Migration and Torture: Building a Map of Knowledge

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Abstract   The article presents a systematic literature review on migration, torture and health.

Keywords   Migration. Torture. Literature review. Health. Asylum seekers.

Summary   1 The "Refugee Crisis". – 2 Research on Migration and Torture. – 3 Where Next? Concluding Remarks.

1   The 'Refugee Crisis'

We already have more than twenty-five years of academic research on migration and torture; the field has developed into an increasingly complex one since the first descriptive and epidemiological studies.

The recent war in Syria, added to previous conflicts in Afghanistan, Iran, Iraq, has led to mass displacement, especially since 2015, to neighbouring countries and Europe, in what has come to be known as the *refugee crisis*. The concept *crisis* as applied to Europe is a relative one. According to 2018 UNCHR figures,[1] while there are 22.5 million refugees in the world, the top hosting countries are Turkey (2.9 M), Pakistan (1.4 M), Lebanon (1 M), Iran (979,000), Uganda (940,000) and Ethiopia (791,000). While 30% of those living in Lebanon (a country with a very unstable religious and political equilibrium)

Published in *Torture*, 28(2), 2018 (courtesy).

[1]   Resettlement data finder accesed in `http://rsq.unhcr.org/en` (2019-10-16).

are refugees,[2] in Europe the proportion of refugees is marginal in demographic terms, even including the increase in the last two years.

Several episodes have marked the European political confrontation around the 'refugee crisis' in this period. These include, (a) Germany's decision to both open its doors in 2015 and 2016 and accept more than one million refugees, and then subsequently restrict entry in 2017 after the political environment altered due to various factors, including two Islamist attacks attributed to newly arrived refugees. (b) The EU decision in May 2017 to transfer 160,000 asylum seekers that were stuck in Greece and Italy to other European member states was met with widespread resistance. The European Union was not able to fully act on the decision and the transfer could only partially take place. As a result, around 65,000 refugees remained in both countries, and especially on the Greek Islands in precarious conditions. (c) In March 2016, in exchange for political and financial benefits, the EU signed an agreement with Turkey (recognised as *a safe country*) to accept people being sent back from Greece. In spite of that, only around 2,000 persons[3] were sent back due to resistance of the Greek courts to apply the agreement (Roman et al. 2016). Those who were returned faced detention in overcrowded cells and deportation (Ulusoy, Battjes 2017).

Europe is now trying similarly unacceptable arrangements with Libya, Egypt, Sudan, and Nigeria, among others, countries which can never be considered as *safe countries* for refugees to be sent back to.

The true refugee crisis is of course that around 4,600 persons are estimated to have died trying to cross the Mediterranean in the 2015-18 period,[4] the sufferings of hundreds of migrants exploited, victims of extortion, tortured and abused on their way north, pushed back at borders violating *non-refoulement* principles or abandoned to their fate on the sea.

2 Research on Migration and Torture

It is worthwhile attempting a structural map of knowledge of where we are currently with respect to research. Figure 1 is not meant to be exhaustive, but illustrative.

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[2] https://ec.europa.eu/echo/files/aid/countries/factsheets/lebanon_syrian_crisis_en.pdf (2019-10-16).

[3] http://www.dw.com/en/the-eu-turkey-refugee-agreement-a-review/a-43028295 (2019-10-16).

[4] https://www.opensocietyfoundations.org/explainers/understanding-migration-and-asylum-euro-pean-union (2019-09-01).

TRUST

Torture in home country	Torture during migration process	Asylum-Claim	Refugee Humanitarian Protection

Torture and persecution ***

Kidnapping – Extorsion – Trafficking

Massive Human Rights Violation in Borders – Walls and Fences

Migrant Detention Centers in third countries / Borders

Screening – Access to legal System – Information *

Poverty **
Limited access to healthcare **
Denial of work permit *

Dispersal *
Stigma⁰

Cultural Barriers *
Translation – Mediation⁰

Detention ***

Delays in procedure-decisions **

Interview process *
Court hearings *

Credibility of allegations ***

Post-Migration conditions ***

Access to justice *
Political action *
Reparation *

Rehabilitation *

Rejection: Undocumented migrants ***

Deportation – Risks at arrival *

Negative factors : (0) No evidence (*) Indicative evidence (**) Strong evidence (***) Conclusive evidence.
Torture is according to UNCAT definition (torture during migration progress includes where the State fails the obligation to protect).
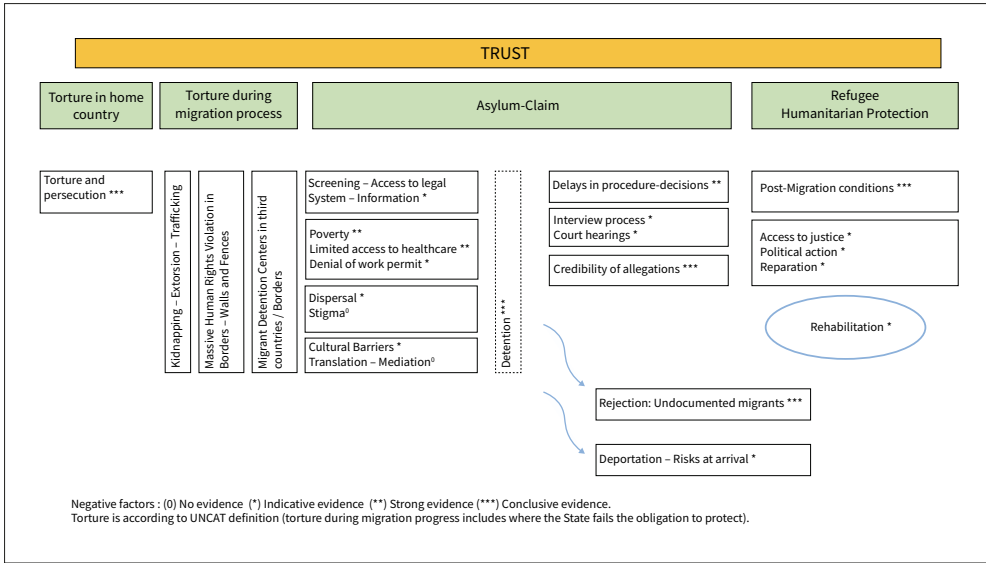
Figure 1 Migration and torture. Psychosocial determinations of health and well-being and right to rehabilitation

2.1   Overarching Issues

The Mental Health Impact of Torture

Different reviews since the 1990s have provided strong evidence of the mental health impact of persecution and torture (Johnson, Thompson 2008; Momartin et al. 2003; Steel et al. 2009). Just to mention one, a meta-analysis of 161 articles reporting results from a sample of 81,866 refugees from 40 countries showed that torture emerges as the strongest pre-migration factor associated with PTSD and depression, followed by cumulative exposure to potentially traumatic events (Steel et al. 2009).

Distrust as a Cross-Cutting Element

The impact of hardship and torture is not only measurable in clinical terms though. As academic research has shown, if one psychological element illustrates the migrant's experience and provides a framework of understanding of his or her inner experience, it is that of *trust*. The decision to flee for torture survivors is part of a complex process. Voutira and Harrell-Bond (1995) showed, among oth-

ers, how adaptive distrust shaped the experience of survivors of war and torture. There is a mixture of individual, community, institutional and social mistrust shaped by the context of violence and menace behind the decision to flee (Lyytinen 2017). Key decisions during the route that could mean the difference between being dead or alive depended on *trusting* decisions. For years, mistrust is the norm (Daniel, Knudsen 1995). Particularly as refugees are often used as a bargaining chip in political disputes amongst countries, traders and local authorities, who often have their own hidden agenda, and NGO's and iNGOs can be unwilling to provide support for an extended period of time (Stedman, Tanner 2003).

Country of destination is rarely a decision of the asylum-seeker. Studies show that, at the beginning, the main concern is to find a safe place. Final destination, however, depends on having funds and very circumstantial decisions made in the heat of the moment, as well as being directed by smugglers, police, the military, governments, and/or agencies to particular countries with little choice (Robinson, Segrott 2002). Dispersal within a country or between countries can destabilise precarious social networks as well as disrupt the fragile bonds of trust of early psychological care (Griffiths 2012; Ní Raghallaigh 2014).

Crossing Borders: When Torture Happens During Flight

Borders have become places of very serious human rights violations, as the Special Rapporteur against Torture (2018) has noted in his latest thematic report. To give an example, just on the border between Guatemala and Mexico, according to official figures and reports of local organizations,[5] an estimated 20,000 people were reported missing (*desaparecidos*) in the period 2015-17 at the hands of organised crime and trafficking with the necessary cooperation of the State and local police forces. This is to be added to the general situation in the Mexican-United States border itself, where there has been an estimated 800 cases of missing people in the last two years. According to independent reports, the US is maintaining a policy of illegal detention of asylum-seekers including extreme conditions in cells, indefinite separation of minors from their parents, lack of information and access to legal counsel, victimisation and other forms of coercion to accept returning to Mexico, in what human rights groups and the rapporteur himself have considered as amounting to systemic State torture (Hope Border Institute 2018; Human Rights First 2017). Eu-

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[5] Centro Fray Matias de Córdoba: http://cdhfray-matias.org/web. Movimiento Migrante Mesoamericano: https://movimientomigrantemesoameri-cano.org/inicio (2019-10-16).

rope pursues similar policies by funding detention centres and co-ercive actions in North Africa where the systematic violations of human rights including torture and summary executions that take place have been denounced.[6]

There is a special need to address the challenges of migrants who, along their migration route, have suffered violence (including torture by non-State actors and sexual violence). They should be offered similar protection against further abuses and exploitation and to ensure access to basic human rights (to health, housing, education, rehabilitation, etc).

Detention Centres

The Global Detention Project (GDT) monitors detention of immigrants in 'host' countries,[7] and has a global map and detailed data of around 2,000 immigration-related detention sites across the globe. Within the United States, which is the most dramatic example, there has been a sustained expansion with between 430,000-470,000 individuals being recently subject to some form of immigration detention annually compared to numbers as low as 6,000 in 1995 and 16,000 in 1998. Europe has also experienced a rapid expansion of detention, including outsourcing detention to border countries.

There is a large body of literature that analyses the health impact of detention on victims fleeing torture and violence in their countries and indicates that detention substantially worsens the health of asylum-seekers (Fazel, Silove 2006; Keller et al. 2003; Robjant et al. 2009; Sobhanian et al. 2006; Storm, Engberg 2013). Data show symptoms of depression, anxiety, exacerbation of PTSD, marked increase in reported negative mood states, suicidal ideation and self-destructive thoughts. In all the studies the impacts are directly related to length of detention. Prolonged or indefinite detention *per se* produces learned helplessness and powerlessness (Storm, Engberg 2013). The transnational DEVAS study showed in 23 EU countries that almost half of the detainees in migration centres inside Europe did not understand the reason for their detention and equate their detention centre with that of a prison. Approximately one third referred to clear physical consequences and half described a negative impact on mental health. There was a general sense of indignity among detainees (Jesuit Refugee Service – Europe 2010). This is specially so in the subgroup of torture survivors (Filges et al. 2018; Storm, Engberg

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6   See reports: http://ddhhfronterasur2017.org/es. See reports and maps by Migreurop: http://www.migreurop.org (2019-10-16).

7   https://www.globaldetentionproject.org (2019-10-16).

2013). According to recommendations from the United Nations' High Commissioner for Refugees (UNHCR 2012) and the Special Rapporteur on Torture (2018), torture survivors and other vulnerable groups should generally not be detained. Health professionals should actively oppose this measure based on ethical and deontological principles (Brooker et al. 2016; Pearman, Olinga-Shannon 2017).

Accessing the System of Protection for Torture Survivors

There is an important concern in the anti-torture sector that torture survivors who suffer trauma-related mental disorders are being refused protection by countries in which they seek asylum. A pioneering study (Silove et al. 2006) followed a consecutive sample (n=73) of recently arrived asylum seekers attending immigration agents in Sydney, Australia. Participants were followed up to assess the outcomes of their refugee applications. Although the participants reported high rates of torture (51%), and this group is of course at the highest risk of suffering a combination of post-traumatic stress disorder (PTSD) and major depression, neither past torture nor current psychiatric disorder predicted the outcomes of refugee applications. Although the Asylum Procedures Directive 32/2013 (European Council 2013) establishes special measures to detect and properly document torture survivors,[8] there are serious concerns regarding its proper application (IRCT 2016).

Faced with the increasing numbers of asylum seekers, a number of initial screening tools – up to 20 documented in academic journals and grey literature – have been proposed, the majority of large institutions having their own. There are suggestions and formats from national and international bodies including guidelines from the European Union itself (PROTECT Project 2016) (see also Mewes et al. 2018). The scene is variegated and requires revision as most are non-validated instruments that can be classified into two broad categories: (a) short clinical measures based on abbreviated diagnoses of post-traumatic stress or general psychological distress that can be applied by administrative staff (i.e. Hollifield et al. 2013); and, (b) general indicators of vulnerability (i.e. UNHCR et al. 2016). It should be remembered that there is a low to moderate correlation between experiences of torture and psychiatric disorders, and that PTSD is nei-

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[8]   The Asylum Procedures Directive (recast) was adopted by the European Parliament and the Council in 2013 and was to be transposed into Member States' national legislations by July 2015. The Commission presented in July 2016 a Proposal for a new Asylum Procedure Regulation. Point 31 states that "National measures dealing with identification and documentation of symptoms and signs of torture or other serious acts of physical or psychological violence, including acts of sexual violence, in procedures covered by this Directive may, inter alia, be based on the [...] Istanbul Protocol" (European Council 2013).

ther the only nor the most likely consequence of torture in the long term. Issues of transcultural validity of screening tools are also relevant. A review of validated measures and more theoretical debate and consensus is needed (Gadeberg, Norredam 2016; McColl et al. 2008).

2.2   Post-Migration without Status

Silove and colleagues have been providing sustained evidence of the negative impact on mental health of conditions of reception for asylum seekers in Australia, showing that its impact was even greater than torture and persecution in country of origin (Silove 2000; Steel, Silove 2001; Steel et al. 2009). A Norwegian case-control study in an in-patient psychiatric ward found highly significant differences in PTSD prevalence between asylum seekers, living in centres (n=53, 43.3%), and refugees (n=45, 11%), associated to the stresses of life in reception centres and the risk of being expelled from the country more than the experiences in countries of origin (Iversen, Morken 2004). Other studies have expanded these results to medical conditions (Porter 2007). In a recent systematic review (Kalt et al. 2013), combining data from 23 peer-reviewed studies among asylum-seekers (30% torture survivors), it was concluded that highly stressful asylum-seeking processes produced adverse mental and somatic health effects, associated to specific forms of exclusion linked to social conditions and hostile policy environments.

Whilst these conditions vary from country to country, there are some salient themes:

Poverty

Asylum seekers face economic hardship through an increasingly short and limited system of State social support and assistance even where there is one (Allsopp et al. 2014). While waiting for a determination decision, they often receive basic temporary benefits, well below the minimum of the country, usually aggravated by the denial of permission to work. This situation can extend for a long period of time. As an example, in a 2013 study for *Freedom for Torture*, Pettitt (2013) reveals that more than half of a sample of 84 torture survivors in the UK asylum system reported that they could never or not often afford to buy enough food of sufficient quality and variety to meet their needs for a nutritionally balanced diet; 34 were never able to buy enough food of any quality to avoid hunger; 53 could not buy adequate winter clothing. It is hard to imagine the situation of asylum seekers in countries with even lower levels of assistance.

Access to Healthcare

According to the HealthQUEST study (European Commission 2008), most European countries limit the access of migrants and asylum seekers to health care, usually reducing it to basic care and emergencies. The system of free specialised healthcare is usually banned. The study shows that in Europe providing comprehensive adequate care (including mental health) would, paradoxically, save costs. In the United States where there is no national health system, the situation is so precarious that Asgary et al. (2013) showed in a sample of sub-Saharan asylum seekers (most of them torture survivors) that they had better access to social and health services in their home African countries than in the US.

Stigma

There is growing evidence that perceived discrimination carries a psychological toll. A wide study following a participatory action research process in Scotland showed how this was linked to mental health problems, especially in VoT (victims of torture) (Quinn 2014).

Cultural Barriers

Language and culture have been documented as central sources of stress, particularly in the long term (Montgomery 2011). The role of cultural mediators is crucial, undoubtedly another insufficiently researched topic.

Access to Justice and Providing Meaning to the Experience of Torture

Arriving in a host country is, for many survivors, part of a process of social and political commitment which cannot be easily continued. Giving testimony, being part of an ideological or political movement, helping those who remain in their country, and pursuing justice can be essential elements to providing meaning to the experience of torture and to have a sense of continuity in life. The asylum system too often victimises survivors and keeps them in a vulnerable legal position that precludes any possibility of activism or empowerment and the impacts of this are not well researched (EATIP et al. 2002; Tay, Silove 2017).

2.3   Facing Assessment

Abbreviated Procedures

McColl et al. (2008) have shown that processes that are too *fast-track* can preclude proper medical documentation of allegations of torture or persecution.

Delay of Decision

In a series of focus group with survivors of torture in UK, the three biggest problems described were uncertainty, lack of perspective and a shortened future associated with endless waiting for a decision (Haoussou 2017). Although the European Asylum Procedures Directive 32/2013 (European Council 2013) envisages a maximum of six months for an asylum determination, the decision normally takes much longer, sometimes years. At the American border, asylum claimants often spend many years waiting for the adjudication of their cases creating a limbo situation (Haas 2017). A cross-sectional survey with Iraqi refugees whose determinations were pending showed that survivors waiting for a decision generally felt socially isolated and lacking in control over their life circumstances with a strong sense of injustice (Johnston et al. 2009).

Stress of the Interview and Court Hearings

After initial acceptance, and after a long waiting process, survivors of torture must prepare and undergo an in-depth interview (and sometimes a court hearing) where their fate will be decided. This is not a neutral process. A recent study in Berlin suggested that the asylum interview might decrease posttraumatic avoidance but trigger posttraumatic intrusions (Schock et al. 2015). Due to this stress, the interview might have a negative result. Similar studies in other countries have found less conclusive results (Hocking et al. 2015).

Medical Reports

Some studies show the importance of medical reports for proper documentation of torture. In a sample of close to 2,000 asylum-seekers in the US, 89% of those with a medical report from Physicians for Human Rights (PHR) were granted asylum, compared to the national average of 37.5% (Lustig et al. 2008). We need more data on which as-

pects of forensic assessment in general and the Istanbul Protocol in particular are relevant for an administrative body or court to make a final decision on a protection claim, a much needed demand in the anti-torture sector (Freedom for Torture 2016; Pérez-Sales et al. 2017).

Credibility

It is probably the assessment of the credibility of allegations of torture that is the one of the most complex issues and on which, paradoxically, there is less academic research (Jubany 2017). On the one hand, there is a debate on whether health professional should make judgments of credibility (Good 2004). The debate often mistakes the credibility of the victim with the credibility of the victim's account. There is arguably an ethical duty to have a forensic report provided, especially in contexts in which the victim of torture lacks any other evidentiary element, has fled without any documentation, and there are no physical injuries or witnesses that can support her allegations (Pérez-Sales 2017a, 2017b). This is particularly the case when considering the crude reality that torture survivors are being refused protection in all likelihood due to the difficulties in giving a proper account of the facts (Silove et al. 2006; Masinda 2004).

There are numerous guidelines for credibility assessment of the different institutions and bodies working within the framework of asylum (Gyulai et al. 2013; Home Office 2015; Kane 2008; Mackey, Barnes 2013; Mind 2010), with very different perspectives and approaches and sometimes conflicting criteria. While in some cases the victim's account is said to be the weakest piece of evidence, in others it is the opposite that is emphasised and guidelines are worked out for the analysis of the narrative and its relationship with sources of corroboration or triangulation. None of the available guides to best practice have been validated and they are in any case only recommendations from experts. We also lack data for comparing credibility in this area with credibility in other fields and the standards of proof required (Freedom for Torture 2016).

It unfortunately remains the case that the asylum determination process relies heavily on remembering and narrating traumatising stories in a *convincing* way and without contradictions, despite mental health issues.

Deportation

In 2016 alone, the EU allocated a total of 806 million Euros to activities related to the deportation of migrants, including the expulsion of 113,835 people to the 15 countries with which Europe has

signed a repatriation partnership agreement and the financing of migrant centres in countries such as Pakistan or Lybia. This figure would have increased noticeably if the agreement with Turkey had not been a failure[9] and if transfer among EU members in application of the Dublin procedure were included.[10] During President Obama's administration, a record 2.5-3 million immigrants were deported in his eight years in office. In 2016, immigrant detention and deportation machinery alone in the US cost 3.3 billion dollars (Baker 2017). What happens with asylum-claimers who have been rejected and deported? Although some organizations try to keep track of them (Amnesty International 2017), there is scarce data on their fate. There are some ethnographic studies on the hardships of reintegration after deportation for economic migrants (e.g. Khosravi 2018) but literature is scarce on rejected asylum claimants.

The organisation Justice First followed in 2011 a sample of Congolese people deported from France and found out that all failed asylum seekers had been imprisoned, tortured, forced to pay a ransom, raped or subjected to sexual harassment upon their return (Ramos 2011). Reports from Freedom for Torture (2012) and Human Rights Watch (2012) have documented the systematic detention and torture of Tamils who were rejected asylum claimants and deported to Sri Lanka. Similar data have been reported for deportees to Eritrea, Malta, Libya including summary executions of deportees in Sudan (Alpes et al. 2017). There are documented cases of detention and torture of Ugandan citizens that demanded asylum due to being a member of the Lgtbq community (Onyoin 2017), and already mentioned is the fate of people deported to Turkey in application of the EU-Turkey agreement. This data should not be a surprise. In many countries, the deported person is handed to the national authorities on arrival. Having claimed asylum is viewed as suspicious and the person is often immediately detained and interrogated.

All together, these studies suggest that there is a real danger for deported people and this must be the responsibility of deporting authorities that do not have a post-deportation follow-up system (Stefanovska 2016). Additionally, a Rights Disability International campaign claims that deporting people with severe mental disorders or disabilities to countries where they will have no access to proper care or treatment or be secluded in institutions with conditions that can

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9 http://www.publico.es/internacional/union-euro-pea-agencia-deporta-cion-masiva-migrantes.html (2019-10-16).

10 In January 2011, the European Court of Human Rights (EchRT) declared that the transfer of one person from Belgium to Greece in application of the Dublin rules violated Article 3 (torture and inhuman or degrading treatment or punishment) and Article 13 (effective remedy) of the European Chart of Human Rights. Following this decision, most of the member States of the European Union stopped Dublin transfers to Greece.

amount to torture should be enough to stop deportation and humanitarian protection should always be granted (Kanter, Rosenthal 2018).[11]

The Top of the Vulnerability Pyramid: Undocumented Migrants

The alternative for survivors whose application has been rejected is to stay undocumented in the host country in even worst conditions than before. If asylum seekers and refugees suffer poverty, stigma, lack of health services or a work permit, this is to be added to having to hide from police, being defenceless from crime and violence and working in the underground economy. Overwhelming data show that this is the group with the highest risk of severe mental health disorders. One study, among many, in Zurich (Switzerland) showed that more than 80% had at least one clinically significant symptom, and more than 50% fulfilled the criteria for PTSD. This should come as no surprise as more than 60% had suffered imprisonment and 30% torture. The prevalence of torture was slightly lower than those of asylum seekers, but the prevalence of mental health problems was higher. The study showed, again, not only that refugee and humanitarian decision-making procedures may be failing but also that undocumented migrants are probably the most vulnerable and affected of populations due to an aggravation of pre-migration symptoms and the impossibility of access to treatment according to their right to rehabilitation (Mueller et al. 2011).

Once Status is Granted: "El Dorado"

The long journey finally ends for an estimated 30-40% of torture survivors that ask for international protection obtaining it (Silove et al. 2006; Mueller et al. 2011; UNHCR 2017). The majority is, thus, undetected or rejected. There is a large body of literature showing that the refugee population, even with protection status, has very high levels of psychological suffering resulting from their pre-migration experiences, but particularly from life in the new host country (Porter 2007; Porter, Haslam 2005). A decent standard of living is not guaranteed.

Right to Rehabilitation

Torture survivors have a right to rehabilitation, as set out in the Convention against Torture and General Comment No. 3. Programs for

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11 https://www.driadvocacy.org (2019-10-16).

VoT who move about are a challenge. There is a need for short-term interventions that follow the do-no-harm principles in contexts where it might not be the time to talk. This creates a special set of conditions for rehabilitation programs that deserve special research, including long-term follow-up and non-clinical measures.

3 Where Next? Concluding Remarks

The over twenty-five years of research in the field appears to provide conclusive evidence regarding the negative impact on torture survivors of human right violations taking place throughout the *migration continuum*.

This idea of a migration continuum deserves special attention. Migrants who along their migration route have been suffering violence (including torture by non-State actors, sexual violence, and being unable to access basic conditions that respect human dignity) should be also offered protection and access to basic human rights (to health, housing, education, rehabilitation etc).

Figure 1 is intended to show a summary of the relationship between mental health and well-being and pre- and post-migration factors and the amount and strength of available evidence. Although we need more studies on psychosocial determinants during the asylum claim process, there is strong evidence on the impact of poverty and limitations of access to health care. Most of the research highlighted here is in relatively well-off host countries which reflects the absence of literature in more complex situations (e.g. Lebanon and Greece, not to mention other neighbouring countries to refugee-producing countries in the rest of the world). More research is especially needed regarding the migration process itself and the impact of massive human rights violations at borders, migrant detention centres in third countries, and by State and non-State actors on victims of persecution and torture fleeing from their country. This also applies to research on what happens to people being denied protection and deported to their countries of origin. Although there are indicative data, more research is also needed on the screening process and appropriateness of detention of torture survivors and vulnerable populations, the impact of the asylum process and interviews, on the role of translators and cultural mediators, and the effect of policies of dispersal and delays in procedure decisions. With respect to proper identification procedures, the need is poignant and urgent. Finally, we still lack more research and stronger evidence on the efficacy of rehabilitation programs for migrant torture survivors.

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