Livelihood Support with MHPSS

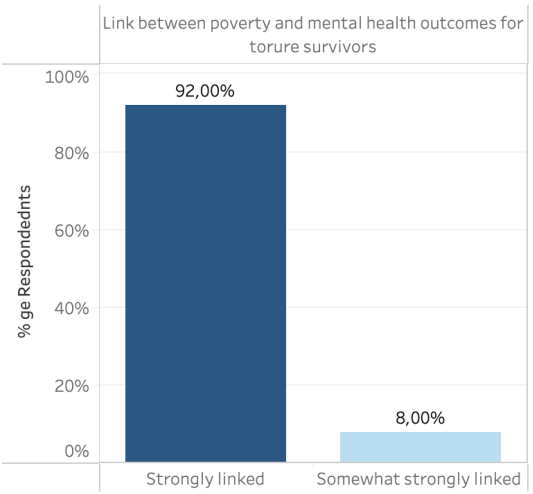
Question	Response	Number of Respondents
What do you believe could be the potential benefits or advantages in integrating Livelihood Support with MHPSS for torture survivors in LMICs?	Improved mental health outcomes	21
	Holistic recovery	20
	Improved psychological well-being	19
	Increased economic stability	17
	Greater social integration	16
Why do you believe it is important to integrate Livelihood Support with MHPSS in the rehabiliation of torture survivors in LMICs?	To enhance the effectiveness of rehabilitation programs	20
	To promote holistic recovery among torture survivors	19
	To address the root causes of trauma and poverty and social inequalities	18
	To promote long-term resilience and independence	16

0 5 10 15 20

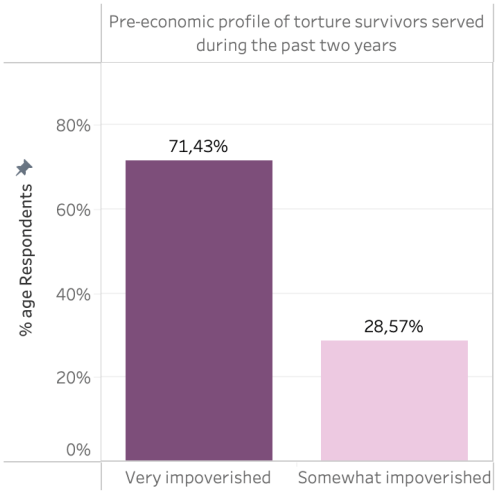
21 Respondents responded to above Questions. Number of Respondents for each Response broken down by Question. Color shows Number of Respondednts agreed to particular Response. The view is filtered on Response, which excludes NA.

***Figure 3**: Key Findings of the Study*

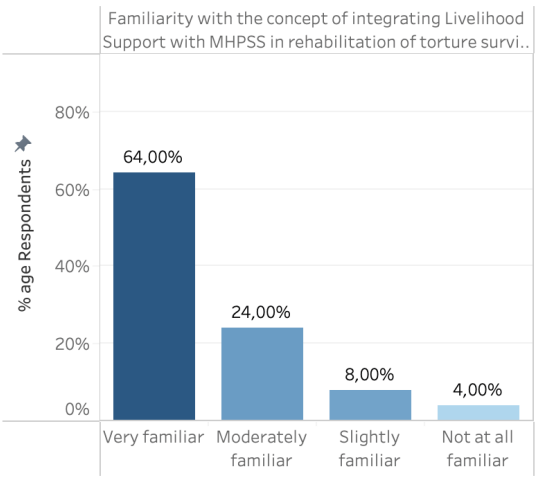
a. link between poverty and mental health outcomes for torture survivors



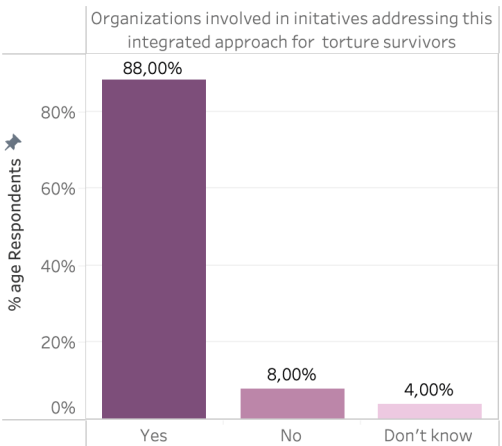
b. pre-economic profile of torture survivors served during last 2 years



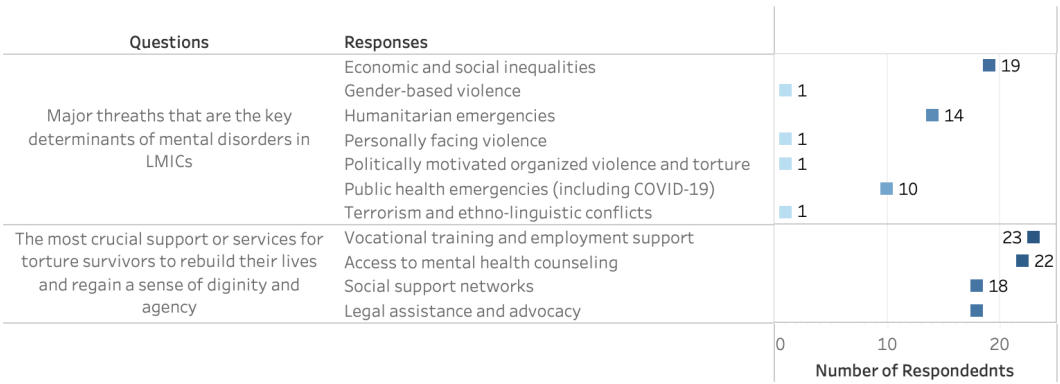
e. familiarity with the concept of integrating livelihood support with MHPSS



d. involvement in initiatives addressing livelihood support integration with MHPSS



key determinants of mental disorders & crucial support or services for the torture survivors in humanitarian settings in LMICs



Need of Integrating Livelihood Support with MHPSS

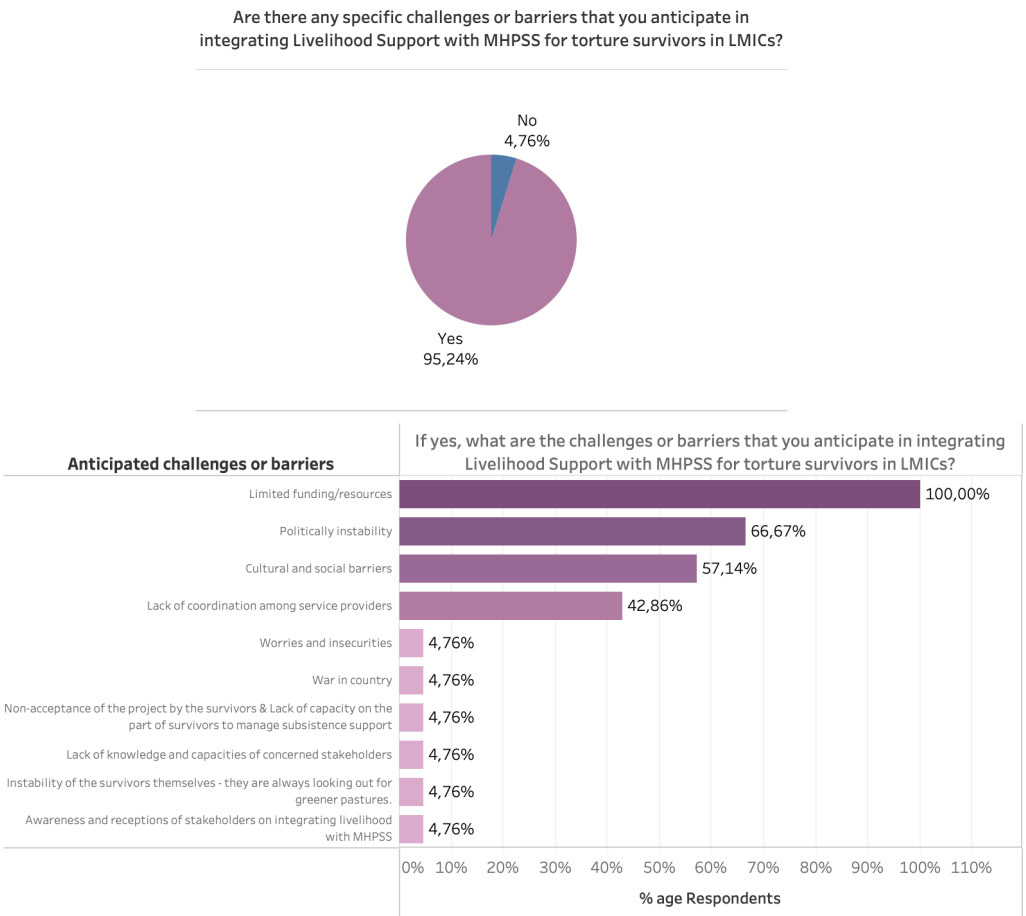
Two-thirds (71.43%) of respondents indicated that the torture survivors served during the past two years were very impoverished, while the rest 28.57% responded to somewhat impoverished (Figure 3 (b)). This data highlights the high prevalence of extreme poverty among survivors attended in IRCT centers.

A majority (88%) of respondents were either very familiar or moderately familiar with the concept of integrating livelihood support and a similar percentage had been involved in such initiatives.

The most commonly anticipated benefits include improved mental health outcomes (100%), holistic recovery (95.24%), improved psychological well-being (90.48%), increased economic stability (80.95%) and greater social integration (76.19%) (Figure 2).

Out of 25, 23 respondents (92%) identified vocational training and employment support, 22 (88%) recognized Access to mental health counseling while 18 (72%) highlighted Social support networks and 18 (72%) identified Legal assistance and advocacy as crucial support services for survivors to rebuild their lives and regain a sense of dignity and agen-

***Figure 4**: Anticipated Challenges or Barriers in Integrating Livelihood Support with MHPSS for Torture Survivors in LMICs*



cy (Figure 3 (e)). The high percentage of respondents identifying vocational training and employment support as crucial aligns with the need to integrate livelihood support with MHPSS for rehabilitation of torture survivors.

Recommendations

Based on the results of the survey most IRCT centres find essential to improve livelihoods programmes. The results provide support to the need to enhance coordination among stakeholders, addressing cultural and social barriers, securing sustainable funding, and developing strategies to overcome anticipated challenges or barriers in integrating livelihood support with MHPSS for torture survivors in LMICs. However, 100% of the respondents have recognized limited funding and resources as one of the highly anticipated challenges or barriers (Figure 4). Therefore, it is recommended to develop sustainable funding mechanisms through partnerships with donors, international organizations, and government agencies to ensure adequate financial resources for integrated interventions. Establishing fundraising initiatives, grant applications, and advocacy campaigns to secure funding for comprehensive support programs is suggested.

Apart from the aforementioned major recommendation, some additional suggestions provided by the respondents were:

- Prioritize the safety and security of torture survivors engaging in economic activities by conducting thorough risk assessments and ensuring a secure environment for their livelihood initiatives.
- Evaluate if the rehabilitation services offered to survivors allow them to engage in economic activities effectively and ensure that these services support their participation in livelihood programs.
- Organize training programs to equip survivors with the necessary skills and knowledge to manage economic activities successfully, fostering their capacity for sustainable livelihoods.
- Provide survivors with sufficient start-up funds for their economic ventures and establish mechanisms for regular monitoring and support to ensure the effective utilization of resources.
- Empower survivors through capacity-building initiatives focused on livelihood management skills, financial literacy, and entrepreneurship to enhance their economic self-sufficiency.

Conclusion

The integration of livelihood support with MHPSS in the rehabilitation of torture survivors in LMICs is a critical and underexplored area that requires urgent attention. The study underscores the profound impact of torture on individuals' economic well-being and the perception by most IRCT centres of the need for a comprehensive approach that addresses both economic and psychosocial needs. Furthermore, the results advocate for developing coordinated initiatives and long-term longitudinal research to collect evidence on which are the elements of success of the integrated programmes.

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Annex 1: Questionnaire

1. In your experience, what are the primary challenges faced by torture survivors in LMICs during their rehabilitation and reintegration process?
(please be as detailed as possible)

_____

_____

_____

2. In your opinion, to what extent are poverty and mental health outcomes of torture survivors linked?

○ Strongly linked ○ Somewhat strongly linked ○ Slightly linked ○ Not at all linked

3. What specific support or services do you believe are most crucial for torture survivors to rebuild their lives and regain a sense of dignity and agency?
(select all that applies)

○ Access to mental health counseling
○ Social support networks
○ Vocational training and employment support
○ Legal assistance and advocacy

4. How familiar are you with the concept of integrating Livelihood Support with MHPSS in rehabilitation programs for torture survivors?

○ Not at all familiar ○ Slightly familiar ○ Moderately familiar ○ Very familiar

5. Has your organization been involved in any initiatives that integrate Livelihood Support with MHPSS for torture survivors?

○ Yes ○ No ○ Don't know

6. Do you agree that socioeconomic status and Mental Health & Psycho-Social (MHPSS) wellbeing are inter-related with one another?

○ Strongly Disagree ○ Disagree ○ Neither ○ Agree ○ Strongly agree

6.a. Provide the reason to choose the option above. (please be as detailed as possible)

_____

_____

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7. Does your country have health specific budget?

○ Yes ○ No ○ Don't know

8. If yes, what is the percentage of budget allocated for mental health in your country?

○ Less than 1% ○ 1-2% ○ 2-3% ○ 3-4% ○ 4-5% ○ More than 5%

○ Other (please specify) _____

9. Is mental health integrated in primary health care system in your country?

○ Yes ○ No ○ Don't know

10. If yes, in what ways mental health is integrated into the primary health care system in your country? (please be as detailed as possible)

_____

_____

11. Which of the following major threats are key determinants of mental disorders in your country? (select all that applies)

○ Economic and social inequalities ○ Public health emergencies (including COVID-19)

○ Humanitarian emergencies (including conflict and forced displacement)

○ Other (please specify) _____

12. How many of your torture survivors (clients) were engaged in survival crime?

○ Less than 1% ○ 1-10% ○ 10-20% ○ 20-30% ○ 30-40% ○ 40- 50%

○ More than 50% ○ Other (please specify) _____

13. How many torture survivors did your center serve during the past two years?

○ Please specify _____

14. According to your national poverty line, what is the pre-economic profile of torture survivors you have served during the past two years?

○ Very impoverished ○ Somewhat impoverished

○ Moderately affluent ○ Very affluent

15. Do you believe it is important to integrate Livelihood Support with MHPSS in the rehabilitation of torture survivors in LMICs?

○ Yes ○ No

16. If yes, why do you believe it is important to integrate Livelihood Support with MHPSS in the rehabilitation of torture survivors in LMICs?
(select all that applies)

○ To address the root causes of trauma and povertymic and social inequalities

○ To promote long-term resilience and independence

○ To enhance the effectiveness of rehabilitation programs

○ To promote holistic recovery among torture survivors

17. Do you foresee any potential benefits or advantages in integrating Livelihood Support with MHPSS for torture survivors in LMICs?

○ Yes ○ No

18. If yes, what potential benefits or advantages do you foresee in integrating Livelihood Support with MHPSS for torture survivors in LMICs?
(select all that applies)

○ Improved mental health outcomes ○ Greater social integration

○ Increased economic stability ○ Improved Psychological Well-being

○ Holistic recovery

19. Are there any specific challenges or barriers that you anticipate in integrating Livelihood Support with MHPSS for torture survivors in LMICs?

○ Yes ○ No

20. If yes, what are the challenges or barriers that you anticipate in integrating Livelihood Support with MHPSS for torture survivors in LMICs?
(select all that applies)

○ Limited funding/resources
○ Lack of coordination among service providers
○ Political instability
○ Cultural and social barriers
○ Other (Please specify) _____

21. Based on your expertise, what recommendations would you offer to ensure effective integration of Livelihood Support with MHPSS for torture survivors in LMICs? (please be as detailed as possible)

_____

_____

_____

22. What, if any, are there any specific strategies or approaches that you believe would enhance the sustainability and impact of integrated interventions for torture survivors in LMICs? (please be as detailed as possible)

_____

_____

_____

23. In your view, what role can organizations like IRCT, governments, NGOs, and other stakeholders play in supporting the integration of Livelihood Support with MHPSS for torture survivors in LMICs? (please be as detailed as possible)

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Does prison labour rehabilitate, punish, discipline or exploit a traumatised and racialised population in Australian and American prisons?

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Key points of interest

- Many incarcerated people have histories of trauma, which is compounded by the trauma of deprivation of liberty and, in some circumstances, ill-treatment while imprisoned.
- One of the objectives of prison labour is rehabilitation of criminalised and incarcerated people. However, this article argues that prison labour is often exploitative and fails to impart marketable skills or engender self-confidence. It is thus at odds with an objective of rehabilitation through assisting currently and formerly incarcerated people, including those who are victim-survivors of trauma, to secure livelihoods to support themselves and their families.
- The article draws parallels between the rehabilitative needs of victim survivors of torture and criminalised survivors of trauma, to recommend a strengthening of legal protections around prison labour and a pivot to healing and empowerment of incarcerated people.

Abstract

This article describes the incarcerated population in Australia and the US as being comprised of people primarily from racialised and marginalised communities, of whom many have histories of trauma. It is argued that their pre-existing trauma is compounded by trauma arising from both deprivation of liberty in and of itself, and their treatment and conditions in prison. The article compares and draws parallels between rehabilitation as understood under the *UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* with rehabilitation as an objective of the criminal legal system, arguing for the need for the criminal legal system to refocus from reducing reoffending to pursuing healing. The article argues that contemporary prison labour in Australia and the US should be analysed in the context of historical slavery and forced labour. It considers the different objectives of prison labour, concluding that it is not feasible to effectively achieve multiple objectives (e.g. rehabilitation versus recouping State costs associated with incarceration). The significant risk that prison labour as it currently operates can amount to exploitative or degrading treatment is explored in the article, which argues that international legal protections need to be strengthened. The article also recommends that there needs to be improved transparency and research regarding the use and effectiveness of prison labour in these jurisdictions (and more broadly) in achieving rehabilitation, particularly livelihoods in the community, after release from prison.

Keywords: prison labour; trauma; rehabilitation; criminogenic factors; labour rights.

*** Aboriginal and/or Torres Strait Islander people are warned that the names of deceased Aboriginal people are included in this article.***

Introduction

Prison labour in Australia and the US ostensibly has many objectives, including supporting incarcerated people's rehabilitation by increasing their employability upon their release. However, a narrow understanding of what rehabilitation entails for a traumatised and racialised prison population, and serious shortcomings in international legal protections for incarcerated people who work, limits the potential of prison labour to be an avenue for healing and empowerment. There needs to be a shift away from categorising incarcerated people as being inherently 'less deserving' victim-survivors of trauma (as discussed below, many incarcerated people have, indeed, histories of trauma) than those victim-survivors who have avoided becoming entangled in the criminal legal system. Adopting this alternative approach would support the requisite reforms to facilitate prison labour being a means of successfully integrating livelihoods into rehabilitation following trauma, including the trauma caused by criminalisation and incarceration.

Is there a 'right' type of victim? The parallels between the rehabilitative needs of victim survivors of torture and criminalised survivors of trauma

This article argues that parallels can be drawn between the rehabilitative needs of survivors of torture and incarcerated people who are survivors of trauma, particularly with regards to the role that livelihoods can play in achieving rehabilitation. This article proposes that there are lessons for the criminal legal system in the rehabilitative approach to victim survivors of torture. There will, of course, also be circumstances where there is some overlap between these two groups; for example, where criminalised survivors of trauma have been tortured during police interrogations.

Arguably, a key reason for the difference in the underlying ethos in the approach to supporting criminalised victim survivors of trauma is that so-called 'criminals/perpetrators/offenders' do not, in the eyes of society, fit Christie's characterisation of an ideal victim: "a person or category of individuals, who... most readily are given the complete and legitimate status of being a victim" (Christie, 1986, p. 18). The deeply entrenched stigma and lack of empathy for incarcerated people is a significant obstacle to rehabilitation. There should be a move away from this false delineation between the 'right' type of victim survivor of trauma and the 'wrong' type (those who are convicted of crimes). This entails centring healing and empowerment of criminalised individuals who have histories of trauma, and addressing society's structural shortcomings (e.g. lack of housing, healthcare, and access to work and education) that contribute to people being criminalised in the first place. As Mulcahy explains

> the focus of penal policy and practice should be recalibrated to put healing at the centre of relationships and interventions, assisting 'unrecovered trauma survivors' with offending behaviour to make better sense of themselves and their multiplicity of personal struggles... to pursue their vision of a good life (Mulcahy, 2019, p.6).

Part of healing and leading a good life is being able to financially support oneself and one's family. This is a key reason why there needs to be a reckoning with the current, and as this article argues, deeply flawed approach to prison labour.

However, this article is not endorsing the use of deprivation of liberty as a vehicle for achieving rehabilitation (including through the use of prison labour). There are inherent limitations to achieving rehabilitation within the confines of a prison. Rather, the article explores how protections for incarcerated people may be strengthened, within the current limitations of the criminal legal system, to better achieve the goal of rehabilitation through securing livelihoods, including through drawing lessons from the approaches to the rehabilitation of survivors of torture and ill-treatment.

The need to strengthen legal protections for working incarcerated people

While some protections of incarcerated workers can be found in the *UN Standard Minimum Rules for the Treatment of Prisoners* ('the Mandela Rules') and other human rights instruments, this article primarily focuses on the *Forced Labour Convention, 1930 (No. 29)* ('the Labour Convention'). Importantly, the Labour Convention excludes from the definition of forced or compulsory labour

> any work or service exacted from any person as a consequence of a conviction in a court of law, provided that the said work or service is carried out under the supervision and control of a public authority and that the said person is not hired to or placed at the disposal of private individuals, companies or associations (Article 2(2)).

However, even where prison labour may not *technically* meet the international legal definition of compulsory or forced labour (or it does, but there is a failure to properly categorise it as such), this article argues that often prison labour in some

countries, like Australia, amounts to 'coerced labour', if not 'forced labour' under international law. In these circumstances there is a high risk of exploitation, which is fundamentally at odds with rehabilitation.

The over-representation of racialised and marginalised communities in Australian and US prisons, and thus, in prison labour

Any analysis of prison labour must address the fact that, in the US and Australia, overwhelmingly, incarcerated people come from racialised and marginalised communities. The International Labour Organisation (ILO) Committee of Experts on the Application of Conventions and Recommendations (CEACR) has clearly stated that, even if the offence which is being punished by imprisonment does *not* come under the protection of the *Abolition of Forced Labour Convention, 1957 (No.105)* , "if the penal punishment [prison labour] is meted out more severely to certain groups defined in racial, social, national or religious terms, and this punishment involves compulsory labour, the situation is in violation of Article 1(e) of the Convention" (which states that "[e]ach Member of the International Labour Organisation which ratifies this Convention undertakes to suppress and not to make use of any form of forced or compulsory labour as a means of racial, social, national or religious discrimination"). In the US, African Americans are incarcerated at 4.8 times the rate of white Americans (Nellis, 2021, p. 6). In recognition of this overrepresentation, the CEACR has requested that the USA:

> continue to provide information on the measures taken or envisaged, both in law and in practice, to identify and reduce racial and ethnic disparities in the criminal justice system to ensure that punishment involving compulsory labour is not meted out more severely to certain racial and ethnic groups (CEACR, 2021).

Granted, the US position on prison labour is particularly alarming, with the 13th Amendment providing for a prohibition of slavery and involuntary servitude "except as a punishment for crime whereof the party shall have been duly convicted." However, the gap in international legal protections, which risk undermining State efforts of achieving rehabilitation through prison labour, disproportionately impact on racialised communities in other countries too. For instance, in 2022-2023, 32.5% of the prison population in Australia was Aboriginal and Torres Strait Islander. In contrast, at 30 June 2021, Aboriginal and Torres Strait Islander people in Australia represented only 3.8% of the total Australian population (ABS, 2023).

A traumatised, racialised and marginalised prison population

Pre-existing trauma

Furthermore, many of the world's incarcerated people have histories of trauma (to be distinguished from histories of torture, as defined under the UN *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (CAT), and other forms of ill-treatment at the hands of State authorities). For example, a study in Wales found that 80% of interview participants were exposed to an Adverse Childhood Experience (ACE), a "traumatic or stressful [experience] occurring before the age of 18 years". Almost half had experienced four or more. ACEs include maltreatment (verbal, physical and sexual abuse and emotional and physical neglect), and household ACEs (parental separation, mental illness, domestic violence, alcohol abuse, drug use, incarceration). In the USA, "over 90% reported at least one ACE and 50% reported four or more ACEs" (Ford et al, 2019, p. 4). The UN Special Rapporteur on Torture reported that many incarcerated women are "victims of horrific domestic and sexual violence" (Edwards, 2023, [14]), a finding that is reflected in the Australian context as well, with studies concluding that 70-90% of incarcerated women have a history of emotional, sexual or physical abuse (ANROWS, 2020, p.5). A US study found that 44% of incarcerated women had post-traumatic stress disorder (PTSD) (Centre for Women's Justice, p. 6). Mulcahy explains that it "is likely that the majority of men and women in any given prison, anywhere in the world, are unrecovered trauma survivors. Their offending behaviour is only one of many incapacitating symptoms of their dysregulated stress response system" (Mulcahy, 2019, p.8). The imprisoned population also has a high incidence of mental ill-health. For example, in a study by the Australian Institute of Health and Welfare (AIHW), 51% of prison entrants (63% for women) reported a mental health condition at some stage in their lives (AIHW, 2023, p.44), and 21% reported a history of self-harm (AIHW, 2023, p.52).

While it is well-established that many people in prisons have pre-existing histories of trauma, particular attention should be paid to Indigenous peoples, who have experienced decades of destructive State policies ranging from genocide, including massacres (Colonial Frontier Massacres, Australia) and removal and institutionalisation of children, to protectionism and assimilation. In Australia, a legacy of colonisation is intergenerational trauma and an overrepresentation of Aboriginal and Torres Strait Islander people in prison (AIHW, 2023, p.137). The watershed Australian *Bringing Them Home Report*, which focused on the Stolen Generation (Aboriginal children

removed from their families pursuant to government policy between the mid-1800s to the 1970s (Healing Foundation)), stated that

> [s]eparation and institutionalisation can amount to traumas. Almost invariably they were traumatically carried out with force, lies, regimentation and an absence of comfort and affection. All too often they also involved brutality and abuse. Trauma compounded trauma'.

The trauma of incarceration

Then there is the trauma of incarceration, which can come from the individual's deprivation of liberty *in and of itself*, as well as the treatment and conditions in detention. The deprivation of liberty can have wide-reaching negative impacts on those who are imprisoned, including an inability to care and provide for dependants (2 in 5 Australian prison entrants reported having dependent children in the community (AIHW, 2023, p.vii)), loss of custody of children, and disconnection from Country and culture (the UN Subcommittee on Prevention of Torture has recommended that Indigenous people be placed in prisons near their communities (SPT Annual Report, 2013, [89] (f), (g), (h) and (i)). Even the eventual release from prison can be a traumatic event (AIHW, 2023, p. 137).

Trauma pre-existing incarceration and trauma resulting from deprivation of liberty in and of itself may then be compounded by harmful practices and conditions in prisons. Such practices are well-documented around the world, in many cases rising to the level of ill-treatment and even torture. For example, an Aboriginal woman, who is a victim survivor of sexual assault, who was forcibly strip searched in an Australian Capital Territory prison, described her experience as follows:

> At this time, I was menstruating heavily due to all the blood thinning medication I take on a daily basis. Here I ask you to remember that I am a rape victim. So you can only imagine the horror, the screams, the degrading feeling, the absolute fear and shame [I] was experiencing' (Lachsz, 2023, p. 37).

In the coronial inquest into the death in custody of Veronica Nelson, a proud Gunditjmara, Dja Dja Wurrung, Wiradjuri and Yorta Yorta woman who died in Victoria's women's prison, Dame Phyllis Frost Centre, the Coroner found that, in relation to her opioid withdrawal, "the treatment she received constituted cruel and inhumane treatment" (Finding into death with inquest, 2023, [417]). Particularly for women who are victim survivors of domestic and family violence, their experiences in prisons can replicate those they have previously experienced, as prisons are "built on an ethos of power, surveillance and control" (ANROWS, 2020, p. 5).

Thus, the trauma arising from criminalisation and imprisonment can find its origin in the myriad knock-on effects, arising from deprivation of liberty in and of itself, in 'the unavoidable level of suffering inherent in detention'(e.g. *Shylokov and others v Russia* (2021) [70]), and, in some circumstances, conditions and treatment that rise to the level of ill-treatment or even torture at the hands of the State.

Does rehabilitation in prison address people's trauma or 'criminogenic factors'?

Despite significant numbers of incarcerated people having histories of trauma and abuse at the hands of non-State actors prior to imprisonment (histories that have often contributed to their involvement in the criminal legal system), and, in some cases, having been subjected to conditions and treatment in detention (including police custody and prisons) that may amount to torture or ill-treatment (or that may not meet the requisite legal thresholds, but still cause harms that traumatise), there is a significant divergence in approaches to rehabilitation for torture survivors and criminalised trauma survivors.

Yet there are lessons for the criminal legal system in the UN CAT's approach to rehabilitation, given the parallels between the rehabilitative needs of survivors of torture and of criminalised survivors of trauma (who, at times, also then become survivors of torture and ill-treatment, inflicted on them while incarcerated). A shift in the criminal legal system from a risk-management model to one of healing would benefit all, including better supporting the legal system's objective of community safety. Healing should be centred in the different mechanisms by which rehabilitation is pursued, including prison labour practices.

Rehabilitation centring healing and empowerment

Under Article 14 of the UN CAT, States Parties are required to "ensure in [their] 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 General Comment 3, the UN Committee against Torture (the Committee) stated that

> [r]ehabilitation refers to the restoration of function or the acquisition of new skills required as a result of the changed circumstances of a victim in the aftermath of torture or ill-treatment. 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', including vocational training (UN CAT, 2012, [11], [12]).

Crucially, members of the International Rehabilitation Council for Torture Victims (IRCT) have included employment and economic security in the definition of torture victims' quality of life (IRCT, 2020). There is a clear recognition of the need for a holistic approach to rehabilitation for torture victim survivors, in which individuals' basic needs are met, rather than focusing solely on medical or psychosocial support. A holistic approach recognises that people have

> households to feed... often battling against the unemployment and disability directly caused by the torture they have suffered. Put simply, if basic needs like food, sanitation or proper housing – the outcomes of poverty – are not addressed by our member centres as they treat survivors, rehabilitation is unlikely to succeed (IRCT, Livelihoods).

Rehabilitation centring reducing the risk of reoffending

In contrast, in the context of the criminal legal system, the focus of rehabilitation is on reducing reoffending, increasing reintegration (UN General Assembly Resolution, 2021) and improving community safety (UNODC handbook, 2018, p. 3), with "the period of imprisonment... used to ensure, so far as possible, the reintegration of such persons into society upon release so that they can lead a law-abiding and self-supporting life." This preparation includes offering work (Mandela Rules, Rule 4). The 'essential aim' of the criminal legal system is the individual's "reformation and social rehabilitation" (*International Covenant on Civil and Political Rights* (ICCPR) Art 10(3)). This almost invariably entails a deficit approach, rather than a strengths-based approach, with a focus on addressing criminogenic needs (the "risk factors associated with recidivism" - which are not necessarily causal (UNODC, 2018, p. 22-23)). Yet this approach has been criticised:

> the almost exclusive focus on direct criminogenic factors can overlook a holistic and formulation led consideration of an individual's life experiences and as a consequence may be unable to offer therapeutic support for important aspects of an individual narrative (for example, adversity, discrimination, trauma) (Taylor, 2012, p. 201-3).

It is clear that there is some overlap in the rehabilitation stratagems for torture survivors and criminalised survivors of trauma (even if there is a very different underlying ethos), in that both ostensibly seek to address people's basic needs, such as housing and employment (or a means of income, including welfare payments; although this paper focuses instead on work and employment). In Australia, 46% of people entering prison reported they had been unemployed during the 30 days before prison. This figure was 57% for Aboriginal and Torres Strait Islander people (AIHW, 2023, p. 76). 43% were homeless in the four weeks prior to imprisonment (AIHW, 2023, p.80), and 48% expected to be homeless upon release (AIHW, 2023, p. 81).

The focus on addressing the 'criminogenic factors' of criminalised, incarcerated survivors of trauma, rather than healing and empowerment (in stark contrast to the approach for survivors of torture), has normalised underpaid (or even 'volunteer') work by incarcerated people. Justifications include claiming that underpaid/unpaid prison labour is central to rehabilitation, or that it is simply a reprieve from mundane prison life. And while some incarcerated people actively seek underpaid/unpaid work while in prison, that should not be used as a reason to limit their rights as workers in such an extraordinary manner.

The ambiguity regarding whether the purpose of prison labour is commerce, punishment, discipline or rehabilitation

Shackled to the history of slavery, forced labour and exploitation of racialised and colonised communities

An analysis of contemporary prison labour practices in the US and Australia cannot be undertaken in a vacuum, but rather should account for historical practices of slavery and forced labour, particularly of racialised and incarcerated people. The US's history of slavery and forced labour is well known, and many commentators have linked historical practices to contemporary prison labour. Le Baron explains that "[j]ust as in historic systems of prison labour, the economic logic of prison labour is inseparable from its cultural and social logics" (LeBaron, 2018, p. 169).

After the American Civil War and the end of chattel slavery, some of the Southern states established 'Black Codes', enabling ongoing access to cheap labour. Although the statutes were, on their face, not targeted at racialised people, the conduct that was criminalised (such as loitering, breaking curfew, vagrancy, being unemployed, failing to carry proof of employment, living together out of wedlock, and not having a permanent residence) disproportionately impacted on African American people. In fact, after the end of slavery, the Louisiana prison population was, for the first time, majority African American. (Whitehouse, 2017, p. 94-5; VOTE 2023, p.8-9). As Pehl

notes, "[c]onvicts were a cheap and pliant labor pool... [private enterprises] discovered they had a vested economic interest in maintaining a steady stream of law-breaking bodies to risk in hazardous occupations' (Pehl, 2019, p. 78). In a current matter before the courts in the US regarding the conditions of prison labour, the complainants stated that "[l]ike chattel slavery before it, convict leasing was brutal. But unlike enslaved people, who were considered an investment, Black prisoners were considered expendable" (VOTE 2023, p.8-9).

In the US, there were different types of convict leasing. The prison could maintain the care of the incarcerated people, while leasing them out to work on railroads, mines, and private plantations (VOTE 2023, p.8-9). With much of the infrastructure in the South destroyed during the war, states claimed they were unable to accommodate incarcerated people, and so entered into lease agreements whereby state prisons leased out convicts to private enterprises for a small fee, on the condition that those enterprises housed and fed them (Whitehouse, 2017, p. 95). Northern States also used prison labour, but through a contract system whereby the labour was carried out in the prison itself (e.g. Sing Sing prison) (Pehl, 2019, p. 80).

The legacy of this history persisted with the Jim Crow laws resulting in African American people continuing to be incarcerated at greater rates (VOTE 2023, p.8-9). In 1915, President Wilson urged States to end the use of convict labour, portraying it as incompatible with a civilised society, but the responses were varied. In the 1930s, with fewer jobs available in the community, there was increased resistance to incarcerated people working (Pehl, 2019, p. 81). The American Federation of Labor (a federation of unions) characterised "the state-use system as fair and humane" (this system was one in which goods were produced by incarcerated people for the prisons or other State agencies) but were opposed to the sale of prison products on the free market (Pehl, 2019, p. 91-92). Then, in the US in the 1970s, there was a political shift to 'law and order' approaches, and at the same time, private for-profit entities were given access to the labour of incarcerated people (Pehl, 2019, p. 94-5; LeBaron, 2018, p. 164-5).

Australia's history of exploiting Aboriginal and Torres Strait Islander people for their labour is not as well-known as America's history. The *Royal Commission into Aboriginal Deaths in Custody* (RCIADIC) described how, in the past, Aboriginal people were paid in tobacco, tea and rations, and were "forced to move onto reserves, and to work for government authorities" (RCIADIC, 1991, 10.8.1, 10.8.2). When people were paid in cash, part of the payment had to be made to the Protector in trust, and Aboriginal people had to ask permission to make purchases other than with the pocket money they were paid (RCIADIC, 1991, 10.8.10). Aboriginal children were taken from their parents to be domestic servants and rural apprentices. They were required to perform the most menial and poorly paid occupations for employers not of their own choosing. If they left employment, they were punished, sometimes in juvenile detention centres, while their exploitation as cheap labour was justified as 'uplift' and 'civilisation' (RCIADIC, 1991, 10.8.15). Children were indentured from 1897 to 1970 (RCIADIC, 1991, 2.16), and as late as 1969, workers in Aboriginal communities were paid in rations and pocket money instead of wages (RCIADIC, 1991, 2.28). At the end of 2023, there was a $180m settlement from the Western Australian Government for stolen wages (Murphy, 2023), and there is currently a class action before the courts in the Northern Territory (Mackay, 2023), which has recently reached a $202m settlement (Houlbrook-Walk, 2024). And Australia, like the US, has a history of using chain gangs in prisons ('[s]till neck-chained, the native prisoners work outside on the roads' (Roth, 1901, p. 19)).

Australia was not the only colony to exploit the labour of colonised people. For example, in "Spanish America, prisoners sentenced to hard labour by the colonial courts were also leased to private employers who used them in mines, manufactures, and mills" (Guido, 2019, p. 2). In fact, "it was clear from the preparatory work that the [Labour] Convention had grown out of international concern over slavery and so-called 'native labour' in colonies" (ILO, 1999).

A contemporary view of prison labour as having a rehabilitative purpose

The contemporary understanding of prison labour often focuses on a rehabilitative objective, to reduce the risk of further offending "by teaching [incarcerated people] marketable skills which they can use to find and retain employment upon release," the oft cited challenge being insufficient work opportunities or programs for imprisoned people (UNODC, 2017, p.13-14, 16). There are, however, significant, entrenched impediments to achieving this goal of rehabilitation.

On one view of prison labour, the criminal system's rehabilitative goal might be achieved by assisting incarcerated people to "learn the habit of working", since "many offenders have never been successful in securing or holding jobs in the free world" (LeBaron, 2018, p. 170). This conceptualisation of prison labour as assisting incarcerated people to make a *choice* to be 'productive citizens' is certainly not a new one (Pehl, 2019, p. 77). However, this approach, focused on addressing incarcerated people's imagined moral failings, rather than on teaching useful vocational skills and providing opportunities to gain the sort of experience that will assist people to obtain employment upon

their release, warrants caution, and perhaps even cynicism. As Whitehouse, considering the US context, notes

> [t]his deceptive trope, also known as the "culture of poverty myth", completely discounts the true underlying reasons for minority poverty in America, such as the legacy of slavery and institutionalized racism, and instead posits that impoverished and particularly minority Americans end up in prison because they prefer a life of crime to getting a job (Whitehouse, 2017, p. 93).

The focus should shift away from blaming incarcerated people to addressing individual needs (e.g. unhealed trauma), providing opportunities to learn marketable skills that are in demand, and addressing systemic and structural barriers to employment (e.g. lack of stable housing, stigmatisation of criminalised people and racism).

Prison labour as a commercial enterprise

Prison labour is seen by some governments as an opportunity to recoup the significant costs of incarcerating people, with States taking advantage of cheap prison labour to deliver State services, a means by which to ensure prison operations (delivering both goods and services), or as a means of making a profit (by either the State or private entity) (White, 1999, p247).

Despite assumptions that it is mainly private companies which benefit from prison labour, it is often State or public entities which are the most common clients, such as hospitals and courts (Neves, 2015, p. 29). For example, in California, incarcerated firefighters reportedly save the state $1 billion per year (being paid $2 per day, as opposed to the $34.44 paid per hour to non-incarcerated firefighters (LeBaron, 2018, p. 168-9)). In Australia, incarcerated people undertook warehousing operations to distribute personal protective equipment across Victorian prisons during the pandemic (Corrections Victoria, 2021). Prison labour has been proposed as a means by which to cover labour shortages, such as picking fruit on Australian farms during the pandemic, when there were international border restrictions (Sakkal, 2021) (and UK labour shortages for meat suppliers, following Brexit (Mantouvalou, 2021); this is not a uniquely Australian or US phenomenon).

Disappointingly, union resistance to the meagre wages of incarcerated workers has focused on the rights of workers in the community, rather than solidarity with incarcerated people working in prisons. Products produced in prisons, being sold at lower market prices due to cheap (or free) prison labour, have long been perceived as unfair competition for those entities that employ free workers (Prison Labour: II, 1932, p. 506). It was an issue raised by free workers and labour unions in the depression in the US from the 1870s – 1890s, during which incarcerated people in the north produced what would be valued today at $35 billion worth of goods (Pehl, 2019, p. 78-79). More recently, the Australian Council of Trade Unions (ACTU) appealed to the ILO, having received complaints that prison labour (production of horse blankets) was threatening local employment (White, 1999, p. 246). The focus of the ACTU was on small and medium sized enterprises being unable to compete with prison wages which "were sometimes ten times lower than in normal companies" (ILO, 1999).

The juxtaposition of union priorities with the experiences of incarcerated workers is exemplified by the account of an incarcerated person in Tasmania, Australia

> [f]ifty metres from where I am writing this letter, a hundred men are locked inside a dark and noisy factory punching holes in pieces of metal which will go towards making ping-pong tables and chalk boards to be sold at K-Mart and other major retail chains; the same retailers who made a public spectacle of burning furniture made by Chinese forced prison labour (White, 1999, p. 246).

Prison labour cannot effectively serve multiple purposes simultaneously

There are other potential purposes of prison labour, additional to those discussed above. Since the 1770s, prison work has been perceived as a means by which to address idleness (Simon, 1999, Chapter 1, p. 2), improve prison atmospheres (UNODC, 2017, p. 16-19), and keep incarcerated people occupied and more compliant with prison rules. Prison labour has been seen as a way that incarcerated people can 'give back' to the community through public works (White, 1999, p. 247), and making financial contributions to victims' compensation (Neves, 2015, p. 10). Prison labour has been used for both discipline (it is "intrinsically useful, not as an activity of production, but by virtue of the effect it has on the human mechanism... Penal labour must be seen as the very machinery that transforms the violent, agitated, unreflective convict into a part that plays its role with perfect regularity" (Foucault, 1977)) and as a deterrent by way of "hard, boring and monotonous work" (White, 1999, p. 247), although it is a well-established ethos of the criminal legal system that people are sent to prison *as* punishment, not *for* punishment. Earning a wage while in prison is also a means by which incarcerated people can pay for prison services and goods (such as phone calls), although this raises broader questions regarding the appropriateness of people in prison being required to cover (often exorbitant) costs of their incarceration, especially given the low wages

that people generally earn. Clearly, some of these many purported objectives are complementary, but others are entirely at odds.

The question as to whether prison labour can, in fact, effectively serve a multiplicity of purposes is a fundamental one. An evaluation in Victoria, Australia, concluded that

> The effectiveness of the Prison Industries is marred by competing objectives and changing priorities. Sometimes Ministers... want the Prison Industries to generate income, at other times they desire better rehabilitation/training and at other times they are primarily concerned with keeping prisoners occupied (Buchanan, 2007, p. 3).

Ultimately, Buchanan recommended that there be "less preoccupation with generating as much revenue as possible in the short run to offset the cost of managing the prison population" (Buchanan, 2007, p. 8).

Prison labour, if it exists, should have an objective of rehabilitation, to be achieved through people accessing meaningful livelihoods, both during and after their incarceration. Pursuing multiple objectives (some of which are arguably on ethically precarious ground) should not be permitted where this would negatively impact on the incarcerated person's rehabilitation.

Some forms of contemporary prison labour may amount to cruel, inhuman or degrading treatment or punishment

While not the focus of this article, it is important to note that there are circumstances where contemporary prison labour may amount to cruel, inhuman or degrading treatment or punishment (or even to torture). That is not to say that all prison labour is inherently torturous, but some of the jobs incarcerated people are given, and the conditions in which they work, are, arguably, inherently degrading.

Despite the international frameworks suggesting otherwise, coerced prison labour can be characterised as inherently degrading, especially in circumstances where there are sanctions additional to loss of access to meagre incomes for refusing to work. In the US, for example, ""[a]ggravated" work offenses include disobeying repeated instructions as to how to perform work assignments (even if the instruction makes a person unsafe)," leading to disciplinary measures including solitary confinement and loss of privileges such as personal phone calls and family visits (VOTE 2023, p. 14).

There are also instances where the work that incarcerated people undertake is unskilled, monotonous, dangerous or demeaning. For example, a class action before the Louisiana courts details the following:

> Plaintiffs are forced to hoe, dig, and weed for hours, sometimes without access to clean drinking water. Breaks are uncommon. Shade and sanitary toilet facilities are nearly unheard of. Despite the availability of modern agricultural machinery, Plaintiffs and class members are forced to pick plantation crops by hand or use outdated tools, without training or standard protective gear (VOTE 2023, p. 12-13).

The plaintiffs also describe how many daily tasks assigned to incarcerated men on the Farm Line are designed to enforce powerlessness. For instance, Plaintiffs and class members have been forced to dig and refill holes. Some must "goose-pick," or pull blades of grass by hand. Others must water crops using a Styrofoam cup. This definitionally pointless labor—extracted under threat of further punishment and serious harm—is humiliating and degrading. It is arbitrary and traumatic. An exercise of power, the Farm Line systematically treats Plaintiffs and class members as deserving of little, if any, dignity (VOTE 2023, p. 15).

The plaintiffs allege that their working conditions may amount to cruel and unusual punishment (VOTE 2023, p. 35-37). There are other examples of treatment that could amount to cruel, inhuman or degrading treatment. In the Arizona prison labour program, the practice of shackling incarcerated workers at the ankle is a clear example of "state-organized prison labour... [taking] a public and humiliating form" (LeBaron, 2018, p. 169). During the pandemic, despite hand sanitiser being contraband in prisons and masks not being made available to them, incarcerated people faced disciplinary action if they refused to work bottling sanitiser, making masks and face shields, or digging mass graves for victims (Dreier, 2020).

The operation and impact of prison labour could be understood through the prism of Pérez-Sales' 'torturing environments'. Pérez-Sales defines a torturing environment as

> a set of conditions or practices that obliterate the control and will of a detainee and that compromise the self [that] is formed by a set of cumulative or sequential attacks to basic needs, creating physical, cognitive and emotional exhaustion and confusion, and the interconnection of the expectations of pain with actual physical pain and actions targeted to the self. Its final purpose is to break the will of the person (Pérez-Sales, 2020, p. 339).

Of particular relevance is the impact of Australian and US prison labour programs, that treat incarcerated people as unworthy of meaningful and dignified work, on criminalised trauma victim survivors' sense of identity.

Livelihoods as a road to rehabilitation: Strengthening protections against exploitation of incarcerated people

In circumstances where prison labour is blatantly exploitative or inherently degrading, any purported rehabilitative objective for incarcerated people, many of whom have histories of trauma, cannot be achieved. However, there are concrete steps that can be taken to strengthen protections not only for incarcerated people in the US and Australia, but for the 11.2 million incarcerated people around the world. Taking these steps will bring rehabilitation as understood under the CAT and by the criminal legal system in closer alignment.

International and regional human rights protections

Protections against forced or compulsory labour are found in a number of human rights instruments. For example, under the *International Covenant on Economic, Social and Cultural Rights*, there are relevant rights in Article 6 (right to work), Article 7 (just and favourable work conditions), and Article 8 (rights relating to unions). There are, however, significant shortcomings in international law with regards to protections for working incarcerated people. Under the ICCPR, for instance, performance of hard labour in pursuance of a sentence to punishment by a competent court does not constitute prohibited forced or compulsory labour (ICCPR Article 8(3)(b)) (see also *European Convention on Human Rights* (Article 4), *African Charter on Human and Peoples' Rights* (Articles 5, 15) and *American Convention on Human Rights* (Article 6)). The Mandela Rules only provide for "a system of equitable remuneration", rather than the same minimum wages as workers in the community (Rule 103(1)). The shortcomings in international human rights law are then often incorporated in domestic human rights acts (e.g. *Human Rights Act 2004* (ACT) s26; *Human Rights Act 2019* (Qu) s18; *Charter of Human Rights and Responsibilities Act 2006* (Vic) s11).

There are a number of instruments that directly address prison labour. The Mandela Rules were updated in 2015, removing the *requirement* for incarcerated people to work (Milman-Sivan, 2020, p. 519). While the Mandela Rules are non-binding, countries can and should take steps to align domestic legislation with these minimum standards (and, in fact, could aim to exceed them). Of particular note are Rule 97 which requires that "[p]rison labour must not be of an afflictive nature; [p]risoners shall not be held in slavery or servitude; [n]o prisoner shall be required to work for the personal or private benefit of any prison staff," and Rule 99 that states that vocational training "must not be subordinated to the purpose of making a financial profit from an industry in the prison," and that work "shall resemble as closely as possible those of similar work outside of prisons, so as to prepare prisoners for the conditions of normal occupational life." The Rules also provide that prison industries should preferably not be operated by private contractors (Rule 100(1)). Rule 96(2) of the Mandela Rules requires that there be "sufficient work of a useful nature," and Rule 98 provides that "[s]o far as possible the work provided shall be such as will maintain or increase the prisoners' ability to earn an honest living after release," as well as for vocational training and choice regarding the type of work undertaken. The Mandela Rules also provide for occupational health and safety and indemnification (Rule 101), and regulation of working hours (Rule 102). Further protections can be found regionally (e.g. in the Basic Principles for the Treatment of Prisoners (Principle 8) and European Prison Rules (26.1 – 26.17)).

However, the Mandela Rules cement the divergence between rights of incarcerated and non-incarcerated workers, and cannot provide the protections that could, and should, be secured by an amended Labour Convention.

International labour protections

A stark failure to protect incarcerated workers: The most striking absence of labour protections can be found in the Labour Convention, which excludes some prison labour from its definition of forced or compulsory labour (which is defined as "all work or service which is exacted from any person under the menace of any penalty and for which the said person has not offered himself voluntarily" (Article 2(1))).

The Labour Convention permits the State to coerce labour from incarcerated people, whereas private entities are required to have the incarcerated person's consent. This absence of protection exists in a context where there has been an increase in incarcerated people working for private entities (either within the prison walls or in the community) and a trend in some countries of using privately-operated prisons (ILO, 2007, p. 59). There are many ways in which incarcerated people might work for private entities, including: "education/training to gain qualifications; produc[ing] goods or provid[ing] services for the market; work[ing] outside prison as part of pre-release scheme; contributing to the running of prisons run by private entities" (ILO, 2007, p. 61-2).

The ILO has been criticised for "persistently treat[ing] prison work for private entities with great suspicion, while effectively granting a free hand to public work providers" (Milman-Sivan, 2020, p. 506). The underlying assumption, that needs to be challenged, is that the State cannot be an "oppressive employer" that exploits incarcerated people (Milman-Sivan, 2020, p. 516). This assumption does not account for the widespread abuses that happen in prisons around the

world at the hands of State authorities. Nor does it account for the fiscal pressures which States are under, particularly in those countries where the prison population continues to increase, to recoup costs. Recouping costs by extracting labour from incarcerated people might even be characterised by some as 'fiscally responsible'.

Hiring or placing incarcerated people at the disposal of private companies: With regards to the privatisation of prison labour, the ILO has described the relationship between incarcerated workers, the public authority and the private company as normally being a triangular one; whereby the contractual relationship (relating to incarcerated workers) exists between the private company and public authority, and another direct relationship exists between the public authority and incarcerated worker. In contrast to free workers in the community, there is no direct contractual relationship between the incarcerated person and the private entity, and thus an absence of the labour law protections that normally flow from employment contracts (ILO, 2007, p. 63). In fact, the Neves study found that "most countries don't allow for the establishment of contracts between the inmates and employers" (Neves, 2015, p. 25).

The ILO has made clear "workshops which may be operated by private undertakings inside prisons, as well as to work organized by privately run prisons" runs afoul of the Labour Convention, where people are hired to or placed at the disposal of private entities (ILO, 2007, p. 62). However, determining *when* people are hired or placed at the disposal of private companies can be a difficult matter to assess, given the opacity that often accompanies these arrangements. Countries including Australia, Germany, and the United Kingdom have continually flouted the ILO's guidance, and have indicated continuing intentions to do so, in "a fundamental normative disagreement as to the regulation of prison labour" (Milman-Sivan, 2020, p. 506, 512). Milman-Sivan has characterised the status quo as "essentially a compliance rebellion against [the ILO's] prison labour policies... a legitimacy crisis" (Milman-Sivan, 2020, p. 505). Meanwhile, these States have relied on arguments that "private entities provide work opportunities that are rehabilitative and are otherwise in short supply," with benefits outweighing the risks (Milman-Sivan, 2020, p. 511-12). And so, ostensibly in pursuit of rehabilitation, States continue to expose incarcerated people to exploitation 'for their own benefit', even where these States have received expert guidance that this is in contravention of the Labour Convention.

Consenting to work for private entities: Where incarcerated people work for private entities, the Labour Convention requires their consent. However, the issue of consent is a particularly difficult one, although the ILO is of the view that it is not an insurmountable obstacle. The ILO has recommended that there be written consent (i.e. formal consent) (ILO, 2007, p. 65), that there be no loss of rights or privileges for refusing to work, and there be indicators authenticating the consent, citing the most reliable indicator as being whether the work is performed "under conditions which approximate a free labour relationship" (ILO, 2007, p. 65-6).

However, determining loss of rights or privileges is not straightforward, given that parole considerations frequently include whether the individual has participated in work programs while incarcerated. In fact, working in prison is a means by which to demonstrate the extent of the individual's 'rehabilitation', and the ILO has accepted that incarcerated people's refusal to work may result in an "unfavourable assessment of behaviour [to be] taken into account for non-reduction of sentence" (ILO, 2007, p. 65). In a coercive prison context, where refusing to work for a private entity can directly impact someone's chances of release from prison, it is arguably virtually impossible to determine whether consent was genuinely and freely given. Moreover, it is rare for work conditions for incarcerated people to approximate market conditions, particularly given the often exploitative wages paid.

Working conditions: The ILO has identified work conditions as being central to determining whether incarcerated people have given genuine consent to work for private entities. Yet this approach risks a situation where incarcerated people working for private entities may end up having better working conditions than incarcerated people who are working for the State (ILO, 2007, p. 67). Such a discrepancy would clearly be an unjust outcome, at odds with healing and rehabilitation. Addressing this inconsistency would either require that incarcerated people are never permitted to work for private entities, or that everyone in prison is afforded the same protections as each other, regardless of whether the 'employer' is a State or private entity (and from this author's perspective, ideally the same protections as free people working in the community).

The ILO has identified some of the working conditions to be taken into account in an assessment, although it has differentiated between which protections should be fully afforded to incarcerated people (occupational safety) versus those that can be compromised on (wages) (ILO, 2007, p. 65-6). The ILO has also identified some objective and measurable advantages, such as "learning... skills which could be deployed by prisoners when released; the offer of continuing the work of the same type upon their release" (ILO, 2007, p. 66).

Fair remuneration: It should be self-evident that paying incarcerated people proper wages is essential to making them feel part of society (Prison Labour: II, 1932, p. 506). If rehabilita-

tion is the primary objective of prison labour, then exploitation of incarcerated people must cease. Yet, incarcerated people are generally paid poor wages. For example, in Victoria, Australia, people are paid $6.50- $8.95 per day" (Deputy Commissioner's Instruction, 2020). People who refuse to work or are dismissed are not paid at all (Corrections Victoria, 2020, p. 5). In some states in the USA (e.g. Georgia and Texas), people are paid nothing. At the Federal level, UNICOR (the US federal prison industries) employs 22,560 incarcerated people, who are paid $0.23 - $1.15 per hour. In 2001, UNICOR made $583.5 million in sales (Prison Policy Initiative, 2019). Again, this is not an issue unique to Australia and the US; for example, in the UK, under the *National Minimum Wage Act 1998*, incarcerated workers are excluded from the national minimum pay protections if they work in the prison (including for private employers), but have protections if they work for employers outside the prison walls (Mantouvalou, 2021).

Reasons to properly pay incarcerated people are manifold: it enables them to save money that they can access upon release, it enables them to support their families while incarcerated, and it assists them to pay the, at times, exorbitant costs of living in prisons. Poor prison labour wages can increase the risk of people returning to illicit sources of income on release, "as a way to earn enough money to get by when they are shut out of the so-called legitimate workforce" (Leung, 2018, p. 697-8). Particularly where people are excluded from government benefits, the importance of having decent savings upon their release from prison is even more important for their survival (for basic necessities such as housing, food and healthcare) (Prison Policy Initiative, 2017). Being able to support their family by earning decent wages while incarcerated is also key, given that it is inevitable that families will be impacted financially by the incarceration of their family member; "infliction of suffering on persons who have had no share in the crime... may be avoided if the [person] can earn what is needed to keep [their] family while in prison" (Prison Labour: II, 1932, p. 506).

Despite the fact that detaining authorities have human rights obligations to provide services to a certain standard to incarcerated people, some detaining authorities seemingly prioritise recouping costs of incarceration, rather than meeting their obligations to the people to whom they owe a duty of care. The cost of living in prisons is frequently exorbitant, and there are often deductions made from people's pay, compounding the injustice of their meagre wages. Incarcerated people may have to pay inflated prices for "necessities like food, hygiene products, warm clothing, medications, and medical care" (VOTE 2023, p. 12-13). In 43 states in the USA, Corrections charges people room and board; in 35, people may be charged for medical treatment. In Victoria, Australia, phone calls cost between 60¢-90¢ per minute (Hall, 2023). People may also be fined as part of disciplinary action (Corrections Victoria, 2023). As Whitehouse rightly points out, in these circumstances, where there is such low pay, people "are taking on twice the economic burden" (Whitehouse, 2017, p. 99). And because prison labour often fails to teach marketable skills, wages may end up being the sole benefit of engaging in work (Prison Policy Initiative, 2017). Ultimately, fair remuneration is essential for prison work to provide the intended rehabilitative benefits.

Proper remuneration could take into account the incarcerated person's qualifications, skills and experience, as well as their progress as a worker while incarcerated. Although beyond the scope of this paper, the author anticipates resistance to a shift towards fair remuneration by those arguing that such a policy might lead to undesirable inequities where welfare payments for those unemployed in the community are insufficient. In brief response, it is suggested that an appropriate solution would be to increase welfare payments in the community so that they are adequate, rather than to persist with drastically underpaying incarcerated people.

Meaningful, tailored work and a respectful workplace

The purpose of prison labour should be more than the "prevention of idleness" or "burning time" (Buchanan, 2007, p. 5). Although one of the purported benefits of prison labour is that it develops incarcerated people's skills, Leung has described how, in the US, "the vast majority of prisoner-workers are employed in positions that have little growth potential and do not teach them marketable skills." This leads to people being "employed in low-skill positions, such as piecing together clothing for Victoria's Secret, stamping license plates, or stitching [US] flags" (Leung, 2018, p. 682-3).

It is crucial for people to be treated respectfully at work. Yet this is not always the case. In a prison labour study in England, a participant described their experience of prison labour:

> We're treated like little children.... It's degrading.... Some people don't mind it, but I do (Simon, 1999, Ch4, p. 109).

That study outlined the factors that affected whether incarcerated people tried to use a "prison-acquired skill, and whether those who tried succeeded." On that list of factors the researchers included self-image and self-confidence (Simon, 1999, p. 165). The study concluded that

> if prison work is to foster personal competence it must be work which is planned, for and with the inmate, to be

> relevant to his or her pre-sentence experience and to his or her hopes for work on release. (Simon, 1999, p. 193-194).

Livelihoods as a road to rehabilitation: Opportunities for employment upon release

Criminal records are a significant barrier to formerly incarcerated people finding work, including in their trade. While it is clear that their offending does not always impact on their ability to do the work, employers "sometimes use a criminal conviction as an indicator of an applicant's character or trustworthiness." Even some of the private entities which use prison labour (paying lower wages than to their free workers) then require a criminal history check for people to work while in the community (Leung, 2018, p. 704). As highlighted by the Irish Penal Reform Trust

> [h]igh levels of resilience should not be a prerequisite for [people with convictions] to move on with their lives and reintegrate into society but the findings on negotiating the labour market and navigating the workplace suggest that [people] will almost certainly struggle without them (Irish Penal Reform Trust, 2024, p. 28).

While legislative protections against discrimination on the grounds of irrelevant criminal records are important (*Anti-Discrimination Act 1998* (Tas) s16(q), *Anti-Discrimination Act 1992* (NT) s19(q), *Discrimination Act 1991* (ACT) s7(1)(k)), more proactive steps need to be taken to support people to get jobs, including preparatory steps while they are still incarcerated. Prisons should have measures in place to ensure that the work done by incarcerated people matches the work that is available and in demand in outside labour markets (Simon, 1999, p. 188). Organisations and programs assisting formerly incarcerated people to gain employment also need to be properly funded (e.g. Women's Chance organisation in the UK, Philadelphia's Fair Chance Hiring Initiative).

Improved transparency and better research

Prisons are, by their very nature, opaque environments, but the lack of transparency with regard to prison labour is particularly striking. For example, Australian governments have relied on contracts for operations of private prisons being 'commercial-in-confidence' as the reason for refusing to provide information, including to oversight bodies (ILO, 1999). A study of a number of countries found that "that prison administrations rarely quantify expenditure with operation costs of prison labour, making it an impossible task to calculate the profit rate of those activities" (Neves, 2015, p. 37). The lack of transparency is a risk for both corrupt practices and mismanagement, as exemplified in the UK, where "pressure to get work from prisoners had induced the workshops... to expand considerably their trade with private companies, taking on contracts which they had not the ability to manage" (Simon, 1999, Ch1, p. 9-10).

This opacity is exacerbated by the fact that prison labour is an aspect of prisons that is under-researched. However, the research that has been undertaken across a number of jurisdictions indicates that prison work is low skilled, restricted to manual activities, and has "no impact on... chances of securing employment after release" (Neves, 2015, p.11). In the Neves study, none of the countries evaluated labour reintegration (Neves, 2015, p. 31), and in an Australian study, in Victoria, the researchers highlighted that their evaluation was hindered by the lack of information (Buchanan, 2007, p. 12).

Conclusion

The considerable shortcomings in protections for incarcerated workers internationally, and persistent failure to conceptualise rehabilitation for incarcerated people as healing from pre-existing trauma and trauma resulting from their contact with the criminal legal system needs to be addressed. Strengthening international legal protections (which are then incorporated in domestic legislation in Australia and the US, with accompanying constitutional amendments for the latter (Williams, 2021)) would have the benefit of not only avoiding harms flowing from exploitative or degrading prison labour, but of providing a basis for meaningful livelihoods for incarcerated and formerly incarcerated people, supporting their rehabilitation from past traumas.

While this article has focused on the gaps and failures when it comes to prison labour, benefits of labour while in prison could flow for incarcerated people, under the right circumstances. For example, in Australia since 2011, The Torch program has "embrac[ed] program participants as artists rather than offenders,' assisting Aboriginal people to reconnect with their "culture and earn income from art sales (with 100% of the artwork price going directly to the artist), licensing and projects." Participants in the program identified benefits as including "an increased sense of well-being and confidence... pre-release skills and exploration of post-release career opportunities... [and] better relationships with family and the wider community."

As one program participant described, "[i]n the past I was a crook, you know, a jail bird, but now I am an artist. My daughter is so proud of that. I never used to think of myself that way" (the Torch website).

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Imagery rehearsal therapy and mianserin for trauma-affected refugees: Follow-up of a randomized controlled trial

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Key points of interest

- Follow-up studies on effective treatments for trauma-affected refugees are limited.
- Improvement during treatment for trauma-affected refugees may be maintained at six-month follow-up post-treatment.
- Add-on treatment with Imagery rehearsal therapy or mianserin was not superior to treatment as usual at six-month follow-up post-treatment.

Abstract

Introduction: In order to identify the efficacy of treatment interventions for trauma-affected refugees follow-up studies are highly warranted. Hence, the overall aim of this study was to examine the efficacy of sleep-enhancing treatment, IRT and mianserin, in a sample of 219 trauma-affected refugees at six-month follow-up post-treatment. *Methods*: Data were derived from a four-armed randomized controlled trial in a sample of trauma-affected refugees with PTSD. All four arms received Treatment as Usual (TAU), an interdisciplinary treatment approach: one group received solely TAU, serving as a control group, whereas the remaining three groups were active-treatment groups receiving add-on treatment with either IRT, mianserin, or a combination. Mixed models were used to analyze the combinations of the two treatment factors (IRT vs. non-IRT and mianserin vs non-mianserin) and time (baseline vs follow-up and post-treatment vs follow-up) for the primary outcome sleep quality and for several secondary outcome measures. *Results:* A total of 36.7% of the participants had been exposed to torture and 44% had been imprisoned. The only significant effect of IRT was on well-being (measured with WHO-5), where IRT showed higher improvement in well-being six months post-treatment (p =.027). There was no significant effect of mianserin on any of the outcome measures. *Discussion:* This follow-up study found improvements from baseline to post-treatment on sleep quality and most of the secondary outcome measures that were maintained for all treatment conditions at the six-month follow-up assessment. A limitation of the study was that a high proportion (53.4%) of the participants did not attend the follow-up evaluation. The results indicate that add-on IRT-treatment and add-on mianserin-treatment were not superior to TAU at six-month follow-up post-treatment.

Keywords: IRT, Sleep, PTSD, treatment, refugee

Introduction

There are currently 82.4 million forcibly displaced persons worldwide; 20.7 million are refugees. This number is increasing rapidly since Russia's invasion of Ukraine, where UNHCR has estimated that more than 6.5 million people have been forced to flee their home (UNHCR, 2022). Many refugees have experienced psychological and physical trauma related to war, imprisonment, torture, and loss of loved ones that may lead to significant distress resulting in severe mental and physical health problems (Bogic et al., 2015; Miller & Rasmussen, 2016). These pre-migration traumas are often accompanied by post-migration stressors such as reduced social networks, new societal rules, and cross-cultural challenges while integrating into countries of settlement (Li et al., 2016; Miller & Rasmussen, 2016). Thus, refugees are of particular concern to mental health practitioners since this population presents a complex and heterogeneous mental health conditions with lower recovery rates than other trauma-affected populations (Crumlish & O'Rourke, 2010; Ter Heide & Smid, 2015). The most common mental health disorder for refugees is PTSD (Giacco et al., 2018; Williams et al., 2011), commonly co-occurring with depression and anxiety (Abu Suhaiban et al., 2019). The estimated prevalence of PTSD in refugee populations is approximately 30%, and refugees are about ten times more likely to develop PTSD than the general population (Fazel et al., 2005; Steel et al., 2009). Furthermore, refugees frequently present a more complex symptom pattern, often meeting the criteria for complex PTSD (Hyland et al., 2018). Despite the size of the problem, treatment for trauma-affected refugees is not adequately explored within the field of psychiatry (Carlsson et al., 2014; Nordbrandt et al., 2015; Giacco et al., 2017; Turrini et al., 2019; Tribe et al., 2019; Thompson et al., 2018; Nosè et al., 2017; Kip et al., 2020; Uphoff et al., 2020). Studies investigating the efficacy of psychotherapy for PTSD among refugees are limited (Morina & Sterr, 2019; Nordbrandt et al., 2020). However, meta-analyses indicate that trauma-focused therapies may be effective, although there is heterogeneity in the studies' findings (Kip et al., 2020; Lambert & Alhassoon, 2015). Furthermore, studies examining the effectiveness of pharmacological treatment for trauma-affected refugees are scarce (Sonne et al., 2017). Thus, adequate treatment of this population remains a challenge, and identifying effective psychotherapeutic and psychopharmacological treatments for trauma-affected refugees in a western setting is of utmost importance.

Problems with poor sleep quality, including difficulties initiating or maintaining sleep and nightmares, are part of the diagnostic criteria for PTSD according to ICD-10 World Health Organization, 2016). Studies indicate that 70-91% of individuals diagnosed with PTSD experience trouble falling or staying asleep (Maher et al., 2006) and the prevalence of nightmares is high in PTSD-patients, with estimates ranging from 50-70% and 40-50% (Leskin et al., 2002; Ohayon & Shapiro, 2000). Until recently, sleep disturbances have been conceptualized as a secondary PTSD-symptom, expected to resolve once the primary symptoms have been treated. Contrary to this view, research has shown that disturbed sleep is often a residual symptom after completed PTSD treatment (Spoormaker & Montgomery, 2008). One study discovered that insomnia was a residual complaint in 13 out of 27 participants after PTSD was successfully treated with trauma-focused CBT (Zayfert & DeViva, 2004). Therefore, it has been debated whether sleep disturbances constitute a core rather than a secondary feature of PTSD, where poor sleep is likely to maintain and exacerbate PTSD symptom severity. According to this view, it is recommended that sleep-focused treatment is incorporated into standard treatment for PTSD (Spoormaker & Montgomery, 2008). Research investigating the link between PTSD and sleep-enhancing treatment among refugees is scarce, especially studies examining the long-term efficacy of sleep-enhancing psychiatric interventions (Sandahl et al., 2017).

A meta-analysis of the relatively few studies that have been conducted concluded that Imagery Rehearsal Therapy (IRT) is the first-choice psychological treatment for nightmares (Augedal et al., 2012). IRT is an adapted CBT targeting nightmares by restructuring disturbing dreams. Furthermore, two studies have demonstrated promising long-term effects of IRT in non-refugee populations. One study has shown long-lasting effects of IRT in reducing sleep-problems, anxiety- and depression symptoms in a population with heterogeneous mental disorders, although the study did not include a control group (Swart et al., 2013). Another study found a clinically meaningful reduction in nightmare severity among chronic nightmare sufferers at 3 and 30 months follow-up compared to a wait-list control (Krakow et al., 1993).

There is a paucity of studies examining the long-term effects of sedating antidepressants in treating sleep disturbances and PTSD symptoms. Mianserin is a sedating noradrenergic and serotonergic antidepressant, commonly used to treat depression (Sandahl, et al., 2021). A study found that sleep improved the most following treatment combining sertraline with mianserin (in addition to receiving trauma-focused CBT) from baseline to follow-up. The authors suggest that this may be attributable to mianserin's use due to its acknowledged effect on sleep disturbances. However, the study did not include a control group (Buhmann et al., 2015). Furthermore, a study has examined mirtazapine, similar to mianserin in receptor profile, and found that combining sertraline and mirtazapine

may be clinically advantageous in reducing PTSD symptoms, relative to sertraline treatment alone at post-treatment (Schneier et al., 2015). However, the study did not include a follow-up assessment investigating the long-term effects.

This article is a follow-up study to the original trial conducted by Sandahl et al. (2021), investigating the effects of IRT and mianserin six months after end of treatment. Sandahl et al. (2021) conducted an RCT investigating the effect of a psychotherapeutic (IRT) and psychopharmacological treatment (mianserin) targeting sleep disturbances in a population of 219 trauma-affected refugees. The original trial hypothesized that sleep-enhancing add-on treatment with IRT and mianserin would be superior to TAU on the primary outcome, Pittsburgh Sleep Quality Index (PSQI), measuring sleep quality post-treatment (Sandahl et al., 2021). However, the study did not find add-on treatment with IRT or mianserin to be more effective than TAU on the primary or secondary outcomes, except the Sheehan Disability Scale (SDS), measuring level of functioning, where IRT was superior to TAU (Sandahl et al., 2021).

Follow-up studies on effective treatments for trauma-affected refugees are limited, face methodological challenges, and often only have short follow-up durations (Bolton, 2018). In order to identify the efficacy of treatment interventions for trauma-affected refugees follow-up studies are highly warranted. Hence, the overall aim of this study was to examine the efficacy of sleep-enhancing treatment, IRT and mianserin in 219 refugees with PTSD, sleep disturbances, and nightmares at six-month follow-up post-treatment.

Materials and methods

Study Design

The original trial was a four-armed randomized controlled trial (RCT), with an allocation ratio of 1:1:1:1, where the block size was unknown to the investigator. The study used a 2 (IRT vs non-IRT) x 2 (mianserin vs non-mianserin) factorial design: **1)** Treatment as usual (TAU), **2)** TAU and add-on treatment with mianserin **3)** TAU and add-on treatment with IRT **4)** TAU and add-on treatment with both IRT and mianserin. In this follow-up study, there will be referred to the following four treatment-conditions: non-IRT, non-mianserin, IRT, and mianserin. The IRT treatment condition comprises Groups 3 & 4 listed above, and the mianserin treatment condition combines Groups 2 & 4. The Non-IRT treatment condition is composed of Groups 1 & 2, and finally, the non-mianserin group is a mix of 1 & 3. The randomization was stratified by gender.

Participants

The data were collected – and participants recruited – at the Competence Centre for Transcultural Psychiatry (CTP), a specialized outpatient mental health facility treating trauma-affected refugees. A total of 219 participants were recruited, of whom 102 attended the follow-up assessment, six months post-treatment. Power calculations and inclusion and exclusion criteria for the original trial are reported by Sandahl et al. (2017) and Sandahl et al. (2021).

Assessment

All participants were screened in a 2-3-hour pre-treatment interview with a medical doctor, documenting the patient's history with trauma, psychiatric, and social background. Using a standardized interview-form, sociodemographic data were collected, which among other things, included questions regarding the number of years in the host country, educational level, and affiliation to the labour market.

To confirm the presence of a PTSD diagnosis and other related comorbid disorders, part of SCAN (Schedules for Clinical Assessment in Neuropsychiatry) and the ICD-10 research criteria were applied in the baseline interview.

Treatment and assessment were conducted in the participants' desired language, and trained interpreters were available if needed. The interpreters were affiliated with CTP and were experienced with psychotherapy, psycho-educational sessions, and questionnaires.

Treatment Modalities

Treatment as usual (TAU): The participants were all offered TAU. TAU was an interdisciplinary treatment approach comprising pharmacological treatment (according to standard pharmacological treatment practice at CTP), physiotherapy, psychoeducation, and manual-based CBT, covering 6-8 months. The psychologists at CTP used CBT interventions from the second wave (Prolonged Exposure Therapy) and the third wave (ACT). TAU was divided into two parts: 1) 2-4 months of treatment managed by a medical doctor (6 sessions) and physiotherapist (8 sessions), and 2) 4-8 months of treatment provided by a medical doctor (4 sessions) and psychologist (16 sessions) (for further details on the TAU condition, cf. Sandahl et al., 2017 and Sandahl et al., 2021).

Imagery rehearsal therapy (IRT): IRT is a treatment-method specifically targeting problems with sleep and nightmares. In the study, IRT was integrated into six therapy sessions and administered by a psychologist supervised and trained for this specific method. IRT consists mainly of three parts: 1) psychoeducation and cognitive restructuring, 2) visualizing and pleas-

ant representation exercises, and 3) rewriting nightmares and exercises of new representations (Sandahl et al., 2017).

Mianserin: The participants in the mianserin groups received 10 mg. of mianserin from the treating medical doctor. Depending on the effect and side effects, the dose could be increased successively to a maximum dosage of 30 mg. Medication adherence was gauged directly by measuring the concentration of mianserin in the blood after phase one and phase two (post-treatment). This objective measure was supplemented with subjective patient self-reports, where the participants were asked to report whether they had taken their medication as prescribed (Sandahl et al., 2017).

Measures

Participants filled out self-report questionnaires and observer ratings at baseline, post-treatment, and at follow-up. Several of the applied self-administered rating scales and observer ratings had been used previously, and in several different settings, for evaluating the outcome of treatment in trauma-affected refugees. However, the validity in refugee samples has only been studied for a few of the included instruments (Mollica et al., 1992).

Primary outcome measure: The Pittsburgh Sleep Quality Index (PSQI; Insana et al., 2013) is a validated self-report questionnaire for evaluating subjective sleep quality and the severity of sleep disturbances. The measure consists of 19 items combined to form seven component scores of sleep: sleep quality, sleep latency, sleep duration, habitual sleep efficiency, sleep disturbances, use of sleep medications, and daytime dysfunction, each weighted equally from 0-3 points. The seven component scores are added to obtain a global PSQI-score ranging from 0-21 points, which differentiates good sleep (PSQI total score ≤5) from poor sleep (PSQI total score >5).

Secondary outcome measurements, self-administered rating scales: The Harvard Trauma Questionnaire (HTQ; (Mollica et al., 1992)) part IV is a self-administered rating scale measuring traumatic experiences and PTSD symptom severity consisting of 16 items with a score range from 1 to 4, where 1 is the best score. HTQ is the most prevalent scale for evaluating PTSD symptoms in refugees. The HTQ was originally developed for use with refugees and the scale is perceived as reliable in a clinical refugee sample.

Disturbing Dreams and Nightmare Severity Index (DDNSI; (Krakow et al., 1993)) is a 5-item self-report inventory assessing the frequency and severity of nightmares and disturbing dreams. The global score ranges from 1 to 37, where 1 is the best score.

Hopkins Symptom Checklist (HSCL-25; (Kleijn et al., 2001)) is a validated self-administered symptom inventory that contains 25 questions measuring symptoms of anxiety and depression on a scale from 1 to 4, where 1 is the best score.

Sheehan Disability Scale (SDS; (Arbuckle et al., 2009)) is a five-item self-rated questionnaire measuring functional impairment regarding family, work, and social networks on a scale from 0 to 10 where 0 is the best score).

The World Health Organisation Well-being Index (WHO-5; (Topp et al., 2015)) is a five-item self-rated questionnaire, assessing subjective psychological well-being during the last two weeks. The global score ranges from 0 (worst possible) to 100 (best possible).

Secondary outcome measurements, observer rating scales

Global Assessment of Functioning – Symptoms (GAF-S) and Functioning (GAF-F) are widely used, observer rating scales used to evaluate the degree of psychiatric symptoms and global functioning in adults on a scale between 0 (worst) and 100 (best) (Bastin et al., 2013).

Data Analysis

Data were analyzed using STATA/SE 16.1 for windows. The baseline characteristics and descriptive data were analyzed using T-tests and one-way ANOVA.

Mixed models were used to analyze the combinations of the two treatment factors (IRT vs. non-IRT and mianserin vs non-mianserin) and time (baseline vs follow-up and post-treatment vs follow-up). Main effects and interaction-effects are reported in table 2 (baseline vs follow-up) and table 3 (post-treatment vs follow-up). This analysis is acceptable due to a non-significant interaction between mianserin and IRT. Furthermore, the assumptions of parametric tests were met: the data were normally distributed, and the data are independent. Homoscedasticity was tested with the Cameron–Trivedi decomposition, and the normality of the residuals was tested with the Shapiro–Wilk test; both tests indicated that the two criteria were reasonably well met.

Using Stata's *margins*-command, means and differences for baseline and post-treatment ratings were estimated. The *contrast*-command was used to determine interaction-effects and to test group differences.

Robust standard errors were used in the mixed model analyses, and the main analysis was performed with an intention-to-treat (ITT) sample. The mixed-model analyses were repeated on a reduced per-protocol sample.

Results

A total of 110 participants were randomized to add-on treatment with IRT and 108 participants were randomized to add-on treatment with mianserin. As table 1 illustrates, a total of 102 participants attended the 6-months follow-up assessment, which corresponds to 46% of the 219 participants enrolled in the study at baseline.

Pre-Treatment Characteristics

We distinguish between the follow-up group, comprising participants attending the follow-up evaluation, and the non-follow-up group, referring to those 117 participants that did not participate in the follow-up assessment.

The majority of the participants in the follow-up group originated from Iraq (*n*= 26 / 26.8%) and Syria (*n*=28 / 28.9%), were diagnosed with comorbid depression (*n*=68, 87.2%), had a trauma dating back further than ten years (*n*=60

Table 1. *Pre-treatment characteristics*

	Non follow-up sample (n = 117)	*Follow-up sample (n = 102)*
Demographic information	**Mean (SD*)**	
Age	42.2 (10.9)	47.0 (9.1)
Years since arrival in Denmark	13.8 (9.6)	12.7 (9.7)
	N (%)	
Male gender	60 (51)	50(49)
Female gender	57 (49)	52 (51)
Country of origin		
Afghanistan	13 (11.8)	13 (13.4)
Iran	9 (8.2)	10 (10.3)
Iraq	28 (25.5)	26 (26.8)
Lebanon	9 (8.2)	6 (6.2)
Syria	30 (27.3)	28 (28.9)
Other	21 (19)	21 (27.3)
Refugee camp before arrival in DK	21 (23.6)	21 (27.3)
Danish Asylum Centre	57 (68.7)	40 (67.8)
Trauma history		
War	106 (96.4)	99 (99)
Torture	35 (35.5)	33 (36.7)
Imprisonment	43 (41.4)	40 (44)
Soldier	26 (26.5)	21 (23)
Sexual harassment	10 (14)	13 (17.1)
Violence from relatives	37 (42)	23 (30.3)
Cranial traumas	30 (36.6)	32 (38.1)
> 10 years since the trauma	66 (73.3)	60 (72.9)
Psychosocial status		
Needing translater during the therapy sessions	40 (56.3)	55 (79.1)
Affiliation to the labour market / studying	32 (33.6)	34 (38.6)
Income from labour	6 (5.8)	7 (7.5)
Living alone all the time	15 (14.3)	13 (14)
Education > 10 years from home country	45 (43.3)	42 (45.2)
Work experience in Denmark	56 (54.9)	40 (42.4)
Diagnoses (ICD-10) additional to PTSD		
Depression	81 (95.3)	68 (87.2)
Enduring personality change after catastrophic experience (F62.0)	5 (10.4)	2 (5)
Functional impairment since 10 years	10 (8.6)	14 (17.3)
Previous treatment		
Previously admitted to psychiatric hospital	11 (11.2)	12 (13)
Any psychopharmacological treatment at baseline	67 (59.3)	75 (76.5)

* SD, Standard Deviation

/ 72.9%), and had lived at a Danish asylum centre (n=40 / 67.8%). A total of 36.7% (n=33) of the participants in the follow-up groups had been exposed to torture and 44% (n=40) had been imprisoned.

T-tests of the participants' socio-demographics indicated no significant group difference between the non-follow-up sample and follow-up sample regarding gender, years since the arrival to the host country, country of origin, affiliation to the labour market, education level, income, and whether they were living alone all the time. Likewise, analyses of pre-treatment psychopathologies (additional to PTSD) and trauma history discovered no significant differences between the non-follow-up and follow-up groups. Finally, the follow-up and the non-follow-up group did not differ significantly regarding the number of attended psychotherapeutic sessions.

Differences between participants in the follow-up and non-follow-up groups revealed a significant age difference, difference regarding the usage of a language translator in the therapy session with a mean age of 42.2 in the non-follow-up group and a mean age of 47.0 in the follow-up group. The usage of a language translator in the therapy sessions similarly differed in the two groups, where the non-follow-up group (n= 55 / 79.71%) used a translator more often than the follow-up group (n=40/ 56.3%). Finally, the analysis demonstrated a significant difference between the two groups regarding medication, where the non-follow-up group included participants with more concurrently prescribed medicines at baseline (n= 67 / 59.3% vs. n=75 / 76.53%).

Comparing The Non-Follow-Up And Follow-Up Group

Table 1 illustrates the non-follow-up and follow-up group's observed mean score on several outcome variables at baseline and post-treatment. As table 1 shows, the two groups were comparable concerning their scores on almost every outcome measure at baseline and post-treatment, indicating that the participants attending follow-up did not differ from the non-follow-up group. The similarity between the two groups implies that we can expect patterns of missing data to be random in the follow-up assessment.

Primary Analysis

Tables 2 and 3 illustrate the mixed model regression analyses with main and interaction effects of IRT and mianserin at three different assessment times, baseline vs. follow-up, and post-treatment vs follow-up. The observed mean and standard error (SE) of pre- and follow-up scores for IRT & non-IRT and mianserin & non-mianserin are presented in table 2, whereas the observed mean and SE of post-treatment and follow-up scores are presented in table 3. Tables 2 and 3 contain three different p-values, describing: **1)** main effects (ME) of IRT/non-IRT and mianserin/non-mianserin, indicating whether symptoms change significantly over time in each of these treatment conditions. **2)** difference p-value, referring to whether treatment conditions differ at baseline, post-treatment, and follow-up. **3)** interaction effects, describing whether the treatment conditions result in significantly different changes over time.

Primary outcome, PSQI

Main effects: There was a significant difference between baseline and follow-up at the PSQI-score for all treatment conditions: IRT (p = 0.002), non-IRT (p = 0.005), mianserin (p = 0.003) and non-mianserin (p = 0.003), signalling better subjective sleep quality over time. The difference between baseline and follow-up did not reach the Minimal Clinically Important Difference (MCID) of 2.5 scale points on PSQI. However, the difference between baseline and follow-up for the IRT treatment condition was close to the MCID (2.26 scale points).

There were no significant main-effects between post-treatment and follow-up for either of the treatment conditions on the PSQI-score.

Interaction effects: There were no interaction-effects between time (baseline and follow-up) and treatment conditions, indicating that IRT (p = 0.60) and mianserin (p = 0.99) did not improve subjective sleep quality more than non-IRT and non-mianserin. Likewise, the analysis did not find an interaction effect between time (post-treatment and follow-up) and treatment condition (p = 0.74).

Secondary Outcomes For The IRT-Treatment Condition

Main effects: There was a significant difference between baseline and follow-up for all secondary outcome variables for the IRT treatment condition, indicating overall improvement of symptoms and functioning. Furthermore, there was a significant main effect of non-IRT from baseline to follow-up in the following outcome variables: HTQ, HSCL-25, and a marginally significant effect on GAF-S (p = 0.055).

There was a significant main effect of the IRT-treatment condition on the time post-treatment vs follow-up on two outcome variables: HSCL, which signals fewer symptoms of anxiety and depression at follow-up assessment, and GAF-S that is showing a greater level of functioning at follow-up than at post-treatment assessment. Furthermore, the analysis revealed a significant difference from post-treatment to follow-up on the non-IRT group at DDNSI.

Interaction effects: Using the mixed model, the interaction between time (measured either as the difference between base-

line and follow-up scores or between post-treatment and follow-up), and treatment condition (IRT vs non-IRT) was only significant for the WHO-5 outcome variable ($p = 0.027$) when comparing baseline and follow-up. Thus, there was a significantly larger improvement in well-being in the IRT treatment condition than in the non-IRT treatment condition from baseline to follow-up.

Table 2. Mixed model analyses baseline vs follow-up

Rating-scale	*Treatment-condition*	*Mean pre-treatment score*	*Mean follow-up score*	*Difference (SE)*	*P-value*
PSQI	**IRT**	16.50 (0.29)	14.24 (0.73)	-2.26 (0.72)	**0.002*** (ME)
	Non-IRT	16.01 (0.28)	14.25 (0.65)	-1.76 (0.63)	**0.005*** (ME)
	Difference	0.49 (0.4)	-0.01 (0.99)	-0.51 (0.97)	
	Difference, p-value	0.22 (difference treatment condition at baseline)	0.99 (difference treatment condition at follow up)	0.604 (IE)	
	Mianserin	16.43 (0.29)	14.42 (0.72)	-2.0 (0.68)	**0.003***
	Non-mianserin	16.10 (0.28)	14.08 (0.7)	-2.02 (0.67)	**0.003***
	Difference	0.32 (0.4)	0.34 (0.99)	0.02 (0.97)	
	Difference, p-value	0.42	0.73	0.99	
HTQ	**IRT**	3.12 (0.04)	2.79 (0.08)	-0.33 (0.08)	**0.003***
	Non-IRT	3.11 (0.04)	2.87 (0.08)	-0.23 (0.07)	**0.002***
	Difference	0.01 (0.06)	-0.09 (0.11)	-0.1 (0.11)	
	Difference, p-value	0.88	0.42	0.36	
	Mianserin	3.13 (0.04)	2.9 (0.07)	-0.22 (0.07)	**0.003***
	Non-mianserin	3.1 (0.04)	2.77 (0.08)	-0.33 (0.08)	**<0.001****
	Difference	0.03 (0.06)	0.14 (0.11)	0.12 (0.11)	
	Difference, p-value	0.63	0.19	0.28	
HSCL-25	**IRT**	3.02 (0.04)	2.72 (0.08)	-0.38 (0.07)	**<0.001****
	Non-IRT	2.95 (0.05)	2.64 (0.08)	-0.23 (0.08)	**0.003***
	Difference	0.07 (0.07)	-0.07 (0.11)	-0.14 (0.11)	
	Difference, p-value	0.32 (0.4)	0.52	0.18	
	Mianserin	2.99 (0.05)	2.74 (0.08)	-0.25 (0.07)	**0.001***
	Non-mianserin	2.98 (0.05)	2.62 (0.08)	-0.36 (0.08)	**<0.001****
	Difference	0.02 (0.07)	0.12 (0.11)	0.1 (0.11)	
	Difference, p-value	0.80	0.29	0.33	

Rating-scale	*Treatment-condition*	*Mean pre-treatment score*	*Mean follow-up score*	*Difference (SE)*	*P-value*
WHO-5	**IRT**	16.16 (1.48)	29.95 (2.93)	13.78 (2.56)	**<0.001****
	Non-IRT	18.59 (1.61)	22.6 (3.42)	4 (3.57)	**0.26**
	Difference	-2.43 (2.18)	7.35 (4.5)	9.77 (4.41)	
	Difference, p-value	0.26	0.1	**0.027***	
	Mianserin	17.3 (1.62)	27.9 (3.66)	10.49 (3.44)	**0.002***
	Non-mianserin	17.4 (1.46)	24.79 (2.68)	7.28 (2.8)	**0.009***
	Difference	-0.07 (2.18)	3.14 (4.6)	3.21 (4.49)	
	Difference, p-value	0.97	0.5	0.47	
DDNSI	**IRT**	17.13 (0.7)	14.44 (1.01)	-2.69 (1.16)	**0.020***
	Non-IRT	16.15 (0.74)	14.77 (1.03)	-1.39 (1.12)	**0.21**
	Difference	0.97 (1.02)	-0.33 (1.48)	-1.30 (1.65)	
	Difference, p-value	0.34	0.82	0.43	
	Mianserin	16.16 (0.7)	13.67 (0.99)	-2.48 (1.12)	**0.027***
	Non-mianserin	17.11 (0.74)	15.5 (1.05)	-1.61 (1.16)	**0.17**
	Difference	-0.95 (1.02)	-1.82 (1.48)	-0.87 (1.65)	
	Difference, p-value	0.35	0.22	0.6	
SDS	**IRT**	22.94 (0.57)	19.04 (1.17)	-3.89 (1.19)	**0.001***
	Non-IRT	21.03 (0.63)	19.38 (1.25)	-1.64 (1.24)	**0.19**
	Difference	1.91 (0.85)	-0.34 (1.72)	-2.25 (1.73)	
	Difference, p-value	0.024*	0.84	0.19	
	Mianserin	22.54 (0.61)	19.67 (1.28)	-2.83 (1.35)	**0.04***
	Non-mianserin	21.45 (0.58)	18.72 (1.14)	-2.7 (1.08)	**0.01***
	Difference	1.09 (0.85)	0.96 (1.18)	-0.13 (1.75)	
	Difference, p-value	0.2	0.17	0.94	
GAF-F	**IRT**	51.58 (0.8)	55.66 (1.94)	4.08 (2.06)	**0.048***
	Non-IRT	51.57 (0.74)	52.01 (1.92)	0.45 (2.01)	**0.83**
	Difference	0.02 (1.08)	3.65 (2.71)	3.63 (2.86)	
	Difference, p-value	0.99	0.18	0.2	
	Mianserin	51.82 (0.76)	53.61 (1.69)	1.77 (1.78)	**0.32**
	Non-mianserin	51.33 (0.77)	52.01 (1.93)	2.76 (2.27)	**0.23**
	Difference	0.49 (1.08)	0.5 (2.72)	-0.99 (2.86)	
	Difference, p-value	0.65	0.85	0.73	

Rating-scale	*Treatment-condition*	*Mean pre-treatment score*	*Mean follow-up score*	*Difference (SE)*	*P-value*
GAF-S	**IRT**	50.58 (0.57)	56.72 (1.37)	6.14 (1.5)	**<0.001****
	Non-IRT	51.38 (0.51)	55.15 (1.87)	3.76 (1.96)	**0.055**
	Difference	-0.81 (0.77)	1.57 (2.3)	2.38 (2.46)	
	Difference, p-value	0.29	0.5	0.33	
	Mianserin	50.85 (0.52)	55.9 (1.59)	5.03 (1.7)	**0.003***
	Non-mianserin	51.10 (0.57)	55.99 (1.7)	4.87 (1.80)	**0.007***
	Difference	-0.25 (0.77)	-0.09 (2.32)	0.16 (2.47)	
	Difference, p-value	0.74	0.97	0.95	

PSQI, 1–21 (1 best score); HTQ, 1–4 (1 best score); HSCL-25 ,1–4 (1 best score); WHO-5, 0–100 (100 best score); DDNSI, 1–37 (1 best score); SDS, 0–10 (0 best score); GAF-F, 0–100 (100 best score).
Abbreviations: IRT, imagery rehearsal therapy; SE, standard error; PSQI, Pittsburgh Sleep Quality Index; HTQ, Harvard Trauma Questionnaire; HSCL25, Hopkins Symptom Checklist-25; WHO-5, Well Being Index; DDNSI, Disturbing Dreams and Nightmare Severity Index; SDS, Sheehan Disability Scale; GAF-F/-S, Global Assessment of Functioning (function/symptoms).The table presents mixed-model estimates of means, SE, p-values and effect size. The p-values are presented for differences in pre-treatment and post-treatment scores and changes over time between the add-on treatment condition and the no add-on condition corresponding to the interaction of each treatment with time. *p ≤ .05.

Table 3. *Mixed model analyses post-treatment vs follow-up*

Rating-scale	*Treatment-condition*	*Mean post-treatment score*	*Mean follow-up score*	*Difference (SE)*	*P-value*
PSQI	**IRT**	14.41 (0.48)	14.08 (0.7)	-0.34 (0.54)	**0.53**
	Non-IRT	14.38 (0.44)	14.32 (0.63)	-0.07 (0.61)	**0.91**
	Difference	0.03 (0.65)	-0.24 (0.95)	-0.27 (0.82)	
	Difference, p-value	0.97	0.8	0.74	
	Mianserin	15.18 (0.44)	14.38 (0.7)	-0.8 (0.6)	**0.19**
	Non-mianserin	13.62 (0.49)	14.00 (0.63)	0.39 (0.54)	**0.47**
	Difference	1.57 (0.66)	0.38 (0.96)	-1.19 (0.82)	
	Difference, p-value	0.017*	0.69	0.15	
HTQ	**IRT**	2.88 (0.07)	2.79 (0.08)	-0.08 (0.06)	**0.2**
	Non-IRT	3.0 (0.06)	2.87 (0.08)	-0.13 (0.08)	**0.09**
	Difference	-0.12 (0.09)	-0.07 (0.11)	0.05 (0.1)	
	Difference, p-value	0.19	0.51	0.61	
	Mianserin	3.02 (0.06)	2.9 (0.07)	-0.12 (0.08)	**0.11**
	Non-mianserin	2.85 (0.07)	2.76 (0.08)	-0.09 (0.06)	**0.14**
	Difference	0.17 (0.09)	0.13 (0.11)	0.04 (0.1)	
	Difference, p-value	0.07	0.23	0.7	

Rating-scale	*Treatment-condition*	*Mean post-treatment score*	*Mean follow-up score*	*Difference (SE)*	*P-value*
HSCL-25	**IRT**	2.77 (0.08)	2.64 (0.08)	-0.13 (0.06)	**0.027***
	Non-IRT	2.86 (0.07)	2.72 (0.08)	-0.14 (0.08)	**0.07**
	Difference	-0.09 (0.01)	-0.08 (0.11)	0.01 (0.1)	
	Difference, p-value	0.38	0.49	0.90	
	Mianserin	2.89 (0.07)	2.73 (0.08)	-0.16 (0.07)	**0.028***
	Non-mianserin	2.74 (0.08)	2.62 (0.08)	-0.11 (0.06)	**0.08**
	Difference	0.16 (0.1)	0.11 (0.11)	-0.05 (0.1)	
	Difference, p-value	0.13	0.34	0.62	
WHO-5	**IRT**	26.44 (2.65)	29.35 (2.88)	2.89 (2.31)	**0.21**
	Non-IRT	24.34 (2.32)	21.24 (3.22)	-3.12 (2.85)	**0.27**
	Difference	2.1 (3.52)	8.11 (4.33)	6.01 (3.72)	
	Difference, p-value	0.55	0.06	0.11	
	Mianserin	25.63 (2.54)	27.71 (3.55)	2.00 (2.92)	**0.49**
	Non-mianserin	25.21 (2.48)	23.06 (2.5)	-2.23 (2.21)	**0.31**
	Difference	0.42 (3.56)	3.14 (4.6)	4.23 (3.72)	
	Difference, p-value	0.91	0.5	0.26	
DDNSI	**IRT**	16.40 (0.75)	14.93 (0.99)	-1.5 (1.02)	**0.14**
	Non-IRT	16.82 (0.81)	14.56 (1.01)	-2.28 (1.16)	**0.04***
	Difference	-0.42 (1.11)	0.36 (1.44)	0.78 (1.52)	
	Difference, p-value	0.7	0.8	0.61	
	Mianserin	16.68 (0.73)	13.7 (1.00)	-2.98 (1.17)	**0.01***
	Non-mianserin	16.54 (0.82)	15.75 (1.01)	-0.79 (0.96)	**0.41**
	Difference	0.13 (1.1)	-2.06 (1.45)	-2.19 (1.52)	
	Difference, p-value	0.9	0.16	0.15	
SDS	**IRT**	20.8 (0.9)	19.65 (1.09)	-1.14 (0.9)	**0.21**
	Non-IRT	21.58 (0.73)	19.35 (1.22)	-2.21 (1.18)	**0.06**
	Difference	-0.77 (1.16)	0.3 (1.65)	1.07 (1.50)	
	Difference, p-value	0.51	0.86	0.48	
	Mianserin	22.1 (0.82)	19.69 (1.26)	-2.37 (1.14)	**0.04***
	Non-mianserin	21.56 (0.73)	19.35 (1.22)	-0.97 (0.95)	**0.30**
	Difference	1.79 (1.18)	0.39 (1.67)	-1.4 (1.49)	
	Difference, p-value	0.13	0.82	0.35	

Rating-scale	*Treatment-condition*	*Mean post-treatment score*	*Mean follow-up score*	*Difference (SE)*	*P-value*
GAF-F	**IRT**	55.01 (1.26)	55.66 (1.94)	0.65 (1.78)	**0.72**
	Non-IRT	53.44 (1.14)	52.01 (1.93)	-1.43 (1.79)	**0.42**
	Difference	1.57 (1.71)	3.65 (2.71)	2.08 (2.49)	
	Difference, p-value	0.36	0.18	0.41	
	Mianserin	53.71 (1.24)	53.61 (1.69)	-0.11 (1.52)	**0.94**
	Non-mianserin	54.77 (1.17)	54.12 (1.93)	-0.67 (2.03)	**0.74**
	Difference	-1.06 (1.71)	0.5 (2.72)	0.56 (2.51)	
	Difference, p-value	0.53	0.85	0.82	
GAF-S	**IRT**	54.04 (1.15)	56.33 (1.33)	2.28 (1.0)	**0.02***
	Non-IRT	53.37 (1.06)	54.26 (1.78)	0.88 (1.89)	**0.64**
	Difference	0.67 (1.56)	2.07 (2.21)	1.4 (2.14)	
	Difference, p-value	0.67	0.36	0.51	
	Mianserin	53.42 (1.03)	55.84 (1.46)	2.42 (1.46)	**0.10**
	Non-mianserin	54.01 (1.19)	54.77 (1.69)	0.75 (1.56)	**0.63**
	Difference	-0.6 (1.58)	1.07 (2.24)	1.67 (2.14)	
	Difference, p-value	0.71	0.63	0.44	

PSQI, 1–21 (1 best score); HTQ, 1–4 (1 best score); HSCL-25, 1–4 (1 best score); WHO-5, 0–100 (100 best score); DDNSI, 1–37 (1 best score); SDS, 0–10 (0 best score); GAF-F, 0–100 (100 best score).
Abbreviations: IRT, imagery rehearsal therapy; SE, standard error; PSQI, Pittsburgh Sleep Quality Index; HTQ, Harvard Trauma Questionnaire; HSCL25, Hopkins Symptom Checklist-25; WHO-5, Well Being Index; DDNSI, Disturbing Dreams and Nightmare Severity Index; SDS, Sheehan Disability Scale; GAF-F/-S, Global Assessment of Functioning (function/symptoms). The table presents mixed-model estimates of means, SE, p-values and effect size. The p-values are presented for differences in pre-treatment and post-treatment scores and changes over time between the add-on treatment condition and the non add-on condition corresponding to the interaction of each treatment with time. *p ≤ .05

Secondary Variables For The Mianserin Treatment Condition
Main effects: There was a significant main effect of the mianserin-group on the time baseline vs follow-up in the following outcome-variables: HTQ, showing fewer PTSD-symptoms, HSCL-25, indicating fewer anxiety and depression symptoms, WHO-5, reflecting subjectively better well-being, DDNSI, indicating a reduction in nightmares and bad dreams, SDS and GAF-S, signalling improved psychosocial functioning and less severe symptoms. Furthermore, there was a significant main effect of the non-mianserin-group on the time baseline vs follow-up in the following outcome variables: HTQ, HSCL-25, WHO-5, SDS, and GAF-S. Finally, there was a significant main effect of the mianserin treatment condition on time post-treatment vs follow-up on the following variables: HSCL, DDNSI, and SDS.

Interaction effects: There were no significant interactions between time (pre-treatment vs follow-up and post-treatment vs. follow-up) and treatment condition (mianserin vs non-mianserin) on any outcome variables.

Completer Analysis
In the follow-up group, 23 patients participated in four or more IRT-sessions (IRT treatment completers) whereas 14 were adherent to medication (mianserin completers). The mean dose of mianserin was 13.49 (6.23). The attendance rate (calculated as number of sessions attended/number of sessions planned)

for medical doctor sessions was 0.68. The mixed-model analyses on the reduced per-protocol sample confirmed the results of the intention-to-treat analysis showing a borderline significant difference between IRT treatment completers and non-IRT on WHO-5 when comparing baseline and follow-up.

Discussion

This follow-up study compared the effectiveness of add-on psychotherapeutic IRT treatment and add-on psychopharmacological mianserin treatment with an active control intervention on sleep disturbances in trauma-affected refugees at six months follow-up. Similarly to the original trial, data from this follow-up study did not find add-on treatment with IRT or mianserin to be superior to TAU in improving subjective sleep quality on the primary outcome measure PSQI at six months follow-up. The study's only significant difference was between IRT and non-IRT on the secondary measure, WHO-5, where IRT showed greater advantages in achieving improved well-being.

The IRT group did have a non-significant numerical advantage for every primary and secondary outcome measure from baseline to follow-up. Moreover, the number of treatment completers was low for mianserin as well as IRT.

In the following section, IRT and mianserin will be discussed separately.

Imagery Rehearsal Therapy

The study found no significant differences in sleep quality between IRT and non-IRT neither from baseline to follow-up nor from post-treatment to follow-up, indicating that add-on treatment with IRT was not superior to TAU. WHO-5 was the only secondary outcome measure, where IRT was superior to TAU from baseline to follow-up. This significant effect on WHO-5 was mainly due to an interaction between post-treatment and follow-up, where the non-IRT treatment condition experienced a reduction in well-being, whereas the well-being score was increased for the IRT treatment condition. This result differed from the original study, where the level of functioning measured on SDS was the only outcome variable, where IRT was significantly superior to non-IRT from baseline to post-treatment (Sandahl et al., 2021).

In the original trial, the IRT treatment condition had a non-statistical numerical advantage over non-IRT on the primary and secondary outcome measures. The same pattern could be seen when looking at treatment response between baseline and follow-up, but not when only looking at post-treatment to follow-up.

The non-significant difference between IRT and non-IRT can potentially be attributed to TAU treatment. Parts of TAU focus on psychoeducation about good sleep-hygiene, potentially overlapping with psychoeducation in IRT. Furthermore, a study indicates that IRT is less effective in reducing nightmare anxiety in PTSD participants than in individuals who only suffer from nightmares without a clinical diagnosis (Thünker & Pietrowsky, 2012). These factors could explain why IRT was not superior to TAU in improving sleep.

Mianserin

Add-on medication with mianserin was not superior to TAU on the primary or any of the secondary outcome measures neither from baseline to follow-up nor from post-treatment to follow-up. This aligns with the original trial (Sandahl et al., 2021), where add-on treatment with mianserin did not significantly affect PSQI or any other secondary outcome measures from baseline to post-treatment. Treatment with mianserin did have a numerical non-significant advantage on every symptomatic and functional outcome measure from post-treatment to follow-up, differing from the results found in the original study where the mianserin treatment condition was inferior to the non-mianserin treatment condition on every outcome measure.

The research literature regarding the efficacy of mianserin for treating PTSD and sleep disturbances is scarce and characterized by ambiguity. Similarly, this study did not provide evidence for the efficacy of mianserin compared to TAU. Another follow-up study at CTP found evidence supporting the usage of mianserin and sertraline for treating sleep disturbances from baseline to follow-up, although several methodological limitations were present. Most importantly, the study was not able to separate the effect of sertraline from mianserin (Buhmann et al., 2015). Furthermore, an RCT examining a non-refugee population found that combining sertraline and mirtazapine (a drug similar to mianserin in receptor profile) may be clinically advantageous in reducing PTSD symptoms, relative to sertraline treatment alone (Schneier et al., 2015). However, the authors did not find that mirtazapine enhanced sleep quality. Another study by Alderman et al., (2009) similarly found that mirtazapine was effective in the treatment of combat-related PTSD among military veterans, where mean scores of PTSD symptoms were reduced significantly after three months of psychopharmacological treatment. However, the study by Alderman et al., (2009) was conducted with a small sample size, without a control group, and a different population, which may explain the differing results.

An additional potentially important factor is the low number of IRT and mianserin completers. Non-adherence to treatment is a common challenge in refugee populations (Chaudri, 2004), which may be due to various factors including beliefs

about the cause of mental health disorders, barriers in the relationship between doctor/psychologist and patient, patient autonomy and social network (Kortmann, 2010).

Effects of Psychotherapy at Follow-up

This follow-up study found improvements from baseline to post-treatment on sleep quality and most of the secondary outcome measures that were maintained for all treatment conditions at the six-months follow-up assessment.

Only a few longitudinal studies have examined the effects of psychotherapeutic treatment for trauma-affected refugees at follpw-up, yielding mixed findings. A study showed no clinically significant improvement in mental health neither at the 9-month or 23-month follow-up after admission to a multidisciplinary treatment (Carlsson et al., 2010). Contrary to these studies, a study by Neuner et al. (2004), found that *Narrative Exposure Therapy* had a clinical significance on PTSD-symptoms among African refugees. More specifically, there was a significant main effect from pre-treatment to post-treatment and post-treatment to the one-year follow-up, indicating improved mental health after the end of treatment. Finally, a meta-analysis by Macedo et al. (2018) investigated the long-term effects of CBT on PTSD in a heterogeneous population. In summary, the meta-analysis did not provide conclusive evidence for a long-term treatment effect of CBT, mainly due to methodological limitations (Macedo et al., 2018). Thus, research cannot without ambiguity conclude that CBT has long-term treatment effects in any PTSD population. However, the findings of our study contribute to evidence suggesting that TAU, including trauma-focused CBT, enhances trauma-affected refugees' mental health at post-treatment, which is maintained at a six-month follow-up.

Strengths And Limitations

The key strengths of this study are its randomized design, the usage of subjective self-administered rating scales as well as observer rating scales (measuring a variety of mental health outcomes), and the initial confirmation of a PTSD diagnosis with a clinician-administered interview. The active control group design accounts for any spontaneous recovery effects while posing fewer ethical dilemmas than waiting list control.

Furthermore, another strength is that the study is a pragmatic clinical trial in which few exclusion criteria were used and without strict inclusion criteria, intentionally creating a pool of heterogeneous participants, typically treated at a trauma clinic for refugees. This increases the generalizability of the results due to the multicultural sample and the allowance of multiple comorbidities. Conversely, the cultural heterogeneity may have had a significant impact on the psychometric quality of the outcome measures, since cultural and linguistic meanings of scales can differ, potentially creating test bias resulting in unreliable results.

Several important limitations need to be considered. First, this study had a limited follow-up period of six months with a high portion of participants not attending the follow-up evaluation (53.4%), which resulted in lower power and low robustness of the results that were not powered to produce a conclusive test of efficacy.

Even though mixed regression modelling is effective in its ability to handle missing data, the accuracy of the statistical model's estimation is still reduced. Second, some participants did receive mianserin in the follow-up period due to positive drug response, which complicates the study of the psychopharmacological treatment's long-term effects, since several participants were in treatment with psychopharmacology at the follow-up assessment. Finally, the follow-up period is vulnerable to confounding environmental influences, making causal statements related to mianserin or IRT more difficult than in the trial from baseline to post-treatment.

Conclusion

To our knowledge, this is the first large-scale follow-up study examining the therapeutic and psychopharmacological treatment of sleep disturbances in trauma-affected refugees. It is essential to evaluate whether a treatment has sustained effect beyond treatment or merely works as an initial response that only lasts during the trial.

This follow-up study's primary conclusion was that sleep quality and most of the secondary outcomes improved from baseline to post-treatment and that these gains were maintained for all the treatment conditions at the six-month follow-up assessment. Furthermore, we did not find the IRT or mianserin treatment conditions superior to TAU in improving sleep disturbances or on any symptomatic and functional outcome measure (besides WHO-5) at the six-month follow-up.

This study has demonstrated that the treatment of trauma-affected refugees remains a challenge. Further research is required to examine the linkage between sleep disturbances, nightmares, and PTSD symptoms to assess whether sleep-enhancing treatment modalities, including therapeutic and psychopharmacological interventions, are useful in the future treatment of PTSD.

Contributors

Hinuga Sandahl and Jessica Carlsson designed and conducted the study. Anders Nielsen and Felix Klich performed the statisti-

cal analysis and wrote the first draft of the manuscript. Stig Bernt Poulsen advised on methodological issues. All authors contributed to and have approved the final manuscript.

Ethical Considerations statement

The RCT was approved by The Ethics Committee of the Capital Region of Denmark (H-15014503), the Danish Medicines Agency (EudraCT: 2015-004153-40) and the Danish Data Protection Agency (2012-58-0004) and was registered at ClinicalTrials.gov ID (NCT02761161), April 27, 2016.

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Data availability statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy and ethical restrictions.

Conflicts of Interest and Source of Funding

The authors declare that they have no financial or other competing interests.

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UN Special Rapporteur on Torture's most recent report to the General Assembly: 'Investigating, prosecuting and preventing wartime sexual torture, and providing rehabilitation to victims and survivors'

Berta Soley[1]

The latest report by Dr. Alice Jill Edwards, UN Special Rapporteur on Torture (SRT), published on the 18th July 2024.

In this report, the SRT examines the devastating impact of sexual torture in wartime, its underreporting, and the need for stronger legal frameworks to address it. Sexual torture is described as any form of verbal, emotional, psychological or physical aggression that violates intimate areas. It includes forced nudity, rape, genital mutilation, and forced pregnancies, targeting different vulnerable groups like women, children, LGBTQ+ individuals, and men. As such, sexual torture in conflict and war contexts is used as a weapon of war that affects not only the direct victims but also families and communities at large.

The report highlights several key areas for action, arguing that sexual violence in conflict should be framed as torture under international law, providing stronger legal protection and removing the stigma often faced by survivors. Dr. Edwards emphasizes the need to shift shame from victims to perpetrators, improve evidence-gathering processes, and ensure that survivors receive appropriate rehabilitation, which requires tailored therapeutic approaches. Survivors must also play an active role in shaping the programs designed to help them.

Underreporting of sexual torture remains a major issue, with societal barriers, fear of reprisals, and lack of access to justice contributing to this problem. Confidentiality and proper evidence collection are essential for protecting survivors, and psychological evidence is crucial in documenting the impact of sexual torture. Interviewing survivors requires trained professionals who can elicit sensitive information without causing further harm.

The report also explores the behaviour of perpetrators, noting that social, psychological, and situational factors drive ordinary individuals to commit torture. Understanding these dynamics is essential for preventing future violence. The SRT calls for more research into perpetrator behaviour and better training for military personnel to prevent sexual torture.

Rehabilitation for survivors remains inadequate, with many reparation programs underfunded and difficult to access. Effective rehabilitation must be holistic, addressing physical, psychological, and socio-economic needs, and should involve survivors in its design. States should adopt zero-tolerance policies for torture, ensure accountability for perpetrators, and provide comprehensive support for survivors.

The report concludes with recommendations for improving legal frameworks, increasing survivor-centred services, and holding perpetrators accountable to prevent sexual torture in conflict and promote healing for survivors.

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