TORTURE 3 2024

Journal on Rehabilitation of Torture Victims and Prevention of Torture

VOLUME 34, N° 3, 2024, ISSN 1018-8185

TORURE

Journal on Rehabilitation of Torture Victims and Prevention of Torture

Published by the International Rehabilitation Council for Torture Victims (IRCT), Copenhagen, Denmark.
TORTURE is indexed and included in MEDLINE. Citations from the articles indexed, the indexing terms and the English abstracts printed in the journal will be included in the databases.

Volume 34, Nº 3, 2024
ISBN 1018-8185

The Journal has been published since 1991 as Torture – Quarterly Journal on Rehabilitation of Torture Victims and Prevention of Torture, and was relaunched as Torture from 2004, as an international scientific core field journal on torture.

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Subscription
http://irct.org/media-and-resources/publications#torture-journal
The Journal is free of charge.

Front page: Mogens Andersen, Denmark
Layout by Pedro López Andradas

Content

Torture, 2024, 34(3), 3-14
https://doi.org/10.7146/torture.v34i3.152020 *Editorial*

Denial of abortion rights as a form of ill-treatment or torture

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Acronyms
CAT - Committee Against Torture
CEDAW. Working Group on the issue of discrimination against women in law and in practice
CESCR. Committee on Economic, Social and Cultural Rights (CESCR)
CRPD.- Committee on the Rights of Persons with Disabilities
ECtHR - European Court of Human Rights
HRC - Human Rights Committee
IACtHR. Inter-American Court of Human Rights
SRT. Special Rapporteur on Torture and other cruel, inhuman or degrading treatment or punishment.
SRT – Health. Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health
SRT- Disabilities. Special Rapporteur on the rights of persons with disabilities
SR VAW - Special Rapporteur on Violence Against Women
WGDAW (Working Group on Discrimination Against Women)

Abortion and the right to abortion are sensitive issues in which elements linked to the right of women to decide about their bodies are interpolated with critical cultural, ideological and religious considerations. Quite often, there is a dissociation between the jurisprudential positions in the international legal system, national legislation and civil society.

Over the past three decades, there has been a notable advancement in the recognition of abortion rights within the context of national legal systems across the globe. It is noteworthy that there have only been four instances where progress has been reversed, namely in the United States, Nicaragua, El Salvador, and Poland. (Center for Reproductive Rights, 2022).

Table 1 summarizes the legal status of regulation in the world (Center for Reproductive Rights, 2022).

These advancements cannot hide that 134 countries have penalties for women who attempt abortions. It should be noted that even in jurisdictions where abortion is legally permitted, it is still subject to criminalization, including the possibility of life imprisonment at the discretion of the judge. In most cases, these

***Table 1**. Legal status of abortion (adapted from Center for Reproductive Rights, 2022)*

Category	Countries (%)	Conditions under which abortion is allowed
On request	77 (38%)	On request by the woman, with varying gestational limits (usually 12 weeks) and on additional circumstances once that limit has expired.
Socioeconomic grounds	12 (6%)	Under broad circumstances such as age, economic status or others. Most also include rape, incest or foetal diagnosis.
Preserve health	47 (23%)	Under health or therapeutic grounds. Some of them only physical health, while others (20) include mental health
Save the pregnant person's life	44 (22%)	Only when the pregnant person´s life is at risk. Some of them (12) also include rape, incest or foetal diagnosis.
Prohibited on any grounds	21 (10%)	In some countries this includes criminalization under legal offenses.

Source: Adapted from Center for Reprodctuve Rights (2022)

are offences under the criminal code. With data updated in 2022, in 91 countries the penalties are between 0 and 5 years imprisonment, in 25 countries between 5 and 10 years and 10 countries between 10 years and life imprisonment (Ambast et al., 2023).

According to a recent review of studies, this criminalisation has a strong negative impact on women: delayed access to abortion care, unsafe abortion or increased risks of maternal mortality or morbidity, opportunity costs with discrimination for those who have fewer resources, including travelling, paying private care, emotional distress, poor quality postabortion care, undernalised and experienced stigma among others (De Londras et al., 2022). Moreover, epidemiological data indicate that women with limited resources, rural women, and those with lower educational attainment, as well as those seeking abortion due to rape or for health reasons, are less likely to have access to it (De Londras et al., 2022).

All these data provide ground for for a full decriminalisation of abortion (WHO & HRP, 2022).

Epidemiology of unsafe abortions

Roughly 121 million unintended pregnancies occurred each year between 2015 and 2019. Of these unintended pregnancies, 61% ended in abortion (Guttmacher Institute, 2022). Significantly, abortion rates are similar in countries where abortion is restricted and those where the procedure is broadly legal.

According to the WHO, between 4.7% and 13.2% of all maternal deaths are attributed to unsafe abortions (WHO & HRP, 2022). This equates to between 13,865 and 38,940 lives lost annually worldwide, besides many more women experiencing serious morbidities. Developing countries account for 97% of unsafe abortions. Moreover, the proportion of abortions that are unsafe is also significantly higher in countries with highly restrictive abortion laws than in those with less restrictive laws (WHO & HRP, 2022). Over half (53.8%) of all unsafe abortions occur in Asia, while another quarter (24.8%) occur in Africa. An estimated 7% of women aged 15-44 years are treated every year for complications of unsafe abortion (WHO & HRP, 2022).

Relationship between abortion and mental health

One of the most contentious issues in the debate surrounding the legal framework of abortion is the question of psychological suffering, both in the context of pregnancy interruption and its denial. Those who advocate for anti-abortion positions frequently assert that abortion results in enduring psychological trauma for women. Conversely, those who support the right to abortion, also base their arguments, among other considerations, on the psychological suffering and long-lasting consequences associated with the denial of abortion.

Several longitudinal studies and reviews have sought to examine the relationship between abortion (or the refusal of abortion) and mental health. The majority of these studies have been conducted in the United States, with a particular focus on the impact of regressive legal reforms in that country. A smaller number have been conducted in Central European and Scandinavian countries using cohort studies. As a result, the findings may not apply to the majority of countries globally, where the context and conditions for women entail many more psychosocial and socioeconomic vulnerabilities and ideological, cultural and religious constraints.

A summary of key findings from these studies, relevant here, are:

1. There is a lack of empirical evidence to support that terminating a pregnancy causes mental health problems in terms of affective disorders, anxiety disorders, or otherwise. In the United States, the majority of authors cite the Turnaway study. The study included 1,132 women recruited from 30 abortion facilities across the United States. Participants were divided into three groups: *Turnaways*: Women who were denied an abortion due to gestational limits; *Near-limits*: Women who received an abortion close to the facility's gestational limit; and *First-trimester*: Women who received an abortion in the first trimester. Participants were interviewed semi-annually from 2008 to 2016. The study concluded that (a) Abortion does not harm mental health**:** Women who received abortions did not experience worse mental health outcomes than those denied abortions. Both groups experienced a decline in emotional distress over time (b) Turnaways experienced initial increases in stress and anxiety**,** but these declined over the follow-up period (c) Women who were denied an abortion reported worse physical health over time, including more complications from childbirth and higher rates of chronic pain (d) Women denied abortions were more likely to experience economic hardship, including lower employment rates, higher poverty rates, and greater reliance on public assistance. (i.e. Their children also faced more developmental challenges and economic disadvantages. (f) Denial of abortion was linked to a greater likelihood of remaining in abusive relationships, particularly among women experiencing intimate partner violence. (g) Existing children of women denied abortions faced greater instability, including poorer maternal bonding and household stress (Biggs et al., 2017; Foster et al., 2018, 2022; Ogbu-Nwobodo et al., 2022). Other longitudinal studies in the US population have found similar results. (Rocca, 2013).

2. There are inconclusive results regarding the relationship between abortion and suicide rates when controlling for previous mental health indicators and socioeconomic variables, as shown by a large cohort study in a sample of nearly 50.000 women followed over five years in Denmark (Steinberg et al., 2019). Nevertheless, epidemiological data show there is an increase in suicidal ideation and attempts of suicide among women of reproductive age in the US States where there are restrictive laws or abortion is forbidden (Zandberg et al., 2023) and the absolute ban on abortion in Nicaragua lead to an increase in reproductive-age young women suicide deaths using organophosphate pesticides (Moloney, 2009). Furthermore, ecological data from 162 countries provide significant evidence that abortion laws reduce maternal mortality due to medical complications and suicide (Latt et al., 2019).
3. Children born from unwanted pregnancies. The Prague Study examined long-term outcomes of children born from unwanted pregnancies to mothers twice denied abortions in the early 1960s in Czechoslovakia. It tracked 220 children and matched controls over three decades to assess differences in psychosocial development, educational achievement, mental health, and family dynamics. In a series of studies, the authors showed that children born from unwanted pregnancies faced more socio-emotional challenges, poorer educational outcomes, and increased psychiatric care usage compared to peers from accepted pregnancies. Family instability and socioeconomic factors partly mediated these effects (David, 2011).

It is important to reiterate that all of these studies have been conducted with populations from the Global North. Such findings can obscure the reality of the most vulnerable individuals and contexts where human rights are denied, and discrimination is more prevalent. An intersectional approach is crucial when examining data related to mental health, emotional distress, and abortion.

Denying women and girls abortion services as ill-treatment? The position of international human rights bodies.

Based on the aforementioned studies and ethical and medical debates, a growing number of international health and human rights bodies, including the World Health Organisation, consider that abortion should be considered among unalienable women's rights, as an integral part of Sexual and Reproductive Rights. Table 2 summarizes their foundations in international law in chronological order.

Concurrent with the advancement of SRR is a parallel evolution demanding that abortion be decriminalized and that states guarantee access to safe and legal abortion.

***Table 2**: Legal foundations of sexual and reproductive rights.*

- Universal Declaration of Human Rights (UDHR) (1948). Articles 1 and 25.
- International Covenant on Economic, Social and Cultural Rights (ICESCR) (1966). Article 12: Right to the highest attainable standard of physical and mental health; Article 10: Protection and assistance for families, especially mothers before and after childbirth.
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (1979). Article 12: Access to healthcare services, including family planning. Article 16: Equal rights in matters of marriage and family, including decisions on the number and spacing of children.
- International Conference on Population and Development (ICPD) Programme of Action (1994). Recognizes reproductive rights as part of human rights. Stresses the right to decide freely on reproduction without discrimination, coercion, or violence.
- Beijing Declaration and Platform for Action (1995). Calls for the elimination of practices that violate women's reproductive rights.
- Convention on the Rights of Persons with Disabilities (2008): article 25 a) underscores the right of persons with disabilities to enjoy the same choices and services around sexual and reproductive health as other individuals.
- 2030 Agenda for Sustainable Development (2015). Sustainable Development Goals. Goal 5. Achieve Gender Equality and Empower All Women and Girls. Goal 5.6. Ensure Universal Access to Sexual and Reproductive Health and Rights (Indicators: Proportion of women aged 15-49 who make their own informed decisions regarding sexual relations, contraceptive use, and reproductive health care; Number of countries with laws and regulations guaranteeing access to sexual and reproductive health care).

***Table 3**. Denial of abortion as a violation of sexual, reproductive and health rights.*

Body	Reference document	Selected Wording
SRT – Health	A/76/172, para. 20, 40, 51	Sexual and reproductive health encompasses (...) safe abortion services and the availability of trained medical and professional personnel and skilled providers. (...). Safe and legal abortion is a necessary component of comprehensive health services (...). States should provide it, including access to post-exposure prevention, emergency contraception and safe abortion services
	A/66/254, 2011, para. 27	Criminal prohibition of abortion is a clear expression of State interference with a woman's sexual and reproductive health because it restricts a woman's control over her body, possibly subjecting her to unnecessary health risks. (...). States are obliged to ensure that women are not denied access to necessary post-abortion medical services, irrespective of the legality of the abortion undertaken.
	E/CN.4/2004/49, 2004, para. 30.	In all circumstances, women should have access to quality health care for the management of complications arising from abortion.
HRC	General Comment No. 28: CCPR/C/21/Rev.1/ Add.10, para 10.	States should ensure women do not have to undertake life-threatening clandestine abortions.
CAT	CAT/C/POL/CO/5-6, 2013, para. 23	The document highlights the State's responsibility to guarantee that women, particularly those who have been raped and who have chosen to terminate their pregnancies, have access to legal abortions in secure settings. It emphasises the necessity to prevent the exercise of conscientious objection from impeding individuals' access to the services to which they are legally entitled.
CESCR	General Comment No. 14, E/C.12/2000/4, 2000, para. 8, 14	The freedoms [protected under the right to health] include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference (...). Right to health includes a right to access health information including on SRH.
	General comment No. 22, E/C.12/GC/22, 2016, para. 5 Paras. 41, 18 and 45	States should repeal and refrain from enacting laws and policies that create barriers to access to SRH including biased counselling requirements and mandatory waiting periods for access to abortion. All individuals and groups have a right to evidence-based information on SRH including safe abortion and post-abortion care. States must guarantee physical and mental health care to victims of sexual and domestic violence, including safe abortion care.
CRPD and CEDAW	Guaranteeing sexual and reproductive health and rights for all women, in particular women with disabilities, 2018, para. 2	Access to safe and legal abortion, as well as related services and information, are essential aspects of women's reproductive health and a prerequisite for safeguarding their human rights to life, health, equality before the law and equal protection of the law, non-discrimination, information, privacy, bodily integrity and freedom from torture and ill-treatment.
CEDAW	General Recommendation No. 34: CEDAW/C/ GC/34, 2016, para. 39 a)	States should provide safe abortion and high-quality abortion care regardless of whether abortion is legal.
WGDAW	A/HRC/32/44, 2016, para. 107 c) and d)	States should allow women to terminate pregnancy on request during the first trimester or later in specific cases. States must provide women and girls with medical treatment for unsafe abortions.

Body	Reference document	Selected Wording
IACtHR.	Advisory Opinion OC-29/22 of May 30, 2022. Serie A No. 29, for 152.	The State has a reinforced obligation to ensure access, without discrimination, to good quality sexual and reproductive health for women deprived of liberty **(...)** "(iii) comprehensive and timely care for cases in which they have been victims of violence and rape, including access to prophylactic therapies, emergency contraception and psychosocial care (...)".
	Case I.V. v. Bolivia Judgment of November 30, 2016, para. 157. Case of Manuela et al. v. El Salvador. Judgment of November 2, 2021, para. 192	The right to sexual and reproductive health is part of the right to health. It is related to reproductive autonomy and freedom, in terms of the right to make autonomous decisions about their life plan, their body, and their sexual and reproductive health, free from all violence, coercion, and discrimination.

Over the past fifteen years, a body of jurisprudence from the committees, experts, and courts has reinforced the notion that when this right is not guaranteed and this results in significant distress for women, it can be considered a form of cruel, inhuman, or degrading treatment (see Table 3). Together these bodies establish, including prior information, the existence of qualified professionals and quality resources, emergency contraception and post-exposure prevention, adequate care, post-abortion care and the management of complications that may arise, in a prompt, diligent, non-discriminatory manner, free of coercion, reprisals or criminalisation, with respect for the autonomous decisions made by women.

Denial of abortion services as torture

But in some cases, the aforementioned treaty bodies and experts and international courts have explicitly linked abortion to the right to integrity and the eradication of torture and have determined that under certain circumstances the denial of the right to termination of pregnancy could constitute torture. Table 4 provides a summary of the principal cases in which the denial of abortion is deemed to constitute a breach of articles related to torture.

The number of cases is growing and includes almost all the competent bodies in the matter. The analysis of the body of law shows a wide range of reasons why the denial of the right to abortion could constitute a form of ill-treatment or torture.

- A form of **discriminatory torture** based on gender stereotypes, especially when it entails criminal prosecution that adds additional psychological suffering to the victim.
- **Punitive and discriminatory torture** linked to restrictive laws prohibiting abortion even in cases of incest, rape, foetal harm or risk to the life or health of the woman, reinforced when there are special conditions of vulnerability, such as age, disabilities, health status, being in detention, severe illness of the foetus or foetal death.
- Situations of **punitive or investigative torture** in cases where information or confessions are sought for criminal purposes from women seeking emergency medical care following illegal abortions.
- **Punitive torture** associated with anti-abortion laws that carry prison or jail sentences that stigmatise and criminalise women, disrupting their life plans.
- Institutional mistreatment of women causing **severe physical or psychological suffering** including access to abortion, violation of medical secrecy and confidentiality.
- **Severe suffering and ongoing re-traumatisation** of women associated with being forced to continue a pregnancy resulting from incest or rape, which is a daily reminder of the extreme violence suffered.
- **Physical and psychological suffering** associated with forcing the woman to resort to illegal abortions that carry a substantial risk to her life and health.

Taking together, we see the four elements of the definition of torture reflected in the above situations:

1. There is an **action** of the State either affirmative (i.e. criminalizing abortion) or as an omission (i.e. restricting access to abortion services)
2. **Severity of suffering**. The question arises as to what level of intensity is required for pain or suffering to be considered "severe"? This is a topic of debate in relation to any case of alleged ill-treatment or torture. Concerning abortion, there is some caselaw regarding extreme examples where suffering seems beyond discussion (i.e. pregnancy after incest or rape in a minor). However, in many other cases, there is a more

blurred threshold. Furthermore, there is not a clear answer from epidemiological and clinical studies on the physical and mental pain and suffering that may be endured by women who are prevented from legally terminating their pregnancies. The studies demonstrate that the legal coercion of a woman to carry an unwanted pregnancy to term can have markedly disparate effects on women's mental health. In some cases, the impact is less severe or transient. In other cases, however, it can result in significant distress, particularly in countries where there is a high level of stigma and discrimination. In some instances, this has even lead to suicide. The right to abortion should be contingent upon the respect of fundamental human rights, rather than contingent upon the potential for mental suffering. From the pespective of physical suffering, there is a clear link between legal restrictions on abortion and the safety of the procedure itself. Unsafe abortions are a very relevant factor when considering the severity of suffering, both in terms of mortality and morbidity (Sifris, 2014). When considering that the severity of mental or physical suffering could amount to ill-treatment and torture, we are assuming that *in most women* there is suffering, as we do not need to probe for all individuals that prolonged solitary confinement or continuous sleep deprivation are harmful and amount to CIDT. Sometimes the CAT or the HRC have considered that due to specific vulnerabilities and circumstances, the suffering of the woman could be considered *prima facie* due to the especially harmful circumstances under assessment.

3. **Intentionality**. The point of consideration here is whether the state seeks to intentionally inflict suffering on women when acting against the right to abortion. Most committees include here the *foreseeability* of pain and suffering within the concept of intention. When pain and suffering are a *likely and logical consequence of conduct*, the intentionality criteria would be met. The CAT and the HRC are especially prone to this line of interpretation.
4. **Purpose**. Since CEDAW's creation and positioning, gender *discrimination* has been the most frequently cited purpose related to the denial of abortion. The prohibition and criminalisation would be deeply rooted in a cross-cutting patriarchal culture in the international human rights realm (Meda & Hadi, 2017; Sifris, 2014). From this point of view, restrictions on abortion would be a consequence of a male-centric organisation of social institutions imposing the policing of women's bodies. These perspectives provide the rationale for legislation that restricts access to abortion, thereby further entrenching the subordination of women. Moreover, from an intersectional standpoint, this phenomenon must be considered alongside race-based and class-based discrimination, as women from disadvantaged socioeconomic backgrounds and those who identify as racial minorities are more likely to resort to unsafe abortion services. (Prandini & Erdman, 2022; Webster, 2016). As some authors have argued, the meaning of abortion legislation would most likely be very different if the capacity to bear children were vested in men, given the overwhelming majority of male legislators. (Sifris, 2014). As only women become pregnant, legislation restrictions on abortion are in itself discriminatory. Moreover, the legislation that punishes abortions never includes male responsibility: only women must bear the consequences of unwanted pregnancies. There are also other elements of discrimination considered by the different committees. For instance, women forced to bear a child are also forced in myriad ways, including to have less paid jobs, have less oportunities to study and, in general, less oportunities to pursue their life goals.

Furthermore, in the joint document by the CEDAW, SRT, SR on Health; SRT – Disabilities and SR-VAW, the authors go further to say that more generally, it can be considered that this discrimination satisfies both the purpose and intent elements. This same line has been followed by the CAT (table 3) which states that "[b]oth men and women and boys and girls may be subject to violations of the Convention on the basis of their actual or perceived non-conformity with socially determined gender roles[1]". (CAT/C/GC/2, para. 22).

The consideration of discrimination as the key element in the analysis of the denial of abortion as torture ties in with dignity and moral harm as the core element of the concept of torture. (Webster, 2016).

Weight of each of the elements of the definition in the Committee's decisions.

The various UN committees focus on different motivations as part of the teleological element (punitive, based on discrimination, in the case of CEDAW, the HRC and CAT, as well as some cases of interrogational or indagatory torture in the case of the CAT). However, it is the severity of the physical and psychological suffering caused by the restrictions that are, in most cases, the determining factor in understanding the right to integrity to have been violated, without specific vulnerability factors being required. In fact, they only appear in cases where the absolute prohibition forces women to decide cases of foetal malformations incompatible with life or in cases of rape.

1 CAT: General Comment No. 2: Implementation of article 2 by States Parties, CAT/C/GC/2, 24 January 2008, para. 22.

***Table 4**. Denial of rights to abortion as CIDT or Torture. Relevant caselaw.*

Body	Reference document	Key points
SRT	A/HRC/31/57, 2016, paras. 43-44	Highly restrictive abortion laws that prohibit abortions even in cases of incest, rape or foetal impairment or to safeguard the life or health of the woman violate women's right to be free from torture and ill-treatment. The practice of extracting, for prosecution purposes, confessions from women seeking emergency medical care as a result of illegal abortion in particular amounts to torture or ill-treatment
	A/HRC/22/53, 2013, paras. 46	Policies that inhibit reproductive rights, including the lack of sexual and reproductive health services for women, may rise to the level of CIDT.
	A/HRC/7/3, 2008, para. 36	There are forms of "torture" that can occur in conjunction with rape, among which it cites the denial of the right to abortion.
CEDAW	General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19, CEDAW/C/GC/35, 2017, para. 18	Violations of women's sexual and reproductive health and rights, such as forced sterilization, forced abortion, forced pregnancy, criminalization of abortion, denial or delay of safe abortion and/or post-abortion care, forced continuation of pregnancy, and abuse and mistreatment of women and girls seeking sexual and reproductive health information, goods and services, are forms of gender-based violence that, depending on the circumstances, may amount to torture or cruel, inhuman or degrading treatment.
CEDAW, SRT, SR on Health; SRT – Disabilities; SR-VAW	Denial of abortion services and the prohibition of torture and cruel, inhuman and degrading treatment	The denial of the right to abortion is regarded as a form of **discriminatory treatment** that may amount to torture or cruel, inhuman or degrading treatment**.** The prevailing stereotypes regarding the role of women as mothers receive greater consideration than their health. The suffering caused by the involuntary continuation of an unwanted pregnancy, the risks associated with clandestine abortions, and the stigma and even criminal prosecution associated with it in some societies can result in significant physical and psychological distress for victims in situations of particular vulnerability.
CAT	CAT/C/CR/32/5, 2004, para. 7 m)	The CAT has found **punitive or indagatory CIDT** in cases of denial or conditioning of access to post-abortion medical treatment after clandestine abortions.
	General Comment No. 2, 2008, CAT/C/GC/2, para. 22	The Committee recognized that discriminatory treatment satisfies the specific intent requirement for torture or CIDT when women are deprived of medical treatment, "particularly involving reproductive decisions."
	CAT/C/SLE/CO/1, 2014, para. 17 CAT/C/BOL/CO/2, 2013, para. 23 CAT/C/PRY/CO/4-6, 2011, para. 22 CAT/C/NER/CO/1, 2019, para. 27 CAT/C/PER/CO/6, 2023, paras. 15-16	In several resolutions related to cases from Sierra Leone, Bolivia, Paraguay and Niger, the Committee against Torture has determined that the lack of access to abortion in **cases of rape or incest** may constitute a violation of the Convention against Torture, given the potential for **continued re-traumatization** associated with rape. The Committee is concerned that these restrictions push women into undergoing illegal abortions that not only endanger their lives and health but also expose them to criminal penalties. The CAT evaluates the denial of access to emergency oral contraceptives to **rape victims** as a potential violation of the right to be free from torture.
	CAT/C/NIC/CO/1, 2009, para. 16 CAT/C/PER/CO/4, 2006, para. 23 CAT/C/CHL/CO/5, 2018	In Country reports on Nicaragua, Peru and Chile, the CAT states that **punitive abortion** laws should be reassessed since they may lead to violations of a woman's right to be free from inhuman and cruel treatment. The CAT also reminds the Peruvian government of the responsibility that medical personnel employed by the State.
	CAT/C/PER/CO/5-6, 2013, paras. 15 CAT/C/POL/CO/5-6, 2013, para. 23 CAT/C/SLE/CO/1, 2014, para. 17	In Country reports on Peru, Poland and Sierra Leone the CAT states that the promotion of reproductive rights is part of the State's affirmative obligation to prevent acts of torture and CIDT.
	CAT/C/POL/CO/7, 2019, para. 33	In a Country report on Polonia, the Committee highlights the legal and bureaucratic impediments that result in significant physical and mental suffering in instances where abortion is permitted, and which give rise to state accountability under the Convention against Torture.

Body	Reference document	Key points
HRC	General Comment Nº 28, 2000, para. 11	It is argued that forced abortion, forced sterilization, female genital mutilation, domestic violence against women, and the lack of access to safe abortion for women who have become pregnant as a result of rape can lead to violations of the right to freedom from torture or other ill-treatment.
	General Comment No. 36, 2019, para. 8	Restrictions on the ability of women or girls to have access to abortion must not, inter alia, endanger their lives or subject them to physical or mental pain or suffering in a manner that violates the right not to be subjected to torture of the International Covenant on Civil and Political Rights. States should provide safe, legal, and effective access to abortion when carrying a pregnancy to term would cause substantial pain or suffering, especially when the pregnancy is the result of rape.
	CCPR/CO/82/MAR, 2004, para. 29 CCPR/CO/79/LKA, 2003, para 12 K.L. v. Peru, CCPR/C/85/D/1153/2003, 2003, para. 6.4	In resolutions related to Morocco, Sri Lanka and Peru, the Committee states that the criminalisation of abortion may violate Article 7
	CCPR/C/IRL/CO/4, 2014, para. 9	The Committee states that the serious suffering caused by the denial of access to abortion to pregnant women due to rape or in cases of an unviable foetus due to an anomaly or serious health risks contravenes Article 7 of the ICCPR.
	L.M.R. v. Argentina, CCPR/C/101/D/1608/2007, 2007, para. 9.2	It considers the age and disability of the victim as vulnerability factors that increase the suffering of a rape victim who is denied access to abortion.
	K.L. v. Peru, CCPR/C/85/D/1153/2003, 2003, para. 6.3 and 6.5	It considers the mother's minority as a factor of vulnerability and the suffering generated by the denial of access to abortion due to serious illness of the foetus and states a violation of the right to be free from torture and other CIDT under Article 7 of the ICCPR. Furthermore, it is stated that the right safeguarded by Article 7 of the Covenant extends beyond physical pain to encompass moral suffering. This protection is of particular significance in the context of minors.
	Mellet v. Ireland, CCPR/C/116/D/2324/2013, 2016, paras. 7.4-7.6 ; 7.10,7-11 Whelan v. Ireland CCPR/C/119/D/2425/2014, 2017, paras. 7.4-7.7; 7-9, 7-11	Denial of abortion, health care and bereavement support, in cases where the foetus is diagnosed with a life-threatening condition, caused suffering of sufficient intensity to amount to torture. The Committee also considered the issue of discrimination in healthcare concerning women who choose to continue with pregnancies.
ECtHR	P. and S. v. Poland, App. No. 57375/08, Eur. Ct. H.R. paras. 76-77, 2012	The ECtHR condemned Poland for a violation of Art. 3 ECHR, related to ill-treatment and torture, by applying a series of dilatory measures on a minor pregnant after a rape to prevent her from exercising her right to an abortion. Also considered that "*the general stigma attached to abortion and sexual violence ..., caus*[ed] *much distress and suffering, both physically and mentally*".
	R.R. v. Poland, App. No. 27617/04, 2011, paras. 159-161	The ECtHR condemned Poland for a violation of Art. 3 ECHR by applying a series of dilatory measures in access to prenatal genetic testing when an ultrasound scan revealed a possible foetal abnormality.
IACHR	Case B v El Salvador. Provisional Measures. Resolution of the Inter-American Court of Human Rights of May 29, 2013, paras. 14 and 17	The failure to adopt the provisional measures requested (abortion) by a pregnant woman with a foetus with lesions incompatible with life is considered a violation of Articles 4 and 5 of the American Convention (right to life and moral integrity). The State is condemned on grounds of obstetric violence.
	Case of Valencia Campos et al. v. Bolivia. Judgment of October 18, 2022, para. 242.	The IACHR considers the denial of medical care to a detainee who has suffered an abortion to be a violation of Article 5 (right to integrity, but also to health, due to her special physical vulnerability).

However, in the case of the regional courts (mainly the ECtHR or the IACHR), attention is paid not only to the seriousness of the suffering but especially to the victim's conditions of vulnerability. Consequently, in regional Courts, determining whether the threshold for ill-treatment has been reached would necessitate, in most cases, a context-specific approach that considers individual characteristics and circumstances. By contrast, the tendency of the Joint Document and HRC is that the consideration of discrimination as amounting to torture would be met regardless of specific contextual factors, especially when there is the additional social or economic burden of belonging to a marginalised or disadvantaged group.

Conditions that are afforded particular consideration concerning severe suffering. Relevance to forensic assessment using the Istanbul Protocol.

The Istanbul Protocol does not mention in any of its sections the violation of the right to abortion nor does it illustrate or provide specific indications for its forensic assessment. The review of jurisprudence shows that there are seven groups of elements that contribute to the particular suffering of victims and that should consequently be considered in an Istanbul Protocol in a case linked to the right to abortion (Table 5).

In seeking accountability for violations that predominantly result in severe mental suffering, petitioners may encounter substantial obstacles in demonstrating the extent of their distress to the court. In contrast to physical injuries, mental harm may be overlooked by healthcare professionals, perceived as more subjective, and may be less visible. A lack of understanding of, or sensitization to, mental health and trauma may result in courts undervaluing such injuries.

There is no document, to our knowledge, that addresses redress for these types of ill-treatment. Alongside medical and psychological rehabilitation, it is essential to take into account reparation linked to family and community impact and harm linked to stigma and marginalisation. Courts should consider measures that address the whole of society and the communities to which they belong as well as measures to compensate for the moral and dignity damage suffered.

Furthermore, the State's responsibility is often engaged not only by the application of restrictive and discriminatory laws or policies, but also by actions by medical professionals who fail to meet ethical standards, by the failure to appropriately regulate private healthcare settings, or the failure to sanction violence by private individuals, such as a spouse or intimate partner, elements that require proper documentation. All these aspects can be considered in the framework of reparation measures.

Table 5*. Elements to explore in forensic assessment of the denial of the right to abortion as ill-treatment or torture using the Istanbul Protocol.*

1. Factors arising from previous conditions of vulnerability of the victim, i.e. prior to the pregnancy
2. Factors arising from the specifics of the pregnancy itself or from the physical condition of the woman or the foetus that place additional physical or psychological stress on the woman or foetus
3. Burden of lack of information to make a meaningful decision
4. Factors arising from conditions of vulnerability generated by public institutions after the abortion or the denial of abortion including economic burden and having to resort to non-trusted care providers
5. Conditions of State health care and possible negligent, discriminatory, abusive or humiliating treatment, including placing women in a position of powerlessness.
6. Factors arising from social or gender stereotypes and stigma linked to cultural, ideological or religious factors and especially those involving a component of psychological harm, in particular criminalisation, humiliation, shame or guilt.
7. Suffering linked to arrest and criminal investigations, including extracting confessions, deportation or loss of child custody.

Reflections on the future

The impact of self-managed abortion.

Historically, abortion was criminalized to protect women from unsafe procedures performed by unqualified individuals. However, the advent of medical abortion using drugs has enabled safer and less stigmatized options, particularly in early pregnancy stages[2]. Integrating these methods into primary healthcare can reduce discrimination and eliminate the risks associated with clandestine abortions (CHRHL, 2016). International networks promoting "autonomous abortion" now provide mutual support, emphasizing autonomy, solidarity, and compassion (Moloney, 2009). These networks challenge punitive abortion laws,

2 The usual combination is the use of Mifepristone, a progesterone receptor antagonist and Misoprostol a synthetic prostaglandin E1 analogue. Together have a high efficacy rate (95–98%) for terminating pregnancies up to 10 weeks. When used under proper guidance, the combination is considered safe and effective, with minimal risk of complications (World Health Organization, 2014). Available at https://iris.who.int/bitstream/handle/10665/97415/9789241548717_eng.pdf

advocating for health systems to adopt these safer methods rather than penalize past unsafe practices[3].

Revolutionary changes need time.

Sexual and reproductive rights are considered second-generation rights, linked to the International Covenant on Social, Economic, and Cultural Rights (1966). Since that time, there has been a growing body of legal foundations that support, strengthen, and further develop these rights reviewed here. Nevertheless, there is a significant disparity in the pace of implementation between countries and regional areas due to the religious and cultural diversity that presents a challenging context. The process is expected to continue evolving until a more unified approach is achieved. This indicates that international health organizations such as the WHO and the UN treaty bodies that advocate for non-compliance with these rights to be considered cruel, inhuman, or degrading treatment have a vision that, to some extent, may still be considered to be somewhat detached from the sociological and political reality of some of the signatory countries, particularly in certain regions of Latin America, Africa, and Asia, and now the US.

This can sometimes give rise to impassioned discussions. Ireland held a referendum in 2018, resulting in the legalization of abortion, influenced in part by the Human Rights Committee's decisions. After being urged to implement legal and policy changes, on December 30, 2020, Argentina's Senate passed a law legalizing abortion during the first 14 weeks of pregnancy. The law was passed following years of advocacy by feminist and human rights groups, including the "Green Wave" (Marea Verde) movement, which became a symbol of reproductive rights in Latin America. The combined action of women's activism, political initiatives and the concurring views of international bodies succeeded in pushing an agenda that, while not completely decriminalising abortion, opens the door to full recognition of women's rights.

Acknowledgements

Thanks to Nora Sveaass (Former SPT and CAT member and Expert on sexual and reproductive rights), Michele Heisler (Medical Director) and Payal Shah (Lead on Reproductive Justice programme) at Physicians for Human Rights-US, for their useful comments on earlier versions.

3 Efforts to criminalize these networks have been criticized by the Special Rapporteur on the Situation of Human Rights Defenders. (Prandini & Erdman, 2022)

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Torture, 2024, 34(3), 15-40
https://doi.org/10.7146/torture.v34i3.143968 *Review*

Children who survive torture: A systematic review of screening, documentation and treatment of torture injuries in children

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Key points of interest

- Screening methods to identify child survivors of torture need to be developed.
- Both individual- and group-based treatment and both normal and more intensified treatment can reduce symptoms of PTSD, but the evidence is limited.
- TF-CBT and NET can reduce PTSD by up to one year after treatment in child survivors of torture, although the result should be interpreted with caution.

Abstract

Background: Children all over the world are subjected to torture, but few are identified as victims of these actions. Knowledge that facilitates identification, documentation, and treatment of torture injuries in children can allow redress and rehabilitation for more children in need. *Objective*: To synthesise research regarding screening, documentation, and treatment of child survivors of torture. *Methods*: A systematic literature review was conducted. A total of 4795 titles and/or abstracts were screened, of which 80 articles were included. Grey literature was also included. *Results*: Screening for torture exposure usually consisted of questions that were included in trauma questionnaires. Questions about perpetrators in the traumatic events were missing from more than half of the studies. Although children were screened mainly for psychological injuries, it was primarily physical injuries that were documented. The evidence on treatment effects was limited. However, there was a tendency that Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Narrative Exposure Therapy (NET) significantly reduced PTSD up to three months to one year after the end of treatment. Treatments with individual and group-based formats, as well as those with normal and more intensified approaches, were found to have an effect on PTSD.

Keywords: Child, Documentation, Rehabilitation, Screening, Torture

Introduction

Torture of children has a long history, dating back to ancient Greece (Evans, 2020). Historical findings include the systematic abuse of Indigenous children during the colonial era and violence in educational institutions (Durrant, 2022). During World War II, children were subjected to fatal medical experiments (Weindling et al., 2016), and military dictatorships, war, and genocide have also involved child torture (Quiroga, 2009). Torture of children occurs in both times of war and peace and both high-income and low-income countries (Marc, 2016; Quiroga, 2009). At present, refugee children are abused by border police (Burgund Isakov et al., 2022) and forcibly separated from their families and detained (Oberg et al., 2021). Homeless children are subjected to violence and killed by the police (Quiro-

ga, 2009). Forced recruitment of child soldiers has tripled since 1900 (Kamøy et al., 2021), and very violent interrogation methods in the judicial system affecting children are reported worldwide (Mèndez, 2015; The World Organisation Against Torture (OMCT), 2021; UNICEF, 2015). Torture of children appears to be increasing according to the United Nations (UN) (United Nations Voluntary Fund for Victims of Torture, 2016), yet the issue is conspicuous by its absence in both research and socio-political debate (den Otter et al., 2013; Pérez-Sales, 2019). Children who survive torture often must live with the physical and mental health consequences of violence without being identified as victims of torture and offered treatment. Leading experts in the field have, therefore, pointed to an urgent need for research and a knowledge base that facilitates the identification, documentation, and treatment of children who survive torture (den Otter et al., 2013; Pérez-Sales, 2019). A step in this direction took place in 2022, when the UN Guidelines on the documentation of torture, the Istanbul Protocol (IP), were updated to include sections on children (UN Office of the High Commissioner for Human Rights (OHCHR), 2022). The current review has adopted the UN definition of torture in the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) (UN General Assembly, 1984, Article 1).

Torture is not a limited act or method. Instead, torture can be understood as a situation in a specific context that is more or less protracted. The situation usually involves combined physical and psychological actions that often cause traumatisation (Patel et al., 2016; Steel et al., 2009) and other severe physical and mental consequences for the victim (Reyes, 2007). A person who is subjected to torture is often put in a state of helplessness and powerlessness, something that is reinforced by the fact that the perpetrator represents the public, which is one of the criteria in the UN's definition of torture (Marc, 2016; Quiroga, 2009). Children exposed to torture are at particularly severe risk of injury as the human organs, not least the brain, are most sensitive to external influences at the beginning of their development (Bosquet Enlow et al., 2012). Children have a lower pain threshold than adults (Quiroga, 2009) and have a limited capacity to endure their stress reactions without the support of adults who confirm, comfort, and convey security (Marc, 2016). Although the long-term consequences after torture vary among torture victims, research has shown an association between adverse childhood experiences and morbidity and mortality later in life (Felitti et al., 1998; Petruccelli et al., 2019).

The distinction between physical and psychological injuries, which sometimes appears in the literature on torture, can be considered somewhat simplistic as there are often several psychological, physical, and social processes in interaction with each other that affect how the injuries are manifested and sustained (Reyes, 2007). The manifestations of torture injuries also change over time, and many, not least children, heal and recover from their physical injuries, which makes it difficult to detect them in the event of delayed documentation. The psychological injuries from torture, on the other hand, are often more challenging to heal and usually persist long after the bodily injuries have healed (Pérez-Sales, 2019; Quiroga, 2009). Documented torture injuries in children include neurological damage, pain, scarring, damage to nerves and blood vessels, visual and hearing impairments, dental injuries, post-traumatic stress, depression, sleep problems, difficulty concentrating, emotional dysregulation, separation anxiety, and regressive symptoms such as bedwetting (Alayarian, 2009; Quiroga, 2009).

By its very nature, the interventions offered within the framework of torture rehabilitation will vary depending on what needs to be treated. Due to the limited availability of knowledge about torture rehabilitation for children, the following are instead some standard components of torture rehabilitation for adults: social support, pain rehabilitation, and psychological trauma treatment (Sjölund et al., 2009). Torture rehabilitation has long been a neglected area in research, especially for children who have survived torture. Increased knowledge that facilitates the identification, documentation, and treatment of torture injuries in children is an essential step towards redress for all children who have been subjected to torture and an equally important step in preventing further children from being subjected to torture.

The objective of this review is to synthesise research regarding screening, documentation, and treatment of child survivors of torture with the overall aim of collecting, developing, and spreading knowledge that facilitates the identification and treatment of torture injuries in children.

The specific research questions were:

1. How are child survivors of torture identified and screened? What screening instruments are used for child survivors of torture?
2. How are torture injuries documented in children?
3. What interventions are available for child survivors of torture, and what effect do they have?

Method

The review aligns with the PRISMA protocol (Page et al., 2021).

Eligibility criteria

Inclusion criteria: Original articles written in English, Swedish, Norwegian or Danish. No time limit. Children <18 years of age who have been subjected to torture, according to the definition of the Convention Against Torture, would constitute all or part of the sample in the studies. Grey literature in the form of reports and care guidelines was also included.

Exclusion criteria: Review articles and literature that deal only with adults, studies that lack the necessary basis for assessing torture, such as information about whether the act has been deliberate, what purpose it has had, and whether the state in question has seriously failed in its efforts to prevent and protect the children. Thus, studies dealing with trafficking and domestic violence, such as intrafamilial child torture, have been excluded. Since the updated Istanbul protocol was the starting point for the study, the protocol has not been included in our results.

Search strategy

Scientific articles were searched in PubMed, Cinahl, PsychInfo, Cochrane Library and AMED. A complete account of the search strategy is available upon request from the first author.

Reports and care guidelines were searched in the resource database Mental Health and Human Rights Info (HHRI) using the keywords "torture" and "children." The search was limited to "manual and guidelines." Experts in the field were also consulted for relevant literature. The literature search was performed in November and December 2022.

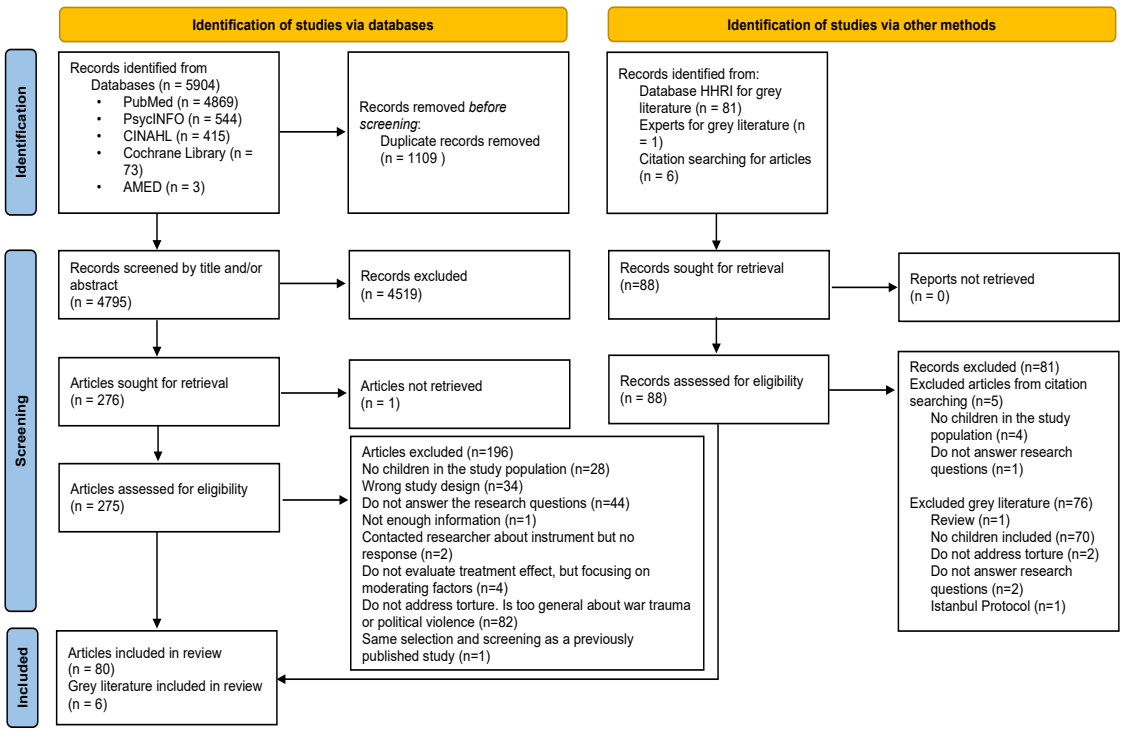
Screening and study selection

All hits in the scientific databases were imported into Covidence, a web-based tool for systematic reviews. Both authors performed all steps of the screening process blind to each other. Any conflicts were resolved by reaching a consensus after a discussion. A total of 80 scientific articles and six reports/guidelines were included. Figure 1 shows the flow of the screening process.

Data extraction and data analysis

Two of the 80 included scientific articles were categorised as guidelines. Of the remaining 78 scientific articles, 56 were classified as screening, 14 as documentation and 13 as treatment. Five articles were categorised under both screening and treatment. Data were then extracted into matrixes. Even though some

***Figure 1**. PRISMA flow diagram of the screening process.*



studies had mixed populations of children and adults, the method for screening and documentation was the same in most studies; therefore, the data extracted reflects the method used for the children. For the treatment studies, a comparative analysis of the effect was made between the type of treatment given, the intervention format and the intensity of the intervention, where normal intensity was compared with a more intensified treatment. These comparisons were made as they were considered interesting from a clinical perspective.

Risk of bias

The treatment studies were assessed for risk of bias with either A revised tool to assess risk of bias in randomised trials (RoB2-tool) (Sterne et al., 2019) for the RCT-studies or Risk Of Bias In Non-randomized Studies-of Interventions (ROBINS-I) (Sterne et al., 2016). All RCT-studies were assessed to have some concerns about the risk of bias. In the non-randomized studies of intervention (NRSI), four were evaluated to have a serious risk of bias and one critical risk of bias (see Supplementary material 1).

Results

Characteristics of included studies

Table 1 displays the characteristics of the included studies. The children in the study samples were usually made up of children who had fled, children in war and conflict zones, and former child soldiers. Some of the research participants had been exposed to torture, but not all. The age range was broad in the samples, with some studies only including children and others mixing children with young adults or adults.

Screening for torture exposure

Details on the 56 screening studies are displayed in an article matrix in Supplementary Material 2. The method for screening for exposure to torture was either through specific instruments (66 percent) or with interviews that were not based on a screening instrument (30 percent). Questions about the perpetrator occurred in 41 percent (n=23) of the studies, of which 16 studies were based on screening instruments and 7 studies were based on interviews.

From the above it was possible to extract 18 screening instruments (See Table 2). Twelve of the instruments used in the studies ask questions about the perpetrator or provide other information about the context in which the violence took place that could be considered sufficient to suspect torture, for example, former child soldiers. In some instruments, the term torture is used in the questions without the term being explained, and in other instruments, questions about specific torture methods are asked.

Screening for torture injuries

Most screening studies (n=50) screened for psychological and/or psychosocial symptoms. Symptoms of PTSD (n=40) were most common, followed by depression and anxiety (n=19), behavioural problems (n=11), and general mental and cognitive symptoms (n=7).

Only 12 (21.4%) of the studies screened for physical injuries. Most (n=10) had performed the screening through medical examinations such as X-rays, medical examinations of the genitals and rectum, and tests for, e.g., Hepatitis B and C. Two studies had questionnaires for somatic symptoms, and one study also used an instrument which mainly assesses children's physiological development in areas such as gross and fine motor skills, vision and hearing. (See supplementary material 2)

Documentation of torture injuries

Details on the 14 documentation studies (Allodi & Cowgill, 1982; Amone P'Olak, 2009; Clément et al., 2017; Guy, 2009; Haar et al., 2019; Keten et al., 2013; Lykke & Timilsena, 2002; Mateen et al., 2012; Olsen et al., 2006; Petersen, Larsen, et al., 1998; Petersen & Wandall, 1995; Ruchman et al., 2020; Russo et al., 2020; Tsai et al., 2012) are displayed in an article matrix in Supplementary material 3.

Torture survivors were identified in refugee camps (n=2), through patient record reviews (n=2), through rehabilitation centres (n=3), via a lawyer in the asylum process (n=1) and via grassroots organisation (n=1). In five studies, it was unclear how the identification took place. Examination of patient records consisted of forensic patient investigations and patient databases containing health data and diagnoses. Furthermore, a study that identified torture survivors through a rehabilitation centre reviewed documentation from the centre. Mixed professions carried out the documentation, whereas, in some studies, there was a team with different professions. The following professions carried out the documentation: Psychologist (n=1), Physician (n=8 of which one psychiatrist), Lawyer (n=1), and Social worker (n=1). In six studies, it was unclear who carried out the documentation.

In three of the studies, only the children were interviewed; in two other studies, children were interviewed with a parent. In one study, younger children were interviewed together with a parent and older children were interviewed without a parent if they were considered old enough to answer the questions themselves. However, in most studies, it is unclear who was interviewed (n=9).

***Table 1**. Characteristics of included studies for screening, documentation and treatment (n=78). N denotes the number of studies. Four studies were conducted in more than one country.*

Where the study was conducted

- Africa: n=31 (Algeria:1, Burundi:1, Ethiopia:1, Nigeria:1, Rwanda:2, Sierra Leone:3, Sudan:2, The Democratic Republic of Congo:7, Uganda:13)
- Australia & New Zealand: n=3 (Australia: 2, New Zealand:1)
- Europe: n=17 (Albania &Macedonia:1, Bosnia:1, Denmark:3, France:1, Germany:2, Italy:2, Norway:1, Sweden:3, Turkey:1, United Kingdom:3)
- Middle East: n=10 (Iraq:2, Jordan:1, Lebanon:1, the occupied Palestinian territory:6)
- North America: n=9 (Canada:1, USA:8)
- South America: n=1 (Peru)
- Southeast Asia: n=14 (Bangladesh:1, Cambodia:1, East Timor:1, Indonesia:1, Kashmir:1, Nepal: 6, Sri Lanka:1, Thailand:2)

Study population

- Children/adults
    - Only children: n=36
    - Only children and young adults, 0–25 years: n=11
    - Both children and adults: n=27
    - Retrospective screening studies where the sample was children at the time of the torture: n=4
- Studies that included children ≤ 7 years: n=25* (screening: 17, documentation:2, treatment: 2)
- Context
    - Refugee
        - Children that have escaped to the Western world (Europe/USA/Australia): n=22
        - Children that have escaped to non-western parts of the world: n=10
        - Children in immigration detention in the Western world: n=5
    - War and conflict
        - Children in war- and conflict zones: n=21
        - Abducted children/forcibly recruited as child soldiers: n=15
        - Children in war- and conflict zones who have been exposed to sexual violence: n=2
        - Children who survived genocide: n=2
    - Homeless children: n=1
- Studies where the whole study sample consisted of only torture survivors: n=5
- Studies conducted in another country than the potential torture occurred: n=30

*One study was categorised as both a screening and treatment study.

In six of the documentation studies, it appears that a psychological assessment has been carried out, while in all studies, there has been documentation of physical injuries. Eight studies state that they have followed a protocol in the documentation of torture where most followed the Istanbul Protocol (n=7). Of the studies that followed IP, three had followed all three parts of the protocol, psychological, psychosocial and physical, and four had only conducted the physical assessment.

Treatments for child survivors of torture

All included treatment studies had a psychological intervention. Even though broad searches were carried out, no somatic treatment studies were found. Details about the treatment studies and their effects can be found in the article matrix, Annex 1. The studies included children exclusively (=8) or mixed children with young adults (n=5).

The design of the treatment studies consisted of eight RCTs and five NRSIs. In two studies, the intervention consisted of contextually adapted TF-CBT (McMullen et al., 2013; O'Callaghan et al., 2013) and in four studies, treatment consisted of narrative exposure therapy (NET) (Ertl et al., 2011; Onyut et al., 2005; Ruf et al., 2010; Schaal et al., 2009) two of which had the child-friendly version KIDNET (Onyut et al., 2005; Ruf et al., 2010). Two studies included treatment consisting of more

Table 2. *Screening instruments, which include questions about torture*

Instrument (studies that used the instrument)	Questions about torture	Questions about the perpetrator
Adolescent Complex Emergency Exposure Scale (Mels et al., 2009)	No question specifically concerns torture, but questions are included about, e.g. being recruited into an armed force, forced to kill, injure or rape. The instrument is specially designed for war-affected youth in the specific region of the Democratic Republic of Congo.	Not specified
Child Psychosocial Distress Screener (CPDS) (Jordans et al., 2009)	Ask, among other things, if the child has experienced shocking events. Exploratory questions: e.g. witnessed the murder of family members. The questionnaire contains different parts, partly about experienced events but also about perceived psychosocial stress. Questions are addressed to both the child and teachers at school.	Not specified
Child Soldiers Trauma Questionnaire (CSTQ) (Klasen et al., 2009)	It has two subscales: 13 questions in a victim subscale (abduction; exposure to: shooting, bomb explosion, massacre, air raid; deprivation: food, water; witnessed: injury, murder; victim: death threat, beatings, injury, rape) and 6 questions in a perpetrator subscale if the child was the perpetrator (fighting, looting, abduction, torture, injury, killing).	No. The context is former child soldiers.
Child War Trauma Questionnaire (adapted version) (Betancourt et al., 2011)	The questions are categorised to: -Witness violence (13 questions), - Revolutionary United Front (RUF)-related abuse and violence/injury (12 questions), -as well as single questions concerning killed others, survivors of violence and sexual abuse, death of mother or father. Several questions could be classified as questions about torture and other questions not. The original was made for the target group of war-affected Lebanese youth. This version has been adapted for a context in Sierra Leone.	Yes
Detention Experience Checklist (Steel et al., 2004)	Some incidents could be classified as torture in the case of children, such as witnessing physical assault, being physically assaulted by an official, insufficient water in hot weather, separation from family, being held in solitary confinement, denial of access to basic items. It was designed for the study based on reports from current and former detainees of common experiences in detention.	Yes
Gaza Traumatic Exposure Checklist (Asia 2010)	Questions concern exposure to, for example, beating and humiliation, deprivation of water, food, toilet visits, and witnessing the murder of a family member, among other things, to threaten. The majority of the questions concern general traumatic war events.	Yes
Gaza Traumatic Event Checklist (Massad et al., 2017; Thabet et al., 1999; Thabet et al., 2000)	Questions include whether you have witnessed the beating of a family member or if you yourself have been beaten by the army. Can be completed by children 6-16 years old. Also available in revised version.	Yes
Harvard-Uppsala Trauma Questionnaire for Children (HUTQ-C) (Sundelin-Wahlsten et al., 2001; Taib et al., 2019)	Includes one question that asks specifically about torture. There are other items that could be classified under torture such as brainwashing, forced isolation, forced separation from parents. Age is filled in when the incident occurred and if the trauma was repeated. Adapted version of the Harvard trauma questionnaire that includes extra questions for children.	No
Harvard Trauma Questionnaire (HTQ) Geltman et al., 2005; Möhlen et al., 2005)	The instrument consists of two parts. One part with a list of traumatic events and one part with symptoms of PTSD. The part that lists traumatic events has an event specifically for torture. There are also events such as deprivation of food and water, brainwashing, forced isolation.	No

HURIDOCS standard formats: a tool for documenting human rights violations. (Chu et al., 2013)	Is not a specific instrument but functions as a coding system that includes over 70 acts or situations under the category of torture.	Yes, and defines what is considered to be a perpetrator.
Persecution in the Child (Hjern et al., 1998)	There are direct questions about torture, e.g. whether the child has witnessed the parent being tortured. Or if the child has been physically abused by a uniformed or non-uniformed person from the state. There are other issues, but they do not concern torture.	Yes
PTSD Traumatic Event Checklist of the Kiddie Schedule of Affective Disorders and Schizophrenia (Kohrt et al., 2010; Kohrt et al., 2008)	The instrument contains questions about traumatic events, partly "general" ones such as car accidents, natural disasters, and domestic violence. Questions have been added, one of which relates specifically to torture. The instrument has been adapted to the context.	No. The context is former child soldiers in the adapted version.
Trauma History Profile (THP) (Betancourt et al., 2012)	Have questions like "Extreme interpersonal violence", Physical maltreatment/ abuse, Emotional abuse/psychological maltreatment, Sexual maltreatment abuse. Uses the term maltreatment and not torture. Several of the questions do not concern torture but concern general war events, as well as violence in schools and natural disasters. The interviewer asked supplementary questions such as whether the child was a direct victim or witness to the incident.	Not specified
Trauma Questionnaire (Tremblay et al., 2009)	Developed for the study from Harvard Trauma Questionnaire. History of the trauma. Exposure to the worst traumatic event (which may include torture), including place and date.	Not specified
Violence, War and Abduction Exposure Scale (Ertl et al., 2011)	Some items could be related to torture, others not. Developed specifically for use in northern Uganda.	Yes
War Experiences Checklist (WEC) (Amone-P'Olak 2006; McMullen et al., 2013; McMullen et al., 2012)	The questions are divided into eight themes: 1. Separation from parents/relatives 2. Exposed to and role in combat 3. Deprivation and other hardships 4. Participation in rituals during captivity 5. Injured and victims of violence and intimidation 6. Witnessed beatings, mutilations, abductions, killings and village raids 8. Laid landmines and staged ambushes 9. Sexual abuse The instrument was available in different versions with different numbers of questions and adapted questions.	No. The context is partly former child soldiers.
War Trauma Experience Checklist (WTEC) (Ovuga et al, 2008)	On the 15-item WTEC there is one question about whether you yourself have been tortured, one question about whether you have witnessed someone else being tortured and one question about whether you have been forced to torture someone.	No. The context is former child soldiers.
Wartime Violence Checklist (Neugebauer et al., 2009)	No question uses specifically the term torture. The questions are divided into 6 categories. 1) Bereavement, 2) Witnessing violence against people, 3) Witnessing violence against property, 4) Direct victimization, 5) Witnessing rape/sexual mutilation, 6) Hiding under dead bodies. Adapted version to Rwandan context.	No. The context is the genocide in Rwanda.

established and comprehensive mental health programs under the auspices of Médecins Sans Frontières (MSF) (Lokuge et al., 2013; Martínez Torre et al., 2022), of which one study consisted partly of trauma-focused therapy (Lokuge et al., 2013) and the other of a Mental Health and Psychosocial Support (MHPSS) program with psychological interventions such as psychoeducation and psychological first aid (Martínez Torre et al., 2022). Five studies had interventions with varying trauma-focused elements (Betancourt et al., 2014; Durà-Vilà et al., 2013; Gupta & Zimmer, 2008; Layne et al., 2008; O'Callaghan et al., 2014) in which two contained exposures (Gupta & Zimmer, 2008; Layne et al., 2008).

The intervention format was either individual (n=7) or in groups (n=6), and some group interventions were classroom-based. The intensity of the interventions was grouped into either normal or a more intensified treatment, where our definition of more intensified is based on a comparison with the standard approach for TF-CBT, which is once a week for 90 minutes. Anything beyond that, both the number of sessions and the minutes were counted as an intensification of the standard setup. Four treatments were of normal intensity, and four were more intensified. In five studies, there was not enough information to make an assessment.

There was a variation in the follow-up time where 8 studies had a short-term follow-up of up to 4 months, and 5 studies had a longer follow-up time between 6-12 months. The most common outcome measure was PTSD, followed by depression, anxiety, behavioural problems, prosocial behaviour and functional impairment.

Effects of the interventions

The result from different types of interventions is presented for the most frequent measured outcome measures, PTSD, depression and anxiety, behavioural problems, prosocial behaviour and functional impairment. For comparison between format and intensity, the result presents the effect for PTSD solely. Effect size is given if it has been reported in the study. Figure 2 displays the effect on symptoms of PTSD for the different categories.

Effect from different types of treatments: PTSD: TF-CBT significantly reduced symptoms of PTSD after treatment compared to the control group with a large effect size (η_p^2 .518-.665). After three months, there was a sustained significant reduction in PTSD symptoms compared to before the start of treatment when analysis was performed within the intervention group (McMullen et al., 2013; O'Callaghan et al., 2013). NET was also shown to significantly reduce PTSD symptoms compared to the control group over a 6–12-month period with a moderate to large effect size (Cohen's d 0.72, Hedge's g 1.9, η^2 0.26) (Ertl et al., 2011; Ruf et al., 2010; Schaal et al., 2009) or over nine months when a within-group analysis was performed for the intervention group (Onyut et al., 2005). Interventions with varying trauma-focused elements showed mixed results, where one out of three RCTs found the treatment to significantly reduce PTSD symptoms compared to the control group after the end of treatment with a moderate effect size (Cohen's d 0.40). The effect was sustained within the treatment group after three months with a small effect size (η_p^2 0.04) (O'Callaghan et al., 2014). Of the two interventions that had no statistically significant difference between the groups (Betancourt et al., 2014; Layne et al., 2008), a within-group analysis showed a significant reduction in both the intervention group and the active control group for one of these studies (Layne et al., 2008). One NRSI-study found a significant reduction within the treatment group after 4-6 weeks (Gupta & Zimmer, 2008).

Depression and anxiety: Symptoms of depression and anxiety were significantly reduced after TF-CBT in both studies after the end of treatment compared to the control group with a large effect size (η_p^2 0.517- .567) (McMullen et al., 2013; O'Callaghan et al., 2013). No comparative long-term follow-up was performed, but a within-group analysis after three months showed a sustained significant reduction in PTSD symptoms in the TF-CBT group (McMullen et al., 2013; O'Callaghan et al., 2013). Different outcomes were found after NET, where a significant reduction in depression after six months compared to the control group with a large effect size (η2 0.26) was seen (Schaal et al., 2009) and where there was no significant difference between the groups (Ertl et al., 2011). Interventions with varying trauma-focused elements could not demonstrate any reduction in depression compared to the control group (Layne et al., 2008; O'Callaghan et al., 2014). However, a within-group analysis for one intervention group found a significant reduction in symptoms of anxiety and depression after three months with a large effect size (η_p^2=.32) in one study (O'Callaghan et al., 2014).

Behavioural problems: In one study, behaviour problems were significantly reduced after TF-CBT compared to the control group with a large effect size (ηp2 0.259). After three months, a significant reduction in behavioural problems was seen in the TF-CBT group, but no comparative analysis with the control group was performed (O'Callaghan et al., 2013). Among the studies with interventions with varying trauma-focused elements, there was no significant difference in behavioural problems compared to the control group (O'Callaghan et al., 2014). However, within-group analyses in the treatment

group showed a significant reduction in behavioural problems after the end of treatment (Durà-Vilà et al., 2013) and after three months with a large effect size (η_p^2=.13) (O'Callaghan et al., 2014). None of the studies with NET as a treatment had behavioural problems as an outcome measure.

Prosocial behaviour: Prosocial behaviour increased significantly after completion of TF-CBT compared to a control group with a moderate effect size (η_p^2 0.099) in one study. No comparative analysis between the groups was performed at the three-month follow-up, but analysis within the TF-CBT group showed a significant improvement in prosocial behaviour after three months (O'Callaghan et al., 2013). For interventions with varying trauma-focused elements, both significant improvements in prosocial behaviour with a moderate effect size (Cohen's d 0.39) were seen (Betancourt et al., 2014) and no significant difference compared to the control group (O'Callaghan et al., 2014). The positive improvement was seen after the end of treatment but did not persist after six months (Betancourt et al., 2014). A within-group analysis showed positive improvement after three months for the intervention group with a moderate effect size (η_p^2=.08) (O'Callaghan et al., 2014). None of the studies with NET as a treatment had prosocial behaviour as an outcome measure.

Functional impairment: The level of function increased significantly in two studies with NET as an intervention compared to the control group over a 6–12-month period after the end of treatment with a large effect size (Cohen's d 0.83, Hedge's *g* 1.7) (Ertl et al., 2011; Ruf et al., 2010). In one study with intervention with varying trauma-focused elements, the level of function also increased significantly after the end of treatment compared to the control group with a moderate effect size (Cohen's d 0.32). However, after six months, there was no difference between the groups (Betancourt et al., 2014). None of the studies with TF-CBT as a treatment had functional impairment as an outcome measure.

Effects of normal or a more intensified treatment: PTSD: Among the interventions that were given more intensively, all RCT-studies had significantly reduced PTSD symptoms compared to control with a moderate to large effect size (Cohen's d 0.40 - 0.72, η^2 0.26) (Ertl et al., 2011; O'Callaghan et al., 2014; Schaal et al., 2009) and in one study when performing a within-group analysis (Gupta & Zimmer, 2008). A significant reduction in PTSD symptoms was seen in one out of three RCT-studies for interventions given at normal intensity compared to the control group with a large effect size (Hedge's *g* 1.9) (Ruf et al., 2010) or in two studies within the treatment group (Layne et al., 2008; Onyut et al., 2005).

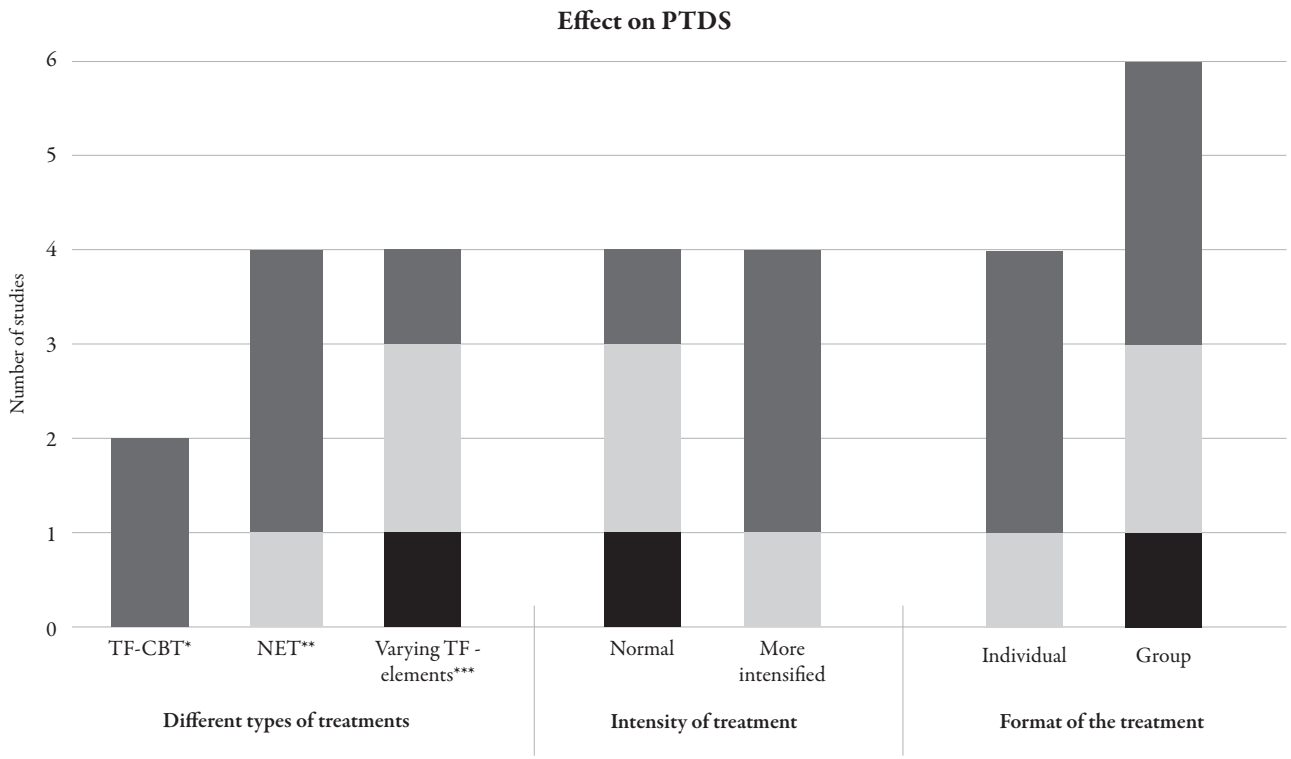
Effects of individual and group-based treatment: PTSD: Among the interventions given individually, a significant reduction in symptoms of PTSD was seen in all RCTs compared to the control group with a moderate to large effect size (Cohen's d=0.72, Hedge's *g* 1.9, η^2 0.26) (Ertl et al., 2011; Ruf et al., 2010; Schaal et al., 2009) or when comparing within the intervention group before and nine months after the end of treatment (Onyut et al., 2005). For the interventions given in groups, a significant reduction in PTSD symptoms compared to the control group was shown in three studies with a moderate to large effect size (Cohen's d 0.40, η_p^2 0.518 and .665) (McMullen et al., 2013; O'Callaghan et al., 2014; O'Callaghan et al., 2013) while two studies showed no difference between control and intervention group (Betancourt et al., 2014; Layne et al., 2008). Within-group analysis in the intervention group showed a significant reduction in PTSD symptoms in two group-based studies (Gupta & Zimmer, 2008; Layne et al., 2008).

Guidelines, reports, and health care program

The included guidelines, reports and health care program contained sections devoted to children. The health care program, which is a Swedish regional one, gives an example of how to pose a question to children about potential exposure to torture (Region Skåne, 2022). Furthermore, the care program mentions two screening instruments to support identifying whether the child has been subjected to torture: Child and Adolescent Trauma Screen CATS (Sachser et al., 2017) and Linköping Youth Lifetime Event Scale LYLES (Nilsson et al., 2010). However, these instruments are not specific to exposure to torture. The program describes how a medical certificate for *suspicion* of torture should be designed. The medical certificate then forms the basis for whether an investigation of torture will be carried out according to IP. The program also brings up referral procedures, for example, in cases of chronic pain and mental illness in children (Region Skåne, 2022).

Several guidelines included sections on children with a focus on conducting interviews with children who have, among other things, been subjected to torture (UNHCR, 2010; Peel et al., 2005; Tepina & Giffard, 2015; Thakkar et al., 2015; UNHCR, 2003) or specifically sexual torture (Volpellier, 2009). Some common points that were highlighted in these guidelines were the importance of obtaining consent from the child and custodian and deciding about the custodian's presence in each individual case, that documentation is carried out by staff with pediatric competence, and to adapt the environment and framework of the interview to the child's needs and level of development. Concerning rehabilitation after torture, one field manual, DIGNITY, contains child-specific information with descriptions of how several physical and psychological torture

Figure 2. *Treatment effect on symptoms of PTSD*



*Trauma focused cognitive behavioural therapy, **Narrative exposure therapy, ***Interventions with varying trauma focused elements

injuries manifest themselves in children as well as guidance in the assessment and rehabilitation of torture injuries in children (DIGNITY, 2013).

Discussion

The aim of the present study was to synthesise research and grey literature regarding screening, documentation and treatment of torture injuries for child survivors of torture.

The instruments intended to identify and screen for potentially traumatic events, including torture, generally lacked questions that provided sufficient evidence to identify torture victims. There was a lack of questions about who the actors behind the traumatic life events had been. This makes it challenging to identify state interference, which is a key criterion for torture as defined in the Convention Against Torture (UN General Assembly, 1984). Furthermore, in some instruments, the term torture is used in the questions without explaining the term. There may be a risk of underreporting in cases where children (and adults) do not understand that the actions were torture and a risk of overreporting in cases where other incidents are equated with torture. Generic screening for the identification of torture of children needs to be developed both in terms of wording and content. Child-adapted questions that provide information about perpetrators but also address different expressions and processes of pain and suffering in children are therefore essential when identifying torture according to the definition of the Convention Against Torture (UN General Assembly, 1984). However urgent it may be to detect torture against children, it is important that the responsibility for identifying the perpetrators is not placed on the children subjected to torture. The child's right to protection and other basic needs must always be ensured in cases where torture documentation is used for the purpose of prosecuting crimes and perpetrators. Furthermore, the children might not recall the perpetrator (UN Office of the High Commissioner for Human Rights (OHCHR), 2022).

Screening for mental health symptoms was dominated by instruments measuring symptoms of PTSD. Although PTSD is a common diagnosis among torture survivors, an almost exclusive focus on the diagnosis risks overshadowing other expressions of pain and suffering that are not included in the diagnosis (Patel et al., 2016; van Willigen, 1999). In contrast to the screening studies, which were dominated by questions about psychological symptoms, there was a clear emphasis on physical torture injuries in the studies that included more extensive torture documentation. This can partly be explained by the fact that several studies have excluded psychological assessment from the documentation, which in turn risks distorting knowledge about the health consequences of torture for children. In the long run, this can make it more difficult to identify both exposure to torture and care needs among the children. Solid documentation of torture injuries of a child requires, in addition to the profession-specific competence, also child-specific knowledge of, among other things, developmental expressions and reactions to pain and suffering (UNHCR, 2022).

The results from the treatment studies showed that TF-CBT and NET, two exposure-based trauma treatments, significantly reduced symptoms of PTSD up to three months to one year after the end of treatment (Ertl et al., 2011; McMullen et al., 2013; O'Callaghan et al., 2013; Onyut et al., 2005; Ruf et al., 2010; Schaal et al., 2009). Of all treatments with varying trauma-focused elements, only two treatments included structured exposure, and both significantly reduced symptoms of PTSD within the treatment group (Gupta & Zimmer, 2008; Layne et al., 2008). The results show that exposure may constitute an important component in the psychological treatment of PTSD for this group. The National Institute for Health and Care Excellence (NICE) has conducted a systematic review of the treatment of PTSD in children that supports TF-CBT in reducing PTSD symptoms in children up to one year after the end of treatment (National Guideline Alliance (UK), 2018). Furthermore, a Cochrane review gives some evidence that CBT reduces PTSD compared to other psychological treatments up to one month after the end of treatment in children and adolescents suffering from trauma (Gillies et al., 2016). None of the treatment studies in the present systematic review included the trauma treatment Eye Movement Desensitization and Reprocessing Therapy (EMDR). According to NICE, EMDR can be offered to children as a second choice after TF-CBT (National Guideline Alliance (UK), 2018). EMDR for children with PTSD is recommended in the DIGNITY Field Manual (DIGNITY, 2013), which is based on a scientific study that has shown positive results (Ahmad & Sundelin-Wahlsten, 2008).

The results show that a more intensified trauma treatment for children can have an effect on PTSD among a sample that partly included children exposed to torture (Ertl et al., 2011; Gupta & Zimmer, 2008; O'Callaghan et al., 2014; Schaal et al., 2009). To the best of the authors' knowledge, a more intensified trauma treatment for children has not yet been highlighted in any guidelines or systematic reviews. However, some studies support that high-intensity treatment with EMDR and Prolonged Exposure (PE) may reduce PTSD in children between the ages of 12 and 18 (Hendriks et al., 2017; van Pelt et al., 2021). Additional treatment formats investigated in the current review were the effect of individual- and group-based treatment. The results show that treatments with both formats have an effect on reduced PTSD. However, the systematic review by NICE only supports individual treatments for TF-CBT (National Guideline Alliance (UK), 2018).

The present review found that several of the psychological treatments in the studies had significant effects on outcome measures other than PTSD in children, some of whom had survived torture. There was, inter alia, a decrease in depressive symptoms and/or anxiety (McMullen et al., 2013; O'Callaghan et al., 2014; O'Callaghan et al., 2013; Schaal et al., 2009), behavioural problems (Durà-Vilà et al., 2013; O'Callaghan et al., 2014; O'Callaghan et al., 2013) and an increase in prosocial behaviours (Betancourt et al., 2014; O'Callaghan et al., 2014; O'Callaghan et al., 2013) and level of functioning (Ertl et al., 2011; Ruf et al., 2010). This is somewhat contradictory results to a Cochrane review on psychological treatments for children exposed to trauma where no differences were found compared to control in anxiety, depression, and behaviour. However, the Cochrane review found improved function (Gillies et al., 2016).

All treatment studies in the present literature review have included psychological or psychosocial treatment. Despite broad searches, no treatments for physical torture injuries or pain rehabilitation for children could be identified. Meanwhile, treatment interventions in these areas are highlighted in a care program and DIGNITY's field manual (DIGNITY, 2013; Region Skåne, 2022). This knowledge gap calls for more research in this area.

The samples in the treatment studies usually included children from the age of seven onwards. This means that treatment for younger children who have survived torture, among other things, is an unresearched area. This is also confirmed in the systematic review by NICE, where treatment efficacy could only be established in children between the ages of seven and 17 (National Guideline Alliance (UK), 2018).

Finally, the representation of the countries of origin of the studies should not be interpreted as a reflection of the real prev-

alence of child torture in the world. The lack of studies conducted in some countries is more likely to be explained, among other things, by the notion of torture as something happening elsewhere, and by the security risks that the research would entail. Much of the work for tortured individuals in countries with repressive regimes is carried out in silence (Başoğlu, 1999). Furthermore, work in this field might also occur in various settings that cannot be found through a systematic review.

Strengths and limitations

The current study has led to difficult distinctions between torture and broader definitions of violence and vulnerability among children. A decision on whether the sample of the studies consisted of torture survivors was based on the Torture Convention's definition of torture. Although the framework for assessment was the definition of torture, there was room for more difficult considerations and interpretations. For example, decisions to exclude victims of trafficking, which turned out to be a relatively well-researched area, can be discussed and problematised afterwards. In addition, many studies lacked sufficient information to allow an assessment of whether parts of the sample had been subjected to torture.

The quality assessment of the treatment articles showed that none of the treatment studies achieved high quality. The RCTs were judged to have some risk of bias, and the non-randomized trials had a severe or critical risk of bias. This means that the results from the treatment studies should be interpreted with some caution.

The samples in both the screening, documentation and treatment studies were heterogeneous. Few studies had samples consisting solely of a torture population, especially with only children. The samples in many studies also consisted of mixed age groups of children, young adults and adults. In addition, the treatment studies included a variety of methods, components, varied outcome measures and instruments. This affects the generalizability of the results to the group of child survivors of torture. It also makes it difficult to draw clear conclusions about which treatments are most effective for the target group. Despite this, the literature study still contributes to providing some support for certain types of treatments.

Conclusions and future directions for clinic and research

Many existing trauma screening instruments are deficient in screening for torture; where some of the reasons are how questions about torture are formulated and that the screening instrument does not ask about the perpetrator. Therefore, we suggest the development of a generic screening instrument that can facilitate the identification of child survivors of torture in various social services that encounter the target group. Although the evidence is scarce, the results of the study indicate that trauma treatments with exposure, such as TF-CBT and NET, have a positive effect on both PTSD and other psychological outcome measures in children, some of whom have been subjected to torture. Furthermore, trauma treatment in a group format, as well as in an intensified form, could be implemented in the clinic and further evaluated in research with long-term follow-up for the specific target group. Research also needs to include the youngest children.

Funding

This work was supported by Hildur Nordin's Memorial Fund.

Acknowledgements

Frida Johansson Metso, coordinator at the Swedish Red Cross Competence Centre for Rehabilitation of Torture and War Trauma, and Niklas Möller, clinical psychologist at the Swedish Red Cross treatment center in Uppsala, for support during the working process. Camilla Juhlin, lawyer and migration advisor at the Swedish Red Cross, for sharing knowledge and important perspectives. Karin Löfroth at Södertörn University Library for guidance in the search process.

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Submitted 8th of March 2024
Accepted 16th of Oct. 2024

Annex 1. Article matrix of the treatment studies

First author, year published, country	Design	Intervention	Comparator	Study population, follow up & data collection of outcomes	Effect (effect size is presented when reported in the study)
Betancourt et al., 2014 Sierra Leone	Randomzied controlled study (RCT)	Youth Readiness Intervention (YRI) combines elements of Interpersonal psychotherapy (IPT) and cognitive behavioral therapy (CBT). The main components of YRI are as follows: psychoeducation about trauma, strategies for self-regulation and relaxation (e.g., belly breathing), cognitive restructuring of distortions linked to trauma, behavioral activation, social skills training, problem solving. Immediately after the YRI intervention was completed, all participants (both those who received the YRI and controls) were randomized to either a subsidized education program n=220 or wait-list n=216. **Structural exposure:** No **Intensity:**10–12 sessions of 90 min per week **Format:** Group	Did not receive the intervention. Nothing more is specified.	**Study population:** War-affected children, including former child soldiers in Sierra Leone. N= treatment group (n=222), control group (n=214) Age: 15-24 Gender distribution: 55% boys in treatment group, 53% boys in control group **Follow-up:** post-intervention and 6 months For children who went to school, there was a follow-up after 8 months regarding enrolment, attendance and performance in school. **Data collection:** Self-reporting instruments: Psychological distress: Oxford Measure of Psychosocial Adjustment Prosocial behavior: Oxford Measure of Psychosocial Adjustment Emotion regulation: Difficulties in Emotion Regulation Scale Functional impairment: The World Health Organization Disability Adjustment Scale (WHODAS) Social supportive behavior: Inventory of Socially Supportive Behaviors PTSD: University of California, Los Angeles (UCLA) Post-Traumatic Stress Disorder Reaction Index (PTSD) School performance: Classroom performance scale (Filled in by the teacher)	**PTSD:** No significant difference between the groups at post-intervention (p=.88) and 6-month follow-up (p=.33). **Prosocial behavior:** A significant improvement in prosocial behavior for the intervention group compared to control with a moderate effect size (p=.001, Cohen's d 0.39) at post-intervention. After 6 months, there was no significant difference (p=.92). **Psychological distress:** No significant difference between the groups postintervention (p=.92) and 6-month follow-up (p=.83). **Functional impairment:** A significant improvement in the level of functioning of the intervention group compared to control with a moderate effect size (p=.007, Cohen's d 0.32) at post-intervention. At the 6-month follow-up there was no significant difference between the groups (p=.54). **Emotion regulation:** A significant improvement in the intervention group compared to control with a moderate effect size (p=.01, Cohen's d 0.31) at post-intervention. At 6-month follow-up, there was no significant difference between the groups (p=.84). **Social supportive behavior:** A significant improvement for the intervention group compared to control with a small effect size (p=.02, Cohen's d 0.29) at postintervention. At 6-month follow-up, no significant difference is seen between the groups (p=.47). **School performance:** Those who participated in the psychosocial treatment program had significantly better attendance in school (p<.01) and significantly better academic performance (p<.05) compared to control after 8 months.

First author, year published, country	Design	Intervention	Comparator	Study population, follow up & data collection of outcomes	Effect (effect size is presented when reported in the study)
Durà-Vilà et al., 2013 United Kingdom	Non-randomized study of intervention (NRSI). Pilot study	Trauma therapeutic treatment components are combined with practical support measures according to the individual's needs (focus on trauma narratives, family treatment and cognitive therapy). **Structural exposure:** It's unclear if and how much exposure. Mentions "narrative work" but not how and how much. **Intensity:** Different number of sessions (single consultations 0–2 sessions, short interventions 3–9 sessions, longer interventions ≥ 10 sessions. Nothing more is specified. **Format:** Individual	N/A	**Study population:** Refugee children (from all over the world) who fled to the UK who were assessed to have psychological distress or problems. N= 102 Age: 13–17 Gender distribution: boys:girls 3:1 **Follow-up:** post-intervention immediately after completion **For the evaluation of treatment:** N=48 where the outcome has been assessed by a therapist. It is unclear what has been assessed. N=35 where Strengths and Difficulties Questionnaire (SDQ) both before and after treatment. (n=24 has been filled in by the teacher, n=11 has been filled in by the parents). No age or gender distribution is given for these subgroups. **Data collection:** Questionnaires Behavioral screening (both behavioral problems and positive attributes): Strengths and Difficulties Questionnaire, (SDQ), Clinical Interviews Assessment of outcomes by a therapist.	**Behavioral problems:** A significant improvement within the group (p=.01).
Ertl et al., 2011 Uganda	RCT	Narrative exposure therapy (NET) **Structural exposure:** Yes **Intensity:** 8 sessions 3 times/week of 90–120 minutes/session **Format:** Individual	Two control groups. Control group 1: supportive counseling combined with academic catching up program Control group 2: waitlist	**Study population:** Former child soldiers who have PTSD and live in camps for internally displaced people in Uganda. N= 85, intervention n=29, Control group 1 n=28, control group 2 n=28 Age: 12–25 Gender distribution: 55% girls/women, 45% boys/men **Follow-up:** 3-, 6- and 12-months post-treatment **Data collection:** Self-reporting instruments: PTSD: Clinician-Administered PTSD Scale (CAPS) Functional impairment: CASP Guilt: CASP Depression: Mini International Neuropsychiatric Interview Stigmatization: shortened version of The Perceived Stigmatization Questionnaire Suicidal ideation: MINI	**PTSD:** After 12 months, there was a significant reduction in symptoms of PTSD in the NET group with a moderate effect size (Cohen's d 0.72 and 0.66, respectively) compared to an active control group (academic catch-up) and waitlist control. **Depression:** No statistically significant difference between the groups over a 12-month period. **Functional impairment:** After 12 months, there was a significant improvement in the NET group with a large effect size (Cohen's d 0.83 and 0.97, respectively) compared to an active control group and waitlist control. **Stigmatization:** No statistically significant difference between the groups over a 12-month period. **Guilt:** Over a 12-month period, there was a significant difference in reduction of guilt between the NET group and the waitlist control in favor of the NET group (p<.001) with a large effect size (Cohen's d 0.97). There was no significant difference between the NET group and the active control (p=.16). **Suicidal ideation:** No statistically significant difference between the groups over a 12-month period.

First author, year published, country	Design	Intervention	Comparator	Study population, follow up & data collection of outcomes	Effect (effect size is presented when reported in the study)
Gupta et al., 2008 Sierra Leone	NRSI	Trauma processing intervention consisting of, among other things, sharing war experiences and providing accurate information about the war, normalizing children's reactions, instilling hope, and creative exercises (singing, dancing, drawing, writing, role-playing, playing instruments). **Structural exposure:** Contains exposure but it is unclear how much. **Intensity:** A total of 8 sessions of 60 minutes were given 2 times/ week over a 4-week period. **Format:** In a group integrated into a classroom.	N/A	**Study population:** War-affected and displaced children in Sierra Leone. N= 315 Age: 8–17 (average 10.7 years)) Gender distribution: 53% boys **Follow-up:** 4-6 weeks post-treatment **Data collection:** Interviews based on self-reporting instruments. PTSD: Impact of Events Scale (IES) Childrens' general emotions: self-developed eight-item questionnaire	**PTSD:** A significant reduction within the group after 4-6 weeks (p<.0001). **Childrens' general emotions:** No significance test has been performed. The majority of the children who participated in the trauma processing intervention reported feeling much better (22.3%) or better (73.4%) after sharing their bad memories of the war. Overall, 95% reported that their concentration problems at school were also better or much better, and 96% reported that their bad dreams and/or nightmares decreased. More than half of the children said they felt relief while participating in the structured activities and 36% experienced sadness. About 5% of the children reported mixed emotions or fear while participating in the intervention.
Layne et al., 2008 Bosnia	RCT	Trauma and grief therapy for adolescents containing trauma therapeutic components (e.g. psychoeducation, emotion regulation, relaxation, social skills training, trauma and grief processing, problem solving and planning for the future). **Structured exposure:** Yes, in one part of the treatment. **Intensity:** 17 sessions, 1 time/week of 60-90 minutes **Format:** Group - Classroom-based	Classroom-based psychoeducation and exercises in emotion regulation, relaxation and problem solving. Parts of the same manual as for the intervention group.	**Study population:** War-affected children who suffered a significant trauma before, during or after the war; significant current psychological stress, e.g., PTSD, depression, and significant functional impairment e.g., in relationships and school performance. N= 127 (Treatment: N=66, control group: n=61) Age: 13–19 Gender distribution: active control group: 66% girls, intervention: 67% girls **Follow-up:** Post-intervention and 4 months **Data collection:** Self-reporting instruments: PTSD: Posttraumatic stress disorder reaction Index (RI), Depression: Depression Self-Rating Scale (DSRS), Traumatic and existential grief: UCLA Grief Inventory	**PTSD:** No significant difference between the groups. Within-group analysis showed significantly reduced symptoms of PTSD for both the trauma and grief therapy group and the active control group (p<.01) **Depression:** No significant difference between the groups. **Traumatic and existential grief:** No significant difference between the groups. Within-group analysis showed a significant reduction for the trauma and grief therapy group (p<.001) at postintervention but not for the active control group.

First author, year published, country	Design	Intervention	Comparator	Study population, follow up & data collection of outcomes	Effect (effect size is presented when reported in the study)
Lokuge et al., 2013 Democratic Republic of the Congo, Iraq, the occupied Palestinian territory	Retrospective intervention study without control group.	Mental health program run by Médecins Sans Frontières (MSF), which partly consisted of trauma-focused therapy. MSF mental health guidelines include acute crisis management, drug treatment, CBT techniques such as cognitive restructuring, mindfulness, relaxation, and social support. **Structured exposure:** Unclear if and how much. Refers to exposure in Médecins Sans Frontières guidelines but unclear if it was used in the study. **Intensity:** Varied the number of sessions as needed. In the Democratic Republic of Congo it was most common with 2-5 sessions and in Palestine 44% received more than 10 sessions. Nothing more is stated about the intensity. **Format:** Individual	N/A	**Study population:** War-affected children in the Democratic Republic of Congo, Iraq and the occupied Palestinian territory N= 3025 (n=1767 children and young adults up to 19 years) Age: 0–19 years in the children/young adults' group. Gender distribution= Children <15 years 53% boys, 47% girls 15–19 years: 32% boys, 68% girls **Follow-up:** Immediately at discharge. **Data collection:** Data was used from MSF's medical record system. Patient demographics, symptoms associated with: PTSD Anxiety, depression Somatoform Symptoms Behavioral problems Other symptoms	Nothing specifically reported on the different outcome measures. The most commonly reported symptom in the children and adolescents was anxiety, followed by behavioral problems and somatic symptoms. 97% of those who completed treatment self-reported improvements in their main reported symptoms (no significance tests are presented for the self-reported improved symptoms).

First author, year published, country	Design	Intervention	Comparator	Study population, follow up & data collection of outcomes	Effect (effect size is presented when reported in the study)
Martinez Torre et al., 2022 Nigeria	Retrospective intervention study without control group.	Mental Health and psychosocial support (MHPSS) program, under the auspices of Médecins Sans Frontières, with psychological interventions such as psychoeducation and emergency crisis management, as well as drug treatment and social support. **Structured exposure:** No **Intensity:** The number of sessions ranged from 1 to 14. The median was 2 sessions. Lacks information on length and how often they were given. **Format:** Individual	N/A	**Study population:** War-affected persons, including children and former child soldiers in Nigeria. N= 11 709 (4025 in the age group 1-25 years) Age: 1–25 (Children and young Adults Group) (The entire sample average 32.7 years.) Gender distribution: 26% boys/men in the age group 1–25 years **Follow-up:** Measurement after each session. No further follow-ups. **Data collection:** Medical records from the MHPSS program were analyzed retrospectively. Eight mental, neurological, and substance use symptoms were categorized: Somatic symptoms Anxiety-related symptoms Post-traumatic symptoms Depression-related symptoms Psychosis-related symptoms Behavioral problems Cognitive symptoms Other symptoms The severity of these symptoms was measured by counselors by using the Clinical Global Impression-Improvement (CGI-I) scale and the Mental Health Global State (MHGS) scale.	There is no specific report on the individual outcome measures. In the children, 45.2% (n = 239) improved overall, but 53.5% (n = 283) showed no change at the end of treatment. Some (1.3%; n = 7) had worse symptoms. **Children with somatic symptoms (OR: 2.3, p < 0.001), post-traumatic symptoms (OR: 2, p < 0.001), anxiety (OR: 1.6, p = 0.001) and depression (OR:** 1.5, p = 0.002) were more likely to have improved outcomes.

First author, year published, country	Design	Intervention	Comparator	Study population, follow up & data collection of outcomes	Effect (effect size is presented when reported in the study)
McMullen et al., 2013 Democratic Republic of the Congo	RCT	Trauma-focused cognitive-behavioral therapy (TF-CBT). (contextually adapted) **Structured exposure:** Yes **Intensity:** 15 sessions. No information about the duration and frequency of the sessions. **Format:** Group	Waiting list (which was shortened due to ethical reasons, which led to no comparative analysis being performed at the 3-month follow-up).	**Study population:** War-affected children, including former child soldiers in the Democratic Republic of Congo N= 50 (39 former child soldiers) Age: 13–17 Gender distribution: 100% boys **Follow-up:** Postintervention and 3 months. **Data collection:** Interviews based on self-reporting instruments: PTSD: The UCLA-PTSD Reaction Index Psychological distress: The African Youth Psychosocial Assessment Depression and anxiety: AYPA (formerly known as the Acholi Psychosocial Assessment Instrument (APAI))	**PTSD:** Significant reduction in the TF-CBT group (p<.001) with a large effect size (ηp2 .665) and with a slightly larger effect size when former child soldiers were analyzed separately (ηp2 688) at postintervention. No between-group analysis at 3-month follow-up but within-group analysis showed significant reduction in the TF-CBT group with a large effect size (p < .001, d 2.17). **Depression and anxiety:** Significant reduction in the TF-CBT group (p<.001) with a large effect size (ηp2 .567) with a slightly larger effect size when former child soldiers were analyzed separately (ηp2 .587) compared to control. No between-group analysis at 3-month follow-up but within-group analysis showed significant reduction in the TF-CBT group with a large effect size (p < .001, Cohen's d 2.64). **Psychological distress:** Significant reduction in the TF-CBT group (p<.001) with a large effect size (ηp2 .617) and a slightly larger effect size when former child soldiers were analyzed separately (ηp2 .643) compared to control. No between-group analysis at 3-month follow-up but within-group analysis showed significant reduction in the TF-CBT group with a large effect size (p < .001, Cohen's d 2.03).

First author, year published, country	Design	Intervention	Comparator	Study population, follow up & data collection of outcomes	Effect (effect size is presented when reported in the study)
O'Callaghan et al., 2013 Democratic Republic of the Congo	RCT	TF-CBT (contextually adapted) **Structured exposure:** Yes **Intensity:** 15 sessions. No information about the duration and frequency of the sessions. **Format:** Group except for three of the sessions that were given individually.	Waiting list (which was shortened due to ethical reasons, which led to no comparative analysis being performed at the 3-month follow-up).	**Study population:** War-affected girls who have either been directly exposed to or witnessed rape and inappropriate sexual touching in the Democratic Republic of Congo. N= 52, intervention n=24, control n=28 Age: 12–17 Gender distribution: 100% girls **Follow-up:** Postintervention and 3 months. **Data collection:** Self-reporting instruments: PTSD: the UCLA PTSD Reaction Index (Revised) Depression/Anxiety/Behavioral Problems/Prosocial Behavior: African Youth Psychosocial Assessment Instrument (AYPA)	**PTSD:** Significant reduction in the TF-CBT group compared to control with a large effect size ($p < .001$, $\eta p2$ 0.518) at post-intervention. No between-group analysis at 3-month follow-up but within-group analysis shows significant reduction at 3 months for the TF-CBT group with a large effect size ($p<.001$, Cohen's d 2.04). **Depression and anxiety:** Significant reduction in the TF-CBT group with a large effect size ($p < .001$, $\eta p2$ 0.517) compared to post-intervention control. No between-group analysis at 3-month follow-up but within-group analysis shows a significant reduction in depression and anxiety symptoms at 3 months for the TF-CBT group with a large effect size ($p<.001$, Cohen's d 2.45). **Behavioral problems:** A significant reduction in the TF-CBT group with a large effect size ($p < .001$, $\eta p2$ 0.259) compared to control. No between-group analysis at 3-month follow-up but within-group analysis shows a significant reduction at 3 months for the TF-CBT group with a large effect size ($p<.001$, Cohen's d .95). **Prosocial behavior:** A significant improvement in the TF-CBT group was a moderate effect size ($p < .001$, $\eta p2$ 0.099) compared to control. No between-group analysis at 3-month follow-up but within-group analysis shows a significant improvement at 3 months for the TF-CBT group with a large effect size ($p<.001$, Cohen's d 1.57).

First author, year published, country	Design	Intervention	Comparator	Study population, follow up & data collection of outcomes	Effect (effect size is presented when reported in the study)
O'Callaghan et al., 2014 Democratic Republic of the Congo	RCT Pilot study	Psychosocial treatment program with a focus on reintegration into society. **The manual is based on three main components:** 1. Life skills programs for young people, 2. Various videos depicting what young people, parents and society can do to promote the re-integration of abducted children, 3. Relaxation exercises according to TF-CBT **Structured exposure:** No **Intensity:** A total of 8 sessions, 3 times/week of 2 hours. **Format:** Group	Waiting list (which was shortened due to ethical reasons, which led to no comparative analysis being performed at the 3-month follow-up).	**Study population:** War-affected children N= 159, intervention n=79, control n=80 Age: 7–18 Gender distribution: 55% boys/ 45% girls **Follow-up:** Postintervention and 3 months **Data collection:** Interview based on self-reporting instruments: PTSD: Child Revised Impact of Events Scale (CRIES-8). Depression/Anxiety/Behavioral Problems/Prosocial Behavior: African Youth Psychosocial Assessment Instrument (AYPA)	**PTSD:** Significant reduction (p=.009) with a moderate effect size (Cohen's d 0.40) for the intervention group compared to control at post-intervention. No between-group analysis at 3-month follow-up but within-group analysis shows a significant reduction at 3 months with a small effect size (p=.036, ηp2 0.04) for the intervention group. **Depression and anxiety:** No significant difference between the groups (p=.738). No between-group analysis at 3-month follow-up but within-group analysis shows a significant reduction at 3 months with a large effect size (p<.001, ηp2 .32) for the intervention group. **Behavioral problems:** No difference between the groups (p=.756). No between-group analysis at 3-month follow-up but within-group analysis for the intervention group shows a significant reduction at 3 months with a large effect size (p<.001, ηp2 .13). **Prosocial behavior:** No significant difference between the groups (p=.171). No between-group analysis at 3-month follow-up but within-group analysis for the intervention group showed a significant improvement at 3 months with a moderate effect size (p<.001, ηp2 .08)
Onyut et al., 2005 Uganda	NRSI	KIDNET (Child-friendly version of NET) **Structured exposure:** Yes **Intensity:** 4-6 sessions of 1-2 hours. No information on the frequency of sessions. **Format:** Individual	N/A	**Study population:** Refugees with PTSD, from Somalia in Uganda living in refugee camps. N= 6 Age: 13–17 Gender distribution: 50 % girls /50% boys **Follow-up:** Postintervention and 9 months **Data collection:** Self-reporting instruments: PTSD: The Posttraumatic Diagnostic Scale (PDS) Depression: Hopkins Symptom Checklist-25 (HSCL)	**PTSD:** Significant reduction over a nine-month period within the group (p < 0.01). **Depression:** No significance values are reported but 4 out of 6 had major depression prior to the start of KIDNET and at post- and 9-month follow-up, none met criteria for clinically significant depression.

First author, year published, country	Design	Intervention	Comparator	Study population, follow up & data collection of outcomes	Effect (effect size is presented when reported in the study)
Ruf et al., 2010 Germany	RCT	KIDNET **Structured exposure:** Yes **Intensity:** 8 sessions 1 time/week of 90–120 minutes **Format:** Individual	Waiting list (which was shortened due to ethical reasons, which led to no comparative analysis being performed at the 12-month follow-up).	**Study population:** Traumatized refugee children diagnosed with PTSD living in Germany. N= 26, intervention n=13, control n=13 Age: 7–16 Gender distribution: 54% girls, 46% boys **Follow-up:** 4 weeks, 6 and 12 months **Data collection:** Self-reporting instruments: PTSD-diagnostics with UCLA PTSD Index for DSM-IV with additional questions about everyday functioning at school, with friends and in the family. General psychiatric diagnostics to investigate comorbidity: Mini International Neuropsychiatric Interview for Children and Adolescents Cognitive function: Raven's progressive matrices. Carried out through professional assessment.	**PTSD:** There was a significant reduction in the KIDNET group compared to control over time up to 6 months ($p<.01$) with a large effect size (Hedge's g 1.9). No between-group analysis was performed at 12 months. Within-group analysis for the KIDNET group showed a significant reduction in PTSD symptoms with a large effect size (Hedge's g 1.8) after 12 months. **Functional impairment:** A statistically significant improvement was seen in the KIDNET group compared to control over a 6-month period ($p<.05$) with a large effect size (Hedge's g 1.7). **Cognitive function:** There was a significant group x time effect in favor of the KIDNET group compared to waitlist control over a 6-month period for nonverbal cognitive function ($p<.05$) as measured by Raven's test. **Psychiatric comorbidity:** No statistical difference between groups at the 6-month follow-up.
Schaal et al., 2009 Rwanda	RCT	NET + Grief counseling session **Structured exposure:** Yes **Intensity:** 4 sessions 1 time/week of 2-2.5 hours (3 sessions with NET and 1 session with grief counselling) **Format:** Individual	IPT in groups.	**Study population:** Orphans of the Rwandan genocide who have PTSD. They were ≤ 18 years old when the genocide happened. N=26, (IPT n=14, NET n=12) Age: 14–28 (average 19.2) The worst traumatic event had occurred at an average age of 10.2 years. Gender distribution: 38.5% boys/men, 61.5% girls/women **Follow-up:** 3 and 6 months **Data collection:** Self-reporting instruments: PTSD: the Clinician-Administered PTSD Scale, CAPS Symptoms of depression: the depression section from the Mini-International Neuropsychiatric Interview (MINI) Severity of depression: Hamilton Depression Rating Scale Guilt: Two questions from CAPS	**PTSD:** No significant difference between NET group and active control at 3 months but after 6 months there was a significant difference in favor of the NET group ($p<.01$) with a large effect size of treatment X time interaction ($p<0.05$, $\eta 2$ 0.26). **Depression:** No significant difference in depressive symptoms between the groups after 3 months but after 6 months there was a significant difference in favor of the NET group with a large effect size of treatment X time interaction ($p = 0.05$, $\eta 2$ 0.23). The severity of depression (Hamilton Depression Rating scale) decreased significantly more in the NET group compared to the active control group ($p<.05$) **Guilt:** At 3 months, there was a significant difference between the groups ($p<.05$) where the NET group had less guilt than the active group. At 6 months, there was no statistical difference between the groups.

Torture, 2024, 34(3), 41-53
https://doi.org/10.7146/torture.v34i3.147571 *Research paper*

Overcrowding in prisons: Health and legal implications

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Key points of interest

- No universal definition of overcrowding exists.
- More than 120 countries have prison systems that exceed their own occupancy capacity, some with more than 250%.
- Overcrowding can lead to ill-treatment, other human rights violations and deterioration of the health of people in prison.
- While alternatives to detention exist, they remain underutilised.
- Some countries have successfully reduced prison overcrowding.

Abstract

Introduction: Prison overcrowding can be defined in different ways, and no universal definition exists. More than 120 countries report prison occupancy rates above their own capacity. This paper provides an overview of legal and health implications of overcrowding, analyses potential causes, and provides examples of how different countries utilised non-custodial measures to reduce overcrowding to disseminate good practices as inspiration for other contexts. *Methods*: Desk study based on literature searches in medical (Pubmed and Medline) and legal sources, including Google Scholar on legal opinions, Global Lex and decisions of UN treaty bodies and regional human rights mechanisms supplemented by online searches for grey literature. In addition, examples from other countries were sought to corroborate and illustrate the points made. *Results*: A range of international standards exist that provide for the conditions and treatment of people in prisons to prevent prison overcrowding and protect them from its consequences. Nonetheless, overcrowding is persistent across many countries. It is often associated with violations of human rights, including, among others, the right to be free from torture and ill-treatment, the right to health, and the right to liberty and security. The underlying factors contributing to overcrowding vary and include, among others, overuse of imprisonment, excessive use of pre-trial detention, lack of access to a lawyer and underutilisation of non-custodial measures as an alternative to detention. Non-custodial measures can be applied throughout the criminal justice process, and some countries have successfully managed to reduce their prison populations by implementing such measures. *Discussion*: Overcrowding affects many aspects of prison life, impeding the provision of a humane and rehabilitative environment. Beyond the harm caused to persons in prisons, this may negatively impact society at large in terms of security, public health, and economy. Political will is essential in reducing prison overcrowding.

Keywords: overcrowding, detention, torture and ill-treatment, right to health, prison.

Introduction

The number of persons deprived of liberty is increasing every year. Currently, more than 11.5 million people worldwide are incarcerated (Penal Reform International [PRI] & Thailand Institute of Justice [TIJ], 2024). Prison overcrowding threatens the achievement of the stated purposes of imprisonment, i.e., to deter, incapacitate, rehabilitate and punish (United Nations Office on Drugs and Crime [UNODC], 2019).

Punitive policies, criminalisation of poverty and status, as well as systemic racism and discrimination, are the key drivers of imprisonment (PRI & TIJ, 2024). In many parts of the world, states have adopted strict laws based on "tough on crime" policies, contributing to a rise in criminalisation and higher incarceration rates with more frequent and longer use of remand detention, the imposition of mandatory minimum sentences, longer prison sentences and limited recourse to non-custodial alternatives (PRI, 2018; European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment [CPT], 2022a). Currently, on a global level, only one in three countries' prison systems operate within capacity. The overcrowding level varies from country to country, with 59 countries reporting that they operate at 150% capacity and eight countries exceeding 300% (PRI & TIJ, 2024). Within the European region, twelve countries reported overcrowding in 2023 (Aebi & Cocco, 2024).

No universal definition of overcrowding has been adopted yet. The most common definition relates to spatial density such as living space per person or number of beds (CPT, 2015; Simpson et al., 2019). According to the CPT, minimum cell standards in European prisons are 6m² for single-occupancy, in addition to the sanitary facility and 4m² per person for multiple-occupancy cells, in addition to a "fully-partitioned" sanitary facility. All cells should have no less than 2m between their walls and measure at least 2.5m in height (CPT, 2015). Similar standards do not exist at the regional level outside Europe.

Overcrowding has also been defined based on operational capacity, i.e., the ratio of prison population to staffing levels (Tartaro, 2002). This ratio focuses on the extent to which a prison can adequately function in a safe and humane manner (UNODC, 2013). Overcrowding has also been defined in social science literature based on social density, emphasising the extent to which people are forced to socialise with others. Such a definition can, for example, be the number of persons per cell or the percentage of persons housed in group versus single cells (Tartaro, 2002). The lack of a common definition of overcrowding, together with the absence of publicly available data, hinders access to precise knowledge on the magnitude of global prison overcrowding and comparison across countries. Moreover, published data often lack the necessary disaggregation to understand the composition of the prison population and, thereby, the needs of people in prison and eligibility for non-custodial measures. In some instances, states with repressive governments withhold data or hinder access to it (Sarkin, 2009).

Overcrowding is rarely uniform across different prisons in one country or even within prisons. For various reasons, some prisons may experience severe overcrowding in the same country while others are occupied under capacity. Overcrowding is rarely static, varying from one day to another as persons are released and admitted.

Prison authorities, human rights advocates, researchers, and international bodies have long recognised prison overcrowding as a problem impacting the overall functioning of the penitentiary system.

This paper aims to provide an overview of legal and health implications of overcrowding and examine its consequences for prisoners and in relation to rights and standards. It also discusses factors that may contribute to overcrowding and provides examples of how different countries have utilised non-custodial measures to reduce overcrowding to disseminate some of the good practices that may serve as inspiration for other contexts.

The impact of overcrowding and the rights of persons in prisons

Overcrowding is not just a matter of lack of space. It affects almost every aspect of prison life, hampering efforts to create safe and effective prison systems. An overcrowded prison is less safe, secure and humane, especially for those in situations of in-

Figure 1. *Prison overcrowding*

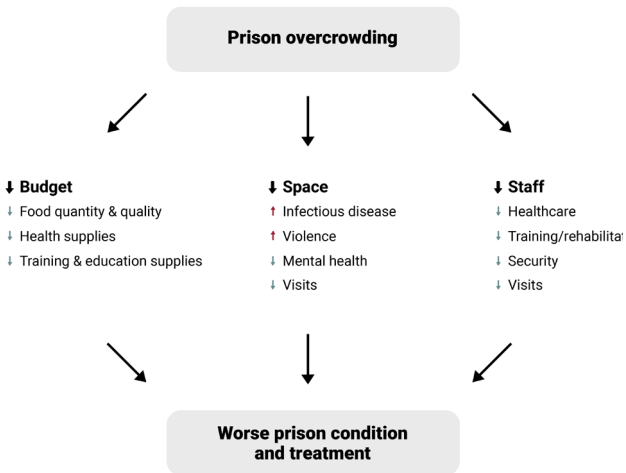

***Table 1**: Standards related to prison overcrowding and non-custodial measures*

- UN Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules) (United Nations General Assembly [UNGA], 2015)
- UN Standard Minimum Rules for Non-Custodial Measures (Tokyo Rules) (UNGA, 1990)
- Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders (Bangkok Rules) (UNGA, 2011)
- Ouagadougou Declaration and Plan of Action on Accelerating Prisons' and Penal Reforms in Africa (African Commission on Human and Peoples' Rights [ACHPR], 2002)
- Principles on the Decriminalization of Petty Offences in Africa (ACHPR, 2018)
- Guidelines on Conditions of Arrest, Police Custody and Pretrial Detention in Africa (Luanda Guidelines) (ACHPR, 2015)
- Principles and Best Practices on the Protection of Persons Deprived of Liberty in the Americas (Inter-American Commission on Human Rights [IACHR], 2015)
- Dhaka Declaration on Reducing Overcrowding in Prisons in South Asia (South Asian Association for Regional Cooperation [SAARC], 2010)
- Recommendation No. R (99) 22 concerning prison overcrowding and prison population inflation (Council of Europe [CoE], 2015)
- Recommendation CM/Rec (2017) 3 on community sanctions (CoE, 2017)

creased vulnerability. Overcrowding may have more adverse consequences when prison conditions are already compromised.

Prison overcrowding often translates into reduced budget, staff and space per person, resulting in a range of adverse effects and worsening of prison conditions (MacDonald, 2018; HRC, 2015; Egelund, 2020; Aon et al., 2021). Thus, we perceive the mechanism through which overcrowding affects prison life as per Figure 1.

The institutional capacity to provide services to people in prison and organise meaningful activities and individualised programs often does not match demand in overcrowded prisons. As a result, persons in prison spend more time locked in their cells with fewer opportunities to access appropriate programs that would foster their rehabilitation and reintegration. This ultimately undermines the stated objectives of imprisonment: to keep society safe and to rehabilitate persons in prison (UNODC, 2019).

The Test of Totality of Conditions used by some courts considers how conditions affect persons in prison in a particular prison setting. It specifically examines whether it is possible to ensure a reasonable degree of privacy, adequate hygiene, sanitary conditions, nutrition, appropriate out-of-cell activities and rehabilitation and other programs for reintegration into society (Kamber, 2022). It also provides a multi-dimensional scale which includes core conditions of adequate circumstances, such as the space available for people (Albrecht, 2011).

The United Nations and regional human rights bodies have adopted minimum standards for prison management and the rights of persons in detention. For details, see textbox.

The standards mentioned above guide states regarding prison overcrowding and non-custodial measures. States have obligations to prevent human rights violations as provided by various international human rights conventions. They have a special duty of care for those deprived of liberty and must ensure that those persons are able to enjoy all human rights except those related to the deprivation of liberty.

Impact on the right to freedom from torture and ill-treatment

Freedom from torture and other cruel, inhuman or degrading treatment or punishment is one of the fundamental rights, and an absolute prohibition of torture and ill-treatment is enshrined in several international and regional human rights treaties.[1] Conditions and treatment in prisons may amount to torture or ill-treatment when they do not meet minimum standards and, therefore, cause suffering. However, in most cases, when the international and regional bodies reviewed situations in prisons, they noted that while overcrowding can on its own amount to torture or ill-treatment, the consequences of overcrowding often intersect with other forms of ill-treatment, which may accumulatively amount to torture.

The United Nations Committee against Torture (CAT) has, in several cases, found that overcrowding may be among the elements leading to a violation of Article 1 and Article 16 of the Convention against Torture and Other Cruel, Inhuman

1 Article 5 of the Universal Declaration of Human Rights (UHDR), Article 7 of the International Covenant on Civil and Political Rights (ICCPR), and the regional conventions, such as the European Convention on Human Rights, the African Charter on Human and Peoples' Rights and the American Convention on Human Rights, all protect the right to be free from torture.

or Degrading Treatment or Punishment. In the *case of A.N. v Burundi,* the complainant alleged that he shared a cell with 80 other persons in a poorly lit room with only a few small windows, where he slept on the cold cement floor without a mattress. The Committee concluded that the complainant's claims must be fully considered. They reviewed not only the conditions in prisons but also the treatment that the complainant suffered by the police, including being violently beaten for half an hour, causing him extreme pain and mental suffering, and the committee found that the abuse inflicted upon him constituted acts of torture within the meaning of article 1 of the Convention (CAT, 2017, §7.4. & 8.2). Similarly, in *Gallardo Martínez et al. v. Mexico,* the complainant alleged that during his detention, he was forced to live in overcrowded conditions (six persons in an area measuring 2 by 4 m), placed in solitary confinement, deprived of sleep and confined to his cell for 22 hours per day. The Committee found that the facts in his case regarding the conditions in prison and during arrest, including beatings and threats of rape and killing his daughter and partner, constituted acts of torture under article 1 of the Convention (CAT, 2022a, §§7.3-7.4).

The regional human rights bodies and courts have also repeatedly found that overcrowding in prisons violates the right to humane treatment and freedom from torture and cruel, inhuman or degrading treatment.

In a call to reduce prison overcrowding, the CPT noted that "Prison overcrowding undermines any efforts to give practical meaning to the prohibition of torture and other forms of ill-treatment since it can result in a violation of human rights." (CPT, 2022b). The European Court of Human Rights (ECtHR) has also repeatedly found that overcrowding can amount to a violation of Article 3 of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. For example, in the case of *Mursic v. Croatia,* the Court explored three elements to determine whether lack of personal space reaches a violation of article 3: i) whether each detainee has an individual sleeping space, ii) whether each detainee has a space of at least $3m^2$ and iii) whether the overall surface space is sufficient to allow persons in detention to move freely between furniture items (ECtHR 2016, §148). Further, the Court noted that personal space less than $3m^2$ is considered so severe that a strong presumption of violating Article 3 arises (ECtHR, 2016, §137). However, in certain circumstances, that strong presumption could be rebutted by the cumulative effects of other factors, such as the short, occasional and rare nature of the reduction of space and having sufficient freedom of movement outside the cell while being detained in an appropriate detention facility where there are no other aggravating conditions present (ECtHR, 2016, § 140). In 2020, the same Court reaffirmed the strong presumption of a violation of Article 3 when a person in detention in Ukraine had less than $3m^2$ of personal space over a considerably long duration [ranging between 82 and 1113 days]. The Court found that the situation had been aggravated by the fact that the applicant had been confined to the cell for most of the day except for one-hour daily walk, improper isolation of the toilet, lack of fresh air, poor ventilation, dampness, and insects in the cells (ECtHR, 2020, §§ 94-97).

In the case of *Boyce et al. v Barbados*, the Inter-American Court of Human Rights (IACtHR) found "that the combined conditions of detention, particularly the use of slop-bucket, the lack of adequate lighting and ventilation (...) as well as the overcrowded conditions, together amount to treatment contrary to the dignity of every human being and thus constituted a violation of Articles 5 (1) and 5 (2) of the American Convention." (IACtHR, 2007, §86). In 2012, the same court reviewed a case of prison conditions in Honduras, finding that cell conditions were contrary to human dignity due to, among other factors, overcrowding and emphasised that its previously established case law on the main standards on prison conditions and obligations found that overcrowding is a violation of personal integrity that hinders essential prison functions (IACtHR, 2012, §§65, 67a).

Impact on the right to health

The right to health is enshrined in the Constitution of the World Health Organization as a fundamental right *"of every human being without distinction of race, religion, political belief, economic or social condition"* (WHO, 1948, preamble). This is further affirmed in various forms, including the Universal Declaration of Human Rights (UNGA, 1948), the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966), and the Declaration of Alma-Ata (WHO, 1978). Health is also strongly present in the Sustainable Development Goals (goal three in addition to health indicators in all other goals) (UNGA, 2015b, p. 14) and the Nelson Mandela Rules.

A relative shortage of human resources due to overcrowding would violate Nelson Mandela Rule 25.2, which calls for "sufficient qualified personnel...". Overcrowding is also a significant challenge to the conduct of timely and effective initial medical assessments as medical personnel struggle to see all new persons as stipulated in Rule 30: "A physician or other qualified health-care professionals...shall see, talk with and examine every prisoner as soon as possible following his or her admission...". In one country, during a training on the topic, prison staff cited overcrowding as a challenge to the initial medical assessment (Aon et al., 2021). Similarly, this is

frequently mentioned during monitoring visits by independent monitoring bodies of which two authors are members. Prison medical staff with competing priorities are likely to neglect less urgent duties such as those stipulated in Rule 35, namely the "regular inspect[ion]" of food, hygiene, ventilation and bedding (UNGA, 2015a).

Overcrowding poses a particular risk for transmission of air-borne infections. For example, a study of tuberculosis in a central prison in the Democratic Republic of Congo found that persons in overcrowded cells (defined as >50 persons per $40m^2$) were almost ten times more likely to be infected than those in less crowded cells (odds ratio: 9.8, CI: 3.1,31.6) (Kalonji et al., 2016). In a Russian study, the odds of tuberculosis infection were about six times higher in overcrowded cells (defined as >2 persons per bed) compared to normal occupancy cells (Lobacheva et al., 2007). The COVID-19 pandemic provides another example: Overcrowding renders social distancing nearly impossible and complicates the quarantine of those exposed and the isolation of those infected. The higher the prison occupancy rate in Texas state prisons, the larger the COVID-19 outbreak (Vest et al., 2021).

The first systematic literature review of the relationship between cell spatial density and infectious disease was published in 2019, with only seven articles meeting its inclusion criteria (Simpson et al., 2019). This is a testament to the dearth of rigorous research into the association between overcrowding and infectious disease in prisons. Although the systematic review found a statistically significant association between overcrowding and some infectious diseases, such as pneumococcal disease and infectious dermatoses, the authors assessed the evidence as mostly fair or poor quality (Simpson et al., 2019).

Evidence is even more scant regarding the effect of overcrowding on non-communicable diseases and mental health. Suicide is posited as the leading cause of prison mortality, and self-harm has been demonstrated to constitute a significant morbidity burden (Favril et al., 2020; Fazel et al., 2017). However, there exists no evidence of an association between prison overcrowding and suicide (Fazel et al., 2017; Leese et al., 2006; Van Ginneken et al., 2017). Fazel et al.'s review of 20 countries found no statistically significant association between overcrowding (based on prison population versus capacity) and suicide (β:0.99, CI: -0.45,2.4). However, evidence is more mixed regarding the association between self-harm and prison overcrowding. Two studies examining data over extended years in a Swiss prison found a statistically significant association (Baggio et al., 2018; Wolf et al., 2016), but a systematic review and meta-analysis of 35 studies from 20 countries found no statistically significant association between single-cell occupancy and self-harm (OR:1.5, CI:0.8,2.9). This may be related to how overcrowding is defined across studies.

Nevertheless, persons in prison were found to be more likely to suffer depression in overcrowded prisons (β:0.05, $p<0.01$) when controlling for other factors, such as security level, in a study of all state prisons in the US. Overcrowding was defined as an index combining the ratio of prison population to design capacity and staffing (Edgemon & Clay-Warner, 2019).

In many prisons across the world, the number of health staff is insufficient to cover the needs of persons in prison who tend to have a higher demand for health care due to poor detention conditions and over-representation of vulnerable groups. For example, in Zambia, which has a prison population of 21,000, there was only one prison physician in 2020 (Egelund, 2020). As a result, persons in prison either do not receive care at all or receive delayed or substandard care. In many contexts, persons in prison must be taken to a clinic outside the prison, which requires escorts, which is a serious challenge for understaffed prisons. As such, missed medical appointments become a standard feature. Further, the administration of psychoactive medication, which should take place under observation, is complicated due to staff shortages, especially during the night shift. This can negatively affect treatment effectiveness and quality of life for people (MacDonald, 2018). Where direct observation of medication consumption is not observed, a black market in psychoactive medications may flourish.

In overcrowded prisons, people may need to take turns sleeping due to a lack of space or sleep only in certain positions that allow them to lie down in limited space (PRI, 2012a). Sleep deprivation has been shown to result in impaired neurocognitive and motor functioning, increased anxiety, and increased sensitivity and response to pain (Schneider et al., 2021). Chronic sleep deprivation has been associated with physiological changes such as increased blood pressure and inflammatory markers (Schneider et al., 2021).

Most research into the health consequences of overcrowding focuses on Western countries, especially the US. The effects of overcrowding on health may manifest differently across contexts, and research into the health effects of overcrowding in different contexts is needed. That said, there is already sufficient evidence that prison overcrowding has adverse health effects and must be avoided.

Impact on the right to liberty and security

Article 9 of the International Covenant on Civil and Political Rights (ICCPR, 1966) prohibits arbitrary arrest or detention and stipulates that deprivation of liberty should always be by the law. The Working Group on Arbitrary Detention stated

that the principle that deprivation of liberty shall be imposed proportionately to meet a pressing public need is most relevant to detention pending trial. This implies that pretrial detention should be a measure of last resort. However, international and regional bodies have expressed their concern over the increasing use of pretrial detention and its excessive length, noting its significant contribution to overcrowding, leading to a situation where, in some prisons, pretrial detainees constitute the majority of the population (Human Rights Council [HRC], 2015). In addition, a lack of staff resources in prison may result in necessary documents supporting a request for early release not being produced on time.

The Nelson Mandela Rule 1 states that "The safety and security of prisoners, staff, service providers and visitors shall be ensured at all times." (UNGA, 2015a). However, inadequate staffing levels due to overcrowding may lead to serious breaches of the right to security of detainees and instances where authorities fail to protect detainees from inter-prisoner violence (HRC, 2015). Various studies have examined the relationship between crowding and misconduct in prisons with mixed results (Franklin et al., 2006; Glazener & Nakamura, 2020). Franklin et al.'s meta-analysis of 16 studies in the US concluded that overcrowding did not predict misconduct, whereas Glazener and Nakamura found that overcrowding did predict misconduct in a study of 24 institutions in Pennsylvania (Franklin et al., 2006; Glazener & Nakamura, 2020). Interestingly, the relationship between misconduct and crowding was not found to be constant, diminishing as crowding increased. This suggests the existence of a threshold of overcrowding, after which misconduct is not affected. Glazener and Nakamura did not find a statistically significant relationship between overcrowding and *violent* misconduct (Glazener & Nakamura, 2020).

A study of the association between institutional factors and prison violence in Switzerland concluded that more violence occurred when both overcrowding and turnover increased (Baggio et al., 2020). Overcrowding has also been associated with self-reported hostility among persons in prison in a study examining national US data from 5,552 persons across 214 prisons (Edgemon & Clay-Warner, 2019).

Overcrowding may be a burden not only on persons in prisons but also on prison staff. In a survey among 66 correctional officers in three Alabama prisons in the US where occupancy ranged from 154% to 206%, all officers reported high levels of stress, "impaired job performance", increased violence, and that they were "fearful of inmates" (Martin et al., 2012).

Impact on the right to equality and non-discrimination

Another right often violated due to prison overcrowding is the right to equality and non-discrimination. Article 26 of ICCPR (1966) prescribes that "All persons are equal before the law and are entitled without any discrimination to the equal protection of the law." Nonetheless, several human rights bodies attest to how overcrowding is associated with failure to address the needs of vulnerable groups such as racial minorities, indigenous populations, women, juveniles as well as migrants and persons with mental illness. Facilities may lack the resources to separate groups according to international standards, e.g., children from adults; persons with physical disabilities may be held in environments that do not accommodate them; and those with mental illness may not receive adequate care and treatment. ((HRC, 2015).

Impact on the right to privacy and family life

The right to privacy and family life is enshrined in the Universal Declaration of Human Rights (UHDR, art. 12), ICCPR and other regional instruments guaranteeing that "no one shall be subject to arbitrary or unlawful interference with his privacy and family" (ICCPR, 1966, art. 17). Human rights bodies have documented several instances of violation of privacy in detention due to overcrowding.

In addition to the lack of privacy, prison overcrowding affects the right to family life. In some cases, persons may need to be moved far away from their families due to lack of space in prisons located close to the family. This severely impacts families' ability to visit their loved ones as many cannot afford the cost of long-distance travel. In other instances, a lack of sufficient staff hinders the smooth operation of visits, thus reducing the time people in detention can spend with loved ones.

Causes of overcrowding

While Europe has seen a decrease of 27% in its prison population between 2000 and 2021, prison populations grew by 43% in Asia and 38% in Africa (PRI & TIJ, 2022). The section below explores some of the main factors that have affected the growth of prison populations worldwide.

Excessive use of pretrial detention

Article 9(3) of the ICCPR (1966) states: "It shall not be the general rule that persons awaiting trial shall be detained in custody, but release may be subject to guarantees to appear for trial, at any other stage of the judicial proceedings, and should occasion arise, for execution of the judgement". Nonetheless, around one-third of the global prison population is detained on remand (PRI & TIJ, 2023).

Pre-trial detention has risen by over 30% globally in the last decade (Walmsley, 2020), and even when non-custodial alternatives are provided in legislation, they remain underused. For example, around 40% of people in Kenyan prisons are being held pre-trial, many arrested for petty offences which would attract sentences of less than six months, despite provisions in the Constitution (2010) which state that a custodial remand is not permissible if the alleged offence is punishable only by a fine or short-term imprisonment (Jacobson et al., 2017). While Jordan has reduced its population on remand from 47,9% in 2005 to 36,8% in 2019, many persons in prisons are still detained in pre-trial detention despite the country having laws i) stating that detention should be exceptional and unavoidable, ii) providing alternatives to detention and iii) requiring that the competent judge must be satisfied that the detention is a means to prevent real danger (Abuanzeh, 2022).

Longer sentences and delayed release

In some countries, legislation provides a mandatory minimum sentence for specific offences. In the United States, for example, the most common mandatory sentences are for five and 10 years based on the weight of the drug or the presence of a firearm. Such laws prevent judges from considering other relevant factors, such as the defendant's role in the offence or the likelihood of committing a future offence. Mandatory sentencing laws disproportionately affect people of colour and contribute to prison overcrowding (Families Against Mandatory Minimums, 2002).

In some cases, sentencing legislation also provides for serving more extended periods of the sentence before one is eligible for early release or probation. For example, in South Africa, the law prescribes that those who have received a minimum sentence need to serve 80% of their sentence or 25 years, whichever is shorter, to be released on parole, although a shorter period of two-thirds of the sentence may be stipulated by the sentencing court (*Correctional Services Act No 111* 1998 (SA), S 73(5)(b)(5)).

Deficiencies in the criminal justice system

In many countries, the criminal justice system is under increasing pressure to process a rising number of cases due to overcriminalisation. States that implement 'tough on crime' policies do not always invest equally in their criminal justice system. The system requires sufficient judges, effective file management, speedy procedures and workable alternatives to detention. Many cases require years to reach a final verdict while those accused languish in prisons on remand. For example, a 2017 audit of the criminal justice system in Kenya showed that 38% of criminal cases were completed within 308 to 1060 days (National Council on the Administration of Justice, 2016).

Lack of effective implementation of alternatives to imprisonment

Even if countries have adopted laws that provide alternatives to imprisonment, especially in the pre-trial stage, the implementation of such laws is lacking. For example, the government of Uganda has adopted the Community Service Act 2000 (UG), which sets up a National Service Committee with the aim of rehabilitating persons convicted of petty offences, decongesting prisons, and promoting the rights and dignity of persons in prison (PRI, 2012b). However, implementation is lacking due to limited resources or community service not being seen as a priority (PRI, 2012b).

Similarly, Kenya adopted the Community Service Order Act in 1998 to regulate and introduce community service for persons whose sentences do not exceed three years of imprisonment, with or without the option of a fine (*The Community Service Orders Acts No.10* 1998 (KE)). In addition to the community service option, Kenyan laws also provide for the option of bail and bonds (Article 49 (1) of the Constitution, 2010). The use of community service options was quite widespread in early 2000 in Kenya, shortly after the introduction of the Act, but has since not been used as regularly because of a lack of awareness about the law as many magistrate judges who received training upon the introduction of the Act were either promoted or replaced (PRI, 2005).

The Sierra Leone *Criminal Procedure Act No. 32* 1965 (SL) section 79 provides bail for persons charged with certain felonies. Many judges are reluctant to grant bail (ILRAJ, 2023).

The Philippines has one of the highest overcrowding rates despite a Community Service Act stating that "the court in the discretion may, in lieu of service in jail, require that the penalties of arrest minor and arrest mayor may be served by the defendant by rendering community service in the place where the crime was committed, under such terms as the court shall determine, taking into consideration the gravity of the offence and the circumstances of the case, which shall be under the supervision of a probation officer." (Community Act, 2019).

Criminalisation of poverty and drug offences

Criminalisation of poverty and status remains one of the key drivers of imprisonment (PRI & TIJ, 2024). "Criminalization of poverty" refers to the fact that persons living in poverty are over-represented in detention (PRI & TIJ, 2024). This is partly due to laws that lead to incarceration for acts related to poverty, such as the inability to repay small debts or begging. For ex-

ample, 42 out of 54 African countries criminalise people with no fixed address or means of subsistence (PRI & TIJ, 2022).

Further, laws that impose strong criminal sanctions for drug offences have led to the imprisonment of millions worldwide (PRI & TIJ, 2022). For example, in the Philippines, 53% of women in prisons are incarcerated mostly for low-level offences such as possession of small quantities of drugs, and sentences are going up to 20 years or life imprisonment. In Kenya, a person in possession of 1-5 grams of a drug (other than cannabis) faces life imprisonment and a fine of no less than 20 million shillings (more than 150.000 USD) (International Drug Policy Consortium, 2018; Narcotics, Drugs and Psychotropic Substances (Control) Amendment Bill 2020 (KE).

Detention of persons with mental disabilities

The United Nations Convention for the Rights of People of Disabilities guides states regarding the enjoyment of rights of persons with disabilities when deprived of liberty. In particular, Article 14 provides for deprivation of liberty on an equal basis (disability should not be used as a ground for detention), and when a person with disabilities is detained, states should treat such individuals in compliance with international human rights law, including by providing reasonable accommodation (UNCRPD, 2006). The Nelson Mandela Rules caution against the imprisonment of those with severe mental disability "for whom staying in prison would mean an exacerbation of their condition" (UNGA, 2015a). Nonetheless, about 14% of persons in prisons worldwide have a mental illness, and this number is as high as almost 50% in the US, much higher than in the general community (Horne & Newman, 2015; PRI & TIJ, 2018). A systematic review in low and middle-income country prisons estimated the prevalence of mental illness to be much higher than national rates, 16 times higher for non-affective psychosis and six times higher for major depression (Baranyi et al., 2019). This suggests that mentally ill people are more likely to be incarcerated, but conditions of incarceration may also exacerbate or even create mental illness (Quandt & Jones, 2021).

Lack of access to legal aid

The United Nations Principles and Guidelines on Access to Legal Aid in Criminal Justice Systems note that states, when designing legal aid schemes, should ensure that "vulnerable groups such as persons with mental disabilities have access to criminal justice, including promoting the use of alternatives and sanctions to deprivation of liberty and deprivation of liberty should be used as the last resort (UNODC, 2013). Once in prison, the Nelson Mandela Rules provide that persons in detention shall have "adequate opportunity, time and facilities to be visited by and to communicate and consult with a legal advisor of their own choice or legal aid provider, without delay" (UNGA, 2015a, rule 61.1). Yet, many are unable to challenge their detention owing to a lack of access to legal representation and legal aid and even the unavailability of judges (HRC, 2015).

Even countries that adopted the laws to provide legal aid are behind in the effective implementation. For example, Kenya adopted the Legal Aid Act in 2016 to facilitate access to justice by providing affordable, accessible, sustainable, credible and accountable legal aid services in accordance with the Constitution (2010), including a legal aid scheme to Indigenous persons as well as legal awareness (*Legal Aid Act* 2016 (Kenya)). However, the UN Committee against Torture expressed concerns that many face difficulties in obtaining free legal assistance (CAT, 2022b). The Constitution of the Philippines provides for access to legal aid, specifically noting that free access to the courts and quasi-judicial bodies shall not be denied to any person because of poverty. Further, the Constitution also tasks the Commission on Human Rights to provide adequate legal aid services to the underprivileged whose rights have been violated or need protection (Philippines, 1987). Despite the Constitution guaranteeing a right to legal aid, the 2018 World Justice Survey project found that only 20% of the population had access to legal assistance. The cost of services, inconvenience due to traffic and distance as well as lack of communication with lawyers were cited as reasons for failing to obtain legal assistance (Thomson Reuters Foundation, 2021). In recent years, Jordan has prioritised access to legal aid by enacting the Legal Aid Regulation in 2018 to assist persons from vulnerable communities, those charged with felonies, and individuals with large families in obtaining legal services. While Jordan has made progress, in the latest Universal Periodic Review (UPR) in January 2024, several countries recommended that the government continue strengthening the legal aid system and implementing the alternatives. (UNGA, 2024).

Alternatives to imprisonment

The Commentary on the Tokyo Rules defines a non-custodial measure as "any decision made by a competent authority to submit a person suspected of, accused of or sentenced for an offence to certain conditions and obligations that do not include imprisonment; such decision can be made at any stage of the administration of criminal justice." (UN Centre for Social Development and Humanitarian Affairs, 1993). The scope of the application of non-custodial measures should apply without discrimination at all stages of criminal proceedings. Non-custodial measures should be used by the principle of minimum intervention and with the person's consent, while the decision to impose

Table 2. *Overview of common non-custodial measures at each stage of the justice process*

Stages in the criminal justice process	Pre-trial Stage	Trial and sentencing stage	Post-trial Stage
Non-custodial measures	– Home arrest – Reporting obligation – Restriction on leaving or entering a specific space – Retention of travel documents – Bail or bond – Electronic monitoring	– Fines – Suspended/deferred sentence – Probation, judicial supervision – Community service – Diversion to treatment – Restrictions on movement – Electronic monitoring	– Parole or early conditional release – Temporary release – Compassionate release – Pardon or amnesty – Electronic monitoring
Justice actors responsible for deciding on custodial and non-custodial measures	– Police – Prosecution – Judiciary	– Prosecution – Judiciary	– Executive – Prison services – Parole boards – Judiciary

non-custodial measures must be reviewed by judicial or other independent authority (UNGA, 1990, Rule 2.1, 2.2 and 3).

The UN High Commissioner for Human Rights has called for the application of alternatives to detention to - among other reasons - decongest prisons. In a 2015 report, he urged states to revisit their eligibility criteria and widen their scope of application while noting the importance of alternatives for vulnerable groups (HRC, 2015).

Legislation should provide for various non-custodial measures and consider them throughout the criminal justice process (pretrial, trial, sentencing, and post-sentencing stages).

States must ensure such measures are human rights compliant, target the most vulnerable and allow application at all stages of criminal proceedings (UNODC, 2011). A range of justice actors are in a position to promote and implement non-custodial measures. Table 2 provides an overview of common non-custodial measures at each stage and the responsible actors taking relevant decisions.

Most recently, it has been suggested to deduct days from the prison sentence for persons experiencing overcrowding to allow for earlier release (Forero-Cuellar A., 2023).

Non-custodial measures should be prioritised for persons meeting certain conditions, including pre-trial detainees who do not pose a serious threat or risk, those convicted of minor offences or technical violations of probation/parole or who are low-risk, and those nearing the end of their sentence as well as those with severe mental disabilities or serious health conditions, seniors, juveniles, pregnant or victimised women and those with special caretaking responsibilities.

However, while these alternatives to detention are seen as opportunities to reduce overcrowding, some states implement alternatives arbitrarily to repressively restrict fundamental freedoms. For example, in Tunisia, various non-custodial measures have been applied in the context of a national emergency without proper judicial oversight, and persons have been placed under house arrest and ordered to report regularly to the police through administrative processes without a trial (Amnesty International, 2016).

Furthermore, the use of electronic monitoring has been widely criticised as an in-home type of deprivation of liberty, too restrictive, allowing only limited time outside of the house and not allowing individuals to participate in everyday activities, missing family events, or being unable to work or attend schools (Schenwar, 2020).

Overall, research points towards the risk of "net-widening" when alternatives are applied to persons who would not otherwise have received a criminal sanction (Aebi, M. F. et al. 2015). Therefore, a critical approach towards the way non-custodial alternatives are being used in practice is necessary.

Despite the challenges and risks, various countries have successfully implemented alternatives to reduce overcrowding in detention facilities.

Estonia has decreased its prison population through legal reforms, including decriminalisation, not punishing misdemeanour attempts and broader reliance on probation and community services (CPT, 2018).

Ukraine decreased its prison population from 218,800 in 2000 to 49,823 in 2021 by introducing laws that stipulate the

use of pre-trial detention only as a last resort, reducing sentences and increasing the use of non-custodial alternatives (Pravo Justice, 2019).

Malawi reduced the proportion of people in prison on pre-trail detention from 40% to 17% through improved access to legal aid. The paralegal program allows trained non-lawyers to provide legal advice and assistance (UNODC, 2013).

In 2022, Jordan judges handed down 4,193 rulings with alternative punishments, including sentencing 1,400 for first-time offences to community service. This comes on the heels of a reformed criminal justice code allowing the application of non-custodial measures, including behaviour rehabilitation programs, community service, travel bans, and electronic monitoring for less serious crimes (The Arab Renaissance for Democracy and Development, 2023).

In 2022, 73% of Liberian prisoners were on pre-trial (United Nations Development Programme [UNDP], 2022). To address the severe overcrowding, the Chief Justice of Liberia issued a directive with orders to release persons who had served their sentence but had outstanding restitution to settle the amount due, stop admission of new persons accused of minor offences, and release all persons on pre-trial held for offences triable at magistrate courts who had been in jail beyond 30 days (UNDP, 2022).

The COVID-19 pandemic is a case in point, as many states implemented measures that significantly reduced prison populations. The Moroccan King issued pardons for 5,645 persons in prison as a preventive measure based on the criteria of age, precarious health, the length of their sentence and good behaviour displayed (Africa News, 2020). In Uganda, the Prison Services, along with the Attorney General and the President, ordered the release of 2,000 persons in prisons to decongest prisons. Among those eligible for release were persons who had completed three-quarters of their sentence, breast-feeding women and persons above the age of 60 (CGTN Africa, 2023). Jordan released 1,500 persons (Luck, 2020), and the Philippines released around 10,000 persons whose sentences did not exceed 6 months, as well as elderly and sick (Al Jazeera, 2020). The Kenyan prison population decreased by 25% in March-August 2020 when more than 12,000 persons were released and ordered to conduct community service or pay bond or bail. The National Council on the Administration of Justice in Kenya imposed several rules, including police bonds for minor offences, suspension of new admissions to prison and supervision of persons on probation by phone instead of physical reporting (UNODC, 2021).

Conclusion

Many countries struggle to address overcrowding, and prison populations worldwide continue to rise. Various UN and regional bodies have urged States to alleviate prison overcrowding. Overcrowding negatively affects the enjoyment of human rights by persons in prisons, including their right to be free from torture and other ill-treatment and the right to health. Overcrowding is associated with reduced space and often reduced budget and staff per person, which affects all aspects of prison life, leading to prisons not offering an environment conducive to their stated purpose of rehabilitation. When prisons fail to rehabilitate and prepare persons for reintegration upon release, this may negatively impact society in terms of security, public health, and economy.

Some countries have successfully reduced overcrowding, including through the use of non-custodial measures. Various elements have played a role in this success. Firstly, a policy shift away from deploying imprisonment as the predominant way to prevent and reduce crime. This policy shift, when applied through legal and policy reforms related to decriminalisation and the provision of non-custodial alternatives to detention, has shown positive results in terms of reducing overcrowding and, thus, the risk of human rights violations inside prisons. In addition, similar legal reforms targeting marginalised populations, such as those living in poverty and petty and status offences, can ease overcrowding, especially in pre-trial detention.

Reducing prison overcrowding is a shared responsibility of law makers, prosecutors, judges, prison and probation services, and other relevant criminal justice actors. Measures need to be adopted and applied at all stages of the criminal justice process to reduce admissions and accelerate releases from prisons to ensure positive and significant outcomes.

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Submitted 25th of July 2024
Accepted 22nd of Oct. 2024

Torture, 2024, 34(3), 54-63
https://doi.org/10.7146/torture.v34i3.147953 *Research paper*

Acceptability and preliminary effects of intensive brief trauma-focused PTSD treatment for refugees: a pilot study

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Key points of interest

- Intensive brief trauma-focused PTSD treatment significantly reduced PTSD symptoms in a heterogeneous sample of refugees.
- The intensive brief trauma-focused PTSD program was well-received by participating refugees, and no adverse events were detected.
- Further research, with a larger sample size and an active control group, is needed to confirm that Intensive brief trauma-focused PTSD treatment is an effective treatment option for refugees in outpatient settings.

Abstract

Background: Post-Traumatic Stress Disorder (PTSD) is a significant mental health concern in refugee populations exposed to trauma and displacement. Traditional treatments for PTSD often involve lengthy interventions. However, there's a growing interest in exploring more condensed, intensive treatments to improve outcomes and accessibility for refugees. *Objective*: This study aimed to evaluate the acceptability and preliminary effects of an intensive brief trauma-focused PTSD treatment (ITT) program delivered to refugees at the Swedish Red Cross Treatment Center for Persons Affected by War and Torture in Uppsala, Sweden. *Method*: Ten participants were enrolled in the study and received ITT over five consecutive weekdays comprising Eye Movement Desensitization and Reprocessing Therapy (EMDR), prolonged exposure (PE), and physical activity (PA). Acceptability was assessed by analysing journal notes and clinicians' and patients' open-ended responses to sets of questions designed to elicit the patients' experiences and potential adverse events. Baseline and follow-up data regarding PTSD, disability, and anxiety or depression were collected and analysed. *Results*: The study demonstrated that ITT is an acceptable and viable treatment option for refugees with PTSD. No serious adverse events were reported, although some found the treatment very taxing. Overall, the ordeals were perceived as worthwhile. The statistical analyses showed substantial and significantly reduced PTSD symptoms and anxiety levels. Reductions in depression symptoms and disability were also observed but were non-significant. *Conclusions*: The results suggest that this brief and massed treatment program for refugees with PTSD is a well-received and in a very preliminary assessment, might be an effective treatment option. Identifying less suitable candidates and conducting larger, controlled studies with longer follow-up periods are needed to establish ITT's efficacy in this population.

Keywords: trauma, post-traumatic stress disorder, intensive treatment, refugees, EMDR, prolonged exposure

Introduction

Providing effective psychotherapy and adequate psychological support for refugees traumatised by war, conflicts, flight, persecution, or torture is of utmost importance. It is estimated that 108 million individuals are displaced due to persecution, conflict, violence, human rights violations, and events seriously disturbing public order in the world today (UNHCR, 2022). The prevalence rates of post-traumatic stress disorder (PTSD), depression, and anxiety are alarmingly high among refugees, with estimates reaching up to 31, 32, and 12 %, respectively (Blackmore et al., 2020). Notably, these disorders often co-occur at elevated rates, which means even greater individual suffering (Teodorescu et al., 2012; Tinghög et al., 2017). A recent systematic review also reported the prevalence rate of complex PTSD (CPTSD) to be as high as up to 38 % in treatment-seeking samples of refugees (de Silva et al., 2021). The high prevalence of CPTSD among refugees underscores the considerable challenges in achieving treatment efficacy, given that CPTSD is associated with lower treatment effects (Cloitre, 2021).

Thus, societies face immense challenges when it comes to addressing the tremendous psychological needs of refugees. At the same time, there is a widespread assumption that traditional trauma-focused psychological interventions can overwhelm refugees (and patients with CPTSD in particular), and hence should, an adapted or phased approach be used instead (Cloitre et al., 2012; Nickerson et al., 2011). Even though the empirical support for these claims is questionable (De Jongh et al., 2016; Heide et al., 2016), the effect is that the psychological needs of refugees are often left unattended due to worries among healthcare personnel to do more harm than good in combination with an understanding that it is not an efficient use of scarce resources.

To optimise the use of resources, it would be of great value to find an evidence-based treatment for refugees that is both effective and safe and that alleviates adverse symptoms quicker than more traditional treatments. Intensive brief trauma-focused PTSD treatment (ITT) is a type of intervention that potentially could fill these needs and purposes as it is effective and safe in non-refugee populations (Auren et al., 2022; Van Woudenberg et al., 2018). In this study, we will investigate the efficacy and acceptability of an ITT program for refugees, which has not previously been evaluated.

For the general populations with PTSD, most treatment guidelines, as well as systematic reviews, favour trauma-focused therapy, e.g., (Bisson et al., 2013; Bryant, 2019; Tol et al., 2013) such as prolonged exposure (PE), cognitive processing therapy as well as eye movement desensitisation and reprocessing (EMDR). The evidence base relating to refugees specifically is less robust, but the present-day findings are nonetheless concurrent (Turrini et al., 2019). In recent years, several studies, primarily from the Netherlands, have shown that intensive brief trauma-focused PTSD treatment programs (6-8 days), including PE, EMDR, and physical activity (PA), appear to be at least as effective as more traditional trauma-focused approaches in reducing PTSD symptomology (Alting van Geusau et al., 2021; Auren et al., 2022; Van Woudenberg et al., 2018; Voorendonk et al., 2020). This massed and condensed format, utilising therapist rotation (i.e., when multiple therapists alternate in treating the patient), appears to be advantageous in that it reduces dropout rates and keeps the therapy more focused on the essential exposure elements than traditional trauma-focused therapy and hence reduces therapist drift (Hendriks, 2019; Van Minnen et al., 2018). It thus appears that ITT, at least in theory, is a particularly valuable treatment option for refugees with PTSD or CPTSD in outpatient settings.

It should be noted that psychotherapy for refugees with PTSD usually includes a set of unique challenges. First, the type of experiences resulting in severe traumatisation in war and conflict settings are often more complex and prolonged in comparison to traumatising episodes experienced during peacetime in less chaotic environments or of more single-event characters (Ter Heide & Smid, 2015). Second, many refugees have resettled in distant regions or countries where they lack the proficiency to speak and understand the native language, with the consequence that any psychological treatment must be delivered with the assistance of an interpreter, which can impede treatment success (Sander et al., 2019). Third, when settling in foreign environments, living conditions are often uncertain and stressful (Malm et al., 2020; Tinghög et al., 2017). This often interferes with the patient's ability to follow the treatment plan (Semmlinger & Ehring, 2022) as well as the effect of the treatment (Sonne et al., 2021). Appointments are, for example, missed or continuously rescheduled, or the therapist feels it is necessary to pause the active treatment to focus on stabilisation instead (Shapiro, 2018). Consequently, a pilot project, in which an ITT program was implemented in an outpatient clinic in Sweden specialising in care for refugees who have experienced trauma due to torture, armed conflict and/or flight, was set up. The specific aim of this study is to 1) preliminary evaluate the ITT program's efficacy on symptom and disability reduction among refugees, and 2) assess the acceptability of ITT among refugees, including identification of potentially adverse events.

Methods

The study was a single-centre uncontrolled trial conducted at the Swedish Red Cross Treatment Center for Persons Affected by War and Torture in Uppsala, Sweden. Recruitment com-

menced in February 2021 and concluded on Mars in 2023. It was decided that the data collection would end when data on 8-10 participants had been collected, enabling us to statistically substantiate large effect sizes corresponding to a Cohen's d of about 1.3 when assuming a power of 80% and an alpha of 0.05. Ethical approval for the study was obtained from The National Ethical Review Board in Sweden, Ref. No. 2021-07003-01.

Participants

Broad inclusion criteria were employed to increase the external validity. Participants had to meet the following inclusion criteria: 1) PTSD diagnosis according to DSM-5 2) traumatised due to armed conflicts, torture, persecution, and/or flight 3) at least four events fulfilling criteria A in DSM-5 4) being 18 years or older and 5) cognitive abilities to follow the instructions in EMDR and PE treatment. Individuals assessed as having elevated risk for suicidal or serious self-harm behaviour, harmful substance use, and ongoing psychosis or currently experiencing violent living conditions were excluded from the study.

Recruitment

A total of ten participants were recruited in regular clinical practice. All therapists at the centre were instructed to identify patients who might be interested in participating in this study and who met the inclusion criteria. Both new and long-term patients were eligible for participation. Half of the patients invited to participate declined. There were varied reasons why a patient did not want to participate of which the most common was logistical issues and feeling uncomfortable being treated by multiple therapists. When an individual had expressed interest in participating, formal informed consent was obtained. Thereafter, the preparation phase began, which included working out various logistical issues, e.g., making sure the participants had the practical ability to participate as intended, as well as deciding on traumatic events to target during the treatment week.

Therapists and assessors

All clinicians who delivered EMDR or PE had been trained in the respective methods. The involved clinicians were licensed psychologists or licensed psychotherapists, and one was a licensed health-care counsellor. All were employed at the centre and had extensive experience in providing psychotherapy to refugees with PTSD. None of the clinicians had any previous practical experience with ITT. However, all of them had participated during the adaptation phase during which ITT was delivered to three patients at the clinic. These patients are not included in this study sample. Before and during the early set up of the pilot project, involved clinicians participated in several workshops on ITT led by a researcher and psychologist with experience in setting up an ITT program in an outpatient setting in the Netherlands, i.e. (Alting van Geusau et al., 2021). Supervision of PE and EMDR was continuously provided by certified supervisors and trainers, and collegial supervision was also a regular feature.

It was the involved therapist who assessed the participant for research purposes. The project leader (LV) provided assessment supervision. This in-house project leader had the task of aiding assessors when needed, which included issues about how assessment tools should be administered and used. To further ensure that all participants underwent the same procedure, a detailed folder, describing all study-specific requirements, was compiled, and made available.

Treatment and procedures

The specific intensive brief trauma-focused PTSD treatment program (ITT) evaluated in this study is an adapted version of ITT programs developed for and evaluated in both in and out-patient settings among non-refugee populations (Alting van Geusau et al., 2021; Auren et al., 2022; Van Woudenberg et al., 2018). The main treatment components and treatment strategies are the same, e.g., EMDR, PE, and PA delivered in a massed and condensed format, following the same arrangement each day of treatment using therapist rotation.

Experienced interpreters were booked when needed and, in all cases, when interpreters were needed the same interpreter was used for the entire ITT to make the patient feel as comfortable as possible. The decision of which interpreter to involve was made in collaboration with the patients to ensure both high quality and that the patients felt comfortable. Finding an appropriate interpreter and establishing a good working relationship was accomplished during the preparations leading up to the ITT. The centre has extensive experience working with interpreters to achieve high-quality therapy sessions.

The enrolled patients received treatment for five consecutive working days, each day structured the same way. It includes a 105-minute morning session of PE and a 90-minute EMDR session in the afternoon, provided by certified therapists. The EMDR sessions followed Shapiro's EMDR protocol (2018), with a particular focus on phase 4. In this phase, the aim is to process trauma by combining internal visualisation of the traumatic memory with dual attention stimuli, such as eye movements. The PE sessions consisted of imaginal exposure, involving repeated recounting, revisiting, and processing of the traumatic memory according to the protocol established by Foa and colleagues (2019). In short, imaginal exposure, an essential component of both PE and EMDR, entails repeatedly recounting the most distressing episode of a traumatic event to

gain new insights into one's ability to cope with the traumatic content. This process helps reduce the distress linked to the memory and challenges negative beliefs about the trauma (Foa et al., 2019). The discussion regarding the active mechanisms and differences between EMDR and PE is ongoing and extends beyond the scope of this article.

Even though therapist rotation was used, each participant/patient had a specific therapist assigned to oversee the process and be his or her primary contact person (hereafter referred to as the "primary therapist"). It was also this therapist who prepared the patient for taking part in the ITT program, including the identification and assessment of traumatising memories to be targeted in the EMDR and PE sessions. The preparations were conducted in accordance with standard protocols (Foa et al., 2019; Shapiro, 2018).

Between the two trauma-focused treatment sessions, patients had a break consisting of lunch and 60 minutes of physical activity (PA) exercise or activities together with a physiotherapist or a psychologist. These activities were of low to moderate intensity and individually designed to fit the patient's preference and physical abilities (e.g., walks, relaxation, and music exercises) and hence were not a particular protocol used. The individualised activities were prepared and delivered by psychologists, a physiotherapist, and a musical therapist. All individualised activities included some physical activities and were intended to pause the processing of trauma by redirecting focus to the "here and now" by engaging the patient in a structured activity. During the patient's lunch break, a handover was conducted from the morning PE session to the afternoon EMDR session, providing general information about the completed session and details about the identified hotspots. In the afternoon, at the end of the EMDR session, patients were given the opportunity to reflect on the day together with the therapist. All sessions could involve psychoeducational elements, for instance, making sure the patient properly understood the treatment process and normalising various physical and emotional reactions common when processing trauma memories.

A structured clinical interview was scheduled around three to five weeks before and five weeks after the intervention (Clinician-Administered PTSD Scale for DSM-5; CAPS-5; Weathers et al., 2013). Self-report data regarding symptoms of PTSD, depression, anxiety, and disability were to be collected 1-2 weeks before and 1-2 weeks after the intervention. However, due to various reasons, patient data were not always collected at these pre-established time points (for details see Table 1)

Outcomes measures and acceptability assessment

The primary outcome measure of the study is symptom severity of PTSD, which was measured with CAPS-5 and the PTSD Checklist for DSM-5 (PCL-5; Blevins et al., 2015). CAPS-5 is considered to be the gold standard for PTSD assessment and was in this study used to establish PTSD diagnosis before treatment and to determine if a PTSD diagnosis was still present at follow-up. However, both instruments can be used to measure PTSD severity and an individual score between 0 and 80 is obtained, where a higher score indicates more severe symptomology. A score of 31 or 33 is commonly used to screen for PTSD (Bovin et al., 2016).

The secondary outcomes consisted of anxiety, depression, and disability. Hopkins Symptom Checklist-25 (HSCL-25) consists of two subscales intended to measure both anxiety (10 items) and depression severity (15 items). The score of the subscales - item averaged scores - range from 1–4. When used as a screening instrument to identify probable cases, a score of around 1.75-2.00 is commonly used as a cutoff for both anxiety and depression (Oruc et al., 2008; Ventevogel et al., 2007). Whodas-12, a generic measure of health and disability, was used to assess the participants' disability levels before and after taking part in the intervention. The simple scoring approach where the responses on the twelve individual items (0–4) were summed up (0-48) was used (Üstün et al., 2010).

All self-report measures were available in Swedish, English, Arabic, and Persian at the centre. Participants used the version they preferred or the Swedish version that was filled in with the

***Table 1**. Number of weeks before and after treatment instruments were administered. Mean and SD*

Measurement instruments	Before	After
CAPS-5 (PTSD)	3.7 (3.0)	5.3 (0.5)
PCL-5 (PTSD)	2.8 (4.0)	2.2 (1.4)
Whodas-12 (Disability)	1.6 (1.0)	2.0 (1.3)
HSCL-25 (Depression, Anxiety)	1.9 (1.1)	2.0 (1.3)

assistance of the interpreter. The participants' primary therapist was present when the self-reported scales were administered to assist if needed.

Acceptability is in this study defined as a tolerable and non-harmful experience and the absence of adverse events among patients. However, standard trauma treatment always evokes strong emotional and physical reactions in patients, which is also to be expected in ITT. Thus, non-acceptability in this study means when new or unexpected reactions appear that are not commonly seen in standard treatment. Acceptability was assessed by carefully scrutinising patient-specific qualitative information from three different sources. These sources consisted of patient records and written responses to two sets of questions - one for the patient and one for the primary therapist. All involved therapists were instructed to provide detailed journal notes as well as to report any potential adverse effects in the patient's record. The set of open-ended or probing questions for the patient was designed to elicit their experiences of taking part in ITT and to prompt them to identify aspects they felt were problematic or could be improved, e.g., How did you experience the ITT? Do you experience residual symptoms that you would like to have further treatment for? Would you recommend the ITT for other persons with PTSD? If so, why or why not? Could the arrangement of ITT be improved? The second set of open-ended or probing questions was filled out by the patient's primary therapist and focused on how they felt that the ITT had worked for the specific patient, including describing aspects that had been problematic for the patient. e.g., what difficulties and challenges were encountered during ITT? Was the patient suitable for ITT? Does the patient have residual symptoms and need additional treatment?

Analysis

In this one-group pre- and post-test study, paired t-tests were used to assess treatment effects on symptom and disability levels. When information was missing (6%), cases were excluded from the relevant analyses. Within-group effect sizes are presented as Cohen's d. A Cohen's d of 0,2 is generally interpreted as a small effect, 0.5 as a medium effect, and 0.8 and above as a large effect. To evaluate the robustness of the statistical analyses, an additional series of non-parametric Wilcoxon signed-rank tests were performed. However, all difference measures displayed kurtosis and skewness statistics between -1 and 1, suggesting that parametric statistical methods may nonetheless be appropriate. 95% confidence intervals were calculated for means and effect sizes, while Wilcoxon signed-rank tests are presented as Z-scores with p-values.

Qualitative data of acceptability was analysed and summarised by the following steps: 1) The first author (PT) carefully read all transcripts of open-ended responses to the probing questions filled out by the primary therapists and the participants, while noting similarities and any potential adverse events. 2) Thereafter the first author summarised the findings, while simultaneously reviewing if it was in accordance with an independent and structured thematic reorganisation of the same transcripts made by the second author (LV). 3) The second author went through the patient records to identify if any potential adverse effects could be identified there 4) Finally, the authors discussed the written summary and revised it so it adequately would represent the data. This process was finalised when consensus was reached. It should also be noted that regular team meetings were held where the patient's ITTs were discussed with involved clinicians (LV, NM, and JJ participated in these meetings), providing additional input to which the summary could be contrasted and validated.

Results

The age of the participants ranged from 21 to 63 years (Mean 45.8, SD 13.2), with seven identified as men and three as women. They originated from Afghanistan, Burundi, Congo-Kinshasa, Iran, Iraq, Rwanda, and Syria and had been in Sweden for one to fourteen years (M = 6.4, SD = 4.3); five had lived in Sweden for five years or less. Three participants used an interpreter for all sessions, four required an interpreter for some but not all sessions, and three did not use an interpreter. Reported traumas included various types of events such as sexual violence, torture, relationship violence, persecution, and combat or war-related events, with most of the participants having endured traumas both in childhood and adulthood. In terms of employment status, five were on full or part-time sickness absence, one was an undocumented migrant and unemployed, three were studying, and one was in an apprenticeship. Three participants had previously received trauma-focused therapy treatment interventions, and six had received other types of psychotherapy, either at the Red Cross Treatment Center or elsewhere. All participants, except three, held permanent residency in Sweden.

All participants had a score above 1.75 on the depression subscale (HSCL-25), suggesting that they all would meet the diagnostic criteria of depression (see Figure 4a), while seven out of nine measured reported a symptom load of anxiety indicating plausible clinical anxiety (see Figure 3a). Some participants experienced dissociative symptoms.

All enrolled participants completed the treatment week. Although one participant missed the second day and one treatment program was terminated, in accordance with protocol,

after the fourth day when the treatment objectives were met. On average each patient met with 5.0 different therapists (SD 0.9) and 1.5 physiotherapists/psychologists (SD 0.5) during the treatment week.

Treatment effects

Figures 1 to 5 show the trajectories for all participants in relation to PTSD, anxiety, depression, and disability levels. In Figures 1b to 5b, the mean pre- and post-treatment levels are displayed. Following treatment five of nine participants no longer met the diagnostic criteria of PTSD according to CAPS-5. Table 2 further shows that significant ($p<0.05$) and substantial treatment effects could be detected regarding CAPS-5 (Cohen's d 1.91, CI 95% 0.77-3.02), PCL-5 (Cohen's d 1.31, CI 95% 0.43-2.15) and anxiety (Cohen's d 1.47, CI 95% 0.49-2.41). The treatment effects on disability and depression were however lower and non-significant.

Acceptability

Several participants expressed that the treatment week was very challenging, especially during the first days. It was not uncommon to feel exhausted. Several of the participants also reported having physical symptoms such as headaches, while a couple expressed that they had trouble eating during the lunch break due to low appetite. Participants reported increased irritability, sleeping disturbances, and anxiety, with one individual experiencing dissociative symptoms outside the treatment settings. Dissociate symptoms here refer to a temporary mental state in which a person feels disconnected from their thoughts, feelings, memories, or surroundings, leading to a sense of detachment or altered reality. Such symptoms, while sometimes challenging, are a common and expected part of trauma-focused therapy (Hoeboer et al., 2020) and typically subside as treatment progresses. For this participant, the dissociated symptoms diminished after a few weeks. During this period, ongoing support was provided at the clinic.

The PA sessions were overall highly appreciated, and some felt they were necessary to get through the day. It appeared that relaxation exercises with calming music were particularly appreciated.

Even though most patients found the treatment week to be tough and painful and some experienced that their symptoms even increased, but no one indicated that it was not worth it. Some had recommended ITT to friends or acquaintances, and some wanted to continue the program so they could work with other traumatic episodes not covered during the week. Overall, the participants were satisfied with all the care and encouragement they received at the clinic during the treatment week. Some of the individuals who initially had been nervous about the therapist rotation felt that it had been rather unproblematic or even positive.

***Figure 1**. Individual trajectories CAPS-5 scores (n=9)*

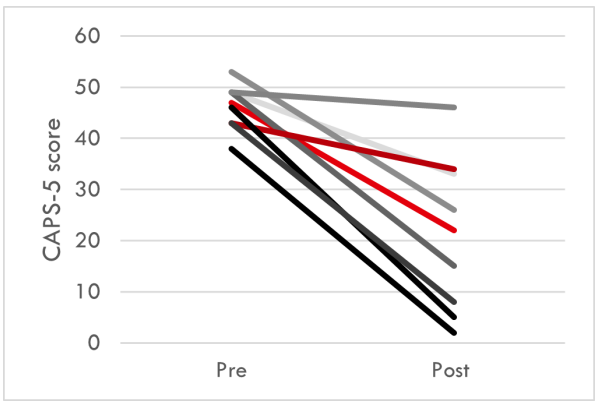

***Figure 2**. Individual trajectories PCL-5 scores (n=10)*

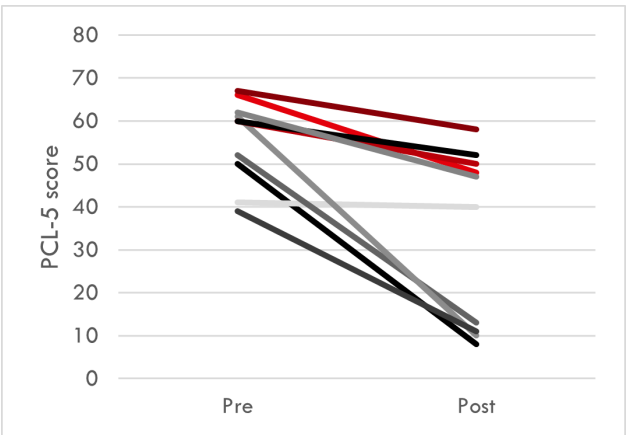

***Figure 3**. Individual trajectories Anxiety scores (HSCL, n=9)*

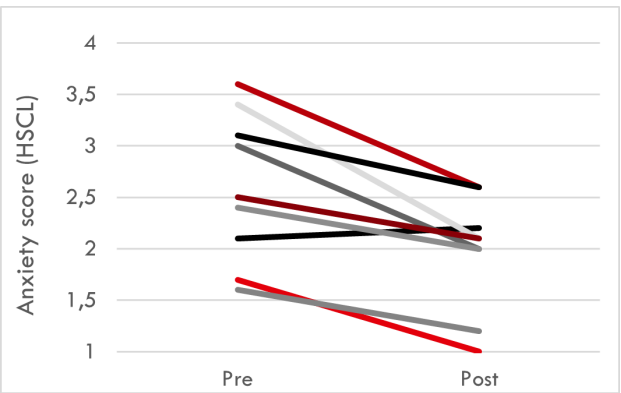

Figure 4. *Individual trajectories Depression scores (HSCL, n=9)*

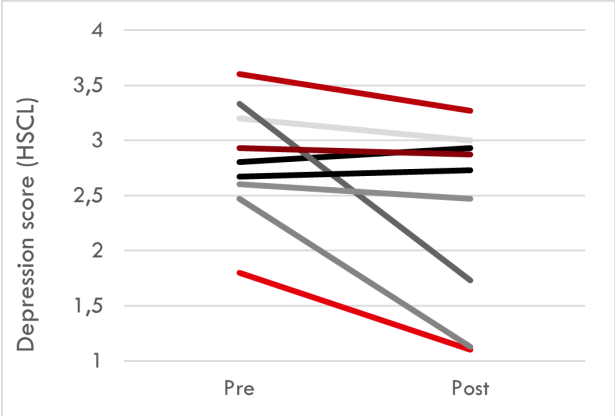

Figure 5. *Individual trajectories Disability scores (WHODAS, n=9)*

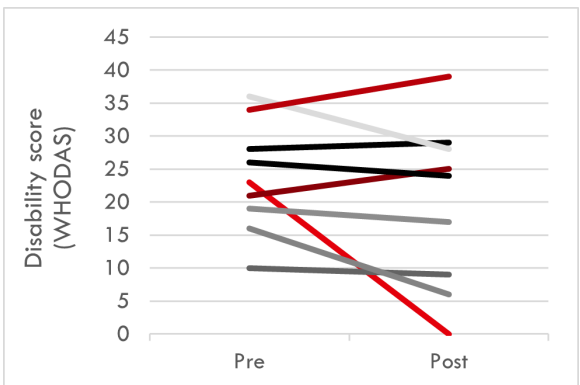

Table 2. *Treatment effects on PTSD, anxiety and depression symptoms, and disability presented as Cohens' d (CI 95%) using pre- and post-treatment measurements.*

	Cohen's d (CI 95%) *
PTSD (CAPS-5)	1.91 (0.77-3.02)
PTSD (PCL-5)	1.31 (0.43-2.15)
Depression (15 items HSCL)	0.75 (-0.02-1.47)
Anxiety (10 items HSCL)	1.47 (0.49-2.41)
Disability (Whodas-12)	0.46 (-0.24-1.14)

*Paired t-tests

Discussion

The results from this pilot study indicate that intensive brief trauma-focused PTSD treatment (ITT) is an acceptable and preliminary effective treatment for PTSD and anxiety among refugees. It was also revealed that although this was perceived as a challenging and highly taxing treatment, it was tolerable and recommended by the participants. No serious adverse or unexpected events were reported. The unwanted symptoms that nonetheless were reported were minor and short-lived and could be addressed by the therapist. These symptoms are commonly encountered also in traditional trauma-focused treatment.

In accordance with ITT studies on other populations, this study showed that participants missed very few therapy sessions (Ragsdale et al., 2020). All participants completed the treatment program and only one participant missed any treatment sessions. Hence this suggests that post-migration stress does not seriously impact refugees' ability to participate. The short and compressed format might make it easier for the participants to remain motivated. Adverse life events may be less likely to influence their motivation i.e., the treatment is only one week. The format may also make the therapist more successful in encouraging and supporting the participants. Neither does the reliance on interpreters seem to negatively impact the process or outcome of the ITT, at least were no such concerns raised by the therapists or the participants themselves.

The individually designed physical activity (PA) was reported as being important for making it through the treatment week. A similar sentiment is echoed in Thoresens et al.'s study where non-refugees undergoing ITT in an outpatient setting perceived the PA as a "mental breathing space" (Thoresen et al., 2022). Some studies have shown that PA boosts the trauma-focused therapy's effect on PTSD severity (e.g., (Rosenbaum et al., 2015). However, a recent RCT study of an ITT program showed that trauma-focused therapy in combination with PA was not more effective in reducing PTSD symptoms than trauma-focused therapy and a guided creative task (Voorendonk et al., 2023). It can nonetheless be argued that some type of recreational activity helps the patients through the emotionally taxing treatment week (Carroll et al., 2007; Deps & Charlier, 2020), hence reducing the risk of dropout.

The treatment effects on PTSD symptomology and anxiety were substantial and in line with findings from other studies on ITT (Sciarrino et al., 2020). That the treatment effects on depression and disability were lower and non-significant or borderline significant is hardly surprising given that ITT is not designed to target such ailments. Any positive treatment effects that ITT may have on depression or disability could be a side effect of reduced PTSD severity and somewhat shared

aetiology (Stander et al., 2014). It is also worth noting that the treatment did not benefit all participants equally, as a few patients reported a rather meagre decline in PTSD severity. In future studies, a close investigation of the variations in treatment success is warranted. Plausible reasons for poorer treatment outcomes, also suggested by therapists in this pilot study, were that participants were exposed to adverse life events (e.g., post-migration stress) around the time of the treatment, that participants were too emotionally detached to benefit fully or due to the shortness of the treatment program. It has also been reported that persistent depressive symptoms are linked with poorer treatment outcomes in ITTs (Burton et al., 2022).

Even though this study demonstrates that massed interventions or ITT could also be effective for refugees traumatised due to torture armed conflict and/or flight, this pilot study has several limitations that should be taken into consideration when interpreting the findings. First, the sample size is small and thus underpowered to statistically corroborate treatment effects that are not substantial, i.e., Cohens' d around 1.0 or more. A larger sample size would also have enabled the identification of specific patient characteristics that predict treatment success. Second, the study participants were used as their own controls. Hence, the study had no control group to which participants were randomly assigned, which would have strengthened the validity of our findings. Third, there was some variation in when pre- and post-measurements were collected in relation to the treatment initiation or finalisation. A longer follow-up period would also have provided valuable information on the stability of the treatment effects. Fourth, the data sometimes had to be collected with the help of interpreters, which, in theory, can influence the participants' interpretations of items in unwanted ways. Finally, it should be noted that the recruitment of participants was difficult, indicating that many eligible participants either declined participation or were not invited to participate. Hence, the sample may be selected in unknown ways. These unknown potential selection effects, in addition to the small sample size, further limit the ability to make any definite claims about the study's external validity. The study, given the heterogeneity of the sample that nonetheless is apparent, still suggests that ITT is both acceptable and effective for refugees with various characteristics.

Conclusion

This study shows that ITT is a viable and acceptable treatment option for refugees who have experienced trauma due to torture, armed conflict, and/or flight. The findings further suggest that ITT is a highly effective method for treating PTSD among refugees in an outpatient setting. These findings should be interpreted in relation to the many unique challenges involved when delivering ITT to refugees. However, further studies with larger samples and longer follow-ups that compare ITT to active controls or first-line treatment are needed to corroborate and expand these results. In-depth investigations that in detail explore the ITT treatment process in this context, both from the perspective of the patient and the treating clinician, are warranted. It would provide valuable knowledge to better understand how specific treatment components influence treatment outcomes and when in the process treatment effects can be detected.

Disclosure statements

None of the authors have any potential conflict of interest to report.

Funding

This study was supported by grants from the Swedish Red Cross Competence Center for Rehabilitation of Torture and War Trauma and through internal resources from the Swedish Red Cross Treatment Center for Persons Affected by War and Torture in Uppsala, Sweden and the Red Cross University, Huddinge, Sweden.

Data availability statement

The data on which this study is based is not readily available due to its private and sensitive nature. The individual scores on the pre- and post-measurements are displayed in the figures included in the manuscript.

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Submitted 7th of Aug. 2024
Accepted 12th of Nov. 2024

Torture, 2024, 34(3), 64-73
https://doi.org/10.7146/torture.v34i3.147785 *Research paper*

"The state has a debt to us, it ended our dreams, our life projects": Reconstructing life projects after torture

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Key points of interest:

- The term 'life project' originates from sentences in the Inter-American Court of Human Rights (IACtHR) and has become part of the legal consciousness of persons affected by serious and systematic human rights violations.
- The term is useful for understanding how torture and other human rights violations impact individual victims' lives and the lives of their children.

Abstract

Introduction: The concept of 'life project' is at the core of several Inter-American Human Rights System decisions. This concept has also become part of the legal consciousness of torture survivors in Peru and is often referred to when they describe the impact of torture and imprisonment on their lives and the lives of their children. *Methods:* The paper is based on qualitative interviews with seven Peruvian torture survivors. *Results:* The interviewees describe damage to their life projects both regarding health and the impact of stigma but place special emphasis on how as a result of being imprisoned, they have been unable to take care of their children for more extended periods, their children have been subjected to violence, and they have had less access to education. Still, the interviewees describe how they reconstruct their life projects and how the concept serves as a starting point for demanding reparations.

Keywords: Life project – reparations – livelihoods – intergenerational consequences of torture and imprisonment

The concept of 'life project' is at the core of several decisions in the Inter-American Human Rights System. This concept refers to the expected development of a person, something that can change drastically with being subjected to torture or other cruel and inhuman treatment and is often referred to when survivors describe the impact of torture and imprisonment on their lives and the lives of their children.

In Peru, persons suspected or accused of terrorism during the internal armed conflict in the 1980s and the authoritarian regime of Alberto Fujimori in the 1990s were routinely subjected to torture and other harsh inhuman treatment or punishment. After the transition to a democratic regime in 2000, several reparation policies towards the population targeted by political violence have been put in place. Some of these policies, such as access to health care, cover the whole of the population affected by state or political violence; others have stricter criteria for inclusion. Many torture survivors with suspicion or sentences for terrorism have been excluded from some schemes. Some have taken their cases to the Inter-American Human Rights System.

The paper takes the concept of 'life project' as it is used by the Inter-American Court of Human Rights (IACtHR) as a starting point and explores how the concept has been included in the legal consciousness of torture survivors in Peru. The paper explores the survivors' descriptions of what they have

lost, including their source of income and sometimes homes, and how they seek to re-construct both housing and livelihood in a context where they have very limited access to physical and mental health care. Still, torture survivors take responsibility for reconstructing their life projects while also making demands towards the state for economic reparations as well as health care and the possibility of education for their children.

On life projects and legal consciousness

The concept of 'life project' is central in legal consciousness in Peru, as persons affected by state or political violence often talk about their life projects and how their life project was damaged or changed due to detention, imprisonment, maltreatment, or the disappearance or death of a loved one. 'Damage to the life project' is a concept developed by the IACtHR and is related to the Court's decisions on reparations. The term is relatively new and places the victim at the centre of the attention (Woolcott & Monje, 2018).

The Inter-American Human Rights System plays an important role in Peru, as persons who have been targeted by state violence often do not find an answer within the Peruvian system. Therefore, the Inter-American Court of Human Rights (IACtHR) is an option after domestic remedies have been exhausted, and individual victims can have their cases tried before the court (Davis & Warner, 2007).

The term 'damage to the life project' was first introduced in the case of Loayza Tamayo v. Peru (CIDH, 1997), the case of a university professor who was detained in 1993 on suspicion of terrorism and subjected to torture, which had consequences for her physical and mental health. In 1999, the IACtHR ruled that states have an obligation to ensure that all children can develop a life project, including children who live on the streets (CIDH, 1999). The concept was established as a reason for reparations on its own in the case Cantoral Benavides v. Peru in 2000 (CIDH, 2000), where the Peruvian state was given the obligation to pay for the victim's university studies. In the case Molina Theissen v. Guatemala from 2004 (CIDH, 2004), the IACtHR refers to the damage to the life project of a family, whereas they establish the damage to the life project of a community in the case Masacre Plan de Sáncez v. Guatemala from 2004 (CIDH, 2004a). IACtHR further developed on the concept in the case of Gutiérrez Soler v. Colombia in 2005 (CIDH, 2005), as the Court found that the crime endured had irreparable damage to the victim's life and had ended the realisation of his expectancies regarding personal and professional development that would otherwise have been possible. (Nuez, 2020; Galdámez, 2007; Quintana, 2021). Thus, the IACtHR establishes that both individuals, families, and communities have the right to a life project (Cancado, 2005).

For the IACtHR, 'life project' refers to the complete development of the person who has been affected, taking into consideration the person's vocation, potential, and circumstances, which allows the person to make certain goals in life and reach them. The harm to the life project is more than the loss of opportunities: Life project relates to a situation which is probable and not only possible within the natural and expected development of a person (Galdámez, 2007). Life projects are related to the right to existence and rely on decent living conditions, safety and human integrity (CIDH, 1999).

A life project represents what a human being has decided to be and to do in life, what a person does to be, Fernández (2007) holds. He identifies three elements as central to a life project: freedom, coexistence, and temporality. Life projects are chosen and carried out within a society, in the company of others, and they are temporal. Damage to the life project affects a person's freedom to develop according to his or her own decision and affects the person's existential being. Furthermore, it damages how a person has chosen to live, truncates their destiny, and makes the person lose the very meaning of life.

Damage to the life project changes the life course of a person (Tonon, 2011). When a person's life project is damaged, it implies a loss of the freedom to seek for the goals that the person has set (Calderón, 2005): thus, damage to the life project implies damage to freedom, understood as having possibilities to carry out such a project (Nuez, 2020). In rulings from the IACtHR, life projects can be damaged both due to violations committed by the state, as well as where the state does not protect citizens and fails to develop institutions so that a person cannot even imagine having a life project, as in the case of Niños de la Calle v. Guatemala (CIDH, 1999; Nuez, 2020). The IACtHR contrasts such a life project with what happened to a person when their lives changed drastically as the result of serious violations of human rights (Galdámez, 2007).

Violations of human rights can cause irreparable damage and may lead to ruptures that influence all aspects of a person's life (Galdámez, 2007), and when the IACtHR meets out reparations, it takes as a starting point, the material damage, the moral damage, and the damage to the life project suffered by the victim (Woolcott & Monje, 2018). The IACtHR has argued that no measure can give back the possibilities of personal realization that was taken away and that it is impossible to quantify the damage in economic terms since the damage is complex and affects many aspects of life. Thus, harm to the life project requires guarantees of non-repetition as well as other measures that go beyond the monetary (Galdámez, 2007). The

Court has obliged states to provide reparations, such as returning a person to her position as a teacher and access to a sentence from the IACtHR.

Legal consciousness focuses on the legal meanings that people attach to events and experiences and how they understand and use legal practices in everyday life: "the ways in which people make sense of law and legal institutions, that is, the understandings which give meaning to people's experiences and actions" (Ewick & Silbey, 1992). Legal consciousness can lead to legal mobilisation, as when cases are taken to court and eventually to the IACtHR. The term helps to grasp how the term 'life project' has become embedded in the way of thinking of many who were targeted by state or political violence in Peru.

Arbitrary detentions and masked judges: Peru in the 1980s and 1990s

The persons interviewed for this project were detained and subjected to harsh treatment and torture during the internal armed conflict in the 1980s, which mainly hit the Andes region of the country, or during the authoritarian regime of Alberto Fujimori (1990 – 2000).

The anti-terrorism legislation established by the Fujimori regime in 1992 allowed for arrests without a warrant based on a vague definition of terrorism and sedition (Laplante, 2006). This also led to many being imprisoned who had no affiliation with the guerrillas (Wurst et al., 2012; García-Godos & Reátegui, 2016; Burt, 2006; Laplante 2006).

Trials with 'faceless' or masked judges were common during the 1990s as a measure to protect the judges' identities and ensure their safety, and several of the interviewees have been sentenced in such trials after some time in detention. Lisa Laplante (2006) describes these trials as cursory: it was not possible to know whether the judges had proper legal training, and there was no possibility of an adequate defence (Castellón & Laplante, 2005; Faverio & Naimark, 2013). Prisoners could be kept in prolonged incommunicado detention during interrogations, and petitions of *habeas corpus* – a request to determine whether the detention is lawful – were denied (Laplante, 2006).

Mistreatment and torture were permitted to get coerced confessions, and the majority of those arrested for terrorism were subjected to torture and mistreatment, especially during interrogations (Laplante, 2006). 64% of those who testified to the Peruvian Truth and Reconciliation Commission (TRC) about being detained by state agents between 1980 and 2000 affirmed having been subjected to torture (CVR, 2003). The persons interviewed for this project talked about torture, sexual violence, and forced nudity in relation to detention, imprisonment and interrogations. Some of the interviewees tell about violence against their children and close family members in relation to their arrest or imprisonment, as Wurst and colleagues (2012) also found in their study.

It is estimated that almost 20.000 persons were imprisoned during the internal armed conflict in Peru between 1980 and 2000, and that 27% of them were either killed or disappeared (CVR, 2003: tomo V, cap. 2.22 'las carceles'; Wurst et al., 2012). In 1996, the Fujimori government created a special commission to review cases of allegedly innocent people imprisoned in maximum-security prisons on charges of terrorism. Almost 800 persons were released through a presidential pardon as a result of this review process, as the commission found that there was no reasonable basis for their detention (CVR, 2003; Laplante, 2006). The use of legal pardons was pragmatic yet contradictory, as those who were pardoned had not committed any crime (Jibaja, 2003). In addition, the CVR estimates that almost half of the 33,954 persons detained between 1983 and 2000 were acquitted through regular judicial proceedings (CVR, 2003; Laplante, 2006). Several of the survivors interviewed for this study belong to these groups.

Peruvian reparations

If the IACtHR finds that someone's life project has been damaged, the Court sets out to find out which kinds of reparation would be accurate. Hence, 'life project' is intrinsically linked to reparations: Victims of crimes against humanity have the right to both reparation and rehabilitation (Sveaass, 2013), and in criminal international law, reparations are a way in which a state can assume responsibility after committing a crime (Calderón, 2005).

Policies and measures of reparation are important because they recognise victims and offer a political and ethical context in which violations of human rights can be repudiated (Lira, 2016). Reparations seek to reconstruct some of what has been destroyed, something that is not possible through a court sentence alone (Tonon, 2011). Reparations can be conceptualised as "rights-based political projects aimed at giving victims due recognition and at enhancing civic trust both among citizens and between citizens and state institutions" (Rubio-Marin & Greiff, 2007, p.321), and form part of the institutional memory of the state. Reparations have plural justice aims (Laplante, 2015), and can aim at preventing similar crimes, or attempt to mend the consequences (Tonon, 2011). Reparation programs often imply that it is possible to repair social bonds, dignify victims of violence and reconstitute what is lost (Ulfe & Málaga Sabogal, 2022).

Reparations in Peru can be divided into two main categories: Administrative reparation schemes granted by the Peru-

vian state through law 28592 on comprehensive reparations[1] (ley 28592 sobre Reparaciones Integrales, 2005; Ministerio de Justicia y Derechos Humanos, 2024), and reparation schemes for particular groups through the Inter-American Human Rights System. The IACtHR has the faculty to oblige states to yield reparations for the damages done (Woolcott & Monje, 2018,), and cases that reach the Inter-American Human Rights System can yield particular reparation schemes. The Peruvian law of comprehensive reparations includes most of the recommendations from Peru's TRC, such as programmes of individual economic reparations, collective reparations, health and education programmes, and symbolic reparations (Coordinadora Nacional por los Derechos Humanos, 2017; Ministerio de Justicia y Derechos Humanos, 2024). Alleged members of guerrilla groups are excluded from being registered as victims, and, thereby, from reparation programs (Rivas & Cori, 2013; Ulfe & Málaga, 2022). Such exclusion is in contravention of international jurisprudence. A special reparation program consisting of reparations in health, education, housing and work was established for the group of persons who were pardoned by the Fujimori government (Jungbluth, 2021), and they have been included in the health reparation scheme (Castellón & Laplante, 2005).

The study: Dealing with the past

The present study represents part of a larger investigation: 'Dealing with the past'. The aim of the study was to explore how survivors of gross and systematic human rights violations and relatives of persons killed in massacres or forcefully disappeared perceive and experience trials and reparations. The authors applied a variety of research approaches, including fieldwork, in-depth interviews with survivors of torture and relatives of persons who have forcefully disappeared, interviews with persons who work professionally in the field, and a review of relevant documents.

Participants: This article is based on interviews with seven persons, five women and two men, all torture survivors. All had been detained or incarcerated between 1980 and 2000, on suspicion of terrorism or of having sympathies with guerrilla groups. The selection was strategic and aimed at exploring the experiences and engagement of survivors who had experiences with legal processes and reparation schemes in Peru. Interviewees were recruited through participation in different activities related to truth, justice, and memory, as well as through snowballing. One of the interviewees had received individual economic reparations at the time of the interview; others had received reparations of other kinds, such as education programs for their children or health.

Interviews: The interviews were conducted between February 2010 and December 2014. They were semi-structured, conducted in Spanish, taped, and later transcribed. Each interview lasted between 40 minutes and one hour.

The interviewees were asked about their thoughts and experiences regarding the possibility of justice through trials and individual economic reparations, and what they would consider justice after what they had endured.

Ethical considerations: The study is carried out according to the Norwegian ethical guidelines for research in social sciences and humanities (NESH, 2021), and was recommended by the Norwegian Social Science Data Services in 2010.

Data analysis: The transcribed interviews were coded and systematised through thematic analysis (Braun & Clarke, 2006). Among the themes identified were the human rights violations endured, the needs that emerged from the human rights violations that were not met, and the different kinds of activities that the interviewees engaged in searching for truth, justice, and memory.

Findings: How life projects were interrupted

Life projects are related to all the things that a person does in order to be (Carlos Fernández Sessarego, 2007), the probable and expected development of a person (Galdámez Zelada, 2007) and is developed in freedom (de la Nuez Sánchez-Cascado, 2020). The persons interviewed for this study had different life projects; some had 'care for their children' as their focus and expected to continue to maintain themselves and their children through their work. Others held jobs in the formal sector, they had studied and planned for careers or were elected for positions in their communities or organisations. They all had in common that the arrest and posterior incarceration led to a loss of livelihood due to prolonged absence from their place of work and that physical and psychological consequences of torture, as well as the stigma endured due to the suspicion or conviction for terrorism, has changed their lives in significant ways. Some had lost their jobs and were unable to return to the kind of work they had prior to their arrest; others spoked about losing most of what they owned.

In the following, I will explore several of the ways in which the interviews describe how their life projects have been interrupted, focusing on health, stigma, and how the lives of their children were affected.

1 For an overview of the different reparation schemes, see the page of the Peruvian ministry of justice.

Health

Life projects are dependent on health: if the health of a person changes, it may alter the freedom to make choices about the future. Consequences of torture are complex and wide-ranging, both in the short and long term (Sveaass, 2023, p.185). The survivors report pains, problems with sight and hearing, numbness, problems with speech, as well as with the use and movement of hands and legs, and they describe nightmares and nervousness – all of which have implications for the possibility of gaining a living.

> They have destroyed me. They have hurt my back. [...] I cannot walk straight because of that. They threw something in my eyes, so I could not see well. Since that day, I do not see much.

Severe injuries and health consequences, as well as the lack of possibilities of treatment, have an impact on the choices available, including choices related to work, career and family life. The question of health, injuries and physical and mental consequences of torture and imprisonment became even more of an everyday challenge due to the lack of health services.

> Medical attention? None. But my family members sent me some herbs from the sierras [...] My wife brought some small worms and oil, and they put the medicine on me here, and so I stopped throwing up blood. After six or seven months, it stopped.

Health services that cover the physical and mental consequences of torture could be repaired, and torture survivors have the right to rehabilitation (Sveaass, 2013). Yet, those interviewed describe a lack of medical attention despite "comprehensive health insurance" for the poorer segments of the population and a program of health reparations that was initiated in 2009 (Pérez-León Acevedo 2010). The program of health reparation covers the majority of those who have an RUV (Register of Victims) credential and has been implemented mainly through the integration of victims into the ordinary SIS system. The Ombudsman (Defensoría del Pueblo) had registered several complaints about such shortcomings as lack of medication, attempts from health personnel to charge victims for health services that should be free, and from victims who were not allowed to register with SIS (Defensoría del Pueblo, 2012).

> The state has the obligation to help me. They say that they are going to help, but there is nothing. They do not even receive me when I want to register for SIS. They say, "not you, this is only for the grandparents and those who live in chositas[2]". But I was affected, too.

Yet, the main worry for those who have received a victim certificate for access to SIS seemed to be that their health problems were not covered. Another worry was that the medication they were asked to buy was often not available at the pharmacies.

> I did affiliate with SIS, but there are things they do not cover, and things they cover. My head, for instance, they do not cover.

When injuries are not covered by SIS, survivors must cover the expenses themselves. Both medical visits and medication are quite expensive, and a medical examination could easily equal a month's pay for the poorer segments of the population, to which several of the interviewees belonged. Health problems are frequent after torture (Quiroga & Jaranson, 2005), and the sequela of torture combined with the lack of adequate healthcare constitute health as an important area in which life projects have been interrupted.

Stigma: being labelled as a terrorist

Life projects are developed in co-existence with others, within a society (Fernández, 2007). Stigma is understood as an attribute that conveys devalued stereotypes (Clair, 2019; Goffman, 1963), has an impact on how a person is perceived in society and, hence, on the liberty to make choices in social life. Several interviewees talked about the stigma of being labelled a 'terrorist'. Some had been imprisoned on suspicion of terrorism, and some had convictions from the 'faceless' courts. One of the interviewees was presented on television as a terrorist a short time after being arrested. The stigma related to suspicions of terrorism or sympathies for the guerrillas influenced all spheres of life: it made it almost impossible to get a job in the formal sector or to travel abroad, and some had become estranged from their families and friends.

> What happens to us, those of us who were indultados[3], is that we suffer the stigma. That they say we are terrorists.

2 Small, rural houses

3 Released with a pardon; refers to persons who were imprisoned during the Fujimori government on suspicion of terrorism, and who were later released by the same government.

The pardons and acquittals were incomplete, and suspicions and sentences can still remain in registers. This makes it difficult to find employment or get an education (Faverio & Naimark, 2013). Some people opted to break off relationships with those who had been incarcerated on suspicion or sentences of terrorism, as they were tainted by such a stigma (Aguirre, 2011). In Fujimori's Perú, anyone who dared oppose the regime was vilified as a terrorist (Burt, 2006), and the idea that if a person was targeted by the police or the armed forces, there had to be a reason for it has been strong. Such ideas were often expressed through the saying *"he must have been a terruco!"*. *Terruco* is a term used to refer to real or supposed members of armed groups and to discredit some of persons with leftist political views and human rights groups. It has been used to stigmatise various sectors of Peruvian society, including family members of detained persons and other victims of violations of human rights and human rights defenders (Aguirre 2011). As Sveaass (1994) reminds us, to be targeted by state violence becomes almost proof in itself that a person is guilty, and to be victim of human rights violations can lead to marginalisation or even social exclusion (Beristain, 2008, p. 8)

> When they opened the gates and let me out, they said I was free. But I've never been able to take up a new life. I was released without a trial. They did not even sentence me. They knew I had not committed any crime [...]. Then they opened the gates and they kicked me out, but only after destroying my family.

A life project presupposes the freedom to make choices (Nuez, 2020), a freedom that this man felt was lost both for himself and his family.

Police records and sentences continue to appear in their files, which contributes to suspicion and stigma – even within their family.

> It is complicated, in our country and in other countries. For instance, there are people who are indultados who travel to other countries. They send them back [to Peru], because they say, 'you've been a terrorist'. This keeps happening. We go to the police to get a background check, and they find your name in their files. Then you don't get a job. It's a constant struggle.

The 'individual's tainted records make them second-class citizens', in Faverio & Naimark's (2013) words: the stigma of having been incarcerated and of having been labelled a "terrorist" limits choices and matters for the possibility of getting work as well as for social interaction.

The impact on the life project of the children

Serious violations of human rights have inter-generational effects: They affect not only the person who is subjected to the violation but also their children. The impact on individuals and on families is indivisible, as it leads to difficulties for the children and changes family dynamics (Beristain, 2008). Hence, torture and harsh and inhumane treatment not only damages the life project of the person subjected to it but also the life projects of their children. Common to all the interviewees was a worry about the children and an emphasis on how the incarceration had impacted their life projects.

The interviewees describe three different ways in which the children were affected: First, by the detention and imprisonment of the parents, and how this impacted on the lives of the children because they did not have their parents present to take care of them. Second, by the violence endured by the children related to the detention or imprisonment of the parent, and third, by how the future of the children was affected as the detention and imprisonment of a parent influenced their possibilities for education and impacted the relationships within the families.

Taking care of the children: Some of the interviewees were single mothers; they were, in their own words, '*mother and father to their children*', so when they were arrested, the children were left unprotected.

> After they detained me, I could not communicate with anyone. My sister looked for me, my children cried because they were small. They did not know what to do with my children.

Some older children took on the responsibility for younger siblings, in other families the children were moved between the homes of different relatives in informal kinship-based fostering, as described by Leinaweaver (2014) and similar to what Wurst and colleagues (2012) find in their study of psychosocial consequences of detentions during the internal armed conflict in Peru. This situation has had an impact on the children's possibility to study, as well as on their participation in social life.

The conditions in prison led to less contact between the imprisoned parent and the children, as prisoners could receive visitors only three or four times a year, and the family members, including the children, were subjected to harsh examination by the police when they entered the premises (Wurst et al., 2012).

> I was in prison without communicating, nothing. Without seeing my children. I thought a lot about my children, how they were, what happened to them. After several months, my children came to see me. I saw my children, and it made me angry, I cried. I cried as I hugged them: 'I am going to get out of here, I am going to get out of here!'

The imprisonment of the parent and the lack of contact had consequences both for the imprisoned parent, for the children and for the relationship between them.

Violence towards the children: Harsh treatment towards the children was common when they visited the prison. In addition, some of the children were subjected to violence or harsh treatment during the detention of the parents or while they were imprisoned.

> My children were without parents, completely abandoned, and one of the girls was raped. That is the worst pain I have to carry [...] The police, they came back to the house and they raped the girl. Whom should she tell? She was left like that.

Such violence towards the children has an impact not only on the child but also on the parent who was left unable to intervene. Sexual violence was used systematically in Peru, both in prisons and in the countryside, most often towards girls and women between 10 and 29 of age (CVR 2003, tomo VI, p. 276). Systematic sexual violence are intentional acts that aim at destroying individuals as well as communities and harms both individuals and the community (Lloret & Wurst, 2007), and sexualised violence affects women's life projects in a series of ways (Escribens, 2012). To be witness to violence towards others without being able to intervene constitutes a particular kind of humiliation (Goffman, 1961), as it also is for a parent to become aware that their children have been subjected to violence related to their detention, even though they were not present.

The impact on the life project of the children: The imprisonment of a parent has changed the relationship between children and their parents, and it has had an impact on the life project of the children: They have not received the care and education that their parents wanted to give them, and the incarceration of their parents have often left them in a socio-economic situation that is worse than it would otherwise have been.

> The years I spent in prison, you destroyed a whole future where I could have educated my children differently.

The lives of the children would have been different had the parents been present, and the children might have been raised with other ideas and more affection had they been able to live with their parents. The imprisonment of the mother affected the physical and mental health of the children (see also Wurst et al., 2012). Yet, the interviews focused on the question of how their children had lost the possibility to study.

> My children have not finished their studies, they dropped out. Sometimes I think, sometimes I cry alone, what to do? I can't do anything. I have often felt bad from thinking too much, and my head hurts.

The educational system above primary school is not free in Peru, and some institutions are quite expensive. Still, many had plans for their children's education, plans that were interrupted by their detention.

Reconstructing a life project

The violence did not end people's capacity to find solutions (Wurst, 2004). In Latin America, women targeted by state violence have engaged in two kinds of action: in the private realm, they engaged in a struggle to support their families, while they created human rights organisations in the public realm (Crisóstomo, 2019). Similarly, the interviewees for this study have rebuilt their lives and that of their families, while some of them have also formed and engaged in organisations to demand reparations and improve their situation through collective efforts. Pérez-Sales (2023) reminds us that victims have led most of the achievements in the struggle for truth, justice, and reparations.

In the private realm, the interviewees sought to improve their health and to reunite with their families. For some of the single mothers, this meant that they had to find a new place to live and gain an income so they could take care of their children again.

> Slowly, I gathered all of my children. [...] my son is still angry with me sometimes. He says, 'First you looked for my brothers and sisters, then you looked for me'. I did not have any money; slowly I managed to get some, so in the end all of us were together. I have not abandoned them, I never wanted to abandon them.

Family ties and networks have often been a strong pillar in reconstructing life after serious violations of rights (Wurst, 2004). The TRC made a series of recommendations, among them for individual and collective reparations, which raised the

expectations for such monetary reparations in the population targeted by state and political violence (Laplante & Theidon, 2007). Programs of collective reparations have been working for some time, while programs of individual economic reparations were implemented in 2011.

> The indignation is there. The wish to search for justice, you carry that with you. The desperation changes over the years and you can be calmer when you say, 'Señores, I demand justice immediately. It has been enough of letting time pass.'

The lack of response from the Peruvian state led some of the interviewees to take their cases to the Inter-American Human Rights System, and in some cases the Court has obliged the Peruvian state to yield them reparations. Some groups have been granted a land area as part of the reparation scheme, and they have built a neighbourhood.

> It is really wonderful, because we have reached all this based on our own hard work, our sacrifice. We have had to face stigmatisation, and we have had to face this government which constantly tries to evict us.

This quote points both to the importance and pride in having built a neighbourhood, and to the fact that even though they had been given the land by the state as part of a reparation scheme, it took both time and effort to ensure the paperwork. Some described the land and the possibility to build their own house as being very repairing.

Discussion

'Life project' originates from the sentencing in the IACtHR, and the concept is developed through the sentencing in the IACtHR as well as academic works. The concept has, in turn, become included in the legal consciousness of Peruvian torture survivors and other persons affected by serious human rights violations and is a useful concept for understanding the impact of torture and other serious human rights violations on the lives of both persons targeted and that of their children and families.

The persons interviewed for this project refer to the concept when they describe and discuss how detention, incarceration, torture and the sequela of torture have impacted their lives and the lives of their children. Hence, the concept contributes to describing and grasping how the violations endured have impacted their lives as well as the lives of their children. A person's life project relates to what is probable, not only possible; what a person can expect their lives will be like, and harm to a person's life project is more and more fundamental than the loss of opportunities (Galdámez, 2007). The persons interviewed for this study had expectations for their lives; they expected to continue working and providing for themselves and their families, either in the informal or the formal sector, to take care of their children and provide an education for them. These are things that they could reasonably expect from life, and which were changed in the moment they were subjected to imprisonment and torture. Their life projects were harmed in a series of different ways: They lost their jobs and their income, some also their houses, and others became estranged to their families. For several of the interviewees, their health has been severely impacted, which in turn has had an impact on their livelihoods, their possibility to work and get an income, and the expenses that they have had related to health.

However, while the interviewees do talk about how their own lives have been impacted by imprisonment and torture, it is noticeable how much emphasis they place on intergenerational aspects: their children's lives and life projects have also been impacted in a series of ways. The children lost important years with their parents, which influenced their thinking and their education. Some of the children had to grow up far too soon as they had to take care of the household and of their siblings, their parents' lack of income mattered both for their childhood and for their future; they lost out on education, and the imprisonment and torture of their parents have impacted on their relationships. Analysing these impacts through a lens of 'life project' contributes to a better understanding both of long-term consequences, and of consequences on the families and children and even larger community.

Former judge Oliver Jackman (CIDH, 2005) has argued that the concept of 'damage to life project' does not address a judicial need. However, our findings suggest that whatever the legal use for the concept, it can contribute to grasping the ways in which gross and systematic human rights violations impact persons' lives.

Concluding remarks

'Life project' refers to the complete development of the person who has been affected, taking into consideration the person's vocation, potential, and circumstances, and which allows the person to make certain goals in life and reach them. The court contrasts such a life project with what happened to a person when their lives changed drastically as the result of serious violations of human rights. 'Life project' is useful to describe how systematic and serious violations of human rights impact the lives of individuals, as it points not only to how the wrongs endured matter for everyday life but even to how they have an impact on the future.

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Submitted 31st of July 2024
Accepted 24th of Nov. 2024

Torture, 2024, 34(3), 74-86
https://doi.org/10.7146/torture.v34i3.145944 *Research paper*

The IRCT global standards on rehabilitation of torture survivors: from adoption to practice

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Key points of interest

- The GSR are a comprehensive framework for rehabilitating torture survivors, addressing their physical, mental, legal, and social needs, aligned with the UN Committee Against Torture's General Comment No. 3.
- The use of the GSR was associated with changes in rehabilitation practices, with improvements in survivor participation, trauma-sensitive care, and advocacy.
- The GSR provided a shared framework that enhanced cross-centre collaboration, aligning diverse organisations under common principles while addressing regional challenges through peer learning and tailored capacity-building.

Abstract

This paper examines the implementation of the Global Standards on Rehabilitation (GSR) by members of the International Rehabilitation Council for Torture Victims (IRCT) and their impact on the quality of rehabilitation services provided to torture survivors. *Methods*: Qualitative and quantitative data were collected through surveys, post-training evaluations, and member feedback to assess the impact of the GSR on rehabilitation practices. *Findings*: Results show significant improvements, including more holistic rehabilitation, increased survivor participation, and stronger advocacy. Key challenges such as resource limitations, political barriers, and resistance to change were identified, alongside recommendations for future focus on survivor engagement, holistic support, and staff training. The paper concludes that the GSR roll-out has strengthened the capacity of IRCT members to provide quality rehabilitation services, highlighting the need for continued support and sustainable funding to expand impact.

Keywords: rehabilitation, global standards on rehabilitation, torture survivors, rehabilitation services

Introduction

The International Rehabilitation Council for Torture Victims (IRCT) is a global network of 171 civil society organisations and independent experts in 76 countries, comprising around 4,000 staff, who support survivors of torture to heal and rebuild their lives through rehabilitation, including medical, psychological, legal and social support.

How were the GSR established and why?

The development of the , the Global Standards on Rehabilitation of Torture Victims (GSR hereby)[1] is precedented by the United Nations Committee Against Torture's General Comment No. 3

1 Find the official document annexed. Read more about the GSR and access the official document (available in 6 different languages) at https://irct.org/gsr/.

(2012) on the implementation of article 14 of the Convention Against Torture (CAT) by States parties, which highlights the right of victims to redress, including compensation and rehabilitation, and requires that states must ensure comprehensive reparations for victims of torture and ill-treatment, encompassing restitution, compensation, holistic rehabilitation, and guarantees of non-repetition. It addresses the need for specialized services to support victims' recovery and the obligation of states to provide adequate training for relevant professionals (UNCAT, 2012).

Building upon the IRCT membership's efforts to prevent torture, fight impunity, and provide redress and holistic rehabilitation to victims, IRCT members embarked into the development of what would represent an internationally recognised framework of minimum standards for holistic torture rehabilitation. The GSR represent IRCT's most comprehensive effort to define how rehabilitation should be structured and how non-state actors can effectively provide as full rehabilitation as possible, as envisioned in General Comment No. 3 (2012).

The process started with a global survey of good practices employed by IRCT members, followed by three phases of revision, between 2016 and 2020:

a. A technical review by experts from the membership to ensure quality,
b. Regional consultations to ensure relevance to the different local contexts in which IRCT members work
c. A political negotiation and adoption process in the IRCT's General Assembly to ensure the widest possible engagement and support in the IRCT membership.

The IRCT General Assembly unanimously adopted the final document on the 6th of October 2020 (see full document as Annex).

Many of the elements detailed in the GSR, are entailed in the UN CAT's General Comment No. 3 (2012), such as the definition and scope of rehabilitation understood as a holistic process designed to restore and uphold the dignity, independence, and overall well-being of survivors of torture. It should, thus, encompass the victims' physical, mental, emotional, legal, and social needs. Beyond offering immediate medical treatment, rehabilitation must ensure survivors have access to long-term, multidisciplinary support services that are customized to their specific situations. The GSR also similarly reflect the key principles of rehabilitation stated in General Comment no. 3:

– Holistic and Comprehensive: Rehabilitation should address the full range of victims' needs, including:
  · Medical care: Physical treatments to address injuries sustained from torture.
  · Psychological support Mental health services, such as therapy and counselling, to address trauma.
  · Legal services: Support to help victims pursue justice, compensation, and protection
  · Social reintegration: Programs aimed at helping survivors regain independence, such as vocational training and employment support.
– Victim-Centred Approach: Rehabilitation must be tailored to the unique needs and circumstances of each survivor. Victims should have a say in choosing the services they need, with respect for their culture, language, and gender-specific requirements.
– Accessible to All Victims: States must ensure that rehabilitation services are available to all victims of torture without discrimination. This includes special attention to refugees, asylum seekers, women, children, persons with disabilities, and other marginalized or vulnerable populations.
– State Responsibility: States have a duty to provide and sustain rehabilitation services, which requires allocating sufficient resources and funding to ensure these programs are accessible, effective, and long-lasting.

Since their adoption, member centres have progressively implemented the GSR, addressing specific challenges and evolving their practices to improve outcomes for survivors. This roll out process began in 2022 with a self-assessment that set up a baseline for members to guide their work towards the implementation of the GSR, which was supported by tools, learning materials and knowledge-sharing spaces co-designed by members, guided by the IRCT Health Advisory Board and the IRCT Secretariat.

Materials and Methods

The implementation of the GSR began in 2022 with the dissemination of a Self-Assessment Tool. This tool was designed to provide an overview of the implementation status of the GSR across member centres and identify the most challenging standards. Participating centres categorized each standard as "implemented," "in progress," "not implemented," or "not applicable."

To monitor the change in the quality of rehabilitation services, qualitative and quantitative data were collected through surveys, post-training evaluations, and member feedback:

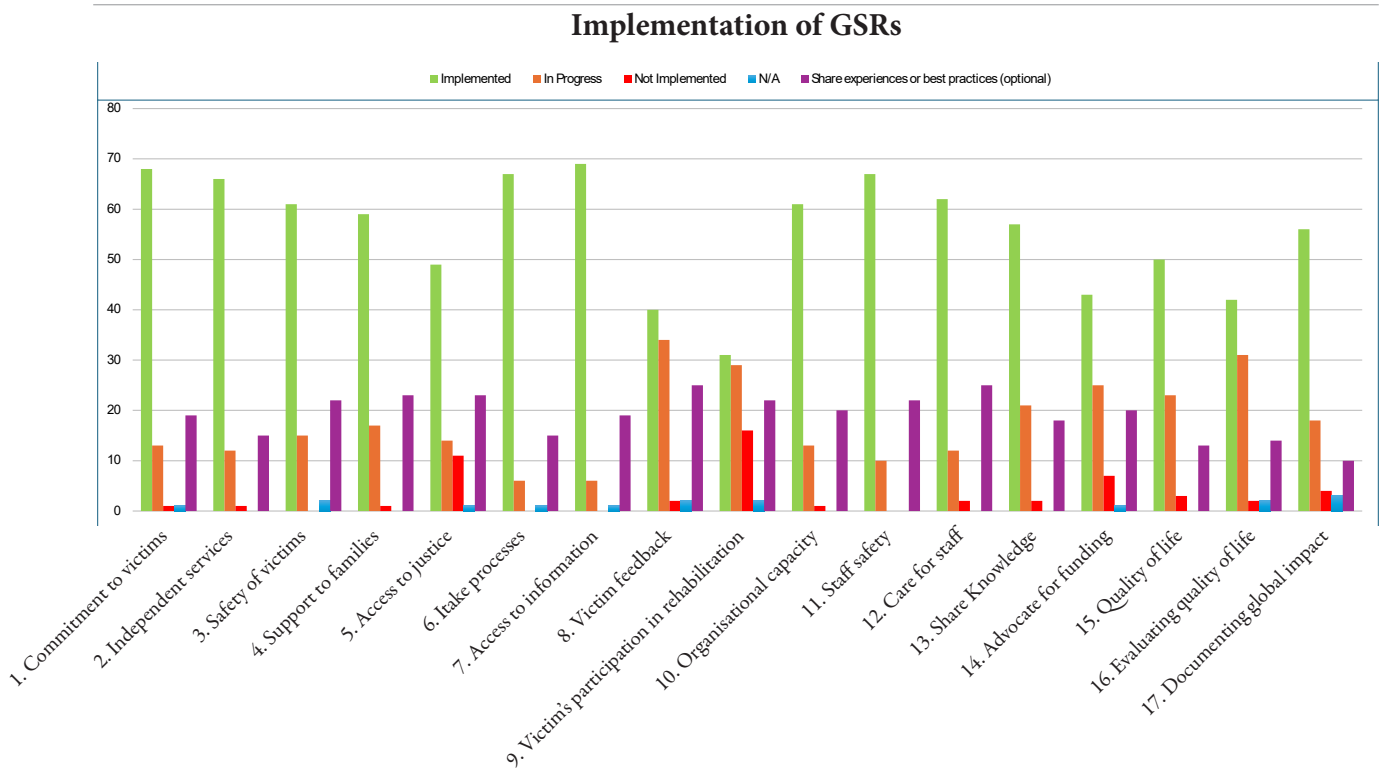
– GSR Self-Assessment Tool: Employed in 2022 to obtain a general overview of the implementation of the GSR by members and to identify the most challenging standards. Each centre was provided with an implementation indicator for each standard and asked to categorize its status as "implemented,"

"in progress," "not implemented," or "not applicable." 85 responses were collected.

- GSR e-course pre-questionnaire[2]: Employed at the beginning of the GSR e-course to assess participants' familiarity and knowledge of the GSR.226 responses were collected.
- GSR e-course post-questionnaire[2]: Employed at the end of the GSR e-course to assess participants' familiarity and knowledge of the GSR (as compared to before taking the e-course), and potential changes that this could have triggered in their work with torture survivors.216 responses were collected.
- GSR regional training pre-questionnaire[2]: employed prior to the regional trainings to understand which standards members wanted to focus the training on, and to map good practices and challenges that could be shared. 87 responses were collected.
- GSR regional training post-questionnaire[2]: employed at the end of the regional trainings to assess the impact of the GSR regional trainings, the usefulness of the different sessions and to understand how participants would transfer these learnings to their organisations and work with survivors. 87 responses were collected.
- Webinars post-questionnaire[2]: employed at the end of each webinar to assess the extend to what they had acquired new learnings that influenced their torture rehabilitation practice. Responses from 30 member centres were collected.
- Data compiled through the Global Impact Data 2023[2]: sent to all members to collect data regarding different aspects related to their work with healing, justice and organisational capacity. For this study, only data related to the questions on the use of the GSR and improvement of rehabilitation services was used. 142 responses were collected.
- Survey conducted for external consultancy[2]: employed to assess the effectiveness of IRCT's support during the GSR roll out, the usefulness of the GSR in their work, the changes that have been anchored in their rehabilitation practices, and the overall impact of the GSR on the quality of their services. 41 responses were collected.
- Interviews with members: 21 interviews were conducted with IRCT member centres to assess the extend to what they use the GSR to assess the quality of their rehabilitation services.

2 The samples of these surveys are annexed as supplementary material.

***Figure 1**. Results from Self-Assessment Survey*



This data was also used by the external consultant who conducted an evaluation to assess whether the support provided by the IRCT to the membership during the GSR roll out was effective. This report is also referenced in this study as Marboeuf 2024

Results

Self-Assessment Tool: Point of Departure

The Self-Assessment Tool was shared among members in 2022, to obtain a general overview of the implementation of the GSR by members and to identify the most challenging standards. Of the participating centres, 85 (representing over 50% of the membership) identified standards S5, S8, S9, S14, and S16 as the most challenging, while standards 1, 2, 7, and 11 had the highest rates of implementation (see annex 1 for a description of each Standard).

This data established a baseline for member centres, highlighting areas requiring improvement and potential support while also identifying strengths where they could assist peers by sharing effective practices.

With this baseline as the point of departure, member centres actively started to work to align their rehabilitation services with the standards, to the extent possible, throughout 2022 to 2024. The implementation process varied across centres, ranging from reflective assessments to comprehensive changes in organizational structures, programming, and direct care for survivors.

Learning & Experience-Sharing Spaces

To support this process, the IRCT developed an e-learning package, which comprised an online course (in English, Spanish, French, Arabic), online and in person knowledge-sharing spaces (webinars[3], regional trainings[4]), and other resources with tools and guidance, that complement and support centres in the process.

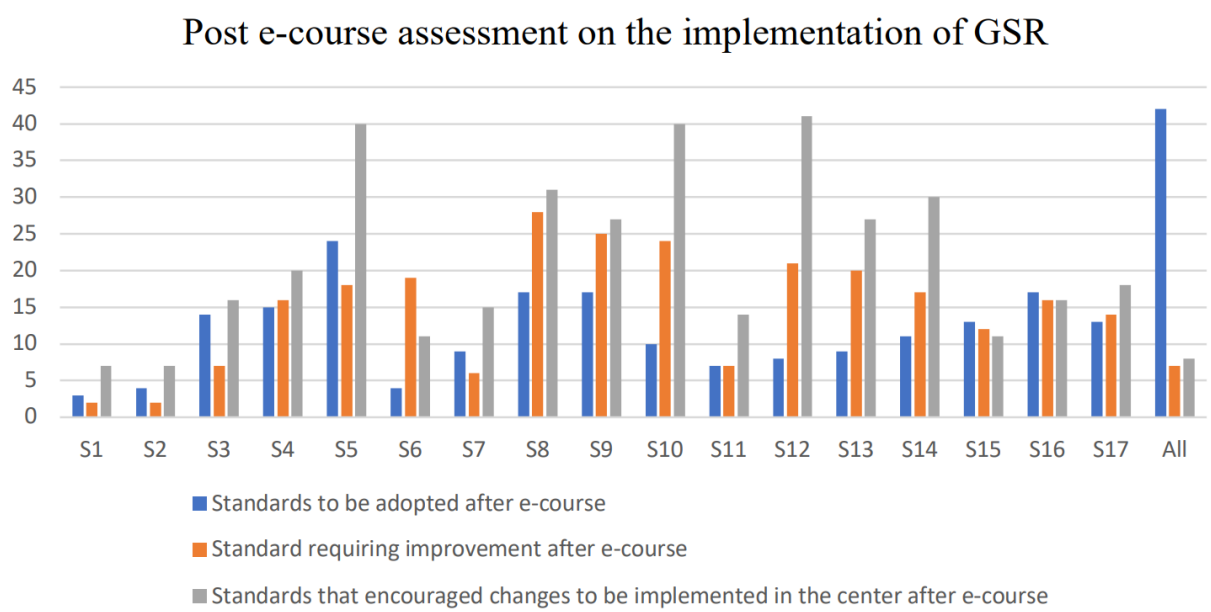
The qualitative feedback collected through the GSR e-course pre and post surveys highlighted the practical applicability of these learning spaces, which provided clear guidelines and tools for implementing the GSR. Members reported the e-course had been key for them to familiarise themselves and get closer to the practical implications of putting the standards into practice, as it equipped them with practical tools and strategies to overcome challenges to implementation, leading to greater confidence and commitment to implementation.

As shown in Figure 2, the e-course prompted some changes in the applicability of the GSR in members' centres. The most adopted standards were S5 and S17, suggesting a focus on fill-

3 Webinars can be accessed here

4 Information can be accessed here

***Figure 1**. Post e-course assessment on the implementation of the GSR*



ing gaps in implementation. Improvement centred on standards S7, S9, and S10, highlighting areas where existing practices required enhancement. S5, S12 and S14 were the standards that prompted the most changes in centres.

The usefulness of the e-learning spaces was particularly noted in areas such as developing organisational policies, enhancing service delivery, and improving survivor engagement. Members also noted the importance of the e-course in improving staff safety and care, as well as the integration of trauma-sensitive techniques and evidence-based treatment methods. Moreover, a shift towards a more client-centred approach was a key focus of the GSR and was successfully promoted through the e-course (Marboeuf 2024).

In feedback after the webinars, 89 percent of participants said these online spaces were useful and that they had acquired new knowledge relevant to their work with torture survivors. The sessions on treating sensitive topics like sexual minorities, intergenerational trauma and best practices for working with child survivors were particularly highlighted as beneficial. All in all, the feedback showed that these sessions helped participants gain a deeper understanding of specific challenges and effective intervention strategies.

Parallel to this, regional trainings -Asia (Philippines) in 2023, Latin America (Colombia) and Sub-Saharan Africa (Kenya) in 2024- were organised to discuss the implications, challenges and lessons learned by members in their practice related to the standards.

Impact on Quality of Rehabilitation Services

Results show that most of them found the GSR to be very useful in their work (59%) (Figure 3), noted changes in their rehabilitation practices since the implementation of the GSR (60%) (Figure 4), and reported a significant impact of the GSR on the quality of rehabilitation provided to torture survivors (58%) (Figure 5).

For instance, Tree of Life in Zimbabwe reported that their rehabilitation processes have been more holistic and intentional, improving the quality of their rehabilitation processes and making them more impactful. Likewise, RCT Zagreb in Croatia said the GSR roll-out conveyed a better support structure and brought focus on important areas of the rehabilitation and integration of survivors, as well as facilitating the monitoring of those elements that need to be improved (Marboeuf 2024, p. 33).

This transformation has occurred both within the organisations (macro) and within the professional practice of those working with survivors (micro), including in areas related to standards that were previously identified as challenging or not implemented, such as access to justice (S5), survivor engagement (S9), rehabilitation funding (S14) and evaluating quality of life (S16). Members reported improvement in organisational practices, such as the establishment of complaint mechanisms for victim feedback (S8), promotion of survivor participation in service planning and implementation (S9), and enhanced advocacy efforts for anti-torture laws and reparation mechanisms (S5).

In Pakistan, the Human Development Organisation (HDO) reported establishing a complaint mechanism for vic-

***Figure 3**. Usefulness of the GSR in members' work*

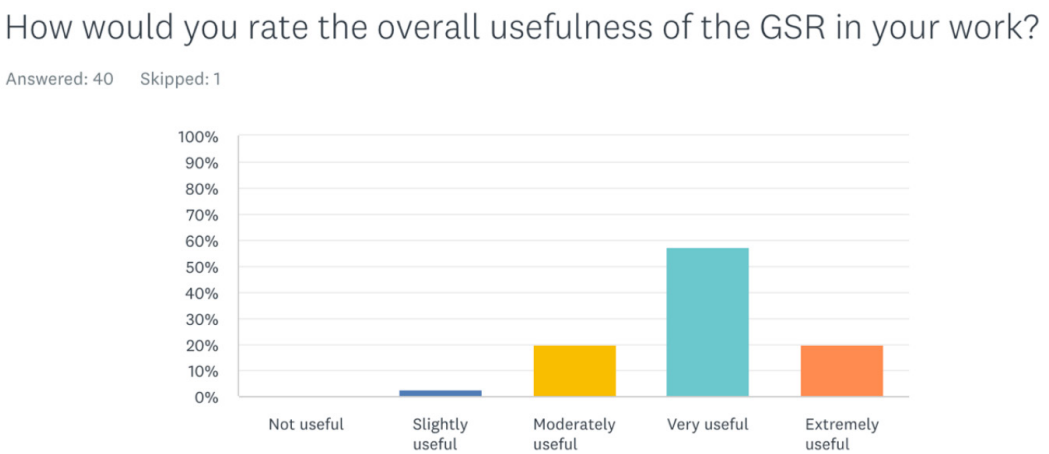


***Figure 4**. Changes in rehabilitation practices*

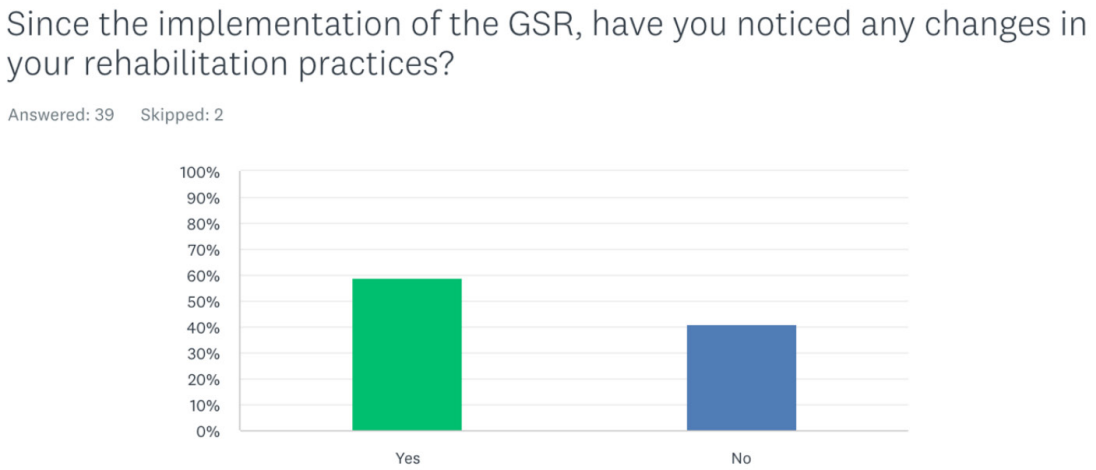
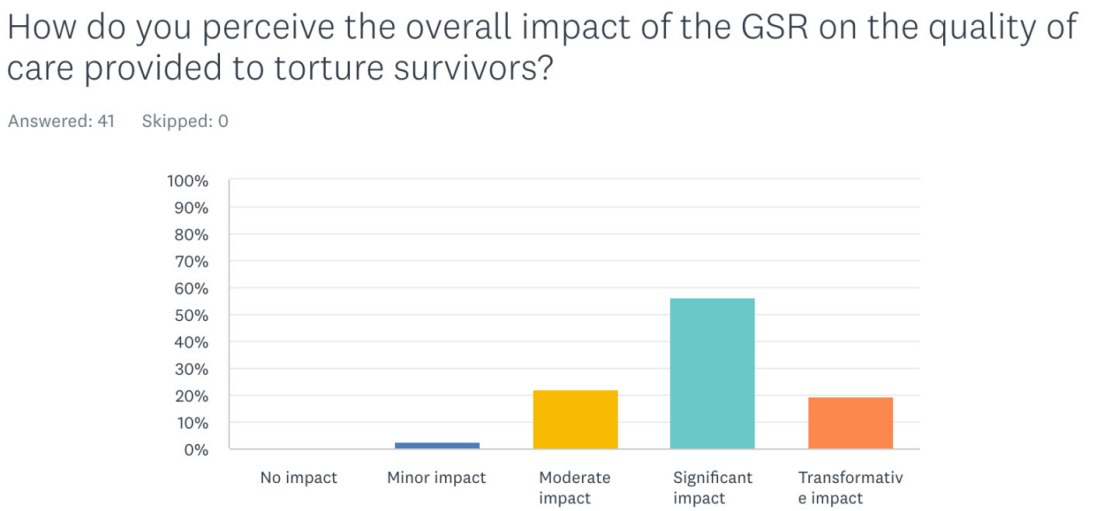


***Figure 5**. Impact of GSR on quality of rehabilitation provided to torture survivors*



tim feedback, promoting survivor participation in project planning and implementation, incorporating safety and protection measures for beneficiaries, and enhancing advocacy efforts for anti-torture laws (Marboeuf 2024 p. 30).

Notably, there has been a significant transformation in survivor participation and feedback (S8, S9), as organisations have increasingly adopted a survivor-centred approach. Members have implemented mechanisms for gathering regular feedback from survivors, actively involving them in service planning and execution, and utilizing this input to enhance service delivery. For example, Aid Organization for Refugees and Asylum Seekers (ASSAF) in Israel introduced a peer rehabilitation program, enabling survivors to contribute directly to both the planning and provision of services by drawing on their lived experiences (Marboeuf 2024, p. 61).

Many organisations have incorporated the standards into their existing frameworks, while others have adopted them as their main framework. For instance, Zentrum ÜBERLEBEN in Germany have directly implemented the GSR as their new framework, whereas Legend Golden Care Foundation in Nigeria have integrated them into their existing framework and reported significantly enhanced service delivery (Marboeuf 2024 p. 31).

Likewise, this process has worked as a catalyser for some organisations to review and enhance their organisational policies

and procedures. This included updating operational documents to align with the GSR, developing new policies for survivor engagement and feedback (S8, S9), and implementing comprehensive safety protocols for staff and survivors (S3, S11). For example, HDO in Pakistan found the GSR highly useful in improving organisational policies, programmes and projects to achieve the objective of maximising impacts of rehabilitation services (Marboeuf 2024, p. 33). The Trauma Centre Cameroon describe how the GSR serve as a check-list for the quality of rehabilitation services they provide (Marboeuf 2024, p. 33).

Moreover, members also noted the importance of the GSR acting as a common language and framework, facilitating dialogue and collaboration between centres. According to Regroupement des Mamans de Kamituga (REMAK) from DRC, the standards serve as a shared language and foundational framework across centres to support torture survivors. Likewise, the Independent Medico Legal Unit (IMLU) in Kenya highlights how these standards help unify rehabilitation centres by promoting standardized approaches for torture survivor support. Psychosoziales Zentrum für Flüchtlinge (PSZ) in Düsseldorf notes that the standards not only provide a common language but also align with national ethical and professional principles in therapy for vulnerable groups (Marboeuf 2024, p. 36-37).

This roll-out process looked different throughout regions. Members in the Global North, with generally better access to resources and funding, reported a smoother implementation process and greater improvements in policy and procedural enhancements. Organisations in the Global South faced more pronounced challenges due to resource constraints, political instability, and limited funding opportunities. These centres often required additional support in areas such as fundraising, advocacy, and capacity building to sustain their implementation efforts (Marboeuf 2024).

The process also inspired members to support their peers in tangible ways, such as improving the healing experience for survivors, refining internal procedures, or optimizing working methodologies to enhance efficiency. This peer support reflects not only a sense of solidarity among professionals assisting torture survivors worldwide but also a commitment to sharing knowledge and expertise to advance the quality of care. An example was the exchange between Psychotrauma Centrum in the Netherlands and Restart in Lebanon, on trauma-informed approaches and care for staff (Marboeuf 2024).

Challenges

It is important to note that some centres experienced challenges with some particular standards due to specific external factors for the given centre. While most of them are already aligned with the majority of the standards in their centres, others may be lacking mechanisms to fully comply with all of them, others are challenged by contextual or sociopolitical circumstances or lack of capacity and resources, and others do not have an organisational structure that allows changes to happen. More specifically, members reported lack of resources (66%), political barriers (56%), insufficient training (41%), and resistance to change (19%) as the main challenging factors to the implementation of the GSR.

Again, challenges look different among different regions. In Sub-Saharan Africa, members noted difficulties in reaching out to survivors and providing services in some remote areas, building trust with survivors, the lack of torture-related documentation, issues related to disability and re-integration, collaboration with traditional healers, and treating survivors from diverse cultural and religious backgrounds. Other challenges are related to the sociopolitical context driven by global trends such as terrorism, political instability, gaps in legal and policy frameworks, and insufficient funding.

In Asia, members reported challenges when engaging survivors, building trust and demonstrating the benefits of rehabilitation services. Other difficulties were also mentioned concerning securing sustainable funding and advocating for justice in cases of sexual and gender-based violence, which are often complicated due to inadequate documentation and complex legal systems.

In Latin America, financial constraints, security concerns, legal and institutional barriers, and issues related to resource allocation and sustainability were prominent. Addressing gender-specific issues such as sexual torture and institutional gender violence, and ensuring cultural sensitivity in interventions, were also highlighted as critical challenges.

Best Practices

Best practices identified by members included holistic victim support, community engagement, advocacy, capacity building, and the integration of livelihood support. Emphasis was placed on ethical practices, the development of robust documentation and evaluation tools, and the importance of cross-cultural learning and adapting services to local contexts. Members highlighted the implementation of comprehensive support that includes medical, psychological, legal, and social assistance. They also stressed how engaging survivors in their rehabilitation processes through survivor engagement practices and participatory needs assessments fosters empowerment and enhances the effectiveness of rehabilitation efforts (Marboeuf 2024).

More specifically, centres in Asia and Sub-Saharan Africa emphasised the importance of integrating livelihood activities as

part of holistic rehabilitation services, which address both immediate psychological needs and empower survivors economically. Whereas in Latin America, members stressed the importance of comprehensive victim and family support, informed consent practices, capacity building and training (Marboeuf 2024).

Discussion

Rolling Out the GSR: Anchoring Change in Rehabilitation Practices

These findings underscore the positive influence of the GSR on enhancing the quality of care provided to torture survivors, highlighting the significant changes members have observed in their practices. The implementation of the GSR has served as an anchor for change in rehabilitation practices, positively impacting both the quality of services and organisational practices. A majority of centres (59%) found the GSR highly useful, with 60% reporting changes in their practices and 58% observing improvements in the quality of rehabilitation services. These shifts are evident in the integration of survivor-centred approaches, enhanced trauma-sensitive practices, and better alignment of organisational policies with ethical and professional standards.

Specific examples, such as Tree of Life in Zimbabwe and RCT Zagreb in Croatia, illustrate how the GSR catalysed changes in operational frameworks and service delivery. Innovations like peer rehabilitation programs (e.g., ASSAF in Israel) demonstrate how the standards have empowered survivors to play active roles in planning and delivering services, fostering both empowerment and more responsive care.

Moreover, the e-learning package, webinars, and regional trainings emerged as transformative components of the rollout. Members consistently highlighted the practical applicability of these spaces, which provided clear guidance, tools, and strategies to overcome implementation challenges. The e-course, in particular, was widely adopted and cited as instrumental in improving confidence and commitment to the standards.

The regional trainings offered a critical space for peer learning and contextual adaptation. By focusing on region-specific challenges and standards, these sessions facilitated deep reflection and exchange of best practices, enabling centres to adapt the GSR to their unique sociopolitical and cultural contexts.

The findings also highlighted several best practices that emerged from the implementation process. These include:

- Holistic Support: Integration of medical, psychological, legal, and livelihood support to address survivors' comprehensive needs.
- Survivor Engagement: Active involvement of survivors in planning and implementation processes, fostering empowerment and more effective interventions.
- Capacity Building and Peer Support: Regional and cross-centre collaborations, such as those between centres in the Netherlands and Lebanon, illustrate the importance of shared learning in advancing care.
- Contextual Adaptation: Centres in Asia and Sub-Saharan Africa demonstrated the value of integrating culturally relevant approaches, while Latin American centres emphasised family-inclusive practices and informed consent.

The emphasis on cross-centre collaboration and shared frameworks has not only enhanced individual centres' capabilities but also strengthened global solidarity and commitment to torture survivors' rehabilitation.

Nonetheless, despite the positive outcomes, members still faced significant challenges to fully implement the GSR in their centres, many of which were shaped by regional contexts. Challenges in the Global South were particularly pronounced, with members in Sub-Saharan Africa, Asia, and Latin America reporting difficulties in funding, outreach, and survivor engagement. Specific barriers, such as cultural and religious sensitivities, political instability, and gaps in legal frameworks, underscored the need for tailored strategies and additional support in these regions.

Future Avenues: Looking Ahead

The Role of the GSR in a Global Movement

For a global torture rehabilitation network such as the IRCT, the GSR represent the world's first comprehensive set of internationally agreed best-practice standards for the health-based rehabilitation of torture survivors. The Board of the UN Voluntary Fund for Victims of Torture took note[5] of the GSR and subsequently the IRCT introduced them to the Fund as a framework for torture rehabilitation programmes to be measured against. The Fund now uses the adoption of the GSR as part of their assessment process of organisations offering rehabilitation services to survivors of torture. Likewise, the World Medical Association (WMA), the world's largest body of medical professionals, recognised the value of the GSR on their Statement on the Right to Rehabilitation for Victims of Torture[6] (WMA, 2024). Moreover, the GSR were presented at the Nordic Mental Health Network as an example of potential catalyst for mental health practitioners (A Human Right Left Behind, 2022).

5 Access the UN document A/77/231 here

6 Access the WMA statement here

The journey toward the practical implementation of the GSR has served as a catalyst for IRCT members to critically evaluate and refine their approaches to working with torture survivors and delivering rehabilitation services. It has also established a common language and framework for members by committing to certain professional guidelines and ethical principles when providing rehabilitation services. Moreover, it has strengthened communication and understanding among different professionals, recognising the value of interdisciplinarity.

Improved Rehabilitation Through the GSR

These results suggest that the GSR roll-out process has enhanced IRCT members' rehabilitation capacity and the quality of services provided to torture survivors. The majority of members reported changes in their rehabilitation practices since they engaged with the GSR roll-out, and most of them have noticed a significant impact of the GSR on the quality of care provided to torture survivors.

Some of the standards that members initially identified as challenging or not implemented (access to justice, survivor engagement, advocating for funding and monitoring quality of life), have been a focus area for them to work on and incorporate in their centres during this roll-out process. While challenges still persist within resources and capacity, reaching out to survivors, accessing justice and documentation of torture cases, changes and improvements have been reported in the areas of survivor engagement, organisational capacity, staff care and fundraising. Moreover, members mention having improved the way they work with families and children (and intergenerational trauma), the integration of trauma-sensitive techniques, evidence-based treatment methods and other types of therapies, and documentation.

Recommendations

The results presented above were discussed with the members, and the feedback indicated some recommendations for the future. These included strengthening advocacy efforts and diversifying funding sources to ensure financial sustainability, prioritising continuous training and professional development for staff, fostering platforms for knowledge exchange and collaboration, and enhancing interdisciplinary teamwork to provide holistic care and prevent re-victimisation during interventions. Organisations suggested prioritising training and capacity-building initiatives to equip staff with the necessary skills in trauma-informed care, advocacy, and sustainable programme management.

The need for continuous support and resources was more acutely felt in the Global South. IRCT members in these regions highlighted the importance of ongoing training, access to updated materials, and the establishment of regional networks for knowledge sharing and support. Additionally, further support and resources for fundraising and advocacy efforts could help organisations overcome financial constraints and sustain their implementation efforts.

There was also a call for more tailored content that addresses the specific cultural and socio-economic contexts of these regions. Participants from the Global South emphasised the need for practical solutions to overcome the unique challenges they face, such as working in conflict zones, dealing with high levels of trauma among survivors, and navigating complex legal and political environments. Hence, future iterations of the support provided by the Secretariat could include more region-specific content and examples, addressing the unique challenges faced by organisations in different regions.

Moreover, members suggested a range of topics for future webinars, reflecting the evolving needs and challenges faced by rehabilitation centres. Suggested topics included trauma and rehabilitation, human rights and legal issues, survivor engagement, specific populations, documentation and advocacy, and miscellaneous topics like web design for outreach and multi-sector collaboration.

Conclusion

The implementation of the Global Standards on Rehabilitation (GSR) marks a pivotal step toward enhancing the quality of care for torture survivors globally. By providing a unified framework, the GSR have facilitated significant advancements in service delivery, survivor participation, and organisational practices. IRCT member centres have demonstrated resilience and adaptability, addressing challenges unique to their regions while leveraging peer support and innovative tools such as e-learning platforms and regional trainings.

Despite disparities in resource availability, the GSR roll-out has catalysed a collective commitment to improving rehabilitation practices. The transformation observed in survivor-centred approaches, interdisciplinary collaboration, and ethical standards underscores the impact of this initiative on both individual organisations and the broader rehabilitation community.

Moving forward, sustaining these advancements will require continued focus on capacity-building, resource mobilization, and fostering collaboration across regions. Tailored strategies to address regional challenges and the evolving needs of survivors will further strengthen the implementation of the GSR, ensuring that all torture survivors receive comprehensive and effective rehabilitation services.

This journey demonstrates the potential of shared standards to unite a global network of professionals, driving collective progress and improving outcomes for torture survivors.

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Submitted 29th of May 2024
Accepted 12th of Dec. 2024

Annex: The Global Standards on Rehabilitation of Torture Victims

Resolution adopted by the 6th general assembly of the International Rehabilitation Council for Torture Victims (IRCT) on 6th October 2020.

Recognising that there exists a continuum of standards in rehabilitation services and that they may change at any given time, depending on the context, political situation and the scale of human rights violations;

Building upon our efforts to prevent torture, fight impunity, and provide redress and holistic rehabilitation to victims;

The members of the International Rehabilitation Council for Torture Victims (IRCT), in our joint work towards the identification, establishment and promotion of minimum standards for holistic rehabilitation delivery, commit ourselves and urge all rehabilitation service providers to:

Standard 1 – Our commitment to victims:
Uphold the well-being and dignity of torture[7] victims[8] as well as professional ethical standards and principles regarding treatment and rehabilitation, including informed consent, confidentiality, do no harm, the best interests of victims, and their free choice about the services they receive, resist re-traumatisation, and apply global best practices, which are all pivotal to the work of rehabilitation centres that are independent and accountable to victims, in accordance with the principles of the UN Committee against Torture's General Comment No. 3 on the right to redress and rehabilitation.

Standard 2– Independent services:
Implement relevant structures and procedures so that rehabilitation can be provided independently, autonomously, in full compliance with applicable professional standards and ethics, and free from any external influence. In particular, rehabilitation centres should prioritise the development and implementation of structures, methodologies, and procedures that are victim-centred, evidence-based, participatory, empowering, holistic, accessible, equitable, respectful, gender sensitive, culturally appropriate, and accountable. Where funding is received from sources that could be perceived to place an external influence on the rehabilitation provider, it is essential to ensure that the organisation's mandate and the principles of victim confidentiality, transparency, and independence of decision-making are prioritised and emphasise the victims' best interests. Torture victims must be informed about measures taken to protect the rehabilitation process from external influence.

Standard 3 – Safety of victims:
Ensure the implementation of every possible safety and safeguarding measure for victims receiving services including all aspects of the relationship with victims, bearing in mind that the best interest of torture victims is a key principle of rehabilitation services. Torture victims must be informed about and provide input into the determination of safeguarding and safety measures.

Standard 4 – Support to families:
Ensure that the specific rehabilitation needs of torture survivors' families, in particular children and vulnerable populations, are considered an essential part of the rehabilitation process. Where resources allow, families should receive support in accordance with their needs. Where relevant, culturally appropriate community-based approaches should be employed during the rehabilitation process.

Standard 5 – Access to justice:
Whenever possible, support victims' access to justice and be advocates for the eradication of torture as a part of the rehabilitation process. This includes supporting victims to document their claims in accordance with the Istanbul Protocol[9] and to file complaints, and advocate for national authorities to adopt and implement national anti-torture laws and National Preventive Mechanisms (NPMs).

7 In this document, the term "torture" covers all acts and omissions that may qualify as "torture" or "cruel, inhuman or degrading treatment or punishment" as defined by the UN Convention against Torture and further elaborated by the practice of the UN Committee against Torture.

8 The IRCT notes that some anti-torture actors prefer to use alternative terminology to "victim" such as "survivor" or "person subjected to torture". For the purpose of clarity and consistency, this document will use the term "victim" to describe any person that has been subjected to torture or cruel, inhuman or degrading treatment or punishment.

9 Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

Standard 6 – Intake Processes:
Establish intake processes through which victims of torture can access rehabilitation services on the basis of self-referral or referral by a third party, such as by competent physical or mental health, social, or legal professionals; human rights defenders; faith-based, indigenous, ethnic and national minority communities; other torture victims or family members. These processes must ensure that, within available resources, torture victims have free, equal and non-discriminatory access to services, regardless of their ability to pay or legal status in the country concerned. To the extent possible, rehabilitation service providers should prioritise outreach, in particular for torture victims who are marginalised, detained, living in remote areas or lack funds for transport costs.

Standard 7 – Access to information:
Provide torture victims with all relevant information concerning the rehabilitation services offered. Rehabilitation centres must respect and promote torture victims' agency in their own lives and their choices regarding rehabilitation. Where possible and appropriate to the service provided, reliable interpreters should be made available at no cost to torture victims. Whenever possible, victims should be able to choose the gender of rehabilitation professionals, including interpreters. Informed consent must be obtained according to relevant professional and ethical standards before and during the process of rehabilitation.

Standard 8 – Victim feedback:
Establish procedures and mechanisms that enable torture victims to provide ongoing feedback, including upon leaving rehabilitation services, in a language they speak, about the services they receive; for example, through the use of standing service user engagement mechanisms, victim satisfaction surveys, service evaluations, focus groups, and other participatory mechanisms. This feedback should be reviewed periodically and form the basis for continuous improvements to the rehabilitation services offered. Satisfaction should be clearly defined and use consistently applied standards. In addition, mechanisms whereby victims can complain and receive a prompt and satisfactory response in relation to the rehabilitation services they receive should be established. Victims should be enabled to effectively engage through measures such as provision of information about complaint possibilities and the establishment of support functions that include other victims.

Standard 9 – Victims' participation in rehabilitation:
Promote the meaningful contribution of victims in service design and delivery, research, decision-making, and governance processes of rehabilitation services through recognition of victims' experience in service development and recruitment processes, open consultative and feedback processes, and other participatory methods that are contextually and situationally appropriate.

Standard 10 – Organisational capacity:
Prioritise continuous training and capacity enhancement for staff and volunteers, for example, in specialised evidence-based treatment methods; trauma sensitive interview techniques; empathetic listening and anti- racism; cultural and gender awareness in accordance with relevant professional standards; and ethics and international human rights standards.

Standard 11 – Staff safety:
Ensure that staff and volunteers are safe, secure and cared for and have the means to report incidents that could compromise their safety or the safety of others through reporting processes or other suitable means that ensure that these risks are documented and that context- appropriate measures are taken to minimise them. In this regard, rehabilitation centres should ensure the adoption and implementation of appropriate policies to prevent and address discrimination, harassment, and sexual and other forms of abuse.

Standard 12 – Care for staff:
Address vicarious trauma and prevention of burnout as an organisational priority for all staff. To that end, provide a robust and supportive well-being infrastructure and working environment for staff through, for example, regular supervision, peer support mechanisms, staff mentoring, psychosocial support techniques, and access to occupational health services.

Standard 13 – Share knowledge:
Disseminate information about torture and its effects to professionals in healthcare and other relevant fields who may come into contact with torture victims. Information should include available and possible approaches to rehabilitation, the specific needs of torture victims (including early identification, assessment, and timely referrals), trauma-informed care, documentation procedures according to the Istanbul Protocol, and regarding the value of providing rehabilitation to facilitate life after torture. Where security considerations allow, the dissemination of this information should be considered a critical moral and social responsibility for centres assisting victims of torture.

Standard 14 – Advocate for rehabilitation funding:
Where possible, attempt to establish or strengthen dialogue with states and their relevant agencies to inform them about torture and its effects and the value of rehabilitation, and to request that they provide funding to support the rehabilitation of torture victims worldwide, preferably through: a) direct funding of rehabilitation centres assisting survivors of torture in their respective countries, b) contributing to the United Nations Voluntary Fund for Victims of Torture (UNVFVT) or c) funding the IRCT's sub-granting programme.

RECOGNISING the importance of a holistic approach to the fight against torture, which encompasses prevention, justice and reparation for victims and that IRCT members contribute to all aspects of this effort to eradicate torture;

The IRCT membership expresses our joint ambition to document and demonstrate our collective global impact on the quality of life of the torture victims we support, and therefore commit to endeavour to:

Standard 15 – Definition of quality of life:
Apply the following definition of quality of life: The subjective well-being of individuals and their communities within their specific social and cultural context in relation to factors such as physical and mental health; family, social and community relations; culture; education; employment; economic security; exposure to physical and psychological violence and freedom; good governance and basic human rights; spiritual life; gender equality and non-discrimination; religious beliefs; legal status; and the natural and living environment.

Standard 16 – Evaluating improvements in quality of life:
Apply evaluation tools that are appropriate to their specific context. This is done with the recognition that IRCT members provide services in very different contexts, including detention, political repression, victims with uncertain legal status, discrimination and poverty, which may have a severe negative effect on victims' quality of life. Furthermore, each member centre will determine which tools are best used to evaluate improvements in all indicators relevant to addressing the needs and improving the quality of life of the torture victims they support, and communicate this to the IRCT membership. In documenting the results of their work, IRCT members are encouraged to take into account how the quality of life of torture victims is connected to the enjoyment of rights, including access to justice, international protection, redress and all five forms of reparation (restitution, compensation, rehabilitation, satisfaction and the right to truth, and guarantees of non-repetition).

Standard 17 – Documenting our global impact:
Share the results of their support to torture victims with the IRCT membership on an annual basis. This will become part of the IRCT's annual Global Impact Report, which demonstrates to the world our collective impact in the lives of torture victims.

Torture, 2024, 34(3), 87-88
https://doi.org/10.7146/torture.v34i3.152171

Historic Abu Ghraib verdict: U.S. Contractor held accountable for torture

Andrea Mølgaard[1]

After years of legal battles, three Iraqi survivors of torture in the Abu Ghraib prison have secured justice in a historic victory in U.S. courts. The jury ruled in favour of the Iraqi plaintiffs, holding a private contractor, CACI Premier Technology, Inc., accountable for its role in the abuse and torture of detainees during the Iraq War.

Background on torture in Abu Ghraib prison

Abu Ghraib, a prison located in Iraq, was used under the regime of Saddam Hussein to torture detainees. Following the regime fall after the American invasion of Iraq in 2003, the U.S. military started using Abu Ghraib as a detention facility.

In 2004, Abu Ghraib gained global notoriety and became a scandal for the U.S. government when leaked photographs revealed acts of torture, humiliation, and inhumane treatment of detainees by U.S. military personnel as well as private contractors, such as CACI, that were hired by the U.S. military to conduct interrogations at Abu Ghraib.

Many of the prisoners were detained by U.S. soldiers on suspicion of belonging to armed groups. However, the International Committee of the Red Cross (ICRC) reported that 70% to 90% were innocent civilians who had been mistakenly arrested (ICRC, 2004).

The abuse at Abu Ghraib in Iraq was not an isolated incident but rather part of a broader pattern of mistreatment that emerged during the U.S.-led 'War on Terror'. This pattern traces its roots to earlier policies and practices developed in detention facilities such as Guantánamo Bay, where U.S. forces also employed harsh interrogation techniques and circumvented standard detention rules through broad interpretations of international law (Human Rights Watch, 2004).

The legal case against CACI

In 2008, the three survivors of torture in Abu Ghraib filed a lawsuit against the American private contractor CACI to seek redress. The U.S. military hired CACI to conduct interrogations, with their primary role being to supply civilian interrogators who assisted military personnel in gathering intelligence from detainees. CACI has unsuccessfully tried to dismiss the case more than 20 times, resulting in the three victims testifying many years after the events, making *Al Shimari, et al. v. CACI* the first case of its kind to be heard by a civil jury (Center for Constitutional Rights, 2024).

The plaintiffs, Suhail Al Shimari, a middle school principal, Asa'ad Zuba'e, a fruit vendor, and Salah Al-Ejaili, a journalist, testified suffering intense physical and psychological abuse, such as beatings, sexual assault, electric shocks, and enforced nudity in the prison of Abu Ghraib (Center for Constitutional Rights, 2024; Barakat 2024).

On November 12, 2024, a federal jury in a U.S. court in Alexandria, Virginia, found CACI liable for its role in the torture of the three survivors (Salah Al-Ejaili, during detention in Abu Ghraib prison in 2003-2004. The jury ordered CACI to pay a total of about 42 million dollars in financial compensation, $32 million in punitive damages, and $3 million in compensatory damages for each of the three plaintiffs (Rizzo 2024). The jury determined that although CACI's interrogators did not directly inflict the abuse, they collaborated with military police to 'soften up' detainees for interrogation, effectively enabling the mistreatment (Barakat 2024).

CACI released a statement expressing disappointment with the verdict and confirming its plan to file an appeal.

The verdict, in this case, carries profound significance for survivors of Abu Ghraib, as it represents a long-awaited acknowledgement of their suffering after years of a legal battle. This reinforces the importance of accountability in cases of human rights abuses and sets a crucial legal precedent, signalling that a private contractor, like those hired for the Abu Ghraib interrogations, can be held accountable for their actions.

The three survivors of Abu Ghraib were unable to sue the U.S. military due to legal protections like immunity, which can shield government bodies and officials from lawsuits (Gräs 2024).

As a result, survivors have no choice but to pursue legal action against the private contractors, like CACI, who were involved in the torture, setting the stage for a significant case.

The Abu Ghraib legal victory can be viewed in relation to the earlier, significant *Salim v. Mitchell* case, in which two psychologists, Mitchell and Jessen, agreed to a settlement — a first for a case involving CIA torture (ACLU 2017). In that case, two psychologists were contracted by the CIA to design, implement, and oversee the agency's post-9/11 torture program. A lawsuit filed in 2015 on behalf of three victims of the program accused Mitchell and Jessen of orchestrating the torture

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and experimentation of detainees. In 2017, after the case survived multiple attempts to be dismissed, the psychologists settled (ACLU 2017). However, the settlement did not include an admission of liability. The legal consequences in the Abu Ghraib case, where CACI was held accountable for its role in torture, may provide momentum to revisit the Mitchell and Jessen case, as well as other similar cases, and demand stronger legal and ethical consequences for their involvement. The American Psychological Association (APA) reacted to the *Salim v. Mitchell* case settlement, emphasising the importance of ethical standards and human rights in psychological practice, underscoring the need for greater professional responsibility in such cases (APA 2017).

Broader implications

This legal victory is an important part of the global fight against torture, as it shows survivors that there is a legal path to redress. Still, it also serves as a reminder that the fight against torture is ongoing and that those responsible, whether state actors or private contractors, must be held accountable and prosecuted both nationally and internationally, in accordance with the anti-torture convention.

It calls for a more robust global commitment to upholding human rights and preventing the use of torture in any form. Moreover, it challenges governments and private contractors to reevaluate their practices and adopt ethical standards that protect the dignity and rights of individuals, particularly in conflict zones.

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Torture, 2024, 34(3), 89-90
https://doi.org/10.7146/torture.v34i3.150109
Letter to the editor

Ocular injuries by less-lethal weapon: a view from Switzerland

Anna Fierz[1]

Dear Editor-in-chief:

Thank you for focussing on this troubling subject in your issue 1/2024. It confirms that many of the difficulties involved are similar worldwide. Countries that use less-lethal weapons include Switzerland, the only Western European democracy besides France to employ multiple kinetic impact projectiles. Our rubber scattershot is comparatively small and light but has led to an uninterrupted series of severe eye injuries since 1980. Legal authorities have long questioned whether these were due to rubber ammunition, though ophthalmologists always knew what was going on. Communication channels were non-existent, and monitoring remains a challenge. Please see my recent open-access review in Eye (Fierz, 2024) for details.

I would like to add the odd point to your commendable editorial (Pérez-Sales et al., 2024). The common denominator is that eye injuries require eye doctors.

In the introduction to Section 4, you list different professionals who should be involved in assessing an ocular injury and conclude by stating that it is unnecessary to have all of them available. While I agree, it is my considered opinion that an ophthalmological evaluation is mandatory. Ideally, it should be commissioned by and transmitted to the legal experts in a similar time frame as the forensic report. (To the best of my knowledge, this is not the case in Switzerland, where prosecutors may rely on forensic evidence alone. I am unaware of the situation elsewhere.) The patient should not have to foot the bill.

Forensic specialists admit that they are unable to interpret comparatively simple ophthalmological findings such as traumatic cataracts without the help of eye doctors (Moreschi, 2013). They cannot be expected to understand the unique vulnerability of the eye to trauma. Eye injuries by kinetic impact projectiles are among the most severe and complex examples of ocular trauma seen in otherwise peaceful countries. Also, forensic specialists usually collaborate closely with prosecutors, which raises the question of bias. I have seen a recent forensic report that did not only ignore the main ophthalmological finding, but explicitly denied it. Due to ongoing legal proceedings, I cannot go into more detail. While it was probably unintentional, I would never have believed such a glaring error could happen here.

Damage thresholds for the eye are lower than for any other organ. Since even the foam dart of a Nerf toy gun may cause permanent visual impairment (Cohen, 2023), any projectile must pose a risk to the eye. Therefore, regulations should prohibit hitting the head. While the kinetic energies of single projectiles are usually higher, multiple projectiles are responsible for the vast majority of reported eye injuries because of their inherent lack of precision. The UN Special Rapporteur on Torture has called for multiple projectiles to be outlawed (Edwards, 2024). In several countries, ophthalmologists and sometimes even their professional associations have gone public about the dangers of kinetic impact projectiles: not only in the States, Chile and France (Fierz, 2024) but also in countries where doing so might be risky, like Iran (Afkhamnejad, 2023), and most recently in Bangladesh (Dhaka Tribune, 2024). I take my hat off to all my colleagues who had and still have the courage to speak up. In my opinion, this is very much a part of our professional responsibilities.

It is interesting to me that the most outspoken civic movements against these weapons - Stop Balas de Goma in Spain and MOCAO in Colombia - developed in countries from which I could find no ophthalmological publications.

In Section 4.3 on the assessment of ocular damage, it is worth mentioning existing classifications such as the Birmingham Eye Trauma Terminology (BETT) (Kuhn, 2002a) or the Ocular Trauma Score (OTS) (Kuhn 2002b). In particular, I missed a mention of traumatic optic neuropathy and post-traumatic secondary glaucoma. Both conditions can lead to blindness. Traumatic optic neuropathy usually develops rapidly. Glaucoma also harms the optic nerve, but its onset is more insidious, and it may not occur until years or even decades later. Affected patients normally do not notice visual field loss until it becomes immediately vision-threatening. Any damage to the optic nerve is irreversible. Normal ageing alone takes a toll on optic nerve fibres, which may be enough to cause sight-threatening progression in persons who are diagnosed late, i.e. with preserved central vision and good visual acuity but advanced field loss.

Therefore, every patient with a significant eye injury needs lifelong ophthalmological follow-up examinations. This even holds true for those with a completely blind eye, as glaucoma can be painful. Also, checking on the health of the only sighted eye becomes even more important. Counselling patients accordingly is vital. In my limited experience, some are lost to

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follow-up despite our best efforts. Sadly, these may be among the most traumatised—for obvious reasons.

There appears to be a global unmet need both for resources for medics/first responders and for standards for collecting data on such injuries (personal communication from Neil Corney, Omega Research Foundation, October 2024). Efforts among the international ophthalmological community are underway. Still, several series of such injuries have not been reported in the ophthalmological literature, perhaps because it is too difficult or dangerous. Anyone with experience in these matters or with good ideas is welcome to contact me or the staff at Omega. Thank you!

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Submitted 8th of September 2024
Accepted 10th of November 2024

Call for Papers. Special section of Torture Journal: Journal on Rehabilitation of Torture Victims and Prevention of Torture

ISRAEL & OCCUPIED PALESTINE

Pau Pérez-Sales, Editor-in-Chief, Torture Journal

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The Palestinian people have endured a protracted process of occupation by Israel. This has resulted in a plethora of documented instances of human rights violations. One year after the Hamas attacks on 7th October 2023 in Israel and Israel's military campaign and associated grave human rights violations in Palestinian territory and other related Arab countries, it is an important duty to analyse emergent issues from a human rights perspective and for the Torture Journal to do so on matters within its scope.

To conduct an analysis in the context of an ongoing war and enormous

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