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
January-June 2010

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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. It also allows us to gather data on victims of torture within our context.

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. It is the second report of its kind as a 2009 report has already been produced. **This report looks at January to June 2010 and describes the group of torture clients who received counselling services during this period**; details the characteristics of clients who completed an Intake Assessment in 2010; provides baseline data in terms of the impact that our services have had on clients; provides examples of individual Client Progress Reports produced in 2010; 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 important partners in this endeavour. The “M&E team” who work hard to ensure the implementation of this project is comprised of Monica Bandeira, Dominique Dix-Peek, and Tsamme Mfundisi. Monica Bandeira manages the project and assists with analysis and knowledge generation from the data obtained. Dominique Dix-Peek is the main researcher involved in the project and ensures its implementation and that data is collected, cleaned and analysed. Tsamme Mfundisi ensures that data is captured, checked and cleaned and participates in some of the analysis. 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 contributed 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 Kirsty Hunter and Caleb Cheza. 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. Gaudence Uwiyeze and Francoise Bigirindavyi 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, Malose Langa, Jabu Masitha, and Nonhlanhla Mngomezulu. Boitumelo Kekana, our clinical coordinator, partners with us to ensure synergy between M&E and clinical systems and procedures. Logistical support for several activities related to M&E has been provided by Melissa Harry, an important part of any project. Implementing the project was dependent on the support, encouragement 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 and others in their journey towards recovery.

TORTURE CLIENTS WHO HAVE RECEIVED PSYCHOSOCIAL SERVICES AT TTP IN 2010

One of the key objectives for the M&E project is to reach a target of 100 clients in 2010. From January to June 2010, 62 clients were seen at TTP. A description of the torture clients seen between January to June 2010 follows.

1) Demographics

   The largest nationality population (33%) are Congolese (from the Democratic Republic of Congo), while Zimbabweans and South Africans make up the next largest populations (23% and 11% respectively). The pie chart below represents the people who received psychosocial services at TTP in 2010 by nationality. "Other" includes one person from each of the following countries: Ethiopia, Rwanda and Sudan.

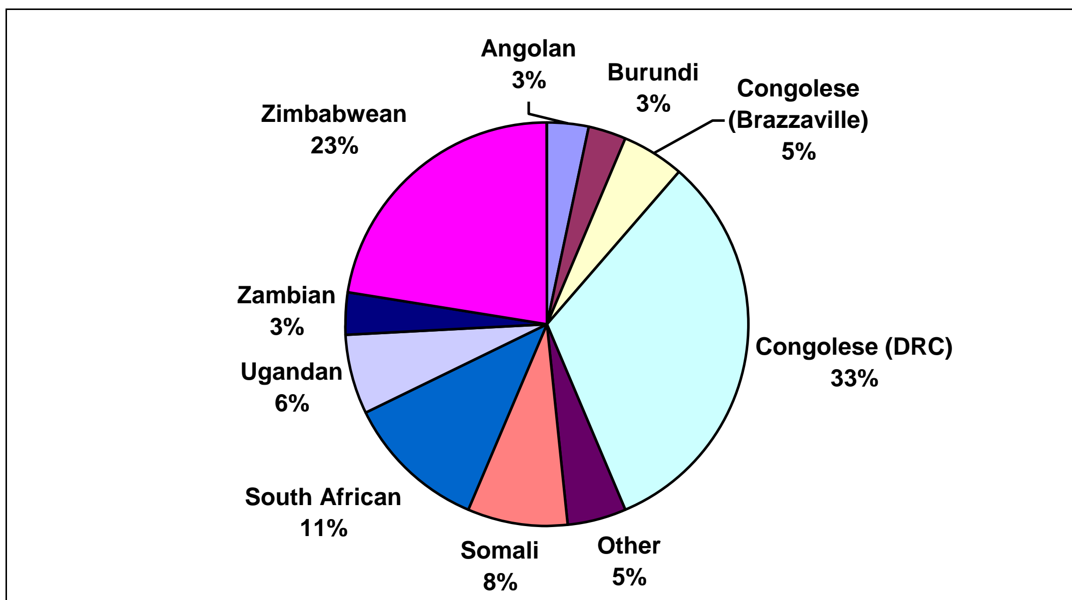


Figure 1: Nationality of clients receiving psychosocial services at TTP

63% of clients who received psychosocial services at TTP from January to June 2010 were women, while 37% were men. The youngest client was 11 years of age, while the oldest was 64. 44% of clients were between the ages of 19 and 38. The mean age for the sample was 36 with a standard deviation of 11.06.

Of the clients seen in 2010, 49 (79%) were direct victims of torture, 9 (15%) were indirect victims, and 4 (6%) were both (as reported by the clinicians). There were a total number of 298 sessions conducted with torture victims in from January to July 2010, with a maximum number of sessions of 22 and an average of 5.7 sessions. The figure below provides a more detailed breakdown of this.

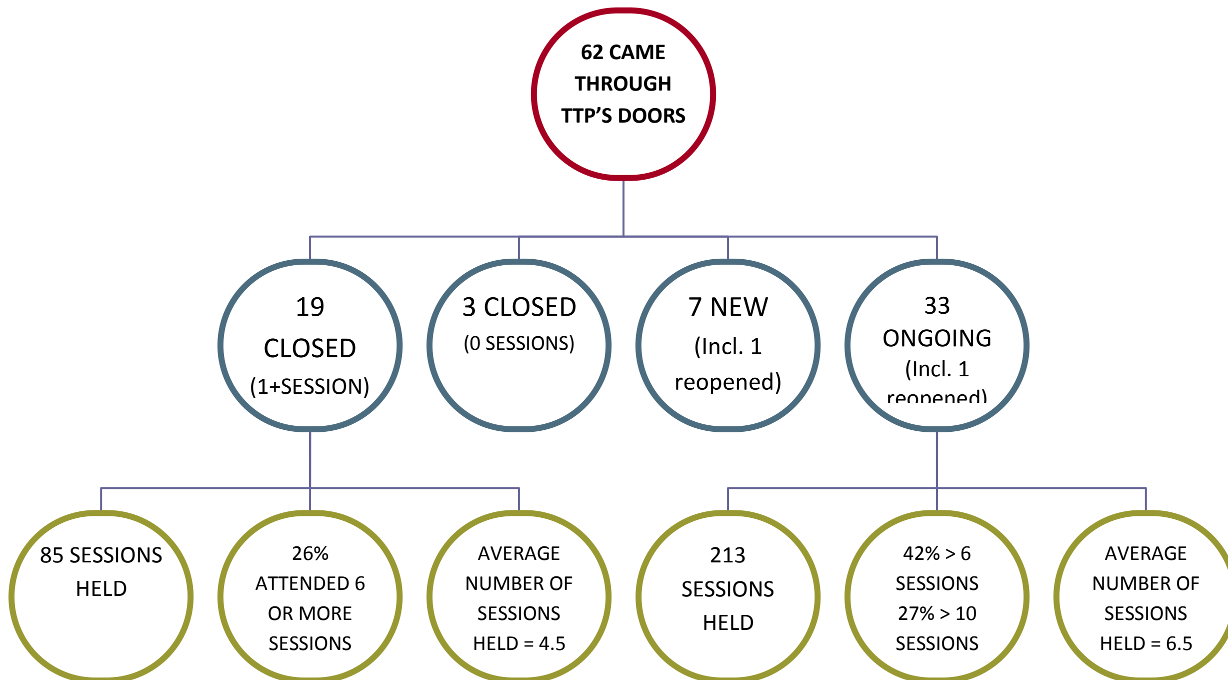


Figure 2: Breakdown of sessions per type of client

2) <u>Traumatic events experienced by clients</u>
Our sample of torture clients experienced an average of two traumatic events each (standard deviation = 1.14) with a total number of traumatic events of 120. Notwithstanding the torture experience, the most reported traumatic events were: assault, rape, war and bereavement. The maximum number of type of traumatic event was six, and the minimum one. The table below indicates the types of traumatic events experienced by the clients at TTP.

Type of Traumatic event	Number	Percentage of people who experienced:
Torture	62	100%
Assault	14	23%
Rape	12	19%
War	10	16%
Bereavement	10	16%
Armed Robbery	5	8%
Xenophobic attacks	3	5%
Witness to trauma	1	2%
Mugging	1	2%
Relationship violence	1	2%
Hostage	1	2%
Total	**120**	

Table 1: Types of traumatic events experienced by torture clients at TTP

3) <u>Types of traumas experienced by clients</u>
Clients were affected by seven types of trauma (as identified by clinicians). There was an average of 1.1 types of trauma per client with a standard deviation of 0.32. The types of traumas most reported by clinicians were continuous trauma followed by multiple traumas and complex traumas (see table below).

Type of trauma	Number	Percentage
Continuous	31	52%
Multiple	9	15%
Complex	9	15%
Once-off	8	13%
Man made	1	2%
Vicarious	1	2%
Secondary	1	2%
Total	**60**	**100%**

Table 2: Types of traumatic events experienced by torture clients at TTP

4) <u>Reaching our target number</u>
When checking whether we will be able to reach our target of 100 clients we need to look at how many clients have been carried over from 2009 since this will influence the how many new clients we need during the year. Of the 62 clients who were seen in 2010, 39 are clients that were carried over from 2009. Factoring this in, we will need to see an additional 61 clients above the 39 carried over from 2009. In order to achieve this, we need to see 6.1 new clients every month (excluding January and December since these months are considered slow at TTP). See the figure below.

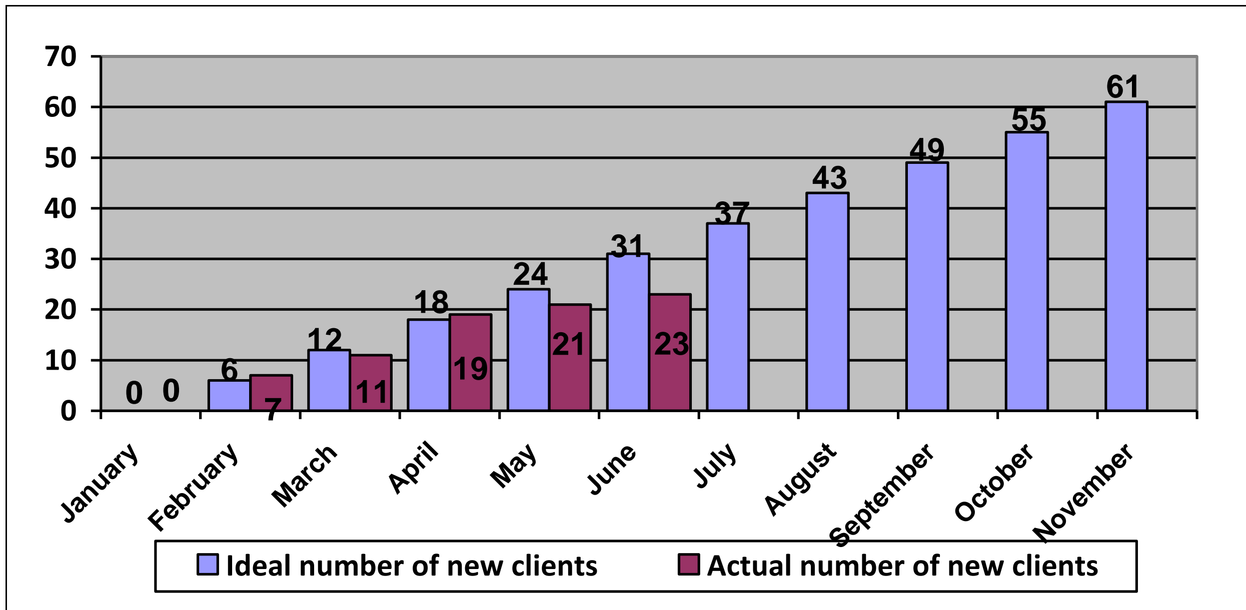


Figure 3: Number of clients who have received psychosocial services at TTP

From January to June, we have seen 23 new clients, while we should have seen 30.5. The difference between the objective and what has been achieved can be attributed to contextual factors (such as the comparative stability within the Zimbabwean borders over the course of 2009 and 2010 or the xenophobic violence in 2008, both of which could have contributed to a decrease in the numbers of Zimbabweans entering the country) and staff capacity.

INTAKE DATA REPORT FROM JANUARY TO JUNE 2010

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 we generate is important to improve 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 from January to June 2010. The report includes new clients from 2010 as well as three clients who had a TTP intake late in 2010 and only completed their intake in 2010. It does not include clients who did not complete an M&E intake in the defined period, or clients who were carried over from 2009.

The report looks at the 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 12 clients were included in the sample. Of these, 10 (83%) were referred to TTP by an external person or organization while 2 (17%) were self-referred. Clients came from five different countries with most clients coming from Zimbabwe and the Congo (Figure **4**).

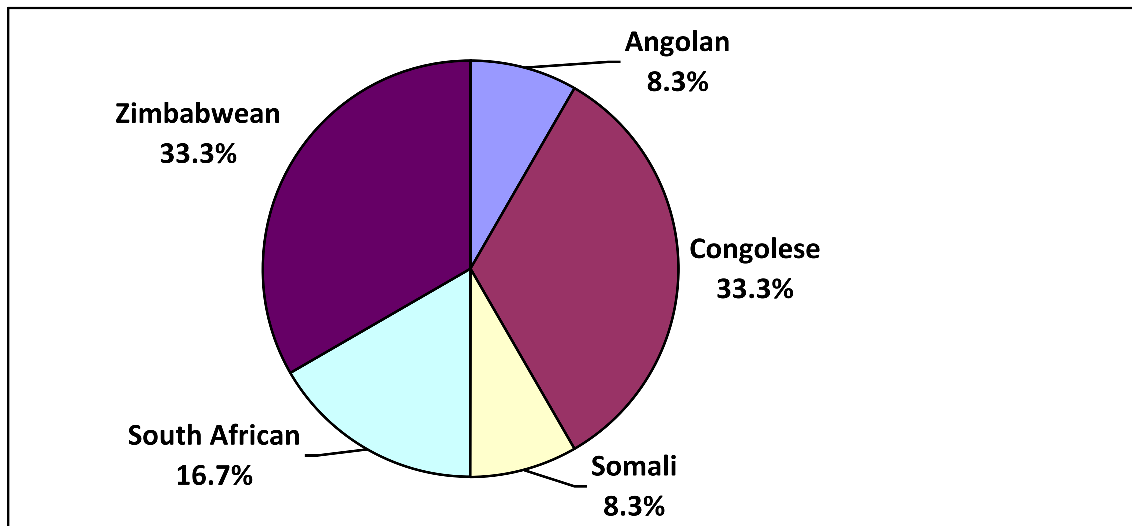


Figure 4: Nationality for M&E intakes from January - June 2010

The sample includes seven women (58%) and five men (42%). The oldest client was 44 years of age while the youngest was 30 at the time of intake. The mean age for the sample was 37 with a standard deviation of 5.77.

One third of the clients (33.3%) reported being married at the time of intake, while a further 33.3% reported being widowed. 16.7% had never been married at the time of intake and 16.7% reported being separated (table below).

Marital Status	**Frequency**	**Percent**
Currently Married	4	33.30%
Never Married	2	16.70%
Separated	2	16.70%
Widowed	4	33.30%
Total	12	100.00%

Table 3: Marital Status for Intakes in 2010

Most clients (58%) were living with their family (which includes living alone with their children). Others were living in a shelter (8%); with their partner/spouse (8%) or with strangers (25%). One quarter of clients had no children at the time of intake. However, many of the clients (42%) had four children at the time of intake. Two clients (17%) had one to two children, while two clients (17%) had five or more children. The mean number of children was 3 with a standard deviation of 2.27.

Before the torture experience, 50% of the clients were employed within semi-skilled, skilled or highly skilled jobs. However, at the time of intake most (50%) were unemployed (table below).

	Pre-torture employment	**Current employment**
Highly skilled/professional	17%	
Semi-skilled	25%	33%
Skilled	8%	
Student	17%	
Unemployed	17%	50%
Unskilled labour	17%	17%
Total	**100%**	**100%**

Table 4: Changes in employment status linked to torture for Intakes in 2010

2) Psychiatric Considerations

For our sample, the mean HTQ: Total Score was 112.5, (standard deviation = 21.29). The mean Self-Perception of Functioning Score for our sample was 2.75 (standard deviation =0.62). The group presented with a mean score of 2.91 for PTSD (standard deviation= 0.47), with 10 people (83%) being checklist positive for PTSD.

The results for this group in terms of anxiety and depression (n=54) are represented in the following table:

	Anxiety	**Depression**
Normal	8%	8%
Borderline	8%	17%
Clinical	83%	75%
Total	**100%**	**100%**

Table 5: Hospital Anxiety and Depression Scale scores for Intakes in 2010

3) Impact of environment (ICF indicators)
When asked about the impact of authority figures on their recovery (n=11) seven clients (58%) reported that authority figures slow down recovery (a little or a great deal). Five (55%) of our sample reported some form of harassment from the police while two people (18%) reported harassment from the Department of Home Affairs (the Government department responsible for approving refugee status). Five people (55%) reported that health professionals support their recovery a little or a great deal (n=9), and six people (60%) reported that family members support their recovery a little or a great deal (n=10).

When asked questions regarding functioning, the following answers were forthcoming (n=9):

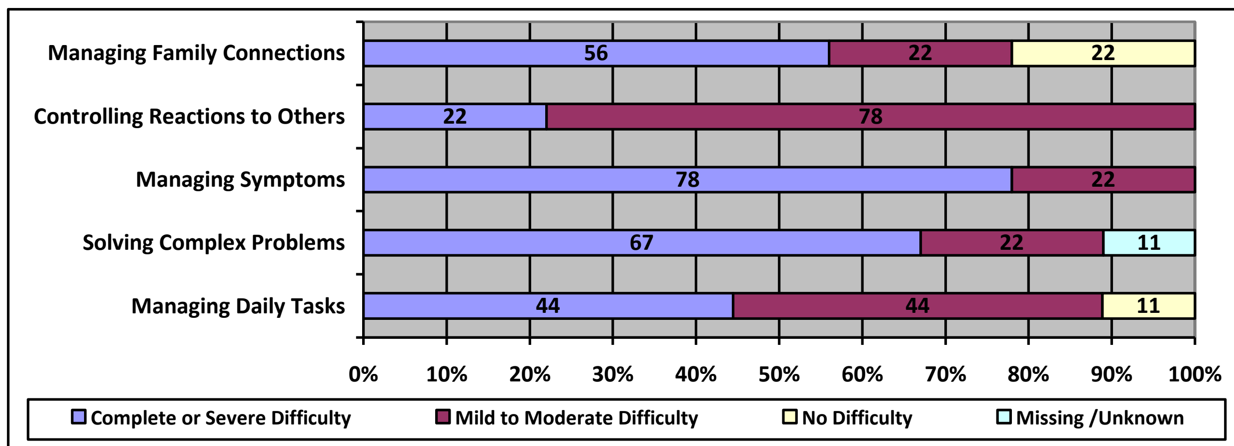


Figure 5: Key dimensions of functioning for intakes January-June 2010

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. 10 clients (83%) reported suffering from at least one medical condition. A broad range of medical conditions were reported including: neck and head aches, chest and side pains, lower extremity pains, high blood pressure and heart palpitations, loss of appetite, insomnia and bipolar disorder. 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
Difficulties in the neck or head area (including headaches, and ear or neck problems)	3	3
Pains/problems in the back, ribs, or abdominal areas	2	1
Pains in feet or legs	2	2
High blood pressure	4	3
Insomnia	1	1
Other	1	1
Total	**13**	**11**
Total %	**100%**	**84%**

Table 6: Categories of medical conditions reported for Intakes in 2010

8 people (67%) reported suffering from a disability, 75% of whom reported that it was due to the torture they experienced. Five clients (42%) reported a disability in the head or neck region.

All of the clients in the sample reported experiencing some form of pain. Of the 23 incidences of pain reported, 16 (70%) 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	3	1
Upper Extremity	2	2
Genital Pain	1	1
Abdomen	3	2
Chest Pain	1	1
Lower Extremity	6	5
Head and Neck	6	4
Generalised Pain	1	0
Total	**23**	**16**
Total %	**100%**	**70%**

Table 7: Areas affected by pain

Despite the high incidence of medical conditions, disability and pain reported by the sample, only two 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 75% of clients saying they do not use any of these substances.

BASELINE IMPACT DATA REPORT FOR JAN – JUN 2010

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 (in 2009) was obtained for 21 clients who completed an Intake and a first assessment (done between sessions 6-8) and 14 clients who completed an intake and a second assessment (done between sessions 12-14). These client groups were discussed in the 2009 report. In order to check that there has been progress towards a 50% increase in clients showing improvement it is necessary to compare the same group used in the baseline, namely clients who have completed an intake and a 1st or second assessment in 2010. Unfortunately, due to difficulties with compliance we have only been able to obtain an intake and a first assessment for two clients within this period.

Given this, below follows a description of these two clients and their progress, which is in line with the progress of the baseline group in terms of improvement. At this stage, however, it is difficult to assess our progress in terms of our target. Besides this group, data was obtained on 11 clients who have received counselling during this year and have completed at least one assessment this year. Below we have analysed the information from this group of individuals. This analysis provides new insight into progress of clients who are at different points of counselling. The 2010 report will hopefully have more information available to analyse and compare to the baseline data.

Impact data for clients with an Intake and a first assessment (n=2)

There were six clients who should have had both an intake and a first assessment from 2010. However, only two of these clients had completed both an intake and client self assessment. The following provides the data for this sample of torture survivors.

1) Demographic information

   Both clients are women, one of whom came from Zimbabwe and the other from Angola. Both clients are in their forties with the mean age for the group being 42.

   At the time of intake, one of the clients was widowed and the other separated. Both of them were living with their family (which could include living alone with their children). One client was employed in semi-skilled labour before the torture experience, and the other was unemployed. However, at the time of intake both clients were unemployed. Both clients had completed their primary school education.

	Pre-Torture Employment (n)	Current Employment (n)
Semi-skilled	1	0
Unemployed	1	2
Total	**2**	**2**

Table 8: Changes in employment status linked to torture of clients with intake and first assessment

2) <u>Service providers' impact on recovery</u>
   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, both clients reported an improvement in the impact of these groups on their recovery. Family members show the most positive impact on the recovery of clients from the time of intake to the time of the first client self-assessment.

	No. of people who reported more positive impact	No. of people who reported impact as staying the same	No. of people who reported more negative impact	n
Authority figures impact on recovery	1		1	2
Health professionals impact on recovery	1	1		2
Family members impact on recovery	2			2
Totals	**4**	**1**	**1**	

Table 9 Changes of impact of different groups on recovery of clients with Intake and first assessment

3) <u>Mental health measures</u>
   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. Both clients showed a decrease in scores across all mental health measures.

   At Intake both clients scored above the cut-off of 2.5 for PTSD. At first assessment, while both clients continued to score above the cut-off for PTSD, both of their scores were

lower. The mean PTSD scores at time of intake were 3.41 and at the first client self-assessment the mean score decreased to 2.91.

Overall, improvements were seen on the Total Score, PTSD and Self-perception of Functioning scores (see table below)

	No. of people whose scores decreased	**No. of people whose scores stayed the same**	**No. of people whose scores increased**	**n**
HTQ total score (trauma)	2			2
PTSD score	2			2
Self-perception of Functioning score	2			2

Table 10 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. One client indicated improvement from the time of intake to the time of the first client self assessment, while the other client's scores increased (indicating a rise in the client's perception of her own anxiety). Both clients could be considered at clinical levels of anxiety at the time of intake and first client self-assessment, however, the anxiety scores decreased for both clients. The mean score for anxiety at intake was 17.5, while the mean score for anxiety at the first client self-assessment was 13.

The depression scores showed that while both clients were at clinical levels for depression at the time of intake, both of them were borderline at the time of the first assessment. The mean scores for depression at time of intake were 16 and at the time of the first client self-assessment this decreased to 9 (table below).

	Intake	**First assessment**
Normal		
Borderline		2
Clinical	2	
Total	**2**	**2**

Table 11 Depression scores 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. One client did not report on the functioning indicators at time of intake and so it is not possible to view change from intake to first assessment. The second client indicated an increase in functioning in terms of solving complex problems and managing her symptoms. She indicated no change in terms of

managing daily tasks, controlling her reactions to others or her family connections from the intake to the first assessment.

Impact data for clients who received counselling and have at least one assessment this year (n=11)

The following analysis is of clients who have received sessions this year and have had at least one assessment this year. This assessment was compared to an earlier assessment done for the client, which may have happened at intake, last year or this year. The two new clients included in the analysis above have been excluded from this group. Although it is useful to make the following analysis for this client group it should be kept in mind that this is not a homogenous group as the number of sessions clients in this group have attended range from 12 to 66. The average number of sessions attended by this group at the time of the follow-up assessment is 31. Therefore, these clients have not been assessed at the same or similar points in their therapeutic treatment. This analysis, however, does provide information on clients who are in longer-term therapy, adding to our existing knowledge of this previously un-assessed group.

1) <u>Demographic information</u>
   Clients came from five different countries with the majority coming from the Congo, followed by Zimbabweans and Rwandans (figure below).

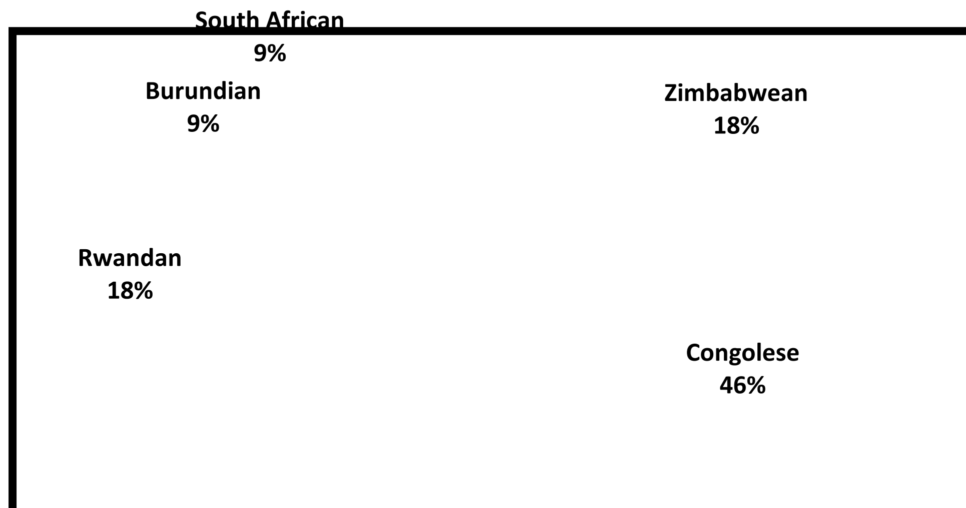


Figure 6: Nationality of clients with counselling and an assessment in 2010

Nine women (82%) and two men (18%) 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 37.

We were able to gather information on marital status, living conditions, educational level, and pre-torture employment for eight of these eleven clients. 36% of the total sample were widowed at the time of intake (see table below).

Marital Status	Frequency	%
Never Married	3	27%
Divorced	1	10%
Widowed	4	36%
Missing	3	27%
Total	**11**	**100%**

Table 12: Marital Status of clients with counselling and an assessment in 2010

Most clients (55%) were living with their family (which could include living alone with their children). Others were living with friends (10%) or in a shelter (10%).

In terms of educational level, 27% had a tertiary level education (see table below).

Educational Level	Frequency	%
Some Primary	1	10%
Completed Primary	2	18%
Completed Secondary	2	18%
Tertiary	3	27%
Missing	3	27%
Total	**11**	**100%**

Table 13: Educational Level of clients with counselling and an assessment in 2010

Before the torture experience, 28% of clients were employed within skilled or highly skilled jobs; 18% were unemployed and 18% were students. However, at the time of intake the majority (82%) were unemployed or employed in unskilled jobs (table below).

	Pre-Torture Employment	Current Employment
Highly skilled/professional	18%	0%
Semi-skilled	9%	0%
Skilled	0%	0%
Student	18%	9%
Unskilled labour	9%	18%
Unemployed	18%	64%
Missing	28%	9%
Total (n=11)	**100%**	**100%**

Table 14: Changes in employment status linked to torture of clients with counselling and an assessment in 2010

2) <u>Service providers' impact on recovery</u>
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 23% of clients reported an improvement in the impact of these groups on their recovery, 50% reported their impact remaining the same, while 27% reported that the impact on their recovery of these groups has worsened. Authority figures' and health professionals' impact on recovery showed the worse results with 30% of clients reporting that their recovery is more negatively impacted by these (table below).

	% 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	20%	50%	30%	10
Health professionals impact on recovery	30%	40%	30%	10
Family members impact on recovery	20%	60%	20%	10
Averages	**23%**	**50%**	**27%**	

Table 15 Changes of impact of different groups on recovery of clients with counselling and an assessment in 2010

3) <u>Mental health measures</u>
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, close to half of the clients (47%) showed a decrease in scores across all HTQ measures. However, between 30% and 60% showed an increase in scores.

At both the previous assessment and the one conducted this year 64% scored above the cut-off of 2,5 for PTSD. The box plot below shows a decrease in the range of scores over time.

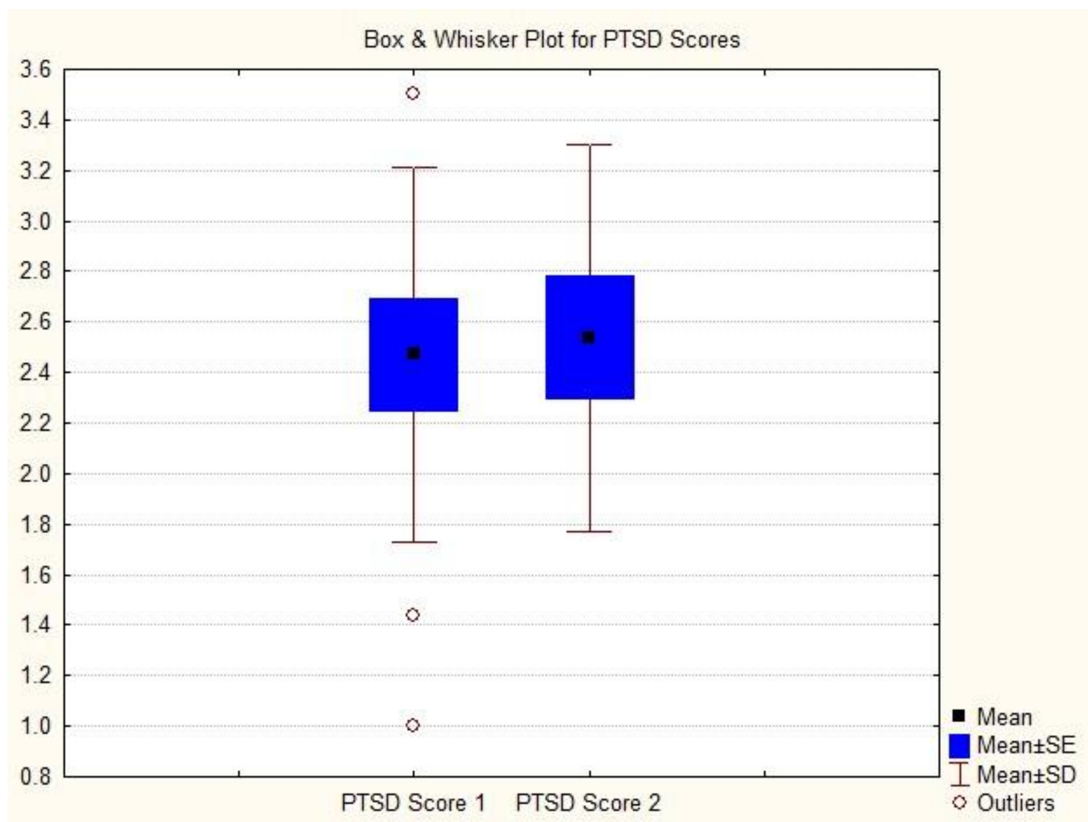


Figure 7: Box plot for PTSD scores for clients with counselling and an assessment in 2010

Overall, improvements were seen on the Total Score (60%) and Self-perception of Functioning scores (50%). Only 30% showed improvement on their PTSD scores (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%	40%	10
PTSD score	30%	10%	60%	10
Self-perception of Functioning score	50%	20%	30%	10
Averages	**47%**	**10%**	**43%**	

Table 16 Changes in scores on the HTQ of clients with counselling and an assessment in 2010

The Hospital Anxiety and Depression Scale (HADS) was used to measure depression and anxiety. Anxiety scores showed a worsening of scores with the percentage of people with clinical anxiety levels going from 60% at an earlier assessment to 70% at latest assessment. There was an increase in the number of borderline cases from 0% to 10%. The percentage of people with normal levels of anxiety decreased from 40% to 20% (table below).

	Earlier assessment	Latest assessment
Normal	40%	20%
Borderline	0%	10%
Clinical	60%	70%
Total	**100%**	**100%**

Table 17 Anxiety scores of clients with counselling and an assessment in 2010

Although improvement along categories is not evident, the average anxiety scores decreased from 10.80 to 10.50. The box plot below shows how the mean and range of anxiety scores from the earlier assessment to the latest assessment had reduced.

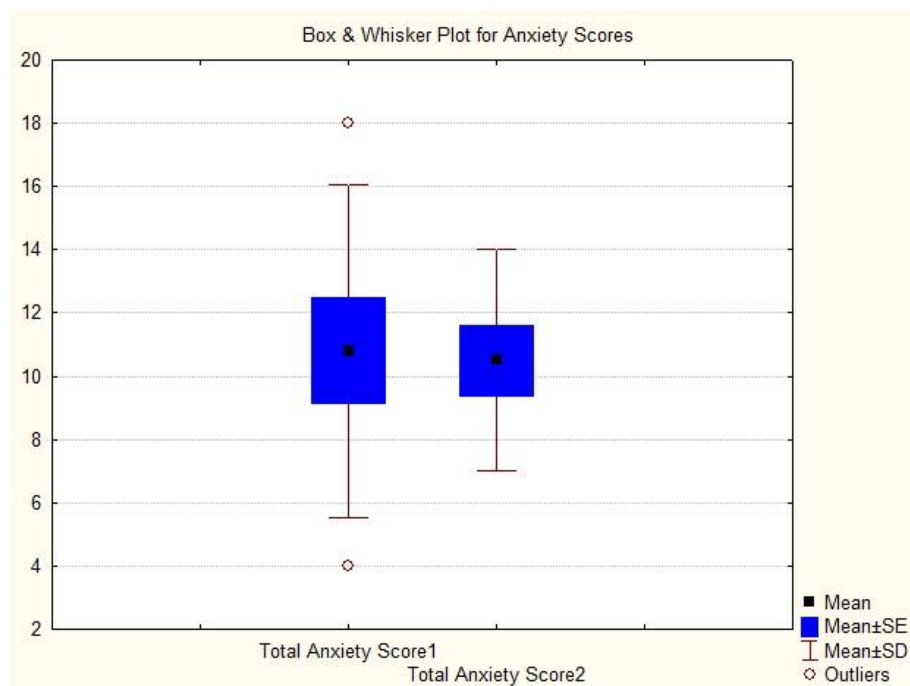


Figure 8 Box plot of Anxiety scores for clients with counselling and an assessment in 2010

Depression scores showed a decrease in the number of people with clinical levels of depression from 50% to 40%. Within the depression scores, there was a decrease in the number of people with normal levels of depression, namely from 20% to 10% (table below).

	Earlier assessment	Latest assessment
Normal	20%	10%
Borderline	30%	50%
Clinical	50%	40%

Total	100%	100%

Table 18 Depression scores of clients with counselling and an assessment in 2010

Overall, the mean depression score at the earlier assessment was 9.9 while at the latest assessment point the mean depression score was 10.40. The box plot below, highlights how the range of score has reduced over time.

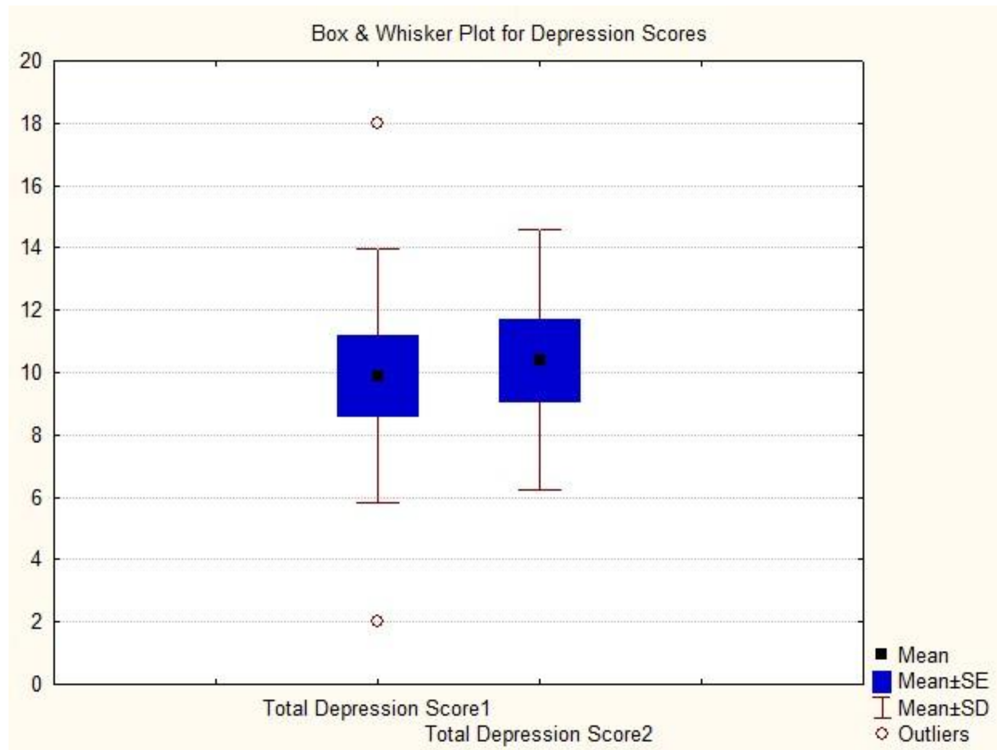


Figure 9 Box plot of Anxiety scores for clients with counselling and an assessment in 2010

Almost half of the clients in this group (45%) showed a decrease in anxiety and depression scores. On the other hand 35% showed an increase in these scores from their previous assessment to their latest one (table below).

	% of people whose scores decreased	**% of people whose scores stayed the same**	**% of people whose scores increased**	**n**
Anxiety	50%	10%	40%	10
Depression	40%	30%	30%	10
Averages	**45%**	**20%**	**35%**	

Table 19 Changes in scores of depression and anxiety of clients with counselling and an assessment in 2010

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 highest number of people showing improvement (36%) was on their ability to manage their symptoms. A number of clients reported increased difficulty in: managing their daily tasks (64%); controlling their reactions to others (50%); solving complex problems (45%); and managing their symptoms (46%). The least number of clients (9%) showed improvement in their ability to manage their daily tasks.

On average, 18% reported an improvement in their functioning, while 45% reported a decrease in functioning and 37% reported no change.

	% of people whose functioning increased	**% of people whose functioning stayed the same**	**% of people whose functioning decreased**	**n**
Solving complex problems	10%	45%	45%	11
Managing daily tasks	9%	27%	64%	11
Managing symptoms	36%	18%	46%	11
Controlling reactions to others	13%	37%	50%	8
Managing family connections	22%	56%	22%	9
Average	**18%**	**37%**	**45%**	

Table 20 Changes in functioning of clients with counselling and an assessment in 2010

CLIENT PROGRESS REPORTS FOR JANUARY TO JUNE 2010

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 2010 was to produce Client Progress Reports (CPRs) which would contain analysis of data obtained from assessments conducted with the clients. CPRs can only be produced once a client has completed two assessments. We set ourselves a target of producing four to six of these in 2010. We have managed to produce 27 CPRs between January and June 2010. These have then been provided to clinicians, who have used the information to reflect on their practice and the progress of the client. While all 27 CPRs are available for viewing, we include only three here as examples of the information being produced.

Client Progress Report 1
Client code: 090510

Data available:

- M&E intake
- 1 Client Self-Assessment

Demographics:

Gender: Female
Nationality: Zimbabwean
Age: 44
Number of children: 7
Number of dependants: 0
Educational level: Completed primary
Pre-torture employment: Semi skilled
Employment at intake: Unemployed

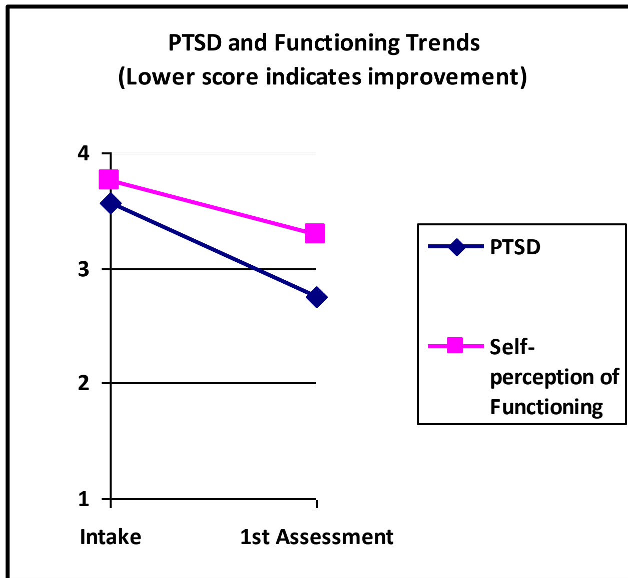
Results:

	Intake	Client Self-Assessment	Progress*
Date done	**29/04/2009**	**29/09/2009**	
Number of sessions completed	-	6	
Authority Figures impact on recovery	Slow down a great deal	Support a great deal	↑
Health professionals impact on recovery	Support a great deal	Support a great deal	→
Family members impact on recovery	Support a little	Support a great deal	↑
Difficulty in solving complex problems	Severe difficulty	Moderate difficulty	↑
Difficulty in completing daily tasks	Moderate difficulty	Moderate difficulty	→
Difficulty in managing symptoms	Complete difficulty	Moderate difficulty	↑
Difficulty in ability to control reactions to others	Complete difficulty	Complete difficulty	→
Difficulty in family connections	Complete difficulty	Complete difficulty	→
PTSD score (> 2.5 = symptomatic for	3.56	2.75	↓

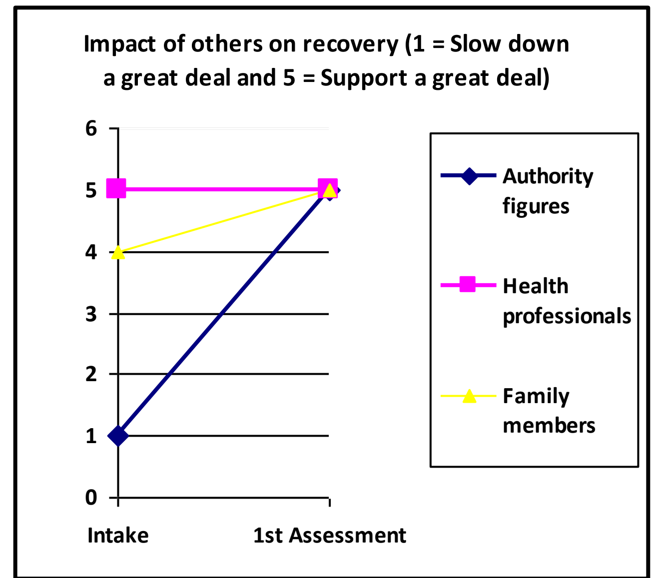
PTSD)			
Self-perception of functioning score (no cut off)	3.75	3.291	↓
Anxiety (0-7 = normal, 8-10 = borderline and 11+ = clinical)	21	11	↓
Depression (0-7 = normal, 8-10 = borderline and 11+ = clinical)	19	8	↓

*** Down indicates improvement**

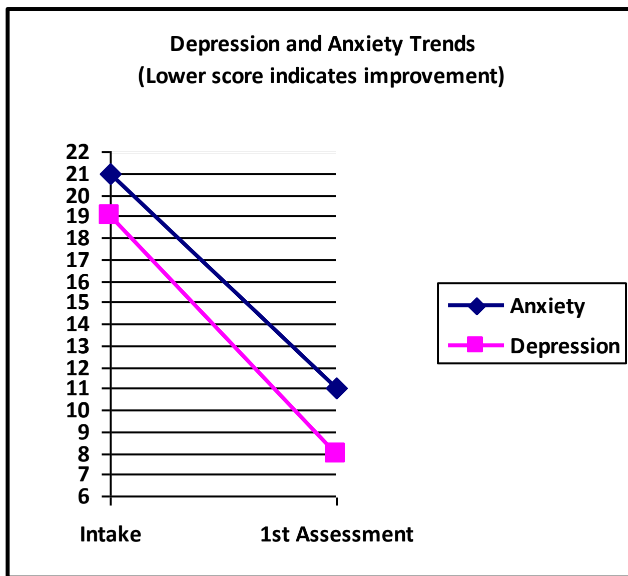
*** Lower score indicates improvement**



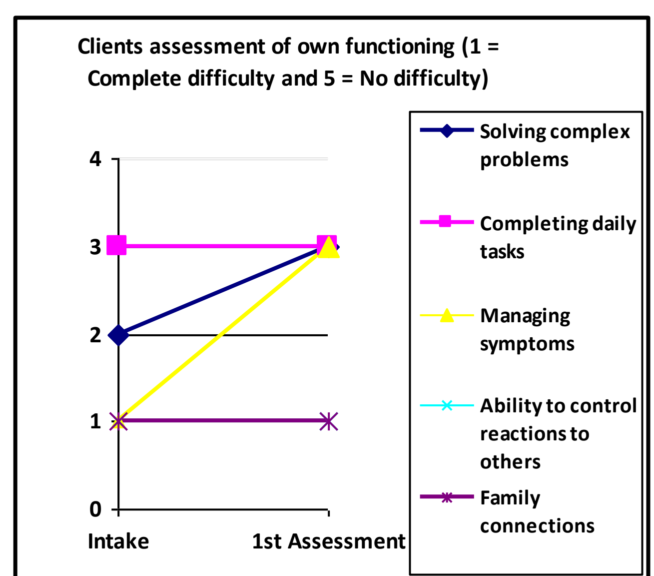
***Higher score indicates improvement**



*** Lower score indicates improvement**



*** Higher score indicates improvement**



Client Progress Report 2
Client code: 130908

Data available:
- Intake
- 3 Client Self-Assessment

Demographics:

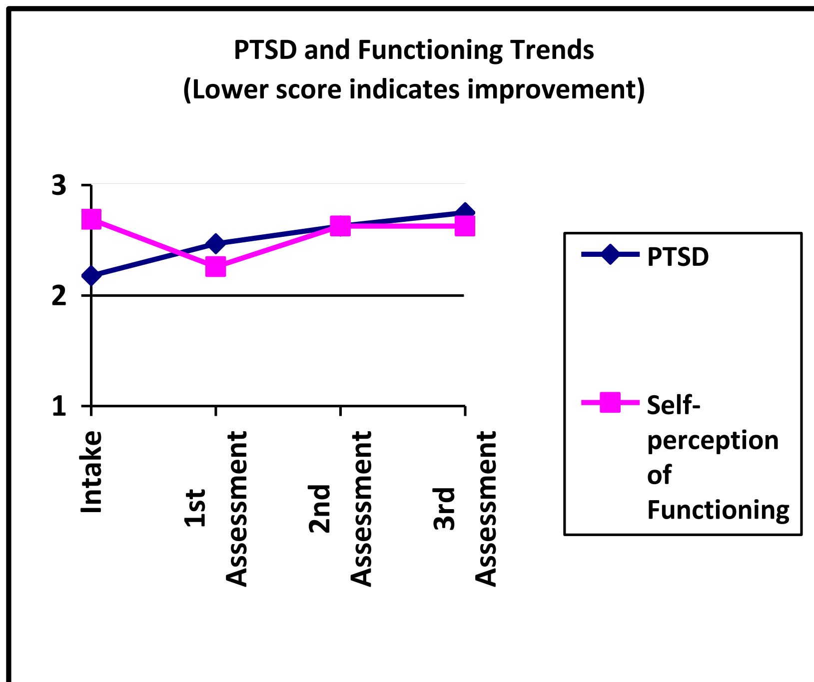
Gender:	Male	Nationality:	South African
Age:	47	Educational level:	Some primary
Number of children:	2	Pre-torture employment:	Student
Number of dependants:	0	Employment at intake:	Unemployed

Results:

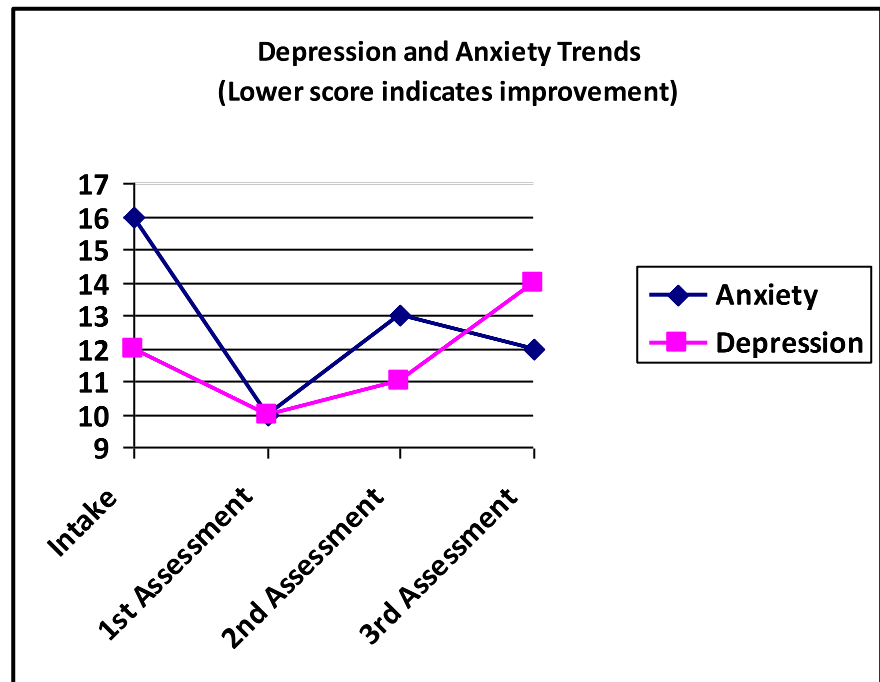
	Intake	**1st Client Self-Assessment**	**2nd Client Self-Assessment**	**3rd Client Self-Assessment**
Date done	**30/09/2008**	**11/12/2008**	**04/12/2009**	**25/05/2010**
Number of sessions completed	-	06	11	18
Authority Figures impact on recovery	Slow down a great deal	Slow down a great deal	Support a little	Slow down a great deal
Health professionals impact on recovery	Support a great deal	Support a little	No impact	Slow down a great deal
Family members impact on recovery	Support a great deal	Slow down a great deal	Support a little	Support a little
Difficulty in solving complex problems	Moderate difficulty	Mild difficulty	Moderate difficulty	Complete difficulty
Difficulty in completing daily tasks	Moderate difficulty	Moderate difficulty	Mild difficulty	Complete difficulty
Difficulty in managing symptoms	-	Moderate difficulty	Moderate difficulty	Severe difficulty
Difficulty in ability to control reactions to others	Complete difficulty	-	Mild difficulty	Moderate difficulty
Difficulty in family connections	Severe difficulty	Moderate difficulty	Mild difficulty	Severe difficulty
PTSD score (> 2.5 = symptomatic for PTSD)	2.18	2.47	2.63	2.75
Self-perception of functioning score (no cut off)	2.69	2.26	2.63	2.63
Anxiety (0-7 = normal, 8-10 = borderline and 11+ = clinical)	16	10	13	12

Depression (0-7 = normal, 8-10 = borderline and 11+ = clinical)	12	10	11	14

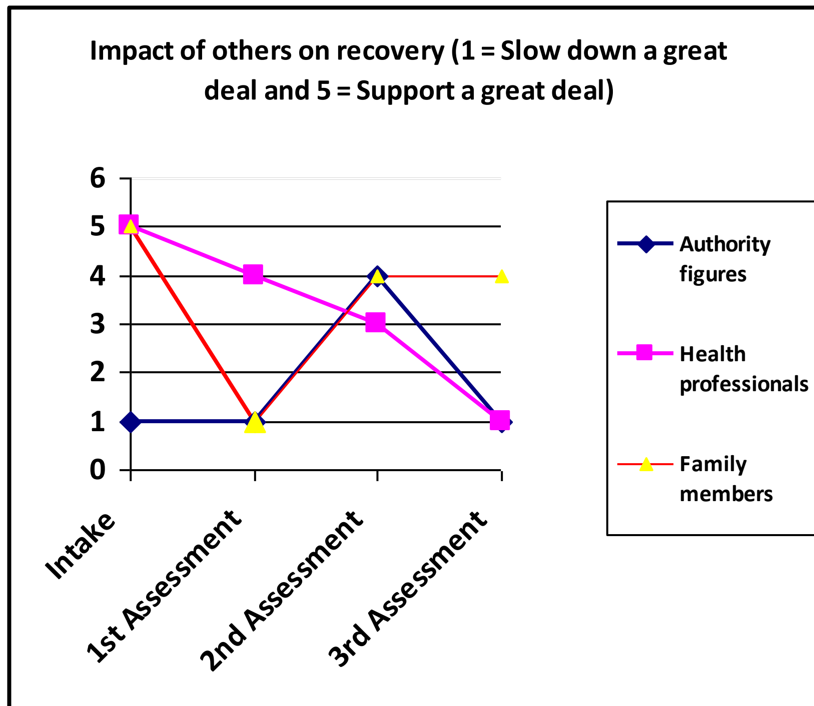
*** Down indicates improvement**

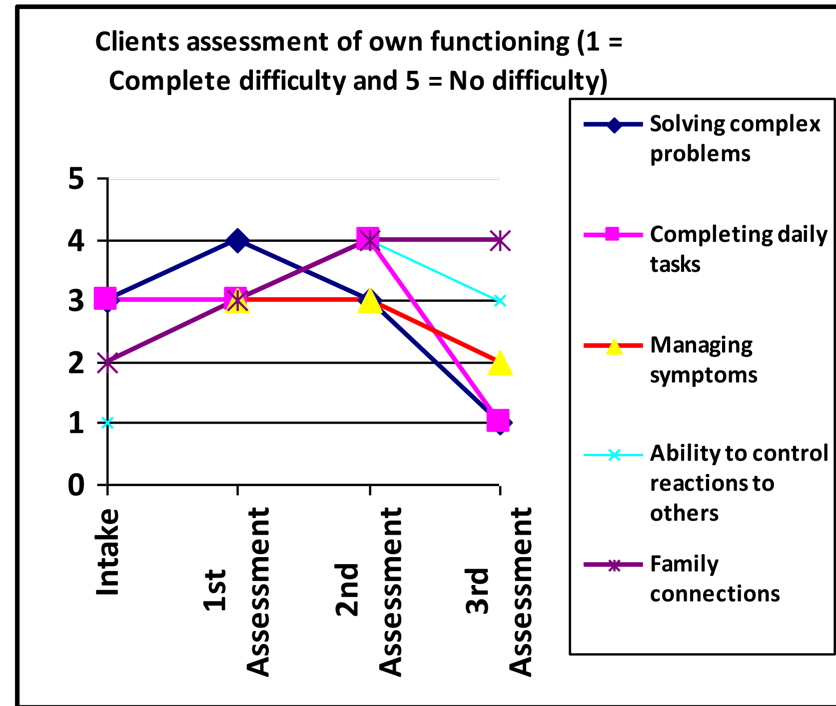


*** Down indicates improvement**



*** Up indicates improvement:**





Client Progress Report 3
Client code: 070909

Data available:

- 6 Client Self-Assessments

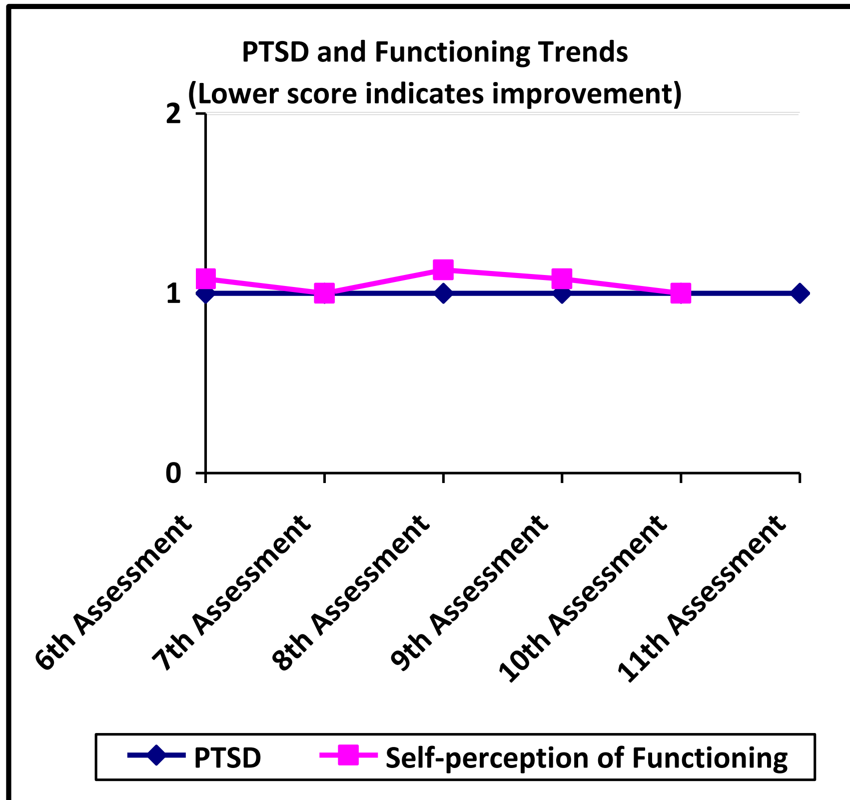
Demographics:

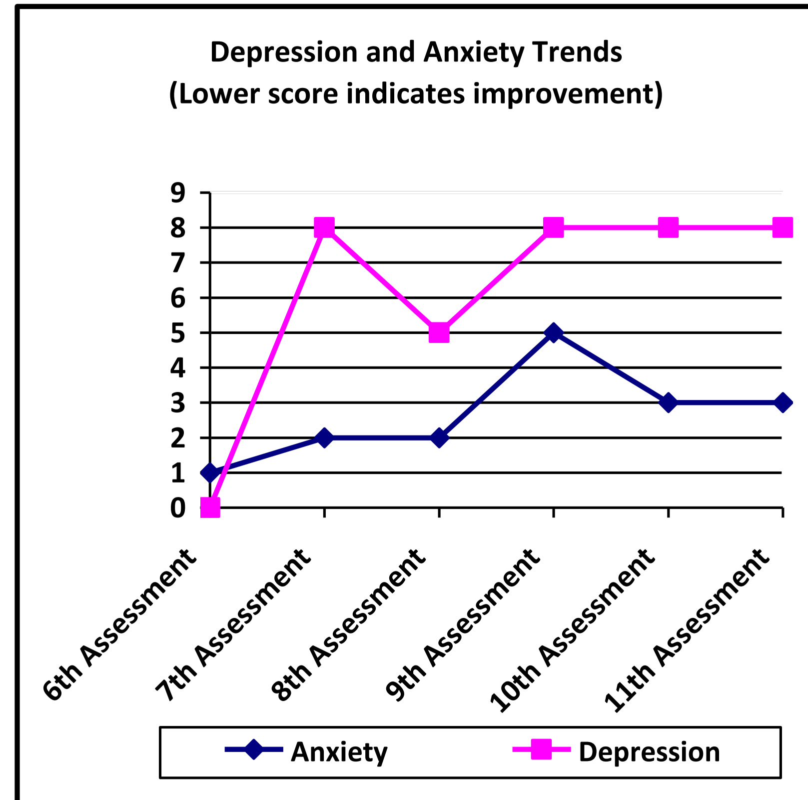
Gender:	Female	Educational level:	Unknown
Nationality:	Congolese (Brazzaville)	Pre-torture employment:	Unknown
Age:	46	Employment at intake:	Unknown
Number of children:	Unknown		
Number of dependants:	Unknown		

Results:

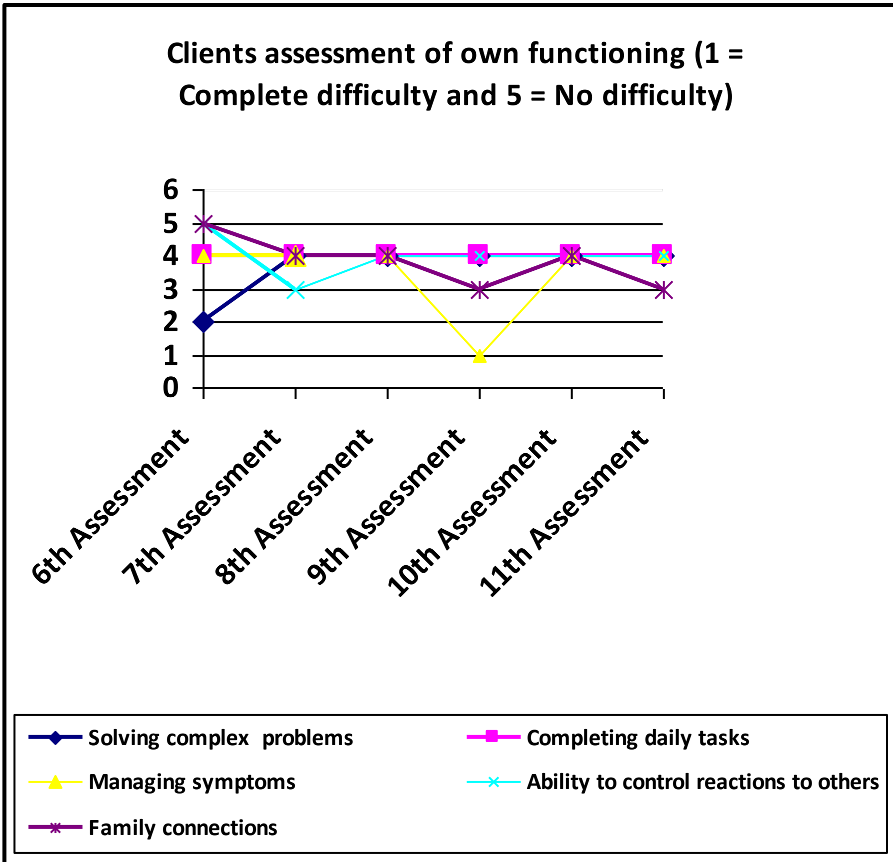
	6th Assessment	**9th Assessment**	**11th Assessment**
Date done	**03/09/2009**	**13/02/2010**	**28/05/2010**
Number of sessions completed	35	54	66
Authority Figures impact on recovery	Slow down a great deal	No impact	No impact
Health professionals impact on recovery	Support a great deal	Support a little	Support a great deal
Family members impact on recovery	Support a great deal	Support a little	Support a little
Difficulty in solving complex problems	Severe difficulty	Mild difficulty	Mild difficulty
Difficulty in completing daily tasks	Mild difficulty	Mild difficulty	Mild difficulty
Difficulty in managing symptoms	Mild difficulty	Complete difficulty	Mild difficulty
Difficulty in ability to control reactions to others	No difficulty	Mild difficulty	Mild difficulty
Difficulty in family connections	No difficulty	Moderate difficulty	Moderate difficulty
PTSD score (> 2.5 = symptomatic for PTSD)	1	1.00	1.00
Self-perception of functioning score (no cut off)	1.08	1.08	-
Anxiety (0-7 = normal, 8-10 = borderline and 11+ = clinical)	1	5	3
Depression (0-7 = normal, 8-10 = borderline and 11+ = clinical)	0	8	8

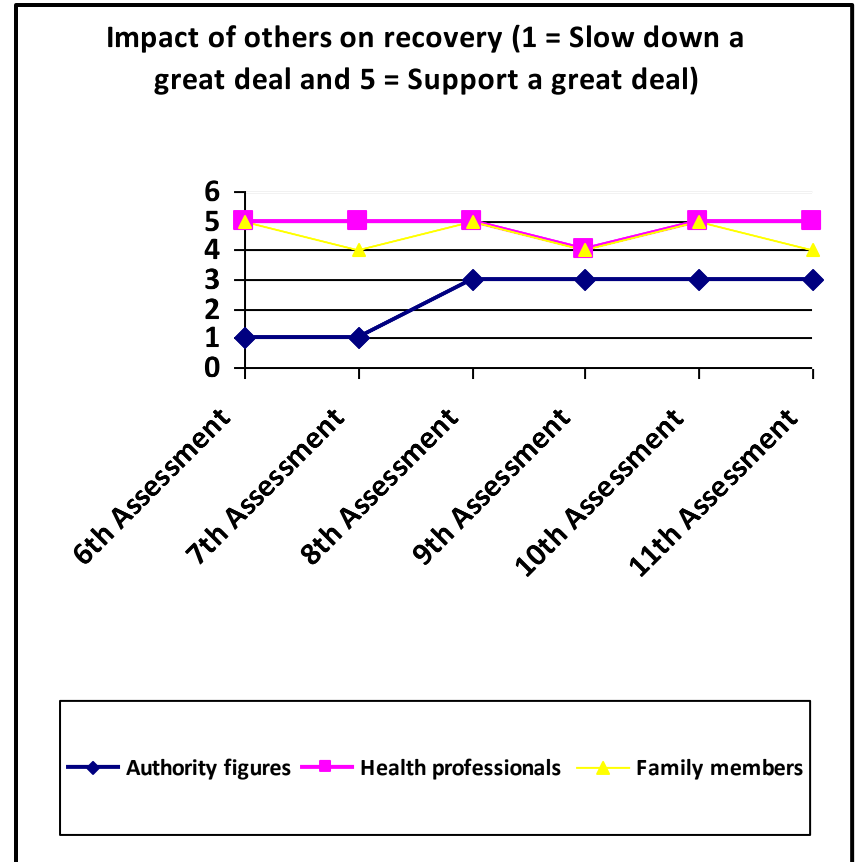
*** Down indicates improvement**





*** Up indicates improvement**





DROP-OUT REPORT FOR M&E FROM JANUARY TO JUNE 2010

Between 2007 and 2008 there was a high number of clients dropping out having had only 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 termination. 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 2010 have been included.

There were 23 new clients who received psychosocial services from TTP in 2010. Of those, seven (30%) clients are considered "new" (i.e. they have had two sessions or less without dropping out), ten (43%) of the clients are considered "ongoing" (i.e. they have had three or more sessions without dropping out), and 6 (26%) cases are "closed". The analysis that follows is for the 6 "closed" cases.

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

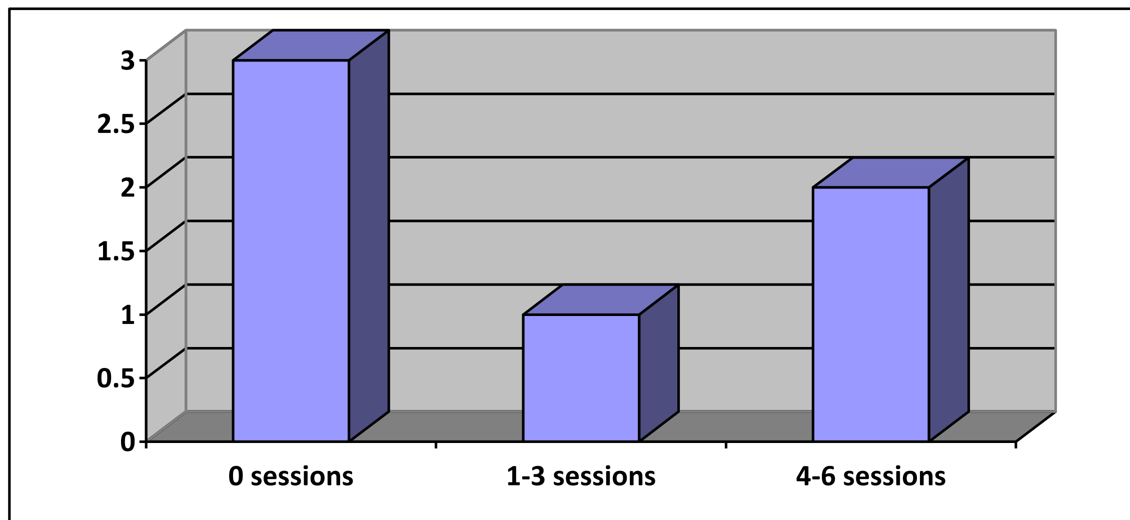


Figure 10: Number of clients who terminated counselling from January - June 2010

As is indicated by the diagram, of the six clients who terminated counselling during 2010, three had not had any counselling sessions, one had one to three sessions and two had between four to six 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:

Total number of individual sessions	Reason for termination (counsellor)	Reason for termination (client)
0	Dropped out after TTP intake: The client never came for his first counselling session despite several contacts made inviting him to honour his appointments.	The client stated that he could not make his first appointment because he was writing exams. He stated that he would like to come back for counselling in the future
0	The clinician has never seen this client and does not have the clients file in his records	The client stated that he was never called after the intake interview
0	The clinician has never seen this client and does not have the clients file in her records	No answer on the telephone
1	Client can no longer attend counselling (e.g. Got a job or moved somewhere)	No answer on the telephone
4	Client stopped coming for counselling without giving a reason	The client said that he stopped coming for counselling because he had difficulties with transport. He also stated that his job shifts had changed and so clashed with counselling. However, he maintained that the service at TTP was excellent and we gave him good advice
5	Client can no longer attend counselling (e.g. Got a job or moved somewhere): moved to Zimbabwe	Phone number given was answered by another person. Client not available on telephone number provided

Table 21: Reason for drop-outs for 2010

COMPLIANCE REPORT FOR JANUARY TO JUNE 2010

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 2010 our target was to achieve a 70% 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 and M&E intake is done. After every session, the clinician should do a counselling Intervention Process Note (IPN) and every six session, the client should do a self-assessment to assess his/her improvement in function 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 from January to June 2010.

1) Overall compliance

   The average amount of data gathered over all instruments is 65%. This amount can be divided according to the amount of data that has been obtained, the amount of data that still can be obtained (data needed) and lost data. Because the termination IPN does not include lost data (see termination IPNs below), this cannot be compared to the other three instruments (intakes, client self-assessments and IPNs). For these three instruments, the average amount of data obtained is 31%. The average amount of lost data for these instruments is 35%. The average amount of data needed is at 34%. The data needed is data that could become either lost or obtained depending on whether or not there is compliance.

2) Compliance per instrument (%)

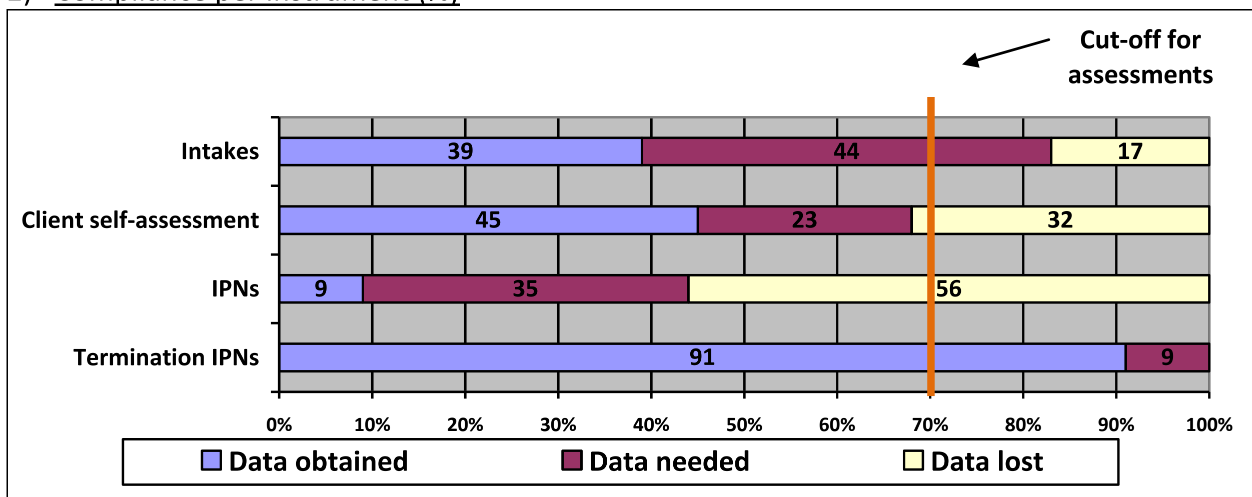


Figure 11: M&E compliance rates (%) per instrument January - June 2010

a) <u>M&E intake</u>
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 should have been impacted on by the counselling process. From January to June in 2010, our overall compliance for the M&E intake indicated that 39% of intakes have been completed. 44% of intakes can still be done within the session timeframe and are not yet lost, and 17% of intakes have been lost (see figure above).

b) <u>Intervention Process Note</u>
After every session, the clinician should complete a counselling intervention process note (IPN). A decision was made that if a clinician did not complete his/her IPNs within three sessions, these IPNs would be considered lost. During 2010, our overall compliance for the IPNs indicated that 9% of IPNs were done within the specific timeframes, 35% can still be done within the session timeframes and are not yet lost, and 56% of all IPNs are lost (see figure above).

c) <u>Client self-assessment</u>
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 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). Between January and June 2010, our overall compliance for the client self-assessments indicates that 45% of all client assessments were done within the specific session time-frames, 23% can still be done within the session time frames and are not yet lost, and 32% of all client self assessments are lost (see figure above).

d) <u>Termination Intervention Process Notes</u>
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 it does not impact on the information gathered regarding the client’s progress. Between January and June 2010, 91% of terminations were completed, and 9% are still outstanding (see figure above).

Compliance to any M&E system is always a challenge. However, when working within a context where few clinicians exist for the number of clients this becomes more difficult. Placing more value on M&E as a way to improve services to clients over seeing more clients is a slow process, but one which we are getting closer to achieving.

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 and contribute to model development. 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 programme.