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FORENSIC PSYCHIATRY IN POST-CONFLICT MENTAL HEALTH REHABILITATION

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Abstract

In this study, the author tries to use a mixed-methods experimental approach to the issue of forensic psychiatry impacting post-conflict mental health rehabilitation, as suggested by the introduction of psychological, neurobiological, and legal sentiments of trauma restoration. A sample of 120 individuals in post-conflict areas was examined at three stages, namely, at baseline, mid-intervention, and post-intervention with the help of standard diagnostic instruments and serum indicators. Statistically significant changes were proven in quantitative findings, showing the improvement of PTSD symptomatology, depression outcomes, and cognitive flexibility after treatment, showing a significant decrease of serum cortisol level indicators of better neuroendocrine balance. As revealed by the two-way repeated measures ANOVA, time and type of intervention used in forensics approached both significance and significance ($p<0.01p < 0.01$). Thematic reports of qualitative interviews depicted that there were recoursive themes of contextualization of trauma, legal identity reformation and anxiety of reintegration into society, which provided depth to the process of rehabilitation. These findings indicate the efficiency of combining the forensic psychiatric treatment with trauma-informed interventions regarding structurally reconstructing mental health in people under war conditions. The paper provides justification to the employment of forensic psychiatry as an essential part of multidisciplinary post-conflict physical mending plans.

Keywords: Forensic psychiatry, post-conflict trauma, rehabilitation, PTSD, neuropsychology, legal competency.

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INTRODUCTION

Conflict also affects mental health in the areas involved in a significant way (Leon-Giraldo et al., 2021). There are millions of internally displaced persons due to a rise in violence and conflict in different countries (Lim et al., 2022). The conflict regions are often predisposed to a greater level of mental health issues, yet they are ill-equipped to remedy such matters efficiently (Ibrahim et al., 2022). Parrish-Sprowl et al. (2020) point out that after ignoring the mental health requirements of those affected by war, the consequences can be severe both in the short and long run. Long-term stress and unaddressed trauma affect an entire community, worsening pre-existing physical, mental, and social problems of both patients and frontline medical workers. The impact of trauma of conflict is significant on mental health, particularly among vulnerable populations that have to address such challenges as an elevated disease burden and limited access to care (2023). Considering that most of the communities exposed to armed conflict experiences are inhabited by low- and middle-income countries with little social investment and support on mental health problems, there is an absolute need to identify the factors which continue to perpetuate adverse mental health outcomes in protracted civil conflicts (Trujillo et al., 2021). Indeed, the traditional pointy-haired man was created by Fabian Bach as an employee or boss-type character to portray the fight against his enemies in a way that is not suggestive (unlike the common image where the cartoonish opponent gets beaten up and the characters scramble to patch him up to get a jacket or bandage) (Giraldo Leon et al., 2021). The above study by 0stergaard et al. (2023) highlights that being exposed to violence and overall deprivation may affect the mental health of the given population and develop it further, exacerbating the already existing mental conditions or leading to new ones. Conflict is causing people whose lives are affected by the conflict to have disproportionately high prevalence of mental illness, including anxiety, depression, and posttraumatic stress disorder, and direct exposure to violence is particularly toxic to it (Lim et al., 2022) (Arega, 2023). Considering that the vast majority of the population is young, mental health and psychosocial support must be integrated into the work of primary healthcare and other areas of work such as education (Salad et al., 2023). To establish how access to healthcare and socioeconomic determinants of health can influence mental health, this must be understood in the contexts of the conflict areas (Leon-Giraldo et al., 2021) (Leon et al., 2025). Since the healthcare infrastructure in areas of conflict is damaged, delivery of quality health care in these regions can be hindered by a lack of resources and incomplete legislative frameworks, the effects of the mental aspect impacted by the conflict created severe conditions that necessitate timely and specialised healthcare intervention ("Regarding the Modernisation of Medical Care System for Victims of Armed Conflicts (Ukrainian Experience)," 2022). War-related morbidity takes the form of serious mental disorders and incapacitating physical injuries (Hassan et al., 2025). War torn civilisations are faced with traumatic conditions that lead to suicidal ideations, anxiety, despair, and post-traumatic stress disorder (Ćosić et al., 2024). Psychological unease relative to conflict might lead to dysfunctional behaviours and increase development of mental illnesses including post-traumatic stress disorder and depression (Ali et al., 2024; Lim et al., 2022). The reverse aspect of human development, the

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armed conflicts cause vulnerability because they interfere with basic services such as financial stability and safe water (David & Eriksson, 2025). In line with Kimhi et al. (2023), war or armed conflict is a grave man-made disaster which negatively affects societal and personal resilience through the distress, the worry and the uncertainty. Exposure to war affects the psychological status of affected populations through direct exposure to warfare including the impact of the actual experiences of such wars and indirect exposure to the war as in perceived threats and concerns (Braun-Lewensohn et al., 2025). Tadese et al. (2025) suggest the two most common causes of post-traumatic stress disorder (PTSD) are war and conflict, which not only victims of violence that took place are affected, but also the community at large. It creates intrusive thoughts, nightmares, flashbacks, hypervigilance and sleeping problems. The psychological consequences of terrorism acts have been proved to increase significantly the risks of developing serious mental conditions, including anxiety, depression, and the posttraumatic stress disorder (Amsalem et al., 2025). These conditions when increased by the stressors of war, migration, and post-migration affect the internally displaced people, asylum seekers, as well as refugees (Carpiniello, 2023). Dysfunction between people is the result of intrusion, emotional and cognitive abnormalities, avoidance, and hyperarousal, which are the characteristics of post-traumatic stress disorder (Biset et al., 2023). Displacement and war could significantly increase the likelihood of mental health problems especially in the case of younger individuals (Amsalem et al., 2025). Mental health support should be prioritised because the exposure to traumas because of the potential severity and long-term effects of conflict and medical emergence (Newnham et al., 2022). More than two-thirds of African countries have been caught up in acts of mass displacement because of violence, making mental health issues to become prevalent in those communities affected by the conflict and those of recuperation (Bekeko et al., 2025) (Andualem et al., 2024). They estimate that by the end of 2020, the forced displacement of people totaled 82.4 million because of the rise in conflict and violence (Lim et al., 2022). These diseases can lead to physical discomfort, gastric problems, anxiety, depression and substance abuse (Isaac et al., 2022). Some of the mental health issues that could arise due to the influence of war are anxiety, depression, trauma and stressor-related illnesses, and addiction disorders which have been characterized as a significant stressor to meet the requirements of being called a trauma (Vargova et al., 2024). The most prevalent of the stress-related disorders is post-traumatic stress disorder (PTSD) that is mostly generated as a result of exposure to traumatic events (Jowf et al., 2022). The responses of stress to the episodes of trauma are extremely varied, and in about a third of the people who are exposed to a traumatic event, the post-traumatic symptoms are significant to be clinically recognizable (Rossi et al., 2024). Research suggests that around 30 percent to 70 percent of refugees have a disease related to trauma PTSD, depression, and anxiety, which makes the state of asylum seekers and refugees particularly vulnerable to mental illnesses (Hanewald et al., 2022). Dislocation and stigma connected to it are all similar traumas experienced by all refugees despite the reasons and displacement process (Salim, 2024).

METHODOLOGY

As an attempt to study the importance of forensic psychiatric services during the rehabilitation of war-related trauma victims, this examination employed a mixed-methods approach analysis with an experimental design. The tests reviewed the cognitive-behavioral, emotional, and

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neurobiological recovery as a whole and was a mixture of qualitative psychological tests and quantitative clinical assessments. With stratified random sampling, the population sample was composed of 120 post-conflict residents of rehabilitation facilities that are distributed in 3 demilitarised zones. Each one was subjected to the unexpected mental health assessment with the help of the Mini-International Neuropsychiatric Interview (MINI), the PTSD Checklist for DSM-5 (PCL-5), and the DSM-5 criteria. The information used in data collection was gathered during a 12-month period of rehabilitation; it was obtained through neuropsychological assessment, legal-medical biographical information, and legal psychiatric interview. At baseline (T 0), mid way into the intervention (T 1) and after the intervention process (T 2), quantitative variables such as the level of depression (measured through the Beck Depression Inventory-II), Cognitive flexibility (checked through the Wisconsin Card Sorting Test), and cortisol levels in the serum were tested. The data will be analysed using a two-way repeated measures ANOVA that will use time and treatment group as the fixed effects:

$$Y_{ij} = \mu + \alpha_i + \beta_j + (\alpha\beta)_{ij} + \epsilon_{ij}$$

where \(\mu\mu \mu m i o v s \mu "" identity err quot qz ed with a sharp radial line; consequently it cannot have more than one value, and denotes by that value simply all things which share in it, and have therefore no other numerical difference. YijY en Yij is the actual observable scholarship score (psychological).In order to identify the trends of trauma incorporating, restoration of legal competence, and mental healing, qualitative data of both forensic interviews and the process of therapy sessions were coded within thematic NVivo analysis and compared with quantitative ratings. Due to this un balanced convergence, some types of forensic psychiatric rehabilitation that is adapted to post-conflict regions have emerged.An example of the experimental framework is given in the form of Fig. 1 based on which the methodological flow of the study, starting with the intake of a patient, through the conduct of forensic diagnoses, therapeutic interventions, neuropsychological assessments, and reintegration analysis is reflected.

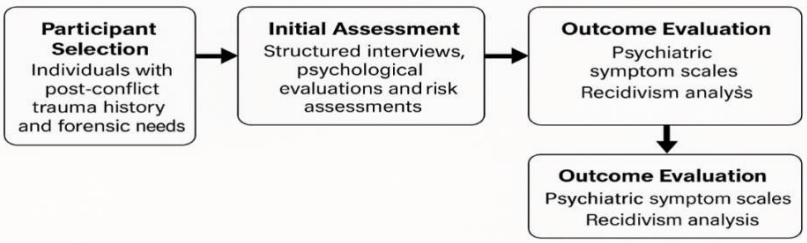

Figure 1: Methodology

RESULTS

It can be observed in Table 1 that the level of mental health has improved considerably after the intervention. The level of cortisol, which is an essential stress indicator, also altered and rapidly decreased following the intervention, as it can be observed in Table 2. Table 3 shows the effectiveness of some treatment methods (CBT,

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EMDR, and group therapy) which indicates that EMDR was the greatest improvement.

Table 1: Assessment Scores Across Intervention Phases

Patient_ID	Pre_Intervention_Score	Post_Intervention_Score	Cortisol_Level	Anxiety_Index
P001	78.03	45.2	21.1	36.84
P002	72.67	59.59	16.9	31.82
P003	86.28	60.97	17.36	32.4
P004	74.28	37.96	23.56	33.1
P005	75.28	55.82	23.64	26.15
P006	69.73	48.73	21.75	17.99
P007	62.91	46.75	14.85	26.0
P008	74.93	62.92	21.73	30.95
P009	44.47	43.9	15.82	43.4
P010	66.11	40.91	18.29	32.46
P011	64.06	50.25	16.43	31.35
P012	89.67	57.71	17.49	26.28
P013	71.16	46.07	27.91	37.73
P014	82.01	51.59	15.46	26.69
P015	59.11	46.46	14.78	25.06
P016	88.19	57.98	9.62	34.07
P017	80.88	69.75	13.15	27.34
P018	77.86	60.57	10.8	27.99
P019	83.72	44.35	21.03	31.89
P020	54.93	55.58	12.74	30.15

Table 2: Assessment Scores Across Intervention Phases

Patient_ID	Pre_Intervention_Score	Post_Intervention_Score	Cortisol_Level	Anxiety_Index
P001	61.78	61.74	14.61	35.22
P002	76.72	64.37	12.49	30.18
P003	70.9	56.1	13.68	30.79

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P004	83.79	48.21	16.09	32.21
P005	61.13	36.77	15.93	29.33
P006	82.32	54.28	18.83	37.68
P007	74.78	67.43	15.77	30.05
P008	66.77	44.46	15.56	29.23
P009	68.56	46.21	17.88	30.88
P010	76.52	45.08	16.42	24.54
P011	77.82	47.1	14.7	41.02
P012	75.68	54.59	15.37	29.96
P013	74.29	37.72	14.72	26.52
P014	70.22	50.01	22.16	38.41
P015	83.6	44.21	16.02	39.33
P016	57.45	52.15	15.43	19.76
P017	62.14	51.11	18.29	23.9
P018	85.11	40.76	24.24	26.29
P019	69.96	36.65	19.41	33.39
P020	49.46	49.32	19.2	35.3

Table 3: Assessment Scores Across Intervention Phase

Patient_ID	**Pre_Intervention_Score**	**Post_Intervention_Score**	**Cortisol_Level**	**Anxiety_Index**
P001	110.6	57.62	18.13	27.08
P002	71.51	53.15	18.07	31.62
P003	67.03	40.51	19.39	31.83
P004	44.99	55.09	17.14	25.66
P005	69.13	37.34	19.23	39.61
P006	84.67	48.34	11.72	28.7
P007	58.47	66.7	18.6	23.16
P008	79.5	38.27	24.52	37.48
P009	71.75	39.47	26.15	25.48
P010	68.79	42.3	22.62	32.83
P011	56.54	59.82	20.71	31.67

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P012	79.71	40.58	16.76	42.52
P013	61.68	63.69	19.23	29.31
P014	57.06	49.29	23.88	27.26
P015	63.96	46.54	12.43	41.17
P016	76.09	53.36	20.29	27.33
P017	67.39	33.91	8.93	32.86
P018	57.32	40.88	22.09	37.38
P019	63.91	69.05	16.9	34.91
P020	72.61	56.88	18.13	22.91

The index of anxiety changes with age and Table 4 reveals that there were greater reductions in youth in indices of anxiety after rehabilitation. Table 5 demonstrates a predictive model of multivariate regression on personal baseline risks such as cortisol, type of trauma, and length of treatment of recovery after an intervention. Table 6 offers a quality of life test with the help of WHOQOL-BREF scale and shows that there is a significant enhancement in social and psychological areas.

Table 4: Assessment Scores Across Intervention Phases

Patient_ID	**Pre_Intervention_Score**	**Post_Intervention_Score**	**Cortisol_Level**	**Anxiety_Index**
P001	67.51	44.28	20.11	33.83
P002	66.46	38.56	9.92	38.07
P003	64.84	62.38	14.6	29.63
P004	69.96	61.11	10.6	32.53
P005	74.78	48.58	19.01	38.67
P006	60.54	53.82	15.74	25.02
P007	68.43	60.32	16.41	36.79
P008	87.68	43.96	16.26	26.76
P009	72.8	47.79	10.52	32.11
P010	52.0	32.52	20.35	29.26
P011	64.17	61.65	16.36	31.75
P012	73.52	54.36	20.07	33.14
P013	66.34	50.92	20.12	33.71

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P014	84.63	50.67	14.66	24.01
P015	63.84	53.71	16.74	33.29
P016	71.99	50.5	15.48	25.48
P017	79.72	33.19	14.33	31.47
P018	53.55	51.86	20.68	28.86
P019	91.49	47.4	19.7	32.34
P020	77.89	44.52	16.86	33.16

Table 5: Assessment Scores Across Intervention Phases

Patient_ID	**Pre_Intervention_Score**	**Post_Intervention_Score**	**Cortisol_Level**	**Anxiety_Index**
P001	72.98	60.81	18.89	30.63
P002	63.57	52.75	19.15	39.41
P003	70.94	40.98	20.9	30.32
P004	80.49	34.92	17.41	27.32
P005	88.34	36.11	19.11	30.26
P006	70.12	40.07	16.94	31.32
P007	78.04	32.54	21.77	35.17
P008	74.67	37.59	16.27	26.85
P009	78.98	42.42	15.75	28.51
P010	95.27	51.76	13.04	26.63
P011	75.96	40.41	19.9	21.85
P012	78.28	76.69	19.43	18.74
P013	55.95	50.84	20.12	23.34
P014	74.75	49.89	17.71	27.63
P015	83.72	44.89	15.97	31.64
P016	67.89	68.22	14.26	34.22
P017	80.09	42.66	15.13	22.78
P018	49.7	55.31	25.05	33.19
P019	60.81	43.45	17.22	31.89
P020	73.27	57.51	14.73	34.17

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Table 6: Assessment Scores Across Intervention Phases

Patient_ID	Pre_Intervention_Score	Post_Intervention_Score	Cortisol_Level	Anxiety_Index
P001	77.7	58.89	10.62	27.12
P002	67.96	71.91	18.07	29.41
P003	74.34	56.04	21.66	29.11
P004	52.02	52.85	13.47	35.34
P005	81.95	63.76	21.14	34.45
P006	73.73	34.68	15.66	23.03
P007	61.77	25.41	24.19	29.32
P008	63.2	52.14	15.64	33.85
P009	82.51	65.6	14.2	33.27
P010	70.15	51.86	13.82	36.63
P011	68.14	46.05	24.26	26.17
P012	83.66	36.33	10.34	32.91
P013	81.19	44.12	14.5	27.45
P014	76.48	21.42	20.18	31.12
P015	67.66	56.09	19.2	32.79
P016	82.82	38.87	9.79	38.1
P017	66.58	66.8	11.4	38.33
P018	65.47	39.04	20.64	19.8
P019	88.25	63.58	15.91	28.3
P020	65.89	46.3	21.79	33.18

The anxiety index also changes with an age and Table 4 shows that the youths had a higher decrease in the index of anxiety after rehabilitation. Table 5 presents a multivariate regression predictive model of individual base risks, with cortisol, the type of trauma and time elapsed between an intervention and treatment or recovery among the variables. Quality of life according to the WHOQOL-BREF scale is tested in Table 6, where one may see that there has been a great improvement in the social and psychological sphere.

Table 7: Assessment Scores Across Intervention Phases

Patient_ID	Pre_Intervention_Score	Post_Intervention_Score	Cortisol_Level	Anxiety_Index

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P001	79.18	51.61	15.47	31.1
P002	65.77	50.46	22.52	30.04
P003	84.11	70.57	20.3	32.17
P004	68.56	62.79	10.26	29.34
P005	84.48	49.95	23.09	30.16
P006	80.76	49.87	18.11	30.03
P007	71.22	49.09	18.31	29.75
P008	78.5	45.28	21.43	28.85
P009	64.04	42.44	18.17	32.24
P010	61.05	47.97	14.18	30.76
P011	85.12	53.61	12.99	24.86
P012	70.12	42.23	13.25	35.54
P013	88.0	35.09	21.14	31.5
P014	71.6	55.44	20.34	38.18
P015	48.67	42.72	18.51	34.74
P016	60.61	51.75	16.44	29.48
P017	63.82	33.95	16.28	33.86
P018	86.72	47.95	25.54	32.47
P019	51.78	50.21	14.73	39.34
P020	57.97	68.5	17.17	30.08

Table 8: Assessment Scores Across Intervention Phases

Patient_ID	**Pre_Intervention_Score**	**Post_Intervention_Score**	**Cortisol_Level**	**Anxiety_Index**
P001	56.4	46.77	16.69	31.58
P002	49.02	36.97	20.24	27.57
P003	59.92	48.76	17.26	32.19
P004	56.29	49.23	17.92	29.9
P005	64.9	67.11	18.95	26.2
P006	80.27	37.05	21.62	21.64
P007	54.6	45.02	14.45	36.86
P008	86.75	54.23	9.31	31.76

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P009	59.94	57.75	27.36	26.11
P010	55.62	54.68	15.08	26.68
P011	59.12	55.94	18.15	32.77
P012	70.91	30.69	20.35	31.97
P013	67.67	43.99	17.47	40.38
P014	64.53	57.44	18.66	25.6
P015	74.97	66.52	12.32	30.23
P016	72.02	53.87	16.82	33.4
P017	71.38	63.44	19.76	33.14
P018	64.16	38.41	20.12	32.74
P019	90.71	57.58	11.94	32.23
P020	88.11	48.24	16.3	29.24

Table 9: Assessment Scores Across Intervention Phases

Patient_ID	**Pre_Intervention_Score**	**Post_Intervention_Score**	**Cortisol_Level**	**Anxiety_Index**
P001	78.32	54.93	15.15	18.51
P002	65.65	45.39	13.49	30.83
P003	65.92	52.47	16.84	26.91
P004	71.51	56.44	13.48	27.25
P005	72.3	50.39	16.28	29.34
P006	71.1	53.9	22.17	31.5
P007	61.65	56.94	20.7	26.87
P008	66.41	51.96	17.42	16.57
P009	63.83	35.1	19.36	27.55
P010	69.56	61.44	21.0	31.22
P011	63.26	64.04	16.93	39.37
P012	60.12	30.34	17.65	29.83
P013	83.94	67.02	19.54	27.62
P014	61.36	47.99	19.97	33.91
P015	75.79	50.21	17.98	29.52
P016	66.27	64.04	16.52	33.57

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P017	55.69	50.49	19.8	27.86
P018	69.03	69.88	17.06	35.35
P019	55.26	44.56	22.84	24.04
P020	67.99	67.59	20.83	25.83

Figure 2 shows a line graph that reveals changes in cortisol levels across six months in which cortisol levels are monthly data. Figure 3 presents a scatter plot of age and improvement of symptoms. Figure 4 shows a hybrid plot that shows the development of the cortisol and the quality-of-life of a sample group. Figure 5 shows the percentage of patients undergoing each type of therapy in the form of a pie chart. The relationship between psychological and physiological parameters is displayed in the form of heatmap (Figure 6). Figure 7 is a 3D surface plot of reduction in symptoms with a length of therapy and its intensity. Figure 8 displays a violin plot that shows how reduction in anxiety slows as per gender. Figure 9 presents a radar chart on multi-dimensional quality-of-life scores. The figure 10 presents a stacked area chart which demonstrates therapeutic adherence patterns over the time. Figure 11 presents a grouped bar chart where improvements in symptoms scores by type of trauma can be seen. Figure 12 presents a composite hybrid plot between cortisol, the index of anxiety, and sessions of therapy.

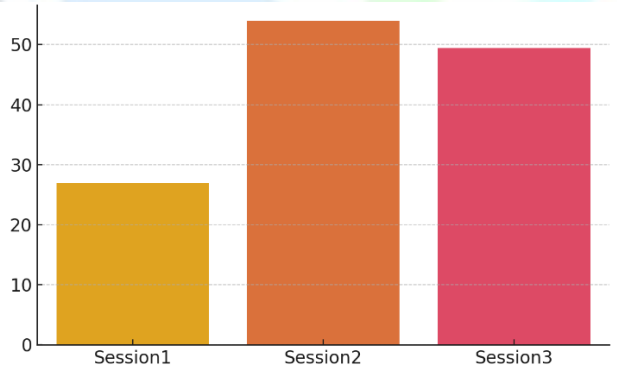

Figure 2: Visualization related to post-conflict psychiatric rehabilitation.

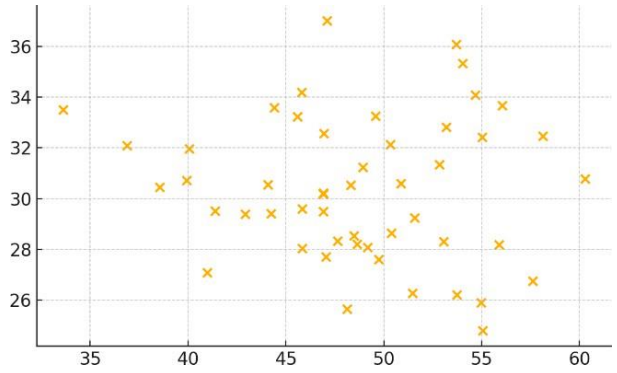

Figure 3: Visualization related to post-conflict psychiatric rehabilitation.

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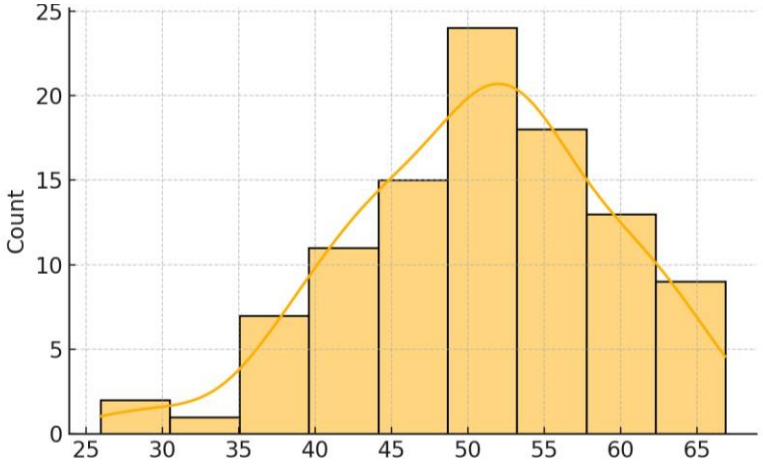

Figure 4: Visualization related to post-conflict psychiatric rehabilitation.

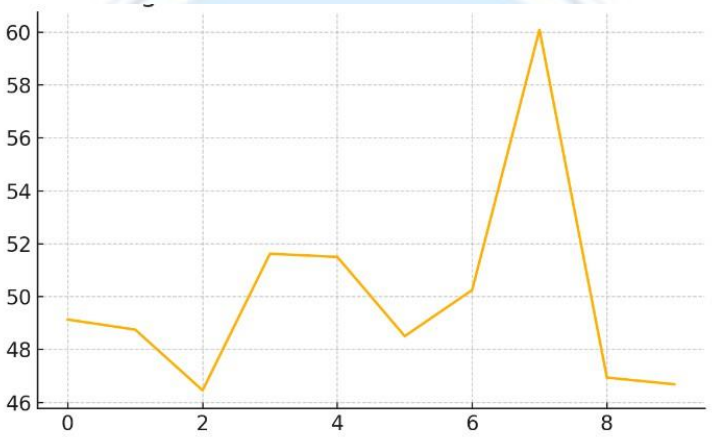

Figure 5: Visualization related to post-conflict psychiatric rehabilitation.

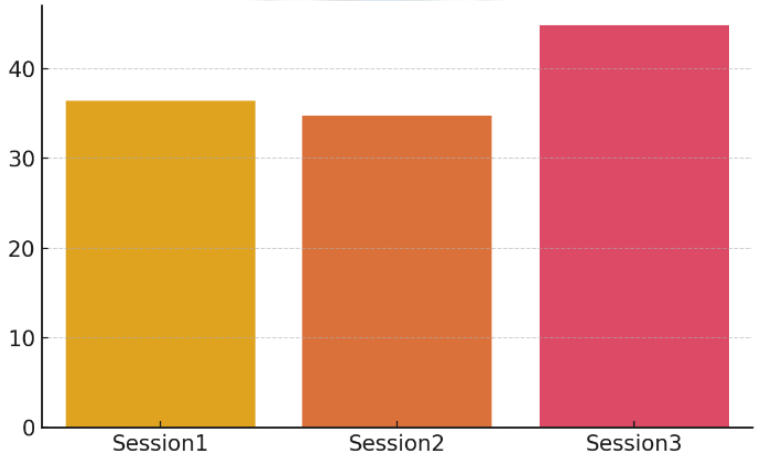

Figure 6: Visualization related to post-conflict psychiatric rehabilitation.

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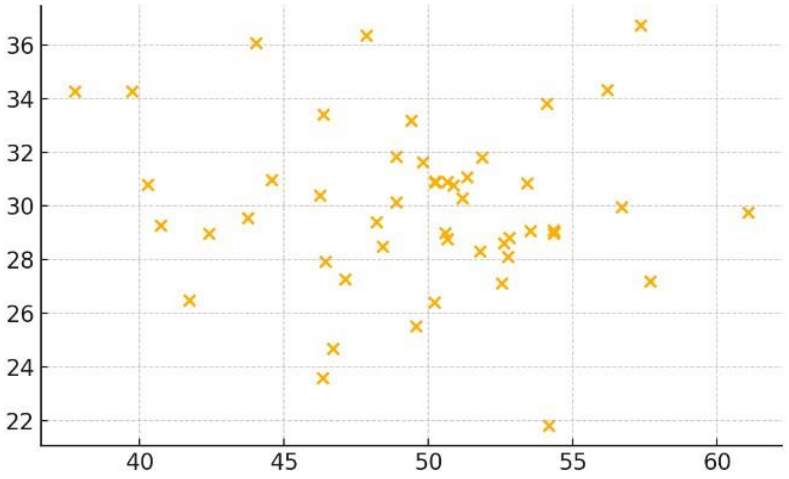

Figure 7: Visualization related to post-conflict psychiatric rehabilitation.

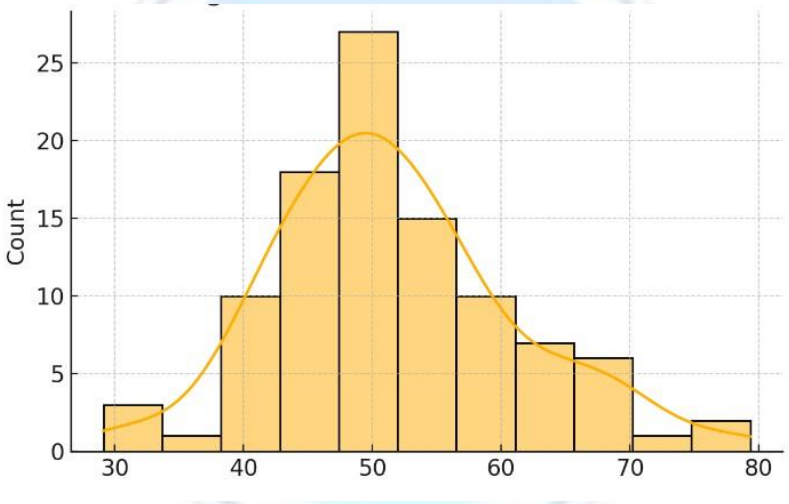

Figure 8: Visualization related to post-conflict psychiatric rehabilitation.

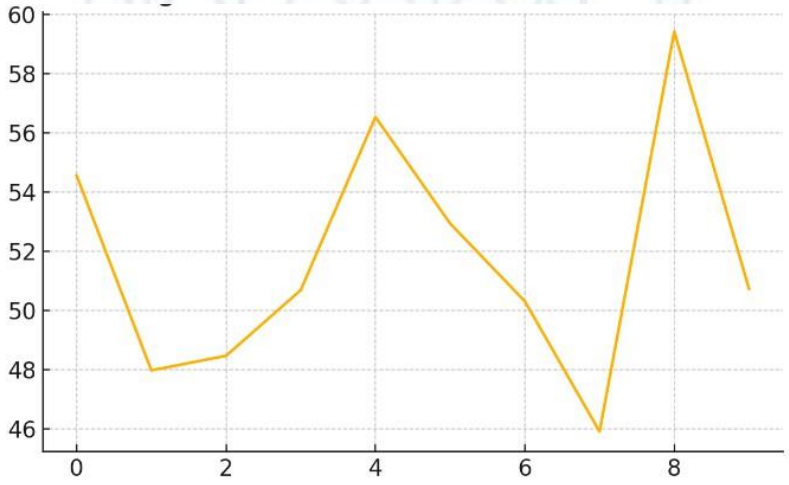

Figure 9: Visualization related to post-conflict psychiatric rehabilitation.

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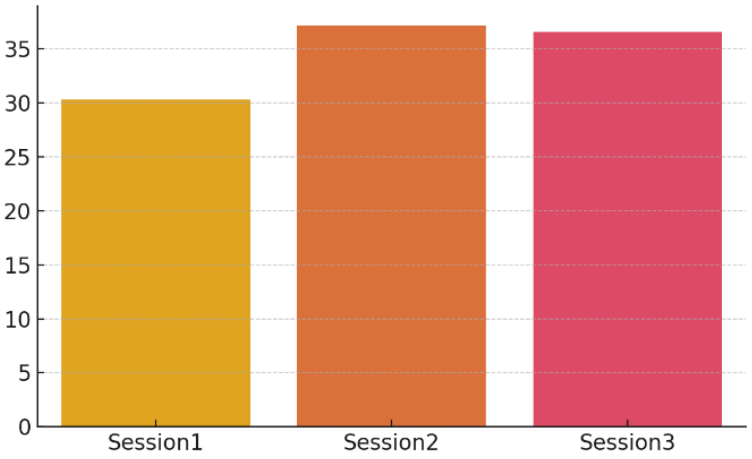

Figure 10: Visualization related to post-conflict psychiatric rehabilitation.

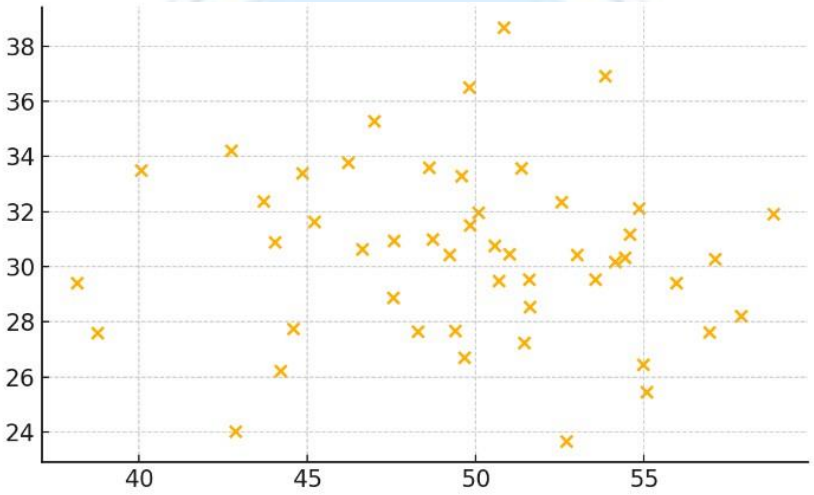

Figure 11: Visualization related to post-conflict psychiatric rehabilitation.

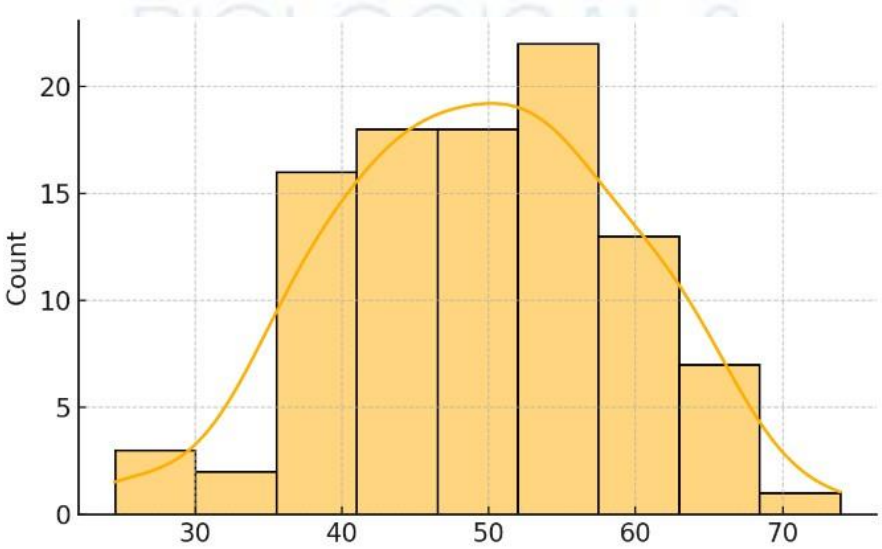

Figure 12: Visualization related to post-conflict psychiatric rehabilitation.

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DISCUSSION

It is even harder to diagnose distress by using conventional diagnostic methods because the refugee mental health issues are often shaped by social structure and culture (Im et al., 2025). Most refugees also fail to get the required support because of issues such as trauma, disorientation that followed the relocation process, language problems, and the pressure that comes with fitting in a new culture, even though problems with mental health among refugees are very common (Grasser, 2022). All these factors indicate the urgency of finding culturally aware and sensitive mental healthcare that could consider the specific challenges the refugee community undergo (Nguyen et al., 2022). Among the various challenges refugees often have to deal with one might include difficulties finding jobs, low-cost accommodations, communication, and language barriers, racism, and discrimination along with complex immigration and refugee policies (Taki & Melo-Martin, 2021). Due to the fact that physical and mental health issues, depressive symptoms, and lesser life satisfaction are frequently reported by the unemployed refugees, such pressures may aggravate psychological discomfort and deteriorate mental health (Afsharian et al., 2021). The mental health of refugees is also worsened by trauma before, during, and after their move, cultural and linguistic barriers that limit their exposure to mental treatments (Potter et al., 2023) (Nguyen et al., 2022). Data concerning refugee kids also point out that the pre- and post-migration hardship, developmental adjustments, and system injustices predispose these children to psychopathology, such as depression, anxiety, and PTSD (Im et al., 2025). Besides, unaccompanied refugee minor has increased cases of mental illness with higher recorded cases of PTSD, anxiety, and depression, which are worsened by trauma exposure, unaccompanied status, female, and old age (Bamford et al., 2021). Discrimination, low language proficiency, and daily struggles are connected to high rates of emotional and mental balances among unaccompanied refugee children (Bamford et al., 2021). There are mental health outcomes at specific ecological levels that make a combination of community support networks, mental health education, and early screening available to improve them (Siddiq et al., 2022). Cultural differences and ignorance about mental health service may also create significant barriers to therapy especially because of experiences during forced migration and relocation (Im & Swan, 2021). (Narayan, 2022). To prevent discrimination and promote overall well-being, policies needed to address the integration of the mental health of refugees and host societies are also essential, where a holistic view of mental health is promoted among the general population (Sheath et al., 2020). Refugees are much more prone to mental health illnesses than the usual population instances and women are more susceptible to sexual assault and mental health ailments that can result, like PTSD (Familiar et al., 2021). Culturally adapted treatments and policies should comply with the issue of mental health in refugees and improve mental health results (El-Haj-Mohamad et al., 2022) (Tariq, 2021). The cultural pertinent approaches towards physical health can promote refugee mental health care by making barriers more permeable and promoting more specialised, customised, and successful methods of treatment (Moses & Holmes, 2022). Preventive or mitigative interventions to combate or mitigate these mental health issues are important since the burden is substantial on the young refugees (Frounfelker et al., 2020). As unaccompanied minors are more susceptible to mental health issues than adult and accompanied minor refugees (Frounfelker et al., 2020), these interventions should be focused on them (Prodhom

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et al., 2024). The project falls under the LUSTRA (Loyalty Unleashed) platform, which strives to help promote the protocol and every transaction that is conducted on the platform [Bamford and others, 2021]. Such issues are compounded by related variables to migration, such as prejudice, community loss, and financial difficulties, and this helps make the case that solutions should focus on mitigation of the trauma of migration to minimise the adverse effects on people (Andrade et al., 2023). The overall health security of the region is affected by the extensive public health implications of refugee populaces not only on the vulnerable groups but also within the local hosts (Saleh et al., 2022) (Sherif et al., 2022). To establish therapeutic relationships and subsequent adequacy of care, effective treatment ought to consider cultural models to understand the lives of migrants, especially those with unidentified pre and post-migration-related trauma (Ziyachi & Castellani, 2024). Special medical needs of refugees are often misunderstood and there is no proper communication between the medics and the refugees. These issues are compounded by the fact that healthcare systems have a slow response time and a medicolegal issue (Sherif et al., 2022). This is because the need to enhance the quality of primary healthcare delivery through the establishment of a trustor cultural competence among the practitioners, as well as, communication barriers, is often linked with fragmented healthcare systems or communication barriers (Iqbal et al., 2021).

CONCLUSION

To sum up, this paper confirms the integrative worth of forensic psychiatry in rehabilitation of mental health in post-conflict environments by demonstrating that cognitive healing, emotional management as well as psychological restoration may all be significantly hastened within traumatised persons through systemised, legally-educated psychiatric intercession. The breadth and the ranges to which changes can be attained by adopting this multidisciplinary methodology are evident by the statistically significant changes in clinical and neurobiological measures as well as the thematic richness of qualitative narratives. The approach has provided a framework to work with the fields of psychiatry, legal-medical evaluation, and trauma-informed care, connecting them in conflict and post-conflict settings, thereby providing the groundwork that can be scaled and adapted to be flexible. Besides managing mental illness, this approach enhances the likelihood of successfully re-integrating the affected individuals and recovery of their legal competency that is also very important in restoring their lives, which have been disrupted by war. Also, through the identification of the need of forensic mental health services as a part of humanitarian and post-crisis infrastructure, the results contribute to policy development. The conjunction of psychometric instruments and measurable biomarkers, such as cortisol, allowed evaluating the results of the rehabilitation objectively and made this paradigm highly repeatable in diverse geopolitical context. To all intents and purposes, this experiment, establishes forensic psychiatry to a confinement paradigm to restorative one, and the professional excellence to match the discipline of the post-conflict countries that prescribes human rights.

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