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Exploration of the Implementation of Istanbul Protocol for Torture Screening in the Refugee Health Team in Trondheim. A Qualitative Study.

A Master Thesis Submitted to the Faculty of Public Health and Nursing in Partial Fulfillment of the Requirements for the Master´s Degree in Public Health - Specializing in Global Health.

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ABSTRACT

Exploration of the Implementation of Istanbul Protocol for
Torture Screening in the Refugee Health Team in Trondheim.
A qualitative study.

Background: The refugee migrant crisis has become an increasingly oppressing matter in the whole world in the past few years. Migration can affect physical, social and mental health and well-being of a person. High rates of PTSD and depression have been observed in torture survivors. Torture also unavoidably impacts individuals who are close to the survivor: family members, children, and spouses. Istanbul protocol contains detailed guidelines on physical and psychological investigation of torture of adults and children. The purpose of this study was to investigate the experiences of health personnel in the Refugee Health Team, during the first implementation of the Istanbul Protocol of Torture Screening in Norway.

Methodology: 10 semi-structured individual interviews were conducted with health personnel working in the Refugee Health Team in Trondheim. The data was transcribed verbatim and analyzed using qualitative content analysis.

Findings: The health personnel involved in this project found that their experience was rewarding. They believe the questionnaire is more thorough and screening more structured, which helps them at different stages of screening to be better prepared to help the patients. On the other hand, some participants felt that they did not get sufficient training.

Conclusion: This present study shows that the use of Istanbul Protocol for Torture screening was appreciated by health personnel and is helpful while receiving asylum seekers and refugees, in order to evaluate their need of help and to guide them within the Norwegian health system for improving their health after exposure to torture.

Keywords: refugees, mental health, Istanbul Protocol, qualitative research, Norway

LIST OF ABBREVIATIONS AND ACRONYMS

UN	United Nations
UNHCR	UN High Commission for Refugees
WHO	World Health Organization
RVTS	The Regional center on violence, traumatic stress and suicide prevention (Ressurssenter om vold, traumatisk stress og selvmordsforebygging)
PTSD	Post-traumatic stress disorder
DSM-5	The fifth version of DSM (Diagnostic and Statistical Manual of Mental Disorders)
CFI	Cultural Formulation Interview
WHODAS	World Health Organization Disability Assessment Schedule (Classification of Functioning, Disability and Health)
NAV	Norwegian Labor and Welfare Administration (Arbeids- og velferdsetaten)
BUP	Clinic for Psychiatric Treatment of Children and Adolescents (Barne- og ungdomspsykiatrisk klinikk)
IRCT	International Rehabilitation Council for Torture Victims
WMA	World Medical Association
WCP	World Council for Psychotherapy
WPA	World Psychiatric Association
BHRC	The Bronx Rights Clinic
DOW	Doctors of the World
CCTI	Group Against Torture and Impunity (El Colectivo Contra la Tortura y la Impunidad)
IPIP	Istanbul Protocol Implementation Project

1. INTRODUCTION

1.1. THE REFUGEE MIGRANT CRISIS

The refugee migrant crisis has become an increasingly oppressing matter in the whole world in the past few years. The number of people uprooted from their homes reached 65.6 million by the end of 2016 (1). They are forced to leave their homes because of war, conflict, persecution, poverty and violence hence the number of asylum seekers and refugees has increased dramatically and has brought the largest single inflow of refugees since the World War II, into Europe (2).

According to The UN High Commission for Refugees (UNHCR) definition:

> "Asylum seekers are people who are seeking sanctuary in a country other than their own, and are waiting for a decision about their status. When an asylum application is successful, the person is awarded refugee status" (3)

> "A refugee is someone who has been forced to flee his or her country because of persecution, war, or violence. A refugee has a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group.", as stated by UNHCR (4).

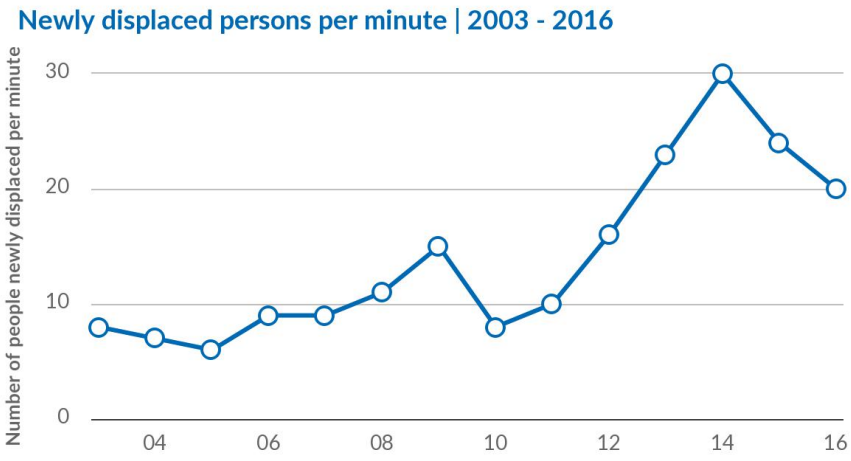

Figure 1 (3)

Figure 1. represents the number of people that have been displaced per minute since 2003 until 2016. As seen from the figure, the number of displaced persons per minute reached its peak in 2014. It has decreased by 10 since, however the number still remains significantly higher than it was in the first decade of the 21st century.

The unmet need for legal pathways of relocation leaves so many people fleeing persecution with only a few possible choices, including many that are trying to reunite with family members in Europe (5).

1.2. IMMIGRANT POPULATION IN NORWAY

At the beginning of 2017 the total number of immigrants in Norway amounted to 884 000, accounting for 16.8 % of the total population. This also includes Norwegians born to immigrant parents (6).

During the period between 1990 and 2015, 141 300 refugees were granted a residence permit. A total of 45 100 family members of only a small portion (23 500) of these 141 300 refugees were accepted into the country. This shows that the majority of refugees do not have any family members with them in Norway (7).

Solely in 2018, there were 2655 asylum applications (8), followed by 2305 applications in 2019 as recorded at the end of the year (9). The most common reasons for immigration to Norway are forced migration from war and persecution, labor and family reunification (6).

2. BACKGROUND

2.1. MENTAL HEALTH OF MIGRANTS

Migration can affect physical, social and mental health and well-being of a person (10). The World Health Organization (WHO) defines mental health as a “state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life,

can work productively and fruitfully, and is able to contribute to her or his community" (11). Refugees and asylum seekers migrants are at heightened risk for certain mental health disorders, including post-traumatic stress disorder (PTSD), depression and psychosis (12). The reasons for this are numerous and they vary from language barriers and difficulties in navigating the health system to individual past experiences within health services which can shape the behaviors surrounding help seeking (6).

Studies have found that depression, PTSD and anxiety disorders are more prevalent among refugees than labor migrants (6). One of the underlying reasons that can explain this difference is the extent to which refugees were exposed to traumatic and torturous experiences before they fled their countries. The other important aspects lie in the post-migration stress that includes health and socioeconomic factors (13).

2.2. TORTURE WITHIN REFUGEE POPULATIONS

An important factor that influences mental health and is highly prevalent in refugee populations is torture. The definition from the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, from 1984, is:

> "Torture means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person, has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions" (14).

The prevalence of violence within refugee populations is difficult to estimate, however it is assumed to be exceptionally high by virtue of the conditions which led to refugee status which inevitably include violence during armed conflict, flight from said conflict, and conditions of life in a refugee camp (15).

2.3. EFFECTS OF VIOLENCE AND TORTURE ON MENTAL HEALTH

The political contexts in which torture happens vary in different countries however the effects on the mental health of individuals that go through it produce alike consequences (16). High rates of PTSD and depression have been observed in torture survivors (17). Torture also unavoidably impacts individuals who are close to the survivor: family members, children, and spouses (15).

Globally, the percentage of individuals who need mental health care but remain untreated is estimated to be high because of the lack of access to high quality mental health services, policy changes and fragmented health systems (18). Even though these barriers are mostly present in low-income countries, there are vulnerable populations in high-income countries that have similarly unmet needs. This undeniably includes refugees in many instances (19).

A study published in 2017 addressing mental health challenges among refugees found that exposure to torture and the total number of trauma events experienced in the course of person's life emerged as the strongest predictors of PTSD and depression (20). This corroborates that torturous experiences can cause a vast variety of mental health conditions that consequently affect one's life in more ways than one. Therefore, it is important that incoming asylum seekers and families of refugees are screened for trauma in order to provide the support and move forward with the treatment they might need (21). Moreover, because of the vulnerability of this group of people, comprehensive integration policies are needed and it is essential that extra steps are taken to ensure that they do enter the health system, are aware of the help they are able to get and that their cases are handled with sensitivity appropriate to their situation (22).

2.4. ISTANBUL PROTOCOL FOR TORTURE SCREENING

United Nations has been a supporter of the Istanbul Protocol for Torture Screening, which was Submitted to the United Nations High Commissioner for Human Rights on the 9th of August in 1999 (14). This protocol presents the *Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*. It is the first set

of international guidelines for the investigation and documentation of torture (23). The document officially uses The United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984) definition of torture. It includes detailed recommendations on procedures of torture investigations including determination of the appropriate investigative body, interviewing the alleged victim and other witnesses, securing and obtaining physical evidence, medical evidence and photography (23). As stated by the protocol:

> "The broad purpose of the investigation is to establish the facts relating to alleged incidents of torture, with a view to identifying those responsible for the incidents and facilitating their prosecution, or for use in the context of other procedures designed to obtain redress for victims" (23)

Istanbul Protocol was made with the involvement of medical and legal expertise in the field of prevention and rehabilitation (24). It includes comprehensive information about relevant international legal standards, ethical codes, assessment of individuals seeking political asylum, documentation of legal investigation of torture, physical and psychological evidence of torture. The documentation methods addressed in the protocol can be used in various contexts, most importantly including the assessment of needs for the care of the victims of torture (25).

Mental health is a key aspect of diagnostical assessment, concerning the fact that torture can lead to the severe and frequently long-lasting impacts that often last longer than physical consequences (26). *The Psychological Evidence of Torture* section of the protocol discusses the possible mental health problems and trauma that patients who have been tortured can experience and the ways in which clinicians are supposed to approach those problems and communicate with the patients. This includes choice of language, use of interpreters and cultural awareness (14).

The Physical Evidence of Torture section explains the importance of communication, empathy and human contact between the patient and the investigator/doctor. It further elaborates how a full physical examination of different body parts should be performed and how the injuries found should be described and related to the experience of torture patient has shared (14).

3. LITERATURE REVIEW

3.1. GAPS AND CHALLENGES IN THE PRACTICE OF PATIENT SCREENING

According to *Health Diplomacy: spotlight on refugees and migrants* document by WHO, published in 2019, access to healthcare systems is one of the most critically deciding factors in determining how refugees integrate in the society of the country they flee to. However, many countries lack structured protocols to monitor the health and wellbeing of refugees at their arrival (27).

A study conducted in the United States examined mental health screening practices in 44 different states and the results have shown that less than 50% of those states ask the refugees about their history of war trauma and torture (28). Refugee healthcare coordinators have expressed that there is very little formal guidance on how to approach the mental health screening of refugees (28).

Another study, also conducted in the US, showed that there is a positive correlation between the lack of cultural sensitivity of the healthcare providers and the patients' negative experience (29). While patients need a better knowledge about the health system, healthcare professionals need appropriate training to be able to recognize the signs and symptoms of torture (29).

On the other hand, in Australia there is a debate on the strain that multiple challenges involving the healthcare of refugees are putting on general practitioners and whether the initial care should rather be provided by specialized refugee health services. Additionally, a nationwide coordinated system in order to support the routines and health practices needed for the health assessment of refugees is completely absent (30).

Within European countries, specialized refugee health services are also rarely existent. For example, in Serbia none of the health personnel have access to sufficient education and training in identifying signs of torture and no standardized assessment instruments are used in regular clinical practice (31).

Studies show that the interventions, such as Cognitive Behavioral Therapy (CBT), Narrative Exposure Therapy (NET) and Eye Movement Desensitization and Reprocessing (EMDR), that have been shown to be helpful to the patients who have suffered war trauma and torture, are mostly delivered by highly specialist mental health care services. However, since this is the case, there is an insufficient number of such specialized professionals to be able to cover the needs of refugees (28).

In summary, the barriers identified by these studies and confirmed by WHO in their report, that prevent refugees from receiving adequate health check-ups and the help they need are: the documentation to be filled out is mostly in the host language, services are not adapted to the need of refugees in terms of the cultural practices, support programs for healthcare professionals working with refugees are lacking and hence the training for them is often inadequate (27).

Understandably so, there is a need for a more systematic and standardized approach that will help both the health workers and the refugees, as well as an increase in healthcare providers trained specifically to help refugee populations (26).

3.2. ISTANBUL PROTOCOL – STRENGTHS AND LIMITATIONS

The Istanbul Protocol Document is endorsed by key healthcare organizations, including the World Medical Association (WMA), the World Council of Psychotherapy (WCP), the World Psychiatric Association (WPA) and the International Rehabilitation Council for Torture Victims (IRCT) (26). The Istanbul Protocol has become an UN document however it is not an internationally binding document. Nevertheless, it should be taken as a standard with its general guidelines (24). This document cannot offer a continuously updated handbook because it is impossible to have it include all the changing aspects of rapidly developing fields, hence it also has to be seen as a dynamic product that should be adapted to individual and local circumstances (26).

Similarly, the fifth version of DSM (Diagnostic and Statistical Manual of Mental Disorders) has included significant improvements that can positively impact the way torture survivors are examined and assessed. Some of them are the integration of tools such as the Cultural Formulation Interview (CFI) that is relevant when dealing with situations that are culturally sensitive and specific and inclusion of "idioms of distress" (WHODAS) for impairment and disability (26).

As with every research and document, there are also some limitations that can cause the misuse of the protocol. For example, in Mexico the government has monopolized torture documentation recorded using the Istanbul Protocol methods and has criminalized staff of the Group Against Torture and Impunity (CCTI) for using the protocol (31).

Additionally, a lack of physical and psychological evidence does not mean that torture did not happen. This and other misunderstandings or potentially incorrect interpretations, can lead to possible misuse of the protocol guidelines, such as to exonerate police accused of abuse in absence of medical findings (32).

3.3. IMPLEMENTATION OF ISTANBUL PROTOCOL

The IRCT and the WMA organized the first phase of the Istanbul Protocol Implementation Project (IPIP) that took place between 2003 and 2005 (33). The training seminars were held in multiple countries: Sri Lanka, Georgia, Uganda, Morocco and Mexico. A total of 244 medical professional and 123 lawyers and legal employees attended these seminars (33).

A second phase of the implementation ("Prevention through Documentation Project") took place between 2005 and 2007 (33). Both phases were funded and supported by European Commission. In this phase of the project more countries were added to the original list, including Egypt, Ecuador, Kenya, the Philippines and Serbia (33). The goals were to disseminate knowledge about prevention of torture in the rehabilitation centers for torture victims and encourage cooperation between medical and legal professionals in order to facilitate the implementation if Istanbul Protocol (33).

Despite all of these efforts Istanbul Protocol has not yet been given the importance that it deserves in comparison to the significance that it carries. In most of the places in the world, including developed countries such as Germany and Switzerland, medical and legal professionals are still not familiar with the document (33).

A study was conducted in Turkey evaluating and assessing whether or not the procedures of the Istanbul Protocol were followed. One of the rights of the torture victim clearly indicated in the protocol is to have an interpreter during the medical examination. This study found that there were no interpreters during the medicolegal examinations. Similarly, none of the immigrants were informed about these examinations or requested consent (34). It is stated in the Istanbul Protocol that psychological evaluation is of central importance in examinations of patients (14). Alarmingly, the study found that none of the immigrants had psychological examination (34).

These findings emerged from evaluations of the examination protocols before the Training Program on the Istanbul Protocol started on May 20th, 2009. This training happened in cooperation with Human Rights Foundation of Turkey and United Nations High Commissioner for Refugees and was offered to 100 groups of general practitioners. Only 3450 general practitioners attended the program, out of a total of 60 000 that practice medicine in Turkey. The training was completed on November 18th, 2009 (34).

The evaluation study done in Turkey happened prior to the proper training on Istanbul Protocol guidelines was conducted and no other evaluation study of medical practices in interactions with torture survivors has been executed (34). Health professionals play a crucial role in investigations of torture and maltreatment. Therefore, it is of essential importance that the Istanbul Protocol is incorporated into the curriculum of education programs of professionals involved in these protocols and put into practice. It should also be put on the researchers and policy makers radar in order to facilitate a global process which will further improve health care for refugees (34).

Recently, the so-called accelerated asylum procedures have been introduced and adopted by more and more European countries. Unfortunately, these protocols do not even include special considerations towards vulnerable groups like torture survivors (24).

Comprehensible implementation of Istanbul Protocol is happening for the first time in Norway, within the program of Refugee Health Team in Trondheim, under the project of RVTS (2017-2020) (Appendix F). There are only a few countries where Istanbul Protocol has been officially recognized and implemented to my knowledge, even though it has been an official recommendation by the UN Office of the High Commissioner for Human Rights since 2004. Therefore, the investigation of the current project of the RVTS in Trondheim is imperative in order to assess its initial outcomes for refugees in Norway, to learn about the attitudes of those involved toward the protocol and to explore the effects on experiences of refugees, in depth.

4. PURPOSE AND AIM OF THE STUDY

The aim of this study was to explore the progress of the Resource Center on Violence, Traumatic Stress and Suicide Prevention (RVTS) project of implementation of Istanbul Protocol for Torture Screening and its implications on healthcare providers meeting with asylum seeker and refugee patients subjected to this method.

5. RESEARCH OBJECTIVES

- To investigate the initial phase of *Istanbul Protocol* implementation in Norway
- To explore the thoughts and attitudes of healthcare providers from the Refugee Health Team on the methods, strengths and limitations of the protocol
- To explore the experiences of healthcare providers from the Refugee Health Team from the beginning of the implementation of the protocol, starting with the training, up until today, including collaboration and organization

6. METHODOLOGY

In this section study procedures, data collection, analysis methodologies and ethical aspects will be explained in detail.

6.1. OVERVIEW OF STUDY DESIGN

This study used qualitative method of individual in-depth semi-structured interviews. Data was gathered through 10 face-to-face semi structured interviews with the health personnel of the Refugee Health Team in Trondheim.

The data was analyzed using qualitative content analysis (35).

6.2. CHOICE OF RESEARCH METHODOLOGY

As the aim of the study was to investigate and understand how health personnel in the Norwegian health system perceive methods of Istanbul Protocol and their impact on the health workers and patients, a qualitative method is chosen as appropriate for this kind of research (36).

Through qualitative research one attempts to understand the situations from the subject's point of view. It provides a space for interchange of views between the informant and the researcher and creates a platform for generating awareness and knowledge for both sides (37). Additionally, using semi-structured interview technique allows informants to raise and express opinions and topics that the researcher might not have considered (37). This is not possible to get through a quantitative questionnaire.

Furthermore, qualitative methods generally aim to understand the experiences and attitudes of patients, healthcare workers or the community (38). Research on health services is not isolated from the society in which it is placed, however quantitative methods may lack contextual detail. Therefore, the chosen methodology for this study is qualitative research, as

it focuses on reports of experiences, subjective descriptions and interpretations and can lead to a development of new concepts or to an evaluation of an organizational process (39).

6.3. DATA COLLECTION

6.3.1. Sampling and recruitment

The ongoing project of Istanbul Protocol implementation was started by RVTS in cooperation with the Refugee Health Team. The members working in the team are the only health workers in Trondheim that have been involved in this project, hence they inevitably represent a predetermined group of individuals that fall into the category to be interviewed for the exploration of the first phase of the protocol implementation.

Hence, this study used purposeful sampling which is based on selecting individuals that are specifically knowledgeable about the topic that is of interest to the researcher (40). The purpose of the research plays a big role for the selection of the researcher in this case (41). This study aimed at finding out how health workers experienced the implementation of the RVTS project of Istanbul Protocol for Torture screening. This project has only been conducted in the Refugee Health Team in Trondheim, in Norway. Therefore, the participants in this study were from the organization involved in the process of Istanbul Protocol implementation which corresponds to criterion sampling, one of the purposeful sampling strategies (40). This strategy meets the criterion (42) that all the individuals being interviewed have experience with the phenomenon being studied (43).

The recruitment happened through a joint meeting between the RVTS representative, primary researcher and health personnel at the Refugee Health Team. This was one of the regular RVTS and Refugee Health Team Istanbul Protocol Project meetings where the primary researcher and the RVTS representative talked about the exploration study as part of the project and the plan forward.

6.3.2. Data Collection Instrument - The Interview Guide

Before conducting the interviews, the existing project within RVTS and Refugee Health Team was studied thoroughly by the primary researcher. Istanbul Protocol for Torture Screening was read in detail. The gained insights were used as an inspiration for a semi-structured guide leaving space for personal opinions and experience, as well as comparisons with the system that was in place for torture screening at the Refugee Health team, before the beginning of the implementation of Istanbul Protocol Project. Consequently, the interview guide was created.

6.3.3. Conducting the Interviews

The primary researcher conducted 10 face-to-face semi-structured interviews over the course of 8 months, from February 2019 to September 2019. They included interviews with psychiatric nurses, public health nurses, a physiotherapist and a doctor. The interviews lasted 20-69 minutes with the average length being 40 minutes. The location of the interviews was in the offices of the Refugee Health Team health providers. All interviews were voice recorded by the primary researcher, by Sony IC USB Recorder.

Nine interviews were conducted in English. One interview was held with the help of the interpreter, who was hired from Noricom, on behalf of RVTS. The interpreter was informed about the study and signed the confidentiality agreement (Appendix C) before the beginning of the interview.

The interviews started with a question about the health providers' position and length of employment in the Refugee Health Team. During the interviews the researcher followed the interview guide covering topics, such as how the Istanbul Protocol project started, the experience they had during the initial training, how they feel the current methods they are following differ from how they did the screening beforehand and whether there are benefits to doing it one or the other way, how they experienced these changes, their thoughts on what can be changed and improved in this whole process, their experiences in collaboration with different parties involved in the project, how patients reacted to their questions and how they felt asking them, and the experiences they had with the translators/interpreters.

The structure and order of the questions were flexible, so that it followed a more conversational style, therefore making the participants feel more comfortable sharing their experiences.

6.4. DATA ANALYSIS

6.4.1. Transcription and preparation of raw data

Each interview was audio recorded and transcribed verbatim by the researcher. The first step to data analysis is the transcription as it includes repetitive listening and therefore allows for attentive and close observation (44). Hence, the primary researcher was able to improve the accuracy in representing and understanding the data, which was further improved by paying close attention to punctuation by including pauses, repetition and words such as ‘umm’ or ‘hmm’. Additionally, non-verbal clues were also added to the transcription including body gestures and laughter. Denham and Onwuegbuzie (45) note that this is important in order to accurately represent and interpret the audio-recordings in the written form.

6.4.2. The Choice of Content Analysis Method

Qualitative content analysis was chosen as this approach is particularly suitable when analyzing texts, verbal data and responses to open-ended questions (46). This method requires the researcher to familiarize themselves with the material in great detail, as they examine every part of the material that is in any way relevant to the research question, allowing for an iterative process to take place (35). Consequently, qualitative content analysis also allows for flexibility because if certain important aspects in the material that should be included arise later during the analysis, the coding frame can be modified to include those as well (35).

The characteristic of this method that distinguishes it from some other qualitative methods of data analysis is the focus on selected aspects of material, which is useful when dealing with a lot of data, as it is the case for interview transcripts that are in many cases hundreds of pages (35). Hence, qualitative content analysis is particularly useful to systematically condense large amounts of data into the organized summary units (39), while allowing the researcher to focus on aspects of the material that are related to the research question (35).

There are two types of content analysis: manifest and latent (47). In manifest content analysis, the researcher stays close to the actual text, while in latent content analysis the researcher tries to find the underlying meaning of the text (46). In this study the researcher performed manifest content analysis, by describing what the informants actually said. This required utilization of the actual words from informants and continuous referral back to the original text, which made it possible to stay closer to the original contexts and meanings (48).

6.4.3. Conducting Qualitative Content Analysis

The analysis followed the methodological steps as described by Schreier (35).
These steps included:
1) Creating a coding frame
2) Segmentation of the material
3) Trial coding with the coding frame
4) Carrying out main analysis

As most of the steps of qualitative content analysis are based on the coding frame, it is important to understand what it is – a coding frame is a way of structuring the material in main categories and subcategories by differentiating between different meanings in relation to one's research question (35). As previously mentioned, if new aspects of material emerge the coding frame can be updated accordingly. This ensures that the coding frame is reliable and valid, meaning that its categories represent the concepts in the research question (35).

The analysis in this project was additionally complemented with other supporting literature on conducting qualitative content analysis, including Bengtsson (46), Graneheim and Lundman (49) and Hancock et al (39).

1) Creating a coding frame

The familiarization with the data in this study started with performing all the transcriptions of the interviews and continued by studying each transcript with reading and rereading the material (49). Following this, the primary researcher went through all the transcripts and

annotated any sections, descriptions and concepts relevant to the research objectives of the study, thereby distinguishing between relevant and irrelevant material (35). These sections were then condensed summarizing their topics in a few words, as suggested by Hancock et al (39). Related sections were linked together and out of these categories and subcategories were derived (39).

After analyzing 6 interviews, there were no longer new emerging categories, even though the researcher continued to do analysis for 2 more interviews. By this process, the rules about assigning the sections into relevant categories were developed. Each category was given a name and a description. Schreier (35) states that defining categories concisely is the key to improve analysis reliability and coding consistency.

In this study, one coding frame was developed even though the interviews were conducted with different medical professionals in the Refugee Health Team. One of the reasons for this is that in some groups there was only one informant hence if division had been made their anonymity would not be protected. The other reason is that there were many overlapping topics that emerged from the interviews hence the representation of the results in this way appears to be more interconnected, thorough and solid.

2) Segmentation of the material

The second step of content analysis by Schreier (35) is the process of breaking up the material into meaning units or segmentation.

The primary researcher reviewed each transcript and segmented the material into meaning units. According to Bengtsson (46), a meaning unit is a phrase, sentence or series of sentences containing a singular idea, insight, or perception related to the research objectives. This step was performed with all 10 interviews and with the now developed coding frame in mind. The aim of this step is to have units that each fit in one of the categories of the coding frame (35).

3) Trial coding with the coding frame

The stability and reliability of the coding frame can be assured by testing its consistency over time (35). Therefore, the primary researcher repeated the whole analysis process by applying

the coding frame to the meaning units twice more: first time 10 days after and second time 20 days after the original coding. Some difficulties arose with overlapping of several definitions of categories and the open codes assigned to them, hence the appropriate adjustments were made.

4) Carrying out main analysis

The main analysis consisted of coding all 10 interview transcripts, where meaning units were condensed to open codes, and examples of relevant open codes were assigned to each of the categories according to the finalized coding frame (50). This process was performed according to the examples provided in Appendix D. The main categories found in this study are: Knowledge About Torture and Patients' Rights, Importance of Continuous Support and Communication, Structural Barriers to Implementation of Istanbul Protocol, Difficulties Encountered during Different Stages of Istanbul Protocol Project and New Aspects of the Screening Method.

6.5. ETHICS APPROVAL, INFORMED CONSENT AND CONFIDENTIALITY

This project was exempted from approval of REK - Norwegian Research Ethics Board (Appendix E 2018/1135), because the scope of it was not to record personal, health or medical data, but the experience and/or evaluation of a health service hence it does not fall under the objective of the Health Research Act.

When starting the project of implementation of Istanbul Protocol for Torture Screening the Refugee Health Team members were familiarized with the exploration phase of the project and therefore it was not completely new to them that they would be interviewed. Nevertheless, voluntary participation document 'Informed Consent' (Appendix B) was presented to the participants beforehand, where they read about the aim of the study and that their participation relies completely on voluntary basis and they were aware that they are able to withdraw from the study at any given point in time (37).

They were also asked for the consent to audio record the interview, which was included in the written consent, but also assured verbally. Participants were aware that they are able to quit their participation in the case that they do not wish to have their interview recorded. They were informed that they are able to withdraw their data from the study at any time. Additionally, by this process of informed consent, they received the confirmation that their confidentiality in this study is secured (37).

A list of codes for personal information shared by the participants during the interview, such as other places of work, countries where the patients come from, or any specific remarks that contained any personal information related to the patient or the informant, were created (37). These codes were only available to the researcher. Ultimately, any private data that could possibly identify the participant was anonymized, thereby ensuring confidentiality. Once the interviews were transcribed, the audio tapes, transcriptions and the list of codes, were stored in an encrypted USB-key, in a password-protected file.

The signed consent forms were stored in the locked drawer of the primary researcher's office at NTNU. All of the data generated from this study, including audio tapes, transcriptions, the code list and consent forms will be permanently deleted or shredded, depending in which form they existed, latest 5 years after the completion of the study.

The clinical psychologist from the RVTS team, Håkon Stenmark, was aware when the interviews were taking place and it was agreed between him and the primary researcher that a consultation can be scheduled with the interviewees if a need for additional support arises, so that the well-being of the participants is secured. Additionally, a follow-up will be organized with the participants after the analysis of the research is completed and presented, in order to provide them with the information about the outcomes and implications of the study.

7. FINDINGS

7.1. INTERVIEWEE CHARACTERISTICS

The Refugee Health Team consists of 5 psychiatric nurses, 3 public health nurses, a doctor and a physiotherapist. The psychiatric nurses perform the thorough screening of patients including using the questionnaire developed from Istanbul Protocol, and meeting them as many times as patients wish through this process. The physiotherapist collaborates with the psychiatric nurses and does a check-up of the body, training as well as some conversations similar to the questionnaire with the patients. The public health nurses do the initial screening and work primarily with children. The medical check-up of the torture survivors is done by doctors. All of them were interviewed. Therefore, the sample size for this group is 10.

Among the informants, they have worked in the Refugee Health Team 2 – 25 years. 4 of them were males, 6 of them were females. At the time the study was conducted, all of them were employed in the Refugee Health Team in Trondheim

7.2. INTERVIEW ANALYSIS

The analysis of the interviews yielded 5 main categories and 12 subcategories, as presented in Table 1.

Category	**Subcategory**
Knowledge About Torture and Patients' Rights	Increased awareness about torture victims Increased attention to tortured patients' rights
Importance of Continuous Support and Communication	Communication with RVTS through the project Communication within the Refugee Health Team

Structural Barriers to Implementation of Istanbul Protocol	Lack of standardized structure Collaboration between multiple entities involved in the life of refugees in Norway
Difficulties Encountered during Different Stages of Istanbul Protocol Project	Other heavy duties at the same time Feeling excluded from the project Narrow definition of torture Working with Interpreters
New Aspects of The Screening Method	Reactions to the two new questions in the protocol Differences in the screening before and after the implementation of Istanbul Protocol

Table 1

7.2.1. <u>Knowledge About Torture and Patients' Rights</u>

1) Increased Awareness About Torture Victims

Participants have expressed that by including the Istanbul Protocol Project in their screening practices has made them more aware of which patients have been victims of torture.

> "I have been more aware by asking those questions and by knowing about the project then I am more aware of it I think if they have been tortured or not and also when we had the training day we also talked about what can…what kind of experience that is for them torture…so that is something I think I am more aware of maybe now after this project." (P7)

Through this awareness they expressed that they are able to improve their knowledge and have more sympathy to what the people they are meeting could have gone through before reaching Norway.

> "I think this project has forced us to think once more about what we are doing and that is always helpful because of course the health check-ups like the other work that we are doing is changing from time to time because as the world is changing, people are changing, systems are changing, so I think it´s helpful, most helpful thing maybe is like makes us much even more focused on that we have to develop the work." (P3)

As seen from their comments, this allows them to improve the way they are doing the health check-ups and tailor the treatment to the needs of different patients to help them in a better way.

> "I think it's important for those who work with refugees to at least…if they aren't involved in the project itself that they have this knowledge about torture and that they might be in need of help in one way or another because they don't say that they are tortured but they struggle, if the persons who work with refugees have knowledge about torture, it can be useful, because I think there are ways to get into them and to find a way to make them talk in a good way of course, voluntarily…but you have to be aware of it and have knowledge about it, like I said these questions here they have helped me…" (P4)

> "I think it is very important to show people in Norway and maybe all over that this is important to ask about, to move up to have a focus, more focus on this thing, because for many people it is only a book but it is more than that." (P10)

Additionally, participants noted that it is important to show the significance of screening patients for torture and to raise awareness about the topic of torture to everyone who is working with refugees, even though they are not directly involved with this specific project.

2) Increased Attention to Tortured Patients' Rights

Health personnel indicated that through reading and examining the Istanbul Protocol they have learned that refugees who are torture victims have specific rights.

> "You know people who have experienced torture they should have some more rights than others according to the Istanbul Protocol…" (P3)

Since the involvement of everyone in the team started within this project, they noted that they have newly acquired knowledge about patients and torture, and that they have become more attentive to providing those patients the access to the rights entitled to them by the protocol.

> "It has been something that we have talked about with every patient if they have experienced traumas…but since we started this I think we have more attention to their rights if this is torture." (P2)

The participants also recognized the importance of having this awareness and attention to the special situation of the torture victims.

> "I think it is very important because it is a law and it is very important first of all for the people who have been tortured, for them to give them their rights and about their health situation and also the families…" (P10)

They talked about how this project is very important, especially for those that are asylum seekers and did not get the refugee status yet since recognizing their experience as torture and giving them adequate documentation is important for their case for UDI and gives them special access to rehabilitation and medical services.

> "I also think that the letter that RVTS wrote, it is a confirmation that this patient has been through torture and that he has his rights, I think that is very valuable for the patients, and that is new." (P8)

Additionally, within the project they are able to communicate with RVTS that wrote a confirmation letter stating that the patient has been a victim of torture and has gone through

the Istanbul Protocol Project. The participants believe that this is important because this way their case can be documented to the UDI, and with mutual collaboration, more attention can be given to their rights and needs in order to give them appropriate care.

7.2.2. Importance of Continuous Support and Communication

1) Communication with RVTS through the project

RVTS and the Refugee Health Team have had a collaboration for a long time. The participants said that they meet regularly and have multiple projects together. Since RVTS was the initiator of the Istanbul Protocol project, it was important for health personnel at the Refugee Health Team to have their support through the whole process and to develop a strong partnership during this process through back and forth communication.

> "We meet often with RVTS and talk through the phone or email. It is clear that we do not meet so often as we did before since we are not in the same building, so it happens every now and then and more through the telephone and email. But it goes…the cooperation is as good as before." (P6)

Some members of the team thought that the communication was present more in the beginning of the project and that it faded away with time.

> "It is like we had this starting project and the day and after this it has not been any focus, we just do what we are told to do, so I wish that it has been more talk about it during our meetings maybe." (P7)

> "We had a lot of meetings in the beginning in the first maybe 6 months, I don't remember…we had meetings on regular basis so then it was maybe more in the foreground but then after a while it suddenly just went away." (P4)

They believe that it is important to have this help and support throughout the whole process because you never know what kind of experience you might come across as an interviewer and if you will need some additional training and guidance.

> "I don't think I could have been prepared for it because all stories are very unique, so but it's this guidance afterwards so you can step onto a new level and step onto a new level so you are prepared all the time it's like…it really should be like that to help the interviewer in a way." (P1)

Some similar opinions were also shared regarding the new employees who join the team, since they are less familiar with the starting points of the project and have not been a part of the training.

> "From 2015 we had a lot of new nurses here and other health people and I think we should have maybe more meetings with RVTS maybe they could come for one hour or something, one hour regular meetings, so I think it could have been more discussions…" (P10)

Hence, the opinions of the participants show that this continuous connection and communication could be an important factor in keeping the project going forward. They felt that some of the members of the team are getting disappointed, especially when there are not many patients that agree to be a part of it and hence the motivation to continue ceases. They wish they could develop their new skills and knowledge they acquired in this project. One of the suggestions on how to deal with this was to discuss amongst each other and ask RVTS to give them a status update according to the project.

> "…and we haven't really had a meeting with RVTS about this project since it started or maybe had one meeting since the project really started, we had a lot of meetings before but not after…The meetings we have with RVTS now are more general, not only about this project but other things, so maybe we should have more meetings just to follow up, how are things going…" (P5)

Since there have not been enough meetings to address these issues and the existing meetings are not dedicated to the project according to the informants, some suggestions have come up about the way this could be fixed and the motivation to go forward and the communication could be improved. The participants noted that it would be useful to have more meetings focused only on the Istanbul Protocol Project and to discuss the overall progress of the project together with RVTS.

2) Communication within the Refugee Health Team

Participants have also reflected on the collaboration and communication with their colleagues within the Refugee Health Team. They expressed that they can communicate easily amongst each other and that there is no problem in working on patient cases together in order to assess what falls under the project and what does not. Members of the team have regular weekly meetings, however they noted that anytime there is a doubt and they need to discuss something they can just knock on each other's door to ask questions, resolve doubts and help each other.

> "Obviously we spoke here with the team we could speak if I was in doubt if this was something for the project, I could discuss it with the colleague is this torture or is this…is this by this like the protocol…" (P4)

> "We talk together and work together. The communication has always been good I think, I don't think there has been any change this is how we work." (P7)

These participants expressed the content in the way communication works in the team. They feel confident and comfortable working together and they have transferred their usual way of discussing and working collaboratively to this project as well.
On the other hand, they also believe that there can always be improvement.

> "When it is such a project I always have my normal amount of patients coming and coming and coming so it's a bit…I could have been using more time thinking about

things, we could have been discussing more in the team, but I haven't found a way to do it." (P3)

Even when new projects are going on in the team, all of the health personnel still have their usual load of patients that they need to help coming in, therefore the participants noted that it would be good to discuss even more in the team, but they have not found a way to do so because of other obligations of their work duties.

> "When you have a special thing like this, these questions and this focus, I think you have to work with it all the time and that is what we have done with other new things we have taken into the program here, so I think it is important." (P10)

Nevertheless, the participants indicated that they are aware of the importance of working collaboratively and constantly when a new project starts, to be able to learn from each other and focus on the questions and the project.

7.2.3. Structural Barriers to Implementation of Istanbul Protocol

1) Lack of Standardized Structure of the System

Healthcare workers also talked about their knowledge of the lack of special health teams dedicated to working with refugees.

> "I think that many nurses and doctors who are working with refugees they don't have this team as we have in Trondheim and they are so busy and I think in a municipality it has to be not only the nurses but also the people over you know the chiefs and directors and so on, if you can implement it I think it is necessary that it is more focus on every level." (P2)

They have also expressed the opinion that there is a small number of healthcare workers in smaller communities and they are not sure whether these places have the capacity to implement such a project because all the responsibility might fall onto one person.

> "In smaller communities there is fewer persons who work with this, refugee health, in some communities there might be only one person who does everything, so it might not have the capacity to go all in this sort of project with all these meetings, but obviously Trondheim and the major cities in Norway should absolutely have the opportunity to the patients that have experienced torture." (P4)

Participants are aware that many other countries, but also parts of Norway, do not have these teams and hence they are concerned about the way this project can be implemented in other municipalities and the way the responsibilities can be divided.

> "I know that health directorate is going to implement some of the questions about the protocol when asylum seekers come to Norway, I am not sure they have started but they try to do it to find people early before they went out of the reception centers, so I think they have started now to think about this, but now there are so few asylum seekers coming to Norway, so I think it will be up to every municipality to use this protocol so I think it is important." (P10)

The participants realize that every municipality in the country will have to implement the protocol on their own, however do not seem at ease not knowing how the system functions in the other municipalities. The extent to which they can contribute is to send the medical record of the patient, if the patient allows it.

Because of this lack of knowledge and the seriousness of the project and the protocol, healthcare workers believe that there have to be designated health persons who will take the responsibility for the project and that in this case health directorate can play a big role in organization.

> "The protocol is a big thing, it is a big document, so people don't have time…but maybe if they start that every municipality should have one person who is responsible to implement it and these persons will learn more about it, so I think it has to come from health directorate." (10)

2) Collaboration between Multiple Entities Involved in the Life of Refugees in Norway

The participants have also talked about their collaboration with other entities involved in the lives of refugees here in Trondheim. They think that the family doctors are not so familiar with the torture project.

> "I do not think that family doctor is so familiar with this project…" (P2)

However, they also believe that it is important to find a way to inform them about the project since the Refugee Health Team gives patients help for a limited period of time and they eventually get assigned to a family doctor and specialist health services.

> "The refugee health team we can give support at least two years after they are settled, the way it is now, so a lot of our patients they have a family doctor. I think it would have been a very good thing, that they knew about the project too." (P3)

In the cases where the members of the team work with children, they expressed that their communication with the Clinic for Psychiatric Treatment of Children and Adolescents (BUP) (51) is good since they meet regularly and have cooperated many times.

> "If they still have difficulties then we talk to BUP, so then we can send a message to them and they can help further, but it also depends which BUP, because we have quite stronger relationship with the BUP X because we have much more contact with them…if I ask BUP and they would like to collaborate with us yeah, but it is not automatically working together." (P7)

On the other hand, some of the opinions show that this is not a universal communication, but it also depends which clinic the team collaborates with, because some relationships seem to be better than others.

Furthermore, participants expressed that the cooperation inside the team is easy compared to working with others involved in patient services. They believe that the communication between different entities involved in the life of the refugees is very important and should be

improved in order to provide better and more thorough care for the patient. One of those entities is Norwegian Labor and Welfare Administration (NAV), which was established in 2006 with the aim to maintain a well-functioning job market and provide services and benefits to people at the right time such as unemployment, sickness and child benefits, and pensions (52). It plays a role in the transitional phase in the life of asylum seekers and refugees.

> "I think it is a lot easier to cooperate inside the team, but when patients both go to their fastlege and a psychiatric nurse here I think that it is important that they communicate." (P8)

> "The communication with NAV and family doctors and others involved in their (referring to refugees) lives here needs to be much better!" (P9)

Additionally, the healthcare workers also expressed their opinions about how to improve the communication and suggested a way to inform the other entities about the ongoing projects in the Refugee Health Team.

> "Maybe these patients, maybe we could have a short, I think it has to be short because fastlege they have so much to do so they can't read through a whole document, but a little note in the beginning of the journal when they get it from the patient that 'this patient has been through this project', maybe a short note would be very good, then they also have the opportunity to ask. " (P8)

7.2.4. Difficulties Encountered during Different Stages of Istanbul Protocol Project

1) Other heavy duties at the same time

One of the main difficulties that emerged from the participants comments that hinders the possibility to increase dedication to the Istanbul Protocol Project was lack of time.

> "I was very busy with some big cases which took most of my time so I didn't have the chance to prioritize this project and it some kind of fell in the background because

there was I had a lot of other things to work with so it was not one of my highest priorities" (P4)

Participants expressed that they are no longer placed in the same building with RVTS as they were before, hence they feel that more duties and responsibilities fall on them. Therefore, they have already been discussing amongst themselves that they need better organization and more time to be able to work together and improve the collaboration in the team. They have especially noted that joint meetings between those working with adults and those working with children are needed.

Additionally, members of the team feel that the project kind of fell in the background because they had many other cases and projects going on and did not have time to dedicate themselves to this one.

> "I think we should have used more time about these questions, because the screening is all the questions we ask are a lot of questions…we have some questions to ask because of the authorities they have given us some program for that, so it is a lot of questions and I think we should have used more time, especially since 2015 it was a very busy time, so I had to do things more quick…" (P10)

They noted that using the questionnaire from the Istanbul Protocol and doing a thorough screening takes a lot of time. Additionally, since most consultations require the use of an interpreter, this time is doubled, or sometimes tripled.

> "It is so difficult to understand this and we don't have enough time and you need extra time if you have a translator, perhaps at least double the time, perhaps triple to make some understanding come true." (P9)

Because of these barriers, the healthcare workers noted that they do not believe that this examination can take any more time in the consultation that it already does because this would only increase the number of times a single patient would need to meet with them.

> "I think I have a routine that I ask the questions so that is okay…I am not sure that this project can take more place in health examinations either because this is health

examination for many things so if you are going to like talk 50 minutes about the project then we have to like have patients back many times because we are going to screen them for a lot…" (P7)

Some of the participants said that they even asked for more time to do these specific consultations, however it seems like they cannot find the right amount of time that can be sufficient for a thorough check-up.

> "I think that it has been a little bit frustrating because these kinds of consultations it takes quite much time and although I have asked for more time in the schedule to do this it is almost never enough… it is quite much to do so it has been a little bit frustrating because you feel like you don't have enough time and you also maybe lack a little bit knowledge about these things, so I am not sure what we could do in the team to make it better." (P8)

Following these issues, participants have expressed feelings of frustration by not being able to do everything they are supposed to do, but also by not knowing how to make the situation better.

2) Feeling Excluded from the Project

As the Istanbul Protocol Project begun, a focus group of a few members from the Refugee Health Team and a few members from RVTS was created in order to discuss the project thoroughly and talk about the updates and progress along the way.

> "They settled a group with persons from Refugee Health Care team and the rest from RVTS. I think I am not so included in that but the group that has been working with it I think they still have some meetings." (P2)

> "I have not been involved with RVTS. Those in the focus group have good communication but the rest of us are kind of on the side." (P8)

As a result of this, some participants expressed that they did not feel included in the project. They do not feel that they are included in the meetings or given updates on the progress of the project.

On the other hand, those that were a part of the focus group expressed that the communication has been good and that they have the information they need to work and proceed with the project, however they are also aware of the whole situation and recognize that some other members of the team might feel left out.

> "I was in this focus group so maybe I had more information about this project than the others here because I know that some of them thought that it was a little bit…they didn't know enough about it I felt." (P10)

Additionally, members of the focus group were aware who to talk to if an issue were to arise and they were used to working with RVTS, however they noted that they knew some members of the team did not feel included. They also noted that they were not sure whose responsibility it would be to talk to those that are not included in the focus group and improve this gap in communication, which raises issues of clear task and responsibility divisions.

> "I am so used to communicate with them so I don't see…I think it is okay. But sometimes I was wondering I don't know what my team members think. I know that some of them felt that they were not included. I didn't look at it as my responsibility to go and talk to them." (P3)

Finally, the participants recognized how important it is that the whole team is included in all of the meetings since every member is working with patients to the same extent within this project.

> "It is important that the whole team is included because we are all meeting these families. if we are going to include this project in our practice it is important that the whole team is informed and that we all see why this is important." (P2)

They believe that it is crucial that everyone is aware of the importance of the existence of this project and informed in the same capacity in order to be able to include the project as a permanent and standardized practice in the team.

3) Narrow Definition of Torture

One of the emerging arguments that the informants felt strongly about was regarding what should be done to improve the project is to widen the scope of the patients that fall under the criteria of this project. The definition includes only those that have been tortured by government officials, however many have experienced meeting patients that have been tortured just as badly, or even worse by their families, friends or neighbors, but cannot support them in a structured way as a part of the Istanbul Protocol project.

> "I am thinking quite a lot about a lot of women that I meet these days that have been sexually violated before they came here, that they are not qualified for this torture experience or this project…they end up here finally they have a permanent stay, they are supposed to qualify for work, but they have pain all in their body, they don't sleep, they are grieving about lost children, family in other parts of the world, but they are supposed to act as fresh women but you know… I don't know, because it is a responsibility for Norway in a way as a nation…all the system in a way should just be aware…" (P3)

Participants recalled their experience when talking to the patients that have been tortured by a family member, mob or neighborhood watch. The mutual opinion is that these patients should also be included by widening the definition of what is considered to be torture.

> "…maybe include more patients, or you know widen the scope of the of the group who are included, not only the people who have been tortured by government officials, yeah maybe the people who have been victims of gang violence or serious domestic violence because that can also be maybe not torture by definition but they are really hurt." (P5)

The participants noted that they recognize the pain that patients must had been going through in situations of violence and that it would be an advantage to ask them directly what happened to them and which people have inflicted torture on them.

> "There are some that have said that they have been beaten in the situations in school if they have not done their homework or perform badly in school so those relate to authority persons in school…Then we could have been better at asking directly and more specific about which type of people have been beating them, then we could have found something out." (P6)

They also expressed that it would be very helpful to the patients if the routines of the health check-up for all would be the same as they are in within the Istanbul Protocol Project.

> "…the routines maybe it could be the same. I feel that we try to help them as much as we can, I am not sure that it is needed with everything in the scheme but of course it makes it more thorough and it is easier to see which patients have to go to a specialist and which patient we can maybe treat here. I will of course describe what the patient says, but I think we wait until patient asks for 'I need this form for the UDI' so maybe if we did it in the same way we could help more to the other patients." (P8)

Patients that do not fall under the definition of torture by the protocol can still get the documentation as those who are included in the project, however they need to specifically ask for this, it does not come automatically. This way a big proportion of those that need help is excluded from a thorough screening scheme and might not have the knowledge or awareness that they have the possibility of such a help.

4) Working with Interpreters

Some patients had English as their first language, however for most conversations with the health workers in the team, translators/interpreters were used. The interpreters were always hired from the official interpreter service which means that they are trained and educated interpreters for these kinds of conversations. However, the interpreters have not received a universal training for this new project.

> "We have meetings with interpreter service and talking about the projects that we have but they did not have training with us for this project." (P2)

Some of the members of the team feel like they should have received training for this specific project in order to understand the complexity of the questionnaire and to be a greater support for the health worker who is doing the screening, as this was a new protocol for everyone involved.

> "I am used to working with translator so I should know that so I think this is special it is sensitive so I think that would be a good idea to have some time before to tell the translator what this is." (P8)

> "The interpreters maybe should have gotten more training, because the interview form or whatever it is quite complicated and it is something new for both us, the patient and the interpreter and there is a lot of questions so maybe they should have had more time to prepare for this interview." (P5)

From the experiences of the participants, it can be noted that they feel that the interpreters should receive some explanation and training before the interview if it is known that the conversation is going to be about a particularly difficult topic or experience.

> "If I find a person who has been tortured, the next meeting I would tell about it, so tell the interpreter because we always do that if we know that this can be a tough thing for them also, and sometime you can't it can come very suddenly also, but if we know we speak to them before we start and tell them about it." (P10)

Additionally, participants expressed that it would have been very useful that every interpreter could have gotten a written document about the project so that they can be prepared regardless of the direction in which the conversation with the patient might go.

> "I am wondering if they should have had something written that they could look at a very short description of the project… as a group it would have been better if they were going through the same training because they work in the same project, but the

real life I think at least you have to be assured it is trained interpreters and that you try to talk to them before you start the conversation." (P3)

The participants agreed that in an ideal situation all the interpreters would have received a standardized training in order to avoid relying on their individual experiences working in situations related to torture and traumas. As ideal rarely exists and there is always space for discussions and changes, this represents a point of improvement for the next phases of the project.

7.2.5. Reactions to the New Aspects of the Screening Method

1) Two New Questions in The Protocol

One of the biggest differences between screening before and after the project started was the two questions they came up with as a direct way to ask patients whether they have been imprisoned and if so, were they treated badly during that time. Opinions shared by the participants expressed that they experienced that it is better to have a universal structure for everyone to follow by asking these questions and to be able to actively identify torture victims.

> "We had a lot of discussion about how should we be sure that we could be a little more directly to try to qualify that we are trying actively to identify torture survivors and we were discussing in this group we had many times what should we ask, what is should could be possible to be a part of our health check-up without taking too much space and then we landed on these two questions so the big difference is that now everyone should be asked these two questions." (P3)

The Refugee Health Team was familiar with treating patients who have been victims of torture, however they experienced that, before Istanbul Protocol implementation, in order to find out this information they had to do a little bit of investigation.

> "It was hard to go directly without these questions, it helped me more to find a way to ask the question, the investigation could sometimes be difficult." (P4)

Therefore, they noted that these questions helped them to be straightforward and get specific answers in order to be sure what the next steps to help the patient are.

> "We have two questions that we ask specific now and if they answer yes to that we just inform them about this opportunity to talk more about that to figure out what this is and in order to be able to give them the right treatment, the possibility the good treatment… I think it is better to have these specific questions because if we find patients that have been experiencing torture maybe before we weren´t thinking so clear is this torture or is it not because if it is they have special rights so I think we more easily can find those that have special rights. " (P2)

Additionally, the health personnel talked about how it would have been good to have used more time in asking these questions as there are many in the questionnaire during screening and sometimes they do not have enough time to explain to the patient why they are asked these questions in the first place.

> "I think the questions are okay but we should have more time to speak about it to explain a little bit more about why we ask these two questions, I think so and maybe it is too early on the first time, maybe we should have done that a little bit later, sometimes we do that because when they come here and we think we have to do this screening but they have so many questions so many things to ask about and other things that are important to them so we have to listen to that." (P10)

Participants noted that there are two sides here: the positive side of the questions being direct is that it is easier to identify the victims of torture and hence give them the treatment and rights they are entitled to; the challenging side of questions being direct is that patients are very overwhelmed when they arrive to a new country and have so many questions and doubts themselves that this can add to the burden and impose more doubts in their minds as to why they are being interrogated like that right away.

2) Differences in the Screening Before and After the Implementation of the Istanbul Protocol

The majority of the participants agreed that the biggest difference in screening before and after Istanbul Protocol Project implementation started in Trondheim, was that the questionnaire was now more structured and direct.

> "Before it was more to every health worker doing these check-ups you could do it your own way to find out this information, but now at least we agreed all of us are going to ask everyone we meet about these two questions." (P3)

A crucial role of these questions is to identify one's experience as torture, hence it was important to look into how patients and health workers might have experienced these changes and whether or not these specific definitions might have helped to realize what patients have experienced.

Furthermore, the health workers agreed that the screening before the Istanbul Protocol Project started was not very structured. On the other hand, since the implementation it has become more systematic and thorough.

> "We have talked about it but not very structured, not in that way and not specific… before it was we did not have this specific two questions and also we did not have this all this scheme." (P2)

They noted that the implementation has also included children.

> "I think we implemented it in the screening in the patients more systematic and also for children." (P10)

The participants have also expressed that they believe that this project introduced a better way of screening since it is more thorough and introduces a standard protocol that every health worker and every patient goes through.

> "I think it is better because it has been more thorough, we have a plan for what to do and I think that the job that nurses do is more thorough and it is the same for every patient, it is not just a conversation, every patient goes through the same, and I think this is a good thing." (P8)

Finally, they noted that they would keep the project as it is but have more training ahead of the implementation.

> "I think I would keep it as it is now maybe have some more training ahead of the project before we start…but you know the interview form and the questions are pretty good I think." (P5)

8. DISCUSSION

8.1. DISCUSSION OF THE FINDINGS

Knowledge About Torture and Patients' Rights

The health personnel of the Refugee Health Team expressed that, after training and implementation of the Istanbul Protocol for Torture screening, their awareness about which patients have experienced torture has increased. They also specify that they have gained new insights and knowledge about torture and rights of torture victims, and that it is very important to expand this knowledge to people employed in other institutions that also play a role in the transition of asylum seekers and refugees, as well as the general public.

A study was conducted in New York City where a training for medical residents was provided in order to train them to work with torture survivors (53). This study was inspired by the fact that 5-11% of patients born in foreign countries across the medical centers in the US are torture survivors, however medical professionals mainly remain unaware of this. As such, in the New York City public hospital's primary care clinic none of the patients with torture history were identified by their doctors (53). Consequently, The Bronx Rights Clinic (BHRC) was established to address this gap and a training for residents using Doctors of the World (DOW) (54) humanitarian program was organized. They also went through a clinic

curriculum taking place 1-3 months after the training, in BHRC, where they had to evaluate patients during all their ambulatory months. The clinical evaluation was done using, what they call in this study “Manual of Degrading Treatment or Punishment”, which refers to Istanbul Protocol (53).

Residents filled out pre- and post-training surveys anonymously, which were about residents’ skills, beliefs and attitudes towards working with patients that are torture survivors. This data showed that the residents perceived their own skills of working with torture survivors as limited and that only a few had any previous experiences in this kind of work (53).

On the positive side, there was evident advancement in the knowledge and awareness about torture and torture survivors, which affected the improvement in clinical evaluation of the patients. These findings are similar to what the health personnel in the Refugee Health Team have expressed in this study. They experienced it to be easier to identify torture victims when one is more aware and knowledgeable about these relevant medical aspects (53). However, in this project the researcher did not have the capacity to investigate the accuracy of clinical evaluations.

On the other hand, medical residents that participated in BHRC training signed up voluntarily, as this program was not introduced as general training for all medical residents. This resulted in the majority of those that participated having prior experience with topics of torture and human rights because of their personal interests (53). Similarly, not all medical doctors or residents receive the Istanbul Protocol training in Norway either and therefore it is beneficial to have teams such as the Refugee Health Team that work specifically with refugee health.

Importance of Continuous Support and Communication

All the participants in this study talked about the importance of communication. This is a new protocol for the health personnel and a great deal of support is needed to be able to use these methods successfully. As reported by the members of the team it is easier and more convenient to cooperate within the team compared to the cooperation with other institutions involved in the life of refugees in Norway, such as NAV and BUP. On the other hand, they also expressed that they could always use more time to discuss and work in the team. An elaborate scheme of planning and organization is needed, however, to be able to introduce this

kind of communication across different levels of the healthcare system. Many still remain unaware of the projects that go on in the team and in order for the many transitions that patients go through to be as painless and smooth as possible, it is an imperative that the collaboration of all the entities involved in the lives of refugees in Norway is built up and improved.

The health personnel talked about their experience of working with RVTS. They specify the importance of this cooperation and communication, especially RVTS being the main initiator and holder of Istanbul Protocol Project. It seems that they express that in order to improve the implementation of the Istanbul Protocol for future reference, more back and forth communication and continuous updates and support are needed. In the previously mentioned study conducted with medical residents in New York City, resident-preceptor pairs through a communal precepting model were established in order to ensure that the residents have the support through this process and that the secondary trauma is identified as early as possible (53). Similarly, RVTS has the same role in their collaboration with the Refugee Health Team, whose members expressed that it is of essential importance to have this support in order to be able to step onto a new level and bring these methods of screening into everyday practices in the team.

Barriers to implementation of Istanbul Protocol

Members of the Refugee Health Team raised a concern about the organization of the system in Norway that supports refugees. They expressed that only bigger cities have the capacity to have a special team similar to theirs here in Trondheim, that can help refugees. In most smaller municipalities the whole responsibility falls on one person, which makes the pressure even bigger. The participants noted that the extent to which they are able to communicate with other municipalities is to send the patients' medical records. They are not aware of how the system works across the country. These discrepancies and the lack of a standardized system across different places within the country can present a challenge for the future implementations of the protocol. Being aware of these issues creates a platform for investigation and thorough preparation before the implementation.

Since many countries do not have the facilities that Norway fortunately does and do not have special teams for refugee health care, it would be of great value to study practices of patient

screening in different settings such as rehabilitation centers and refugee camps. A study was performed in five low-income countries' centers (Gaza, Egypt, Mexico, Honduras and South Africa) that are a part of the network of International Rehabilitation Council for Torture Victims (IRCT) that aim to provide health, social and legal services to torture survivors and advocate for the prevention of torture, where they found that the prevalence of those exposed to torture was very high (16). This research showed that health workers in these centers are dealing with limited access to space, equipment, medicines, and technical and emotional support, and the methods used in screening practices are not standardized (16). Therefore, in such settings it would be of essential importance to evaluate those methods, implement a standardized method of screening such as by Istanbul Protocol, and provide training and support in order to help both the patients and the health workers.

A report written here in Norway, examining Norwegian health services states that, since 2001, every individual who is a legal resident in Norway falls under the scheme called Regular General Practitioners scheme, through which they have the right to have their own family doctor (55). However, the data has shown that immigrants tend to use emergency clinics more often. This mostly refers to newly arrived immigrants and low urgency health issues. Additionally, the number of visits to family doctors and specialists is 2-3 times higher in immigrant population compared to Norwegian (55). Nevertheless, the satisfaction with the health services provided to patients is lower in immigrant population even though their visits are more frequent. There are a number of reasons why all of this might be the case: cultural and language barriers, prior experiences of immigrants in health services and doctors' role/competence in this context (55). Even with all of this information available, only a few studies have explored the challenges immigrants encounter in connection to using the health service and they recommend that changes need to be made to make the system more adaptive to specific needs and health problems that are prevalent in the immigrant population.

This report has shown main reasons as to why it is important to have specialized units such as the Refugee Health Team to address these issues and be trained to help vulnerable populations such as asylum seekers and refugees. The implementation of Istanbul Protocol requires a teamwork approach, which is sometimes difficult to achieve in less resourced countries where all duties fall onto specialists (56). Frequent visits to the emergency clinics can be lowered or avoided by having a unit of medical professionals that are equipped specifically to help refugees in the best possible way, which in turn decreases the strain on the health system,

which then allows that more entities play a bigger part in projects such as the Istanbul Protocol project. This is also a relevant aspect of improvement of implementation in the Refugee Health Team itself as certain medical professionals there only work part-time. Hence, if different services were to be used and organized in more efficient manners, then different professionals could also dedicate more time to specific issues.

Difficulties Encountered During Different Stages of Istanbul Protocol Project

This study shows that during the implementation of Istanbul protocol in the daily work of the health personnel in the Refugee Health Team, they encountered certain setbacks which made the implementation of the new methods more difficult.

One of the often-mentioned issues by the health workers in this project was the lack of time to perform the screening thoroughly. A study was conducted in Australia, where the researchers examined the aspects of building trust between the primary doctors and refugees and creating thorough patient documentation (57). The study showed that many patients had psychological problems from the stress of resettlement and previous traumatic and violent experiences, hence they needed additional help, however a strong theme that emerged from interviews with the health workers showed that they do not have enough time to do the work required. This also made it difficult for them to address any issue with the patients that would make the consultation longer (57). Even though this is a finding that corresponds to what the participants expressed in this study, the strain on the health workers is even harder when there does not exist a special health team to work with refugees. As seen in the opinions of the health personnel from the Refugee Health Team in Trondheim, they are aware of this being a big setback in Norway as well, especially in smaller communities.

Health personnel have expressed that there are many patients that they would like to help in the same way that they are trying to do according to the new methods from Istanbul Protocol for Torture Screening, however the definition only includes those tortured by government and officials in the country. Unfortunately, many refugees that need the same if not greater degree of care and help do not fall under this category because their stories are different: they were either tortured by a family member, neighbor or mobs, etc. The health personnel suggest to widen the scope of the definition in order to include them in the project as well.

On the other hand, using an interpreter, as stated by the protocol itself, could be difficult. The Refugee Health Team has been using the same educated interpreters for years, who have come in contact with different traumatic experiences while working together, but nevertheless they have not received a training for this particular project. According to the protocol if there is a need for an interpreter it is important that this bridge in communication is used not only to transfer sentences word to word, but also transmit the cultural background, phrases and language differences. Concluding from the experiences of the participants this aspect has not been sufficiently expanded on during the training, since it is crucial to learn about the cultural and behavioral characteristics in order to recognize relevance of these factors in communication with patients. In order to provide better care through facilitating the understanding of the cultural meaning attached to events in the patients´ lives, both health personnel and interpreters should have been trained in this aspect at the beginning of the project.

The strength of the Istanbul Protocol project generally expressed by the members of the Refugee Health Team was the universal training before start of project. Nevertheless, there are is also a weakness related to this point: different professionals were not included from the very beginning, and it is important to have a universal training for professionals from different backgrounds to avoid differences in assumptions, language and discrepancies that already exist in training among different disciplines.

New aspects of the screening method

The main two new aspects discussed by the participants were the two new questions they started asking the patients and that by using the protocol screening has become more systematic, structured and thorough.

A study conducted in Sri Lanka discussed the practices and ways through which torture victims are examined and screened (56). They reported that issues were encountered in the formats for screening of torture by medical professionals, as they were not designed to document the wide range of situations and findings when examining torture victims. Therefore, most medical practitioners adopted a free style reporting method. This provided them with more space to include multiple aspects of the examinations such as describing the injuries and recounting the narration of the victim (56).

Even though these were free style reports, after assessment by the Supreme courts in fundamental rights applications they were accepted as it was found that they usually followed the order of documentation recommended in the Istanbul Protocol. However, even though Istanbul Protocol was hence already familiar, the study reports that it has not yet been used to create a more comprehensive structure of the reporting system (56).

Before certain changes and agreements took place in the Refugee Health Team in Trondheim, as Istanbul Protocol implementation project started, the participants expressed that they also did a part of examinations in their own way. They specified that this refers to the way they tried to find out whether the patient had experienced torture before. However, they all agree that a universal and structured method is helpful to them and the patients. The approach to and examination of a person who has experienced torture, should be structured and conducted following clear guidelines by a medical professional (58), considering the sensitivity of the events, the vulnerability of the patient and the help that they need. Interviews and examinations can be highly stressful for survivors, especially if they are done by people that are not specifically trained to deal with patients that have a history of trauma and torture. The Istanbul Protocol plays a big role in this regard because it contains information on how to avoid retraumatizing the victims (27).

8.2. TRUSTWORTHINESS OF THE STUDY

In order to address the trustworthiness of the study the following two aspects were examined: credibility and transferability.

Credibility relates to the objectives of the research and how well the data addresses the intended focus of the study (50). The strategy to ensure credibility starts by choosing the most appropriate data collection method to answer the questions of interest (59). In this study this was improved by using the semi-structured interview guide as the data collection instrument. The semi-structured interview guide allowed the researcher to construct the questions based on the literature review and the already existing RVTS Istanbul Protocol project, however it also enabled the flow of the conversation with the participants to be flexible in order to be able to explore opinions and topics that might have not been covered by the previously existing literature, or the researcher. Another way that credibility is improved is ensuring that

the sample is comprised of participants who best represent or have knowledge of the research topic (50), which in this study was achieved by criterion strategy of purposeful sampling through which participants who have the experience with the study's phenomenon were chosen.

Transferability relates to the potential to extend the application of the research findings to other groups or settings (60). In this study the transferability was improved by providing a detailed background about the context of the study and the phenomenon being researched (61). The *Introduction, Background* and *Literature Review* sections of this study provide a detailed account about the context and the background information providing the relevance to research this phenomenon according to the current state and situation of the aspects connecting to it. Additionally, the *Discussion of the Findings* section discusses some parallel studies to this research and shows the relevance in conducting similar studies and applying the same methods in settings with different cultural backgrounds and healthcare systems.

8.3. STRENGTHS AND LIMITATIONS

This study offers the perspectives of the health workers in the Refugee Health Team and it creates a thorough analysis of their perspectives of implementation of the Istanbul Protocol. This is the first comprehensive evaluation of implementation of Istanbul Protocol as it has not been carried out elsewhere in Norway. The present study can open a way for new awareness and suggestions for new and follow-up research to be done.

The study used criterion sampling. By selecting only individuals that meet a specific criterion, which in this case was to be employed in the Refugee Health Team, who have a specific experience of implementing the Istanbul Protocol, experiences and opinions of other groups or individuals that might have given other insights could have been missed (40). It would have been beneficial to find out about opinions and perspectives of the patients that enter the Istanbul Protocol for Torture Screening project and those involved in the other parts of their transition and life in Norway, such as the family doctor and NAV. In addition, RVTS members had a big role in realization of this project and therefore their opinions would be valuable, in order to have a more well-rounded picture for evaluation.

The primary researcher had very limited experience in conducting qualitative interviews. This could have led to introducing bias into the way questions were asked. To minimize this the researcher tried to ask open ended questions and after every interview she carefully analyzed the way she was asking questions in order to improve for the next interview.

Another limitation of this study is that the primary research performed all the coding alone during the content analysis process. It would have been an advantage to have had one more researcher double code to ensure reliability. In order to meet this inexperience, suggestions from a researcher with experience of qualitative research was received.

8.4. CONCLUDING REMARKS

Overall, there are a lot of positive reflections and experiences with the project of implementation of the Istanbul Protocol for Torture Screening that health workers of the Refugee Health Team have been going through in the past few years. They agree that this is something that is necessary and beneficial for the patients, because as the system and people are changing, the way of treatment needs to further develop as well. However, since this is the first such implementation in the country, there are gaps in the awareness of how it is done in other municipalities in Norway as well as in the communication with primary health care practitioners/family doctors and specialist health services. These reflections can help primarily those in the organization of the project to create a better pathway for further development and improvements and those that are in the first line of the protocol implementation to help the patients in a new and more systematic way and to help each other to decrease the knowledge gap about effects of torture and be able to recognize the specific treatment that will help the patient the most.

REFERENCES

1. United Nations High Commissioner for Refugees. Forced displacement worldwide at its highest in decades [Internet]. UNHCR. 2017 [cited 2018Mar12]. Available from: http://www.unhcr.org/afr/news/stories/2017/6/5941561f4/forced-displacement-worldwide-its-highest-decades.html

2. The Refugee Crisis Through Statistics [Internet]. ESI European Stability Initiative. 2017 [cited 2018Mar12]. Available from: https://www.esiweb.org/pdf/ESI%20-%20The%20refugee%20crisis%20through%20statistics%20-%2030%20Jan%202017.pdf

3. 20 people are newly displaced every minute of the day [Internet]. UNHCR Global Trends - Forced displacement in 2016. 2017 [cited 2018Mar12]. Available from: https://www.unhcr.org/globaltrends2016/

4. What is a Refugee? Definition and Meaning | USA for UNHCR [Internet]. Definition and Meaning | USA for UNHCR. [cited 2018Mar12]. Available from: https://www.unrefugees.org/refugee-facts/what-is-a-refugee/

5. Refugee Statistics [Internet]. USA for UNHCR. [cited 2018Mar12]. Available from: https://www.unrefugees.org/refugee-facts/statistics/

6. Hjelde KH, Kale E. Mental health Challenges of Immigrants in Norway. A Literature Review 2009-2017 [Internet]. Norwegian Center for Migration and Minority Health (NAKMI); 2017 [cited 2020Jan28]. Available from: https://www.fhi.no/globalassets/dokumenterfiler/rapporter/2017/mental-health-challenges-of-immigrants-in-norway-nakmi-rapport-1-2017.pdf

7. How many refugees families come to Norway? [Internet]. ssb.no. 2017 [cited 2018Mar12]. Available from: https://www.ssb.no/en/befolkning/artikler-og-publikasjoner/how-many-refugees-families-come-to-norway

8. Asylum applications lodged in Norway by Citizenship, Sex and Age (2018) - UDI [Internet]. UDI. [cited 2019Dec10]. Available from: https://www.udi.no/en/statistics-and-analysis/statistics/asylum-applications-lodged-in-norway-by-citizenship-sex-and-age-2018/

9. Asylum applications lodged in Norway by Citizenship, Sex and Age (2019) - UDI [Internet]. UDI. [cited 2020Jan27]. Available from: https://www.udi.no/en/statistics-and-analysis/statistics/asylum-applications-lodged-in-norway-by-citizenship-sex-and-age-20182/

10. Kumar A, Nirmala BP, Virupaksha HG. Migration and Mental Health: An Interface [Internet]. 2014 [cited 2018Mar13]. J Nat Sci Biol Med. 2014;5(2):233-239. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4121889/

11. Mental health: a state of well-being [Internet]. WHO. 2014 [cited 2018Mar12]. Available from: http://www.who.int/features/factfiles/mental_health/en/

12. Migrant populations, including children, at higher risk of mental health disorders [Internet]. WHO/Europe. World Health Organization; 2017 [cited 2018Mar12]. Available from: http://www.euro.who.int/en/health-topics/health-determinants/migration-and-health/news/news/2017/04/migrant-populations,-including-children,-at-higher-risk-of-mental-health-disorders

13. Bogic M, Njoku A, Priebe S. Long-term mental health of war-refugees: a systematic literature review [Internet]. 2015 [cited 2020Jan27]. BMC Int Health Hum Rights. 2015;15(1):29. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4624599/

14. Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment [Internet]. UN Office of the High Commissioner for Human Rights (OHCHR); 2004 [cited 2018Mar12]. Available from: http://www.ohchr.org/Documents/Publications/training8Rev1en.pdf

15. Lawless MJ, Rabin M, Willard CL. The Prevalence of Torture and Associated Symptoms in United States Iraqi Refugees [Internet]. 2014 [cited 2020Jan20]. Immigrant Minority Health. 2014;16(6):1069-1076. Available from: https://doi.org/10.1007/s10903-013-9817-5

16. Gjerding S, Higson-Smith C, McColl H, et al. Rehabilitation of torture survivors in five countries: common themes and challenges [Internet]. 2010 [cited 2020Jan05] International Journal of Mental Health Systems. 2010;4(16). Available from: https://ijmhs.biomedcentral.com/articles/10.1186/1752-4458-4-16

17. Bryant RA, Chey T, Marnane C, Silove D, Steel Z, Van Ommeren M. Association of Torture and Other Potentially Traumatic Events with Mental Health Outcomes Among Populations Exposed to Mass Conflict and Displacement. A Systematic Review and Meta-analysis [Internet]. 2009 [cited 2018Mar12]. JAMA. 2009;302(5):537-549. Available from: https://jamanetwork.com/journals/jama/fullarticle/184348

18. Arbuckle MR, Scorza P, Wainberg ML, et al. Challenges and Opportunities in Global Mental Health: a Research-to-Practice Perspective. [Internet]. 2017 [cited 2020Jan20]. Curr Psychiatry Rep. 2017;19(5):28. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5553319/

19. Betancourt TS, Chambers DA. Optimizing an Era of Global Mental Health Implementation Science [Internet]. 2016 [cited 2018Mar12]. JAMA Psychiatry. 2016;73(2):99-100. Available from: https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2478072

20. Rees S, Silove D, Ventevogel P. The contemporary refugee crisis: an overview of mental health challenges [Internet]. 2017 [cited 2018Mar12]. World Psychiatry. 2017;16(2):130-139. Available from: http://onlinelibrary.wiley.com/doi/10.1002/wps.20438/full

21. Grasser RL, Javanbakht A, Suhaiban HA. Mental Health of Refugees and Troture Survivors: A Critical Review of Prevalence, Predictors, and Integrated Care [Internet]. 2019 [cited 2020Jan15]. Int J Environ Res Public Health. 2019;16(13):2309.

Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6651013/

22. Health of refugees and migrants. Regional situation analysis, practices, experiences, lessons learned and ways forward [Internet]. WHO European Region. 2018 [cited 2020Jan20]. Available from: https://www.who.int/migrants/publications/EURO-report.pdf

23. Implementing the Istanbul Protocol [Internet]. International Rehabilitation Council for Torture Victims (irct). 2003 [cited 2018Mar12]. Available from: http://irct.org/media-and-resources/latest-news/article/85

24. Haagensen JO. The Role of the Istanbul-Protocol in the uphill battle for torture survivors being granted asylum in Europe and ensuring the perpetrators pay [Internet]. 2007 [cited 2019Oct12]. Torture. 2007;17(3):236-239. Available from: https://irct.org/assets/uploads/1018-8185_2007-3_236-239.pdf

25. Iacopino V, Ozkalipci O, Schlar C. The Istanbul Protocol: international standards for the effective investigation and documentation of torture and ill treatment [Internet]. 1999 [cited 2019Oct12]. Health and Human Rights. 1999;354(9184):1117. Available from: https://www.thelancet.com/journals/lancet/article/PIIS0140673699083816/fulltext

26. Frewer A, Mirzaei S, Wenzel T. The DSM 5 and the Istanbul Protocol: Diagnosis of psychological sequels of torture [Internet]. 2015 [cited 2019Oct12]. Torture. 2015;25(1):51-61. Available from: http://www.corteidh.or.cr/tablas/r35421.pdf

27. Health Diplomacy: spotlight on refugees and migrants [Internet]. WHO Regional Office for Europe. 2019 [cited 2020Jan12]. Available from: https://apps.who.int/iris/bitstream/handle/10665/326918/9789289054331-eng.pdf?sequence=1&isAllowed=y&ua=1#page=211

28. Becher E, Im H, Shannon P, et al. Screening for War Trauma, Torture, and Mental Health Symptoms among Newly Arrived Refugees: A National Survey of U.S. Refugee Health Coordinators [Internet]. 2012 [cited 2019Oct12]. Journal of

Immigrant and Refugee Studies. 2012;10(4):380-394. Available from: https://www.tandfonline.com/doi/full/10.1080/15562948.2012.674324

29. Asgary R, Segar N. Barriers to Health Care Access among Refugee Asylum Seekers [Internet]. 2011 [cited 2019Oct10]. Journal of Health Care for the Poor and Underserved. 2011;22(2):506-522. Available from: https://muse.jhu.edu/article/430668/pdf

30. Burgner D, Paxton G, Woodland L, et al. Health service delivery for newly arrived refugee children: A framework for good practice [Internet]. 2010 [cited 2019Oct05]. Journal of Paediatrics and Child Health. 2010;46(10):560-567. Available from: https://onlinelibrary.wiley.com/doi/full/10.1111/j.1440-1754.2010.01796.x

31. Shedding light on a dark practice. Using the Istanbul Protocol to document torture [Internet]. International Rehabilitation Council for Torture Victims. 2009 [cited 2020Jan10]. Available from: https://irct.org/assets/uploads/pdf_20161120162024.pdf

32. Beynon J, Payne-James J, Vieira DN. Monitoring Detention Custody and Ill-Treatment. A Practical Approach to Detention and Documentation. 1st ed. London: CRC Press; 2017.

33. Frewer A, Furtmayr H. Documentation of Torture and the Istanbul Protocol: applied medical ethics [Internet]. 2010 [cited 2019Oct05]. Medicine, Health Care and Philosophy. 2010;13(3):279-286. Available from: https://link.springer.com/article/10.1007/s11019-010-9248-1

34. Akcan R, Karacaoglu E, Keten A, et al. Medical forensic examination of detained immigrants: is the Istanbul Protocol followed? [Internet]. 2012 [cited 2019Oct10]. Medicine Science and the Law. 2012; 53(1):40-44. Available from: https://journals.sagepub.com/doi/full/10.1258/msl.2012.011090?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%3dpubmed

35. Schreier M. Qualitative content analysis in practice. 1st ed. London: Sage Publications; 2012.

36. Baruch Y. Response Rate in Academic Studies-A Comparative Analysis [Internet]. 1999 [cited 2018Mar12]. Human relations. 1999;52(4):421-438. Available from: https://journals.sagepub.com/doi/pdf/10.1177/001872679905200401

37. Brinkmann S, Kvale S. InterViews: Learning the Craft of Qualitative Research Interviewing. 3rd ed. London: Sage Publications; 2015.

38. Gunaydin S, McCusker K. Research using qualitative, quantitative or mixed methods and choice based on the research [Internet]. 2014 [cited 2019Oct05]. Perfusion. 2014;30(7):537-542. Available from: https://journals.sagepub.com/doi/full/10.1177/0267659114559116

39. Hancock B, Ockleford E, Windridge K. An Introduction to Qualitative Research [Internet]. 2009 [cited 2018Mar12]. The NIHR RDS EM / YH. Available from: https://www.rds-yh.nihr.ac.uk/wp-content/uploads/2013/05/5_Introduction-to-qualitative-research-2009.pdf

40. Hoagwood K, Horwitz SM, Palinkas LA. Purposeful sampling for qualitative data collection and analysis in mixed method implementation research [Internet]. 2015 [cited 2019Oct02]. Administration and Policy in Mental Health. 2015;42(5):533-544. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4012002/

41. Koerber A, McMichael L. Qualitative Sampling Methods [Internet]. 2008 [cited 2019Oct02]. Journal of Business and Technical Communication. 2008;22(4):454-473. Available from: https://journals.sagepub.com/doi/pdf/10.1177/1050651908320362

42. Creswel JW. Qualitative Inquiry and Research Design. Choosing Among Five Approaches. 2nd ed. Lincoln: Sage Publications; 2006.

43. Bloomberg LD, Volpe M. Completing your Qualitative Dissertation: A Road Map from Beginning to End. 2nd edition. London: Sage Publications; 2012.

44. Bailey J. First steps in qualitative data analysis: transcribing [Internet]. 2008 [cited 2019Oct05]. Family Practice. 2008;25(2):127-131. Available from: https://academic.oup.com/fampra/article/25/2/127/497632

45. Denham M, Onwuegbuzie AJ. Beyond Words: Using Nonverbal Communication Data in Research to Enhance Thick Description and Interpretation [Internet]. 2013 [cited 2019Oct10]. International Journal of Qualitative Methods. 2013;12(1):670-696. Available from: https://journals.sagepub.com/doi/full/10.1177/160940691301200137

46. Bengtsson M. How to Plan and Perform a Qualitative Study Using Content Analysis [Internet]. 2016 [cited 2018Mar13]. NursingPlus Open. 2016;2:8-14. Available from: https://www.sciencedirect.com/science/article/pii/S2352900816000029

47. Holzemer W. Improving Health through Nursing Research. 1st ed. Oxford: Wiley-Blackwell; 2010.

48. Burnard P. A method of analyzing interview transcripts in qualitative research [Internet]. 1991 [cited 2019Oct05]. Nurse Education Today. 1991;11(6):461-466. Available from: https://reader.elsevier.com/reader/sd/pii/026069179190009Y?token=D4BE8E4D3017732F0146457461D9696E361742716E3A74EB0426EACCEF3F19B4C0B870205B7D1B86597F25953D3D725F

49. Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness [Internet]. 2004 [cited 2019Oct05]. Nurse Education Today. 2004;24(2):105-112. Available from: https://www.sciencedirect.com/science/article/pii/S0260691703001515

50. Erlingsson C, Brysiewicz P. A hands-on guide to doing content analysis. [Internet]. 2017 [cited 2019Oct10]. African Journal of Emergency Medicine. 2017;7(3):93-9. Available from:

https://www.sciencedirect.com/science/article/pii/S2211419X17300423

51. BUP, Barne- og ungdomspsykiatrisk klinikk. [Internet]. St. Olavs Hospital [cited 2020Jan20]. Available from: https://stolav.no/avdelinger/divisjon-psykisk-helsevern/barne-og-ungdomspsykiatri-bup

52. What is NAV? [Internet]. NAV [cited 2020Jan20]. Available from: https://www.nav.no/en/home/about-nav/what-is-nav

53. Asgary RG, Cooperman N, Metalios EE, et al. Teaching Residents to Work with Torture Survivors: Experience from the Bronx Human Rights Clinic [Internet]. 2008 [cited 2020Jan15]. Journal of General Internal Medicine. 2008;23(7):1038-1042. Available from: https://link.springer.com/article/10.1007/s11606-008-0592-2

54. Doctors of the World. USA: Health is a Human Right. [Internet]. Doctors of the World [cited 2020Jan20]. Available from: http://www.dowusa.org

55. Abebe DS. Public Health Challenges of Immigrants in Norway: A Research Review [Internet]. Norwegian Center for Migration and Minority Health (NAKMI); 2010 [cited 2019Oct20]. Available from: https://www.fhi.no/globalassets/dokumenterfiler/rapporter/2010/public-health-challenges-of-immigrants-in-norway-nakmireport-2-2010.pdf

56. Perera C, Verghese A. Implementation of Istanbul Protocol for effective documentation of torture – review of Sri Lankan perspectives [Internet]. 2011 [cited 2020Jan15]. Journal of Forensic and Legal Medicine. 2011;18(1):1-5. Available from: https://www.sciencedirect.com/science/article/pii/S1752928X10001460

57. Burgess T, Johnson DR, Ziersch AM. I don't think general practice should be the front line: Experiences of general practitioners working with refugees in South Australia [Internet]. 2008 [cited 2019Oct05]. Australia and New Zealand Health Policy. 2008;5:20. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2531177/

58. Akar FA, Arbel R, Benninga Z, et al. The Istanbul Protocol (Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment): Implementation and Education in Israel [Internet]. 2014 [cited 2020Jan15]. Israel Medical Association Journal. 2014;16:137-141. Available from: https://pdfs.semanticscholar.org/8621/7de97fb96b5bf77c4a5641016b39194f6950.pdf

59. Elo S, Kaariainen M, Kanste O, et al. Qualitative Content Analysis: A Focus on Trustworthiness. [Internet]. 2014 [cited 2019Oct05]. SAGE Open. 2014;4:1-10. Available from: https://journals.sagepub.com/doi/full/10.1177/2158244014522633

60. Elo S, Kyngas H. The qualitative content analysis process [Internet]. 2008 [cited 2019Oct02]. Journal of Advanced Nursing. 2008;62(1):107-15. Available from: https://onlinelibrary.wiley.com/doi/full/10.1111/j.1365-2648.2007.04569.x

61. Cho JY, Lee E-H. Reducing confusion about grounded theory and qualitative content analysis: Similarities and differences [Internet]. 2014 [cited 2019Oct10]. The Qualitative Report. 2014;19(32):1 Available from: https://core.ac.uk/download/pdf/51087267.pdf

APPENDICES

APPENDIX A: INTERVIEW GUIDE

- Can we start by you telling me what your profession is?
- How long have you been working at the Refugee Health Team?
- Have you been working primarily with children or adults?
- Can you tell me a little bit about how Istanbul Protocol for Torture Screening started?
- How did you experience the training you had to implement this protocol?
- How do you feel the communication between everyone involved within the project has been?
- How did you experience working with interpreters within this project?
- How does the method of examinations within Istanbul Protocol differ from how it was before the project started?
- Overall, how was the organization of the project from the very beginning?
- How many patients have said yes to proceeding with the screening?
- How do you think patients react to the two new questions you ask them?
- How do you feel about those two questions?
- How do you feel patients have been experiencing this method?
- Do you feel that this project has been valuable for you and the patients?
- Is there something else you would like to add or talk about regarding this topic?

APPENDIX B: INFORMED CONSENT FORM

Evaluation of the Implementation of *Istanbul Protocol for Torture Screening* in the Refugee Health Team in Trondheim. A qualitative study. May 3, 2018.

NTNU
Kunnskap for en bedre verden

INVITATION TO PARTICIPATE IN A RESEARCH PROJECT

Evaluation of the Implementation of *Istanbul Protocol for Torture Screening* in the Refugee Health Team in Trondheim. A qualitative study.

You are invited to participate in a research project whose purpose is to is to explore the progress of the Resource Center on Violence, Traumatic Stress and Suicide Prevention (RVTS) project of implementation of Istanbul Protocol for Torture Screening and its implications on healthcare providers and asylum seeker and refugee patients subjected to this method. It is important that you know what this study is about and what it will involve. Please read the following information carefully and feel free to ask the researcher any questions that you might have.

WHAT IS THE STUDY ABOUT?

The document commonly known as Istanbul Protocol is The Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, which was submitted to the United Nations High Commissioner for Human Rights on the 9th of August in 1999. The complete implementation of Istanbul Protocol is happening for the first time in Norway, within the program of Refugee Health Team in Trondheim, under the project of RVTS (2017-2020). A comprehensive and all-inclusive implementation of Istanbul Protocol has not yet been executed in any place of the world, even though it has been an official recommendation by the UN Office of the High Commissioner for Human Rights since 2004. Consequently, an evaluation study has not been done either. Therefore, the evaluation of the current project of the RVTS in Trondheim is imperative in order to assess its initial outcomes for refugees in Norway, to learn about the attitudes of those involved toward the protocol and to explore the effects on experiences of refugees, in depth.
The study will record the information you provide about the experience you have had during the screening process. The interview will be audio recorded and then transcribed verbatim by the researcher, through which process anything personal that you might have shared will be anonymized.

VOLUNTARY PARTICIPATION AND POSSIBILITY TO WITHDRAW CONSENT (OPT-OUT)

Your participation in this study is voluntary If you wish to take part, you will need to sign the declaration of consent on the last page. It is up to you to decide whether or not to take part in this study. You are free to withdraw from the study at any time, even after signing this form. Withdrawing from this study will not affect the relationship with the researcher or your process of seeking asylum or treatment at RVTS. If you withdraw from this study before the interview is completed, your data will be returned to you or destroyed. If you decide to withdraw your consent afterwards, you can ask for the information you provided to be deleted, unless it has already been analysed or used in scientific publications. If you have any questions you can contact the researcher whose contact details are on the last page of this form, at any point in time.

WHAT WILL HAPPEN TO YOUR INFORMATION?

The information that is recorded about you will only be used as described in the purpose of the study.
All information will be processed and used without your name or personal identification number, or any other information that is directly identifiable to you.
The researcher has the responsibility for the daily operations/running of the Research Project and that any information about you will be handled in a secure manner. Information about you will be anonymised or deleted a maximum of 5 years after the project has ended.

Evaluation of the Implementation of *Istanbul Protocol for Torture Screening* in the Refugee Health Team in Trondheim. A qualitative study. May 3, 2018.

CONSENT FOR PARTICIPATING IN THE RESEARCH PROJECT

I read the provided information and have had the opportunity to ask questions. I understand that my participation is voluntary and that I am free to withdraw at any time. By signing below I voluntarily agree to take part in this study.

Participant's Name:
Contact telephone:
Contact email:
Date/Signature:

Name of the researcher: Biljana Arsenic
Contact telephone: 486 68 719
Contact email: biljana.arsenic@ntnu.no
Date/Signature:

APPENDIX C: CONFIDENTIALITY AGREEMENT

Evaluation of the Implementation of *Istanbul Protocol for Torture Screening* in the Refugee Health Team in Trondheim. A qualitative study. May 3, 2018.

NTNU
Kunnskap for en bedre verden

WHAT IS THE STUDY ABOUT?

The document commonly known as Istanbul Protocol is The Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, which was submitted to the United Nations High Commissioner for Human Rights on the 9th of August in 1999. The complete implementation of Istanbul Protocol is happening for the first time in Norway, within the program of Refugee Health Team in Trondheim, under the project of RVTS (2017-2020). A comprehensive and all-inclusive implementation of Istanbul Protocol has not yet been executed in any place of the world, even though it has been an official recommendation by the UN Office of the High Commissioner for Human Rights since 2004. Consequently, an evaluation study has not been done either. Therefore, the evaluation of the current project of the RVTS in Trondheim is imperative in order to assess its initial outcomes for refugees in Norway, to learn about the attitudes of those involved toward the protocol and to explore the effects on experiences of refugees and health personnel, in depth.

The study will record the information provided about the experience interviewee has had during the screening process. The interview will be audio recorded and then transcribed verbatim by the research, through which process anything personal that the interviewee might have shared will be anonymized.

CONFIDENTIALITY AGREEMENT

You have been hired to/as _____ for Biljana Arsenic and Resource Center on Violence, Traumatic Stress and Suicide Prevention (RVTS), for the research project "Evaluation of the Implementation of *Istanbul Protocol for Torture Screening* in the Refugee Health Team in Trondheim". It is required that you sign this form to show that you are entering into the confidentiality agreement with respect to the data collected in this study.

Evaluation of the Implementation of *Istanbul Protocol for Torture Screening* in the Refugee Health Team in Trondheim. A qualitative study. May 3, 2018.

By signing this form, you agree not to reveal any information about the content of the interview and what is contained on the audio recordings. Furthermore, you agree not to discuss anything regarding the participants or the data collected in this study with anyone other than the principal researcher.

By signing below, you are indicating that you read and understood the above explained conditions and that you will respect this agreement by following them.

Name:
Contact telephone:
Contact email:
Date/Signature:

Name of the researcher: Biljana Arsenic
Contact telephone: 486 68 719
Contact email: biljana.arsenic@ntnu.no
Date/Signature:

APPENDIX D: CREATING THE CODING FRAME

Meaning Unit	I have been more aware by asking those questions and by knowing about the project then I am more aware of it I think if they have been tortured or not	In smaller communities there is fewer persons who work with this, refugee health, in some communities there might be only one person who does everything, so it might not have the capacity to go all in this sort of project	We had a lot of meetings in the beginning in the first maybe 6 months, I don't remember…we had meetings on regular basis so then it was maybe more in the foreground but then after a while it suddenly just went away
Open Code	More aware of if they have been tortured or not	In smaller communities there is fewer persons who work with this	In the beginning more in the foreground but then after a while it went away
Subcategory	Increased Awareness about Torture Victims	Lack of Standardized Structure	Communication with RVTS throughout the project
Category	**Knowledge About Torture and Patients' Rights**	**Structural Barriers to Implementation of Istanbul Protocol**	**Importance of Continuous Support and Communication**

APPENDIX E: REK EXCEPTION ANSWER FORM

REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK midt	Ramunas Kazakauskas	73597510	25.06.2018	2018/1135/REK midt
			Deres dato:	Deres referanse:
			07.05.2018	

Vår referanse må oppgis ved alle henvendelser

Birthe Loa Knizek
NTNU

2018/1135 Evaluering av gjennomføringen av Istanbul-protokollen for torturskjerming i flyktninghelseholdet i Trondheim. En kvalitativ studie.

Vi viser til søknad om forhåndsgodkjenning av ovennevnte forskningsprosjekt. Søknaden ble behandlet av Regional komité for medisinsk og helsefaglig forskningsetikk (REK midt) i møtet 06.06.2018. Vurderingen er gjort med hjemmel i helseforskningsloven § 10.

Forskningsansvarlig: Norges teknisk-naturvitenskapelige universitet
Prosjektleder: Birthe Loa Knizek

Komiteens prosjektsammendrag
Hovedformålet med dette forskningsprosjektet er å evaluere Regionalt ressurssenter om vold, traumatisk stress og selvmordsforebygging (RVTS) sin implementasjon av Istanbulprotokollen for utredning om tortur. Prosjektgruppen skal gjennomføre semistrukturerte dybdeintervju med ti personer som er helsepersonell ved Flyktningehelseteamet og seks flyktninger/asylsøkere som har vært utredet med Istanbulprotokollen og som har vært utsatt for tortur. Alle deltakere skal rekrutteres gjennom RVTS. Studien er samtykkebasert.

Vurdering: Utenfor mandat
Komiteen viser til prosjektprotokoll, målsetting og plan for gjennomføring. Komiteen vurderte om studien faller inn under helseforskningslovens (hfl.) saklige virkeområde, jf. hfl. § 2; det vil si om prosjektet er å forstå som forskning med mål om å fremskaffe kunnskap om helse og sykdom. Komiteen oppfatter at hensikten med studien er å undersøke tjenesten ved RVTS. Hovedfokuset i studien er ikke medisin eller helse, men evaluering av, og erfaring med helsetjenesten.

Komiteen mener derfor at prosjektet framstår som forskning, men ikke som medisinsk eller helsefaglig forskning. Prosjektet er følgelig ikke omfattet av helseforskningslovens saklige virkeområde, jf. helseforskningslovens §§ 2 og 4. Prosjektet kan derfor gjennomføres og publiseres uten godkjenning fra REK. Vi minner imidlertid om at dersom det skal registreres personopplysninger, må prosjektet meldes til Norsk senter for forskningsdata (NSD).

Prosjektleder er ansvarlig for å påse at forskningsprosjektet oppfyller evt. krav nedfelt i andre lover enn helseforskningsloven, som for eksempel personopplysningsloven, forvaltningsloven og forskningsetikkloven.

Vurderingen er gjort på grunnlag av de innsendte dokumenter. Dersom det gjøres endringer i prosjektet, kan dette ha betydning for REKs vurdering. Det må da sendes inn ny søknad/framleggingsvurdering.

Vedtak
Regional komité for medisinsk og helsefaglig forskningsetikk, Midt-Norge har funnet at prosjektet faller

Besøksadresse:
Fakultet for medisin og helsevitenskap Mauritz Hansens gate 2, Øya helsehus

E-post: rek-midt@mh.ntnu.no
Web: http://helseforskning.etikkom.no/

utenfor komiteens mandat, jf. helseforskningsloven § 2.

Komiteens beslutning var enstemmig.

Klageadgang
Du kan klage på komiteens vedtak, jf. helseforskningsloven § 10 og forvaltningsloven § 28 flg. Klagen sendes til REK midt. Klagefristen er tre uker fra du mottar dette brevet. Dersom vedtaket opprettholdes av REK midt, sendes klagen videre til Den nasjonale forskningsetiske komité for medisin og helsefag for endelig vurdering.

Med vennlig hilsen

Vibeke Videm
Professor dr.med. / Overlege
Leder, REK Midt

Ramunas Kazakauskas
rådgiver

Kopi til:*birthe.l.knizek@ntnu.no; siri.forsmo@ntnu.no; rek-midt@mh.ntnu.no*

Regionalt ressurssenter om vold, traumatisk stress og selvmordsforebygging - Region Midt (RVTS Midt)

PROTOKOLL: BEDRING AV RUTINER FOR KARTLEGGING AV TORTURSKADER OG UNDERSØKELSE AV OMFANG AV TORTUR HOS FLYKTNINGER OG ASYLSØKERE BOSATT I TRONDHEIM KOMMUNE

Prosjektleder: Håkon Stenmark, PhD, psykologspesialist, Ressurssenter om vold, traumatisk stress og selvmordsforebygging, Region Midt

Prosjektet er et samarbeid mellom Ressurssenter om vold, traumatisk stress og selvmordsforebygging, Region Midt og Flyktningehelseteamet, Trondheim kommune.

Bakgrunn

Mange flyktninger og asylsøkere som kommer til Norge har opplevd tortur og organisert vold. Den mest utdypende og oftest anvendte definisjon av tortur er den i FNs torturkonvensjon artikkel 1. De fire grunnleggende elementene i torturdefinisjonen er følgende: Tortur er (1) påført alvorlig fysisk eller psykisk smerte eller lidelse, (2) handlingen er forsettlig, (3) den har en hensikt (innhente informasjon, oppnå en tilståelse, straffe, true, tvinge eller diskriminere) og (4) blir gjennomført av, eller med samtykke eller tillatelse fra, offentlig tjenesteperson eller personsom handler på vegne av denne. Dette innebærer at også handlinger i form av overgrep som myndigheter vet om, men unnlater å hindre, straffeforfølge eller kompensere, kan falle inn under det som vurderes som mulige brudd på konvensjonen (United Nations Committee against torture, 2007).

Mange torturoverlevere sliter med senskader, hvor det typiske bildet er en kombinasjon av psykiske og fysiske symptomer. I forhold til psykiske lidelser er det særlig posttraumatisk stressforstyrrelse (PTSD) og depresjon som ofte forekommer etter tortur (Basoglu, Paker, Paker, et al., 1994; Mollica et al., 1998; Van Ommeren et al., 2001). Vanlige fysiske plager etter tortur er leddsmerter, smerter på steder mishandlet, hodepine og seksuell dysfunksjon. Nyere forskning viser også at det er en nær sammenheng mellom PTSD symptomer og kronifisering av smerter (Jenwein et al., 2009).

Postadresse: St. Olavs Hospital HF
Postboks 3250 Sluppen
7006 Trondheim
Besøksadresse: Schwachs gate 1
7031 Trondheim

Telefon: 72 82 20 05
E-post: rvts@stolav.no
Internett: www.rvtsmidt.no

Org.nr.: 883 974 832
bankkontonummer:
1503 27 09122

HELSE MIDT-NORGE

En longitudinell studie av pasienter med PTSD (N=824) viste at PTSD symptomer signifikant påvirket vedlikeholdelse av smerter og at smerter signifikant påvirket vedlikeholdelse av PTSD symptomene. Blant 231 flyktninger som fikk behandling ved tidligere Psykososialt senter for flyktninger i Oslo mellom 1991 og 1995, rapporterte 71% av mennene og 31% av kvinnene at de hadde vært utsatt for fysisk
tortur (Lavik, Hauff, Skrondal & Solberg,1996). I en undersøkelse gjennomført ved asylmottak i Norge oppgav 57% at de hadde vært utsatt for tortur, og 31% av kvinnene og 13% av mennene rapporterte å ha blitt voldtatt (Jakobsen, Sveaass, Johansen & Skogøy, 2007).

I henhold til artikkel 14 i FNs torturkonvensjon har torturofre rett til oppreisning og en rettferdig og adekvat kompensasjon, inkludert en så fullstendig medisinsk og psykologisk rehabilitering som mulig. Dette punktet er også presisert i artikkel 20 i EUs mottaksdirektiv for flyktninger og asylsøkere. Det foregår nå i Norge ikke noen systematisk utredning om flyktninger og asylsøkere har blitt torturert og det er heller ikke klare rutiner for oppfølging.

Internasjonalt har det blitt satt opp retningslinjer for utredning av torturskader med egne manualer for medisinsk utredning, psykologisk utredning og juridisk utredning. Dette er sammenfattet i det som kalles Istanbul protokollen (UNHCR, 2004), hvor WHO anbefaler protokollen som utgangspunkt for utredning av torturoverlevere.

Det har av flere vært pekt på mangelen av systematisk utreding og behandling for disse i Norge. Legeforeningen etterlyste i 2013 et høyspesialisert behandlingstilbud innen spesialisthelsetjenesten for de mest kompliserte torturoverleverne (Norsk psykiatrisk forening. Årsmelding 2013. Oslo: Den norske legeforening, 2014). I aprilnummeret av Tidsskrift for den norske legeforening skriver lege Glenn Dyresen:

«Det ville lettet arbeidet betydelig om det forelå en strategi for utredning og oppfølging av pasienter som sier de har vært utsatt for tortur. Som ledd i forebygging av vold på flyktningmottak og blant asylsøkere er det nødvendig at problemstillingen med tortur og torturofre tas på største alvor.»

<u>Problemstillinger</u>

Kan Istanbul protokollen implementeres ved førstegangs helseundersøkelse for flyktninger og asylsøkere i Trondheim kommune?
Hvor mange av flyktningene og asylsøkerne har opplevd tortur i henhold til FNs definisjon av tortur?
Hvilke former for tortur er anvendt?
Hvilke somatiske og psykiske ettervirkninger oppgis?

<u>Metode</u>
I forhold til vurdering av hvordan implementeringen av Istanbul protokollen har fungert benyttes kvalitativ metode. Kvalitativ metode er velegnet der formålet er å finne ut noe om helsepersonells opplevelser eller oppfatning av hvordan helsetjenester fungerer.
Det vil gjøres kvalitative intervju med ansatte i flyktningehelseteamet for evaluering av implementeringen av Istanbul protokollen.

For vurdering av om personer har opplevd tortur eller organisert vold vil en utrede om de har opplevelser som faller inn under FN definisjonen. Det vil gjøres frekvensmålinger av opplevd tortur i forhold til kjønn, alder, nasjonalitet og asylstatus.

Det vil videre gjøres frekvensmålinger av antall som oppfyller PTSD diagnose og depresjonsdiagnose, suicidaltanker, alkohol, medikament eller stoffmisbruk.
Måleinstrumenter
Sosiodemografiske variabler som alder, nasjonalitet, flyktningestatus, utdannelse, tid i Norge registreres i journal.

PTSD: PSS-I-5 (voksne over 18 år) og CATS for barn/ungdom under 18 år
Dissosieringsreaksjoner: Shutdown dissociation scale
Depresjon: MINI: Alvorlig depressiv episode
Selvmordsfare: MINI Suicidalitet
Smertetilstand: Numerisk Smerteskala
Alkohol/Stoffmisbruk: Short drug screening instrument

Utvalg
Kartleggingen vil gjøres av alle flyktninger og asylsøkere som henvises til Flyktningehelseteamet i Trondheim kommune. Kartleggingen er frivilling og de som ikke ønsker delta trenger ikke det.

Forskningsmiljø
Studien vil finne sted ved Flyktningehelseteamet i Trondheim kommune og gjennomføring vil skje i samarbeid med Ressurssenter om vold, traumatisk stress og selvmordsforebygging – region Midt. Senteret er underlagt Avdeling Forskning og Utvikling (AFFU) ved psykisk helsevern på St. Olavs Hospital. Ved senteret er det rundt 20 stillinger, hvor det nå er 3 fagpersoner med doktorgradskompetanse relatert til traumefeltet. Videre er det et forskningsmiljø ved AFFU, som også kan konsulteres ved behov.

Framgangsmåte

1. Første gangs helseundersøkelse: Ved førstegangs helseundersøkelse av alle flyktninger og asylsøkere som kommer til Trondheim kommune vil det i løpet av undersøkelsen spørres om:

«Har du (eller ditt barn) noen gang vært holdt i fangenskap?»

«Opplevde du der å bli svært dårlig behandlet eller fikk alvorlige trusler mot deg eller kjente?»

Spesifiser_____.

Hvis det ut fra spørsmålene framkommer indikasjon på at opplevelser faller inn under torturdefinisjon skal det settes opp en andregangssamtale for nærmere utredning av om hendelsen faller inn under tortur i henhold til FNs torturkonvensjon og en kartlegging av

psykiske forhold. Andregangssamtalen for voksne gjøres av psykiatrisk sykepleier ved Flyktningehelseteamet, og for barn av helsesøster/jordmor i samarbeid med psykiatrisk sykepleier.

2. Andregangs helseundersøkelse:

1. Kartlegging av traumehendelser for å se om personen har opplevelser som kvalifiserer for tortur i henhold til FNs torturkonvensjon

- Referer til informasjon som ble gitt i førstegangssamtale om vonde opplevelser under fangenskap. Gå nærmere inn på disse opplevelsene.
    - Når skjedde det?
    - Hvem utførte det?
    - Hvor lenge varte det?
    - Hva skjedde?

I forhold til torturkonvensjonen er følgende forhold særlig viktig for å vurdere om hendelsen faller inn under torturkonvensjonen:

a) Alvorlig fysisk eller psykisk smerte eller lidelse. Merk her at det skal være en alvorlighetsgrad i den påførte fysiske eller psykiske smerte/lidelse.

b) Handlingen er forsettlig. Det er ikke på grunn av uhell eller tilfeldighet.

c) Handlingen har en hensikt som for eksempel å innhente informasjon, oppnå en tilståelse, straffe, true, tvinge eller diskriminere.

d) Handlingen blir gjennomført av, eller med samtykke eller tillatelse fra, offentlig tjenesteperson eller person som handler på vegne av denne. Dette innebærer at også handlinger i form av overgrep som myndigheter vet om, men unnlater å hindre, straffeforfølge eller kompensere,kan falle inn under det som vurderes som mulige brudd på konvensjonen. Med offentlig tjenesteperson tenker vi også på personer i militsgrupper som har kontroll over landområder som Al Shabab og IS.

e) Handlingen er ikke en direkte utmålt straff etter et lands juridiske system (som for eksempel idømmelse av 20 piskeslag etter rettsprosess).

Basert på dette krysses det av om personen kvalifiserer for tortur basert på FNs torturkonvensjon. Hvis personen har opplevd tortur fortsettes det med kartlegging av psykiske reaksjoner.

2. Kartlegging av psykiske reaksjoner etter torturen

Kartlegging av voksne

Her tas det for voksne utgangspunkt i følgende utredningsskjema:

PTSD: PSS-I-5
Dissosieringsreaksjoner: Shutdown dissociation scale
Depresjon: MINI: Alvorlig depressiv episode
Selvmordsfare: MINI Suicidalitet
Smertetilstand: Numerisk Smerteskala
Alkohol/Stoffmisbruk: Short drug screening instrument

I tillegg gjøres en klinisk vurdering ut fra samtalen. Hvis det framkommer reaksjoner forenlig med andre psykiske tilstander enn skjemaene spør om kan disse indikeres (for eksempel panikk angst, psykose, sosial fobi). NB: Dette er ikke fastsetting av diagnose men beskrivelse av klinisk vurdering.

Hvis personen viser klare psykiske reaksjoner på andregangssamtalen bør en vurdere om det skal tilbys en oppfølgingssamtale.

Kartlegging av barn og ungdom under 18 år

Barn og ungdom kartlegges i samarbeid mellom helsesøster/jordmor og psykiatrisk sykepleier. Ut fra alder på barn/ungdom vurderes det om samtalen gjøres med barnet/ungdommen, med foreldre eller omsorgsperson (kan være kontaktperson ved mottak eller boenhet), eller med dem sammen. Det anbefales at en også får samtykke til å kontakte per telefon barnehage/skole for komparentopplysninger.

Utredningssamtalen skal fastslå om type traumehendelse kvalifiserer som tortur etter FNs definisjon (se punkt 1). Videre brukes CATS for å fange inn posttraumatiske symptomer. De andre skjemaene i utredningspakken kan brukes etter vurdering av egnethet ut fra alder og problembeskrivelse. Her kan en bruke skrivet «barns utvikling og traumer» som indikerer nyttige tema ut fra ulike aldersgrupper.

Dissosieringsreaksjoner: Shutdown dissociation scale
Depresjon: MINI: Alvorlig depressiv episode
Selvmordsfare: MINI Suicidalitet
Smertetilstand: Numerisk Smerteskala
Alkohol/Stoffmisbruk: Short drug screening instrument

3. Henvisninger for videre oppfølging

a) Alle som oppfyller kriteriene for torturekseponering tilbys legesamtale

b) De som har partner og/eller barn tilbys familiesamtale

c) De som har markerte kroppssmerter tilbys utredning hos fysioterapeut

d) De som har klare psykiske plager henvises for psykologisk oppfølging. Basert på omfang av plager vurderes hvor å henvise

e) De som har opplevd tann-tortur vurderes henvist til tilrettelagt tannhelsestilbud TOO

Fremdriftsplan

Følgende tidsplan for prosjektet er plan:
Vår 2017: Skolering av personalet i Flyktningehelseteamet i forhold til torturdefinisjon og torturutredning. Drøfting med Medisinsk etisk forskningskommite vedrørede eventuell søknad dit.
Høst 2017: Utprøving av registreringer. Samling med evaluering av progresjon.
Vår 2018 – Høst 2019: Gjennomføring av implementeringen av Istanbul protokollen. Innsamling av data. Kvalitative intervju av ansatte i flyktningehelseteamet.
Vår 2020: Bearbeiding av data.
Høst 2020: Arbeid med publisering av materiale i nasjonal og internasjonalt peer reviewed journal.

Finansiering

Prosjektet finansieres gjennom ordinære driftsmidler ved flyktningehelseteamet i Trondheim kommune og ved Ressurssenter om Vold, traumatisk stress og selvmordsforebygging, Region Midt.