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

MONITORING AND EVALUATION PROGRESS REPORT
To End December 2011

Produced by:
Dominique Dix-Peek
With support from Monica Bandeira

"My counsellor helped me a lot to open up. I was like a person jailed in myself but now I am free"

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Cover picture: Cactus flowers adapted from photos.igougo.com

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LIST OF ABBREVIATIONS

CoRMSA: Consortium for Refugees and Migrants in South Africa

CIDT: Cruel, inhuman and degrading treatment

CSVR: Centre for the Study of Violence and Reconciliation

DRC: Democratic Republic of the Congo

HADS: Hospital Anxiety and Depression Scale

HTQ: Harvard Trauma Questionnaire

ICF: International Classification of Functioning and Disability

JRS: Jesuit Refugee Services

LHR: Lawyers for Human Rights

M&E: Monitoring and Evaluation

PTSD: Post Traumatic Stress Disorder

RCT: Rehabilitation and Research Centre for Torture Victims

RAO: Refugee Aid Organisation

SA: South Africa

SACTS: South African Centre for Torture Survivors

SANToC: South African No Torture Consortium

SAWIMA: Southern African Women's Institute on Migration Affairs

TTP: Trauma and Transition Programme

UNHCR: United Nations High Commissioner for Refugees

ZTVP: The Zimbabwean Torture Victims Project

ACKNOWLEDGEMENTS

This report would not have been 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.

The support of the Rehabilitation and Research Centre for Torture Victims (RCT) has ensured the success of this project. They have become important partners in this endeavour.

Without the work of numerous people, this report would not have been possible. The "M&E team" worked hard to ensure the implementation of the Monitoring and Evaluation of this project. Dominique Dix-Peek is the main researcher involved in the project and ensures its implementation and that data is collected, cleaned and analysed. Monica Bandeira manages the project and assists with analysis and knowledge generation from the data obtained.

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.

Implementing the project was dependent on the support, encouragement and guidance of our programme manager Nomfundo Mogapi.

Clinicians have contributed to the M&E system development and implementation despite it making their work "public". They have been key to its success. The clinicians include:

- Marivic Garcia (Full time trauma professional)
- Boitumelo Kekana (Full time trauma professional)
- Malose Langa (Part time trauma professional)
- Megan Bantjes (Part time trauma professional)
- Nonhlanhla Mngomezulu (Sessional trauma professional)

Boitumelo Kekana, our clinical coordinator, partners with us to ensure synergy between M&E and clinical systems and procedures.

Our receptionists are usually the first people that clients meet when coming into the clinic. Mosima Selemela and Pinkey Bahlekazi played a central role in ensuring that clients felt welcome and respected throughout the duration of their therapeutic relationship with us.

Our Community facilitators have referred torture survivors they support in the community for counselling at TTP. These include Modiegi Merafe, Pravilla Naicker and Gaudence Uwiyeze who play an important role in raising awareness regarding torture, its impact and the services we provide.

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, Francoise Bigirindavyi and Serena Thomas provide support to clients who communicate in other languages and play an important role in the therapeutic process with clinicians as well as gathering data for M&E.

Intakes and client assessments were conducted by trained social work interns:

- Kabelo Choma
- Rudo Garidondo
- Nabeelah Karim
- Kirsty Hunter
- Caleb Cheza
- Juliana Munlo
- Cindy Kree

Our intern psychologists have included:

- Sumaiya Mohamed
- Jabu Masitha
- Maire-Claire Kilroe
- Unati Mbete
- Serena Thomas
- Yvette Bowden

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The following are other staff members who have contributed to the project and ensured its success:

- Sonto Mbatha
- Nomvula Mahlangu
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- Ntombifuthi Zondo
- Puleng Montsho
- Jane Ledwaba
- Nthabiseng Mabena

TORTURE AS A FOCUS OF CSVR

"Torture" is used in this document to denote the range of experiences of abuse which the United Nations Convention Against Torture (1984) defines as torture and cruel, inhumane and degrading treatment (CIDT). This convention defines torture as:

> "any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act which he or a third person has committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in, or incidental to lawful sanctions[1]"

As Bantjes and Langa (2011, p.7)[2] state,

> "Often there is a fine line between incidents that meet the legal criteria for torture and those that are considered cruel, inhumane and degrading treatment under international law. Furthermore, an incident can start off as CIDT and escalate into torture."

For this reason, we choose not to differentiate between torture and CIDT for our clinical interventions, and so, for the purposes of this report, "torture" may connote any of the experiences that fall between CIDT and torture.

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[1] United Nations (1984) *Convention against torture and other cruel, inhuman or degrading treatment or punishment.* Retrieved from www2.ohchr.org/English/law/cat.htm on 06/12/2011

[2] Bantjes, M & Langa, M (2011) *Finding our way: developing a community work model for addressing torture.* Unpublished report by the CSVR

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 CSVR began offering a free counselling service to victims of political violence in 1989. Since the mid-1990s we have seen a shift from political violence to criminal violence within the country. From the late 1990s, the CSVR 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, the CSVR 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 the M&E 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 with 2011 being the last year for this phase. This report is one of the outputs under this project. It is the fifth report of its kind as a there have been full year reports produced for 2009, and 2010, and mid -year reports done in 2010 and 2011. This report looks at the data obtained from 2009 to 2011 and describes the group of torture clients who received counselling services during this period.

This report uses the information obtained through the M&E system by detailing the characteristics of clients who completed an intake assessment from 2009 to 2011; providing information regarding the impact that our services have had on clients since the beginning of the project; providing examples of individual Client Progress Reports produced ; describing the drop-out rates for the year, including the reason for drop-out; outlining the compliance rates achieved in terms of documentation of M&E instruments; and indicating how the clients felt about the service they received at the CSVR. Information was analysed using STATISTICA to assess the clients' change over time.

While there have been elements of this report that have demanded explanations, we have chosen this report to be a forum to report on the data. We plan to have a meeting with the

clinical staff to unpack the data gathered in this report and aim to develop a brief follow-up report.

Describing the Monitoring and Evaluation Process:

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). Additionally, while not monitored with the compliance, all interventions should be captured on our database under the IPNs. This includes referrals and telephone calls made; referrals and telephone calls received, consultations with the interpreter or colleagues, and escorting the client to the hospital or assisting the client with interpretations. After every six sessions, the client is asked to complete a self-assessment to assess his/her improvement in function or reduction in symptoms. In 2009, a clinician assessment was to be done at the same time as the client assessment to triangulate the change in clients' functioning. However, this was discontinued in favour of the counselling IPNs. When counselling ends, the clinician should complete a Termination Intervention Process Note (Termination IPN).

TORTURE CLIENTS WHO HAVE RECEIVED PSYCHOSOCIAL SERVICES AT CSVR

185 clients accessed our services from 2009 until the end of 2011. A full description of the torture clients seen over this period follows.

1. Demographic information

   For the full period of the project (2009-2011), the largest population (31%) were Congolese (from the Democratic Republic of Congo) while Zimbabweans and South Africans made up the next largest populations (30% and 12% respectively). There has, however, been an interesting shift in nationality since the beginning of the project. The figure below indicates how there has been a sharp increase in the number of Angolans, Congolese (from both Brazzaville and the DRC), Ethiopians and Somalis while there has been a decrease in the number of South Africans and Zimbabweans from 2009 to 2011.

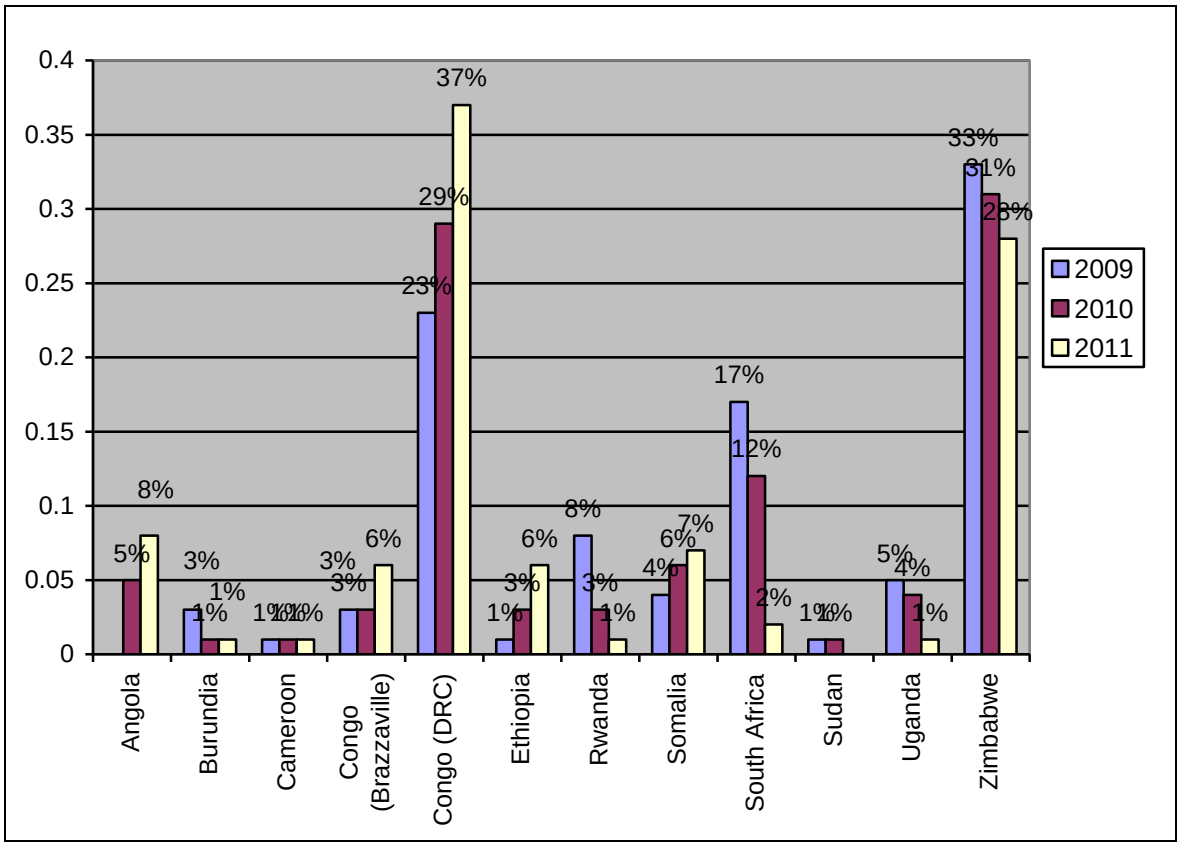


Figure 1: Nationality of clients receiving psychosocial services at TTP from 2009 to 2011

While our clinical team has always seen a large proportion of forced migrants as part of the work done with tortured clients, the population of forced migrants has increased from 83% in 2009 to 98% in 2011.

55% of clients who received psychosocial services at TTP from 2009 to 2011 were women, while 45% were men. This ratio has remained stable from 2009 to 2011.

For this project, the youngest client was 7 and the oldest client 64. Almost half of our sample (49%) was between the ages of 19 and 38. The mean age for the sample was 35 with a standard deviation of 11.33.

Until January 2011, questions about marital status and number of children were only asked during the Torture Intake (rather than the initial TTP intake). For this reason we only have responses from 65 clients on their marital status. Of these, 40% reported never being married at the time of intake, while just under a third (31%) reported being widowed (table below).

Marital Status	**Frequency**	**Percent**
Never married	26	40%
Currently married	15	23%
Separated	2	3%
Divorced	2	3%
Widowed	20	31%
Total	**65**	**100%**

Table 1: Marital status for clients 2009 to end 2011

The majority of clients (55%) reported living with their family (which could include living alone with their children). Others were living with their partner or spouse (6%) in a shelter (17%), with friends (6%) with strangers (7%) or alone (9%) (n=87). 72 clients (39%) reported having children at the time of intake. Of those who did have children, a quarter (26%) had four children while fourteen (19%) had five children or more. The average number of children was 3 with a standard deviation of 2.23.

Our tortured clients reported being well educated, with 62% having completed their high school education, and 34% having completed a tertiary level or post-graduate degree. Before the torture experience, 55% of clients were employed within semi-skilled, skilled or highly skilled jobs. However, at the time of intake, two thirds were unemployed (table below).

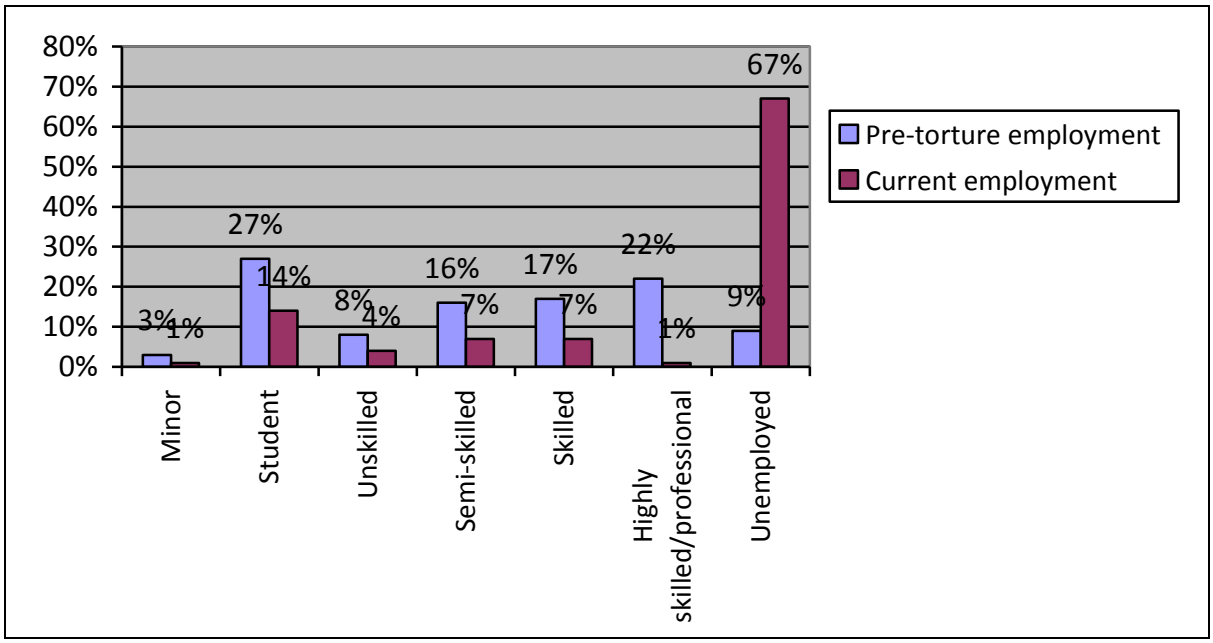


Figure 2: Changes in employment status linked to torture (%) from 2009-2011 (n=102)

Our clients were largely referred by friends or family, other humanitarian organisations or self-referred. The figure below indicates where our clients were referred from. "Other" refers to the Refugee Help Desk, the Consortium for Refugees and Migrants in South Africa (CoRMSA) and a South African No Torture Consortium (SANToC) member organisation.

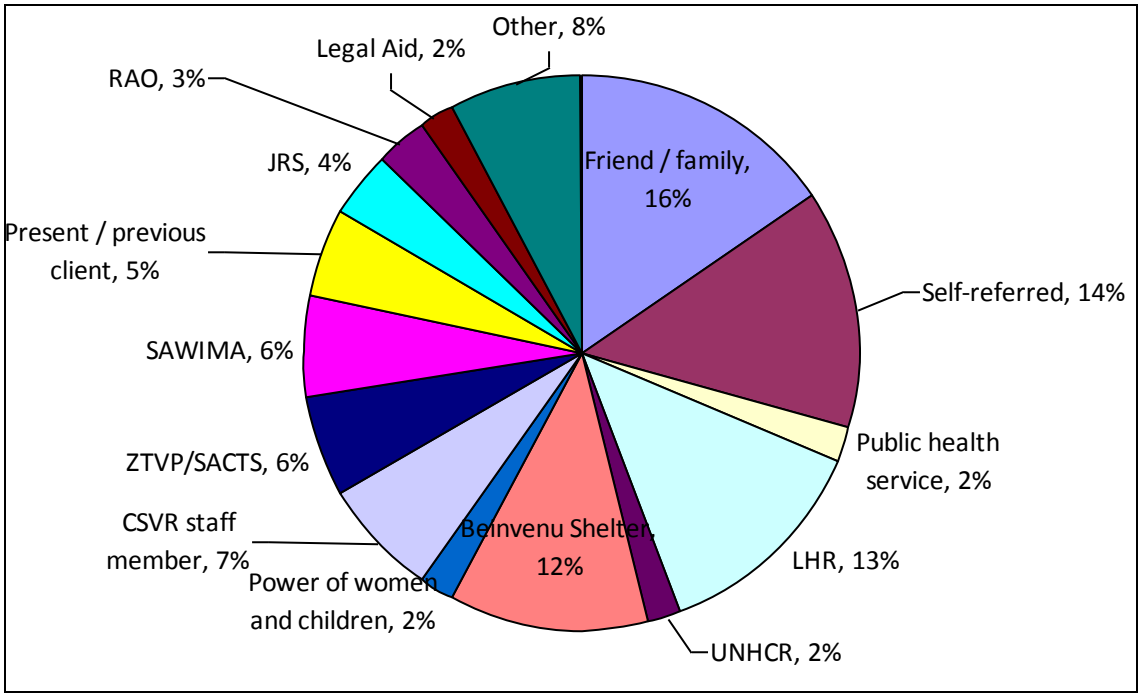


Figure 3: Referral of clients from 2009-2011

Where clients are being referred from impacts our work since it may change the demographics of the clients we see (for instance, we may see an increase in non-nationals as opposed to South Africans). It also indicates other organisations that we are connected with, with whom we should maintain relationships. Additionally, it points to organisations that we are not connecting with and need to spend more resources in marketing ourselves to so that we are accessing a broad spectrum of clients.

2. Traumatic events experienced by clients

Our sample of torture clients from 2009 to 2011 experienced an average of two traumatic events each (standard deviation = 1.49) with a total number of traumatic events of 428. 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 for our clients between 2009 and 2011 were: bereavement, war, assault and rape. The maximum number of types of traumatic events was eight, and the minimum one. The table below indicates the types of traumatic events experienced by the clients at TTP for 2009, 2010 and 2011. Please note that the reason that the cumulative number of clients on the table below does not add up to 185 clients is because a number of clients continued counselling for more than one year, i.e., they were carried over from one year (e.g. 2009) to a following year (e.g. 2010 and 2011).

Type of Traumatic event	**2009**		**2010**		**2011**	
	Number	**Percentage of people who experienced:**	**Number**	**Percentage of people who experienced:**	**Number**	**Percentage of people who experienced:**
Torture	75	100%	102	100%	71	100%
Bereavement	9	12%	22	22%	33	46%
Rape	19	25%	15	15%	25	35%
Assault	13	17%	16	16%	24	34%
War	16	21%	14	14%	23	32%
Witness to trauma	5	7%	2	2%	15	21%
Armed robbery	2	3%	8	8%	8	11%
Xenophobia	1	1%	4	4%	4	6%
Mugging	2	3%	1	1%	4	6%
Hostage	1	1%	1	1%	3	4%
Relationship violence	2	3%	1	1%	3	4%
Car accident	2	3%	1	1%		

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

Knowing what types of traumatic events our clients have experienced is important for us since it allows us to change the focus or provide training to our clinical staff. For instance, with the increase in clients who experienced bereavement cases, training was provided on bereavement and traumatic bereavement, and what therapeutic approaches should be brought to the sessions with clients who had experienced bereavement.

During the initial intake, we ask details of where and when the presenting traumatic event took place. While a client may indicate more than one event, the country (or countries) in which the events took place in is only captured once in the initial intake form. It is important to note that the time taken for the traumatic event to occur and where the traumatic event occurred may relate to either the torture experience or any subsequent traumatic experiences. Thus, it does not necessarily pertain exclusively to the torture experience.

From 2009 until the end of 2011, 157 clients indicated when the event occurred (table below). Of these clients, 78% stated that it had taken more than two years for them to come to CSVR for counselling.

Time taken between traumatic event and TTP intake	**Number of clients (n=157)**	**Percentage**
Less than two weeks	1	1%
3 weeks to 1 month	4	3%
2-6 months	14	9%
7 months – 1 year	16	10%
2-5 years	53	34%
6-10 years	35	22%
10+ years	34	22%

Table 3: Time taken between traumatic event and TTP intake

Torture clients in South Africa may experience a wide range of traumatic events. The graph below indicates that although many non-nationals come to South Africa to seek refuge, while in South Africa they may still be exposed to violent crime, xenophobia and possibly torture at the hands of the South African state.

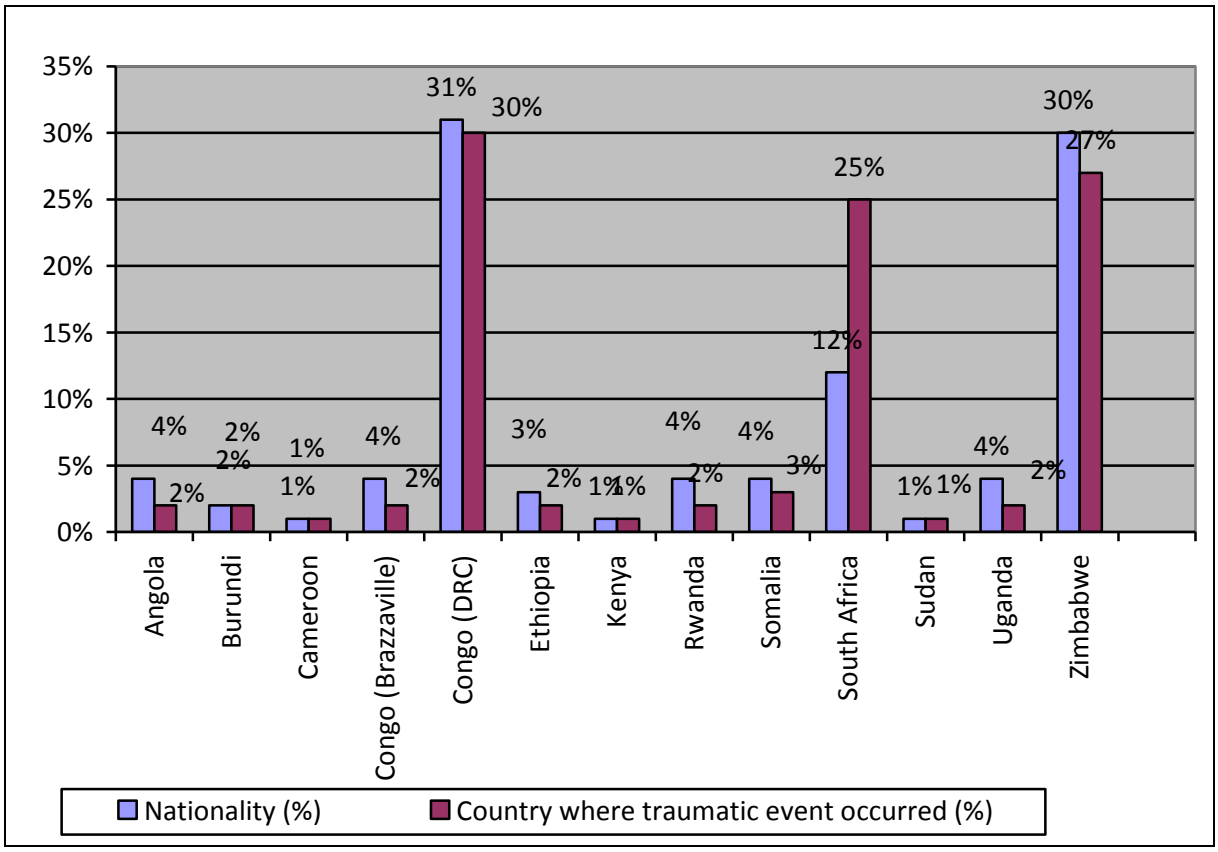


Figure 4: Country where traumatic event occurred compared to country of birth (%)

Torture is complex and its effects can be devastating. However, over and above their torture experiences, many of our clients are traumatised and re-traumatised in a country where they came to seek shelter and refuge. The continuous nature of trauma in South Africa paints a complicated picture of the therapeutic process with torture survivors.

3. <u>Forms of torture experienced by clients</u>

If or when details of the torture experience were divulged to the practitioner, it was asked that this be indicated on the Clinicians' Assessment. However, after the decision was made that clinicians' discontinue the Clinicians' Assessment in favour of Intervention Process Notes, this information went through a period of not being gathered. In 2011, however, space was provided for clinicians to include this information in the database so that it could be used for analysis at a later stage.

The details of the torture experiences were indicated for 75 clients. In total, these 75 clients experienced 339 different forms of torture, with an average of 5 torture experiences each and a standard deviation of 3.20. The maximum number of forms of torture that a client experienced was 15. These torture experiences include beating, kicking or striking with objects, threats and humiliation, rape and starvation, amongst others (table below). "Other" includes exposure to unhygienic conditions, mock executions, suspension from a

rod by hands or feet, forced standing, being forced to write confessions, being shocked repeatedly, exposure to heat, sun or strong light, overexertion or hard labour, blindfolding, denial of medical treatment, being placed in a very small space, near drowning, and mutilation of genitalia.

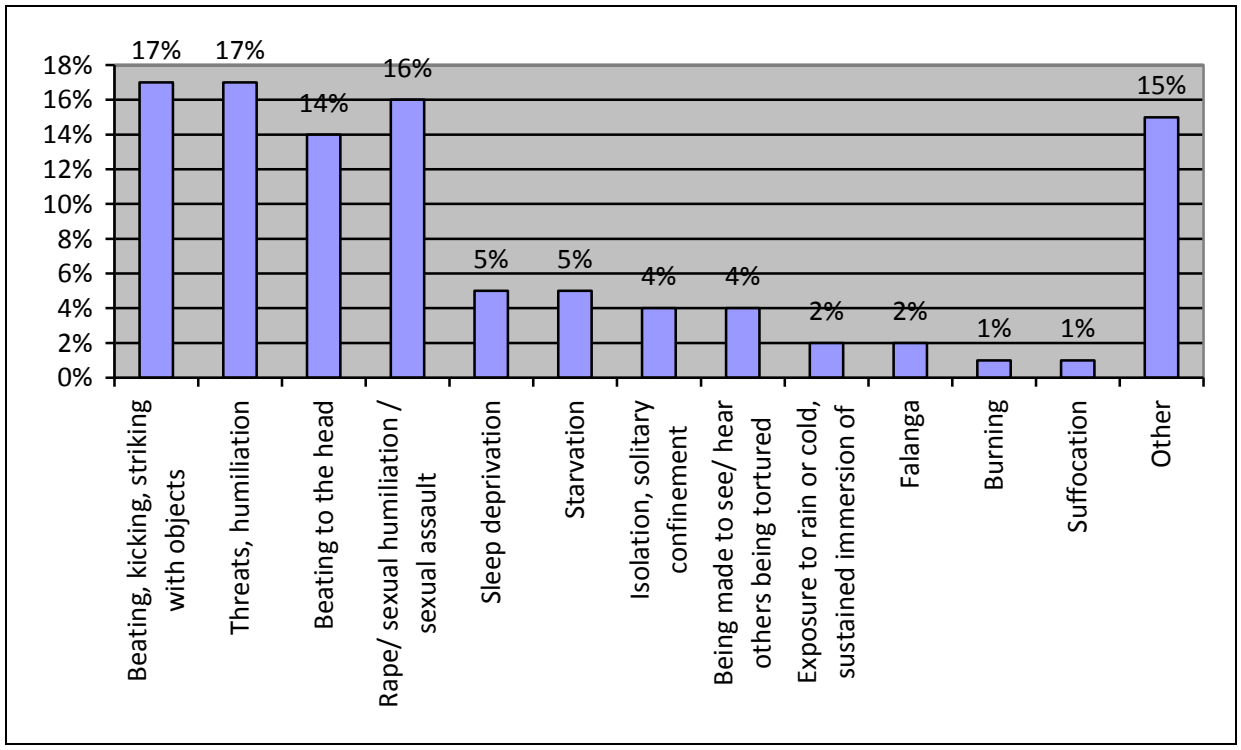


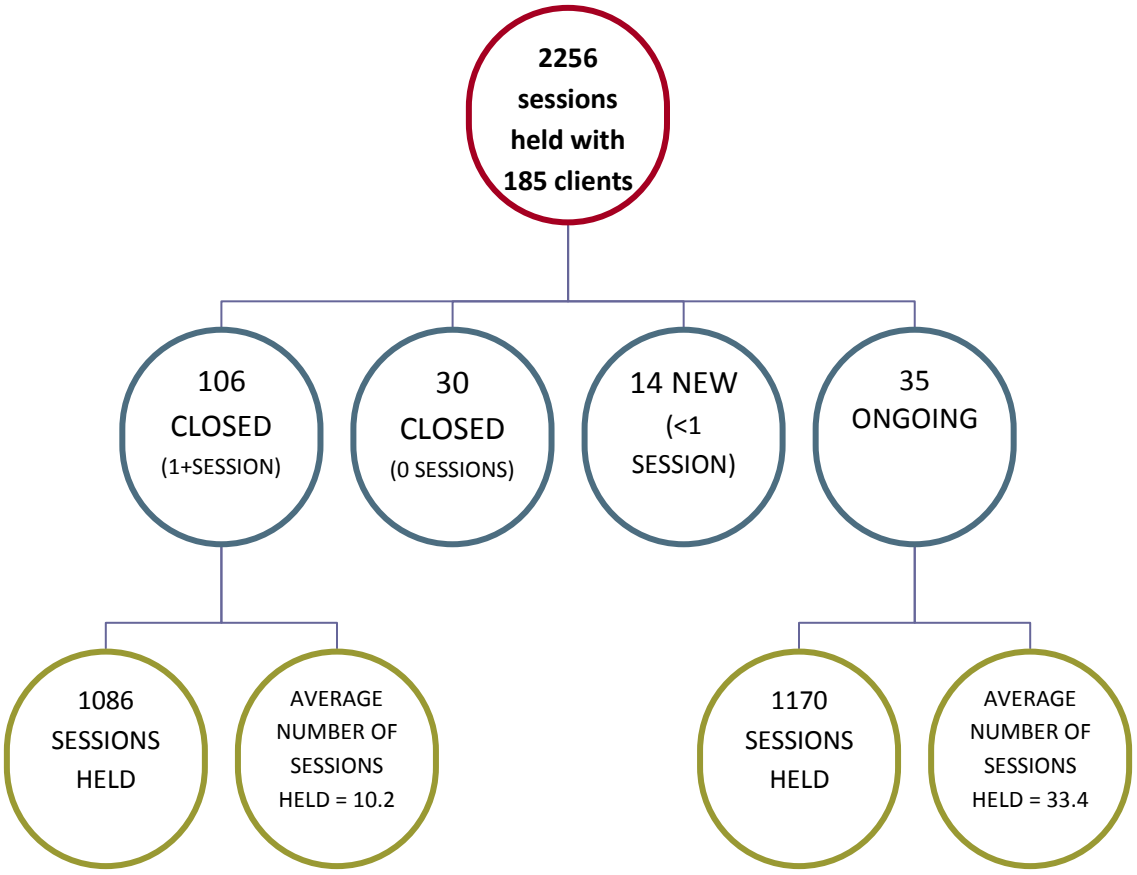
Figure 5: Forms of torture experienced by clients (%)

36 clients indicated who the perpetrator(s) of their torture experience was. For eight torture victims who experienced more than one separate torture event and could specify the perpetrators on both events, both sets of perpetrators were included (total number of torture events indicated is 44). Almost half (45%) of torture experiences were perpetrated by the police, while the military and paramilitary forces perpetrated 18% and 25% of torture experiences respectively.

4. <u>Breakdown of clients according to number of sessions</u>

A total of 2256 individual, family and group sessions were conducted with torture victims from 2009 to 2011 with a maximum of 117 sessions and an average of 12 sessions (standard deviation = 19.01; mode= 1). The figure below provides a more detailed breakdown of this.

Figure 6: Breakdown of sessions per type of client



The following table breaks the number of sessions down per type of client over the three year period:

Type of case	**Breakdown of sessions per client**	**2009 (n=75)**	**2010 (n=102)**	**2011 (n=71)**
Closed (1+ session)	**Number (%)**	**18 (24%)**	**31 (30%)**	**18 (25%)**
	Number of sessions held in year	89	123	88
	Average number of sessions held in year	6.4	4.1	4.8
Closed (0 sessions)	**Number (%)**	**6 (8%)**	**6 (6%)**	**5 (7%)**
New (<1 session)	**Number (%)**	**4 (5%)**	**15 (15%)**	**14 (20%)**
Ongoing	**Number (%)**	**47 (63%)**	**50 (49%)**	**35 (49%)**
	Number of sessions held in year	540	470	415
	Average number of sessions in year	11.5	10	12

Table 4: Breakdown of sessions per client from 2009 to end 2011

The limitation to the table above is that it only indicates the number of sessions per type of client for that specific year. It does not give an indication of the long term nature of many of our clients. To give a broader perspective of this, it is useful to look at it in conjunction with Figure 6 above. This shows that, while in 2011 the average number of sessions held for ongoing cases was 12, because many clients stay on for more than one year, the cumulative number of their sessions increases. This allows for the increase to an average of 33.4 sessions for ongoing clients over the full three years.

This breakdown per session has been useful since it allows the clinical team to put the work that is done into perspective. When these numbers were initially shown to the clinical staff, there was disappointment that so few clients had been seen. However, 2256 sessions over three years is a very high number – especially considering the limited number of clinicians we have (in 2011, for example, there were only two full time clinicians for 71 clients).

Another way that this breakdown has been shown to be useful is in the planning of the clinical work for the following year. In 2009, the average number of sessions held for closed cases was 6.4, and the average number of sessions held for clients who were still coming for therapy was 11.5. However, we are seeing an increase of long term clients (the average number of sessions held for closed cases over the three years is 10.2 and the average number of sessions held for ongoing cases is 33.4 for the three years). Because we can see the increase in the number of sessions that clients are staying, we are able to plan how many clients each clinician should see so that our target number of clients is achieved, while still preventing clinician burnout.

Through this breakdown, we are also able to monitor the number of clients dropping out with one session or less. In 2007 and 2008 we had a high number of clients dropping out after the TTP intake and because of that, one of our objectives was to reduce the number of drop-outs of clients with one session or less. This breakdown gives a means for us to monitor the number of clients who were dropping out after the TTP intake (see the Drop-Out Report, below).

Discussion

It is clear from what is mentioned above that we have gathered a large amount of data through the initial TTP intake. This data has allowed us to increase our knowledge about the clients that we are seeing, increase the documentation of the services that we provide and observe the impact that we are having at TTP. The knowledge that we generate has been important to improve the quality of our practice and we have gained an in-depth understanding of the people who access our services. Without this knowledge we would be limited as to how to intervene. It would also limit us as to how we should change the system to ensure the best quality of service possible. Monitoring and evaluation helps us focus on who we are trying to help. It allows us to see what is happening to the people who we are trying to serve.

Through the M&E process we have learnt the importance of documenting our work. This makes the invisible visible and we are able to generate knowledge from what is documented.

There have, however, been a number of challenges regarding the M&E process and the initial TTP intake. For instance, when setting out the questions asked in the assessment forms, we were very inclusive. We tried to get information on all different aspects of the clients' psychosocial life. While we have cut this down substantially, we still need to evaluate whether we are being too inclusive and asking too much from the client.

Recommendations

In order to document the services provided to a client, improve the quality of service, focus on our clients, plan work and change the system when necessary we have found the M&E system to be essential. However, there are a number of vital areas that need to be observed for this to occur:

1. Gather all necessary information. If the information is unnecessary, decisions should be made as to whether or not to keep gathering it
2. Ensure that information gathered is being analysed and fed back to all participants. This guarantees that discussions can be held around its usefulness, whether information should be continued to be gathered, whether it is being used. This information should inform the M&E process
3. The system should be evaluated to ensure that it is streamlined, that questions are appropriate, that the time intervals are appropriate, and that information that is being gathered is essential
4. Changes to the system should be ongoing when necessary, with the input of all necessary parties

All of the recommendations mentioned above are parts of the assessment process that we are continually trying to perfect. While we feel we have made leaps in streamlining the process and keeping communication open between clinical staff and the M&E team, this is an ongoing process that needs constant evaluation.

INTAKE DATA REPORT

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 2009 to 2011. The report includes all clients between January 2009 and the end of 2011. However, if the client did not complete an intake within the first two sessions, their intakes were excluded from the data since we felt that coming for counselling may have impacted on their functioning.

A total number of 90 clients were included in the sample (49% of the total number of clients who have been seen between 2009 and 2011). This includes all clients who completed an M&E/torture intake within the first two sessions of counselling. As not all of the new clients completed an M&E intake, we need to be cautious about generalising this information. However we 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 functioning 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.

1. <u>Demographic information</u>
   82 of the 90 clients who completed an intake assessment from 2009 to 2011 indicated where they had been referred from. Of these, 84% indicated that they had been referred by an external person or organisation while the other16% had been self-referred.

   Clients came from 12 different countries with the majority coming from the Democratic Republic of Congo (DRC) (See the figure below). For this sample, “other” refers to one person from Cameroon, Kenya and Uganda.

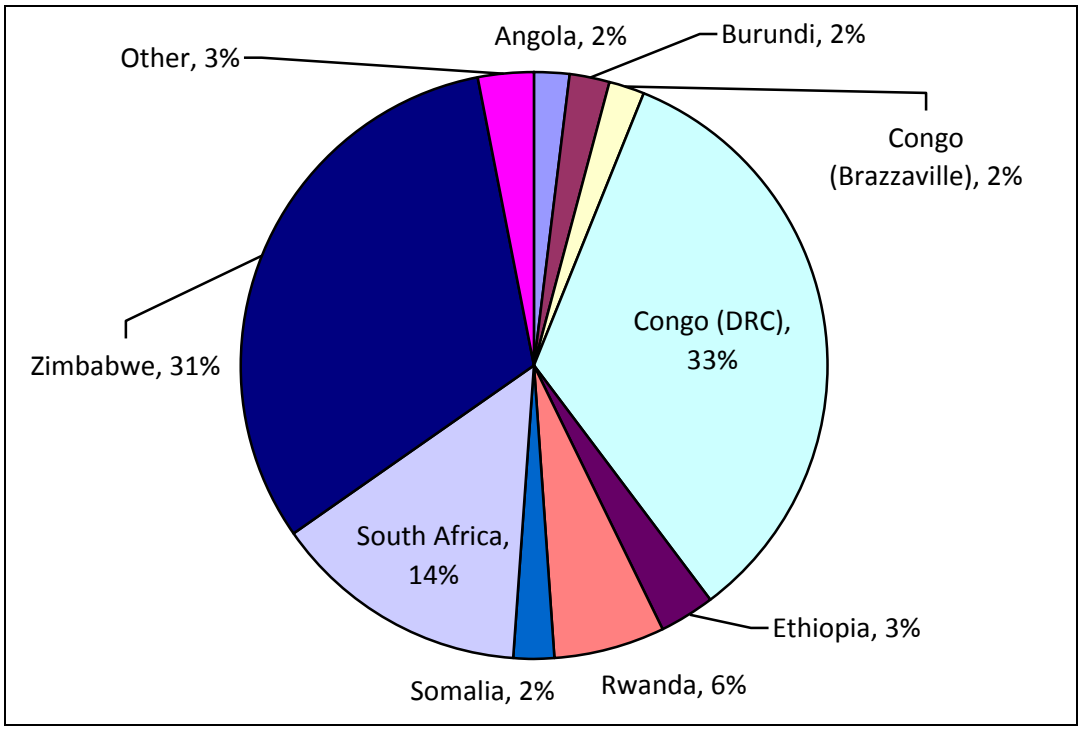


Figure 7: Nationality for M&E intakes

For an in-depth indication of the nationalities of the clients with intake assessments from 2009 to 2011, see the figure below. This table represents the increase in clients from the Congo (both DRC and Brazzaville), and the shift in Zimbabwean clients over the past three years.

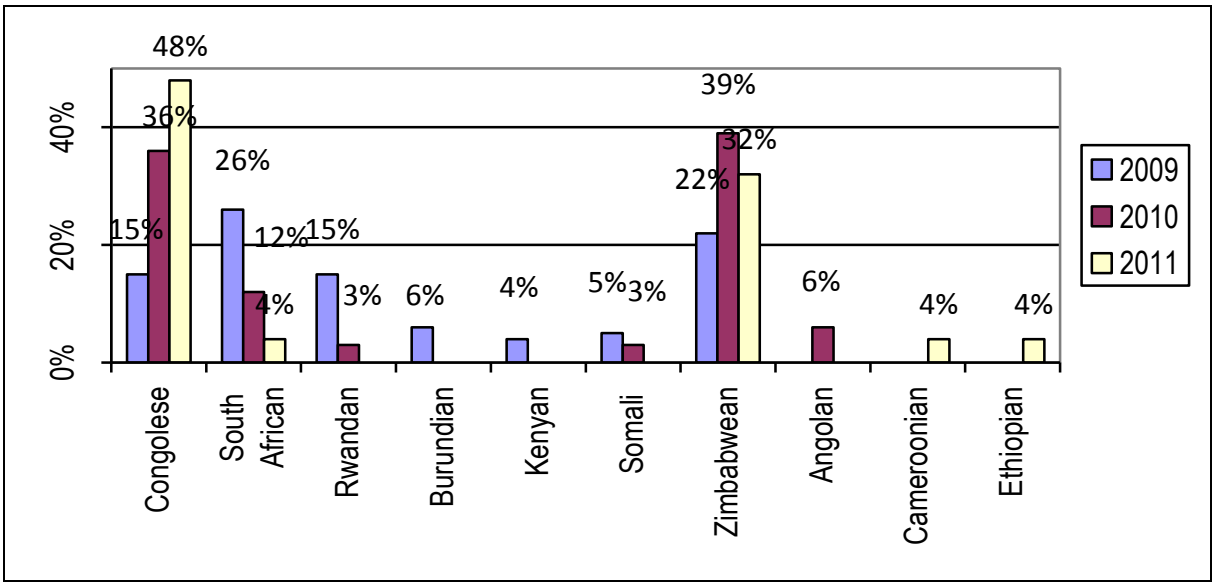


Figure 8: Nationality for M&E intakes in 2009 and 2010

The majority of clients who had an M&E intake were female (58%). The oldest client was 58 years of age, while the youngest was 17. Almost half the clients (48%) were between the ages of 19 to 38 with a mean age of 37 and a standard deviation of 9.76. This is the age where, for the general population, people tend to be the most economically viable. However, as seen below, when looking at the change of employment status for torture clients, the employment status after the torture experience is severely compromised (see figure 9 below).

One third of clients reported being married at the time of intake while 29% reported being widowed (n=85). For a comparison from 2009 to 2011, see the table below.

Marital Status	2009		2010		2011	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Currently Married	9	41%	13	39%	5	21%
Divorced	1	4.5%				
Missing			2	6%	4	17%
Never Married	4	18%	8	24%	7	29%
Separated	1	4.5%	2	6%	1	4%
Widowed	7	32%	8	27%	7	29%
Total	**22**	**100%**	**33**	**100%**	**24**	**100%**

Table 5: Marital Status for intakes from 2009 to 2011

Most clients who completed an M&E intake from 2009 to 2011 (54%) were living with their family (which includes living alone with their children). The rest of the clients were living with strangers, living alone, with their partner or spouse or in a shelter. 59 clients mentioned having one or more children at the time of M&E intake. Of those, 16 clients (27%) had four children, and 11 (19%) had five or more children. The mean number of children was 3 with a standard deviation of 1.79.

The education level of clients at the time of the M&E intake was high with 58 (72%) of the 81 clients who had specified their education level having a high school level education or above. 36% had a tertiary or post-graduate level education. Before the torture experience, 43% were employed in either skilled or highly skilled/professional positions (n=80) while 6% were unemployed. However, at the time of intake, 55 (68%) were unemployed. There were no clients in highly skilled / professional positions (figure below).

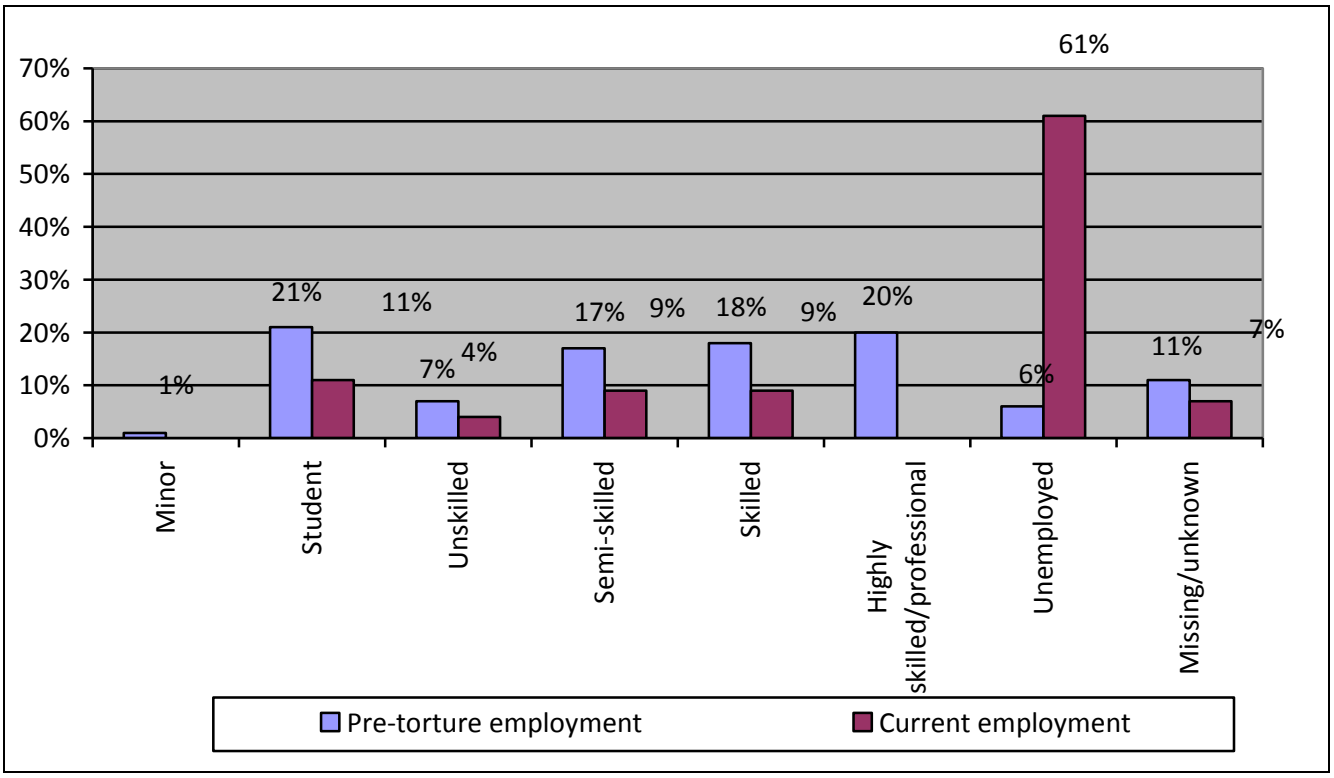


Figure 9: Changes in employment status linked to torture for M&E intakes

2. Psychiatric Considerations

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." (p.15)[3]. 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.

There is a maximum score of 160 for the HTQ: Total score. PTSD and self perception of functioning are measured on a four point scale including, not at all, a little bit, quite a bit and extremely; and assigned a value of 1, 2, 3 or 4 respectively. A score is computed for each scale by averaging the scale value for responses to all the items in the scale, allowing patients to be ordered

[3] 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

from no symptoms to extreme symptoms based on the average score. For both the PTSD score and the self-perception of functioning score there is a maximum score of four. Mollica et al (2004) suggest a cut-off of 2.03 to be symptomatic for PTSD for clinical work with refugee populations. However, we opted for the more conservative cut-off of 2.5 to be considered check-list positive 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, from 2009 to 2011, the mean HTQ: Total score was 108.1 (standard deviation = 27.18). The mean self-perception of functioning score was 2.71 (standard deviation = 0.58). The group presented with a mean score of 2.87 for PTSD (standard deviation = 0.59) with 65 clients (72%) being checklist positive for PTSD. See the table below for a breakdown per year for the self-perception of functioning and PTSD score.

	2009	**2010**	**2011**
Mean Self-perception of functioning score	2.87	2.63	2.63
Mean PTSD score	3.05	2.81	2.75
Mean HTQ: Total score	118.55	107.67	98.08

Table 6: Harvard Trauma Questionnaire for intakes in 2009, 2010 and 2011

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 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.

Between 2009 and 2011, the majority of clients presented with clinical levels of both anxiety and depression (figure below).

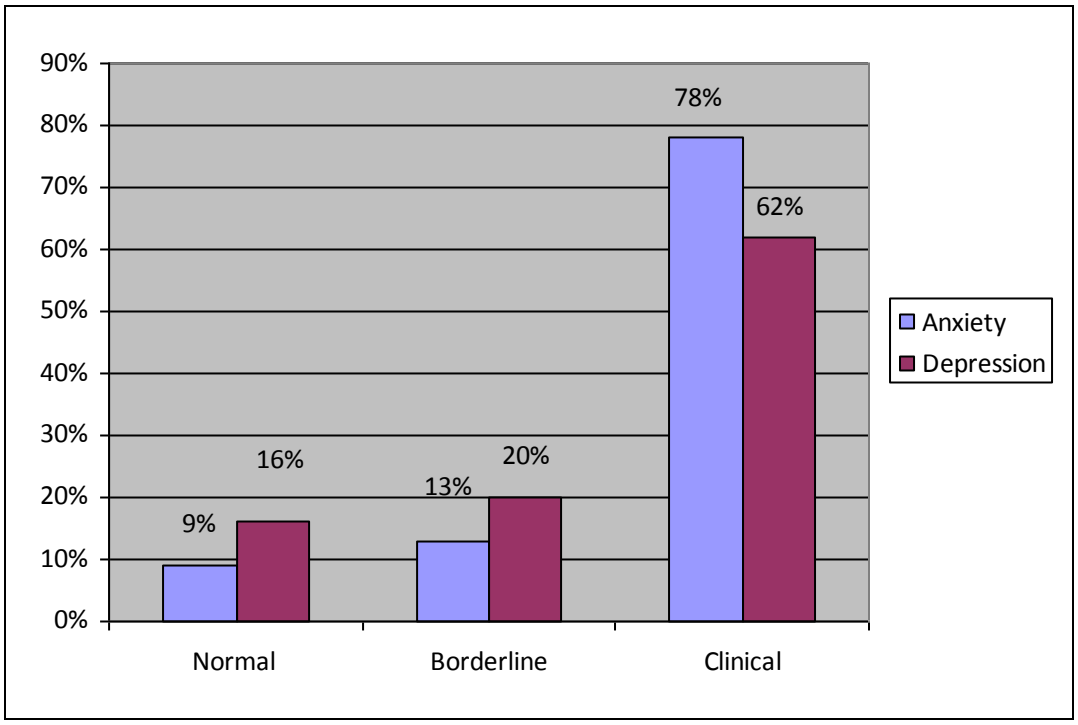


Figure 10: Hospital Anxiety and Depression Scale for M&E intakes from 2009 to 2011

There has been a shift in the anxiety and depression scores from 2009 to 2011. In 2009, 91% of clients were checklist positive for clinical levels of anxiety. This decreased to 52% in 2011. Similarly, in 2009, 68% of clients were checklist positive for depression; however this score dropped to 52% in 2011.

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 – the officials responsible for granting or denying legal status in South Africa), 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.

From 2009 to 2010 we asked about the impact of authority figures on the recovery of our clients. However, in coding the qualitative responses, and through conversations with the clinicians, clinical assistant, and other staff members assisting the clients with their M&E intakes, we decided to specify the question on authority figures such that these relate directly to questions about the impact of the police and home affairs officials on our clients' recovery.

For our sample, prior to the division of the impact of authority figures on the clients' recovery, 63 clients indicated how authority figures impact their recovery. Of those, 33 (52%) indicated that authority figures slow down their recovery (a little or a great deal); 9 (14%) stated that they made no impact on their recovery and 21 (33%) stated that authority figures support their recovery a little or a great deal.

After specifying the question of authority figures such that it related directly to the police and home affairs officials, and through coding the original answers about authority figures, it was indicated that almost half of our clients who had responded (46%) felt that the police and the Department of Home Affairs impacted their recovery negatively. Various forms of harassment were reported in the assessments through statements such as:

- *I lost my documents and the police arrested me. I slept in jail with my baby*
- *They [the police] beat me in my head when I was in Marabastad in July*
- *A policeman took my car and threatened to kill me if I tried to reclaim it*
- *I went to Home affairs several times for renewal of my refugee status, but (was) always sent back without getting the required assistance*
- *I am afraid of the police and rumours from home affairs that Zimbabweans are to be returned home soon*
- *Home affairs officers rejected my application. I have been in South Africa for 6 years. They did not consider the reasons of being a refugee which will put my life in danger if I go back to my country*

There was also a high proportion of clients who indicated that they had not had any contact with the police (28%) or Home Affairs (19%) prior to the Intake assessment, as well as those who indicated that the police and Home Affairs had supported their recovery (a little or a great deal (26% and 35% respectively).

From 2009 to 2011, 57% of clients reported that health professionals (other than CSVR staff) support their recovery (a little or a great deal). Statements such as *"They did all the test(s) and treatment without charging and did it with love"* and *"They always see me and treatment was good"* are indicative of the support they felt that they were getting from health professionals. Similarly, 55% of clients reported that their family supports their recovery (a little or a great deal). However a number of clients report that their family is in their country of origin or dead. Statements such as the following indicate this:

- *"I have had no contact with my family ever since I arrived in South Africa in 1998"*
- *"[I do] not have family members in SA"*
- *"Alone here"*
- *"[I do] not have family here – [I have] no money to call them"*
- *"Seeing that I have no news about my parents and children, my nieces are my family and they support me"*

The questions relating to interactions with different people are useful because, while the clinician may not be able to directly influence the impact of the different people on the client's recovery, they may be able to work with the client to manage these interactions. The clinician can also see what impact the context or environment may have on the client's recovery. In addition this information can be used with the different groups as part of advocacy initiatives.

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.

In terms of the clients' functioning, from 2009 to 2011, the indicator that clients struggled with the most was managing their symptoms (64%) (n=75). Most clients felt that they had complete to severe difficulty with most of the indicators (ranging between 36% and 64%, while 3% to 23% of clients felt that they had no difficulty in the different indicators (figure below).

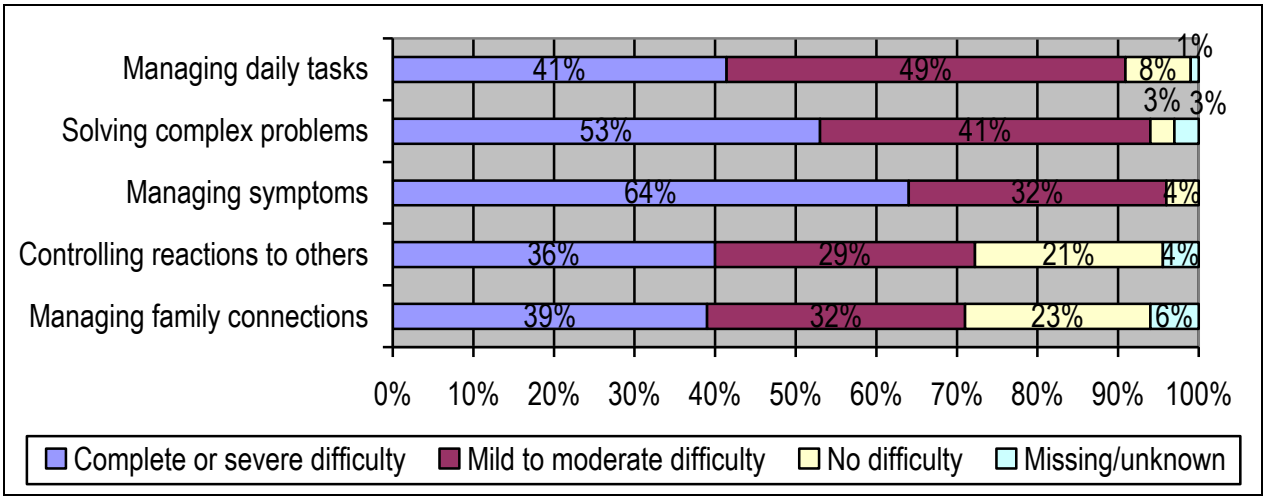


Figure 11: Key dimensions of functioning for intakes

The functioning indicator that clients from 2009 to 2011 have continued to struggle with the most is "Managing Symptoms". This indicator has ranged between 50% in 2010 to 68% in 2009 for clients who felt that they were having severe or complete difficulty when attempting to manage their symptoms. Given that many clients come to CSVR for assistance with, this in unsurprising.

The functioning indicator that clients have felt the least difficulty in controlling has been their ability to control their reactions to others. This has ranged between 50% in 2011 to 72% in 2009.

These functioning indicators have been useful for planning sessions and case management. For instance, if a clinician is able to see what the client is struggling with the most (e.g. Managing Symptoms), the clinician is able to adjust his/her sessions to focus on this and help the client work through his/her functioning problems. It is also useful for the client, since this verbalises where the client is having difficulties where the client may not have noticed / focused on these difficulties before.

5. Physical Health:

Clients were asked if they suffered from any medical conditions, disabilities and/or pain. Where they responded yes, they were asked if this was due to their torture experience(s). Of the 90 clients included in the sample, 43 (48%) reported suffering from at least one medical condition. There were 67 medical conditions reported, of which 51 (76%) were said to be due to the torture experience (table below). For this sample, "other" refers to the client being shot (during the torture experience), diabetes (which the client reports being due to torture), and three miscarriages (which the client did not report whether or not it was due to torture, so it was coded as not being due to the torture experience).

Category of self-reported medical condition	**Incidence**	**Due to Torture**
Head and neck area (including headache, neck ache, and problems with the ears, eyes, nose or mouth)	17	12
Heart palpitations / high blood pressure	9	8
Hypertension	7	7
Medical condition to do with the lower extremities	7	6
Abdominal pain (including stomach and side pains)	4	4
Asthma / breathing difficulties	4	2
Bipolar / major depression	3	1
Difficulties with bowels or genitals	3	3
HIV positive	2	1
Tuberculosis	2	1
Weight loss / loss of appetite	2	1
Chest and back problems	2	1
Insomnia	2	2
Total	**67 (100%)**	**51 (76%)**

Table 7: Categories of medical conditions reported from 2009 to 2011

Thirty clients (33%) reported suffering from at least one type of disability. 74 disabilities were reported, and of those, 51 (69%) were reported to be due to the torture experience. In 2009, 80% of clients who reported a disability reported it in the head and neck (this excludes the chest, shoulders and abdomen). In 2010 this number decreased to 76% and in 2011 decreased again to 72%.

The majority of the sample (80%) reported experiencing some form of pain. Of the 182 incidences of pain reported, 123 (68%) were said to be due to the torture experience (table below). “Other” refers to one client who was shot

	Incidence	**Due to torture**
Shoulder Region Pain	13	10
Upper extremity Pain	17	7
Genitalia Pain	11	8
Abdomen Pain	22	16
Chest and Back Pain	25	15
Lower extremity Pain	39	29
Head and neck region Pain	42	30
Generalised Pain	12	8
Other pain	1	0
Total	**182 (100%)**	**123 (68%)**

Table 8: Areas affected by pain

Despite the high incidences of medical conditions, disabilities and pain reported by our clients, only 17 clients (19%) indicated that they were taking prescription drugs (including anti-retroviral treatment, antibiotics and prescription pain medication). The reported use of substances such as cigarettes, beer, wine and spirits was very low for our 2009-2011 sample with 70 clients (78%) saying that they do not use any of these substances. In 2009, 82% of our sample reported not using any substances, compared to 76% in both 2010 and 2011. Only one client reported being on a non-prescription drug in 2011, and no client reported being on non-prescription drugs in either 2009 or 2010.

Discussion

We have gathered a large amount of data through the M&E intake. This data has allowed us to increase our knowledge about the clients that we are seeing, increase the documentation of the services that we provide and observe the impact that we are having at TTP. The knowledge that we generate has been important in improving the quality of our practice and we have gained an in-depth understanding of the people who access our services. Without this knowledge we would be limited as to how to intervene.

Through the M&E intakes, we are able to see who is a torture client requiring psychosocial services from TTP and who is not. During the initial (TTP) intake, clients give a description of the events that led them to come to TTP. This can be an emotionally arousing process and often evokes the sympathies of the intaker. However, during the M&E (torture) intake, through the questions asked, it becomes evident that some clients are coming to TTP for social needs (such as assistance with documentation, humanitarian or legal assistance) rather than psychosocial assistance. Through the torture intake, we are able to manage these cases and refer them to places that are more able to help them with these needs.

There have, however, been a number of challenges regarding client assessments. An area that we have worked exceptionally hard at is ensuring a paradigm shift in the way that clinical work and M&E is seen. M&E and clinical work should be seen to be inseparable. Many of the challenges listed below indicate some difficulties that we have had in ensuring that M&E and clinical work merge.

- When setting out the questions asked in the assessment forms, we were very inclusive. We tried to get information on all different aspects of the clients' psychosocial life. While this has been cut this down substantially, it still needs to be evaluated to see whether it is too inclusive and asking too much from the client. By reducing what is asked in the assessments to what is considered essential, the process will be streamlined and simplified. While we this process has been streamlined and simplified in the past, it is an ongoing course of action which needs constant attention and evaluation
- Intakes and client assessments can be taxing on the person who is assisting the client with the assessment
  - Client assessments are an energy-consuming process
  - Client assessments may take a long time to complete
  - It can be difficult to contain the client when the staff member assisting the client is tired and without energy or emotional capability from completing assessments with other clients or completing other work necessary at CSVR
- In the past, the practitioner and the client sometimes agreed that the client was able to complete the assessment without any assistance. The challenge with this is that the client may not understand the questions asked – many of which are quite complicated, especially when the client is answering them in his/her second or third language
- Deadlines are essential in this M&E system: It was agreed that after the client had an initial (TTP) intake and was assigned to a clinician, the client would have one session for containment and then complete an M&E (torture) intake within the first two sessions. If the assessment was not completed within the time limit, it would be considered lost. It is important that we are gathering the data within the agreed upon time limit so that the information gathered is comparable with other clients who have completed assessments at a similar session timeline. Meeting deadlines may be difficult – especially when clinicians' priorities may be to counsel and assist the client rather than adhere to the compliance system.

An essential part of monitoring and evaluating clinical work is ensuring that the M&E and clinical work are merged. The challenges listed above reflect how M&E and clinical work should be seen as inseparable and how neither should be seen as mutually exclusive.

Recommendations:

It is essential that there is a paradigm shift when monitoring and evaluating clinical work. There is much work that needs to be done to ensure that this work is seen as inseparable. The best way to do this is to ensure that the reasons for M&E are clear to all people involved in the M&E system – from the clinicians to the managers to the clinical assistants and receptionists. This

ensures that all members of staff are able to assist the clients with the intake assessments and ensures that the client understands why the M&E process is important and beneficial on a personal level.

1. Since completing an assessment may be a taxing process on the person assisting with the intakes, that person (whether it is a clinician, clinical assistant or other staff member) needs to monitor his /her reactions to the assessment and how s/he is feeling both during and after the assessment. If that person needs assistance from colleagues either during or after the assessment, s/he needs to ask for it. This is something that should be monitored during meetings and when checking in with colleagues – even in passing
2. Language may be a challenge – especially when there are such a high number of clients who access our services from other parts of Africa. A translator should be available to assist clients who do not speak the language that the assessment is completed in order to ensure that words can be explained and the meaning is evident. Additionally, the clinician should be available to provide support to the client during the intake process
3. The assessments should be culturally sensitive to ensure that the quality of information being gathered to be at the highest standard possible within the circumstances
4. There needs to be a constant negotiation between what information is being gathering and whether or not it is useful. If it is not being analysed and/or fed back to the practitioners and other staff members, then it needs to be decided whether or not it is useful and whether it should be kept in the assessment. New ways of analysing data should be sought if possible

All of the recommendations mentioned above are parts of the assessment process that we are continually trying to perfect. While we feel we have made leaps in streamlining the process and keeping communication open between the clinical staff and the M&E staff, this is an ongoing process that needs constant evaluation.

IMPACT DATA REPORT

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.

Between 2009 and 2011 data was obtained for 50 clients who completed an M&E (torture) intake and a first assessment (done between sessions 6-8); and 22 clients who completed their intake and both their first assessment and their second assessment (done between sessions 12-14). As not all new clients completed an M&E intake between 2009 and 2011, and then further completed a first assessment, the clients included are proportionally low, representing 27% of all the tortured clients from 2009 to 2011. These numbers drop exponentially for clients who completed their intake, first assessment and second assessment, representing 12% of all the tortured clients from 2009 to 2011. It is essential to note that because this is such a small sample of our group of torture survivors, the data is not generalisable to the broader context of providing psychosocial interventions to torture survivors. However, it is useful in observing what is happening to clients over time.

These client groups 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 as they go through counselling.

Impact data for clients with an intake and a first assessment (n=50)

There were 50 clients who completed both an intake and first assessment (after six sessions) from 2009 to 2011. Through analysing this data, we hope to see what changes there are over the initial six sessions for survivors of torture. The following provides the data for this sample of torture survivors.

1. <u>Demographic information</u>
   There were 24 men and 26 women included in this group. The oldest client was 58 years of age at the time of intake while the youngest was 18. The mean age for the group was 37 with a standard deviation of 9.73.

   Clients came from nine different countries with the largest proportion (38%) coming from the Congo (figure below).

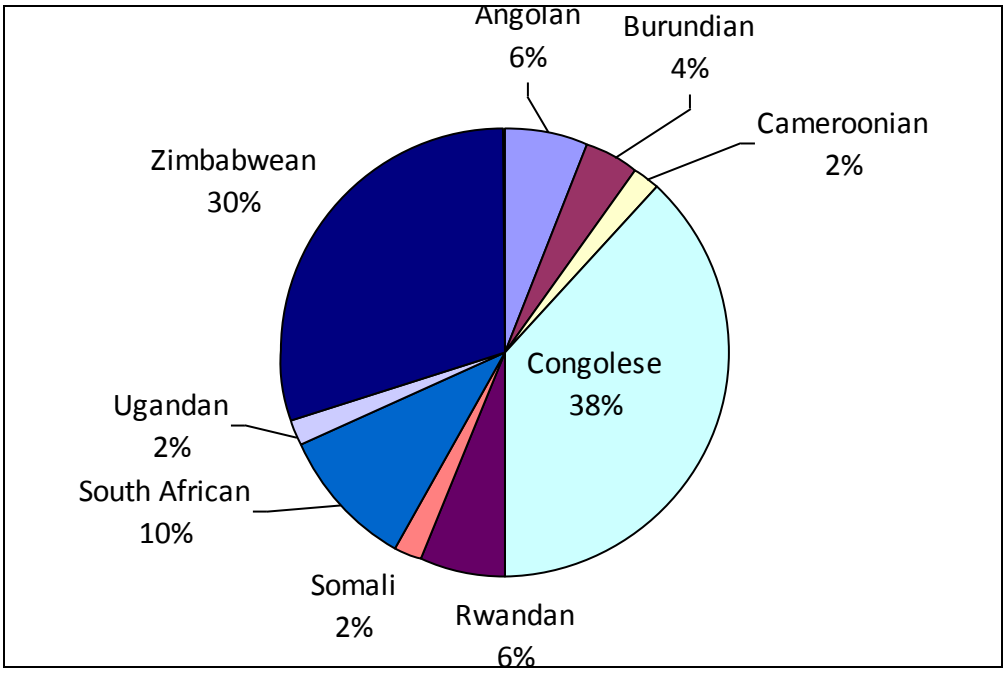


Figure 12: Nationality of clients with intake and first assessment

19 clients (38%) reported never being married at the time of intake (table below).

Marital status	Frequency	%
Currently married	12	24%
Never married	19	38%
Divorced	1	2%
Widowed	15	30%
Separated	2	4%
Missing	1	2%
Total	**50**	**100%**

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

At the time of intake, most clients (58%) were living with their family (which could include living alone with their children). Others were living alone (10%), with friends (4%), with their partner or spouse (6%), in a shelter (12%), or with strangers (6%).

When asked about their education, 70% of the total sample reported that they had completed high school education or above while 44% stated that they had either a tertiary or post-graduate qualification.

Before the torture experience, the majority of clients (56%) were employed in semi-skilled, skilled, highly skilled or professional jobs. However, after the torture experience, 58% of clients were unemployed (figure below).

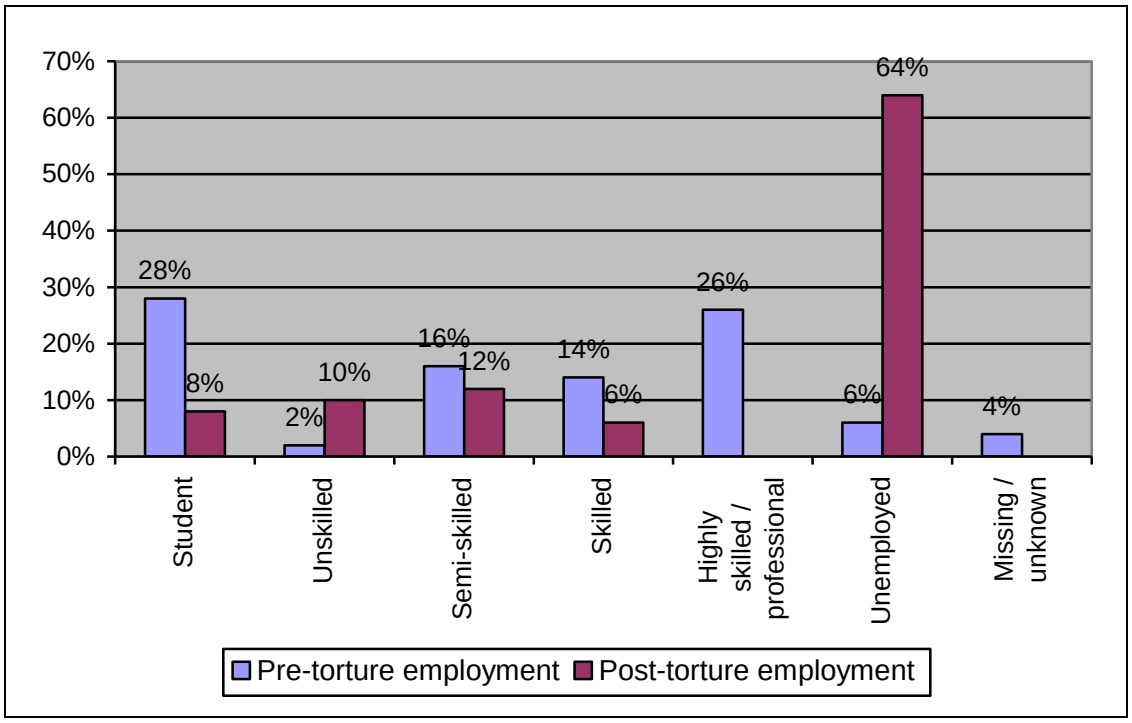


Figure 13: Changes in employment status linked to torture of clients with intake and first assessment

2. Service providers' impact on recovery

In the experience of the clinical team, the role of authority figures (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. As mentioned in the section above, in 2011 we specified "Authority figures" as being the police and the Home Affairs officials. Because of the specification of authority figures, there is limited data for each of these three indicators.

Overall, an average of 37% of clients reported an improvement in the impact of these groups on their recovery, 45% reported that the impact of these groups stayed the same, while 18% reported that the impact on their recovery of these groups had worsened from intake to the first assessment. Health professionals' impact on recovery showed the best results with 47% of clients reporting that their recovery is more positively impacted by this group from the time of the intake to the first assessment (table below).

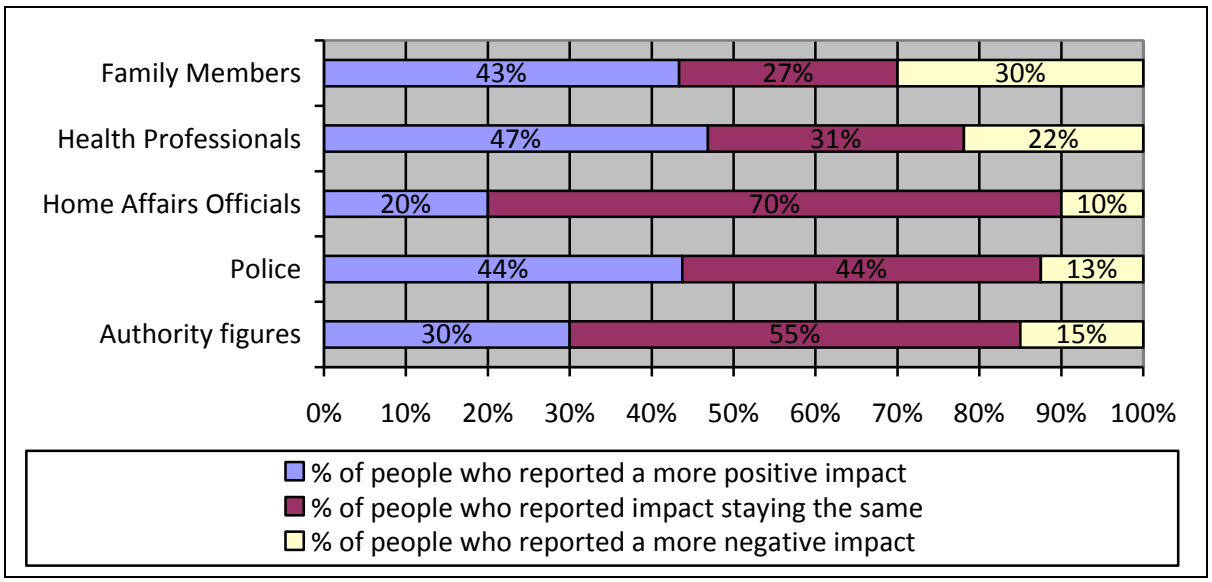


Figure 14: Changes of impact of different groups on recovery on clients with intake and first assessment

As stated previously, while clinical work may not be able change how these groups treat or interact with clients, it may be able to work with clients' ability to manage these interactions.

3. <u>Mental health measures</u>

   As mentioned above, 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." (p.15)[4]. 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.

   There is a maximum score of 160 for the HTQ: Total score. PTSD and self perception of functioning are measured on a four point scale including: not at all, a little bit, quite a bit and extremely; and assigned a value of 1, 2, 3 or 4 respectively. A score is computed for

[4] 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

each scale by averaging the scale value for responses to all the items in the scale, allowing patients to be ordered from no symptoms to extreme symptoms based on the average score. For both the PTSD score and the self-perception of functioning score there is a maximum score of four.

Overall, improvements were seen by 66% of clients on the Total score, 68% of clients on the PTSD score and 66% of clients on the self-perception of functioning score from intake to the first assessment. However, an average of 33% of clients indicated that their symptoms had gotten worse between the intake and the first assessment (table below).

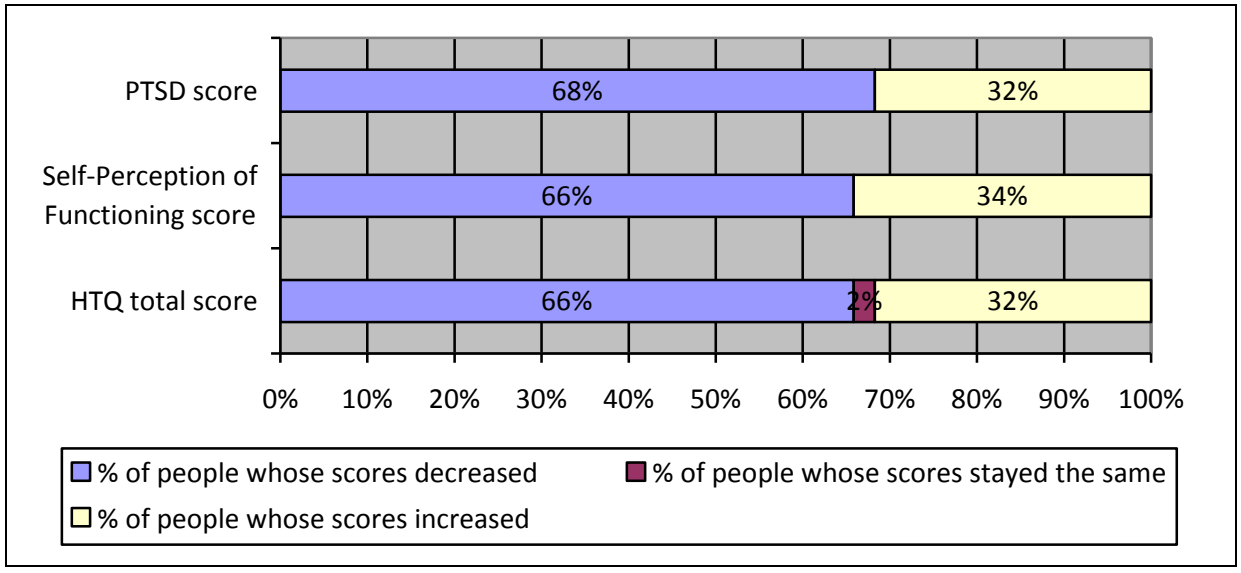


Figure 15: Changes of impact of different groups on recovery on clients with intake and first assessment

Mollica et al (2004) suggest a cut-off of 2.03 to be symptomatic for PTSD for clinical work with refugee populations. However, we opted for the more conservative cut-off of 2.5 to be considered check-list positive 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.

At intake, 28 clients (68%) scored above the cut-off of 2.5 for clinical levels of PTSD. At first assessment this had dropped down to 20 (49%). The mean PTSD score at intake was 2.87. This dropped to 2.51 at first assessment. This represents a significant difference ($p=0.07$ using the T-test with $t=2.84$ and $df=40$). The figure below indicates the change in scores for PTSD from intake to first assessment. In order to ensure that our comparison is valid, we have only included clients who have indicated a PTSD score at both the intake and first client assessment ($n=41$).

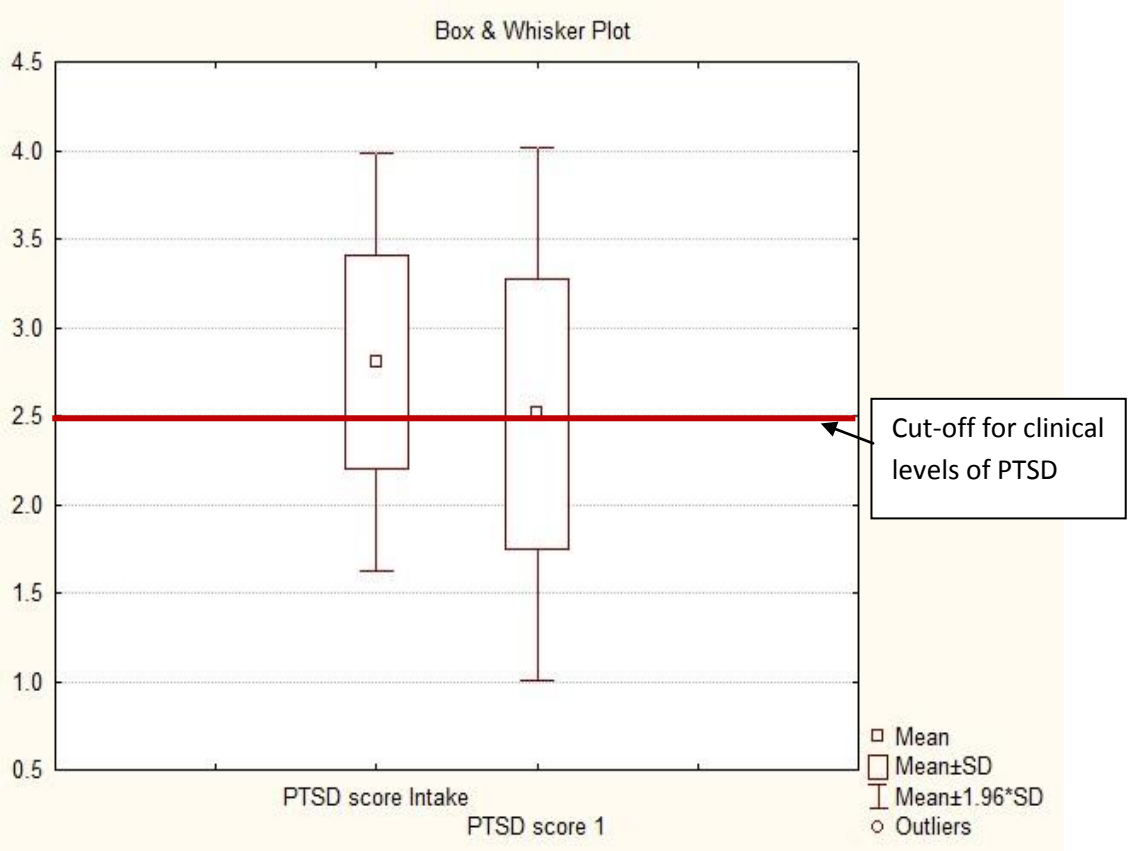


Figure 16: Box plot for PTSD scores for clients with an intake and first assessment

As mentioned in the section above, 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 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.

The percentage of clients who showed a decrease in clinical levels of anxiety decreased by 12% from intake to first assessment. At intake, 74% of clients reported clinical levels of anxiety. This dropped to 67% at first assessment. The borderline cases increased from 15% to 18% from intake to assessment one, and clients with normal levels of anxiety increased from 10% to 15% (table below). Only clients who answered the questions about anxiety in both the intake and the first assessment were included in this sample (n=39).

	Intake	**First assessment**
Normal	4 (10%)	6 (15%)
Borderline	6 (15%)	7 (18%)
Clinical	19 (74%)	26 (67%)
Total	**39 (100%)**	**39 (100%)**

Table 10: Anxiety scores of clients with Intake and first assessment

The depression scores showed improvement with the percentage of people with clinical levels of depression going from 63% at intake to 39.5% at first assessment. There was an increase in the number of normal cases from 16% to 29% (table below).

	Intake	**First assessment**
Normal	6 (16%)	11 (29%)
Borderline	8 (21%)	12 (31.5%)
Clinical	24 (63%)	15 (39.5%)
Total	**38 (100%)**	**38 (100%)**

Table 11: Depression scores of clients with Intake and first assessment

In both the depression and anxiety, the majority of clients reported a decrease in their scores from intake to first assessment. However, 37% of clients reported that their depression scores had increased, while 28% reported that their anxiety scores increased (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	22 (58%)	2 (5%)	14 (37%)	**38**
Anxiety Score	24 (62%)	4 (10%)	11 (28%)	**39**
Average	**60%**	**7.5%**	**32.5%**	

Table 12: Changes in scores on the HADS of clients with Intake and first assessment

The mean score for depression at intake was 11.89 and 10.21 at first assessment. By contrast, the mean score for anxiety was 13.61 at intake and 11.67 at first assessment. While depression did not show a significant decrease in scores ($p=0.062$ using the T-test with $t=1.92$ and $df=37$), the change in scores for anxiety was significant ($p=0.032$ with $t=2.22$ and $df=38$). The figure below shows that while the mean score for anxiety is still above the cut-off of 11 for clinical levels of anxiety, it has decreased between intake and first assessment.

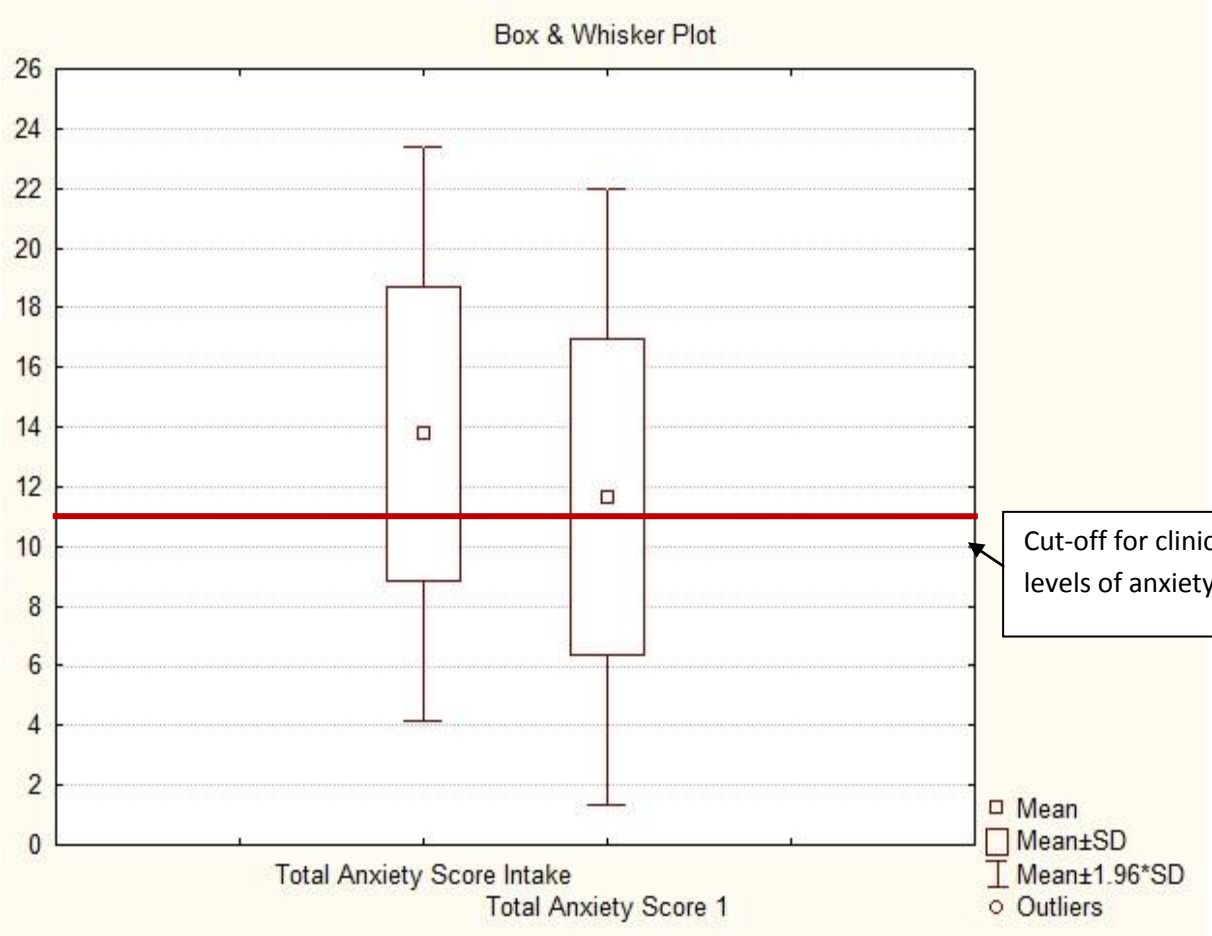


Figure 17: Box plot for Anxiety scores for clients with an intake and first assessment

4. <u>Functioning Indicators</u>

   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 functioning indicator that clients felt that they had improved the most with between intake and the first assessment was their ability to manage their family connections.

   On average, 36.4% of clients reported an improvement in their functioning from intake to first assessment, while 27.8% 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 (36%)	11 (33%)	10 (30%)	**33**
Managing daily tasks	9 (28%)	12 (38%)	11 (34%)	**32**
Managing symptoms	14 (44%)	12 (38%)	6 (19%)	**32**
Controlling reactions to others	9 (26%)	12 (35%)	13 (38%)	**34**
Managing family connections	14 (48%)	7 (24%)	8 (28%)	**29**
Average	**36.4%**	**33.6%**	**27.8%**	

Table 13: Changes in functioning of clients with intake and first assessment

As the table above indicates, the area that clients had the most improvement in terms of the ICF factors was their ability to manage their connections with their families (48%).

Impact data for clients with an intake and both the first assessment and second assessment (n=22)

There were 22 clients who completed the intake and both the first assessment (after six sessions) and second assessment (after 12 sessions) from 2009 to 2011. Through analysing this data, we hope to see what changes there are over time for survivors of torture. The following provides the data for this sample of torture survivors.

1. Demographic information

   There were 8 men and 14 women included in this group. The oldest client was 58 years of age at the time of intake while the youngest was 18. The mean age for the group was 37 with a standard deviation of 10.95.

   Clients came from seven different countries with the largest proportion (36%) coming from the Congo (figure below).

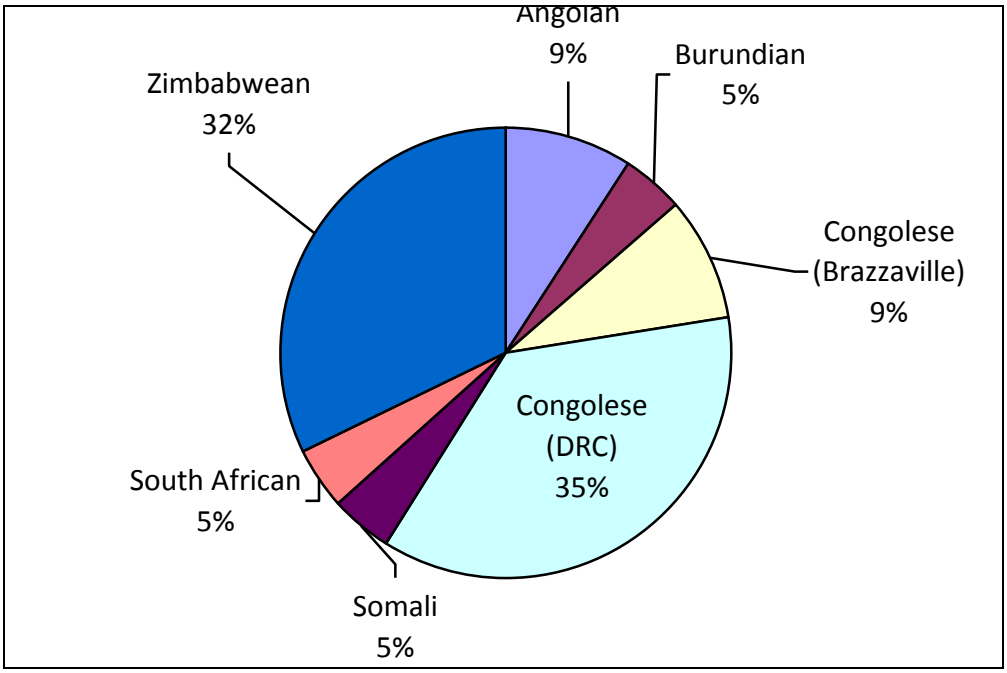


Figure 18: Nationality of clients with intake, first and second assessment

10 clients (45%) reported being widowed at the time of intake (table below).

Marital status	Frequency	%
Currently married	3	14%
Never married	7	32%
Divorced		
Widowed	10	45%
Separated	1	4.5%
Missing	1	4.5%
Total	**22**	**100%**

Table 14: Marital status of clients with intake, first and second assessment

At the time of intake, most clients (59%) were living with their family (which could include living alone with their children). 18% were living with strangers or in a shelter while 9% were living with their partner/spouse or alone. One client was living alone at the time of intake.

When asked about their education, 68% of the total sample reported that they had completed high school education or above while 50% stated that they had either a tertiary or post-graduate qualification.

Before the torture experience, the majority of clients (59%) were employed in semi-skilled, skilled, highly skilled or professional jobs. However, after the torture experience, 64% of clients were unemployed (figure below).

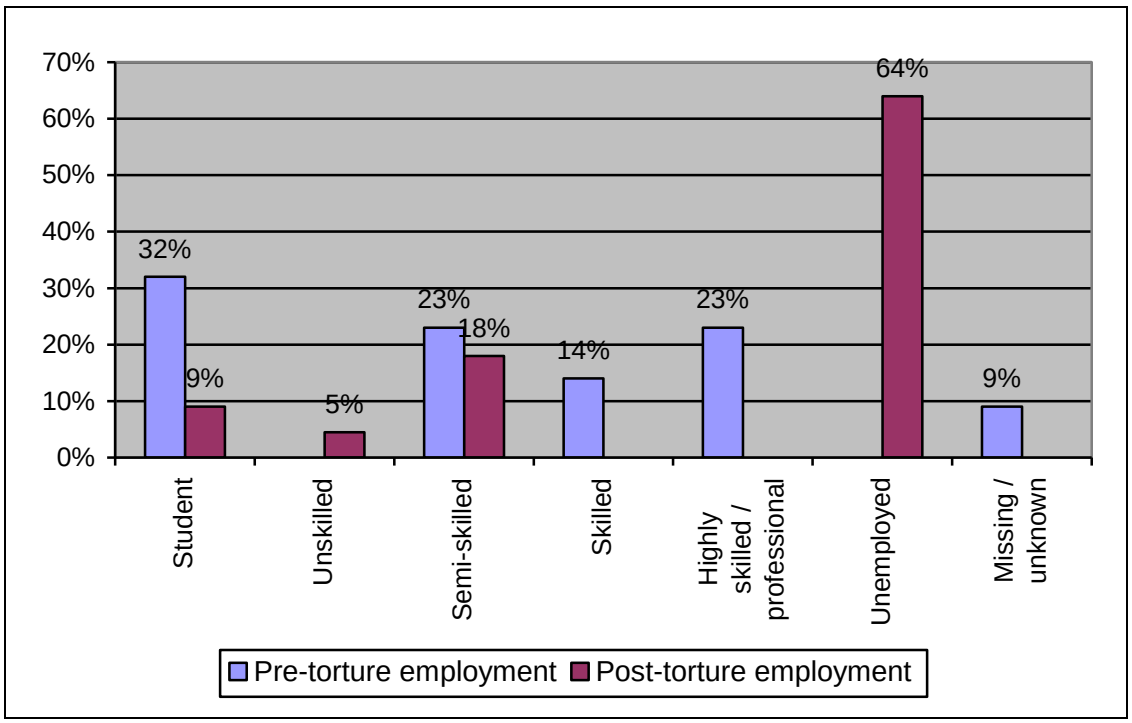


Figure 19: Changes in employment status linked to torture of clients with intake, first and second assessment

2. <u>Service providers' impact on recovery</u>

   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. As mentioned above, in 2011 we specified "Authority figures" as being the police and the Home Affairs officials. Because of the specification of authority figures, there is limited data for each of these three indicators.

   At intake, an average of 45.4% of clients with an intake, first and second assessment indicated that these groups had supported their recovery (a little or a great deal). This increased to 51.2 at second assessment (figure below)

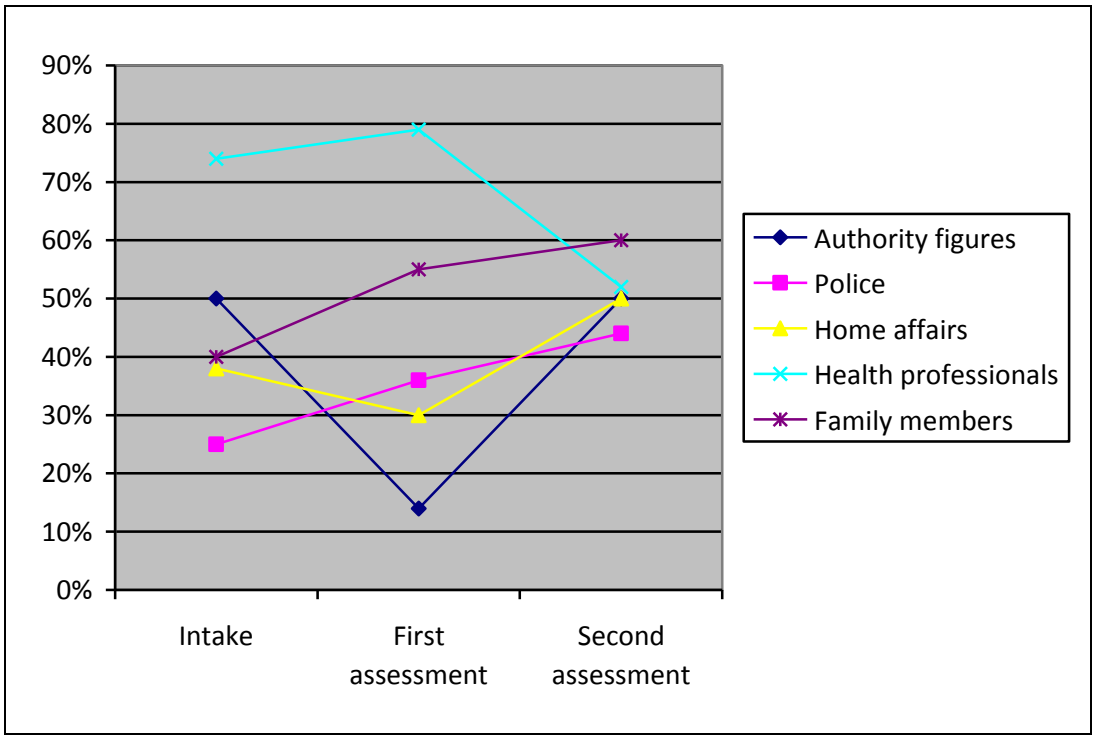


Figure 20: Changes in the percentage of support clients felt that different groups had on their recovery

The figure above indicates that, on average, clients feel that there is a consistent increase in the amount that both the police and their family members support them over time. In contrast, there is a large decline in the amount that clients feel supported by health professionals between the intake and second assessment.

3. Mental health measures

As mentioned above, 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." (p.15)[5]. 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.

[5] 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. PTSD and self perception of functioning are measured on a four point scale including: not at all, a little bit, quite a bit and extremely; and assigned a value of 1, 2, 3 or 4 respectively. A score is computed for each scale by averaging the scale value for responses to all the items in the scale, allowing patients to be ordered from no symptoms to extreme symptoms based on the average score. For both the PTSD score and the self-perception of functioning score there is a maximum score of four.

Mollica et al (2004) suggest a cut-off of 2.03 to be symptomatic for PTSD for clinical work with refugee populations. However, we opted for the more conservative cut-off of 2.5 to be considered check-list positive 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.

At intake, 13 clients (65%) scored above the cut-off of 2.5 for clinical levels of PTSD. At first assessment this had dropped down to 11 (55%) but increased to 12 clients at second assessment (n=20). The mean PTSD score at intake was 2.78. This dropped to 2.45 and increased to 2.47 at second assessment. This does not represent a significant difference. However, as is evident in the figure below, while the mean of the PTSD scores has decreased, the range of scores has increased from intake to assessment one and two.

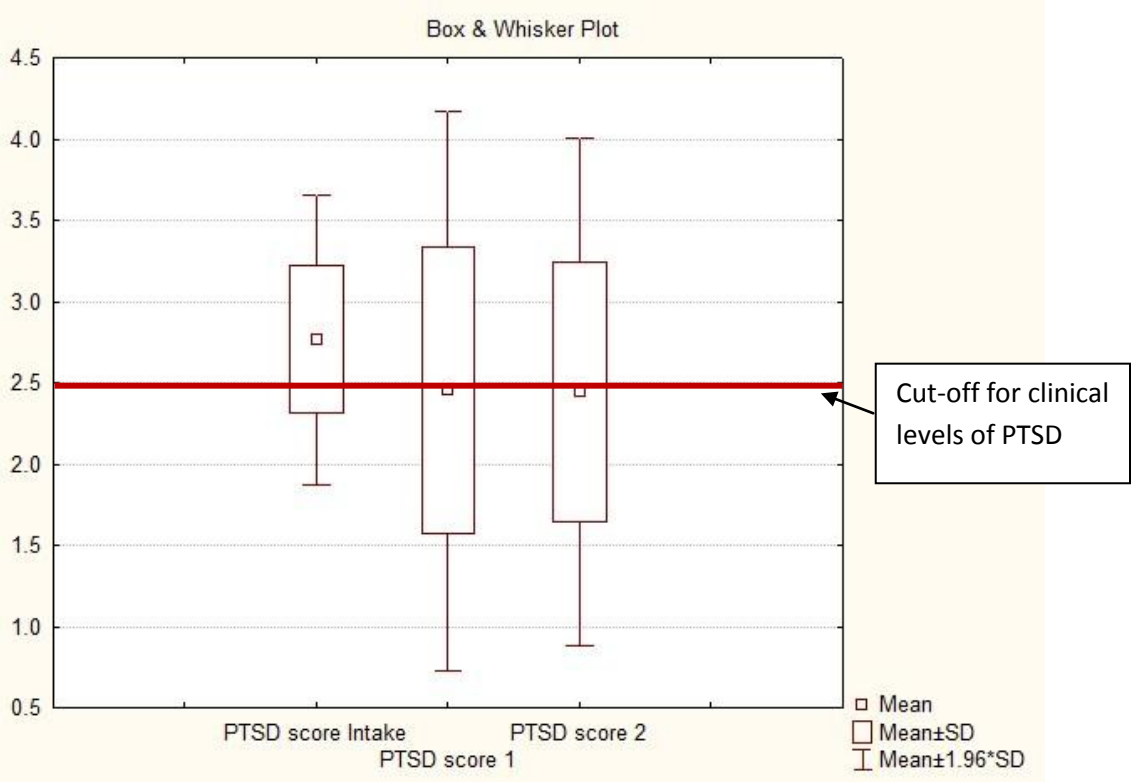


Figure 21: Box plot for PTSD scores for clients over time

The graph below indicates the mean change of scores over all three assessments for the PTSD score and the self-perception of functioning score. This indicates a sharp decrease in scores from intake to first assessment, and then a slight increase to the second assessment.

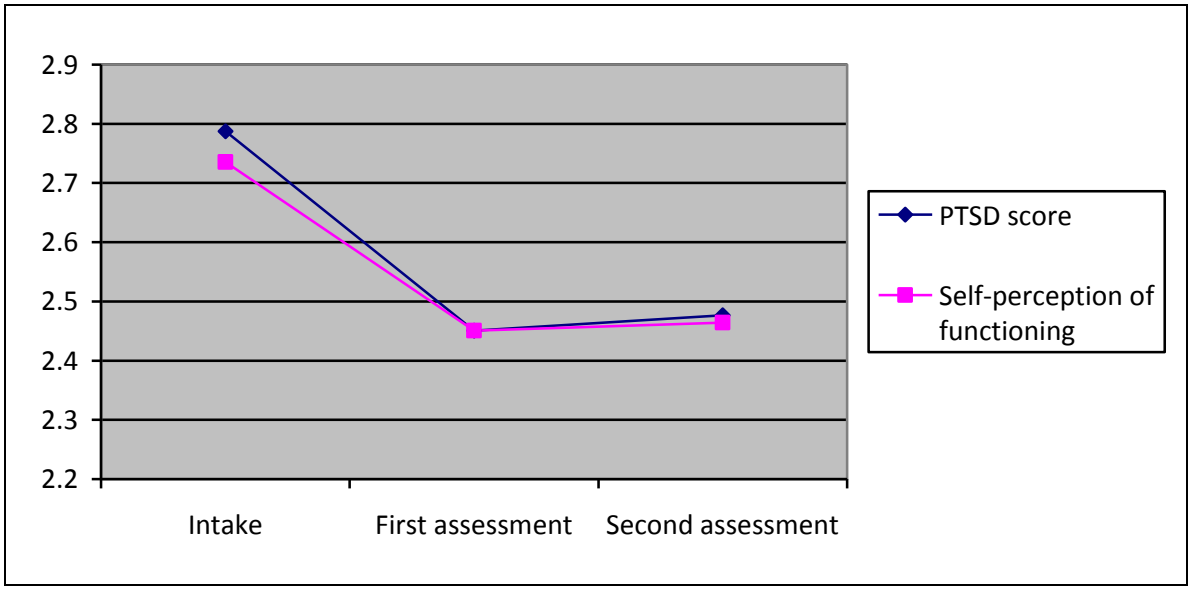


Figure 22: Change in PTSD and self-perception of functioning scores from intake to second assessment

As mentioned in the section above, 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 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.

The percentage of clients who showed a decrease in clinical levels of anxiety decreased by 12% from intake to first assessment. At intake, 72% of clients reported clinical levels of anxiety. This dropped to 67% at first assessment but increased to 72% again at second assessment (table below). Only clients who answered the questions about anxiety in the intake, first assessment and second assessment were included in this sample (n=18).

	Intake	**First assessment**	**Second assessment**
Normal	1 (6%)	4 (22%)	3 (17%)
Borderline	4 (22%)	3 (17%)	2 (11%)
Clinical	13 (72%)	11 (61%)	13 (72%)
Total	**18 (100%)**	**18 (100%)**	**18 (100%)**

Table 15: Anxiety scores of clients with Intake, first assessment and second assessment

The depression scores showed improvement with the percentage of people with clinical levels of depression decreasing from 78% at intake to 44% at both first and second assessment respectively (table below).

	Intake	First assessment	Second assessment
Normal	3 (17%)	4 (22%)	5 (28%)
Borderline	1 (6%)	6 (33%)	5 (28%)
Clinical	14 (78%)	8 (44%)	8 (44%)
Total	**18 (100%)**	**18 (100%)**	**18 (100%)**

Table 16: Depression scores of clients with Intake, first assessment and second assessment

The following figure represents the average change in anxiety and depression scores over time:

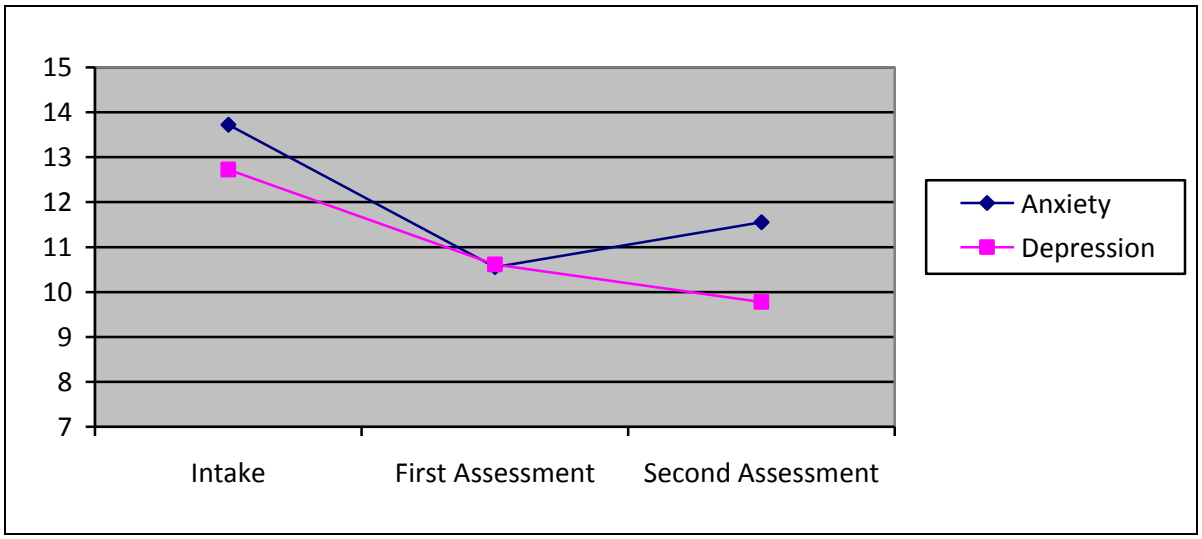


Figure 23: Change in anxiety and depression for intake and assessment one and two

The figure above indicates that while there is a consistent decrease in depression scores over time, the anxiety scores decrease initially, but increase again at second assessment. While the scores for anxiety from intake to first assessment show a significant decrease, the scores from intake to second assessment do not (table below):

	t	df	p
Intake to first assessment	2.46673	19	0.0233*
Intake to second assessment	2.0145	19	0.0583
First assessment to second assessment	-1.0646	17	0.302

Table 17: Significance of anxiety scores for intake and assessment one and two

* Significant at p=0.05

In a similar manner to the anxiety scores above, the depression scores indicated that there was not a significant decrease in scores from intake to first assessment, however there was a significant decrease from intake to second assessment (table below):

	t	df	p
Intake to first assessment	1.6388	17	0.1196
Intake to second assessment	2.3105	17	0.0337*
First assessment to second assessment	0.6945	17	0.4967

Table 18: Significance of depression scores for intake and assessment one and two

* Significant at p=0.05

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 functioning indicator that clients felt that they had improved the most with between intake and the first assessment was their ability to manage their family connections.

On average, 19% of clients reported that they had no difficulty or mild difficulty. This improved to 22% at first assessment and again to 34% at second assessment (figure below).

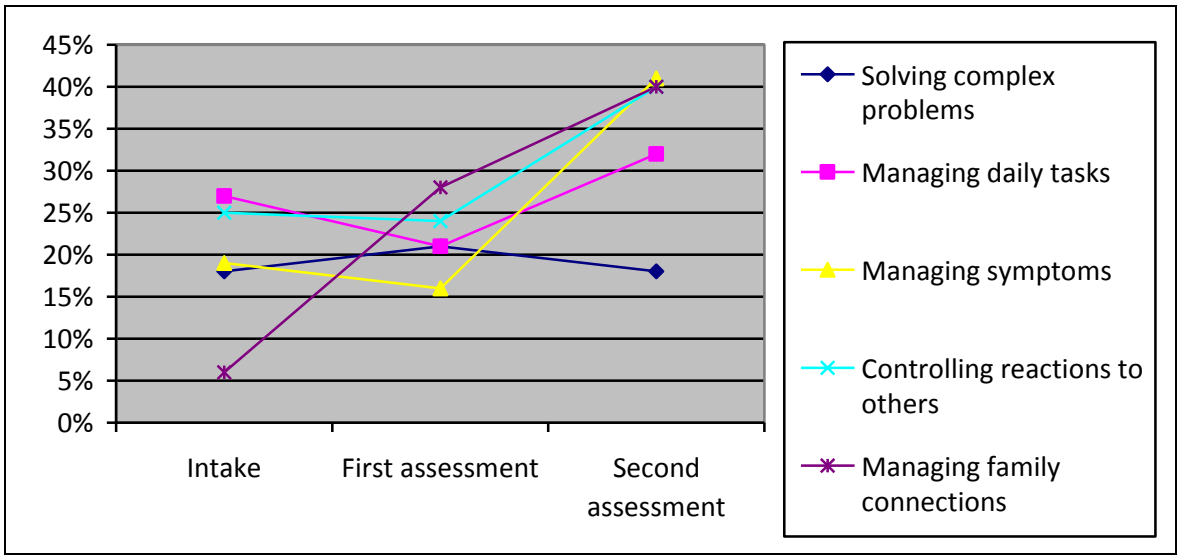


Figure 24: Change in proportion of clients who reported no difficulty or mild difficulty at intake and assessment one and two

As the figure above indicates, clients improved the most in terms of managing the relationships with their family from intake to assessment two. At assessment one they felt more able to solve their complex problems compared to intake, however this decreased at assessment two.

Discussion

One of the central foci of M&E work is being able to see whether an intervention has made an impact. The impact data allows us to ask a number of questions which include:

- Has there been change over time? If so, why? If not, why not?
- What have we learnt from the interventions?
- Do we need to change our interventions?
- Do we need to change the way that we are gathering data or the information that we are gathering?
- How are we able to use this information?
- Who is using this information and why?
- How do we use this information for other areas of work such as advocacy and generating and disseminating knowledge? Who should our audience be?
- How do we feed this information back to the different people involved in the M&E system?

It is essential to use the data obtained to observe what is happening in our clinical interventions and to observe whether or not our clients are improving, and, if they are not, discuss what changes need to occur to ensure that clients are receiving the best services possible. It also gives us the ability to see in what way clients are changing; in which areas and how. Being able to see how clients change over time gives us the ability to plan our treatments and for case management. This information is also essential for the development of a clinical model as well as to advocate for psychosocial treatment for torture survivors.

Recommendations

In order to ensure that information is available to observe changes over time, there are three primary factors that need to be taken into account. First, it is essential that information is being consistently gathered over time. Second, the information needs to be fed back to the different people involved in the M&E system, and third, the M&E system needs to change to take into account trends over time if necessary. These areas will be discussed separately below:

1. Gathering data is essential for any M&E system. This documentation allows us to see how clients' scores change over time, and give us a means to change the systems and procedures if necessary. The compliance to the M&E system is essential for the gathering of data that will allow us to show the impact of our interventions.

   In order to gather and document information consistently, a paradigm shift needs to occur on all levels – there needs to be buy-in from the donor to management, to the clinical staff to the client. The benefits should be communicated to all people involved in the system. These benefits include using the information gathered to improve clinical work and to understand what is happening to whom and when so that clinical work can be adjusted if and when needed. It also means that information can be used for advocacy work and model development – something that is beneficial to all people involved in the system. This is discussed in more detail in the compliance section below.

2. For any M&E system to work, staff members and clients should not feel like they are gathering data and documenting their work unnecessarily. An essential way of ensuring that

both clients and clinicians are not performing redundant tasks is to feed information back to them. An example of this is through the Client Progress Reports (see below), and through discussions over trends over time, such as through the impact report. These reports lead to many discussions and increased questions, which, in turn may lead to changes and improvements in the M&E system.

3. Once information is fed back to the constituent groups, discussions are essential in order to decide whether the impact over time is good enough, and whether systems need to change to make the system better. It is essential to remember that the primary reason that the M&E system exists is to ensure that what we are doing is working. If it is not working, changes need to be made so that it benefits those who we want to benefit.

CLIENT PROGRESS REPORTS

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 2009, 2010 and 2011 (i.e., complete a total of 12 to 18 CPRs between 2009 and 2011). We managed to produce 165 CPRs in this time. 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 numerous activities such as treatment planning, case studies, presentations, for individual supervision and clinical supervision as well as for exploring the complexities of torture cases. The clinician can decide whether or not to show the CPRs to the client.

The Client Progress Reports give an indication of the client's change in symptoms or functioning over time. Each time a client completes an additional assessment after the baseline assessment (usually the Intake), the CPR is updated. Each CPR includes a table of the client's scores in terms of how different groups impact his/her recovery; as well as five factors from the International Classification of Functioning and Disability (ICF) used to a assess how the client perceives his/her functioning to be. It also includes the PTSD, Self-perception of functioning, anxiety and depression scores. These different indicators are then put into line graphs in order to give a visual representation of the client's functioning and symptoms over time.

While all 165 CPRs are available for viewing, we include only three here as examples of the information being produced.

Client Progress Report 1
Data available:

- Intake
- 1 Client Self-Assessment

Demographics:

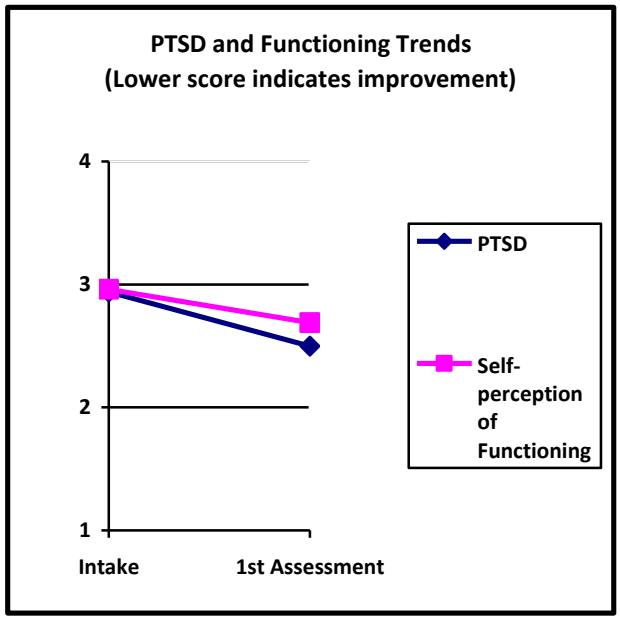
Gender:	Male
Nationality:	South African
Age:	41
Number of children:	2
Number of dependants:	0
Educational level:	Completed secondary
Pre-torture employment:	Unemployed
Employment at intake:	Semi-skilled

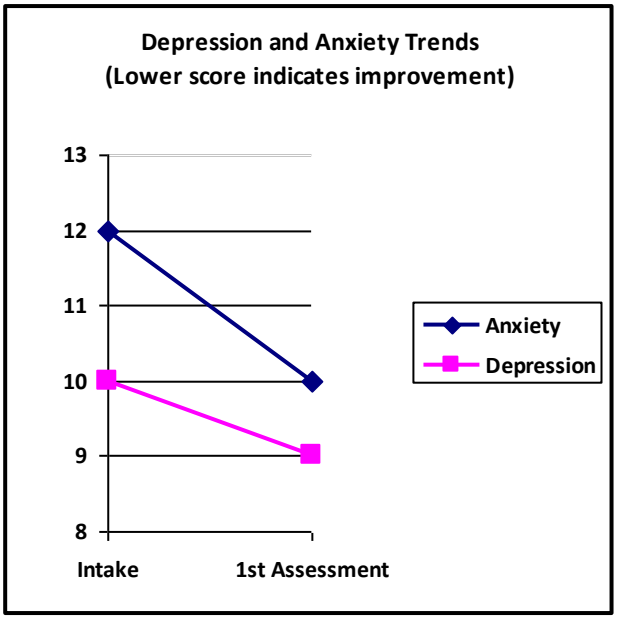
Results:

	Intake	Client Self-Assessment	Progress*
Date done	**06/07/2009**	**13/12/2009**	
Number of sessions completed	-	06	
Authority Figures impact on recovery	No impact	No impact	→
Health professionals impact on recovery	Support a great deal	Support a little	↑
Family members impact on recovery	Slow down a great deal	Support a little	↓
Difficulty in solving complex problems	Moderate difficulty	Mild difficulty	↓
Difficulty in completing daily tasks	Mild difficulty	Mild difficulty	→
Difficulty in managing symptoms	Severe difficulty	Moderate difficulty	↓
Difficulty in ability to control reactions to others	Severe difficulty	Mild difficulty	↓
Difficulty in family connections	Complete difficulty	Moderate difficulty	↓
PTSD score (> 2.5 = symptomatic for PTSD)	2.94	2.5	↓
Self-perception of functioning score (no cut off)	2.96	2.69	↓
Anxiety (0-7 = normal, 8-10 = borderline and 11+ = clinical)	12	10	↓
Depression (0-7 = normal, 8-10 = borderline and 11+ = clinical)	10	9	↓

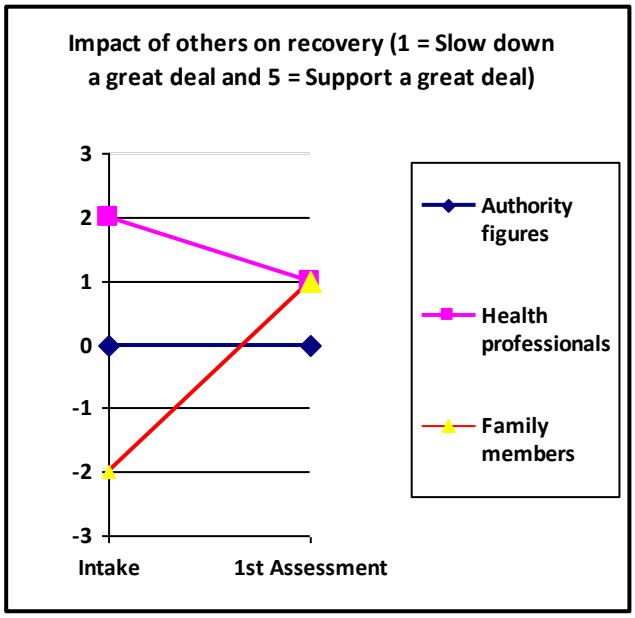
*** Down indicates improvement**

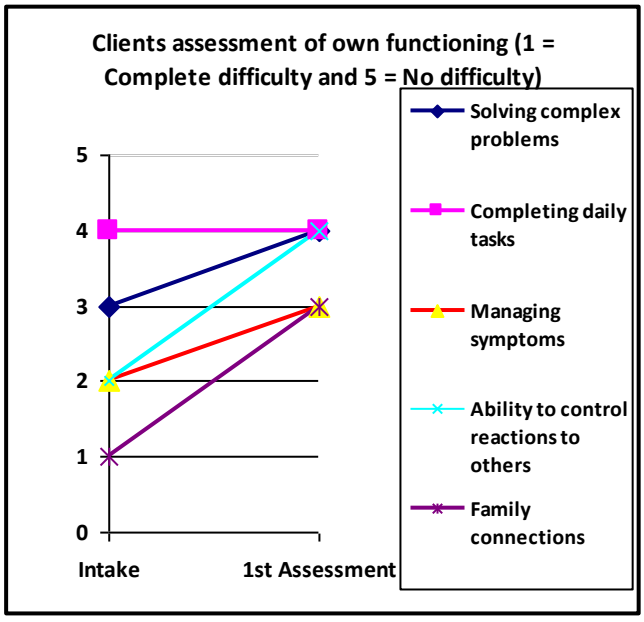
Down indicates improvement:





Up indicates improvement:





Client Progress Report 2:

Data available:

- M&E intake
- 3 Client Self-Assessments

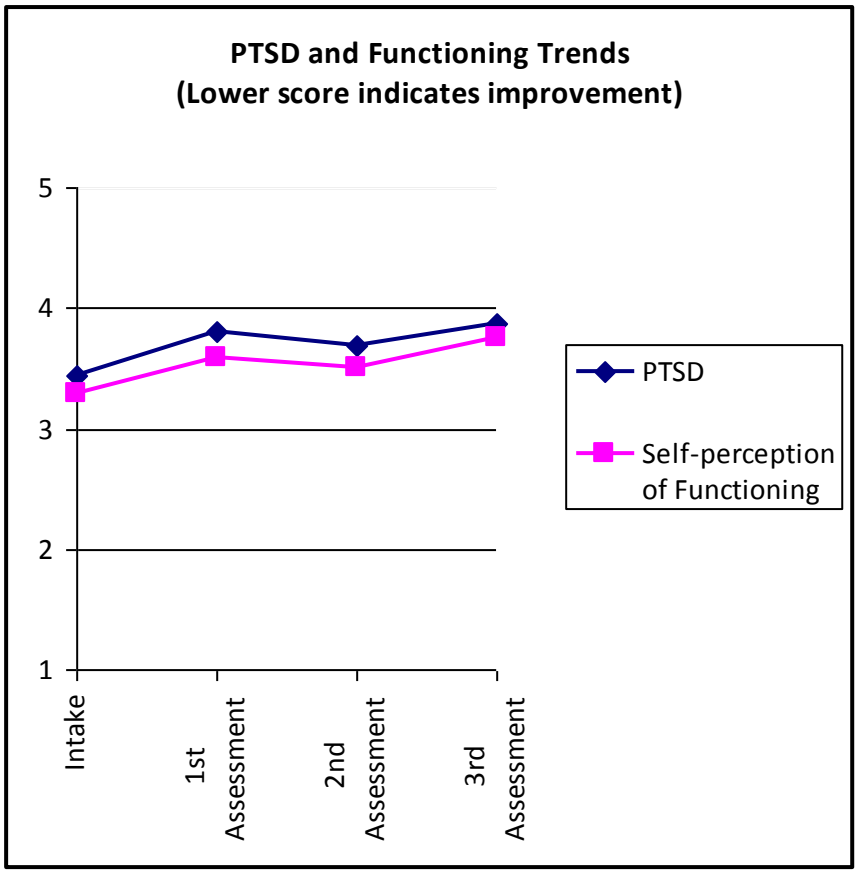
Demographics:

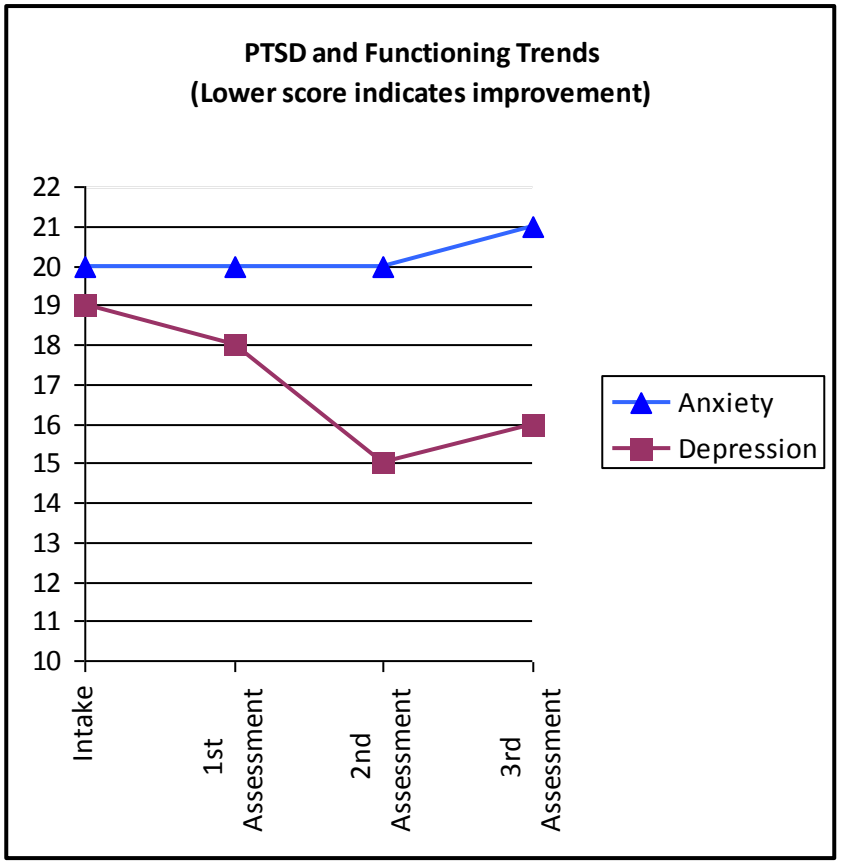
Gender:	Male	Nationality:	Zimbabwean
Age:	25	Number of children:	0
Educational level:	Missing	Number of dependants:	2
Pre-torture employment:	Semi-skilled	Employment at intake:	Unemployed

Results:

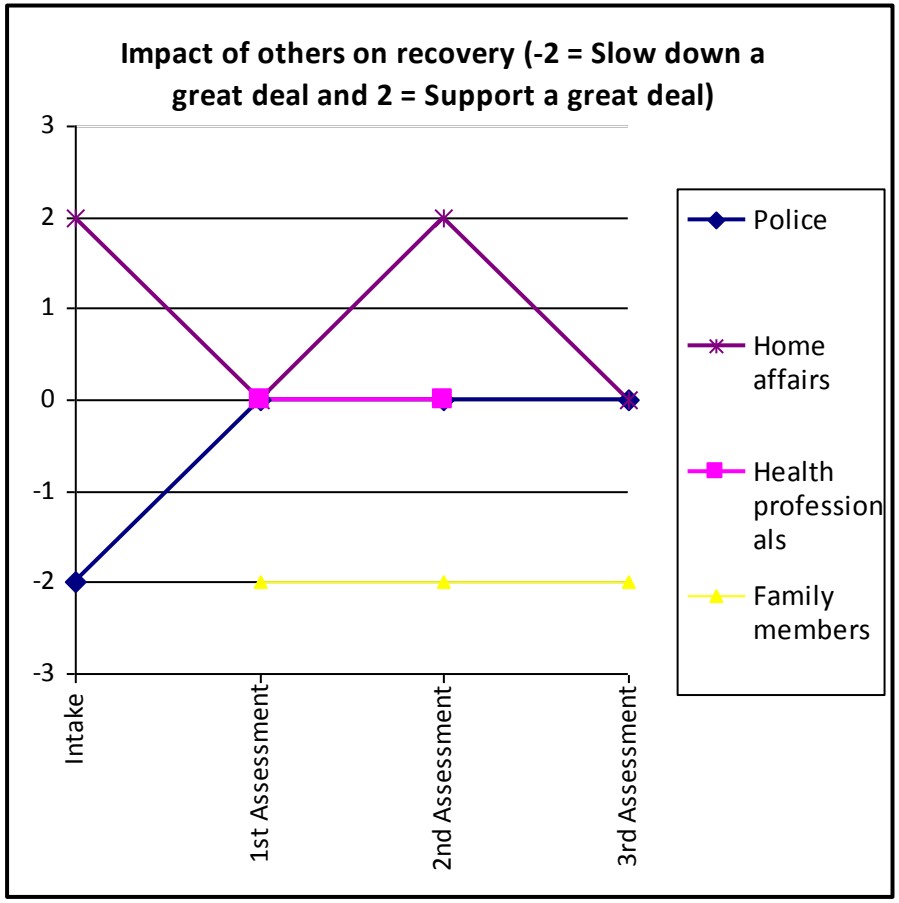
	Intake	1st Client Assessment	2nd Client Assessment	3rd Client Assessment
Date done	**25/08/2011**	**17/09/2011**	**15/10/2011**	**19/11/2011**
Number of sessions completed	-	6	12	18
Impact of the police on recovery	Slow down a great deal	No impact	No impact	No impact
Impact of home affairs on recovery	Support a great deal	No impact	Support a great deal	No impact
Health professionals impact on recovery	-	No impact	No impact	-
Family members impact on recovery	-	Slow down a great deal	Slow down a great deal	Slow down a great deal
Difficulty in solving complex problems	Severe difficulty	Complete difficulty	No difficulty	Severe difficulty
Difficulty in completing daily tasks	Complete difficulty	Complete difficulty	Severe difficulty	Severe difficulty
Difficulty in managing symptoms	Complete difficulty	Severe difficulty	Complete difficulty	Severe difficulty
Difficulty in ability to control reactions to others	Complete difficulty	Severe difficulty	Severe difficulty	Severe difficulty
Difficulty in family connections	Complete difficulty	Severe difficulty	Complete difficulty	Severe difficulty
PTSD score (> 2.5 = symptomatic for PTSD)	3.438	3.813	3.688	3.875
Self-perception of functioning score (no cut off)	3.292	3.583	3.500	3.750
Anxiety (0-7 = normal, 8-10 = borderline and 11+ = clinical)	20	20	20	21
Depression (0-7 = normal, 8-10 = borderline and 11+ = clinical)	19	18	15	16

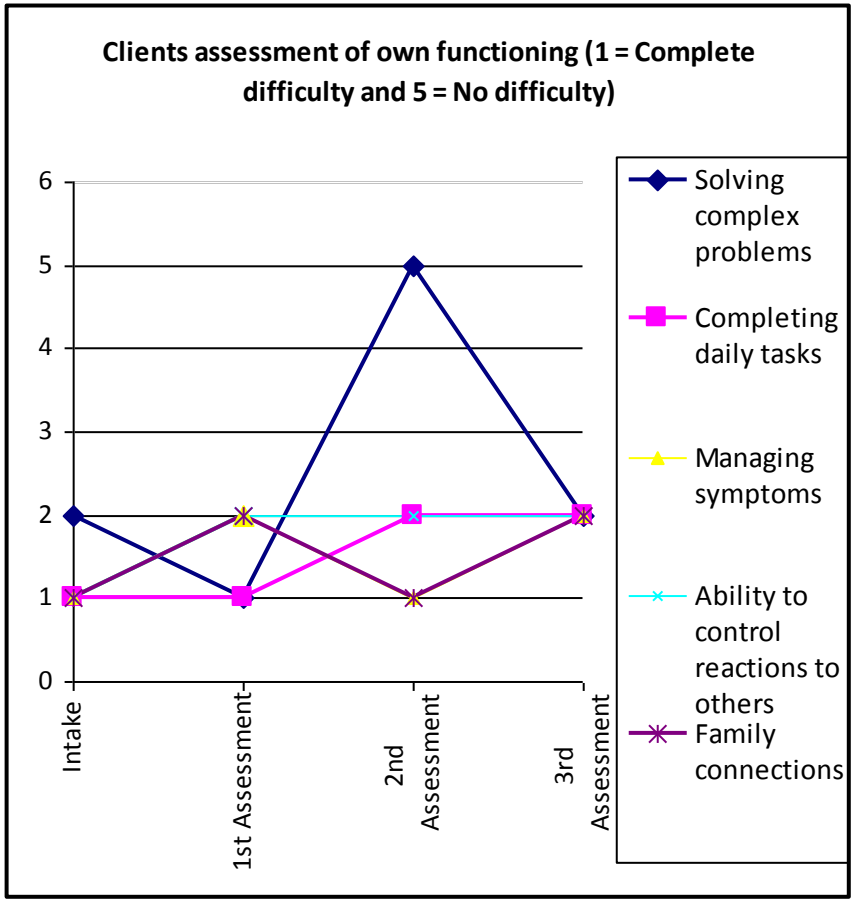
*** Lower score indicates improvement:**





* Higher score indicates improvement





Client Progress Report 3:

Data available:

- M&E intake
- 5 Client Self-Assessments

Demographics:

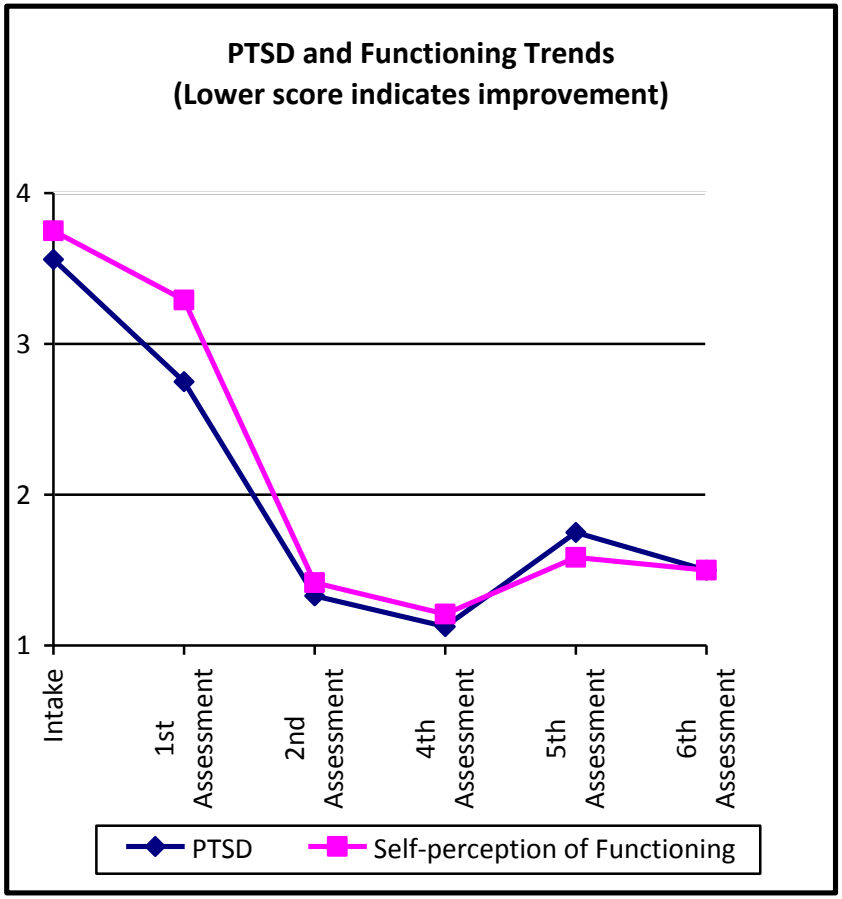
Gender:	Female	Nationality:	Zimbabwean
Age:	44	Educational level:	Completed primary
Number of children:	7	Number of dependants:	0
Pre-torture employment:	Semi skilled	Employment at intake:	Unemployed

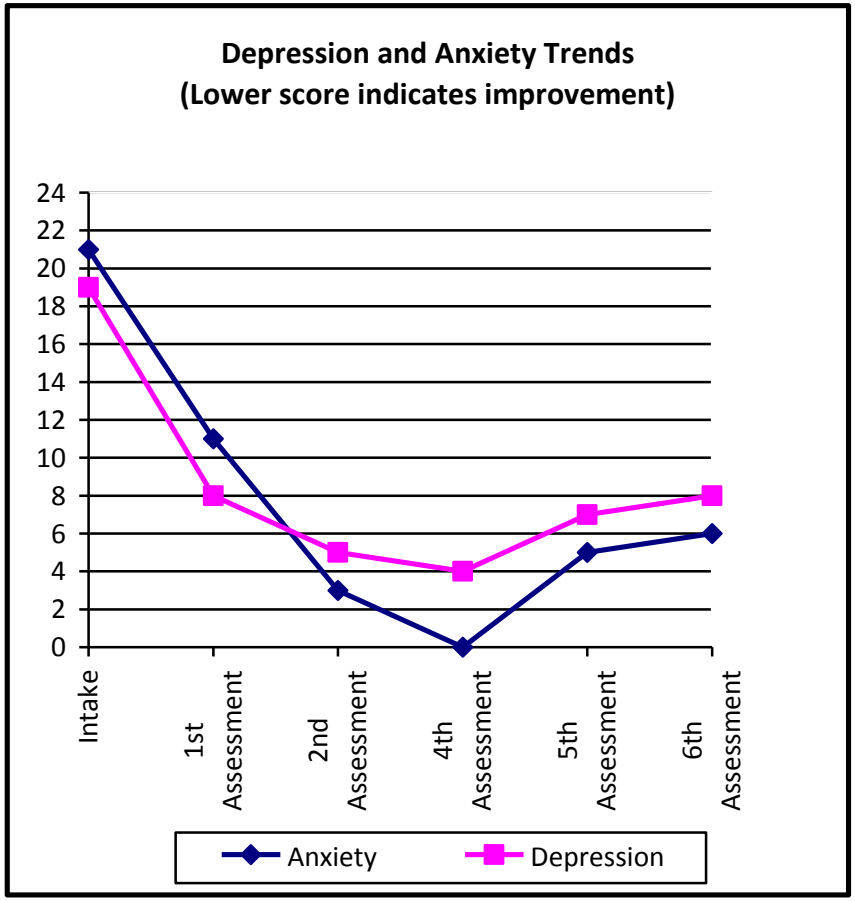
Results:

	Intake	**1st Client Assessment**	**2nd Client 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
Impact of police on recovery			
Impact of home affairs on recovery			
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

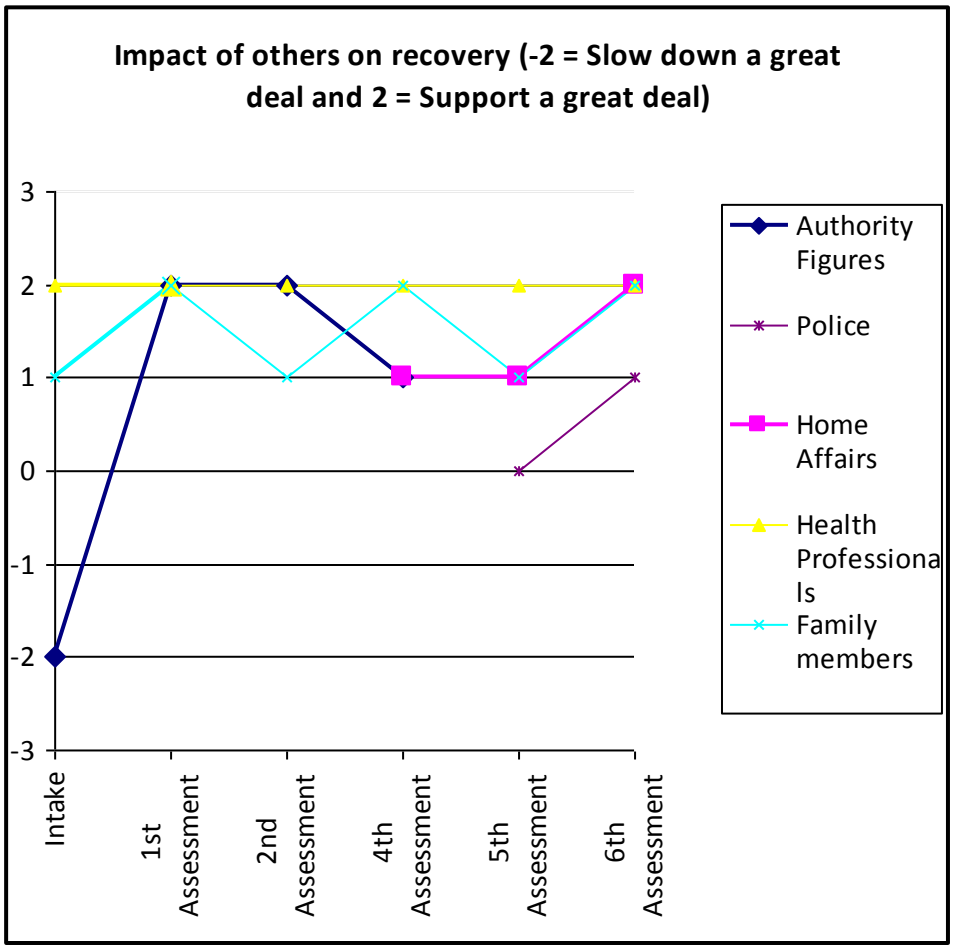
	4th Client Assessment	5th Client Assessment	6th Client Assessment
Date done	**23/11/2010**	**16/08/2011**	**06/09/2011**
Number of sessions completed	24	30	36
Authority Figures impact on recovery	Support a little		
Impact of police on recovery		No impact	Support a little
Impact of home affairs on recovery	Support a little	Support a little	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 great deal	Support a little	Support a great deal
Difficulty in solving complex problems	No difficulty	Mild difficulty	Mild difficulty
Difficulty in completing daily tasks	No difficulty	Mild difficulty	Mild difficulty
Difficulty in managing symptoms	Mild difficulty	Mild difficulty	No difficulty
Difficulty in ability to control reactions to others	No difficulty	Mild difficulty	Mild difficulty
Difficulty in family connections	No difficulty	Mild difficulty	Moderate difficulty
PTSD score (> 2.5 = symptomatic for PTSD)	1.125	1.75	1.5
Self-perception of functioning score (no cut off)	1.208	1.583	1.5
Anxiety (0-7 = normal, 8-10 = borderline and 11+ = clinical)	0	5	6
Depression (0-7 = normal, 8-10 = borderline and 11+ = clinical)	4	7	8

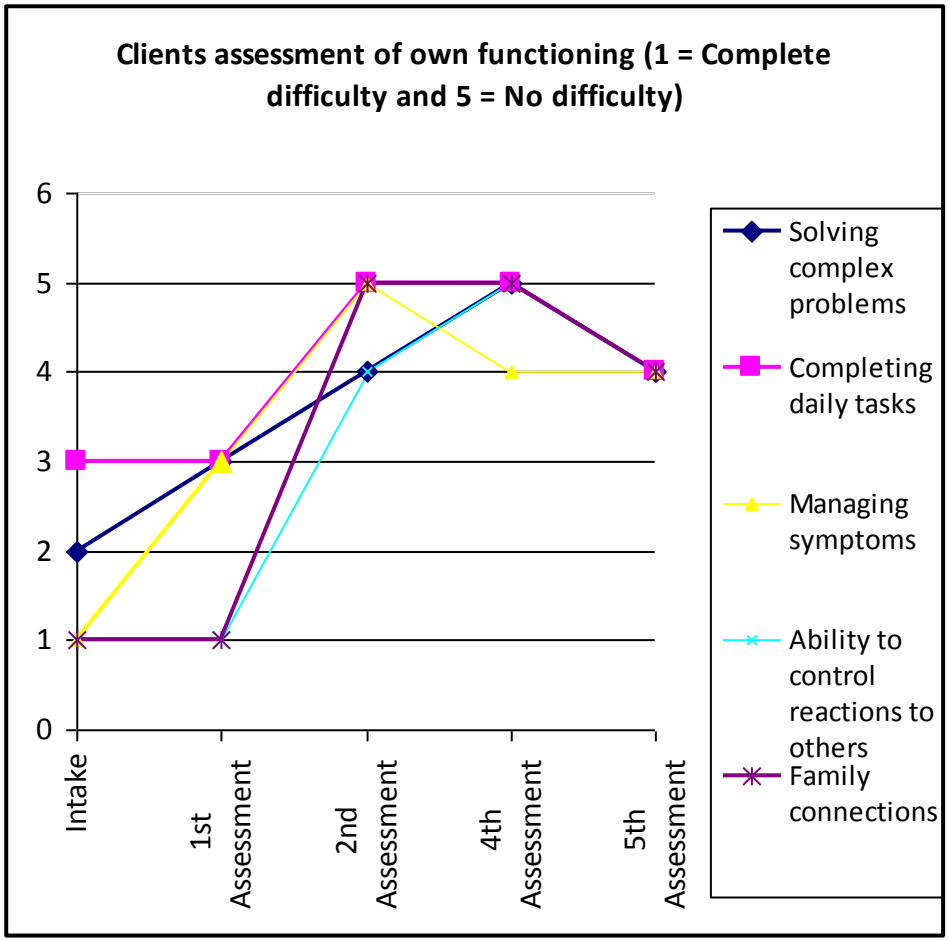
*** Lower score indicates improvement**





*** Higher score indicates improvement**





Discussion

Client Progress Reports (CPRs) have been an interesting and useful part of the Monitoring and Evaluation process. In discussing these with the clinical staff, the feedback has been positive. The clinical team has indicated that the feedback given to clients through the CPRs has been very useful. There were two examples given in practical terms of how the CPRs were used and their usefulness:

1. Client X:
   When Client X first came into the trauma clinic, he had given up on life and was suicidal. He had no place to stay and often did not have anything to eat. Although he had family and friends, he had estranged himself from them. After going through the counselling process, and through working with the client, the client's self-esteem was awakened and he realized that he can determine his own destiny and take initiative. In a short period of time, he was able to get a shack. He applied for – and got – a government grant and got food parcels. His basic needs were met and he was able to begin to heal.

   All of this was done with the help of the CPRs. Through these, he was able to see physical representations of movement in his psychological wellbeing, and could figure out the best course of action for his healing.

2. Client Y:
   Client Y used the CPRs to take over the handling of her symptoms. Because she was able to see what areas needed to be worked on, and what areas were doing well, she was able to use the CPRs to focus on areas that needed improvement. She felt that the CPR gave her autonomy because she was able to focus on the areas needing improvement with little support from her practitioner.

   With the assistance of the CPRs, she and her practitioner agreed to provisionally terminate counselling with the understanding that if she needed emergency counselling, or, if she was struggling, the counselling could continue at any time.

From the M&E side, it has been a very useful and exciting to work with the CPRs as it has allowed us to show progress of clients over time and feed this information back to the practitioners. It provides familiarity and understanding of the client's symptoms and opens up forums for discussion regarding what has changed in the clients' lives and how it has impacted his/her scores.

In addition, it has been exciting to watch how, when we started doing CPRs, there was only a baseline with one or two sessions. Now some clients have up to the 10^{th} or 11^{th} assessment and still growing.

Recommendations

It is essential to feed information back to those who participate in order to influence or increase understanding of the intervention. For us, the Client Progress Reports (CPRs) were the best and most user-friendly way to influence and increase understanding of the interventions. It is useful to have an ongoing discussion about the usefulness of the method chosen to feed information back to participants:

- Has the information been useful?
- Is the layout useful?
- Is it being used in the practitioners' interactions with the clients?
- Is it being used for case management?
- What can be done to improve it?
- Should anything be included or excluded?

This conversation allows any blockages to be addressed and ensures that the Client Progress Report is as useful as possible for both the clinician and the client.

DROP-OUT REPORT

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.

There were 185 clients who received psychosocial services from the CSVR between 2009 and 2011. Of those, 14 (7%) clients are considered "new" (i.e. they have had one session or less without dropping out), 35 (19%) of the clients are considered "ongoing" (i.e. they have had three or more sessions without dropping out), and 136 (74%) cases are "closed". In order to assess the clients dropping out, 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 from 2009 to 2011.

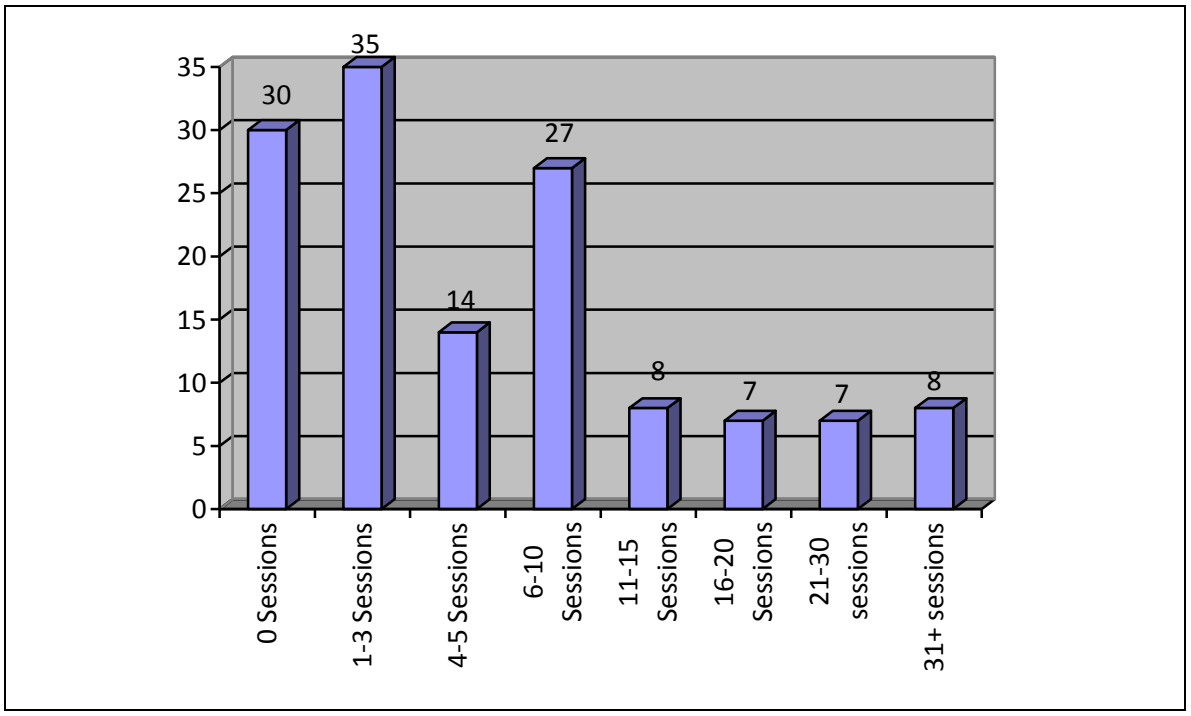


Figure 25: Breakdown of number of clients who terminated counselling by number of sessions held from 2009 to 2011

As is indicated by the diagram above, of the 136 clients who terminated counselling between 2009 and 2011, 30 (22%) did not have any counselling sessions, 35 (22%) had between 1-3 sessions and 30 (22%) had more than 10 sessions.

The following pie chart indicates the reasons for termination for clients who dropped out with zero sessions according to the clinician:

Reason for termination	Number	Percent
Client dropped out after TTP intake	16	53%
Client stopped coming for counselling without giving a reason	3	10%
Client can no longer attend counselling (e.g. got a job or moved)	7	23%
Mix-up with client allocation	3	10%
Referral to another service	1	3%
Total	**30**	**100%**

Table 19: Reasons for termination for clients with 0 sessions 2009-2011

The primary reasons for clients dropping out after the TTP intake were a lack of contact details available for the client. The following gives some reasons from the clinicians' perspectives:

- *Client has no telephone number. He is supposed to call TTP and give us his details and how he can be contacted. Until he does we are closing the case*
- *Contact details unavailable for client*
- *Client did not leave any contact details and never returned to the Trauma Clinic. Was looking for humanitarian assistance rather than counselling*
- *I called [the client] to make arrangements to come for a session. He did not turn up. I have made several calls and all were not responded to*

When phoned to ask the clients their reasons for dropping out, most clients (83%) either did not answer their telephone, their number had changed since the initial intake or the client had not left contact details during the intake interview. However, the following responses emerged from clients who either answered their telephone or had contact details available (n=5):

- *Client stated that she is now working in Randburg and would like to continue counselling*
- *Client stated that he was never called after the intake interview*
- *Client stated that he was never called after the intake interview and would like to come back for counselling*
- *Client stated that no appointment was made with her counsellor and would like to come back for counselling*
- *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*

Mechanisms have been put into place between 2009 and 2011 to ensure that clients do not "fall through the cracks". For instance, after the intake interview the client should be contacted every two weeks while s/he is on the waiting list to update them on the progress of the waiting

list and ensure that the client still wants to come for counselling despite the possible delay caused by capacity problems. Additionally, clinicians sign for each of their cases as soon as it is assigned to them. This information needs continual monitoring and discussions should ensue to ensure that clients no longer fall between the cracks.

Discussion

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. 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 two weeks 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, clients who have 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.

Recommendations:

An important part of any Monitoring and Evaluation system is to understand why people are dropping out early and, if possible, to change the systems and procedures in order to ensure that clients are not dropping out unnecessarily. This includes understanding what the reasons are for clients' dropping out, and, when possible, changing procedures to decrease the number of drop-outs that are inherent in the system.

COMPLIANCE REPORT

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 of M&E as this increases the amount of information available for analysis. For 2009 our target was to achieve a 60% compliance rate for all instruments required as part of the M&E system. This was increased to 70% for 2010 and 90% for 2011.

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).

In 2009, it was not obligatory for clinicians to complete Intervention Process Notes; however, at the same time that a client completed his/her Client Assessment, the clinician should have completed a Clinician's Assessment. During a discussion with the clinicians and managers, we decided that the Clinicians Assessment should be forfeited in place of the Intervention Process Notes. For this reason, from the beginning of 2010 onwards, Clinician Assessments were no longer included in the compliance report, while the counselling IPNs were.

This report indicates what the compliance was per instrument in from 2009 to 2011.

1. <u>Overall compliance</u>
   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 – only included from 2010 onwards
   - Clinicians 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) – only included in 2009
   - 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 four instruments (intakes, client self-assessments, clinician's assessments and IPNs).

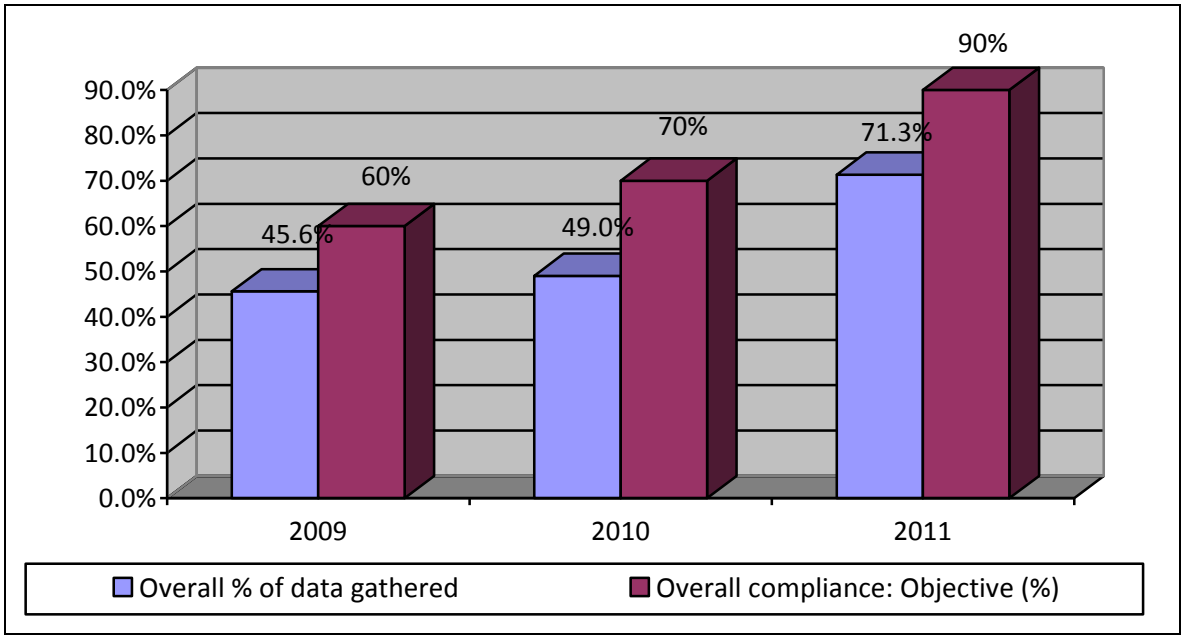


Figure 26: Overall M&E compliance rates (%) in 2009, 2010 and 2011

The average amount of data obtained has increased from 49% in 2009 to 70.6% in 2011. While we still have not achieved our objective of 90% compliance in 2011, this can be explained in the discussion about the compliance per instrument (below):

2. <u>Compliance per instrument (%)</u>
   The following figure indicates the compliance per instrument in 2009, 2010 and 2011 (figure below):

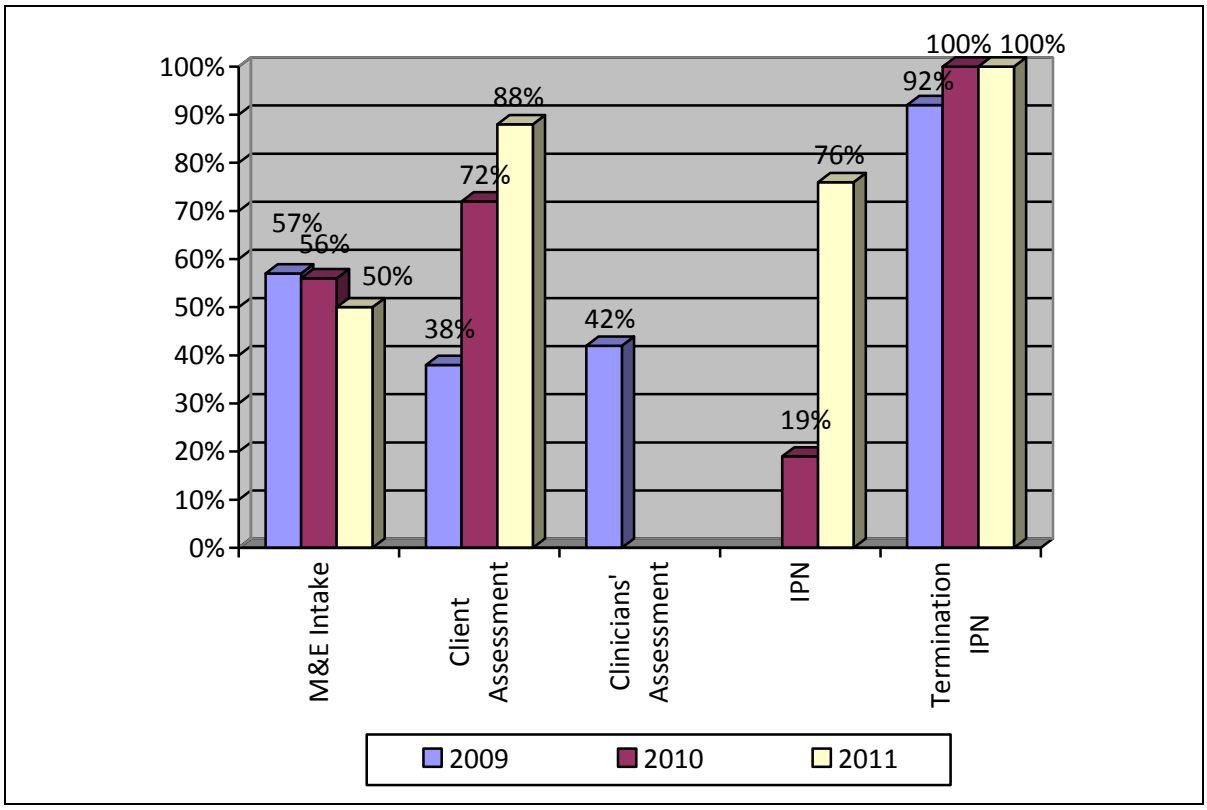


Figure 27: M&E compliance rates (%) per instrument in 2009, 2010 and 2011

As can be seen by the figure above, while the compliance for M&E intakes have dropped between 2009 and 2011 from 57% to 50%, the compliance for client assessments have increased from 38% to 86%. Additionally, while IPNs were not included in the compliance for 2009, the compliance for this instrument has increased from 19% to 76% from 2010 to 2011.

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 two sessions, it is considered "lost" since his/her functioning and symptoms should have been impacted on by the counselling process. The following table indicates the compliance for M&E intakes from 2009 to 2011:

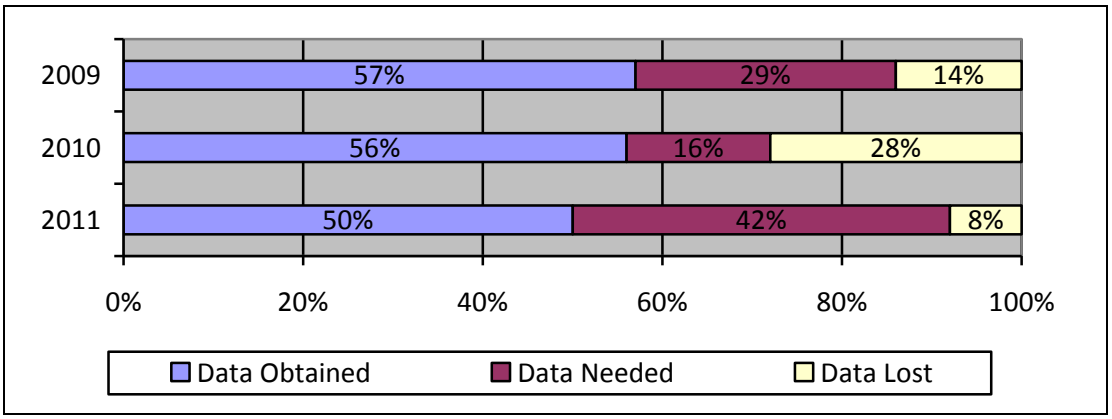


Figure 28: M&E compliance rates (%) for M&E intakes in 2009, 2010 and 2011

The figure above indicates that the obtained data for M&E intakes decreased from 57% to 50% from 2009 to 2011. The decrease in obtained data can be explained by the increase in the number of torture clients who came to CSVR for assistance at the end of 2011 (42% of the new clients in 2011). Due to capacity limitations, these clients had not been assigned a clinician and so had not completed an M&E intake by the end of 2011. However, these clients may be assigned a clinician in 2012 and so may complete their M&E intakes in 2012. For this reason, it is still possible to achieve 92% compliance for new clients in 2011. The two clients who were considered "lost" in 2011 were clients who dropped out after the initial (TTP) intake and chose not to come for counselling.

b) Counselling Sessions Intervention Process Notes

After every session, the clinician should complete a counselling intervention process note (Counselling IPNs). A decision was made that if a clinician did not complete his/her counselling IPNs within three sessions, these IPNs would be considered lost. Counselling IPNs were not included in the information necessary for compliance in 2009 so the figure below indicates the compliance for the IPNs from 2009 to 2011:

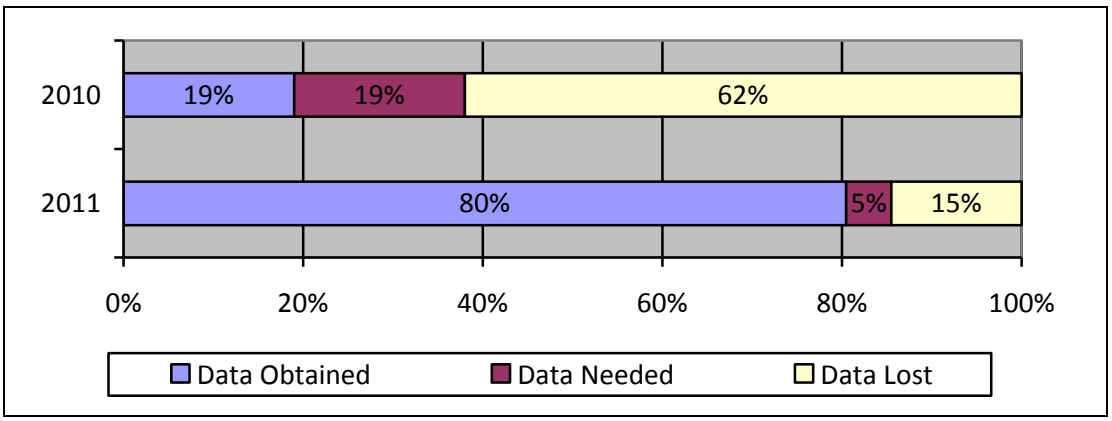


Figure 29: M&E compliance rates (%) for counselling IPNs in 2010 and 2011

The figure above illustrates the dramatic increase in compliance for IPNs from 2010 to 2011. This shift is indicative of the very hard work and dedication on all parts of the clinical team: from the managers, M&E team to the clinicians. The remarkable increase in compliance for intervention process notes over the past two years is, arguably, one of the greatest achievements of the monitoring and evaluation processes. We look forward to being able to use this information for model development, and to see what is and is not working in the therapeutic process.

c) Client Assessments

After completing an M&E intake, a client assessment should be completed 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). The information is considered "lost" if it is not gathered within the window period (i.e. before the sixth session or after the eighth session). The figure below indicates the compliance for the client assessments from 2009 to 2011:

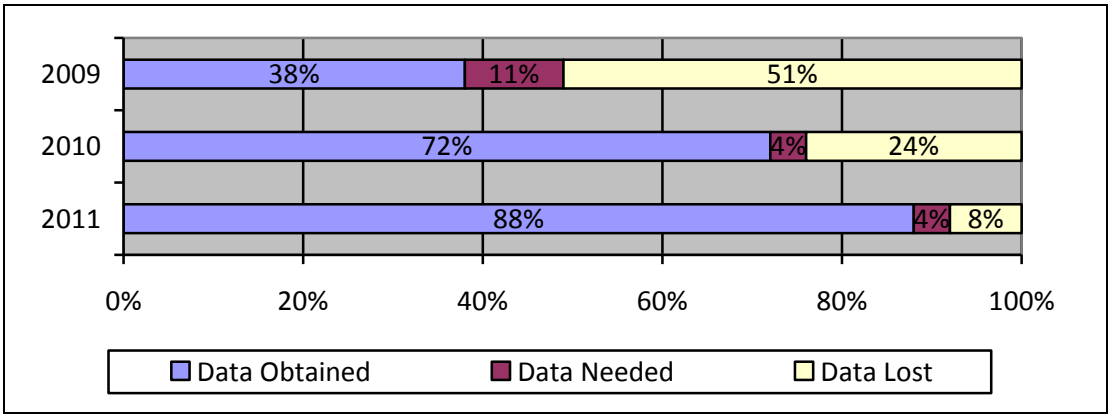


Figure 30: M&E compliance rates (%) for client assessments in 2009, 2010 and 2011

The compliance for client assessments has increased from 38% in 2009 to 88% in 2011. This dramatic increase in compliance for this instrument is indicative of the hard work and dedication of all the different members of the clinical team: the managers, the M&E team, the clinicians and the clinical assistant. This information is very useful in showing the impact that the counselling process has on the client and whether or not his /her symptoms and functioning are getting better or worse over time.

d) Clinician Assessments

In 2009, at the same time that the client completes an assessment, the clinician completes a clinicians' assessment. The same time frames that are employed for the client assessment apply to the clinicians' assessment (i.e., on the sixth session and every six sessions after that with a two session window period). After 2009, we made a decision to discontinue the checking of

clinician assessments as part of the compliance system. The figure below indicates the compliance for the clinicians' assessment in 2009:

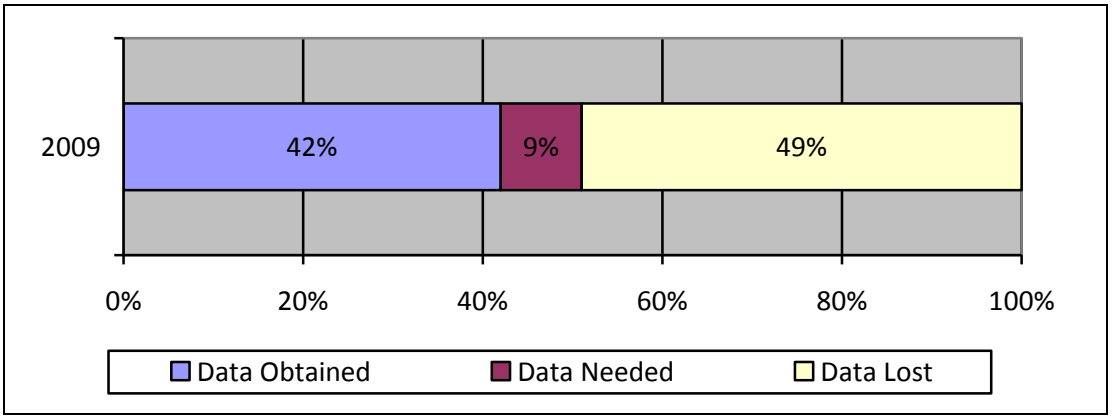


Figure 31: M&E compliance rates (%) for clinicians' assessments in 2009

This figure indicates that, in 2009 we obtained 42% of clinicians' assessments while 49% were lost. Discontinuing the Clinicians Assessments has been useful because it ensured focus on the IPNs. However, there has been information gathered through these assessments that was lost. This was a decision that had to be made, and was the correct decision at the time.

e) Termination Intervention Process Notes

After a client drops out or terminates the sessions with his/her counsellor, the counsellor completes a Termination IPN. There is no lost data for this information since it can be captured any time after termination. The following figure indicates the compliance for Termination IPNs from 2009 to 2011:

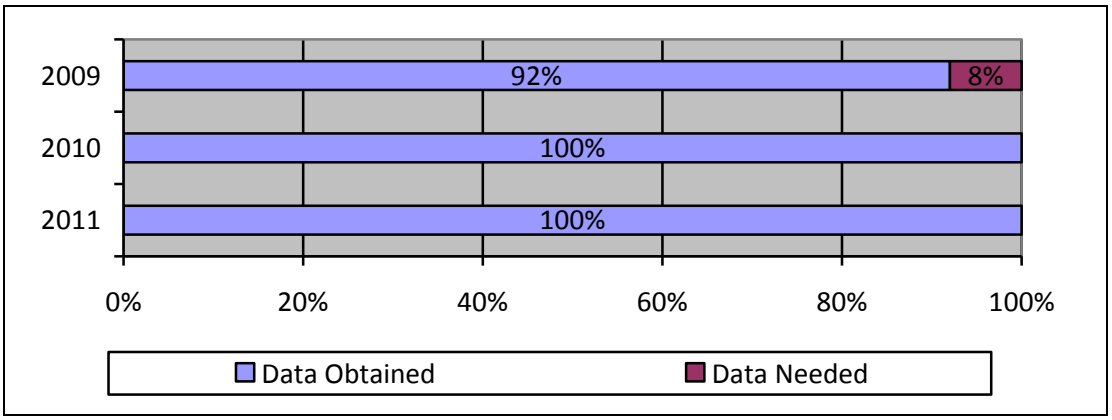


Figure 32: M&E compliance rates (%) for termination IPNs in 2009, 2010 and 2011

The figure above indicates how, from 2009 to 2011, the compliance for Termination IPNs have gone up from 92% to 100%. This information has proven essential in observing why clients drop out and how many sessions they have before dropping out.

Discussion

No M&E system is possible without documentation and ensuring that data is obtained when required so that there is maximum amount of information available for analysis. We have achieved a lot through the documentation of our work. Over and above the dramatic increase in almost all areas of our compliance in the past three years, there is much work that has been documented. There have been 186 client assessments from 2009 to 2011 done within the specific session frames, and 70 clinician assessments done within the same session specifications (figure below).

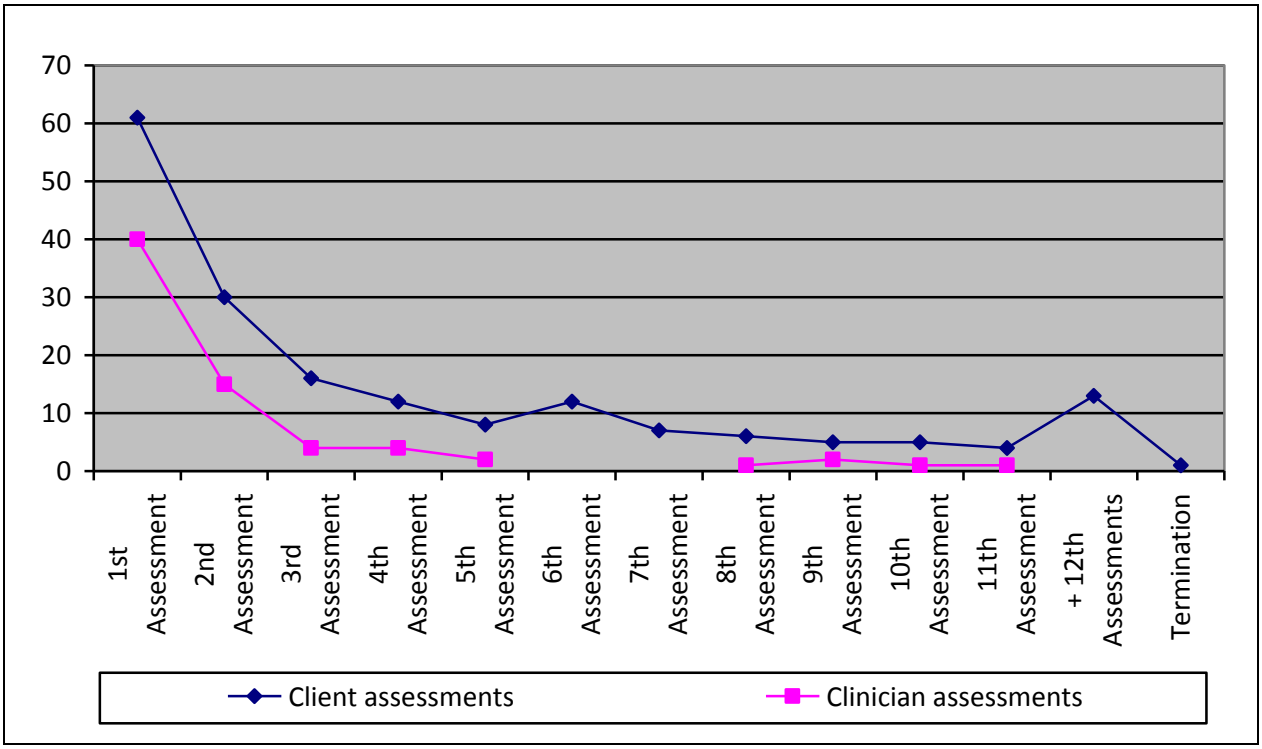


Figure 33: Assessments per 6 session category 2009-2011

Additionally, there has been significant amount of documentation that has occurred over and above what has been mentioned above. It is encouraging that clinicians capture data in addition to what is checked by the M&E team and managers (see figure 34 below). There is a lot of work that goes into the counselling process that is not captured by the individual counselling session IPNs that we check on. These can be captured on the database under Intervention Process Notes. There have been 1547 IPNs captured on the database since the beginning of 2009. The following table indicates the frequency of the different types of interventions

captured during from 2009 to 2011. For this table, “other” includes Termination IPNs (now gathered at the end of the TTP intake form); marital counselling; supervision; crisis intervention; psychiatric assessment; and consultation with either a colleague, interpreter or the psychiatrist:

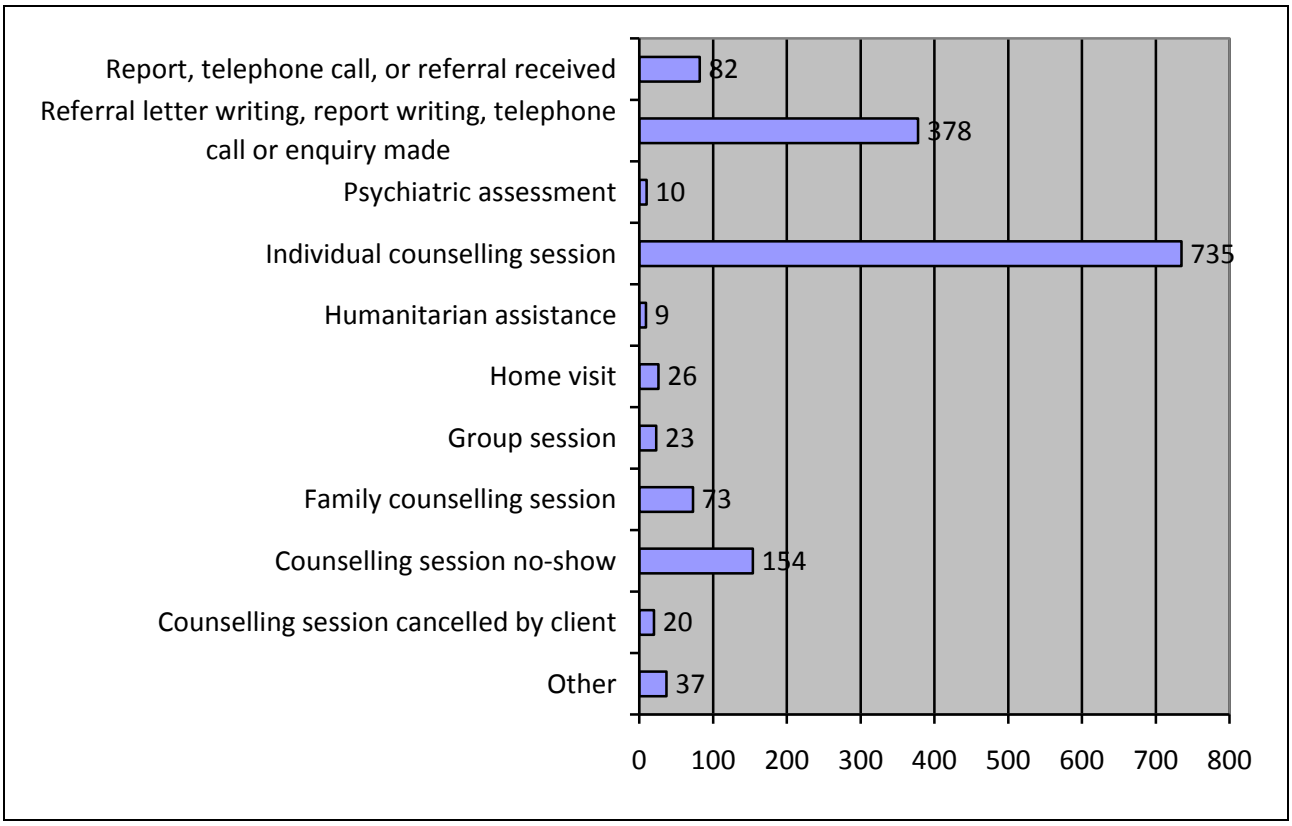


Figure 34: Frequency of IPNs captured on database between 2009 and 2011

It is encouraging that clinicians capture data in addition to what is checked by the M&E team and managers. This is an indication, firstly, of the M&E system being used closer to its full potential, secondly of the fact that when the system is working, there does not necessarily need to be “policing” that ensures compliance with the system, and thirdly, it indicates the work that is done in addition to the individual counselling sessions that is monitored during the compliance. This allows us to paint a more realistic picture of the complex work that goes into work with victims of torture, beyond only counselling sessions.

In spite of the encouraging work that is coming out of the M&E system, however, the checking of compliance is a process that is fraught with challenges. These include:

1. Ensuring compliance to the M&E system has needed a culture shift amongst the staff. The clinical staff has needed to adapt to a new way of practice. This adaptation has included a system that "exposes" their work, i.e., it puts the work done into a more "public" sphere
2. Compliance is an area that needs constant monitoring. This is especially true in an area of the trauma field that has too few clinicians for the number of survivors being seen. A balance has to be reached between the number of clients seen, the time spent with the client, and the time involved in documentation
3. Meeting the obligatory deadlines required for M&E has been a challenge, as has been the requirements for the documentation. Practitioners have indicated that a lack of clarity regarding what is expected or needed for documentation (especially Intervention Process Notes) has made them feel overwhelmed and resistant to the M&E system. This lack of clarity includes:
    - How much information should be written in the IPNs
        - How much information should be filtered or left out?
        - How much information should be included?
        - If information in the IPNs is filtered, is it still worthwhile writing the IPN if it is purely superficial
    - Is the substance of the IPN being lost because of deadlines and commitments?
    - How do you ensure that the practitioner feels confident in documenting:
        - One part of documenting is the feeling that what is being written will be read by a third person which puts pressure on the practitioner to perform.
            - What does it mean to "document properly"?
            - What does it mean to "document well"?
4. Compliance to an M&E system may represent a change in relationships. For instance, high performers in one area (e.g. therapy) may not necessitate high performers in other areas (e.g. compliance). Managing the shift in relationships and the expectations can be challenging for the participants.

Recommendations

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 that is essential for all work done.

Part of the paradigm shift inherent in the M&E process is having all participants understand that M&E is not a form of punishment and is not a performance management tool. The purpose is to reflect and learn from what is being done, to learn more about our interventions and to improve our services to victims of torture. Through the process of M&E, we are able to focus on who we are trying to help, and observe what the impact of our interventions have on people who we are trying to help.

In order to meet deadlines and ensure compliance, we have found two primary ways of ensuring that data is gathered within the specified time limit:

- Involving managers in ensuring that assessments are completed within the time frame. While an M&E system should not be used as a performance management tool, involving managers means that the clinicians are more likely to complete the assessments within the given timeframe
- Completing compliance reports – when a clinician can see what s/he needs to do and how long before it is considered lost helps to remind the clinician to ensure that assessments are completed

QUALITY OF SERVICE RECEIVED AT CSVR

As part of the client assessment form, clients were asked questions about the service that they received at CSVR. However, because we did not have the capacity to analyse the responses from clients, in 2010 we decided to remove these questions from the assessment form. These are the responses from clients who completed the questionnaire regarding the quality of service at TTP from 2009 to 2010 (n=31).

When asked whether the client felt welcome when s/he came for counselling at CSVR, 30 clients said "yes" and one said "no". The follow-up qualitative question asking what made the client feel welcome or unwelcome provided the following response for the client who answered "no" for the first question:

"I was feeling crazy for undergoing TRAUMA COUNSELLING"

Below are some quotes from clients who said that they had felt welcome when coming for counselling at CSVR:

- *"They talk to me nicely"*
- *"When we entered, we were welcomed and because we were speaking French, they found somebody to help us speaking French"*
- *"First of all when I arrived at reception, the way that the receptionist welcomed me is like she was my sister, and when I met [my counsellor], the attention that she gave me her counselling really to this day I still thank CSVR for the service I received"*
- *"The way they respect the people and the way they talk to them"*
- *"Because they welcomed me and gave me time to talk and they listened to me carefully"*
- *"I was welcomed because the time I came they offered me juice and biscuits to get energy. They show me that they are happy with me. If I have got a problem they help me find a solution"*
- *"Firstly I didn't know the place and they managed to communicate with me telephonically and I managed to find the place in the big city"*
- *"The receptionist was very kind. She offered me something to drink and biscuits. The lady who did the interview was also very nice"*
- *"The clinician is like my brother"*
- *"Because I was feeling free and I could open up to her and she is such a good listener"*

When asked whether the client felt supported by his/her counsellor, all 31 clients responded "yes". The following are some quotes from clients who felt supported by their counsellor:

- *"Because she listens to my problems and gives me solutions"*
- *"By being heard and sharing with her. She was like someone who was holding your hand not to fall"*

- *"He wrote letters that helped me"*
- *"My counsellor is a good person who can listen and give advice where possible"*
- *"I was supported because they paid attention to my problems"*
- *"Because she looks at the problems like they are her problems and she will do anything to make me better"*

When asked whether the counselling had helped, all 31 clients stated that it had. The following are quotes from clients who indicated how the counselling had helped them:

- *"She advises me how to look after myself, how to carry on my studies, and how to live a better life"*
- *"It helped a lot. The first time I came with my story, I was listened to and later on I could see that they do care. I was helped by my counsellor with spiritual support and at times he would even give me some advice on how to overcome some of my problems"*
- *"At least I had someone to talk to and share my problems and I get relief"*
- *"I feel a bit better and all the suicidal thoughts I had seem to be fading away. I do feel like taking suicide less than I did before. I always have this hope after counselling"*
- *"When I came I couldn't sleep and I was too emotional. Now I can sleep and I don't cry too much like before"*
- *"I view my situation from a different perspective"*
- *"Because most of the things that used to drive me to anger and make me irritated and feel ashamed of myself, mostly are gone"*

Discussion:

When examining the M&E system, one clinician mentioned that she felt that it was a great loss that we had decided to take the questions about the service received at TTP out of the client assessment forms. For her, the information obtained during this questionnaire had a greater impact to the counselling process and the service that the client obtained from TTP than the questions asked in the Harvard Trauma Questionnaire, Hospital Anxiety and Depression Scale and International Classification of Functioning and Disability for the following reasons:

1. The client is specific about what is important at the trauma clinic and what happens during counselling
2. The questions and responses can be more telling about the clinic and service received than the client assessment form
3. The information gathered is fed back to the trauma clinic through the client satisfaction form
4. The responses given were part of the healing process

The lessons learnt through the client satisfaction questionnaire are useful for the running of the clinic. The client satisfaction questionnaire allows us to get feedback on our service – both in the therapeutic space and outside the counselling room. We are able to see if and where problems are building and where blockages may be.

Recommendations

Because the M&E team was not feeding the information gathered back to the clinical staff members on a constant basis, we felt that this part of the client assessment form was asking questions that were not being used by the practitioners or staff of TTP, and were therefore redundant. For this reason, we chose to take this section of the client assessment out of the form. Additionally, because questions in the client satisfaction questionnaire pertain directly to the clinicians, the clinicians could not administer the assessments. This caused logistical difficulties and put a lot of work and pressure on the clinical assistant, interns and Social Work students.

However, the administration of these questionnaires should be an ongoing discussion and negotiation. If it is useful and we are able to analyse this information, then, with the clinical team, we will decide whether or not to put these questions back into the assessment form, or whether there is an alternative way to gather this information on a regular basis. Additionally, we may look into ways that feed the information back to the clinicians without ongoing analysis and possibly in less formal spaces.

If, however, we are not aware of the information being used, we will recommend that these questions are not included in the assessment form, since it takes time for the client to answer these questions, as well as for a staff member to capture and analyse this information.

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.

There have been a number of lessons learnt through the implementation of the M&E system. These include the following:

- We have always known that we are working hard and that we are impacting our clients' lives. Monitoring and evaluation gives us evidence of this:
  - We can see what we are doing well and where the gaps are
  - We are able to consistently evaluate our work
  - We are able to show progress
  - We can see why people are staying at our clinic
  - We can see what treatment we are giving them and whether it is working
  - We are able to focus on the people that we are trying to help
- Monitoring and evaluation reduces complacency:
  - We are able to monitor and manage areas of concern and ensure that the work that we say that we are doing is being done
  - The process gives cautions and alarms when we are not on track
- We are able to see the importance of documenting work:
  - It makes the invisible visible
  - We are able to generate knowledge
- Monitoring and evaluation is a part of clinical practice and is non-negotiable in all work that is done:
  - Monitoring and evaluation is not a form of punishment
  - It is not a performance management tool
  - It changes the vision of what people see as important for clinical practice
- It is possible to merge research and intervention:
  - It takes time and is difficult but it is possible to marry the two
- Monitoring and evaluation is possible!
  - We believe in ourselves and in our vision
  - Monitoring and evaluation has given us an example of what is possible against all odds

We hope that the information gathered in this report will be useful for other organisations in the work that they do. We also hope that the information may be used to improve the clinical practice and ensure more learning and knowledge generation in the area of torture. We look forward to another year of learning and transforming CSVR into an even more reflective organisation.

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