PROFILING TORTURE II: ADDRESSING TORTURE AND ITS CONSEQUENCES IN SOUTH AFRICA

A PROJECT OF THE TRAUMA AND TRANSITION PROGRAMME OF THE CENTRE FOR THE STUDY OF VIOLENCE AND RECONCILIATION

MONITORING AND EVALUATION PROGRESS REPORT 2009

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RCT
Rehabilitation and Research Centre for Torture Victims

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INTRODUCTION

The Centre for the Study of Violence and Reconciliation (CSVR) is a multi-disciplinary institute whose primary goal is to use its expertise in building reconciliation, democracy and a human rights culture, and in preventing violence in South Africa and in other countries in Africa. The Trauma and Transition Programme (TTP) of the CSVR aims to sustain democracy through addressing the issues of unresolved trauma, torture, criminal violence and forced migration through psychosocial support, research and advocacy in South Africa and the continent.

TTP was set up in 1989 to offer a free counselling service to victims of political violence. Since the mid-1990s we have seen a shift from political violence to criminal violence within the country. From the late 1990s, TTP began counselling refugees and asylum seekers, individuals and groups from various African countries who had experienced violent conflict in their home countries and/or xenophobic violence in South Africa.

With the support of the Rehabilitation and Research Centre for Torture Victims (RCT), since 2007 TTP has embarked on a project aiming to strengthen the struggle against torture in South Africa and the African region. One of our objectives is to develop a comprehensive Monitoring and Evaluating (M&E) system for the psychosocial services provided to victims of torture. The development of all M&E instruments and the system itself was informed by current theory and achieved through collaboration between clinical staff, researchers, external consultants, and RCT staff. The system has changed over time to accommodate challenges encountered through implementation.

As the aims of M&E include the creation of spaces for reflection and learning, it is hoped that this process will help us learn more about our interventions and assist clinicians in improving their services to victims of torture.

A new phase in the project was initiated in 2009 and will run until 2011. This report is one of the outputs under this new project and covers the objectives set under the M&E section. This report looks at 2009 and describes the group of torture clients who received counselling services in 2009; details the characteristics of clients who completed an Intake Assessment in 2009; provides baseline data in terms of the impact that our services have had on clients; provides examples of individual Client Progress Reports produced in 2009; describes the drop-out rates for the year including the reason for drop-out; and outlines the compliance rates achieved in terms of documentation of M&E instruments.

ACKNOWLEDGEMENTS
This report would not be possible without the work of numerous people. The funding for the project comes exclusively from the Rehabilitation and Research Centre for Torture Victims (RCT) who have become partners in this endeavour. The research team that are responsible for the implementation of this project and who produced this report was comprised of Dominique Dix-Peek and Monica Bandeira. The project is fortunate enough to receive continuous and wise support from external consultant Craig Higson-Smith. All the staff at the Trauma and Transition Programme of the CSVR in some way contribute to the M&E system and should be acknowledged. Mosima Selemela our receptionist and Pinki Bahlekazi our relief receptionist are usually the first person clients meet when coming into the clinic, they play a central role in ensuring that clients feel welcome and respected. Community facilitators Modiegi Merafe and Pravilla Naicker have referred torture survivors they support in the community for counselling at TTP. They play an important role in raising awareness regarding torture, its impact and the services we provide. Intakes and Client Assessments were conducted by trained social work interns Cindy Kree and Julianna Munlo. As a number of our clients come from other African countries, interpreters are necessary during therapeutic processes and in order to complete the M&E instruments. Clinical assistants Gaudence Uwiyeze and Serena Thomas provide support to clients who communicate in other languages and play an important role in the therapeutic process with clinicians as well as gathering data for M&E. Clinicians have contributed to the M&E system development and implementation despite it making their work “public”. They have been key to its success. Our clinicians include: Marivic Garcia, Boitumelo Kekana, Megan Bantjes, Malose Langa, Jabu Masitha, Unati Mbete, and Nonhlanhla Mngomezulu. Boitumelo Kekana, our clinical coordinator, partners with us to ensure synergy between M&E and clinical systems and procedures. Implementing the project was dependent on the support and guidance of our programme manager Nomfundo Mogapi. However, none of this would be possible without the participation of our clients who have experienced severe traumas. Their resilience and strength amidst their difficulties continue to inspire us. We hope that this work in some way assists them in their journey towards recovery.

TORTURE CLIENTS WHO HAVE RECEIVED PSYCHOSOCIAL SERVICES AT TTP IN 2009

One of the key objectives for the M&E project is to reach a target of 110 tortured clients receiving individual psychosocial services at TTP per year. 75 torture clients were seen at TTP in 2009. The difference between the objective and what was achieved can be attributed to: contextual factors (such as the comparative stability within the Zimbabwean borders over the course of 2009 or the xenophobic violence in 2008, both of which could have contributed to a decrease in the number of Zimbabweans entering the country) and staff capacity (although the number of clients accessing our services has decreased, we have also noticed that clients tend to stay for longer hereby reducing time available for more clients). A description of the torture clients for 2009 follows.

1) Demographics

75 torture clients were seen at TTP during 2009. The largest nationality group were Zimbabweans (33%), while Congolese and South Africans made up the next largest groups (23% and 17% respectively). The pie chart below represents the people who received psychosocial services at TTP in 2009 by nationality. Other include one person from each of the following countries: Ethiopia, Cameroon, and Sudan.

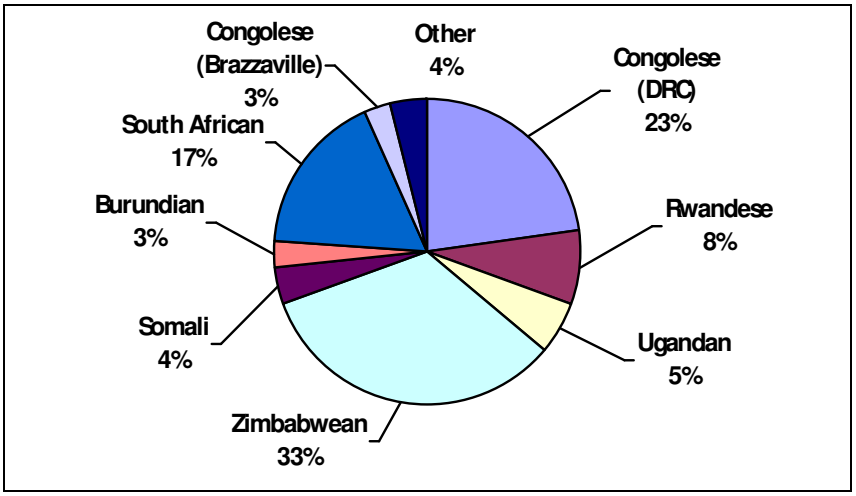


Figure 1 Nationality of torture clients receiving psychosocial services at TTP

The sample was closely divided over gender lines with 44% men and 56% women. The youngest client was 15 years of age, while the oldest was 56. The majority of clients were between the ages of 19 and 38 (63%). The mean age for the sample was 35 with a standard deviation of 9.77.

Of the clients seen in 2009, 59 (79%) were direct victims of torture, 7 (9%) were indirect victims, and 9 (12%) were both. A total number of 629 sessions were conducted with torture victims in 2009, with a maximum number of 34

sessions and an average of 9 sessions (standard deviation=8.36 and mode=8).

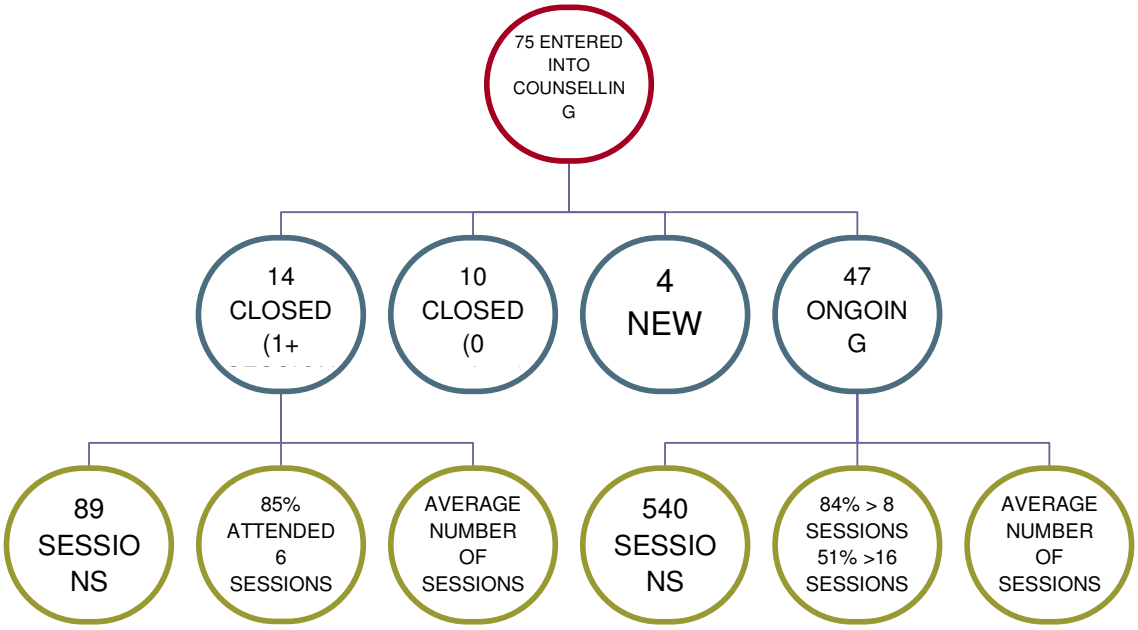


Figure 2 Breakdown of sessions per type of client

2) Traumatic events experienced by clients

Torture clients experienced an average of two traumatic events each (standard deviation: 0.89) with a total number of traumatic events of 147. Notwithstanding the torture experience, the most reported traumatic events were rape, war and assault. The maximum number of type of traumatic event was four, and the minimum one. The table below indicates the types of traumatic events experienced by torture clients at TTP.

Type of Traumatic event	**Number**	**Percentage**
Torture	75	51%
Rape	19	13%
War	16	11%
Assault	13	9%
Bereavement	9	6%
Witness to trauma	5	3%
Armed Robbery	2	1%
Car accident	2	1%
Mugging	2	1%
Relationship violence	2	1%
Hostage	1	1%
Xenophobic attacks	1	1%
Total	**147**	**100%**

Table 1 Types of traumatic events experienced by torture clients for 2009

3) Types of traumas experienced by clients

Clients were affected by 7 types of trauma (as identified by clinicians). There was an average of 1.2 types of trauma per client with a standard deviation of 0.46. The types of traumas most reported by clinicians were continuous trauma followed by multiple traumas (see table below).

Type of trauma	Number	Percentage
Continuous	41	47%
Multiple	18	20%
Once-off	16	18%
Complex	11	12%
Man made	1	1%
Vicarious	1	1%
Secondary	1	1%
Total	**89**	**100%**

Table 2 Types of traumatic events experienced by torture clients for 2009

INTAKE DATA REPORT FOR 2009

Two key objectives of the M&E project are: increased integration of knowledge generation and documentation in TTP, and improved quality of practice within TTP regarding torture rehabilitation services. In order to achieve both of these it is important that we generate knowledge from the information we collect. It is clear that the knowledge generated is important to improving the quality of our practice. Without an in-depth understanding of the people who access our services, we are limited in how best we can intervene. The following report is an analysis of the information we obtained from all clients (survivors of torture) who completed an intake assessment during 2009. This does not cover all victims of torture who received services from our centre as some did not complete an intake, or were cases carried over from 2008. The report looks at four main areas assessed during intake, namely: demographic information, psychiatric considerations, the impact of environmental factors, and physical health.

1) Demographics

A total number of 22 clients were included in the sample. Of these, 19 (86%) were referred to TTP by an external person or organization. Clients came from seven different countries with the majority coming from the Congo (figure below).

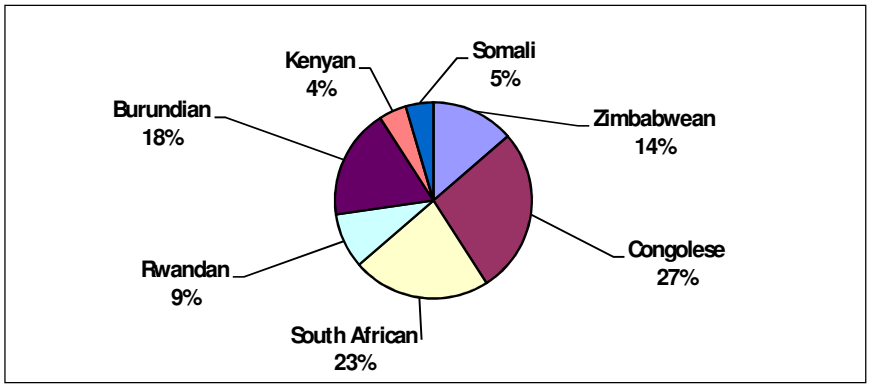


Figure 3: Nationality for Intakes in 2009

The sample was closely divided along gender lines with 12 women (55%) and 10 men (45%). The oldest client was 56 years of age while the youngest was 15 at the time of intake. The majority of clients were between the ages of 22-49 (82%). The mean age for the sample was 34 with a standard deviation of 11.37.

Just over a quarter of the clients (27%) reported being married at the time of intake, while 23% reported being widowed. 41% had never been married at the time of intake (table below).

Marital Status	Frequency	Percent
Currently Married	6	27%
Divorced	1	5%
Never Married	9	41%
Separated	1	5%
Widowed	5	23%
Total	**22**	**100%**

Table 3: Marital Status for Intakes in 2009

Most clients (50%) were living with their family (which could include living alone with their children). Others were living with friends (9%); in a shelter (32%); or with their partners/spouses (9%). 41% of clients did not have children at the time of intake. Of those who did have children, most had two children (23%), while four clients reported having four children or more. The mean number of children was 2 with a standard deviation of 1.63.

Before the torture experience, 45% of clients were employed within semi-skilled, skilled or highly skilled jobs. However, at the time of intake most were unemployed (table below).

	Pre-torture employment	Current employment
Highly skilled/ professional	9%	5%
Semi-skilled	18%	9%
Skilled	18%	5%
Student	18%	14%
Unemployed	18%	59%
Unskilled labour	9%	5%
Missing or Other	9%	5%
Total (n=22)	**100%**	**100%**

Table 4: Changes in employment status linked to torture for Intakes in 2009

2) Psychiatric Considerations

For our sample, the mean HTQ: Total Score was 116.68, (standard deviation = 24.9). The mean Self-Perception of Functioning Score for our sample was 2.84 (standard deviation =0.62). The group presented with a mean score of 3.03 for PTSD (standard deviation= 0.67), with 16 people (73%) being checklist positive for PTSD.

The majority of clients presented with clinical levels of both anxiety and depression (91% and 68% respectively). The results for this group in terms of anxiety and depression (n=22) are represented in the following table:

	Anxiety	Depression
Normal	0%	9%
Borderline	9%	23%
Clinical	91%	68%
Total	**100%**	**100%**

Table 5: Hospital Anxiety and Depression Scale scores for Intakes in 2009

3) Impact of environment (ICF indicators)

When asked about the impact of authority figures on their recovery (n=22) 15 clients (68%) reported that authority figures slow down recovery (a little or a great deal). Eight (36%) and five people (23%) of our sample reported some form of harassment from the police or the Department of Home Affairs (the Government department responsible for approving refugee status) respectively. 10 people (45%) reported that health professionals support their recovery (a little or a great deal), and 10 people (45%) reported that family members support their recovery (a little or a great deal).

When asked questions regarding functioning the following answers were forthcoming:

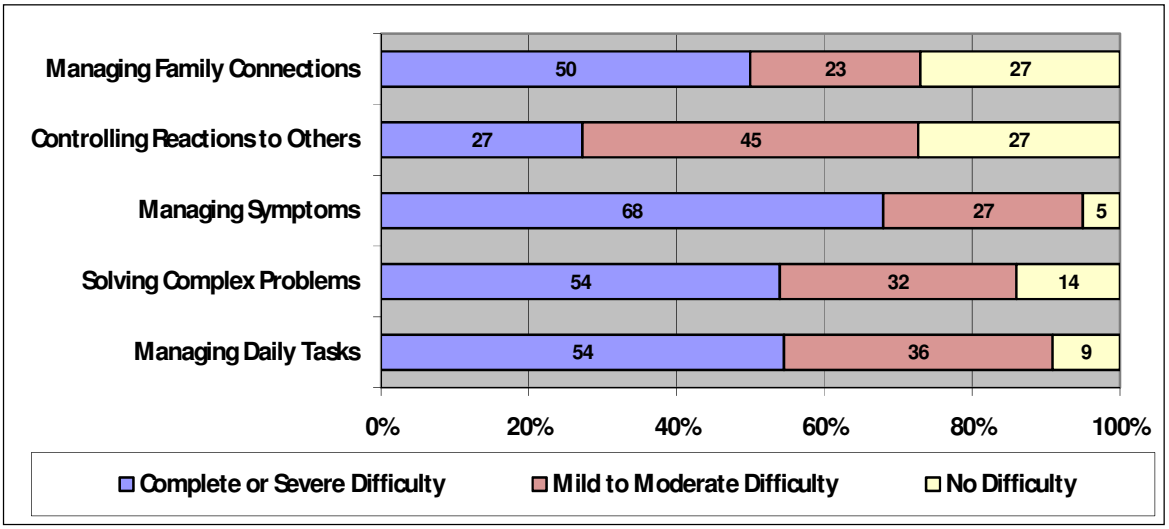


Figure 4: Key dimensions of functioning for Intakes in 2009

4) Physical Health:

Clients were asked if they suffered from any medical conditions, disabilities and pain. Where they responded yes, they were asked if this was due to their torture experiences. 9 clients (41%) reported suffering from at least one medical condition. A broad range of medical conditions were reported including: depression; neck and head aches; feet pain; difficulty urinating or controlling bowel movements; high blood pressure and heart palpitations. The table below provides information on the categories of medical conditions experienced as well as their link to the torture experience.

Category of self-reported medical condition	Incidence	Due to Torture
Emotional difficulties	5	5
Difficulties in the neck or head area (including headaches, and ear or neck problems)	4	2
Pains/problems in the back, ribs, or abdominal areas	4	4
Pains in feet or legs	1	1
Pains in the genital areas	2	2
Other (2)	2	2
Total	18	16
Total %	100%	88%

Table 6: Categories of medical conditions reported for Intakes in 2009

Five people (23%) reported suffering from a disability, 92% of which reported that it was due to the torture they experienced. Most (80%) reported a disability in the head or neck region. The majority of the sample 16 people (or 72%) reported experiencing some form of pain. Of the 29 incidences of pain reported, 26 (90%) incidences of pain were said to be due to torture. The areas of pain are outlined in the following table:

Pain	Incidence	Due to Torture
Shoulder Region	2	2
Upper Extremity	1	1
Genital Pain	2	2
Abdomen	5	4
Chest Pain	1	1
Lower Extremity	8	7
Head and Neck	8	7
Generalised Pain	1	1
Back Pain	1	1
Total	29	26
Total %	100%	90%

Table 7: Areas affected by pain for Intakes in 2009

Despite the high incidence of medical conditions, disability and pain reported by the sample, only five clients indicated that they were taking prescription drugs. Reported use of substances such as cigarettes, beer, wine, and spirits was very low for this sample with 82% of clients saying they do not use any of these substances.

BASELINE IMPACT DATA REPORT FOR 2009

One of the key objectives of the M&E project is to use the data obtained to gather information on the number of people who are or are not showing improvement. This is done in order to ensure that our clients are showing an improvement over time and to learn if they are not in order to improve or alter our interventions. According to the three year project proposal the objective is stated as: 50% increase of the number of clients who report a reduction in symptoms and improvement in functioning after using TTP's services. As this is a three year project the first year has been used to obtain baseline data on impact. In other words, to clarify the extent of impact on the clients for which we have impact information on.

Baseline data has been obtained for different points in the M&E process. We have been able to collect data on 16 clients who completed an Intake and a first assessment (done between sessions 5-8) and 11 clients who completed an intake and a second Assessment (done between sessions 11-14). These client groups are discussed separately. These two groups will be described in terms of demographic information and three areas assessed, namely: the impact of relevant service providers on clients' recovery; the impact on several mental health measures; and the impact on a number of functioning indicators.

Baseline data for clients with an Intake and a first assessment (n=16):

1) Demographic information:
   Clients came from six different countries with the majority coming from South Africa (figure below).

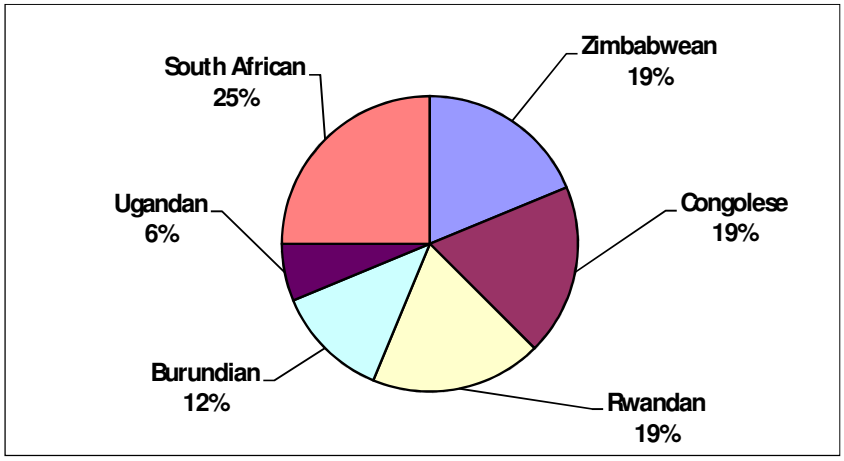


Figure 5: Nationality of clients with Intake and first assessment

   Six women (53%) and 10 men (47%) make up the group. The oldest client was 54 years of age while the youngest was 17 at the time of intake. The mean age for the group was 34.

   Over half of this group (63%) reported never being married at the time of intake (table below).

Marital Status	Frequency	%
Currently Married	3	19%
Never Married	10	63%
Divorced	1	6%
Widowed	2	12%
Total	**16**	**100%**

Table 8: Marital Status of clients with Intake and first assessment

Most clients (56%) were living with their family (which includes living alone with their children). Others were living with friends (6%); in a shelter (6%); alone (19%); or with their partner/spouse (13%). Before the torture experience, the majority of clients (67%) were students or employed within skilled or highly skilled jobs. However, at the time of intake most (73%) were unemployed or employed in unskilled jobs (table below).

	Pre-Torture Employment	Current Employment
Highly skilled/professional	13%	0%
Semi-skilled	0%	7%
Skilled	13%	7%
Student	41%	13%
Unemployed	20%	53%
Unskilled labour	13%	20%
Total (n=15)	100%	100%

Table 9: Changes in employment status linked to torture of clients with Intake and first assessment

2) Service providers' impact on recovery:

Torture survivors require a wide range of assistance, including psychological, social, legal, and medical. In the experience of the clinical team, the role of authority figures, health professionals, and family members is important in terms of the recovery process of survivors of torture. As such, questions regarding the impact of these on their recovery were included in the assessments. Although clinical work may not be able to change how these groups treat or interact with clients, it may be able to work with clients' ability to manage negative interactions. These questions also provide information on some of the contextual factors impacting on clients' recovery.

Overall, an average of 41% of clients reported an improvement in the impact of these groups on their recovery, 23% reported their impact remaining the same, while 26% reported that the impact on their recovery of these groups has worsened. Authority figures' impact on recovery showed the worse results with 44% of clients reporting that their recovery is more negatively impacted by authority figures from the time of intake to the first assessment (table below).

	% of people who reported more positive impact	% of people who reported impact as staying the	% of people who reported more negative impact	n

		same		
Authority figures impact on recovery	37.5%	18.8%	43.8%	16
Health professionals impact on recovery	46.7%	26.7%	26.7%	15
Family members impact on recovery	38.5%	23.1%	38.5%	13
Averages	**40.9%**	**22.9%**	**36.3%**	

Table 10 Changes of impact of different groups on recovery of clients with Intake and first assessment

3) Mental health measures:

The Harvard Trauma Questionnaire (HTQ) provides a total score (indicator of level of trauma), a PTSD score (linked to DSM-IV), and a Self-perception of Functioning Score (indicating lower self-perception of functioning). Higher scores on all of these indicate higher trauma, higher PTSD or lower self-perception of functioning. Overall, the majority of clients (between 60% and 75%) showed a decrease in scores across all mental health measures. However, between 25% and 33% showed an increase in scores.

At Intake 11 (69%) scored above the cut-off of 2,5 for PTSD. At first assessment this dropped down to 7 (44%), which represents a significant difference ($p = 0.040$ using the T-test with $t=2.23$ and $df=16$). The figure below shows that although the mean score has only moved to slightly under the cut-off point of 2,5 there has been a clear shift in the scores.

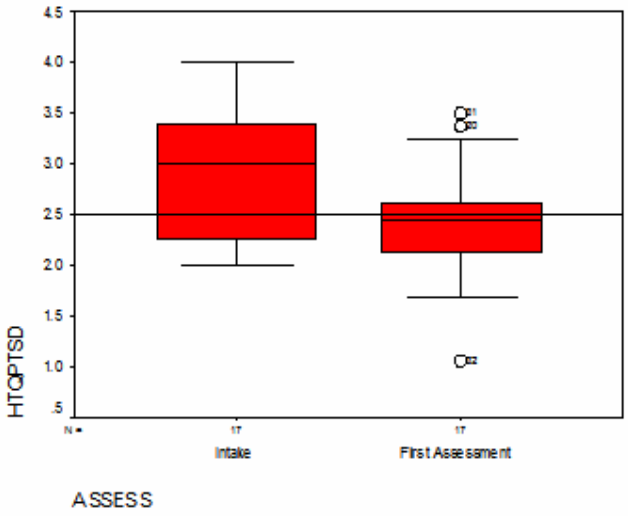


Figure 6 Box plot of PTSD scores at Intake and first assessment

Overall, improvements were seen on the Total Score (60%), PTSD (71%) and Self-perception of Functioning scores (71%). 29% scored higher at the first assessment point on their PTSD and Self-perception of Functioning Score (indicating lower self-perception of functioning) while 33% scored higher on the Total Score (table below).

	% of people whose scores decreased	% of people whose scores stayed the same	% of people whose scores increased	n
HTQ total score (trauma)	60.0%	6.7%	33.3%	15
PTSD score	70.6%	0.0%	29.4%	17
Self-perception of Functioning score	70.6%	0.0%	29.4%	17

Table 11 Changes in scores on the HTQ of clients with Intake and first assessment

The Hospital Anxiety and Depression Scale (HADS) was used to measure depression and anxiety. Anxiety scores showed improvement with the percentage of people with clinical anxiety levels going from 81% at Intake to 68% at first assessment. There was an increase in the number of borderline cases from 6% to 25% (table below).

	Intake	**First assessment**
Normal	13%	6%
Borderline	6%	25%
Clinical	81%	69%
Total	**100%**	**100%**

Table 12 Anxiety scores of clients with Intake and first assessment

Depression scores were similar in that there was a decrease in the number of people with clinical levels of depression from 63% at Intake to 43% at first assessment. Within the depression scores, there was an increase in the number of people with normal levels of depression, namely from 6% to 19% (table below).

	Intake	**First assessment**
Normal	6%	19%
Borderline	31%	38%
Clinical	63%	43%
Total	**100%**	**100%**

Table 13 Depression scores of clients with Intake and first assessment

The majority of people showed a decrease in depression and anxiety scores (75% and 63% respectively). On the other hand 25% showed an increase on these measures from Intake to first assessment.

	% of people whose scores decreased	% of people whose scores stayed the same	% of people whose scores increased	n
Depression	75.0%	0.0%	25.0%	16
Anxiety	62.5%	12.5%	25.0%	16
Averages	**67.7%**	**3.8%**	**28.4%**	

Table 14 Changes in scores of depression and anxiety of clients with Intake and first assessment

4) Functioning Indicators

A number of indicators based on the International Classification of Functioning and Disability (ICF) were developed to assess functioning in areas the clinical team felt were important in terms of their interventions. The majority of clients reported an increase in functioning in terms of solving complex problems (63%) and managing family connections (58%). The difference in solving complex problems was significant at p=0.013 using Wilcoxon's test (z=2.486). Most clients (43%) reported no change in their ability to manage symptoms and managing daily tasks from Intake to first assessment. In terms of controlling reactions to others 47% reported a decrease in their functioning.

On average, 44% reported an improvement in their functioning from Intake to first assessment, while 23% reported a decrease in functioning.

	% of people whose functioning increased	% of people whose functioning stayed the same	% of people whose functioning decreased	n
Solving complex problems	62.5%	31.3%	6.3%	16
Managing daily tasks	43.8%	31.3%	25.0%	16
Managing symptoms	35.7%	42.9%	21.4%	14
Controlling reactions to others	20.0%	33.3%	46.7%	15
Managing family connections	58.3%	25.0%	16.7%	12
Average	**44.1%**	**32.8%**	**23.2%**	

Table 15 Changes in functioning of clients with Intake and first assessment

Baseline data for clients with an Intake and a second assessment (n=11):

1) Demographic information:
Clients came from six different countries with the majority coming from Zimbabwe (figure below).

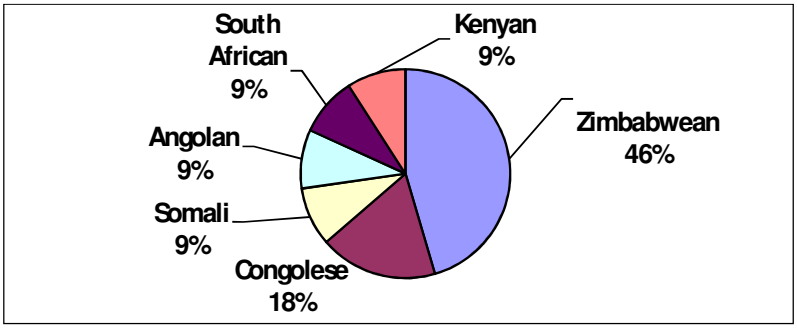


Figure 7: Nationality for clients with an Intake and second Assessment

Five women (45%) and six men (55%) make up the group. The oldest client was 45 years of age while the youngest was 22 at the time of intake. The mean age for the group was 33.

The same number of people (36%) reported either never being married or being married at the time of intake (Table below).

Marital Status	Frequency	%
Currently Married	4	36%
Never Married	4	36%
Separated	2	18%
Widowed	1	10%
Total	**11**	**100%**

Table 16: Marital Status for clients with an Intake and second assessment

Most clients (36%) were living with friends at the time of Intake. Others were living with family (27%), which includes living alone with their children; in a shelter (27%); or with strangers (10%).

Before the torture experience, the majority of clients (73%) were employed within semi-skilled, skilled or highly skilled/professional jobs. However, at the time of intake most (90%) were unemployed (table below).

	Pre-Torture Employment	Current Employment
Highly skilled/professional	27%	0%
Semi-skilled	19%	10%
Skilled	27%	0%
Unemployed	27%	90%
Total (n=15)	100%	100%

Table 17: Changes in employment status linked to torture for clients with an Intake and second assessment

2) Service providers' impact on recovery:
Overall, an average of 56% of clients reported an improvement in the impact of these groups on their recovery, 21% reported their impact remaining the same, while 23% reported that the impact on their recovery of these groups has worsened. Authority figures' impact on recovery showed the worst results with 33% of clients reporting that their recovery is more negatively impacted by authority figures from the time of intake to the second assessment.

	% of people who reported more positive impact	% of people who reported impact as staying the same	% of people who reported more negative impact	n
Authority figures impact on recovery	67%	0%	33%	9
Health professionals impact on recovery	50%	30%	20%	10
Family members impact on recovery	50%	33%	17%	6
Averages	**56%**	**21%**	**23%**	

Table 18 Changes on impact of different groups on recovery for clients with an Intake and second assessment

3) Mental health measures:
The Harvard Trauma Questionnaire (HTQ) provides a total score (indicator of level of trauma), a PTSD score (linked to DSM-IV), and a Self-perception of Functioning Score (indicating lower self-perception of functioning). Higher scores on all of these indicate higher trauma, higher PTSD or lower self-perception of functioning. At Intake 9 clients (82%) scored above the cut-off of 2,5 for PTSD. At second assessment this dropped down to 5 (46%). Changes in the Total score, PTSD score, and a Self-perception of Functioning score from Intake to second assessment were significant (table below).

	Mean at Intake	Mean at second assessment	Significance	n

Total score	118.55	98.27	p=0.024	11
PTSD score	2.94	2.48	p=0.022	11
Self-perception of Functioning score	2.98	2.46	p=0.036	11

Table 19 HTQ changes in means and significance levels for clients with an Intake and second assessment

Overall, improvements were seen on the Total Score (73%), PTSD (82%) and Self-perception of Functioning scores (73%). 18% scored higher at the second assessment point on their PTSD and Total scores, while 27% scored higher on the Self-perception of Functioning Score (indicating lower self-perception of functioning).

	% of people whose scores decreased	% of people whose scores stayed the same	% of people whose scores increased	n
HTQ total score (trauma)	73%	9%	18%	11
PTSD score	82%	0%	18%	11
Self-perception of Functioning score	73%	0%	27%	11
Average	**76%**	**3%**	**21%**	

Table 20 Changes in HTQ scores from Intake to second assessment

The Hospital Anxiety and Depression Scale (HADS) was used to measure depression and anxiety. Anxiety scores showed improvement with the number of people with clinical anxiety levels going from 90% at Intake to 70% at second assessment. There was an increase in the number of borderline cases from 10% to 20% (table below).

n=10	**Intake**	**Second assessment**
Normal	0%	10%
Borderline	10%	20%
Clinical	90%	70%
Total	**100%**	**100%**

Table 21 Anxiety scores for clients with an Intake and second assessment

Although the changes in anxiety scores from Intake to second assessment are not significant, the figure below clearly depicts that the overall clinical picture of anxiety has changed a great deal. As can be seen, although the mean score remains above the cut-off point for clinical anxiety (10), the scores have decreased.

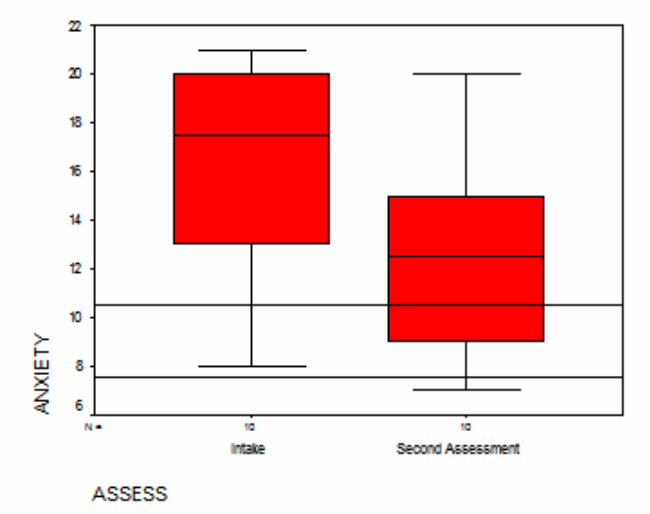


Figure 8 Anxiety scores at Intake and second assessment

Depression scores show an increase in the number of people with clinical levels of depression from 70% at Intake to 90% at second assessment. Within the depression scores, there was an increase in the number of people with normal levels of depression, namely from 0% to 10% (table below).

n=10	Intake	Second assessment
Normal	0%	10%
Borderline	30%	0%
Clinical	70%	90%
Total	**100%**	**100%**

Table 22 Depression scores for clients with an Intake and second assessment

Overall, the majority of clients (90%) showed a decrease in anxiety scores. Depression scores indicate that half of the group showed improvements while the other half deteriorated (table below).

	% of people whose scores decreased	% of people whose scores stayed the same	% of people whose scores increased	n
Depression	50%	0%	50%	10
Anxiety	90%	0%	10%	10
Averages	**65%**	**2%**	**25%**	

Table 23 Changes in Depression and Anxiety scores from Intake to second assessment

4) Functioning Indicators

Data for only four clients was available in terms of these indicators at Intake and second assessment and as such analysis is not possible at this stage.

CLIENT PROGRESS REPORTS FOR 2009

An important part of any M&E process is feeding back information obtained to those who participate so that it may be used to influence or increase understanding of the intervention. In line with this, one of the outputs of the project for 2009 was to produce Client Progress Reports (CPRs) which would contain analysis of data obtained from assessments conducted with clients. We set ourselves a target of producing 4-6 of these in 2009. CPR's can only be produced once a client has completed two assessments. We have managed to produce 30 CPR's in 2009. These have then been provided to clinicians, who have used the information to reflect on their practice and the progress of the client. Clients have also at times been shown the reports to demonstrate their progress. All 30 CPR's are available for viewing, we include only three here as examples of the information being produced.

Client progress report 1

Client code: 190809

Data available:

- M&E intake
- 1 Client Self-Assessment

Demographics:

Gender:	Female
Nationality:	Rwandan
Age:	29
Number of children:	2
Number of dependants:	0
Educational level:	Tertiary
Pre-torture employment:	Highly Skilled/Professional
Employment at intake:	Student

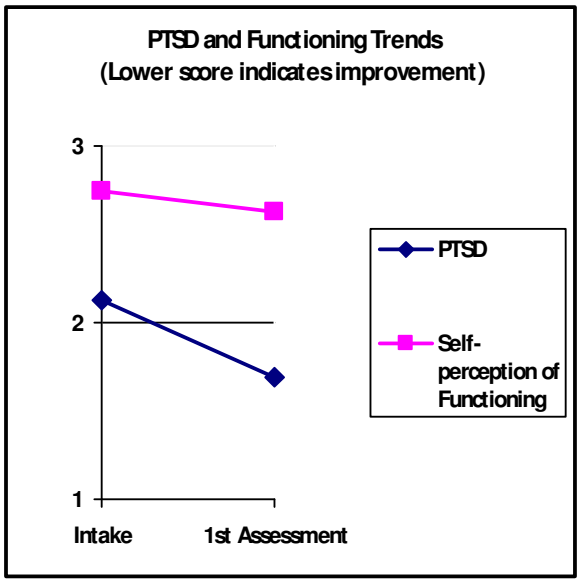
Results:

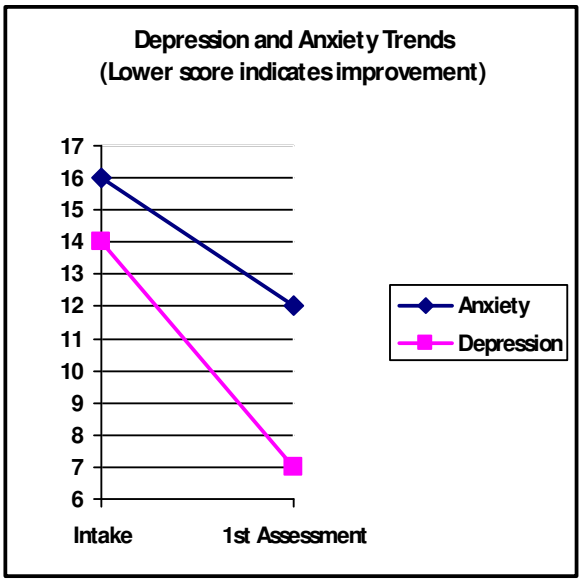
	Intake	**Client Self-Assessment**	**Progress***
Date done	**05/10/2009**	**23/11/2009**	
Number of sessions completed	-	8	
Authority Figures impact on recovery	Slow down a little	No impact	↓
Health professionals impact on recovery	Support a little	Support a great deal	↓
Family members impact on recovery	Slow down a great deal	No impact	↓
Difficulty in solving complex problems	Severe difficulty	Moderate difficulty	↓
Difficulty in completing daily tasks	Severe difficulty	Severe difficulty	→
Difficulty in managing symptoms	Moderate difficulty	Severe difficulty	↑
Difficulty in ability to control reactions to others	Moderate difficulty	Moderate difficulty	→
Difficulty in family connections	Complete difficulty	No difficulty	↓
PTSD score (> 2.5 = symptomatic for PTSD)	2.13	1.69	↓

Self-perception of functioning score (no cut off)	2.75	2.63	↓
Anxiety (0-7 = normal, 8-10 = borderline and 11+ = clinical)	16	12	↓
Depression (0-7 = normal, 8-10 = borderline and 11+ = clinical)	14	7	↓

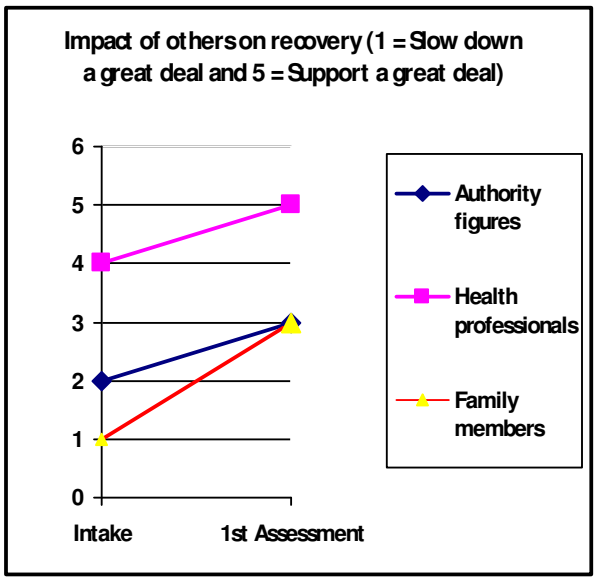
*** Down indicates improvement**

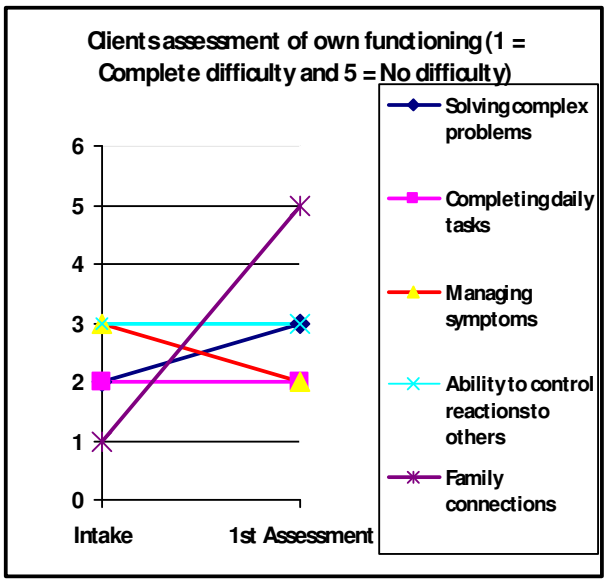
*** Down indicates improvement**





***Up indicates improvement**





Client Progress Report 2
Client code: 100208

Data available:

- M&E intake
- 3 Client Self-Assessments

Demographics:

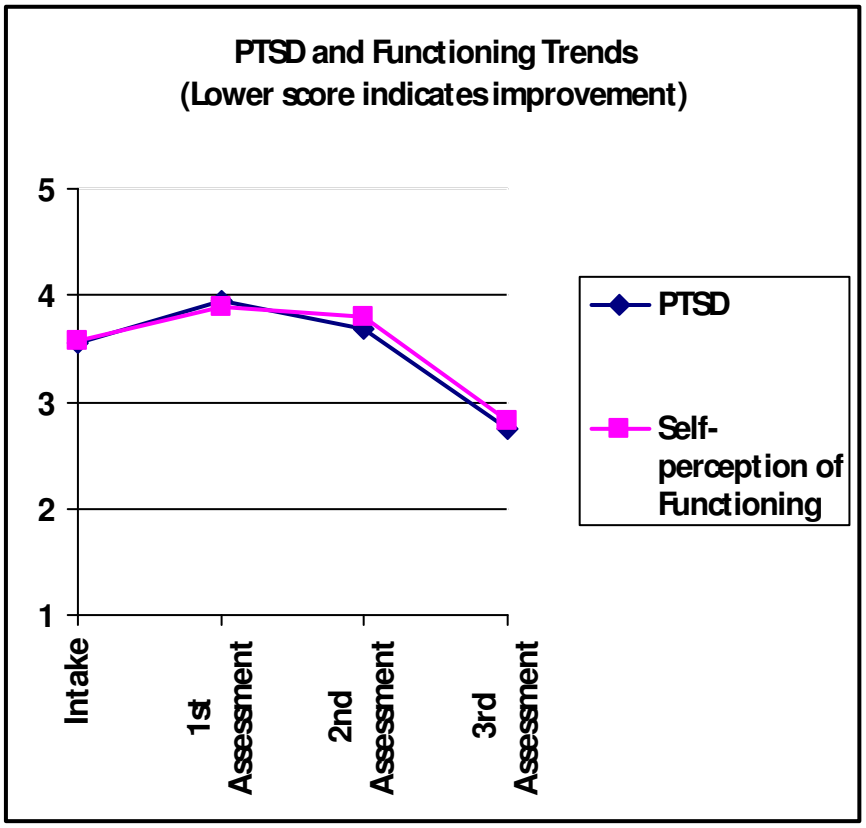
Gender:	Female	Nationality:	Congolese
Age:	45	Number of children:	6
Number of dependants:	2	Educational level:	Tertiary
Pre-torture employment:	Highly skilled	Employment at intake:	Unemployed

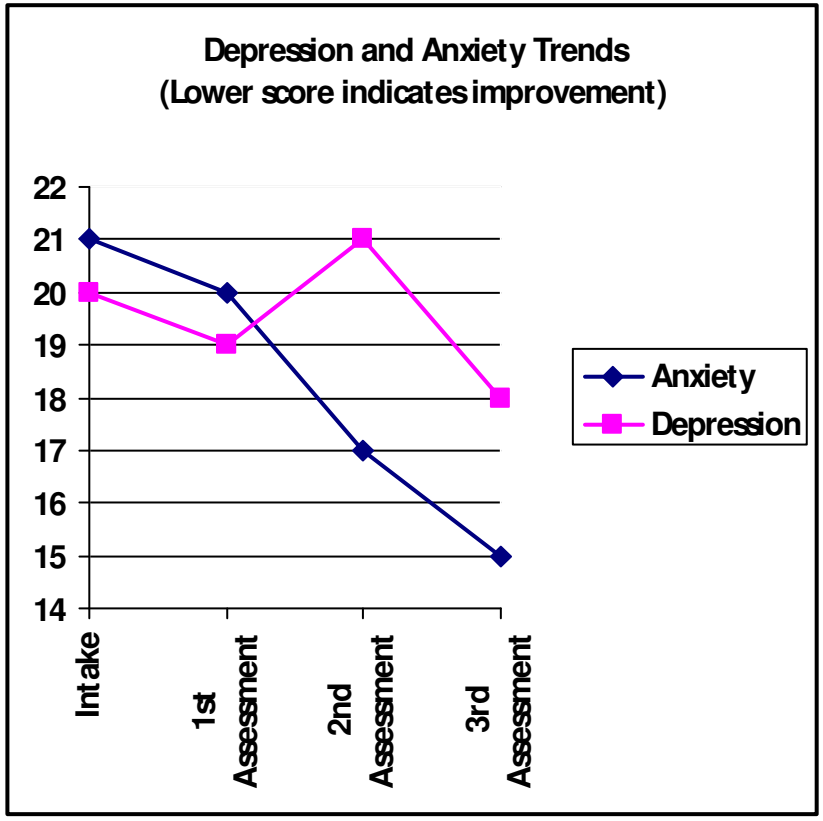
Results:

	Intake	**1st Client Self-Assessment**	**Second Client Self-Assessment**	**3rd Client Self-Assessment**
Date done	**25/03/2008**	**21/07/2008**	**09/09/2009**	**31/10/2009**
Number of sessions completed	-	6	19	24
Authority Figures impact on recovery	Slow down a great deal	No impact	Slow down a great deal	Slow down a great deal
Health professionals impact on recovery	Support a great deal	Support a great deal	Slow down a little	Support a great deal
Family members impact on recovery	-	Support a great deal	Support a great deal	Support a great deal
Difficulty in solving complex problems	-	Moderate difficulty	Complete difficulty	Complete difficulty
Difficulty in completing daily tasks	-	Complete difficulty	Severe difficulty	Mild difficulty
Difficulty in managing symptoms	-	Complete difficulty	Complete difficulty	Mild difficulty
Difficulty in ability to control reactions to others	-	Complete difficulty	Severe difficulty	Complete difficulty
Difficulty in family connections	-	Complete difficulty	Moderate difficulty	No difficulty
PTSD score (> 2.5 = symptomatic for PTSD)	3.56	3.94	3.69	2.75
Self-perception of functioning score (no cut off)	3.58	3.89	3.79	2.83
Anxiety (0-7 = normal, 8-10 = borderline and 11+ = clinical)	21	20	17	15

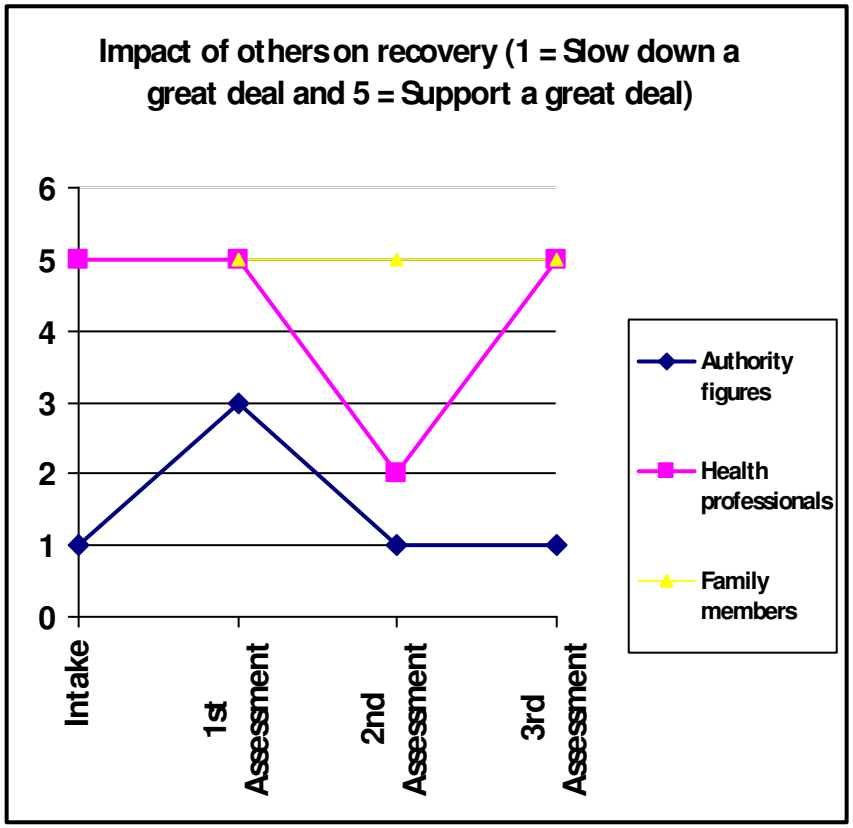
Depression (0-7 = normal, 8-10 = borderline and 11+ = clinical)	20	19	21	18

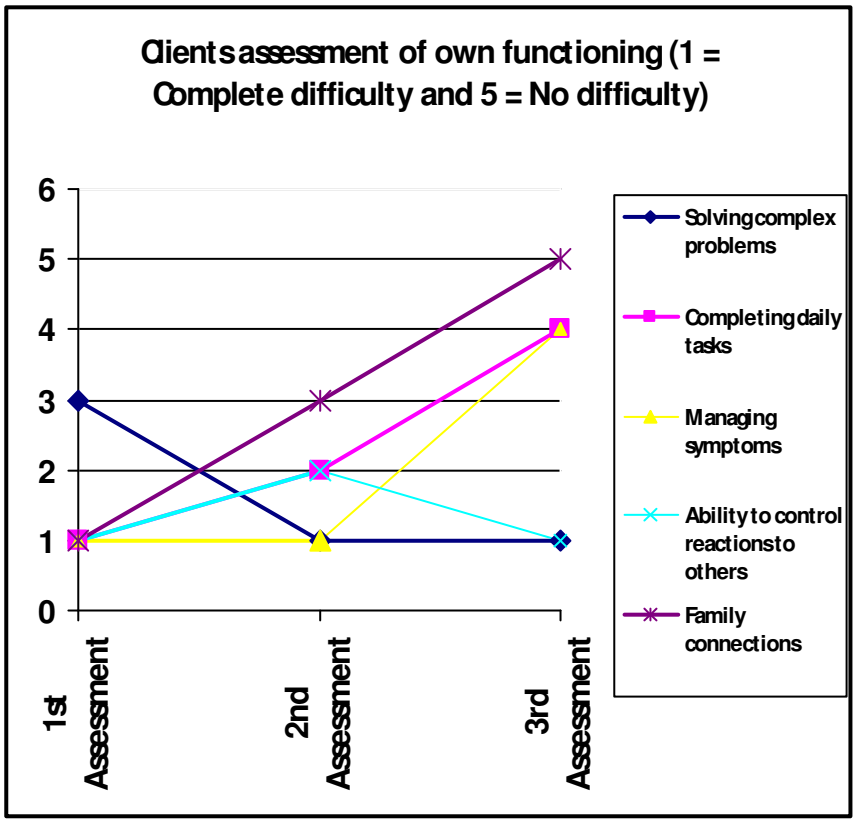
*** Down indicates improvement**





* Up indicates improvement





Client Progress Report 3
Client code: 400707

Data available:

- 3 Client Self-Assessments

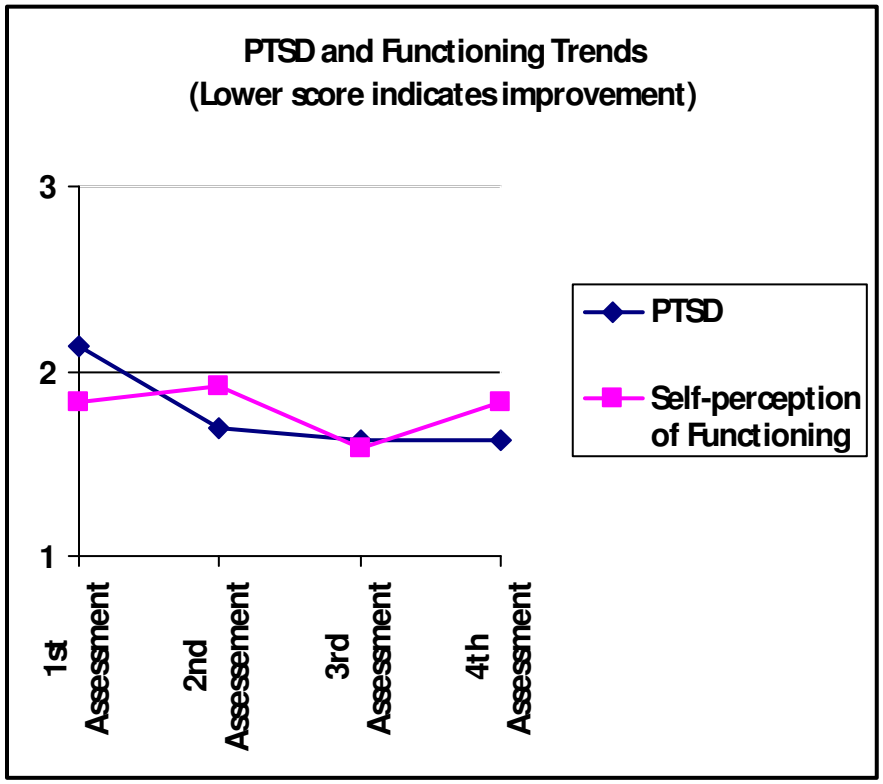
Demographics:

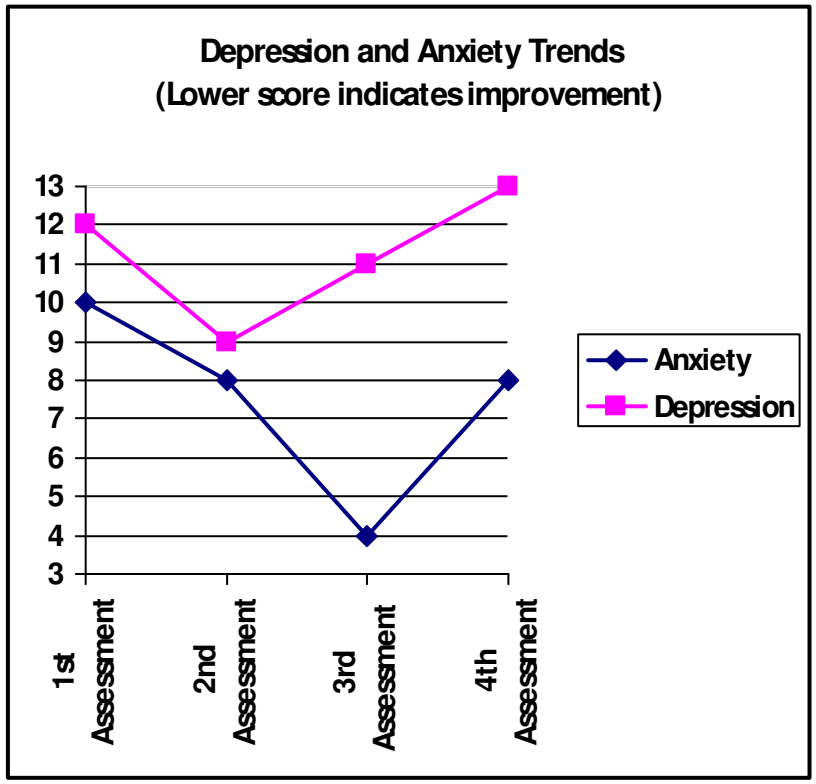
Gender:	Female	Nationality:	Zimbabwean
Age:	27	Number of children:	3
Number of dependants:	9	Educational level:	Tertiary
Pre-torture employment:	Highly skilled	Employment at intake:	Unemployed

Results:

	1st Client Self-Assessment	**2nd Client Self-Assessment**	**3rd Client Self-Assessment**	**4th Client Self-Assessment**
Date done	**13/02/2009**	**02/05/2009**	**22/08/2009**	**19/09/2009**
Number of sessions completed	32	42	47	49
Authority Figures impact on recovery	Support a great deal	Support a great deal	Support a great deal	Slow down a little
Health professionals impact on recovery	Slow down a little	Slow down a little	Slow down a little	Support a little
Family members impact on recovery	Support a great deal	Support a great deal	Support a great deal	Slow down a little
Difficulty in solving complex problems	Moderate difficulty	Moderate difficulty	Mild difficulty	Mild difficulty
Difficulty in completing daily tasks	No difficulty	Moderate difficulty	Mild difficulty	Mild difficulty
Difficulty in managing symptoms	Mild difficulty	Mild difficulty	Mild difficulty	Mild difficulty
Difficulty in ability to control reactions to others	Severe difficulty	Mild difficulty	No difficulty	Moderate difficulty
Difficulty in family connections	Mild difficulty	Mild difficulty	Moderate difficulty	Mild difficulty
PTSD score (> 2.5 = symptomatic for PTSD)	2.13	1.69	1.63	1.63
Self-perception of functioning score (no cut off)	1.83	1.92	1.58	1.83
Anxiety (0-7 = normal, 8-10 = borderline and 11+ = clinical)	10	8	4	8
Depression (0-7 = normal, 8-10 = borderline and 11+ = clinical)	12	9	11	13

* Down indicates improvement





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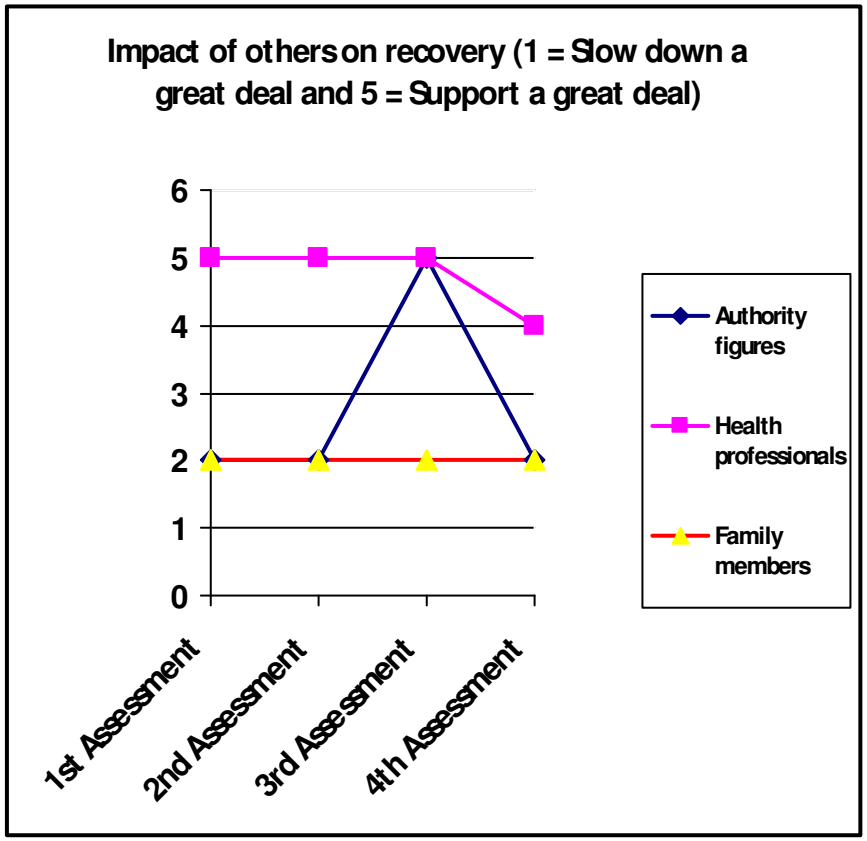

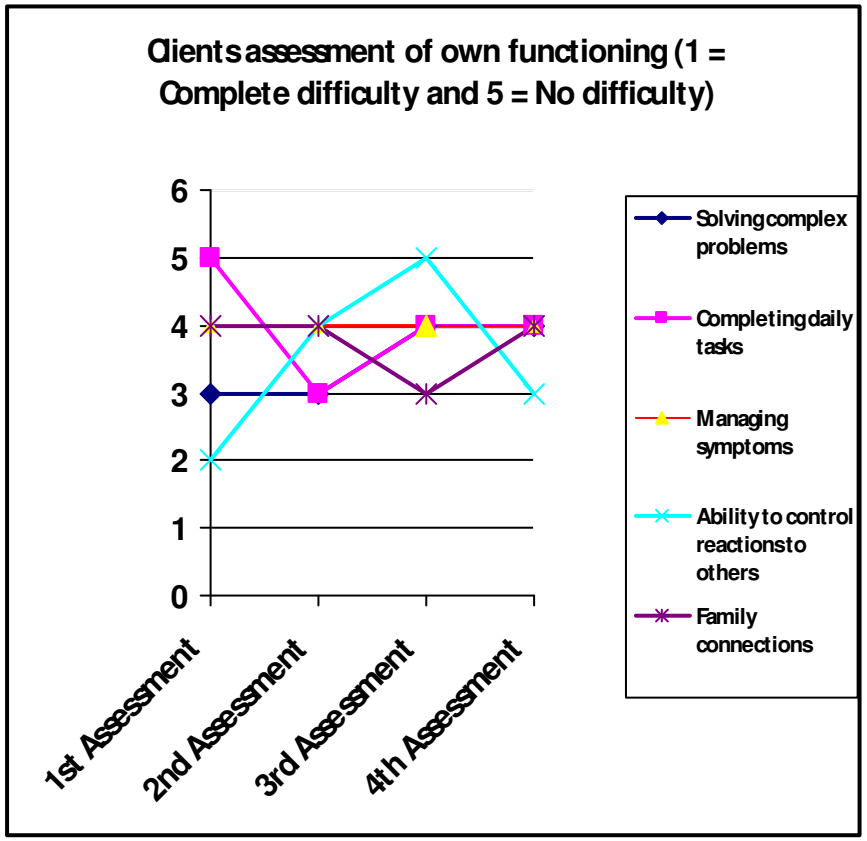

DROP-OUT REPORT FOR M&E 2009

Between 2007 and 2008 there was a high number of clients dropping out having only had one session or less. As such, an objective was set for the project to reduce the number of drop-outs of clients with one session or less. In order to do this it is important to know what the drop-out numbers are and the reasons for this. This report indicates the number of clients who dropped out, how many sessions they had, and the reasons for dropping out. Only new clients in 2009 have been included.

There were 38 new clients who received psychosocial services from TTP in 2009. Of those, six (16%) clients are considered new (i.e. they have had two sessions or less without dropping out), 19 (50%) of the clients are considered ongoing (i.e. they have had three or more sessions without dropping out), one case (2%) was closed during the year but has subsequently been reopened and twelve (32%) cases are closed.

The following diagram indicates how many sessions each client had before s/he stopped coming for individual counselling

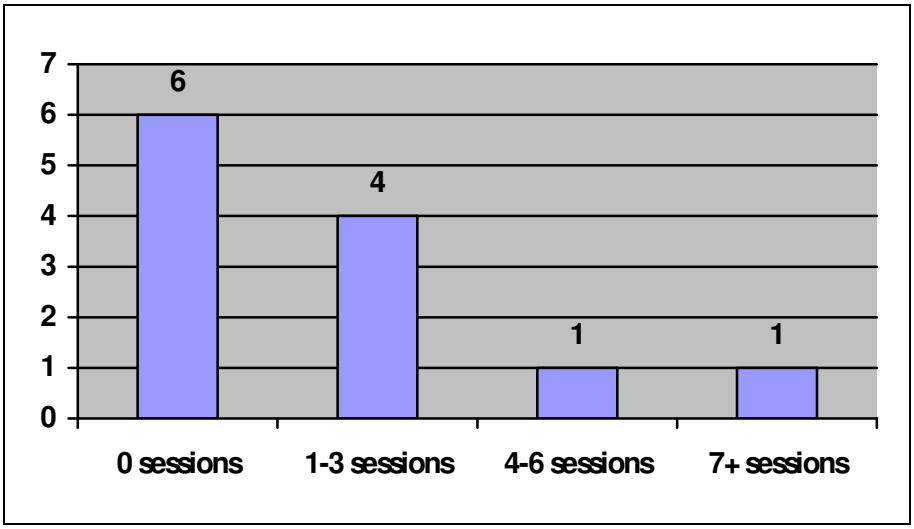

Figure 9 Number of clients dropping out per sessions

As is indicated by the diagram, of the twelve clients who terminated counselling during 2009, 6 (50%) of them had zero sessions, four had one to three sessions, one had between four to six sessions and one had more than seven sessions. The following table indicates the reasons for termination according to the clinician, as well as reasons provided by the client when phoned to ask their reasons for ending their sessions:

Number of individual sessions	Reason for termination provided by clinician	Reason for termination provided by client on follow-up
0	Dropped out after TTP intake: Client did not leave contact details when intake was done (did not have any). Client said that he would contact TTP to give his contact details but has not yet done so. The case will be reopened if he returns.	No contact details available for client
0	Dropped out after TTP intake: The client did not attend his scheduled appointments. Client did not respond to messages that the clinician left on his mobile phone.	Not available on telephone
0	Dropped out after TTP intake: The client did not attend his scheduled appointments. Clinician made several calls to client which were not answered.	Not available on telephone
0	Dropped out after TTP intake: Client found employment and cannot get time off to come for counselling. Several attempts were made to set up an appointment with the client for counselling without success. The case can be re-opened once the client is available for counselling sessions.	No contact details available for client
0	Dropped out after TTP intake: The client never came for first counselling session after intake. She moved to Durban subsequent to her intake. When contacted to find out if she would still be able to attend counselling sessions, she said that she was not sure and promised to contact the Trauma Clinic when she comes back from Durban. This case will remain closed until the client makes contact with the clinic	Client said that she is now working in Randburg and would like to continue counselling.
0	Dropped out after TTP intake: The client did not come to any counselling sessions after the initial session and clinician was unable to get hold of the client on the contact number given.	No answer on telephone
1	Client stopped coming for counselling without giving reason: Client had different / material expectations	Phone number for another person
2	Client wanted psychological report for court case, which clinician could not give within limited time period.	The client had court appointments and could not make the counselling sessions. She said that she would like to continue counselling but will not

		be able to until February after her court appointments are finished. She emphasised that she does not have any problems with the counsellor.
3	Case assigned to MA Clinical student who had to end sessions due to time constraints	Wrong telephone number given
3	Client terminated: The client prematurely decided to terminate the therapeutic relationship. Client mentioned that she was happy the therapist helped her find accommodation and that's all that she wanted.	The client said two different things. The first is that she came for counselling, but it did not help her because she has no money or support, and without the money and support, the counselling does not help. The second is that the counsellor terminated because he said that he could no longer help her. The client said that she would like to continue counselling.
6	Mutual agreement that counselling has been successful	Phone number for another person. Have left messages for her to phone back
9	Mutual agreement that counselling has been successful: The client seemed to be coping well in relation to adjustment and safety issues. These were the main presenting problems at beginning of his counselling process. He is an indirect torture victim and he never seemed interested in focusing on anything related his torture experience. He indicated that he would gladly come back to the Trauma clinic should he experience any emotional problems.	The client said that he would consider continuing counselling at a later stage

Table 24 Reason for drop-outs for 2009

COMPLIANCE REPORT FOR 2009

A key objective for the M&E project is to develop and implement strategies to increase compliance in terms of the M&E system. Ensuring that all data is obtained when required is an important part as this increases the amount of information available for analysis. For 2009 our target was to achieve a 60% compliance rate for all instruments required as part of the M&E system.

After going through a general TTP intake, a client has one session with his/her counsellor in order to contain the client, after which an M&E intake is done. Every six sessions, the client should do an assessment to assess his/her improvement in functioning or reduction in symptoms. When the client terminates counselling (drops out), the clinician should complete a Termination Intervention Process Note. This report indicates what the compliance was per instrument for 2009.

1) Overall compliance
   The average amount of data gathered over all instruments is 62%. This amount includes data that was gathered but later decided that it fell outside acceptable time-frames.

2) Compliance per instrument

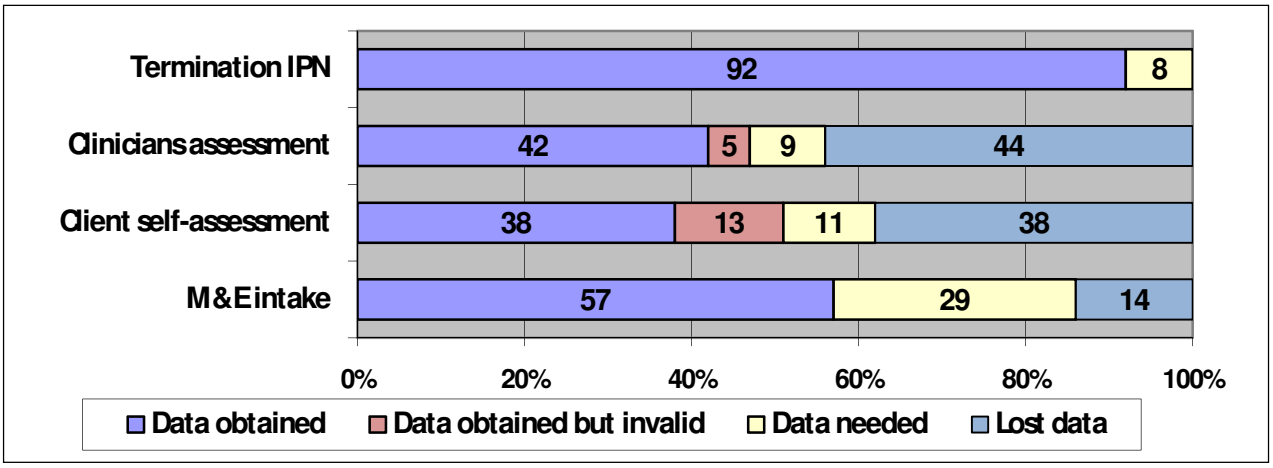

Figure 10 M&E compliance rates (%) per instrument for 2009

a) M&E intake
   As mentioned above, a client should have one session with his/her counsellor before having an M&E intake. If the client has not completed this assessment within 3 sessions, it is considered “lost” since his/her functioning and symptoms may have been impacted on by the counselling process. In 2009, our overall compliance for the M&E intake indicated that 57% of intakes have been completed. 29% of intakes can still be done

within the session time-frame and are not yet lost, and 14% of intakes have been lost (see figure above).

b) Client self-assessment
After completing an M&E intake, the client has six sessions with his/her counsellor. After the sixth session, the client completes his/her first self-assessment. Every six sessions after that, the client completes another self-assessment. If the client has not completed a self-assessment within one session before his/her sixth session (i.e. fifth session) or two sessions after his/her sixth session (i.e. seventh or eighth session) that data is considered "lost". This also applies to clients who complete a self-assessment outside of these sessions (i.e. before the fifth session or after the eighth session). During 2009, our overall compliance for the client self-assessments indicated that 38% of all client assessments were done within the specific session time-frames, 13% were done but outside the time frames (therefore invalid), 11% can still be done within the session time frames and are not yet lost, and 38% of all client self assessments are lost (see figure above).

c) Clinicians' assessment
At the same time that a client completes his/her self assessment, the clinician completes a clinicians' assessment. The same time frames that are employed for the client self-assessment apply to the clinicians assessment (i.e. the clinician must complete the assessment within five to eight sessions). During 2009, our overall compliance for the clinicians assessments indicated that 42% of all client assessments were done within the specific session time-frames, 5% were done but outside the time frames (therefore invalid), 9% can still be done within the session time frames and are not yet lost, and 44% of all client self assessments are lost (see figure above).

d) Termination Intervention Process Notes
After a client drops out or terminates the sessions with his/her counsellor, the counsellor completes a Termination IPN. There is no lost data for this information since there are no deadlines for it. During 2009, 92% of terminations were completed, and 8% are outstanding (see figure above).

CONCLUSION

This report is an important display of what information can be obtained from an M&E system developed for therapeutic work. The information produced can be used not only to influence an individual case but to influence clinical systems and procedures. By learning more about who we see, for how long, why they leave, and how clients may or may not be impacted over time we can improve how and what we do. It is also the type of information that other organisations may find useful for their work. We look forward to another year of learning and transforming TTP into an even more reflective organisation.