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 To End December 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 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 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 project. It is the third report of its kind as a 2009 report and a 2010 mid-year report have already been produced. This report looks at 2010 and describes the group of torture clients who received counselling services during this period, although the impact data includes clients up until 2010. After going through a general TTP intake, a client has one session with his/her counsellor in order to provide immediate support and containment, after which a more comprehensive M&E intake is done. After every session, the clinician should complete a counselling Intervention Process Note (IPN) and after every six sessions, the client is asked to complete a self-assessment to assess his/her improvement in function or reduction in symptoms. When counselling ends, the clinician should complete a Termination Intervention Process Note (Termination IPN).

This report uses the information obtained through this system by detailing the characteristics of clients who completed an intake assessment in 2010; providing baseline data in terms of the

impact that our services have had on clients since the beginning of the project; providing examples of individual Client Progress Reports produced in 2010; describing the drop-out rates for the year, including the reason for drop-out; and outlining 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 Pinkey Bahlekazi, our relief receptionist, are usually the first people 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 the 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, Megan Bantjes, 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 was to reach a target of 100 clients who were victims of torture in 2010. From January to December 2010, 102 torture clients were seen at TTP. A description of the torture clients seen between January and December 2010 follows.

1. Demographic information

   The largest nationality population (31%) were Zimbabwean, while Congolese (from the Democratic Republic of Congo) and South Africans made up the next largest populations (29% and 12% respectively). The number of Zimbabwean and South Africans seen were down from 2009, while the Congolese (DRC) sample rose. In 2009, these populations were: 34% Zimbabwean, 22% Congolese (DRC) and 17% South African.

   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: Burundi, Cameroon, and Sudan.

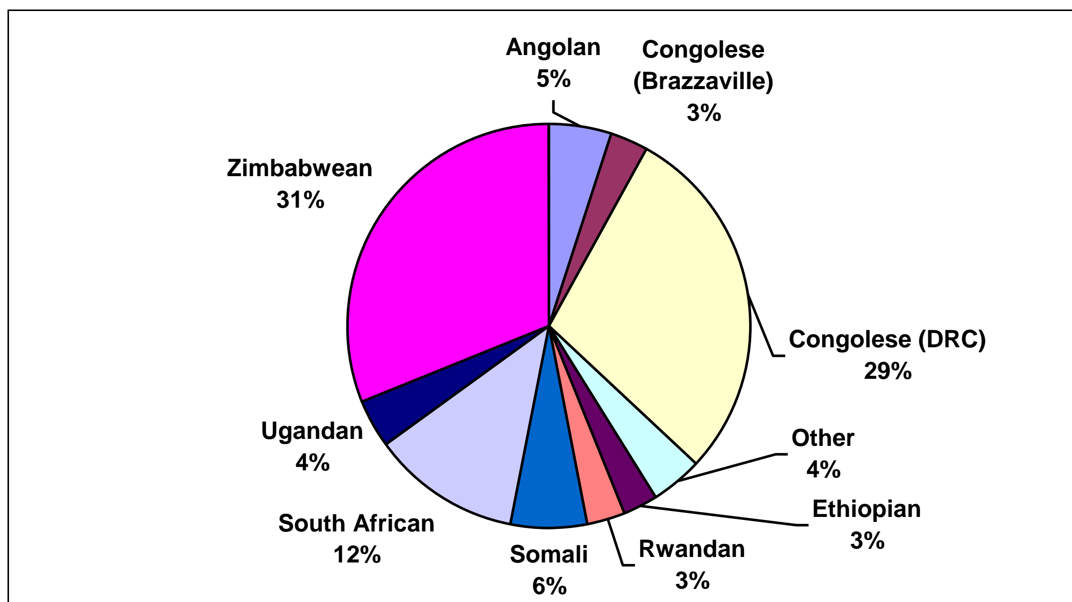

Figure 1: Nationality of clients receiving psychosocial services at TTP in 2010

   58% of clients who received psychosocial services at TTP from January to December 2010 were women, while 42% were men. This is similar to 2009 in which 55% of clients were women and 45% men.

   For our 2010 sample, the youngest client was 18 years of age, while the oldest was 64. 38% of clients were between the ages of 19 and 38. The mean age for the sample was 36 with a standard deviation of 11.27. In 2009, the youngest client was 15 and the oldest 56 years old. 63% of clients were between the ages of 19 and 38. The mean age was 35 with a standard deviation of 9.84.

A total of 598 sessions were conducted with torture victims from January to December 2010, with a maximum of 41 sessions and an average of 7 sessions (standard deviation = 8.39; mode= 3). The figure below provides a more detailed breakdown of this.

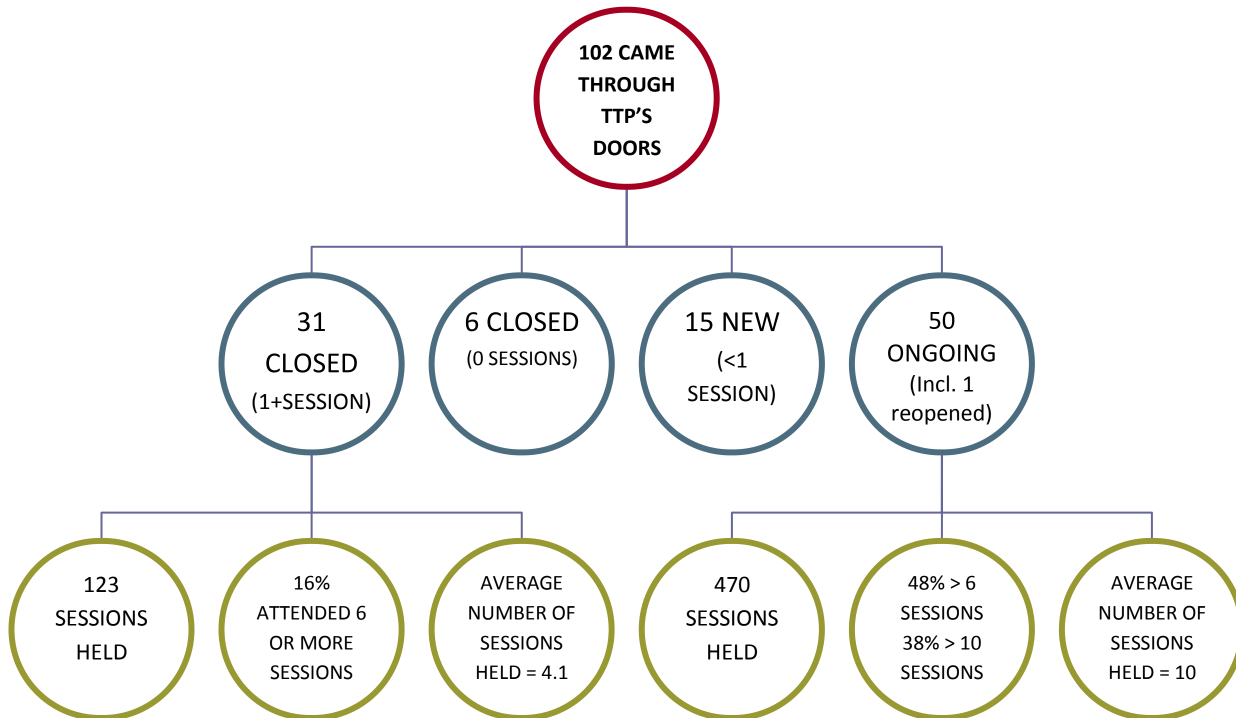

Figure 2: Breakdown of sessions per type of client

The following table compares the above figure for 2009 and 2010.

Type of case	Breakdown of sessions per client	2009 (n=75)	2010 (n=102)
Closed (1+ session)	**Number (%)**	**18 (24%)**	**31 (30%)**
	Number of sessions held	89	123
	6 + sessions	85%	16%
	Average number of sessions held	6.4	4.1
Closed (0 sessions)	**Number (%)**	**6 (8%)**	**6 (6%)**
New (<1 session)	**Number (%)**	**4 (5%)**	**15 (15%)**
Ongoing	**Number (%)**	**47 (63%)**	**50 (49%)**
	Number of sessions held	540	470
	6+ sessions	68%	48%
	Average number of sessions	11.5	10

Table 1: Breakdown of sessions per client in 2009 and 2010

2. Traumatic events experienced by clients
   Our sample of torture clients experienced an average of two traumatic events each (standard deviation = 1.07) with a total number of traumatic events of 187. This information is based primarily on information asked in the initial intake where limited information is asked about the traumatic events experienced by clients. For this reason it should be noted that clients may have experienced more than the average of two traumatic events stated above. Notwithstanding the torture experience, the most reported traumatic events in 2010 were: bereavement, assault, rape, and war. 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 for 2009 and 2010.

Type of Traumatic event	**2009**		**2010**	
	Number	**Percentage of people who experienced:**	**Number**	**Percentage of people who experienced:**
Torture	75	100%	102	100%
Bereavement	9	12%	22	22%
Assault	13	17%	16	16%
Rape	19	25%	15	15%
War	16	21%	14	14%
Armed robbery	2	3%	8	8%
Xenophobia	1	1%	4	4%
Witness to trauma	5	7%	2	2%
Car accident	2	3%	1	1%
Hostage	1	1%	1	1%
Mugging	2	3%	1	1%
Relationship violence	2	3%	1	1%
Human trafficking			1	1%

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

3. Types of traumas experienced by clients
   Clients were affected by seven types of trauma (as identified by clinicians). There was an average of 1.04 types of trauma per client with a standard deviation of 0.24. The types of traumas most reported by clinicians were: continuous trauma followed by complex trauma and multiple traumas (see table below for the 2009 and 2010 comparison).

Type of trauma	**2009**		**2010**	
	Number	**Percentage**	**Number**	**Percentage**
Continuous	41	47%	51	48%
Complex	11	12%	23	22%

Multiple	18	20%	14	13%
Once-off	16	18%	10	9%
Man made	1	1%	6	6%
Vicarious	1	1%	1	1%
Secondary	1	1%	1	1%
Total	**89**	**100%**	**106**	**100%**

Table 3: Types of traumatic events experienced by torture clients at TTP

4. Reaching our target number
   Of the 102 clients who were seen in 2010, 46 were carried over from 2009. Factoring this in, we needed to see an additional 54 clients in 2010 to reach our target number of 100. In order to achieve this, we needed to see 5.4 new clients every month. From January to December, we saw 56 new clients[1]. See the figure below.

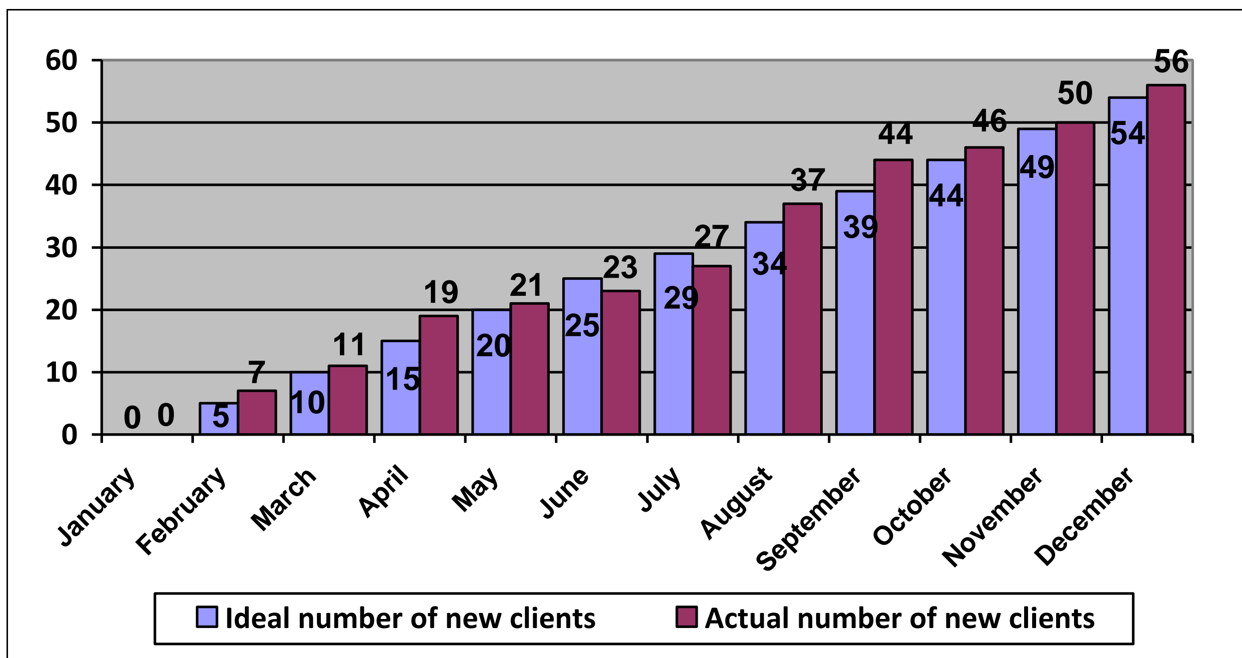

Figure 3: Target versus actual number of clients who received psychosocial services at TTP 2010

[1] The change in number from the June 2010 report is due to children who were included in family counselling sessions and then had individual counselling sessions over and above this.

INTAKE DATA REPORT FOR 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 a torture intake assessment from January to December 2010. The report includes new clients from 2010 as well as three clients who had a general TTP intake late in 2009 and only completed their torture 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.

A total number of 33 clients were included in the sample. There were 56 new clients in 2010, all of whom should have had an intake, however, only 30 clients completed an intake in 2010 and three clients were included from 2009. Nine clients could still complete an intake in 2011 within the agreed upon session limit of three sessions. The other clients' intakes are considered "lost" since they did not complete an intake within the session limit (see M&E compliance below). As not all of the new clients in 2010 completed an M&E intake, we need to be cautious about generalising this information. However we still find the information helpful to direct our interventions and understanding.

The intake form includes demographic information, the Harvard Trauma Questionnaire (HTQ), the Hospital Anxiety and Depression Scale (HADS), five questions that emerged from the International Classification of Functioning, Disability and Health (ICF) as well as questions regarding medical conditions, disabilities and substance use. This report looks at all of these areas.

This report compares the 2010 intake sample with the 2009 sample. In 2009 there were 22 clients included in the sample.

1. Demographic information

   Of the 33 clients who completed an intake assessment in 2010, 29 (88%) were referred to TTP by an external person or organization and the other 4 (12%) were self-referred. Clients came from six different countries with the majority coming from Zimbabwe (Figure 1). This differs from the 2009 report in which most clients came from the Democratic Republic of Congo (27%). No Burundian or Kenyan clients completed a torture intake in 2010.

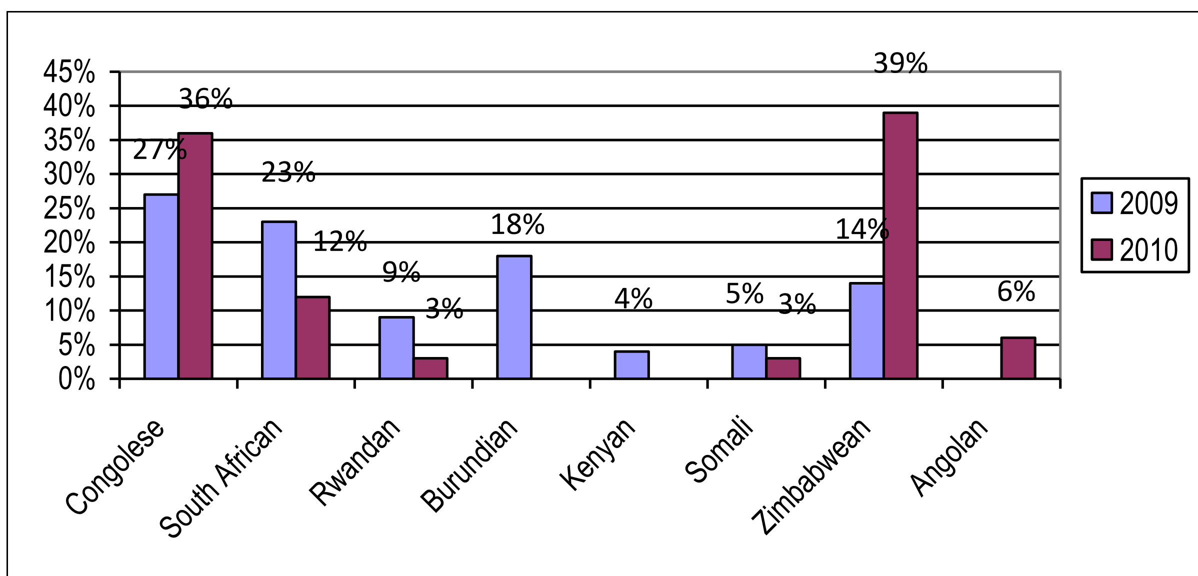

Figure 4: Nationality for M&E intakes in 2009 and 2010

The majority of clients who had an M&E intake in 2010 were female (61%). The oldest client was 57 years of age while the youngest was 18 at the time of intake. This spread is similar to that of 2009 in which the ages were between 15 and 56 years. In 2010, 91% of clients were between the ages of 22 and 49, whereas in 2009 82% of clients were between these ages. The mean age for the sample in 2010 was 39 with a standard deviation of 8.51. In 2009 the mean age was 34 with a standard deviation of 11.37.

More than a third of the clients (36%) reported being married at the time of intake while almost a quarter reported being widowed or never married. For a comparison with 2009, see the table below.

Marital Status	**2009**		**2010**	
	Frequency	**Percent**	**Frequency**	**Percent**
Currently Married	6	27%	12	36%
Divorced	1	4.5%	1	3%
Missing			2	6%
Never Married	9	41%	8	24%
Separated	1	4.5%	2	6%
Widowed	5	23%	8	24%
Total	**22**	**100%**	**33**	**100%**

Table 4: Marital Status for intakes in 2009 and 2010

Most clients (66%) were living with their family (which includes living alone with their children). 19% were living with strangers, living alone (3%), with a partner or spouse (3%), or in a shelter (9%). Eleven clients (33%) did not have children at the time of intake. Of those who did have children, 27% had four children. Five clients (15%) had five children or

more. The mean number of children was 3 with a standard deviation of 2.39. In 2009, 41% of clients did not have children and 19% had four or more children. The mean number of children in 2009 was 2 with a standard deviation of 1.63.

In both 2009 and 2010, before the torture experience, the majority of clients were employed within semi-skilled, skilled or highly skilled jobs. However, at the time of intake most were unemployed (table below).

	2009		2010	
	Pre-torture employment	**Current employment**	**Pre-torture employment**	**Current employment**
Highly skilled/professional	9%	5%	15%	4%
Semi-skilled	18%	9%	18%	18%
Skilled	18%	5%	18%	3%
Student	18%	14%	21%	3%
Unemployed	18%	62%	9%	52%
Unskilled labour	9%	5%	6%	18%
Missing	9%	0%	12%	3%
Total	**100%**	**100%**	**100%**	**100%**

Table 5: Changes in employment status linked to torture for Intakes in 2009 and 2010

2. <u>Psychiatric Considerations</u>
The Harvard Trauma Questionnaire (HTQ) includes 40 symptom items. The first 16 items are linked to the *Diagnostic and Statistical Manual, Fourth Edition* (DSM-IV) using the stipulated sub-domains of re-experiencing traumatic events, avoidance and numbing, and psychological arousal for Post Traumatic Stress Disorder (PTSD). Items 17-40 "aim to gauge personal perceptions of psychosocial functioning in response to the stresses of persecution, violence and displacement."[2] Together items 1-40 give the HTQ: Total score which indicates the levels of trauma that have been experienced. Higher scores on the HTQ Total score and PTSD scores indicate that it is more likely that a client has symptoms associated with trauma and post traumatic stress disorder.

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[2] Mollica, R.F., MacDonald, L.S., Massagli, M.P., & Silove, D.M. (1994) "Measuring Trauma, Measuring Torture: Instructions and guidance on the utilization of the Harvard Program in Refugee Trauma's Versions of The Hopkins Symptom Checklist-25 (HSCL-25) & The Harvard Trauma Questionnaire (HTQ)". Cambridge, MA: Harvard Programme in Refugee Trauma

There is a maximum score of 160 for the HTQ: Total score. For both the PTSD score and the self-perception of functioning score there is a maximum score of four. A PTSD score of more than 2.5 is considered symptomatic for clinical levels of PTSD. There is no cut-off for the self-perception of functioning score, however higher scores on this measure indicate lower self-perception of functioning.

For our sample, in 2010, the mean HTQ: Total score was 107.67, (standard deviation = 23.02). The mean self-perception of functioning score for our sample was 2.63 (standard deviation =0.64). The group presented with a mean score of 2.81 for PTSD (standard deviation= 0.55), with 24 people (73%) being checklist positive for PTSD. In 2009, the mean HTQ: Total score was 116.68 (standard deviation = 24.9). The mean self-perception of functioning score was 2.84 (standard deviation = 0.62). The group presented with a mean score of 3.03 for PTSD (standard deviation = 0.67), with 67 people (73%) being checklist positive for PTSD.

The Hospital Anxiety and Depression Scale (HADS) provides 14 items related to anxiety and depression. There is a maximum score of 21 for both of these psychiatric factors. The scoring of these items reveal that scores of between 0-7 indicate normal levels of anxiety or depression, 8-10 indicate borderline levels and scores of 11 or more indicate clinical levels for these psychiatric factors.

In 2009 and 2010, the majority of clients presented with clinical levels of both anxiety and depression. The results for these groups in terms of anxiety and depression are represented in the following table:

	2009		**2010**	
	Anxiety	**Depression**	**Anxiety**	**Depression**
Normal	0%	9%	6%	15%
Borderline	9%	23%	24%	24%
Clinical	91%	68%	70%	61%
Total	**100%**	**100%**	**100%**	**100%**

Table 6: Hospital Anxiety and Depression Scale score for intakes in 2009 and 2010

3. <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 (such as the police and Home Affairs officials), 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 these interactions. These questions also provide information on some of the contextual factors impacting on clients' recovery.

For our 2010 sample, when asked about the impact of authority figures on their recovery, 10 clients (30%) reported that authority figures slow down their recovery (a little or a great deal). Six clients (18%) reported some form of harassment from the police and 6 clients (18%) reported some form of harassment from home affairs (the government department responsible for approving refugee status). This can be compared to our 2009 sample (n=22) in which 15 clients (68%) reported that authority figures slow down recovery (a little or a great deal). 8 (36%) and 5 people (23%) of our sample reported some form of harassment from the Police or the Department of Home Affairs respectively in 2009.

In 2010, 20 people (60%) reported that health professionals support their recovery (a little or a great deal) and 20 people (60%) reported that family members support their recovery (a little or a great deal). In 2009 (n=22), the same questions revealed that 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).

4. Impact of environment (ICF 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.

   In terms of the clients' functioning, in 2010, at the time of intake, 33% of clients stated that they had severe or complete difficulty in managing their daily tasks, 53% stated they had severe to complete difficulty in solving complex problems, and 50% stated they had severe to complete difficulty in managing their symptoms. In 2009, the number of clients who reported severe to complete difficulties in the areas of managing their daily task, solving complex problems and managing their symptoms were 54%, 54% and 68% respectively. See the table below for a full indication of the 2010 ICF indicators.

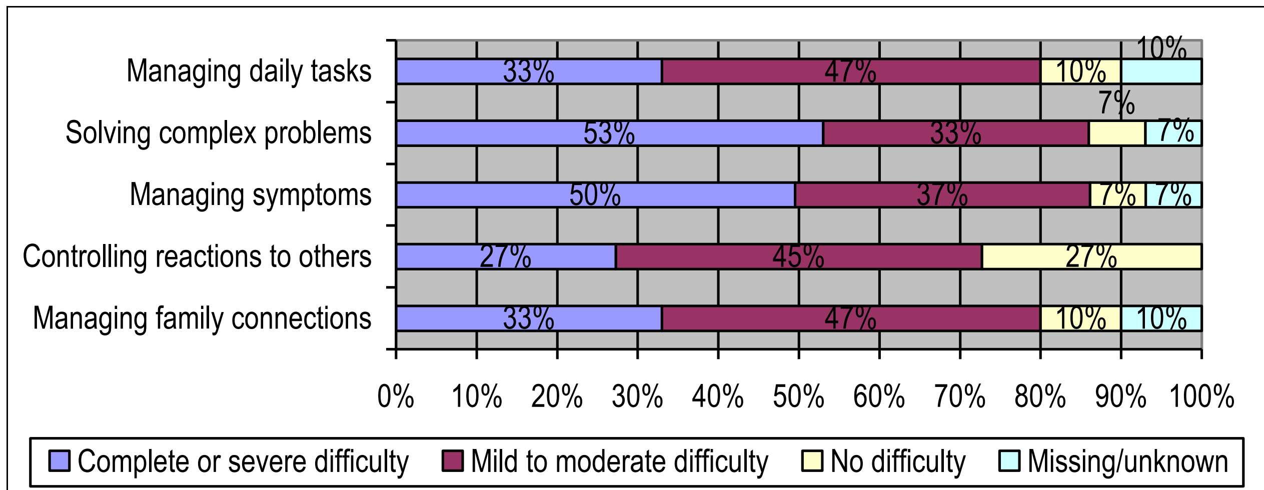


Figure 5: Key dimensions of functioning for intakes in 2010

5. 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. Twelve clients (36%) reported suffering from at least one medical condition in 2010. A broad range of medical conditions were reported including: depression; neck and head aches; feet pains; difficulty urinating or controlling bowel movements; high blood pressure and heart palpitations. In 2009, 9 clients (41%) reported suffering from at least one medical condition. 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	**2009**		**2010**	
	Incidence	**Due to Torture**	**Incidence**	**Due to Torture**
Emotional difficulties	5	5	6	6
Difficulties in the neck or head area (including headaches, and ear or neck problems)	4	2	7	5
Pains/problems in the back, ribs, or abdominal areas	4	4	5	4
Pains in feet or legs	1	1	2	2
Pains in the genital areas	2	2	2	2
Other (2)	2	2	2	2
Total (12)	**18**	**16**	**24**	**21**
Total %	**100%**	**88%**	**100%**	**88%**

Table 7: Categories of medical conditions reported

Sixteen people in 2010 (48%) reported suffering from at least one type of disability, and most of those clients (76%) reported at least one disability in their upper body (including head, neck, chest, shoulders and abdomen). This differs from 2009 in which five people (23%) reported suffering from a disability, of whom 80% reported the disability to be in their head and neck (this excludes the chest, shoulders and abdomen).

The majority of the sample (85%) reported experiencing some form of pain. Of the 74 incidences of pain reported, 38 (51%) incidences of pain were said to be due to torture. In 2009, 72% of clients reported some form of pain and 90% were said to be due to torture. The areas of pain for the 2009 and 2010 sample are outlined in the following table:

Pain	2009		2010	
	Incidence	Due to torture	Incidence	Due to torture
Shoulder Region Pain	2	2	9	3
Upper extremity Pain	1	1	9	3
Genitalia Pain	2	2	4	1
Abdomen Pain	5	4	6	4
Chest Pain	1	1	8	3
Lower extremity Pain	8	7	14	9
Head and neck region Pain	8	7	14	9
Generalised Pain	1	1	5	2
Other pain	1	1	5	4
Total (28)	**29**	**26**	**74**	**38**
Total %	**100%**	**90%**	**100%**	**51%**

Table 8: Areas affected by pain

Despite the high incidence of medical conditions, disability and pain reported by the sample, only four clients (12%) 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 76% of clients saying they do not use any of these substances. This is similar to the 2009 sample in which five clients (22%) indicated having taken prescription drugs and 82% of clients reported not using substances such as cigarettes, beer, wine and spirits.

BASELINE IMPACT DATA REPORT FOR 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 check 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 in the number of clients who report a reduction in symptoms and/or improvement in functioning after using TTP's services. As this is a three year project the first year was 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 M&E (torture) 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 clients who have completed an intake and a first or second assessment in 2010 to a sample with clients who had similar assessments in 2009. Unfortunately, due to difficulties with compliance we have only been able to obtain an intake and a first assessment for five clients in 2010.

Given this, we chose to include the information for all clients who have completed an intake assessment and first client assessment. We have been able to collect data on 30 clients who completed an intake and first assessment and 16 clients who completed an intake and second assessment. We also included 20 clients with an intake and at least one other assessment (where the number of sessions attended is greater than 12). These client groups are discussed separately, and will be described in terms of demographic information as well as three other 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. This analysis provides new insight into progress of clients who are at different points of counselling.

Impact data for clients with an intake and a first assessment (n=30)

There were 30 clients who had both an intake and a first assessment (after 6 sessions) until the end of December 2010. Through analysing this data, we hope to see what the impact of therapy is over the initial 6 sessions for survivors of torture. The following provides the data for this sample of torture survivors.

1. Demographic information
   Clients came from eight different countries with the highest proportion (27%) coming from the Congo (figure below).

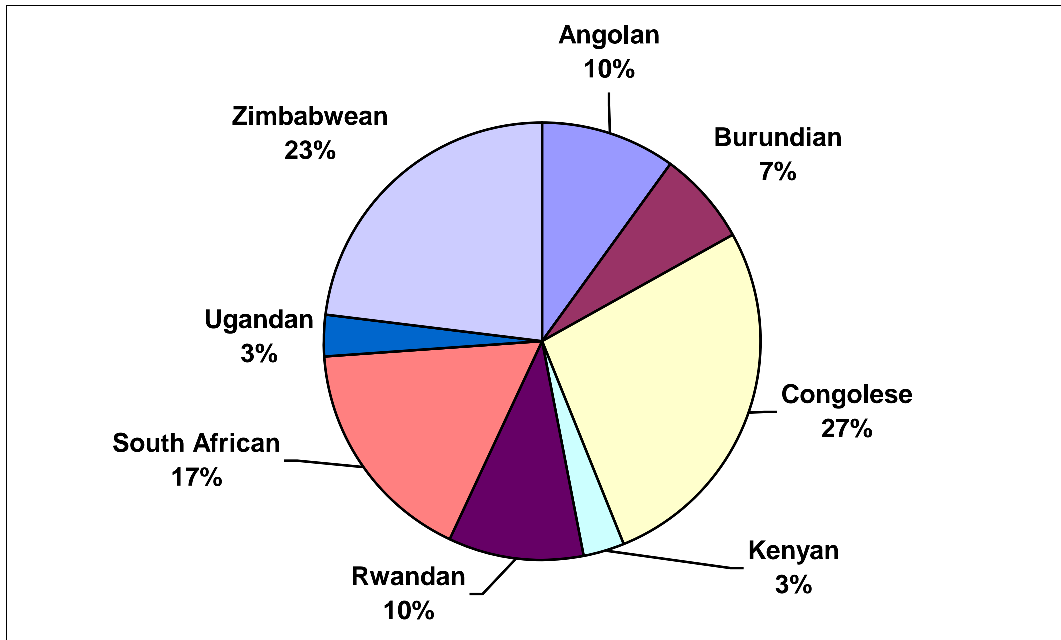


Figure 6: Nationality of clients with intake and first assessment

There were 15 men and 15 women included in this group. The oldest client was 53 years of age at the time of intake while the youngest was 17. The mean age for the group was 36.

More than one third (37%) of these clients reported never being married at the time of intake (table below).

Marital status	Frequency	%
Currently married	9	30%
Never married	11	37%
Divorced	2	7%
Widowed	6	20%
Separated	2	7%
Total	**30**	**100%**

Table 9: Marital status of clients with intake and first assessment

Most clients (57%) were living with their family (which could include living alone with their children). Others were living alone (10%), with friends (7%), with their partner or spouse (10%), in a shelter (13%), or with strangers (3%).

When asked about their education, two thirds of clients (66%) stated that they had a secondary schooling or above, and 43% stated that they had either a tertiary or post-graduate qualification (table below).

Educational Level	Frequency	%
No schooling	2	7%
Some Primary	2	7%
Completed Primary	6	20%
Completed Secondary	7	23%
Tertiary	12	40%
Post graduate	1	3%
Total	**30**	**100%**

Table 10: Educational Level of clients with counselling and first assessment

Before the torture experience, the majority of clients (65%) were employed in semi-skilled, skilled, highly skilled or professional jobs. However, after the torture experience, 64% of clients were unemployed (table below).

	Pre-Torture Employment (n=20)	Current Employment (n=28)
Unemployed	6 (30%)	18 (64%)
Unskilled labour	1 (5%)	7 (25%)
Semi-skilled	2 (10%)	2 (7%)
Skilled	4 (20%)	1 (4%)
Highly skilled/professional	7 (35%)	0
Total	**20 (100%)**	**28 (100%)**

Table 11: Changes in employment status linked to torture of clients with intake and first assessment

2. Service providers' impact on recovery

   In the experience of the clinical team, the role of authority figures (including home affairs and the police), 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.

   Overall, an average of 39% of clients reported an improvement in the impact of these groups on their recovery, 36% reported their impact remaining the same, while 25% reported that the impact on their recovery of these groups has worsened. Family members' impact on recovery showed the best recovery with 47% of clients reporting that their recovery is more positively impacted by these from the time of intake to the first assessment (table below).

	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	6 (32%)	9 (47%)	4 (21%)	**19**
Health professionals impact on recovery	6 (37.5%)	6 (37.5%)	4 (25%)	**16**
Family members impact on recovery	8 (47%)	4 (24%)	5 (29%)	**17**
Average	**7 (39%)**	**6 (36%)**	**4 (25%)**	

Table 12: 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 self-perception of functioning). Higher scores on all of these indicate higher trauma, higher PTSD or lower self-perception of functioning.

Overall, improvements were seen on the Total score (67%), PTSD score (68%) and Self-perception of functioning score (77%). 32% scored higher for PTSD, 23% scored higher on their self-perception of functioning score (indicating a lower self-perception of functioning), while 28% scored higher on the Total score at their first assessment point compared to intake (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)	14 (67%)	1 (5%)	6 (28%)	**21**
PTSD score	15 (68%)	0	7 (32%)	**22**
Self-perception of functioning score	17 (77%)	0	5 (23%)	**22**
Average	**15 (71%)**	**0.3 (2%)**	**6 (27%)**	

Table 13: Changes in scores on the HTQ of clients with Intake and first assessment

At intake 19 clients (63%) scored above the cut-off of 2.5 for clinical levels of PTSD. At first assessment this had dropped down to 13 (44%). While this does not represent a significant difference ($p = 0.0568$ using the T-test with $t=2.015$ and $df = 21$), it does indicate that the PTSD scores of clients have dropped.

The Hospital Anxiety and Depression Scale (HADS) was used to measure depression and anxiety. The percentage of clients who showed a decrease in clinical levels of anxiety

remained similar with 87% and 85% of clients showing clinical levels of anxiety in the intake and first assessment respectively. The borderline cases increased from 3% to 15% from intake to assessment one, and clients with normal levels of anxiety dropped from 10% to 0% (table below).

	Intake	**First assessment**
Normal	3 (10%)	0
Borderline	1 (3%)	3 (15%)
Clinical	26 (87%)	17 (85%)
Total	**30**	**20**

Table 14: Anxiety scores of clients with Intake and first assessment

The depression scores showed improvement with the percentage of people with clinical depression levels going from 70% at intake to 35% at first assessment. There was an increase in the number of borderline cases from 23% to 50% (table below).

	Intake	**First assessment**
Normal	2 (7%)	3 (15%)
Borderline	7 (23%)	10 (50%)
Clinical	21 (70%)	7 (35%)
Total	**30**	**20**

Table 15: Depression scores of clients with Intake and first assessment

In both the depression and anxiety scores from intake and assessment one, the majority of clients reported a decrease in their anxiety and depression from intake to first assessment. However, 20% to 25% showed an increase in scores (table below).

	No. of people whose scores decreased	**No. of people whose scores stayed the same**	**No. of people whose scores increased**	**n**
Depression Score	16 (80%)	0	4 (20%)	**20**
Anxiety Score	13 (65%)	2 (10%)	5 (25%)	**20**
Average	**14.5 (72.5%)**	**1 (5%)**	**4.5 (22.5%)**	

Table 16: Changes in scores on the HADS of clients with Intake and first assessment

While anxiety did not show a significant decrease in scores (p=0.093 using the T-test with t=1.77 and df =20), the change in scores for depression was significant (p=0.035 with t=2.27 and df=20). The figure below shows that the mean score for depression has moved to slightly under the cut-off point of 11.

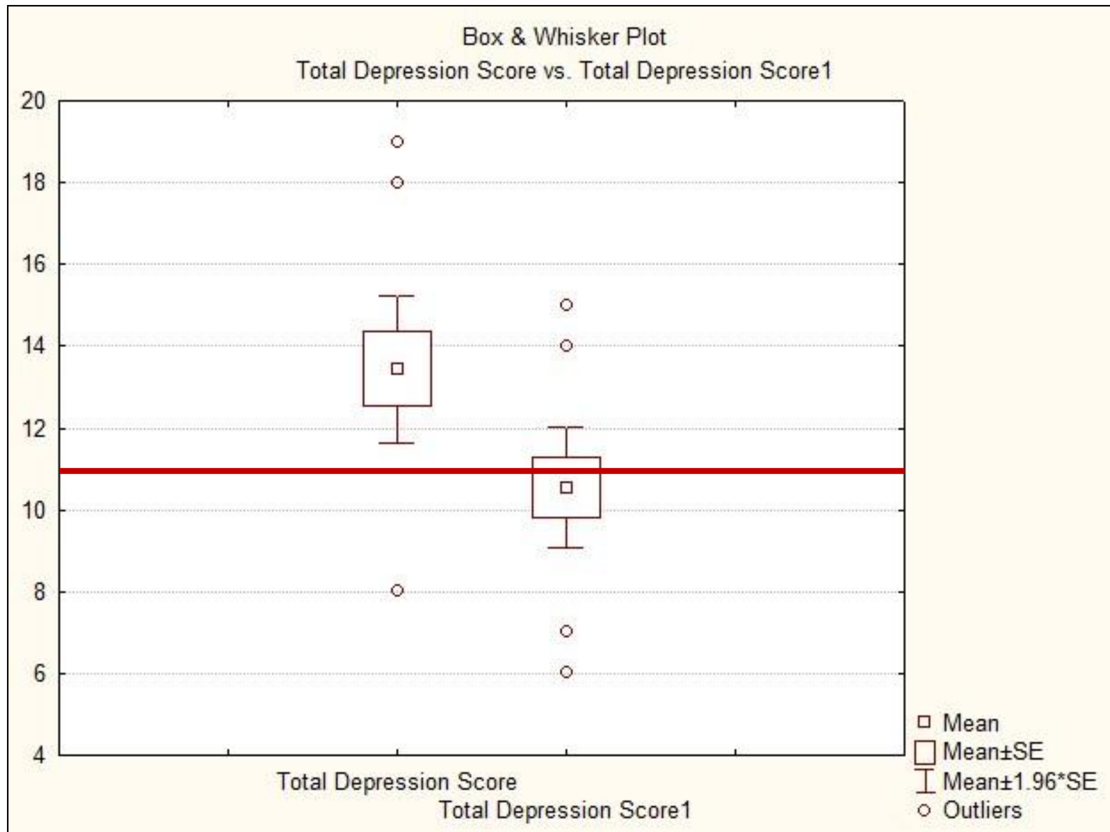


Figure 7: Box plot of depression scores at intake and first assessment

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 (67%) and managing family connections (53%). 41% and 39% of clients reported no change in their ability to manage symptoms and control their reactions to others respectively.

On average, 48% of clients reported an improvement in their functioning from intake to first assessment, while 18% reported a decrease in functioning (table below).

	% of people whose functioning increased	**% of people whose functioning stayed the same**	**% of people whose functioning decreased**	**n**
Solving complex problems	12 (67%)	5 (28%)	1 (5%)	**18**
Managing daily tasks	8 (45%)	6 (33%)	4 (22%)	**18**
Managing symptoms	7 (41%)	7 (41%)	3 (18%)	**17**
Controlling reactions to others	6 (33%)	7 (39%)	5 (28%)	**18**

Managing family connections	8 (53%)	4 (27%)	3 (20%)	**15**
Average	**8.2 (48%)**	**5.8 (34%)**	**3.2 (18%)**	

Table 17: Changes in functioning of clients with intake and first assessment

The difference in difficulties with solving complex problems was significant at p=0.0013 using the T-test with t=3.83 and df=17. The figure below shows that there has been a clear shift in the mean scores from intake to assessment one, indicating that clients have less difficulty solving complex problems at assessment one than at intake. There are no cut-offs for ICF indicators.

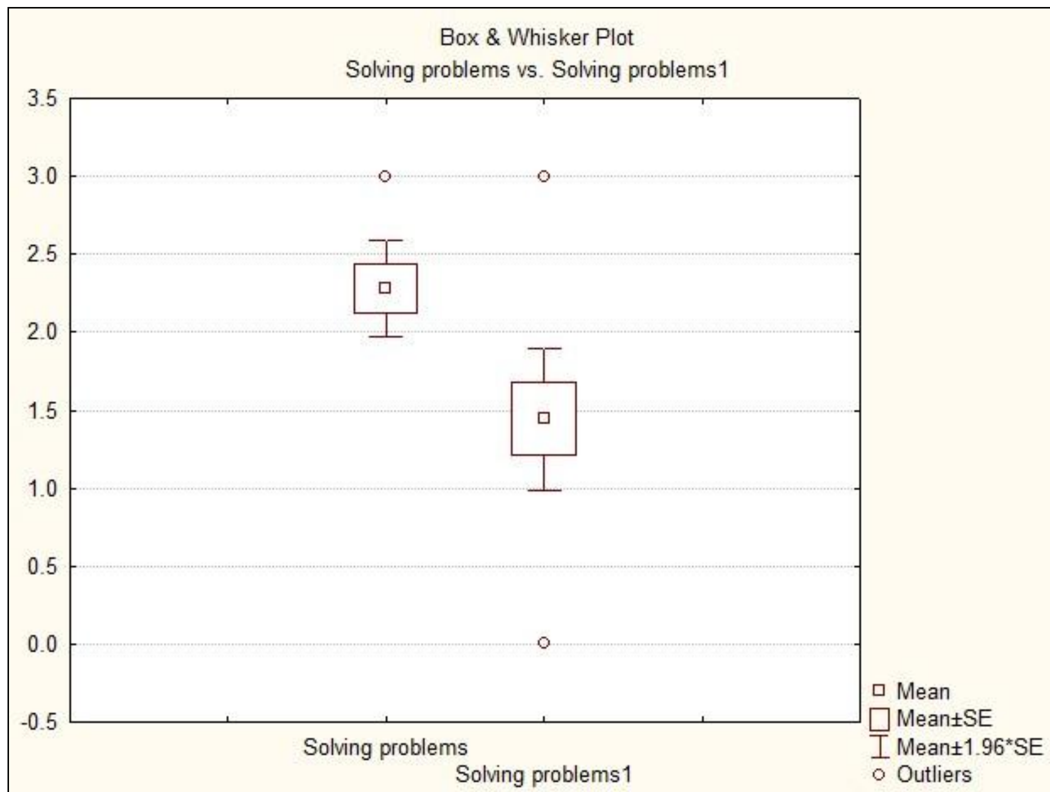


Figure 8: Box plot of ICF indicator: solving complex problems at intake and first assessment

Impact data for clients with an Intake and a second assessment (n=16)

There were 16 clients who had both an intake and a second assessment until end December 2010. The second assessment should be completed on the twelfth session. By looking at clients at this assessment point, we hope to discover new information about the effects of therapy on longer-term clients. The following provides the data for this sample of torture survivors.

1) Demographic information
   Clients in this group came from seven different countries with the majority coming from Zimbabwe (figure below).

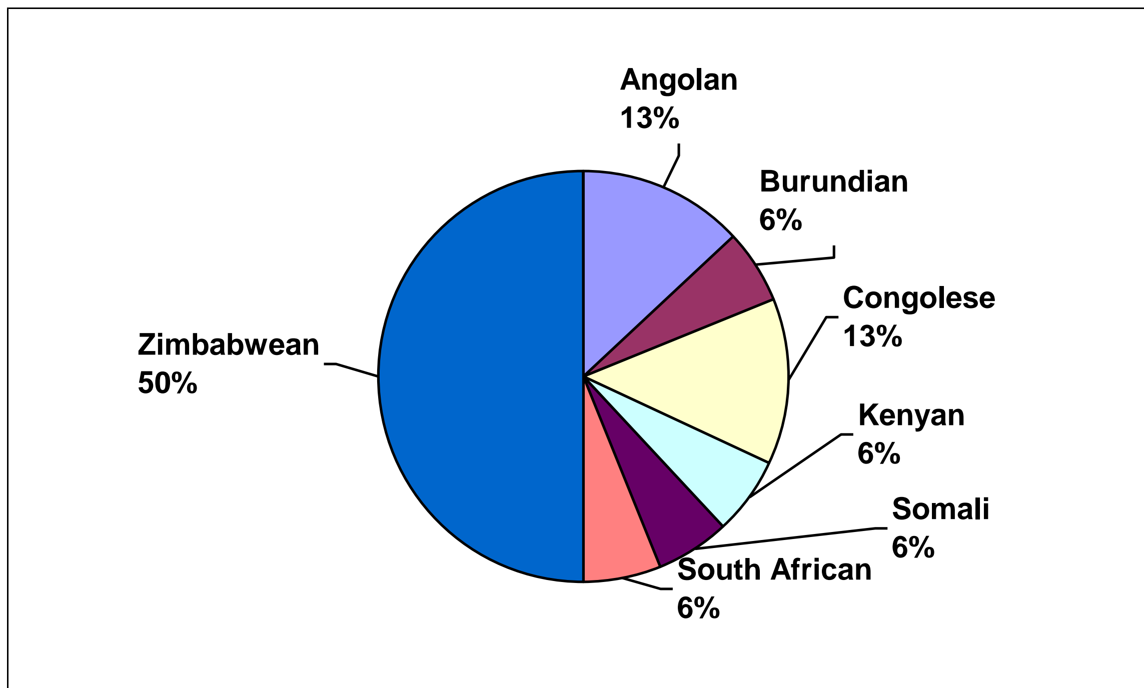


Figure 9: Nationality of clients with an intake and a second assessment

Nine women (56%) and seven men (44%) 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 35.

25% of clients reported being married at the time of intake, while 31% reported never being married (table below).

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

Table 18: Marital Status of clients with an intake and a second assessment

Most clients (50%) were living with their family (which could include living alone with their children). Others were living with friends (19%), in a shelter (19%) or with strangers (12%).

In terms of educational level, 44% had a tertiary level or post-graduate education (see table below).

Educational Level	Frequency	%
No schooling	1	6%
Some Primary	2	12%
Completed Primary	4	25%
Completed Secondary	2	12%
Tertiary	6	38%
Post graduate	1	6%
Total	**16**	**100%**

Table 19: Educational Level of clients with counselling and a second assessment

Before the torture experience, 57% of clients were employed within semi-skilled, skilled or highly skilled jobs; 25% were unemployed and 6% were employed in unskilled labour. However, at the time of intake the majority (94%) were unemployed or employed in unskilled jobs (table below).

	Pre-Torture Employment	Current Employment
Highly skilled/professional	19%	
Skilled	19%	
Semi-skilled	19%	
Unskilled labour	6%	6%
Unemployed	25%	88%
Missing	12%	6%
Total (n=16)	**100%**	**100%**

Table 20: Changes in employment status linked to torture of clients with intake and a second assessment

1. Service providers' impact on recovery

Overall, an average of 58% of clients reported an improvement in the impact of service providers on their recovery, 22% reported their impact remaining the same, while 20% reported that the impact on their recovery of these groups has worsened. Authority figures' and health professionals' impact on recovery showed the worst results with 30% and 20% of clients respectively reporting that their recovery is more negatively impacted by these (table below).

	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	8 (62%)	1 (8%)	4 (30%)	**13**
Health professionals impact on recovery	7 (64%)	3 (27%)	1 (9%)	**11**
Family members impact on recovery	5 (50%)	3 (30%)	2 (20%)	**10**
Average	**7 (58%)**	**2 (22%)**	**2 (20%)**	

Table 21: Changes of impact of different groups on recovery of clients with an intake and a second assessment

2. <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 self-perception of functioning). There is no cut-off for the self-perception of functioning score; however, clients who score above 2.5 on the PTSD score indicate that they are "*checklist positive*" for PTSD. At intake, 11 clients (69%) scored above the cut-off of 2.5 for PTSD. At second assessment this dropped down to 6 (38%). Changes in the Total score, PTSD score and Self-perception of functioning score from intake to second assessment were all significant (table below).

	Mean at intake	Mean at second assessment	Significance	n
Total score	117.21	92.79	P=0.0104	14
PTSD score	2.951	2.384	P=0.0126	14
Self perception of functioning score	2.922	2.357	P=0.0239	14

Table 22: HTQ changes in means and significance

Improvements were seen on the Total score, PTSD score and self-perception of functioning score, all of which indicated that 79% of clients showed a decrease in scores from intake to second assessment. However, 21% showed an increase in scores, indicating lower self-perception of functioning as well as higher PTSD and trauma (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)	11 (79%)	0	3 (21%)	**14**
PTSD score	11 (79%)	0	3 (21%)	**14**
Self-perception of functioning score	11 (79%)	0	3 (21%)	**14**

Average	11 (79%)	0	3 (21%)	

Table 23: Changes in scores on the HTQ of clients with intake and a second assessment

The figure below shows that there has been a clear shift in the scores for PTSD and the mean has shifted to below the cut-off of 2.5.

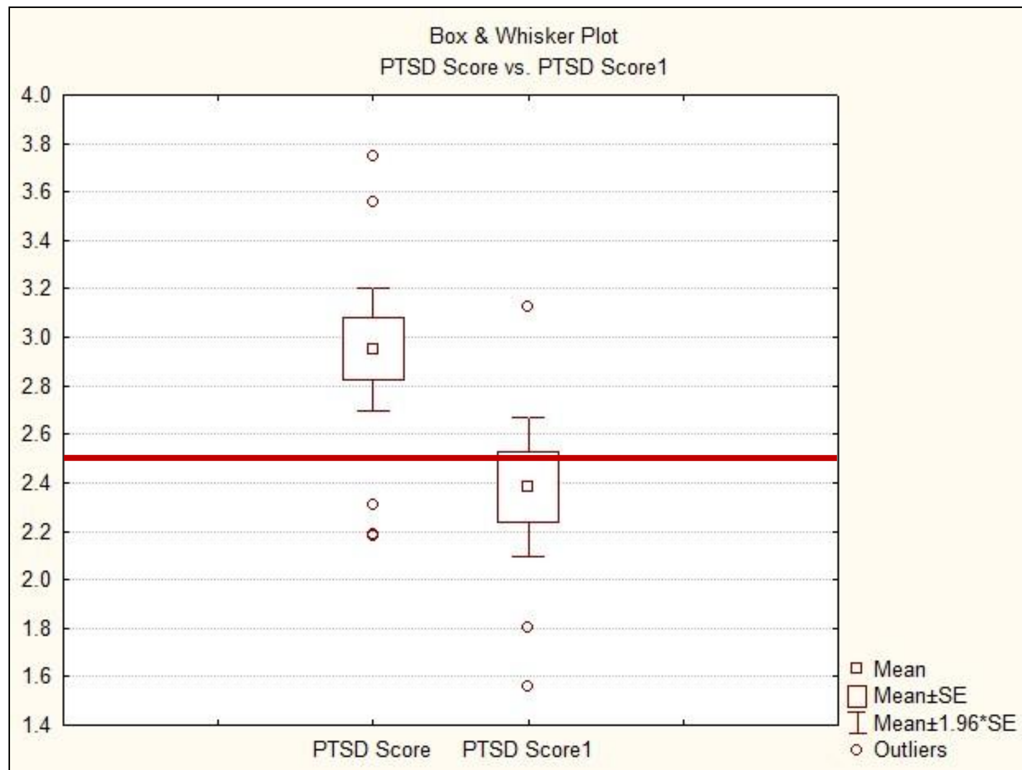


Figure 10: Box plot for PTSD scores for clients with an intake and a second assessment

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 levels going from 100% at intake to 64% at second assessment. There was an increase of number of borderline cases from 0 to 32% (table below).

	Intake	Second assessment
Normal	0	2 (15%)
Borderline	0	3 (21%)
Clinical	16 (100%)	9 (64%)
Total	**16**	**14**

Table 24: Anxiety scores of clients with an intake and a second assessment

Depression scores showed a decrease in the number of people with clinical levels of depression from 81% to 57%. The number of clients with normal levels of depression increased from 0 to 29% from intake to second assessment (table below).

	Intake	Second assessment
Normal	0	4 (29%)
Borderline	3 (19%)	2 (14%)
Clinical	13 (81%)	8 (57%)
Total	**16**	**14**

Table 25: Depression scores of clients with an intake and a second assessment

Overall, the majority of clients (79%) showed a decrease in anxiety and depression scores. 22% of clients showed an increase in scores indicating an increase in anxiety and depression from intake to the second assessment (table below).

	No. of people whose scores decreased	**No. of people whose scores stayed the same**	**No. of people whose scores increased**	**n**
Depression Score	12 (86%)	0	2 (14%)	**14**
Anxiety Score	10 (71%)	0	4 (29%)	**14**
Average	**11 (78.5%)**	**0**	**3 (21.5%)**	

Table 26: Changes in scores on the HADS of clients with Intake and second assessment

The changes in both the anxiety and depression scores are significant (anxiety: p=0.0027 with t=3.703 and df=13; depression: p=0.0143 with t=2.83 and df=13). The following figure indicates how, for anxiety, the mean decreases from 16.5 at intake to 11 at the second assessment.

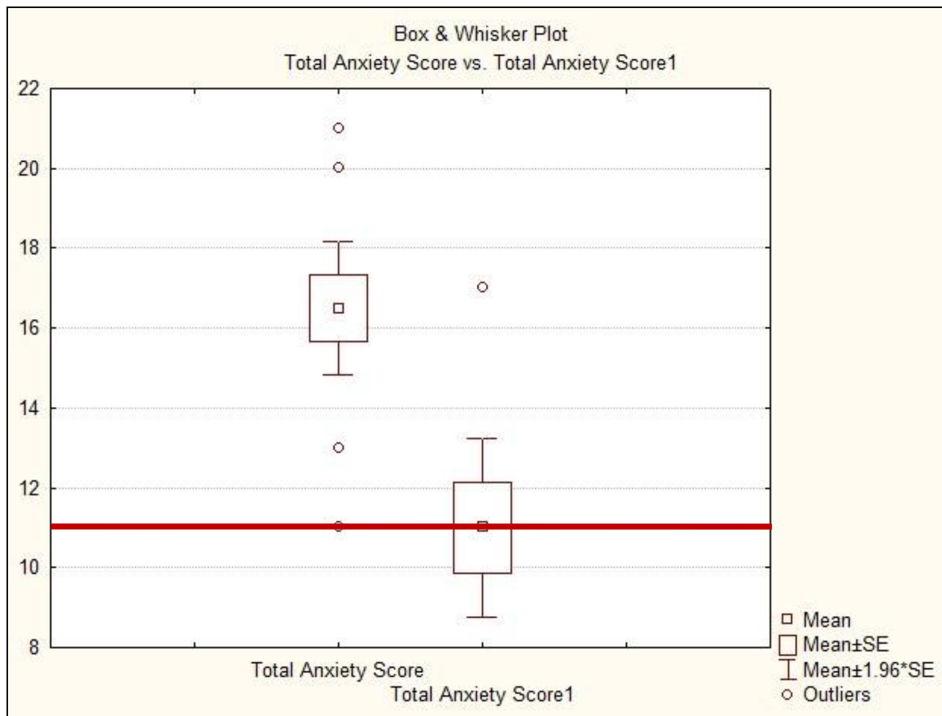


Figure 11: Box plot: anxiety scores for clients with intake and second assessment

3. Functioning Indicators

A number of indicators based on the International Classification of Functioning and Disability (ICF) were developed to assess functioning in areas that the clinical team felt were important in terms of their interventions. The majority (83%) of clients showed improvement on their ability to manage family connections, and 80% showed improvement on their ability to manage symptoms.

On average, 56% of clients reported an improvement in their functioning, while 24% reported a decrease in functioning and 20% reported no change[3] (table below).

	% of people whose functioning increased	**% of people whose functioning stayed the same**	**% of people whose functioning decreased**	**n**
Solving complex problems	2 (33%)	3 (50%)	1 (17%)	**6**
Managing daily tasks	3 (50%)	1 (17%)	2 (33%)	**6**
Managing symptoms	4 (80%)	0	1 (20%)	**5**
Controlling reactions to others	2 (33%)	2 (33%)	2 (33%)	**6**
Managing family connections	5 (83%)	0	1 (17%)	**6**
Average	**3.2 (56%)**	**1.2 (20%)**	**1.4 (24%)**	

Table 27: Changes in functioning of clients with intake and second assessment

[3] Note: the reason why the number of clients who responded to this question is so low is because these questions were only included in the assessments at a later stage

Impact data for clients with an Intake and another assessment (17 sessions or more) (n=20)

The following analysis is of clients who have had an intake and at least one other assessment after the 12th session. By using the last-observation-brought-forward method, we hope to discover new information about clients in longer-term therapy. 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 that this group have attended range from 17 to 74 sessions. The average number of sessions attended by this group at the time of the follow-up assessment is 28. Therefore these clients have not been assessed at the same or similar points in their therapeutic treatment. This analysis, however, adds to our existing knowledge of a previously un-assessed group.

1. Demographic information
   Clients in this group came from seven different countries with the almost half coming from Zimbabwe (figure below).

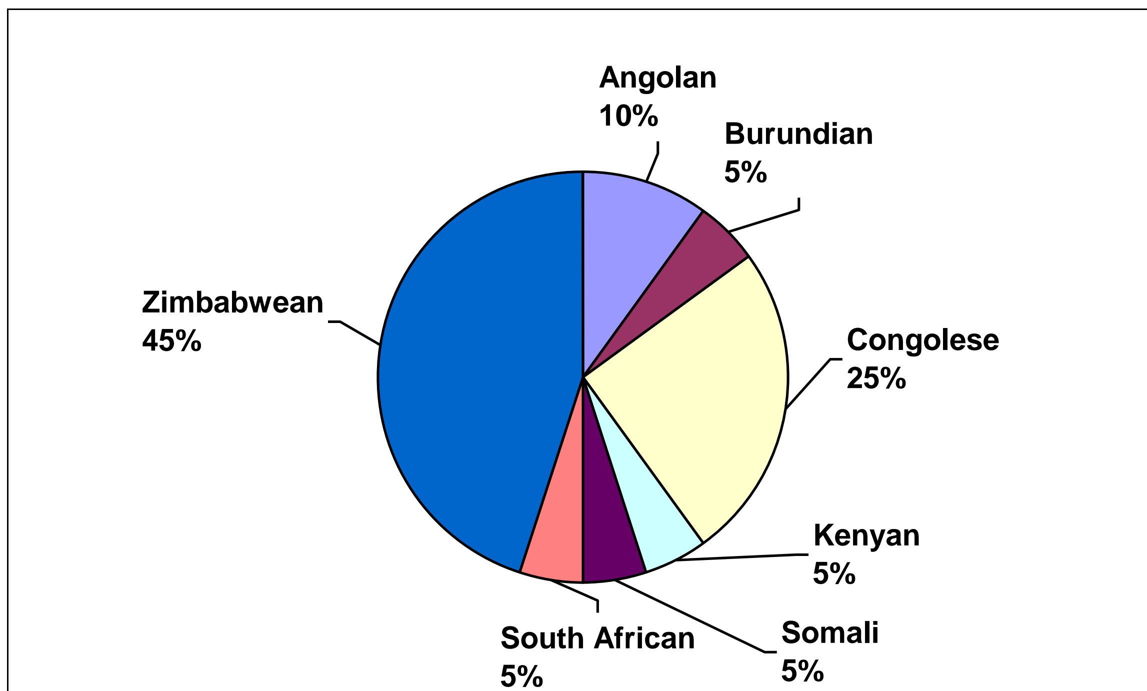


Figure 12: Nationality of longer-term clients

The group is made up of 13 women (65%) and 7 men (35%). 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 35.

25% of clients reported being married at the time of intake, while 31% reported never being married (table below).

Marital Status	Frequency	%
Currently married	4	20%
Never Married	6	30%
Divorced	1	5%
Widowed	6	30%
Separated	3	15%
Total	**20**	**100%**

Table 28: Marital Status of longer-term clients

Most clients (50%) were living with their family (which could include living alone with their children). Others were living with friends (20%), in a shelter (20%) or with strangers (10%).

Forty-five percent of this sample had a tertiary or post graduate level education (see table below), and 60% had completed high school or above.

Educational Level	Frequency	%
No schooling	1	5%
Some Primary	2	10%
Completed Primary	5	25%
Completed Secondary	3	15%
Tertiary	8	40%
Post graduate	1	5%
Total	**20**	**100%**

Table 29: Educational Level of longer-term clients

Before the torture experience, 60% of clients were employed within semi-skilled, skilled or highly skilled jobs; 25% were unemployed and 5% were employed in unskilled labour. However, at the time of intake the majority 95% were unemployed or employed in unskilled jobs (table below).

	Pre-Torture Employment	Current Employment
Highly skilled/professional	25%	
Skilled	15%	
Semi-skilled	20%	
Unskilled labour	5%	10%
Unemployed	25%	85%
Missing	10%	5%
Total	**100%**	**100%**

Table 30: Changes in employment status linked to torture of longer-term clients

2. <u>Service providers' impact on recovery</u>
   Almost two thirds of clients (63%) reported that authority figures (including the police and home affairs – the government department responsible for organising refugee status) had impacted their recovery in a more positive way from intake to their last assessment. However, 31% of clients had reported a more negative impact from authority figures from intake to their last assessment. Overall, an average of 54% of clients reported an improvement in the impact of the service providers on their recovery. 27% of clients reported their impact remaining the same while 19% reported that the impact of these groups on their recovery had worsened (table below).

	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	10 (63%)	1 (6%)	5 (31%)	**16**
Health professionals impact on recovery	8 (57%)	6 (43%)	0	**14**
Family members impact on recovery	5 (42%)	4 (33%)	3 (25%)	**12**
Average	**8 (54%)**	**4 (27%)**	**4 (19%)**	

Table 31: Changes of impact of different groups on recovery of longer-term clients

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 self-perception of functioning). Higher scores on all of these indicate higher trauma, higher PTSD or lower self-perception of functioning. At intake, 14 clients (70%) scored above the cut-off of 2.5 for PTSD. At their last assessment, this dropped down to 7 (35%). Changes in the Total score, PTSD score and Self-perception of functioning score from intake to their last assessment were all significant (table below).

	Mean at intake	Mean at second assessment	Significance	n
Total score	113.24	91.29	p=0.008	17
PTSD score	2.862	2.388	p=0.024	17
Self perception of functioning score	2.814	2.27	p=0.013	17

Table 32: HTQ changes in means and significance of longer-term clients

On average, 76% of clients showed improvements on the Total, PTSD and self-perception of functioning scores (table below).

	No. of people whose scores decreased	No. of people whose scores stayed the same	No. of people whose scores increased	n
PTSD score	13 (76%)	0	4 (24%)	**17**
Self-perception of functioning score	13 (76%)	1 (6%)	3 (18%)	**17**
HTQ total score (trauma)	13 (76%)	0	4 (24%)	**17**
Average	**13 (76%)**	**0.3 (2%)**	**4 (22%)**	

Table 33: Changes in scores on the HTQ of longer-term clients

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 levels going from 90% at intake to 59% at their last assessment. There was an increase of number of borderline cases from 0 to 29% (table below).

	Intake	Most recent assessment
Normal	2 (10%)	2 (12%)
Borderline	0	5 (29%)
Clinical	18 (90%)	10 (59%)
Total	**20**	**17**

Table 34: Anxiety scores of longer-term clients

Depression scores showed a decrease in the number of people with clinical levels of depression from 70% to 59%. The number of clients with normal levels of depression increased from 10% to 18% from intake to second assessment (table below).

	Intake	Most recent assessment
Normal	2 (10%)	3 (18%)
Borderline	4(20%)	4 (23%)
Clinical	14 (70%)	10 (59%)
Total	**20 (100%)**	**17 (100%)**

Table 35: Depression scores of longer-term clients

On average the majority of clients (68%) showed a decrease in anxiety and depression scores from intake to their last assessment. When looked at separately, 53% of clients showed a decrease in their depression scores from intake to their last assessment (indicating a decrease in depression over these two assessment points), and 47% of clients showed an increase in scores (indicating an increase in depression). This is contrasted to anxiety in which 82% of clients showed a decrease in scores from intake to their last assessment, while 18% of clients showed an increase in scores (figure below).

	No. of people whose scores decreased	No. of people whose scores stayed the same	No. of people whose scores increased	n
Depression Score	9 (53%)	0	8 (47%)	**17**
Anxiety Score	14 (82%)	0	3 (18%)	**17**
Average	**11.5 (67.5%)**	**0**	**5.5 (32.5%)**	

Table 36: Changes in scores on the HADS of longer-term clients

The change in anxiety is significant (p=0.003 using the T-test with t=3.397 and df=16) while the change in depression is not significant (p=0.128 with t=1.606 and df=16). The following figure indicates how, for anxiety, the mean decreases from 15.8 at intake to 10.9 for clients' last assessment and scores have decreased.

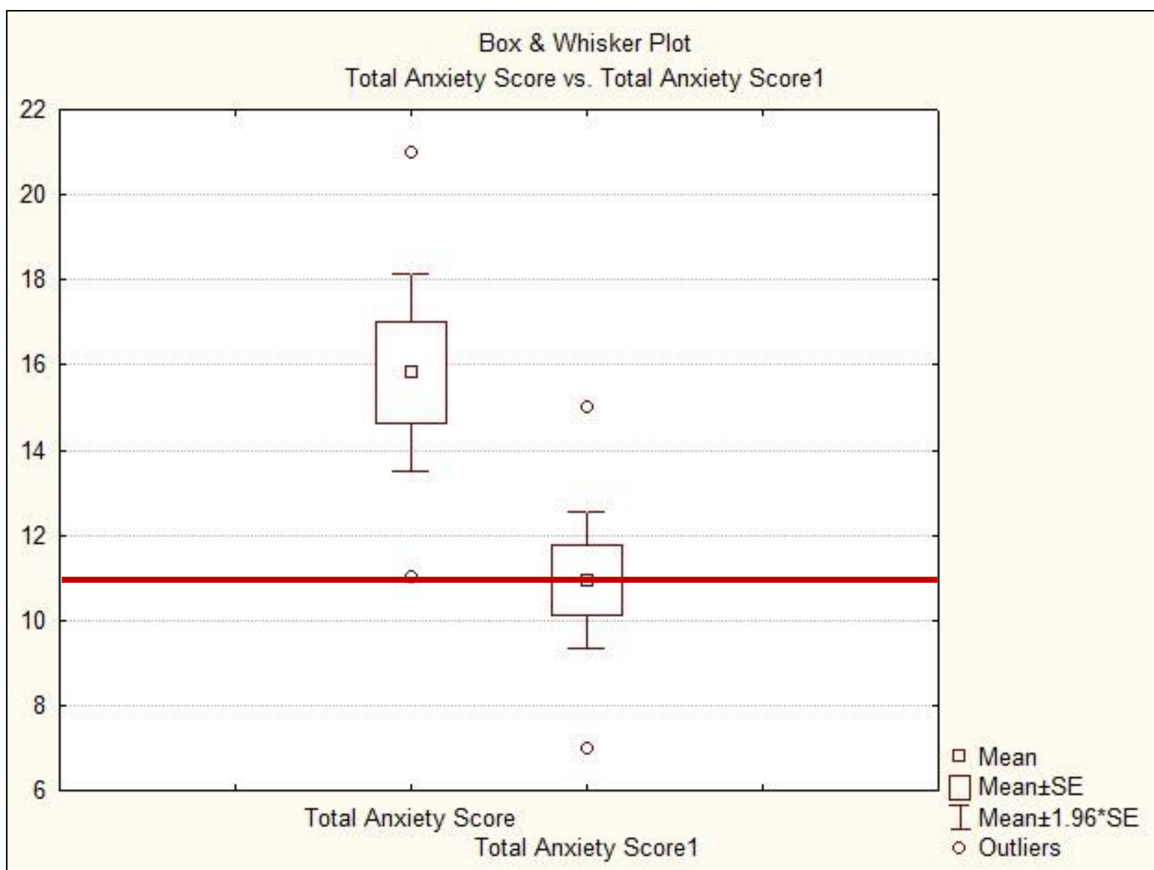


Figure 13: Box plot for Anxiety scores for longer-term clients

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 data collected regarding the functioning of clients over these two assessment points indicated that 67% of clients reported an improvement in their ability to solve complex problems, while 53% reported an improvement in their ability to manage their connections with their families (table below).

	% of people whose functioning increased	**% of people whose functioning stayed the same**	**% of people whose functioning decreased**	**n**
Solving complex problems	12 (67%)	5 (28%)	1 (5%)	**18**
Managing daily tasks	8 (45%)	6 (33%)	4 (22%)	**18**
Managing symptoms	7 (41%)	7 (41%)	3 (18%)	**17**
Controlling reactions to others	6 (33%)	7 (39%)	5 (28%)	**18**
Managing family connections	8 (53%)	4 (27%)	3 (20%)	**15**
Average	**8.2 (48%)**	**5.8 (34%)**	**3.2 (18%)**	

Table 37: Changes in functioning of longer-term clients

While none of the ICF scores were significant, it should be noted that the mean of clients' ability to manage daily tasks increased from 1.5 to 1.88. This indicates that clients felt that they had more difficulty in managing daily tasks from intake to their last assessment (figure below).

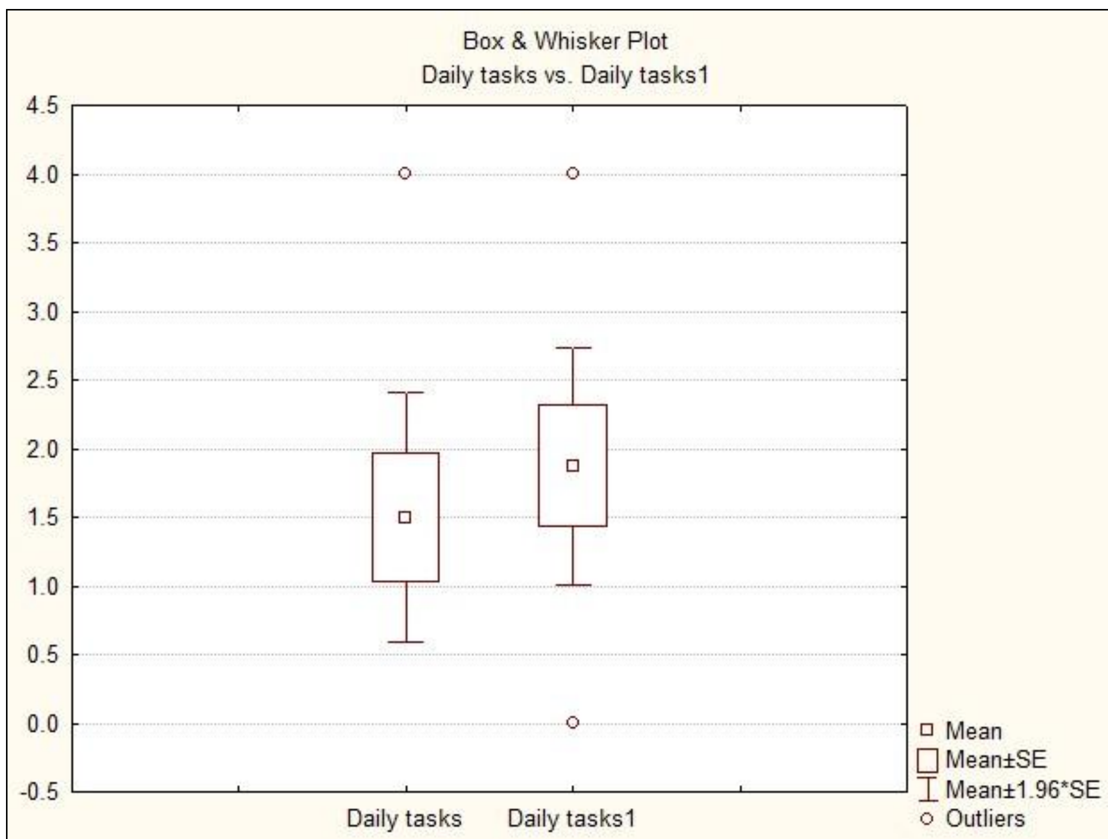


Figure 14: Box plot for ICF score: managing daily tasks for longer-term clients

CLIENT PROGRESS REPORTS FOR 2010

An important part of any M&E process is feeding information obtained back 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 managed to produce 40 CPRs between January and December 2010, up from 30 in 2009. These were provided to clinicians, who used the information to reflect on their practice and the progress of the client. This information can be used by the clinician for treatment planning. While all 40 CPRs are available for viewing, we include only three here as examples of the information being produced.

Client Progress Report 1

Data available:

- M&E intake
- 1 Client Self-Assessment

Demographics:

Gender: Male
Nationality: Zimbabwean
Age: 25
Number of children: 0
Number of dependants: 0
Educational level: Tertiary
Pre-torture employment: Student
Employment at intake: Unemployed

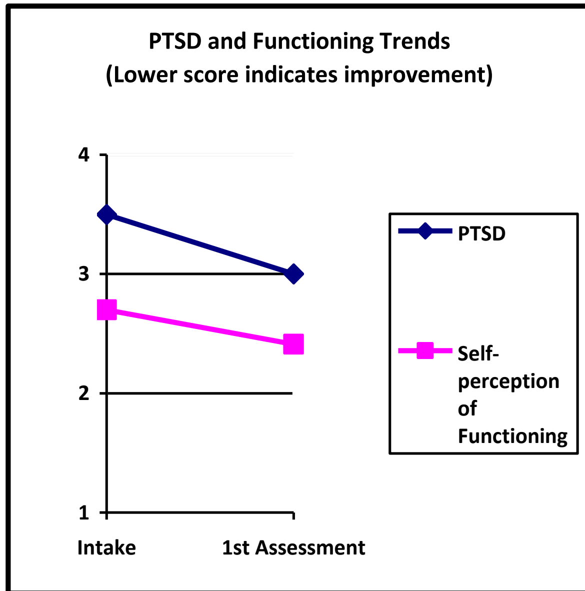
Results:

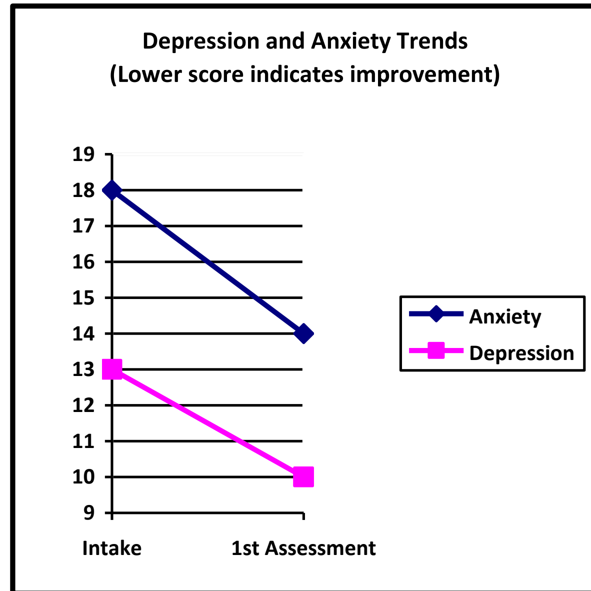
	Intake	**Client Self-Assessment**	**Progress***
Date done	**28/09/2010**	**13/10/2010**	
Number of sessions completed	-	6	
Authority Figures impact on recovery	No impact	Support a great deal	↓
Health professionals impact on recovery	Missing/unknown	Support a great deal	-
Family members impact on recovery	Support a great deal	Support a great deal	→
Difficulty in solving complex problems	Moderate difficulty	Mild difficulty	↓
Difficulty in completing daily tasks	Moderate difficulty	Moderate difficulty	→
Difficulty in managing symptoms	Severe difficulty	Moderate difficulty	↓
Difficulty in ability to control reactions to others	Moderate difficulty	Mild difficulty	↓
Difficulty in family connections	No difficulty	Mild difficulty	↑
PTSD score (> 2.5 = symptomatic for PTSD)	3.5	3.00	↓

Self-perception of functioning score (no cut off)	2.7	2.41	↓
Anxiety (0-7 = normal, 8-10 = borderline and 11+ = clinical)	18	14	↓
Depression (0-7 = normal, 8-10 = borderline and 11+ = clinical)	13	10	↓

*** Down indicates improvement**

Down indicates improvement:





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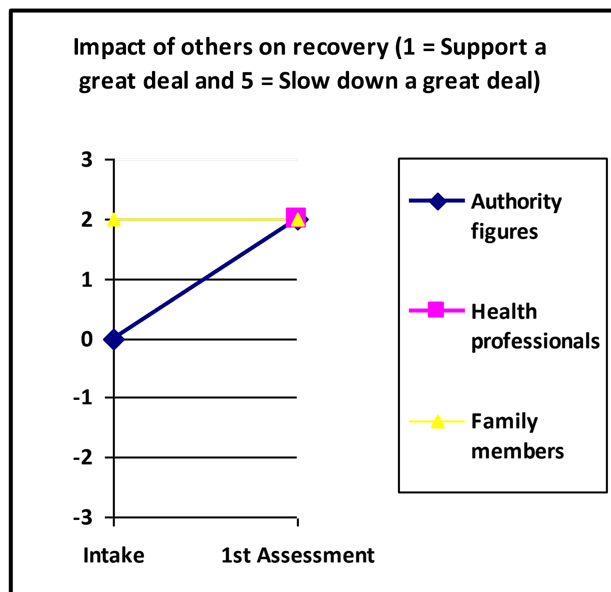
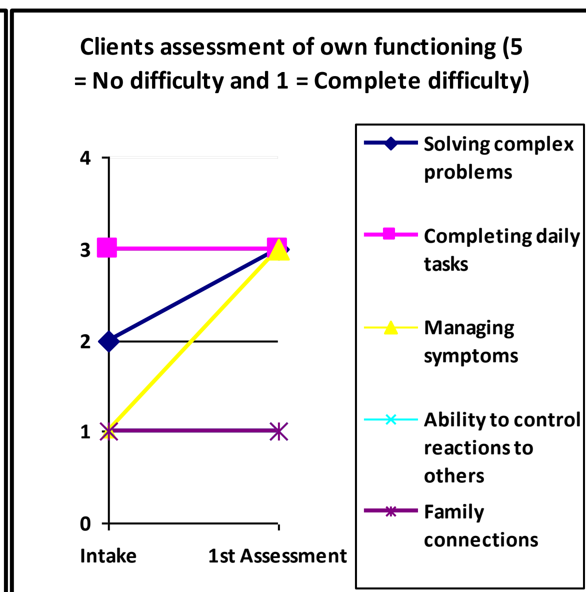




Client Progress Report 2

Data available:

- M&E intake
- 2 Client Self-Assessments

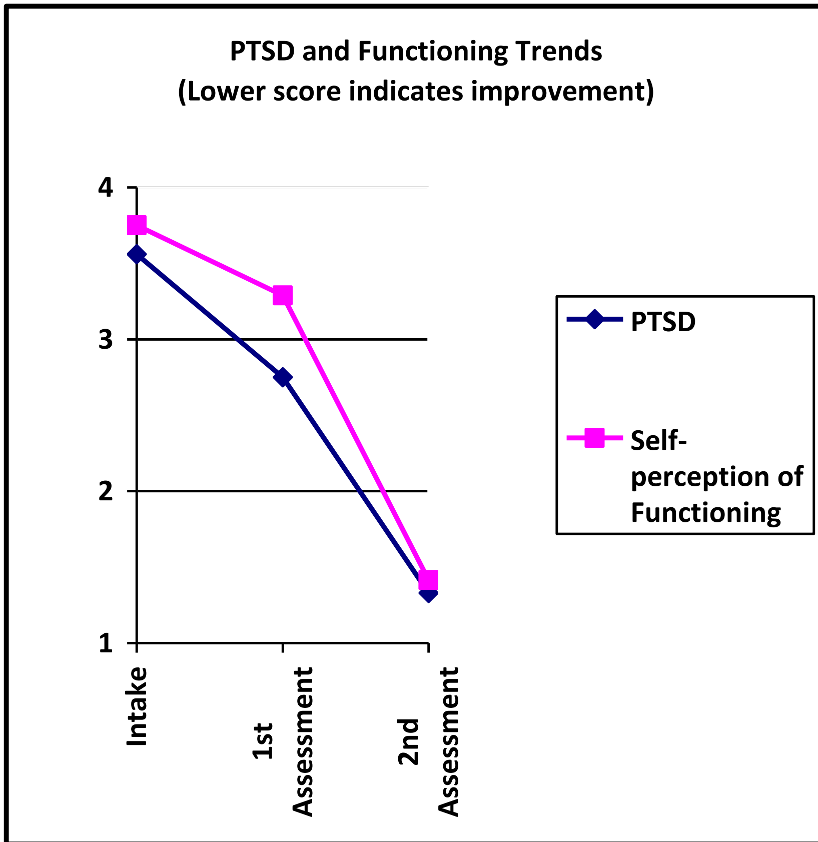
Demographics:

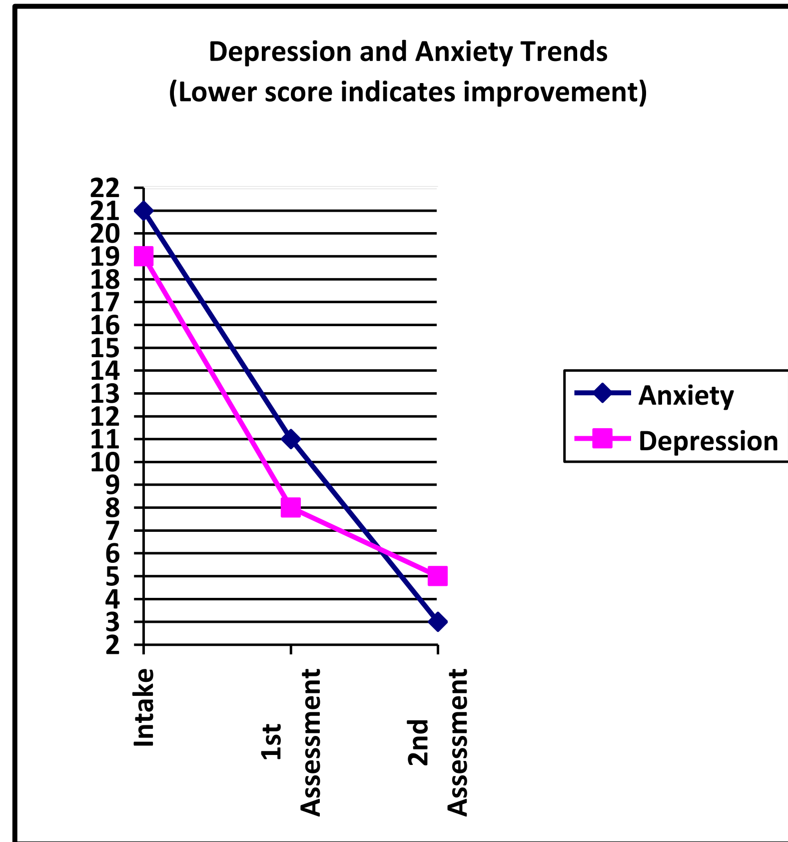
Gender:	Female	Nationality:	Zimbabwean
Age:	44	Educational level:	Completed primary
Number of children:	7	Number of dependants:	0
Pre-torture employment:	Semi skilled	Employment at intake:	Unemployed

Results:

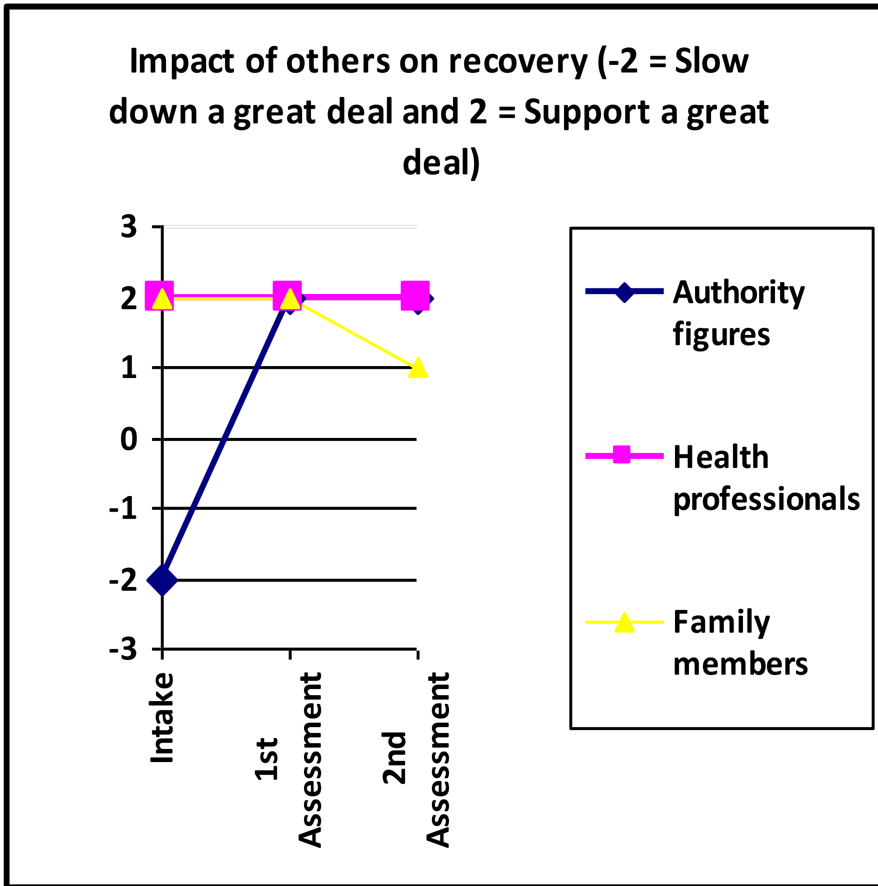
	Intake	**1st Client Self-Assessment**	**2nd Client Self-Assessment**
Date done	**29/04/2009**	**29/09/2009**	**26/08/2010**
Number of sessions completed	-	6	**12**
Authority Figures impact on recovery	Slow down a great deal	Support a great deal	Support a great deal
Health professionals impact on recovery	Support a great deal	Support a great deal	Support a great deal
Family members impact on recovery	Support a little	Support a great deal	Support a little
Difficulty in solving complex problems	Severe difficulty	Moderate difficulty	Mild difficulty
Difficulty in completing daily tasks	Moderate difficulty	Moderate difficulty	No difficulty
Difficulty in managing symptoms	Complete difficulty	Moderate difficulty	No difficulty
Difficulty in ability to control reactions to others	Complete difficulty	Complete difficulty	Mild difficulty
Difficulty in family connections	Complete difficulty	Complete difficulty	No difficulty
PTSD score (> 2.5 = symptomatic for PTSD)	3.56	2.75	1.33
Self-perception of functioning score (no cut off)	3.75	3.291	1.416
Anxiety (0-7 = normal, 8-10 = borderline and 11+ = clinical)	21	11	3
Depression (0-7 = normal, 8-10 = borderline and 11+ = clinical)	19	8	5

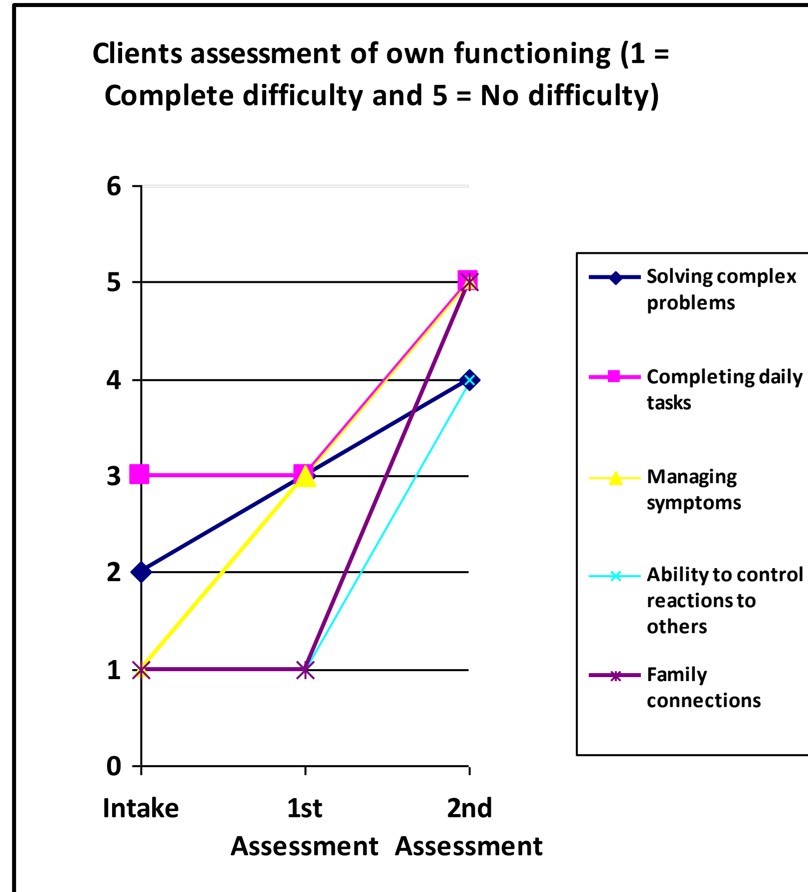
Lower score indicates improvement:





Higher score indicates improvement:





Client Progress Report 3

Data available:

- Intake
- 4 Client Self-Assessments

Demographics:

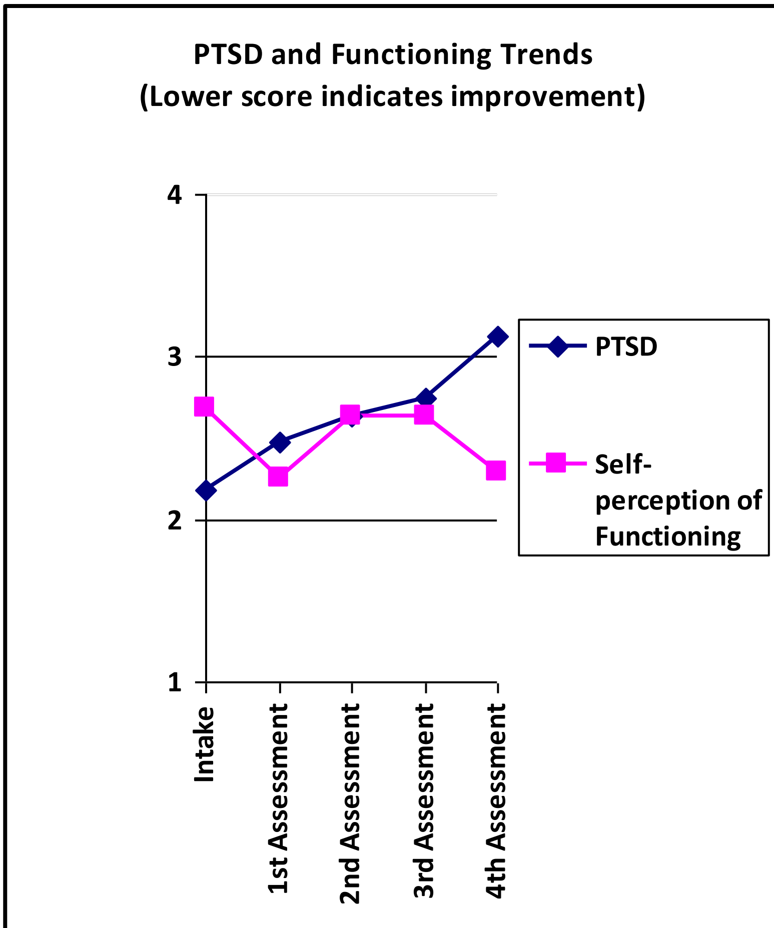
Gender:	Male	Nationality:	South African
Age:	47	Educational level:	Some primary
Number of children:	2	Pre-torture employment:	Student
Number of dependants:	0	Employment at intake:	Unemployed

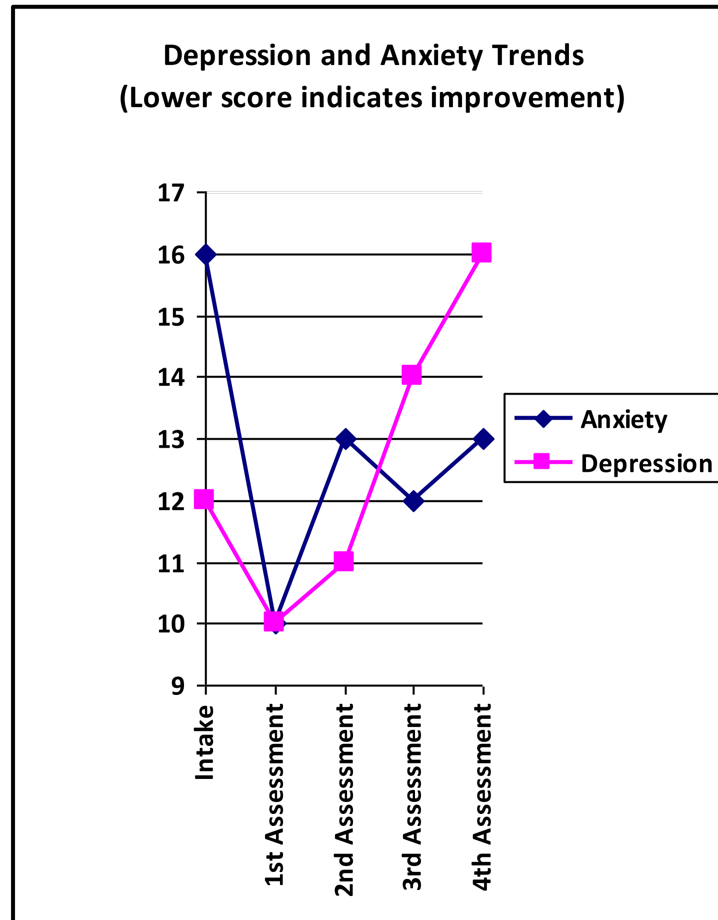
Results:

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

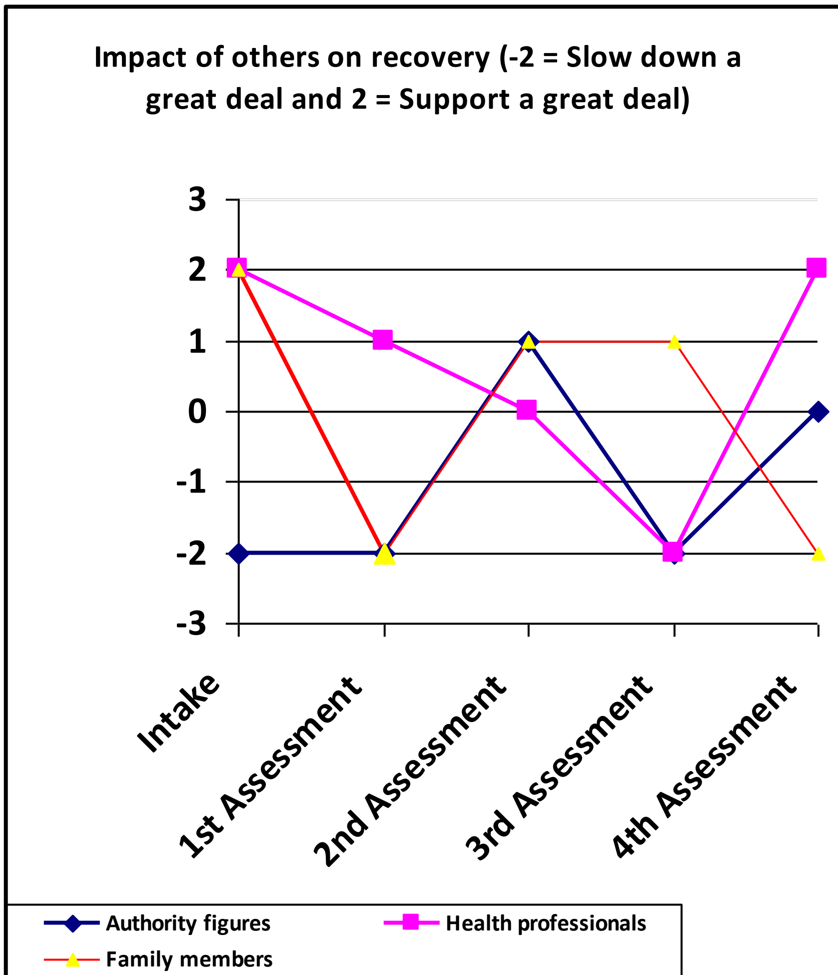
	3rd Client Self-Assessment	4th Client Self-Assessment
Date done	**25/05/2010**	**11/12/2010**
Number of sessions completed	18	25
Authority Figures impact on recovery	Slow down a great deal	No impact
Health professionals impact on recovery	Slow down a great deal	Support a great deal
Family members impact on recovery	Support a little	Slow down a great deal
Difficulty in solving complex problems	Complete difficulty	No difficulty
Difficulty in completing daily tasks	Complete difficulty	Complete difficulty
Difficulty in managing symptoms	Severe difficulty	Complete difficulty
Difficulty in ability to control reactions to others	Moderate difficulty	Complete difficulty
Difficulty in family connections	Severe difficulty	Complete difficulty
PTSD score (> 2.5 = symptomatic for PTSD)	2.75	3.125
Self-perception of functioning score (no cut off)	2.63	2.292
Anxiety (0-7 = normal, 8-10 = borderline and 11+ = clinical)	12	13
Depression (0-7 = normal, 8-10 = borderline and 11+ = clinical)	14	16

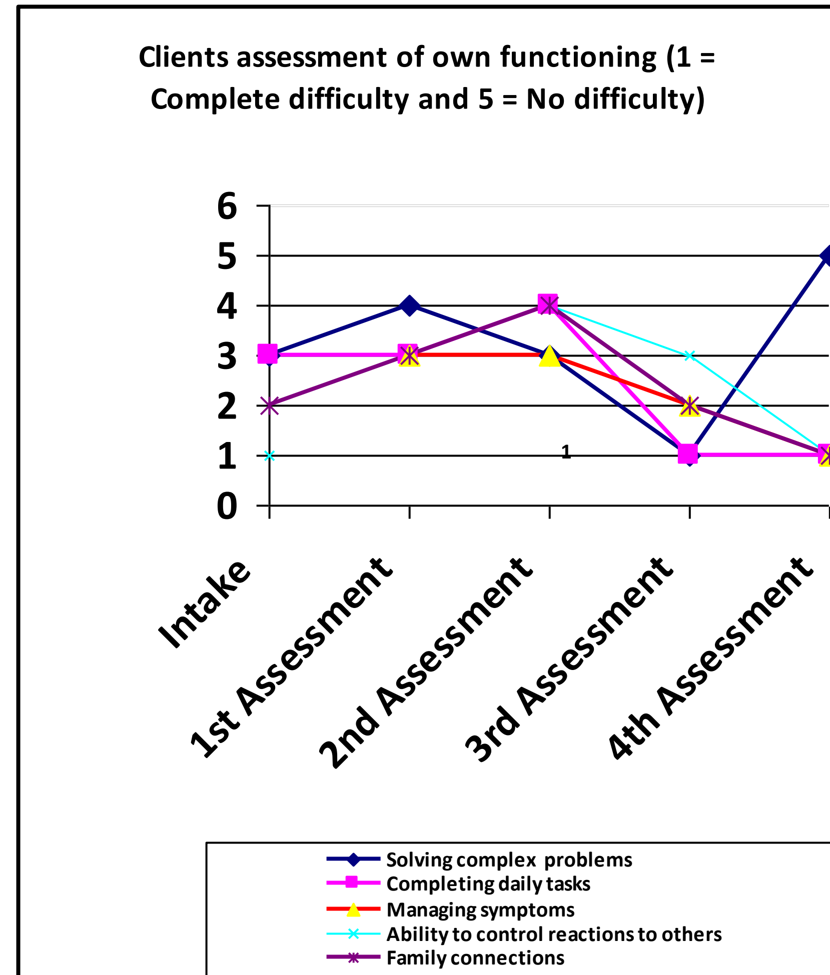
Down indicates improvement:





Up indicates improvement:





DROP-OUT REPORT FOR 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 termination. Only new clients in 2010 have been included.

There were 56 new clients who received psychosocial services from TTP in 2010. Of those, 15 (27%) clients are considered "new" (i.e. they have had two sessions or less without dropping out), 23 (41%) of the clients are considered "ongoing" (i.e. they have had three or more sessions without dropping out), and 18 (32%) cases are "closed". In 2009, 38 new clients received psychosocial services from TTP. Of those, 6 (16%) clients were considered "new", 20 (53%) were considered "ongoing", and 12 (32%) cases were "closed". The analysis that follows is for the "closed" cases.

The following diagram gives a breakdown on sessions held before clients stopped coming for individual counselling in 2009 and 2010.

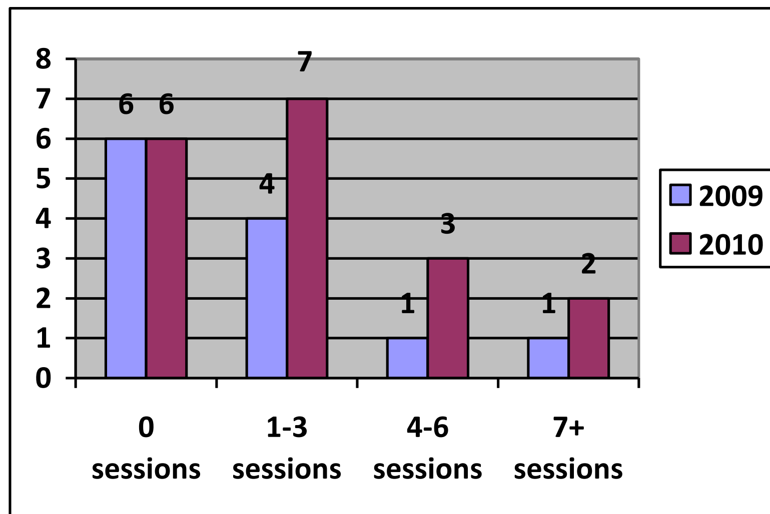


Figure 15: Number of clients who terminated counselling in 2009 and 2010

As is indicated by the diagram, of the 18 clients who terminated counselling during 2010, 6 did not have any counselling sessions, seven had 1-3 sessions, three had between 4-6 sessions, and two had 7 or more sessions. The following table indicates the reasons for termination according to the clinician, as well as responses provided by the client when phoned to ask their reasons for ending their sessions:

Total number of sessions	Reasons for termination (counsellor)	Reason for termination (client)
0	The client dropped out after the TTP intake: The client never came for his first counselling session despite the number of appointments scheduled for him	No answer on the telephone
0	The client 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
0	The client dropped out after TTP intake: Could not get hold of client on telephone number provided	No answer on the telephone. Left voicemail for client, but no response.
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 client dropped out after TTP intake: Client was never allocated. The client was still on waiting list after three months so we had to close the case.	Number unavailable
0	The clinician has never seen this client and does not have the clients file in her records	No answer on the telephone
1	The counsellor terminated: client travelled a lot	No answer on the telephone
1	The client stopped coming for counselling without giving a reason	Number unavailable
2	The client sees no reason for counselling; travels to Cape Town often	Number unavailable
2	The client stopped coming for counselling without giving a reason	The client said that she didn't like the service that she received at reception, however would still like to come for counselling
2	Referral to another counsellor	Number unavailable
3	The client stopped coming for counselling without giving a reason: The client missed three scheduled sessions. He has not made any contact with the Trauma clinic to schedule a new appointment	Left message with friend. Client does not have a contact number
3	The client stopped coming for counselling without giving a reason	No answer on the telephone
4	The client stopped coming for counselling without giving a reason	Client stopped coming for counselling – because he had problems with his health - but would like to come again and made a provisional appointment for January

4	The 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
6	Mutual agreement that counselling has been successful: we reached an agreement that the client would not need any more sessions and needs to focus on developing her career for now	Left voicemail for client
8	Client is busy with earning an income (business/hawking) and lives in Heidelberg, so access is challenging.	Client reported that we didn't phone to make another appointment, but that he was interested to come for counselling
12	Mutual agreement that counselling has been successful	Left voicemail for client

Table 38: Reason for drop-outs for 2010

The information gathered in the drop out report is useful since it indicates where the areas of concern are regarding clients' termination and allows us to reflect and follow up on the reasons for termination provided by both clinicians and clients. We are able to use this information to address concerns raised by clients and inform the staff involved of difficulties.

Through the drop out reports, we have been able to follow up on clients who dropped out but would like to continue counselling. These cases were put back onto the waiting list. We were also able to follow up on cases that had closed due to the time period spent on the waiting list. Because of capacity difficulties it has been necessary to put clients on a waiting list until space opens up in one of the clinicians' caseloads. People on the waiting list should be contacted every three days and informed of their position on the waiting list. Where people on the waiting list are unreachable after more than three attempts, they are removed from the list and the case is closed.

The report also allows us to reflect on our service. For instance, if a client indicates that s/he had a problem with the service, we are able to discuss this with the clinical team and make changes to our practice, if deemed necessary.

Through the drop out report, we have also seen that clients may "fall between the cracks" – for instance, not be allocated or not receive counselling after allocation. In order to deal with this problem, we ensured that all clinicians sign for their clients when the client was allocated to them. This change to the system has ensured that it is clear who the client is assigned to and when, and we are now able to follow up on clients from this allocation list.

COMPLIANCE REPORT FOR 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 an M&E intake is done. After every session, the clinician should complete a counselling Intervention Process Note (IPN) and after every six sessions, the client is asked to complete a self-assessment to assess his/her improvement in function or reduction in symptoms. When counselling comes to an end, the clinician should complete a Termination Intervention Process Note (Termination IPN). This report indicates what the compliance was per instrument in 2010.

1. Overall compliance

The average amount of data gathered over all instruments is 62%. This amount can be divided according to the amount of data that has been obtained and the amount of data that still can be obtained (data needed). It is important we are able to analyse homogenous groups of clients so that the data is comparable. For this reason, we decided that clients need to be assessed at the same /similar points in the therapeutic process. As will be discussed below, data may still be obtained if it falls within the following time limits:

- M&E (torture) intakes: 0-3 sessions
- Client self-assessments: Every six sessions from the sixth session with a two session window period (i.e. 6-8 sessions; 12-14 sessions; 18-20 sessions and so forth
- Counselling Intervention Process Notes (IPNs): within three sessions of the counselling session
- Termination IPNs: no cut-off since this information can be entered at any point after the case has been closed

The data needed is data that could become either lost (with the exception of the termination IPNs) or obtained depending on whether or not there is compliance within the agreed cut-off times.

Because termination IPNs do not have a cut-off for compliance, this element of compliance cannot be compared to the other three instruments (intakes, client self-assessments and IPNs). For these three instruments, the average amount of data obtained was 49%. The average amount of lost data for these instruments was 37% and the average amount of data needed was 13%.

2. Compliance per instrument (%)

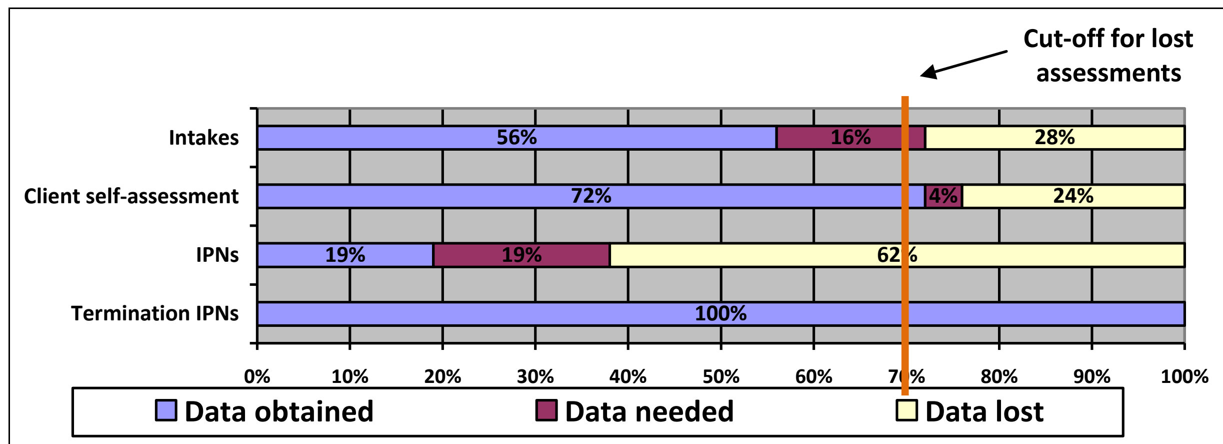


Figure 16: M&E compliance rates (%) per instrument 2010

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 three sessions, it is considered "lost" since his/her functioning and symptoms could have been impacted on by the counselling process. During 2010, our overall compliance for the M&E intake indicated that 56% of intakes were completed. 16% of intakes could still be done within the session timeframe and are not yet lost, and 28% of intakes were lost (see figure above).

b) Intervention Process Note

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 19% of IPNs were done within the specific timeframes, 19% could still be done within the session timeframes and are not yet lost, and 62% of all IPNs were lost (see figure above).

c) 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 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). In 2010, our overall compliance for the client

self-assessments indicates that 72% of all client assessments were done within the specific session time-frames, 4% could still be done within the session time frames and are not yet lost, and 24% of all client self assessments were 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. In 2010, all of the termination IPNs were done (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 rather than 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.

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