Handbook
Client Intake Form:
Developing an assessment tool for psychosocial interventions

2010

Family Rehabilitation Centre (FRC)
Sri Lanka

Reducing the Effects and Incidences of Trauma Project
(RESIST) The Asia Foundation
Sri Lanka

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RESIST Program Team 2010

RESIST Program Team 2010

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Contents

Introduction

Reducing the Effects and Incidences of Trauma (RESIST) Programme of the Asia Foundation was initiated in 2005 with the aim of improving the quality of life of survivors of torture, violence and conflict. The project worked with implementing organizations that provide services ranging from counselling, psychosocial support, medical treatment and physiotherapy. RESIST's partnership with the Family Rehabilitation Centre (FRC) highlighted a need for improved mechanisms to monitor the impacts of the psychosocial support interventions. The FRC, like most other psychosocial service provision agencies, had been conscious of the need to address two particularly important monitoring requirements. These are:

1. The need to quantify the impacts of psychosocial interventions - The demand by donor agencies for statistical evidence that supports the qualitative data on the impacts of psychosocial interventions has increased over the years.
2. The need to base monitoring of psychosocial interventions on locally relevant indicators – Often indicators that are largely medicalized or those which reflect the norms of western cultures are used. The implementing staff may use these without really understanding what is being monitored frequently leading to gaps in impact assessments.

In addition to these, a third specific need was also felt by the project implementing staff of the FRC

3. The need to develop a single monitoring data recording format to reduce the time and hassle of filling different formats for varied aspects that need to be monitored in a psychosocial intervention.

The Client Intake Form (CIF) resulted from RESIST's and the FRC's interest and commitment to address these issues in a meaningful way. The CIF was developed in 2006 - 2008 with the FRC and Shanthiham, two local NGOs providing psychosocial support to survivors of violence, torture and conflict. Due to the armed conflict in the north-east and the security issues prevailing during this period in the country, Shanthiham staff working in Jaffna was unable to participate in the entire process. Development of the CIF assessment tools took a meticulous process which facilitated dynamic participation by the ground level service provider staff, counsellors, field officers and community volunteers of these two organisations. The process is based on the Brief Ethnographic Investigation, developed by the project's international technical advisor, Dr. Jon Hubbard, Research Director for the Centre for Victims of Torture in Minneapolis (CVT). Dr Gameela Samarasinghe, Senior Lecturer, Department of Sociology, University of Colombo contributed as the local technical advisor. The project also worked in close collaboration with the Psychosocial Assessment of Development and Humanitarian Interventions (PADHI) unit of the Social Policy Analysis and Research Centre (SPARC) of the University of Colombo.

The CIF assessment tool is based on the concept of adaptive functioning[1] and was developed through an approach that formulated locally understood indicators of 'competence', 'resilience' and 'wellness'. Community interviews using the BEI methodology was carried out to access community perceptions on these aspects. Bringing in the communities' understanding of these concepts into the assessment form contributed to

[1] RESIST Final report – Phase 1 July 2005 - 2008

design the CIF primarily as a therapeutic tool and in parallel address the monitoring needs of the project intervention.

This Handbook outlines the process through which the CIF was developed and discusses the high points of the process, the application of the CIF and its limitations and its potential. The objective of the Handbook is to develop user friendly guidelines to any organization that wishes to translate qualitative impacts of an intervention into quantifiable monitoring scales. The flexibility of the approach lends itself to be adapted to meet the monitoring and service quality assurance needs of any type of psychosocial intervention or other community focused service provision interventions.

The Handbook is organized into 5 chapters. Chapter 1 presents, in summary, the process of developing the CIF, The history and development of the CIF is discussed in detail in Chapter 2. Chapter 3 discusses the experiences of data collection and analysis and Chapter 4, the significance and use of the Adaptation and Distress scores. Chapter 5 outlines the therapeutic value of the CIF tool.

Chapter 1
The Process – in summary

Developing the Client Intake Form

The Client Intake Form as an assessment tool is based on the concept of adaptive functioning[2] and was developed through a process that used the methodology of Brief Ethnographic Investigations. The methodology was developed by Dr Jon Hubbard, Research Director for the Centre for Victims of Torture in Minneapolis (CVT), specifically for NGOs that provide psychosocial and mental health services. The methodology helps to[3]:

- *quickly and systematically gather information about aspects such as needs, problems, beliefs and strengths*
- *develop culturally relevant indicators for evaluating the effectiveness of psychosocial and mental health interventions*

Application of this methodology to develop the Client Intake Form happened through a succession of steps that enabled a high level of participation by the counsellors and field staff. They worked in collaboration with the technical advisors and a support team at the Asia Foundation and PADHI.

The process could be viewed as having two stages:

- The first focuses on finding out how the community defines adaptation and distress based on their conception of wellbeing and the competence in relation to dealing with the stresses caused by the war. (Preliminary discussions had concluded that the assessment of clients should look at the distress adaptation[4]). A research based on the BEI methodology was carried out to identify community perceptions on competence/wellbeing and war related problems.
- The second stage focused on analysing the data generated from the research and developing assessment measures. These assessment measures were used to structure the assessment form (CIF).

The overview of this process, presented in this chapter, draws on the experiences of the FRC, Shanthiham and RESIST.

The process consists of 7 main steps

1. Identifying the strengths and gaps in the existing monitoring mechanisms and formulating research questions to generate response for the development of indicators
2. Designing the interview of the research and training on methodology
3. Field data collection and review of data
4. Data organizing and sorting responses
5. Developing indicators
6. Formulating monitoring formats based on indicators

[2] Read chapter 4 for more information on this.

[3] Hubbard, J. (2007). Using brief ethnographic interviewing as a method for understanding an issue, problem or idea from a local perspective. Minneapolis, Center for Victims of Torture.

[4] Refer Chapter 4 for details

7. Field testing and revising the format

1 Developing the research question/s

1.1 Understanding what needs to be monitored and the strengths and gaps of the existing monitoring mechanisms

This initial step basically looked at what the counsellors (as ground level service providers) wanted to know about their clients and the level to which this was being monitored through the existing monitoring mechanisms. With the outlining of related concepts by the technical advisors and through discussion, it was decided that what needs to be monitored are the adaptation and distress levels of the clients[5]. Both the implementing partner organisations work in the north and east with conflict, torture and violence survivors providing counselling services. The field research, therefore, aimed at understanding communities' views on adaptation/ competence and problems of war.

1.2 Formulating the research questions

Two main research questions were formulated. The responses to these would be the data that would be analysed to develop assessment measures. Therefore considerable time was allocated to discuss and debate on what to ask and how to phrase the questions. This was important so as to elicit a wide range of responses that are grounded in real life situations. Some aspects that were considered when formulating the questions were:

a) Clarity of the questions – the interviewees need to clearly understand what is being asked. Wording of the question, use of simple language and keeping the question short were priority considerations. Particular importance was given to capturing the precise meaning when translating the questions into local languages (Sinhala and Tamil)

b) Open ended questions – It is important that the interviewees are stimulated to think and come up with their own answers rather than respond with yes or no.

c) Non-leading questions –The manner of asking the question should not influence the interviewee to answer in a certain way/give a particular type of response. Much consideration was given to wording of the question to ensure this. It was also taken up during the practising of conducting the interviews.

These were general measures taken to ensure that the questions are understood in the way the researchers expected and were responded with participants' own experiences. In addition to these, the BEI methodology required the formulation of questions in a particular manner which is described below.

1.2.2 Methodology specific nature of the questions

a) The methodology requires the interviewee to think of a real person when responding to the questions - This helps avoid generalized, abstract

[5] Refer Chapters 2 – 4 for more information on this.

responses. It also helps the interviewee to focus on real life experiences rather than describe a situation as it 'should be'.

b) The questions does not ask for interviewee's own experience but about a person known to him or her - This avoids issues of self disclosure as well as answering with expectations of secondary gains for participation (e.g. highlight/ exaggerate particular needs for which financial or other support is expected).

c) By asking the interviewees to focus on a person other than oneself, it helps minimize/ avoid causing distress and feelings of despondency among people living in vulnerable conditions.

d) The interviewees are specifically requested not to reveal the name of the persons he/she is thinking about when responding to the questions – This helps maintain confidentiality

e) If there are subgroups in the community, the questions are repeated for each of these sub populations: For example, the interviewee is asked to think of someone they know and if this person is a woman, and then the question is repeated for a man.

Interviewees are requested to give four responses to each question. (Refer Appendix 1 for sample questionnaire that was developed for the research)

Field testing the questionnaire with a community that would not participate in the research is an essential step to ensure whether the questions elicit responses that are relevant to the issue that is being studied.

2 Designing the interview

2.1 Sample

Random sampling method was used, ensuring that the sample included all the sub populations in the community and therefore was representative of the community. In this research, the sub populations mainly considered were men and women.

The number of respondents depends on the required number of responses for each question. The interviewees are asked to give four responses to each question. Therefore, involving 50 interviewees in the sample gives 200 responses. However, if at the stage of cleaning the data, some responses are not useful because they are not relevant or are too general, then a few more people would have to be interviewed to have a total to 200 responses.

It is useful to have a substantial number of responses that would give a wide range of views and thereby bring in varied perspectives on the issues about which information is being gathered. According to Dr Hubbard[6] it is useful to have between 150 – 200 responses for each sub population.

[6] Hubbard, J. (2007). Using brief ethnographic interviewing as a method for understanding an issue, problem or idea from a local perspective. Minneapolis, Center for Victims of Torture.

The FRC and Shanthiham worked with an initial target of interviewing 50 people from 5 villages in each of the districts they are active. However, due to security concerns and the ensuing travel difficulties this had to be changed. Nevertheless, the research generated 709 responses.

2.2 Logistics of Interviewing

Time duration - Each interview was generally planned to take between 15 – 20 minutes. However, the experience of the CIF research highlighted that the time duration for an interview could be longer. In such instances the research team agreed to prioritize the quality of the interview over ensuring that a specified number of interviews be completed in a day.

Starting the interview – Ample consideration was given to planning the opening lines of the interview so that the respondents are clear about the purpose of the interview and feel comfortable to participate in it. Explaining the purpose in simple language and with a few words was stressed.

The opening phrase used in the CIF research for the question on adaptation was, "*It would be very helpful for us to know how you can tell a person's life is going well. Think of an adult that you who is doing well, but don't tell me who it is. The person doesn't have to be the best person you know but someone that is doing satisfactorily. Then I am going to ask you a few questions about this person*."

2.3 Training the staff / interviewers

The validity and richness of the data depends on how well the interviews are conducted and therefore training the research team to conduct interviews was a significant step in the process. A team of technical advisors from PADHI provided training for the process through several workshops. This included practising of interviews through role plays with each participant taking a turn to be the counsellor (interviewer) and then the respondent (interviewee).

Some important aspects that were highlighted in the practising were:

- Asking the question as it is phrased in the questionnaire rather than use own words to paraphrase or elaborate

- Ensuring that the responses are not general – for example 'she is good' does not describe a specific quality and therefore is a general response. Interviewers were encouraged to ask why this person was considered good leading to identifying specific qualities/ issues/ situations

- Recording the verbatim – It was important to record the responses as given by the interviewee in his/her own words. Participants were encouraged to avoid summarizing or translating of responses when writing down the answers.

- Ensuring clarity of the response, which also includes writing down the answers clearly.

- The questionnaire requires 4 responses for each question from each sub population. Each of the 4 responses has to be recorded separately. In the practice interviews the participants examined their responses and trained to avoid combining of different ideas into a single response.

3 Data collection

The key aspects considered were maintaining a sampling plan and ensuring that the interviewers have sufficient time to ascertain the quality of the interviews. Although the interviews were expected to take only a short time, this varied widely depending on the respondents. Not scheduling too many interviews for a single day was an option that was used to encourage the interviewers to prioritize quality over quantity.

Ethical considerations such as having the informed consent of the interviewee, maintaining confidentiality and cultural sensitivity were ensured.

Facilitating a meeting of interviewers while the data collection in progressing was useful to identify ground level issues and support interviewers where necessary. Technical support was also made accessible for the interviewers over the telephone.

4 Data organizing - sorting responses

4.1 Transcribing the responses on to cards

The responses spread across a wide range of views/ information and needed to be categorized to understand the main themes or domains that have been frequently highlighted by the community. First, the responses had to be transcribed on to response cards. Although this could be done using a computer package, in this research hand writing the responses on to cards were preferred because it was simple, less dependent on technical devices (computer availability) and was labour intensive (could use the available members of the research team).

The following measures were considered when transcribing:

- Each response card carries only one response
- Transcription was in the language in which the interviews were conducted (Sinhala /Tamil)
- Clear hand writing was maintained as much as possible

4.2 Narrowing responses

When all the responses had been transcribed, these were reviewed again to eliminate the responses that indicate situations that are unlikely to change with the project intervention.

To illustrate the need and the basis of narrowing responses, Dr Hubbard gave the example of[7] examining responses to an interview on “problems related to the war” which could generate responses such as “My house was burned down”. “*While these responses are useful in informing staff about the range of problems people have*

[7] Hubbard, J. (2007). Using brief ethnographic interviewing as a method for understanding an issue, problem or idea from a local perspective. Minneapolis, Center for Victims of Torture.

experienced, a program that offers social support or mental health services is unlikely to have an impact on items like this[8]" He suggests using two participants/staff to independently review the responses and identify what each thinks as not being relevant. These could be compared, discussed and agreed or reviewed by a third team member

As the FRC and Shanthiham provide a specific service (counselling) it was considered useful to narrow the responses to those which would be impacted by counselling and related services.

During this stage data was also cleaned to eliminate responses that were not clear and did not make sense.

4.3 Organizing the data – sorting the data

The cleaned and narrowed data was then sorted into piles that carry common themes. The response cards in each pile are numbered before the sorting begins. This helps to record and check the sort results easily. The BEI methodology[9] suggests many ways of sorting such as using multiple individual sorters (several sorters, each person working on their own) or group sorting or table sorting where responses are marked on a table listing dimensions and characteristics etc.

In the CIF research the method used was multiple groups sorting. Each group worked on their own responses or responses generated from a community similar to their own. This helped them understand the context and the relevance of the responses.

The following are some of the key aspects related to sorting:

- Each team, working separately, categorized the transcribed response cards into groups/piles that they felt carried common themes /ideas

- The research had generated data on two sub groups – women and men. The responses of these were sorted separately for each of the questions.

- There was no limitation on the number of themes/sort piles for each question: The group was free to decide this. However, they were guided not to have too few categories (e.g. only 2 or 3 piles) that would not bring out the varied dimensions captured in the responses

- As sorting into sort piles had to be on common themes/ dimensions, the sorters were encouraged to review the responses carefully rather than sort too quickly. The methodology in fact requests researchers to be alert to sorters who complete their task too quickly because their sorting could be unreliable.

- Sorter groups made categories as they worked, deciding whether each new response card went to a pile that was already made or whether it should form a new pile under a new theme/ category.

[8] ibid
[9] ibid

- Sorter groups could also change the sort piles as they worked and were free to change the categories by re-grouping or dividing sort piles in to more categories/ piles. To motivate such review, sorters were encouraged to consider the quality of the task and carefully consider the reasoning for their categorizing.

- After sorting all the responses into piles, the sorter groups were asked to name the sort piles. To ensure that the each sort pile comprised of relevant responses, they were asked to check whether each response in a pile had a link/ relevance with the name given to that pile

4.4 Practicing sorting of data

It is important that the sorters do a practice sort so that they become familiar with the task of grouping cards on common themes. In the workshop facilitated by Dr Hubbard, he conducted a trial sort with a set of cards that described the features of a car. The research team members worked first individually and then in groups categorizing and re-categorizing these responses. The sort piles were compared and discussed to highlight that sorting responses is entirely based on the understanding and preference of the sorters and that the number of sort piles could vary considerably.

Once the participants were familiar with the practice sort, they began working on the actual responses from the research.

4.5 Recording the sorting

On completion of the sorting, naming each sort pile and re-checking to review consistency of each sort pile, the sorter groups recorded the names of their sort pile along with the number of the response cards under each category.

4.6 Recording information about sorters

The names of the sorters in each group were recorded with the sort pile names so that clarification and discussion on this at latter stages would be easier.

5 Developing indicators

The BEI methodology accommodates several ways of analysing the data, based on whether the need is to assess a specific project intervention or whether a study is being conducted to understand a contextual issue.

The process that led to the development of the CIF had a specific need i.e. to identify specific indicators to measure the impact of their counselling intervention. Therefore, the organized data was used to develop indicators.

To develop indicators, the outcome of the sorting was compared and discussed. The sorter groups had worked as district teams and their themes and sort piling was sometimes similar and sometimes different. The sorters compared the themes/ names of the sort piles. The themes that emerged more frequently in the sorting were identified as significantly important indicators that would capture the impact of the project intervention. Similar themes were combined into one indicator.

Consideration was also given to developing indicators that are likely to change as a result of the project intervention.

Comparison of the themes/ names given to sort piles and discussion about similarities and differences across districts, location specific context, gender and thereafter developing common indicators was a process that involved much discussion and debate. The FRC experience has highlighted that facilitating the time, space and direction to such discussions helped the participants to look in-depth at project impact related aspects and the varied dimensions that need to be considered when forming assessment measures. The process also gave space for the counsellors to draw significantly from their experiences to formulate and refine the indicators.

6 Formulating a monitoring format based on indicators[10]

6.1 Formulating the Client Intake Form

The indicators provided guidance as to what needs to be monitored periodically. Assessment measures in the form of questions based on indicators were, then, formed. Each question carries a corresponding scale of assessment. Thereafter the questions were structured into an assessment form that is referred to as the Client Intake Form (CIF).

The research team recognized apparent domains such as health issues, specific case related aspects, social problems, and social networks etc. which helped structure the form. Assessment measures (questions based on the Indicators) were placed under the appropriate domains.

A scale, placed under each question denotes the level to which that particular aspect affects the client. This rating system was developed by taking into consideration the nature of service provided by the FRC and the monitoring systems that are currently in place. The FRC provides individual counselling support and therefore, the monitoring format accommodates space to note the outcomes of periodic assessments: Initially, a client was expected to come for counselling for approximately 9 months and therefore 4 slots were made available to record assessments at 3 month intervals. Currently, although 4 slots are maintained in the form, termination of a case is reported to generally take place after 6 months, Therefore the assessment form is typically used for 3 assessments.[11]

The CIF has 7 sections ranging from demographic details to identifying the case, psychosocial wellbeing, problem rating scale, impact of problems, support networks to treatment plan and termination form. Under the Problem rating scale, psychosocial and social problems are rated separately.

6.2 Descriptors for questions

While some questions in the CIF are self explanatory, some may be less specific to users/counsellors who may not have participated in the process of developing the CIF. Therefore, counsellors who contributed to the process felt it would be useful to

[10] Please see appendix 2 for a client intake form.
[11] Instructions on using the scales are elaborated in Chapters 3 and 4.

have descriptors for such questions. Some examples of such questions are: Do you have physical disabilities; do you suffer from stomach aches; Do you get support of your family for day to day activities; Do you discuss with your family members before taking important decisions; Do you maintain friendly relationships with community members, relations and friends.

Descriptors were developed for words as those underlined, for which some clients may ask explanations. Having descriptors for these would help the counsellors to actually draw on the community's perceptions that were generated through the research and explain the questions to the client.

A small team of the research participants including counsellors and technical research assistants revisited the original response cards and drew out frequently mentioned responses under the themes/ sort pile names relevant to the respective questions. The most frequently cited and relevant responses under each respective domain were listed as descriptors. (Refer Appendix 4 for a list of descriptors)

7 Field testing and revising the format

7.1 Feedback from field testing of the CIF

The initially developed CIF was field tested by the counsellors and problematic areas were identified. The main strengths of the CIF, as identified by the counsellors who used them were:

I. The CIF guides the counsellors and helps them focus on the range of domains that need to be probed
II. Some sections of the CIF are filled with the client (rating scale on how the client feels about problems etc) and this helps the client better understand his or her condition and the progress made.
III. All district offices are able to use a standardized approach and ensure that key domains related to the psychosocial wellbeing of the client is discussed. Earlier, the level to which this was done varied with counsellor skills and experience.

The main issues that required improvement were

I. The questionnaire was lengthy and could not be filled in one session – The counsellors overcame this problem by completing the first assessment in the first two to three sessions. Modifications to the CIF were also done at a subsequent workshop with technical advisors and the technical support team: Some questions were amalgamated and some other questions were reviewed for duplication and were removed.
II. The data generated through the form was extensive and communicating this periodically to the head office would pose problems – This was discussed at a feedback meeting and a Data Transfer Form was developed to capture the most significant aspects of the assessment.

Developing the Data Transfer Form (DTF)

The Data Transfer Form (DTF) was developed to overcome the problems that would arise when reporting to the head office the periodic statistical responses to a lengthy questionnaire.

To develop the DTF, the counsellors, together with the project's technical advisors and support teams discussed and agreed on the key areas that need to be periodically monitored. Some information generated by the CIF was considered significantly useful by the counsellors when working individually with clients. However, all of this was not essential for project and organizational monitoring purposes. Therefore, key sections and questions that need to be periodically monitored were identified and the DTF was structured. (Read Annex 3 for the complete DTF).

A DTF is filled for every client at 3 month intervals, up to 6 months when termination of the case generally happens. Typically, each client would have 3 DTF forms: The first one at the inception, the second at the mid assessment and the third on termination. These are referred to in documentation and reporting as T_1, T_2 and T_3. The DTF carries only the ratings on each question because a new form is filled for each time of assessment.

An example is cited below:

	Description	Rating of Score				
Q.No	**Somatic**	**1**	**2**	**3**	**4**	**5**
D3	Experience Headaches/ தலை இடி/ හිසරදය					
D4	Back pain or body aches/இடுப்பு வலி மற்றும் உடல் வலி/ ඇට පත රෝදනාව					
D5	Stomach aches/வயிற்று வலி/ උදරාබාදය					
	Adaptation	**1**	**2**	**3**	**4**	**5**
E1	Support from family/உமது குடும்பத்தின் ஒத்தழைப்பை பெறுதல்/ පවුලේ අයගෙන් සහයෝගය					
E2	Consult family in Decision making/தீர்மானங்கள் எடுக்கும் போது குடும்பத்தினருடன் ஆலோசனை பெறுதல்/ තීරණ ගැනීමේදී පවුලේ අය සමග සාකච්ඡා කිරීම					

The column on the left indicates the corresponding number of the question on the CIF form. The column on the right side records the rating given in response to the questions. It is the same scale that is marked in the CIF.

The DTF is actually a copy of the ratings of selected questions. Analysis of data and assessing the overall progress using the DTF is discussed in Chapter 4.

Strengths of the Process

The process of developing intervention assessment measures based on community perceptions and with the active involvement of the ground level implementing staff has many practical benefits. These are seen at varying levels:

a) To the service recipient individuals (clients) - as a therapeutic tool
b) To psychosocial service providers staff at intervention sites (counsellors) – a mechanism that provides guidance and focus to the counselling process

c) To service provider organizations that manages the intervention - a system that generates statistical evidence of the project impact and which helps to maintain quality standards across many project sites.

The main benefits of the process, drawn from the experience of developing the CIF with the FRC are as follows:

- The process actively involves the implementing staff at the intervention sites (in this case, counsellors) in the development of the monitoring tool which they will use. As the FRC experience has highlighted, the counsellors valued the opportunity to design the assessment tool and have a strong sense of ownership of the tool. This was the first opportunity many of them had to participate in a process to develop tools for monitoring and research of the work they do. Space for such involvement contributed to their motivation to not only use the tool but also take an active part in adapting it to changing circumstances or issues that were later experienced.

- Counsellors (service provider staff) have greater clarity of the nature of information that the monitoring questionnaire requires: They understand what they are monitoring.

- The process involved discussion and deliberations that require service provision staff to think deeply about the ground level conditions and the applicability of the tool. This broadened the understanding of the staff /participants of the process and increased the relevance and practicability of the tool.

- The process enabled the service provision organization to design a monitoring tool that actually reflects the changes that are felt by the community with whom the project works. The ability to develop a locally relevant, culturally sensitive monitoring tool increased the organizations ability to systematically capture ‘evidence of changes’ that resulted from their intervention.

- The tool as well as the process are flexible and could be adapted to suit the needs and potential of each organization and community. It could also be used to capture a range of dimensions within a single domain that is being monitored.

Chapter 2

History and development of the Client Intake Form (CIF)

The need

The RESIST project of the Asia Foundation aimed to enable torture affected persons and communities to resume their roles within their family and community. The project worked with psychosocial service providers working in the north and east of the country. When working with the Family Rehabilitation Centre (FRC) to provide technical support, the Asia Foundation identified the FRC's need to improve its monitoring mechanism. The FRC provides counselling services to several communities in the Northern and Eastern provinces and in Anuradhapura in the North Central province. The lack of monitoring indicators that can quantify the impact of their counselling service was an issue that the FRC had been facing. Pressure was high from funding organizations to provide quantified evidence of the impact of the intervention that typically generated qualitative data based on psychopathological indicators. The issues in monitoring that the FRC counsellors and management faced were:

a) The lack of an effective monitoring tool that enabled them to quantify the impact of counselling services (quantified impact being a donor requirement)
b) The use of monitoring indicators that were more medicalized or developed for western cultures and therefore were often not clearly understood by the counsellors – this resulted in the counsellors not clearly assessing the issues and strengths of the service they provide as well as errors in monitoring data
c) Recording monitoring data was a hassle as several forms had to be filled to capture the many dimensions of the impact that were required for project monitoring and management.

The need to assist the FRC and other psychosocial service provision organizations which especially work with survivors of torture, violence and conflict emerged as a significant area of work to which RESIST could contribute effectively.

The technical support team and implementing partners

Development of the CIF was supported by two technical advisors: Dr Gameela Samarasinghe who was RESIST's local technical advisor and senior lecturer at the University of Colombo and Dr Jon Hubbard, Research Director of the Centre for Victims of Torture (CVT) in Minneapolis. The monitoring mechanism using the CIF was based on the concept of adaptive functioning and the research methodology of Brief Ethnographic Investigation introduced by Dr Hubbard.

The project had technical support from the Asia Foundation as well as the Psychosocial Assessment of Development and Humanitarian Interventions (PADHI) programme of the Social Policy and Research Centre (SPARC) affiliated to the University of Colombo.
The initiative was implemented through two partner organizations. One was, of course, the FRC which was active in seven districts in the north and east. The FRC's interest to streamline its monitoring mechanism and the open discussions with RESIST project on the current systems was a significant contributor to the process. The FRC staff's enthusiastic

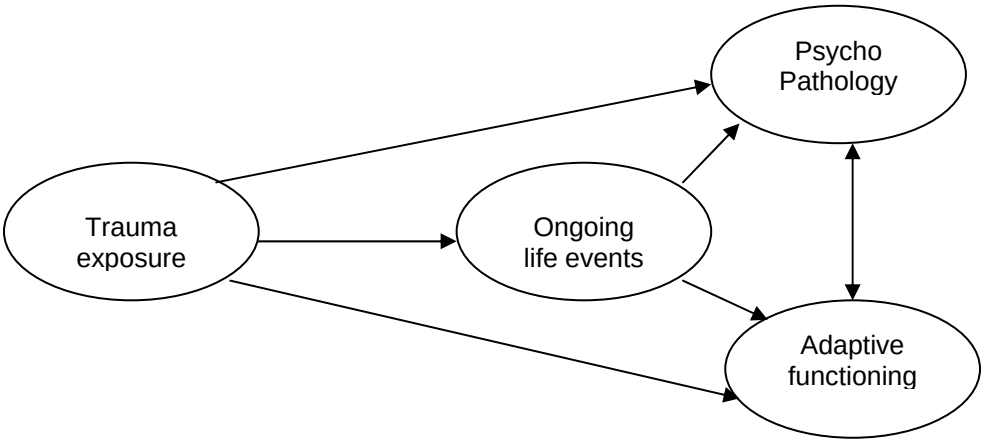
and conscientious participation in the process helped anchor the design of the tool to suit their client base and the context in which they work. They are now applying the CIF tool as their main monitoring mechanism.

The second implementing partner was Shanthiham, an organization working in Jaffna. Shanthiham continuously provided counselling support amidst the challenging circumstances of the armed conflict in the north and has significant experience and well trained staff working in counselling and on psychosocial research. However, due to security issues that prevailed in the country at the time the CIF was developed, Shanthiham could not continuously participate in the project activities that happened outside Jaffna.

Introduction to the concepts and methodology

Dr Hubbard, in two workshops held in March 2006, introduced the methodology and conducted the initial training on the methodology to the technical support team and the implementing partners. The first workshop was held for the FRC from 2 – 4 March 2006 at the Asia Foundation. A similar programme was held for Shanthiham from 6 – 8 March 2006 at the Jaffna library.

The core feature of the methodology is to move away from the linear link between trauma experience and psychopathology and look at the wider dimensions that impact on a person's recovery from a traumatic experience. Dr Hubbard presented a diagram that illustrates these diverse linkages. The diagram brings to focus the necessity of looking at adaptation in other areas in a survivor's life[12].



Dr Hubbard elaborated that this model could be used to obtain information on treatment outcomes but it does not measure the success of the intervention purely on psychopathology. The broader perspective on recovery requires monitoring and evaluation to consider all dimensions across the important functioning of a client's life. Grounding the tool on such a holistic approach enables it to primarily contribute as a therapeutic tool and then as a monitoring tool.

[12] Report on 3 day training on Developing methods and measures of Evaluating the Impact of Psychosocial Interventions, undated report. The Asia Foundation, internal documentation.

Training on using the methodology

Training that started with the introduction to the methodology spread across a succession of workshops conducted at different stages of the process: Implementing of one component of work in the process was followed by feedback sessions and training on the next component.

Preparing the questionnaire and training on interviews
The training process started with the participants working on a matrix of Interventions and evaluations to identify the evaluation needs of their organizations. The identified evaluation needs were, then, prioritized

The concepts of adaptive functioning, resilience and competence[13] were discussed at length during the training session. Resilience and competence enables a person to adapt to adverse circumstances / life events. This discussion was followed by an introduction to data gathering and the analysis process. It was explained that the local communities' definitions of resilience and competence would be translated into indicators that would help design the assessment measures.

Considerable space was set aside in the training to practise interviewing for the research. Dr Hubbard shared a sample questionnaire that requested respondents to give four responses on how a person is doing well[14] Participants paired and interviewed each other, alternatively playing the roles of the interviewer and the interviewee. The responses of the practice interviews were then sorted into categories by the participants. Some of the key categories were social relationships, status, motivation and skills, and behaviours. The most often stated responses were counted to determine the more significant categories/domains.

Interviewing techniques were discussed in a feedback meeting held subsequently. An important outcome was the counsellors' understanding that clarity and specificity of the responses are vital to the process of developing indicators later on.

Feedback on the 1st training programme

- The research method was new to all the participants and created much interest in the process that would follow.
- This was the first opportunity most counsellors had to express their views on the methodology and the content of an evaluation of their project interventions or on research. This was highly appreciated by the counsellors.
- Some participants needed more support to shift their focus from '*what they should do for the people'* to '*how they could measure what they do'*.
- Shantiham research staff were already engaged in discovering local ways of describing mental health and found the methodology stimulating. Given their significant experience in research and counselling, they were well prepared to move ahead with the process

[13] Refer Chapter 4 for a description of these, as presented at the workshop
[14] Refer Chapter 1 – Summary of process for a detailed description of this segment.

- The FRC did not have research staff and therefore needed to work more closely with the technical support team of the Asia Foundation and with PADHI when conducting the interviews.

Training programme 2 – Preparing for Data Collection

Two workshops to which different teams of implementing staff from the FRC participated were conducted on 7th and 17th June 2006. These workshops were designed to train the staff of the implementing organisations on data collection. The team from Shanthiham was unable to participate in these due to security issues and related travel restrictions.

The training programme on June 7th was conducted in Vavunia by RESIST programme manager Jeninne Guthrij, Research and Technical Support Coordinator Dr U Bhanugoban and was assisted by Research and Technical Support Assistant M I M Hasan. Thirty two FRC staff members participated in this

The programme on June 17th was conducted in Colombo by Jeninne Guthrij, Local Technical Advisor Dr Gameela Samarasinghe, Dr U Bhanugoban, Research and Technical Support Assistants M I M Hasan, H R Atukorale and P Rajgopal. Twenty eight FRC staff members participated in this.

The questionnaire
The FRC adapted the sample questionnaire shared by Dr Hubbard and developed research questions that ask ***a)*** interviewees about an adult man and a woman who are doing well and ***b)*** about a man and a woman having problems due to war. It was acknowledged that these questions would also elicit responses that are beyond the realm of counselling. This was, however, expected to provide useful indications of services that are important to the community and which could support the counselling intervention. Such information was expected to give new directions to the FRC. The FRC's Regional Coordinator for the East helped translate the questionnaires into Tamil and Sinhala.

Content
A summary of the first training in March was recaptured at the beginning of the programme to refresh the minds of those who attended it and for the benefit of those who did not participate in the first programme. Interview practices were conducted first for competence questions and then for problems of war.

The method of training was to have participants pair and practise interviewing followed by group critiquing of demonstrations. Ways to improve interviews were suggested by the participants: Some significant considerations were appropriate facial expressions, showing empathy, noncommittal approach to responses and time management of the interview. Ensuring that interviewees are asked for their informed consent and that answers are double checked was also focused on in the practice.

Detailed discussions on appropriate interviewing techniques also covered essential points such as ethical considerations, understanding and adjusting to local norms, techniques for recording interviews, handling sensitive information and ensuring verbatim recording. Building rapport with the interviewee, promoting a sense of confidentiality and using active listening techniques were also emphasized as important aspects to maintain during interviewing. Although the core values on which the initiative is grounded was not explicitly

discussed during the training programmes, it was clear that all participants and the RESIST team worked with a common understanding on maintaining cultural sensitivity and the adhering to the principle of Do No Harm.

Participants' issues and suggestions after conducting trial interviews

- The duration of an interview takes longer than the expected 20 minutes. – It was agreed to prioritize quality of the interview rather than rush to complete a specified number of interviews per day.
- Phrasing of the question on war problems implied that some people have problems due to war but some do not. This was inappropriate to be used in Jaffna as everyone in Jaffna was affected by the war in some way or the other. – It was decided to ask how some people have more trouble coping than others.
- Interviewee expectations – Interviewees could expect financial or other gains for participating as respondents. – To overcome this, it was suggested to clearly explain the purpose of the interview and to stress that financial compensation is not given for participation.
- Security concerns – It was agreed to issue interviewers temporary identity cards or letters that they can show at the check points when travelling to villages to conduct the interviews. The Asia Foundation emphasized that safety and security should be given priority concern and requested participants to avoid dangerous situations /locations

Sampling Method

Random sampling was used. An equal number of women and men would be interviewed to meet a total target of 50 respondents from each village.

Sampling plans of the FRC

District	*Villages*	*Target no of interviews*	Research team	*≠ interviews per researcher*
Mannar	Uyilankulam Jeevanagar Murungan Nanadan Mudalaikuthi	50 from each village	1 counsellor 1 field officer 2 community workers 3 temporary staff	7
Vavunia	Vaarikuttiyar Manikfarm Ennaper Maruthankulam Kandasamy Nagar Kallipuram	50 from each village	1 counsellor 1 field officer 3 community workers 3 temporary staff	6
Trincomallee	Nilaveli Kuchaveli Sumedagam Thambalagamam Sally	50 from each village	1 counsellor 1 field officer 3 community workers 3 temporary staff	6
Batticoloa	Thuraineelavanai	50 from	1 counsellor	

	Kalluthavallai Vallaichenei Kaluvanchikudi Thiruperithurai	each village	1 field officer 3 community workers 3 temporary staff	6
Anuradhapura	Pulmode Maha - siyambalagaskada Yakawewa (in Medawacchiya) Halmillawetiya Yakawewa (in Kebitigollewa)	-	-	-
Akkaraipattu (Ampara)	- (Documented records of finalized specific locations was not accessible at the time of compilation of this Handbook -		-	-

Scheduling of interviews
Interviewing was expected to be conducted within 5 – 10 days. Each team member had the freedom to draw up his or her interviewing schedule. However, they were asked to consider the following aspects when scheduling interviewing:

- The sample should represent all the main categories (sub populations) of the adult community in the village
- Consider the dynamics in the community
- Selecting time for interviews – Is it a time that some sub groups/populations are not present? (For example mid day would mostly find women and elderly people at home but not employed men)

Follow up plan of training programme 2

- Field research teams were requested to send the interview responses to RESIST as they were completed so that these could be transcribed on to response cards for sorting
- Dr Bhanugoban would follow up on the interviewing to ensure quality of data collection

Training programme 3 – Data analysis and Indicator development

Three workshops were conducted between 25 June to 7 July, 2006 for the three groups of participants (sorters) from the FRC and Shantiham. The workshops were facilitated by Dr Jon Hubbard with the support of the technical support team of the Asia Foundation.

Prior to the training programmes, Dr Hubbard, Dr Samarasinghe and the technical support coordinator and assistants met with the staff of PADHI to discuss provision of training and technical support to the implementing partner organizations. The potential use of the data for other research purposes was also discussed.

Training schedule & participants

Group	Participants	Workshop dates
1	4 sorters from FRC Jaffna (temporary research staff & community volunteers)	June 29 - 30
2	Sorters from FRC Batticaloa, Akkaraipattu, Ampara and Anuradhapura (counselling and field staff	3 - 4 July
3	4 research assistants from Shantiham, Jaffna	5- 6 July

Training sessions

The training on sorting and indicator development differed in content and extent based on the progress each team had made in data collection, the quality of data, and the availability of data on time for transcribing on to response cards.

Data collected by the FRC Jaffna team had not reached RESIST and therefore response cards with their data were not available for sorting. The group practiced sorting with the response cards of the FRC East team. They were not trained in the development of indicators as they did not work with response cards from the communities they had interviewed.

Group 2 practiced both sorting and indicator development as they had response cards from the interviews they had conducted. However, throughout the practice sorting and indicator development the participants had to work in two separate groups based on the language they used (Sinhala or Tamil).

Group 3 were the participants from Shantiham. Due to security issues they had been unable to participate in the 2nd training programme where interviewing techniques were practised. However, they had conducted interviews and had sent their responses to RESIST. The responses were not sufficiently detailed / specific to be effectively used in sorting. Therefore the four participants trained on interviewing techniques which they would use to do more interviews later.

Sorting the responses

In all the groups the training on sorting started with a practice sort using features of an imaginary car.[15]

In group 1, sorting of research responses began with responses on men's and women's competence. Participants initially practiced multiple group sorting by working as two groups: One group sorted competence responses for women and the other group, for men. The sorted piles were listed on a sheet of paper. The cards were reshuffled and exchanged between the two groups for another sorting. Again, the sorting results were listed. When the two groups compared the results of their sorting they realised the differences in some categories and similarities in others.

The same cards were reshuffled and sorted again the following day with all the participants (4) working as a single group. Participants worked faster with more agreement on piling.

[15] Refer Chapter 1 for details of sorting method

Again, responses for men and women were sorted separately. The process was repeated for responses on war problems.

At the end of the two day workshop, the team had gained sufficient practice to lead the response card sorting with their research team of the FRC in Jaffna.

Group 2 followed the same process but worked with their response cards and in two separate groups due to language difference. This group also trained in developing indicators.

Developing indicators
Participants identified frequently occurring themes in the sort piles and recognized these to be, respectively, the factors that influence competence and the effects of war related problems. This helped them realize that competence and the problems suffered are two ends of a continuum.

At this stage, the technical support team intentionally played a passive role, giving the participants space for discussion and debate and to extensively draw from their own experiences in counselling to identify the indicators. The technical team stepped in only to provide technical guidance where necessary.

The frequently occurring themes in the sort piles were identified as the indicators of adaptation or problems. However, initially the two groups felt that the differences in the indicators for each location and for women and men were too wide to be amalgamated. They were not willing to use a common set of indicators for women and men or for different locations. In an attempt to better understand the similarities and differences of locations and the sub populations, one team placed the indicators in a table as follows.

Wellbeing/competence			Spectrum		War problems
Common for men and women	*Only for men*	*Only for women*	*Common for men and women*	*Only for men*	*Only for women*
Religious personality	Help others		Loss of income, property, lives	Education affected	Sexual harassment
Self confidence	More freedom		Psychological problems, inferiority complex	substance abuse	
Responsibility			Displacement		
Hard working			Dependence		
Adequate income			Torture and arrest		
Having assets					
Status					
Involved in social service					
Good job					
Good education					

This helped participants understand that common indicators could be used but with gender and location specific descriptors where necessary. Descriptors would help keep a record of the location and gender specific differences in case clarifications are needed. During the training workshop, the participants seemed more inclined to retain location specific

differences in indicators but were willing to use common indicators differentiated only by descriptors for women and men. However, in the subsequent feedback meetings and workshops this was further discussed and common indicators differentiated by descriptors were used for all locations.

The two groups' examination of a common indicator clearly illustrates this flexibility.

Indicator – *Moves freely with people*		
Location	*sub population*	*Descriptor*
Batticaloa/Akkaraipattu	Men	1. Takes part in the festivals in the temple and funerals 2. Leadership role in temple festivals and funerals 3. Takes part in the distribution of funds and provisions provided by govt and NGOs
	Women	1. Moves freely with relatives and neighbours 2. Good understanding with family members, especially with mother in law and sister in law
Anuradhapura	Men	1. Takes part in funerals and other social functions 2. Is a functioning / active member in social welfare movements or clubs
	Women	1. Assists others (relatives, neighbours) when they are in trouble

Training on indicator development also covered identification of indicator domains under which assessment measures based on indicators would be placed. The assessment form was structured to reflect the key domains.

Dr Hubbard stressed the importance of ensuring space for the field research teams from each location to be the final decision makers on what indicators they would want to include in the assessment form.

Follow up plan of training programme 3

- Finalizing the indicators to be completed by July with guidance where necessary by the technical support team.
- Technical team to develop a follow up plan with Dr Hubbard to give support to develop assessment measures and finalize the assessment form
- Capacity building of field staff where necessary

Monitoring the use of the CIF

In January 2007 RESIST, together with technical inputs from PADHI held a feedback meeting for counsellors of the FRC. The feedback meeting followed a 2 day training programme which the FRC had organized for its counsellors in Colombo. The main points of

the counsellors' feedback indicated that the CIF tool has the potential to improve the quality of counselling while contributing to monitoring needs. :

Useful aspects

- With increased familiarity, using the CIF becomes easier. With practice, counsellors are able to remember most of the questions without frequently referring to the form. This increases counsellors' ability to actively listen to the client with undivided attention but still keep a focus on the main domains that need to be covered.
- The CIF is more user friendly than the earlier monitoring formats
- The previous formats had open and broad assessment questions. Counsellors with higher skills and more experience were able to use these more effectively. In the new form specific questions are asked and therefore counsellors with varying skills can use it to the same level of efficacy.
- Although the assessment questions are specific, the scope of assessment is broad because the domains in the CIF cover all the significant aspects of functioning in a client's life
- Previous monitoring system required counsellors to fill several forms resulting in data repetition. This is avoided by having a single form
- Having descriptors were very helpful to illustrate the questions, when necessary.

Issues

- The form takes a long time to fill and require at least 2 – 3 sessions to complete – Despite raising this issue, the counsellors were not wiling to shorten the form. At a workshop held later they strongly expressed that all questions were necessary and that these contributed highly to the counselling process. The counsellors had devised a way of completing the form in 2 – 3 sessions for each time of assessment.
- Space is not provided to record details of the 2nd and 3rd assessments. – To overcome this PADHI and the technical advisory team later introduced a separate note taking form which, however, is not currently used by the counsellors.

The feedback meeting also facilitated space for skills building through conducting and analysing mock counselling sessions. Further capacity building needs of the counsellors were also discussed at this meeting.

Assessing the use of the CIF

In October 2007 Dr Jon Hubbard conducted a workshop to discuss the use of the CIF and revise it if necessary. In feedback meetings with the technical support teams at the Asia Foundation and PADHI, the counsellors had repeatedly mentioned the length of the CIF as an issue but with equal emphasis they expressed unwillingness to shorten it by leaving out any questions.

In the discussion held in October, practical aspects of the CIF as a monitoring tool were examined. The FRC counsellors felt very strongly about the tool they had developed and felt that all the areas probed through the CIF provide important information about the client. Although only a small number of selected questions are reported back to the head office through the DTF for statistical analysis, the counsellors felt that all the questions contributed highly to the healing process by drawing the counsellors and the client's attention to detailed indicators. Finally, a few changes were made: Two questions were merged and one

question that was felt to be a repetition was removed. Other than that, the CIF did not undergo any significant change.

Training on Counselling skills

The need for training to develop counselling skills were discussed at the monitoring meeting in January 2007 and at a subsequent workshop especially aimed for this purpose. This was held from 5 – 6 March 2007 to which a team of 21 participants (psychosocial workers, community volunteers, and field officers) from the FRC participated. The FRC offices in Ampara, Akkaraipattu, Batticaloa, Anuradhapura, Vavuniya, Mannar and Trincomalee were represented at this meeting. The workshop was facilitated by Dr Hubbard with the assistance of Udeni Appuhamilage from PADHI and the technical research assistants M I M Hasan, and Handun Rasari Atukorale. The participants worked in groups to identify their training needs.

Based on this training and PADHI's interactions with the counsellors as collaborators for technical support, Dr Hubbard and PADHI prepared recommendations on counselling training and support for the FRC. The recommendations were made with the aim of "*building capacity of FRC staff to meet the needs of their clients and create systems of support for the staff themselves to carryout the difficult and important work they do*."[16]

Detailed recommendations were made for three areas of work:

- Care provision,
- Assessment and Evaluation
- Supervision.

In all three areas, skills development for counsellors as well as field offices and volunteers was suggested.

The recommendations made to improve care provision skills of counsellors include advanced training on general counselling skills; training on specific therapeutic skills, understanding and managing common post trauma psychological symptoms, specific training on identifying needs and counselling survivors of torture or severe human right abuses. Among the corresponding skills that are suggested for the field staff and volunteers are advanced training on working with families and communities, training on skills and activities of their colleagues and on services offered by other organisations and processes for making proper referrals.

To enhance the effectiveness of assessment and evaluation, the skills development suggested for counsellors were training on clinical interviewing skills and gathering information from clients in ways that contribute to healing, assessing the impact of counsellors' personal experiences on the client and the treatment process, collecting assessment data and filling assessment forms etc. To support the process of assessment and evaluation, the skills recommended for field offices and volunteers included training on

[16] J Hubbard & PADHI, March 2007, Recommendations on Training and Support for FRC, internal document of RESIST project

specific goals for activities such as home visits, training on self-assessments and on conducting final evaluations and observations on termination of clients.

Recommendations also emphasized the need for supervision for counsellors to ensure consistent, confident and non-judgemental help to deal with problems they cannot manage. Providing information of contact persons and contact details to be used in emergencies and facilitating regular case consultations are other recommendations suggested to promote support for counsellors through supervision.

The list of recommendations also included additional training and skills development needs. Amongst these are awareness of basic human rights issues; training on self care for all staff to manage the emotions that often arise when addressing the needs of torture survivors and their families; training of professional roles, boundaries and ethics; and training on providing leadership in emergencies. .

Contribution of the technical support team

The technical support team led by Dr Gameela Samarasinghe at the Asia Foundation worked closely with the PADHI programme of the Social Policy And Research Centre (SPARC) of the University of Colombo to facilitate technical support to counsellors, field officers and community volunteers of the FRC and Shanthiham (in the initial steps of the process). Interaction with the management of the FRC was maintained to regularly update the senior management on the process. The technical support team provided technical inputs in between the main training programmes of the CIF process and thereby ensured that the participants had the necessary guidance and support to maintain the quality of the field surveys and data analysis. They also conducted workshops to monitor the progress of data collection and the application of the CIF after it was formulated by the participating staff of the FRC. Skills development programmes to support the counsellors were incorporated into feedback sessions in addition to conducting specially organised workshops for this purpose.

Chapter 3
Data Collection and analysis

The CIF enables the service provision organization to place a numeric value on the qualitative impacts of the project intervention. This is made possible by using numeric scales to record the changes in the clients' condition, including daily functioning and social aspects. This section discusses how the rating scale in the client assessment form (CIF) is used by the counsellor over 3 assessments; the mechanism to report such data to the head office; and the method of data analysis.

Recording data on the CIF

In the CIF a rating scale of 1 – 5 is used along with a description of what is denoted by the scale. When discussing with the client about his or her condition the counsellor would use the description (e.g. daily / weekly / never / occasionally/ very often etc.) to understand the change in the client's condition. The rating always carries 1 for the least desired situation and 5 for the most desired. This applies to both sections on Adaptation and Distress. The following examples are extracted from the CIF to illustrate this:

Do you experience headaches?

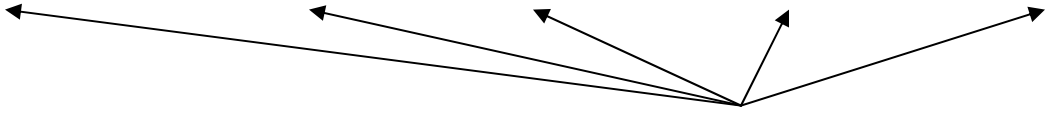
1	Daily	1 2 3 4	2	Weekly	1 2 3 4	3	Monthly	1 2 3 4	4	Occasionally	1 2 3 4	5	Never	1 2 3 4

Do you experience back pains or other body aches?

1	Daily	1 2 3 4	2	Weekly	1 2 3 4	3	Monthly	1 2 3 4	4	Occasionally	1 2 3 4	5	Never	1 2 3 4

Do you discuss with your family members before taking important decisions?

1	Never	1 2 3 4	2	Occasionally	1 2 3 4	3	Sometimes	1 2 3 4	4	Frequently	1 2 3 4	5	Very Often	1 2 3 4

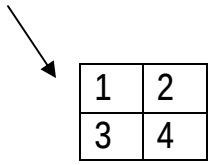


This scale carries indication of the level to which the client is affected

The form also indicates the time of the assessment. This is necessary because the same CIF is used for all the assessments of a single client. The time of assessment is indicated by the squares marked from 1 to 4.

E.g. Do you get the support of your family for your day to day activities?

1	Never	**1**	**2**	2	Occasionally	**1**	**2**	3	Sometimes	**1**	**2**	4	Frequently	**1**	**2**	5	Very Often	**1**	**2**
		3	**4**			**3**	**4**			**3**	**4**			**3**	**4**			**3**	**4**



If it is the first time that a client is being assessed (at intake), square number 1 in the box next to the selected response is ticked off. In the second assessment, after 3 months, the 2 is ticked off in the box relevant to the scale. A third assessment is carried out within the next 3 months. Generally a client is considered ready for closure of the case by 6 months. Therefore the assessments are typically carried out for 6 months. However in the event a client needs further support this is continued up to 9 months in which case the 4th box is used to identify the final assessment

An example is given below

Do you get the support of your family for your day to day activities?

1	Never	1	2	2	Occasionally	1 ✓	2	3	Sometimes	1	2 ✓	4	Frequently	1	2	5	Very Often	1	2
		3	4			3	4			3	4			3	4			3	4

The above scale indicates that in the first visit the client's response to the question ''*Do you get the support of your family for your day to day activities?*' was '*Occasionally*". The rating scale for this is 2. Time of assessment is one. In the second assessment, the reply to the same question was '*Sometimes*' which is 3 on the rating scale. The Time of assessment 2 is marked in the corresponding section.

The same assessment form is used for all the 3 assessments which are done at 3 month intervals. The three assessments are referred to as (T_1, T_2, T_3) in reporting. In case a 4th assessment is needed the 4th square could be used.

The CIF is primarily a therapeutic tool when used with the clients as an individual-based assessment tool. It guides the counsellor in the process of counselling and helps the client to better understand his/her capacity and potential to face life's challenges.

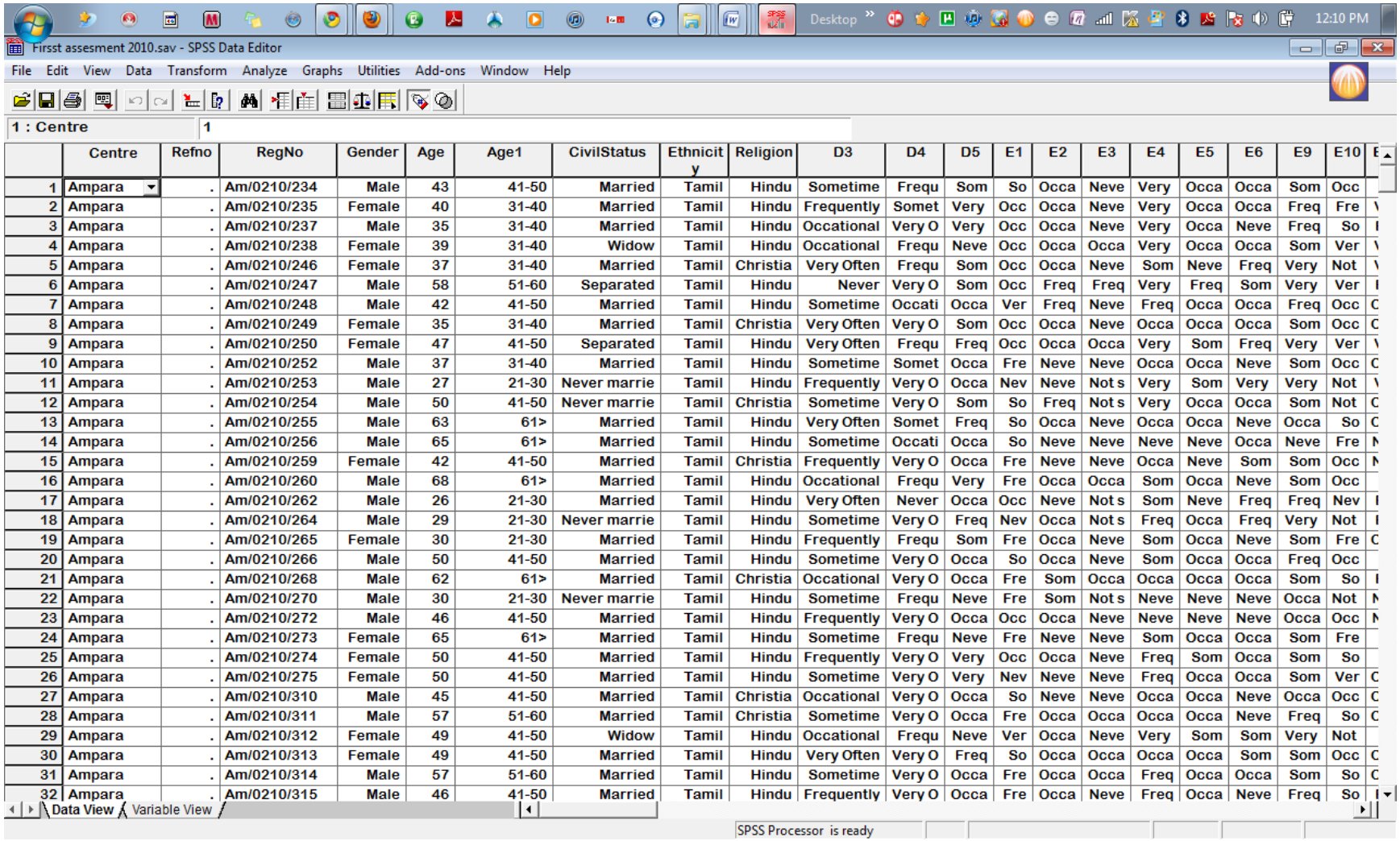
The data generated through the CIF is also used for monitoring the district based and the overall impact of the intervention. Sharing selected data with the head office for monitoring purposes is done through the data transfer forms (DTF). At each time of assessment a new DTF is filled for each client. These are sent to the head office of the FRC periodically. The data is entered under the client's registration number into an electronic data base using SPSS software for statistical analysis. The statistical evidence generated through this enables the FRC to quantify the impact resulting from the counselling service in each district as well as for the organization

Steps followed in CIF data Analysis[17]

1. Fill all data transfer forms in ascending order in separate files for clients.
2. Create SPSS worksheet for the each time of assessment.
3. Enter data when the FRC head office receives the data transfer forms.
4. Check entered data for consistency
5. Calculate the mean values for adaptation and distress scores for all assessments(T1,T2,T3[18])
6. Merge all 3 files after mean scores have been calculated for each assessment.
7. By using the data set, get frequencies to check the validity of the output.
8. Mistakes in the data were seen when doing step 7 even though entered data was checked for consistency. Tracing errors and cleaning and editing data needs to be done in such situations
9. After cleaning and editing the data set, run the frequency tables again to check the output.
10. Use the cleaned data set plan to do the cross tabulations and graphs which are required for analysis and report writing

[17] Listed by technical research assistant M I M Hasan and statistician Prasadi.Fernando.
[18] Time of assessment – 1, 2, 3,

Sample of the merged file after mean scores for T_1, T_2, T_3 have been calculated



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File Edit View Data Transform Analyze Graphs Utilities Add-ons Window Help

1 : Centre 1

	Centre	Refno	RegNo	Gender	Age	Age1	CivilStatus	Ethnicity	Religion	D3	D4	D5	E1	E2	E3	E4	E5	E6	E9	E10	E
1	Ampara	.	Am/0210/234	Male	43	41-50	Married	Tamil	Hindu	Sometime	Frequ	Som	So	Occa	Neve	Very	Occa	Occa	Som	Occ	
2	Ampara	.	Am/0210/235	Female	40	31-40	Married	Tamil	Hindu	Frequently	Somet	Very	Occ	Occa	Neve	Very	Occa	Occa	Freq	Fre	
3	Ampara	.	Am/0210/237	Male	35	31-40	Married	Tamil	Hindu	Occational	Very O	Very	Occ	Occa	Neve	Very	Occa	Neve	Freq	So	
4	Ampara	.	Am/0210/238	Female	39	31-40	Widow	Tamil	Hindu	Occational	Frequ	Neve	Occ	Occa	Occa	Very	Occa	Occa	Som	Ver	
5	Ampara	.	Am/0210/246	Female	37	31-40	Married	Tamil	Christia	Very Often	Frequ	Som	Occ	Occa	Neve	Som	Neve	Freq	Very	Not	
6	Ampara	.	Am/0210/247	Male	58	51-60	Separated	Tamil	Hindu	Never	Very O	Som	Occ	Freq	Freq	Very	Freq	Som	Very	Ver	
7	Ampara	.	Am/0210/248	Male	42	41-50	Married	Tamil	Hindu	Sometime	Occati	Occa	Ver	Freq	Neve	Freq	Occa	Occa	Freq	Occ	
8	Ampara	.	Am/0210/249	Female	35	31-40	Married	Tamil	Christia	Very Often	Very O	Som	Occ	Occa	Neve	Occa	Occa	Occa	Som	Occ	
9	Ampara	.	Am/0210/250	Female	47	41-50	Separated	Tamil	Hindu	Very Often	Frequ	Freq	Occ	Occa	Occa	Very	Som	Freq	Very	Ver	
10	Ampara	.	Am/0210/252	Male	37	31-40	Married	Tamil	Hindu	Sometime	Somet	Occa	Fre	Neve	Neve	Occa	Occa	Neve	Som	Occ	
11	Ampara	.	Am/0210/253	Male	27	21-30	Never marrie	Tamil	Hindu	Frequently	Very O	Occa	Nev	Neve	Not s	Very	Som	Very	Very	Not	
12	Ampara	.	Am/0210/254	Male	50	41-50	Never marrie	Tamil	Christia	Sometime	Very O	Som	So	Freq	Not s	Very	Occa	Occa	Som	Not	
13	Ampara	.	Am/0210/255	Male	63	61>	Married	Tamil	Hindu	Very Often	Somet	Freq	So	Occa	Neve	Occa	Occa	Neve	Occa	So	
14	Ampara	.	Am/0210/256	Male	65	61>	Married	Tamil	Hindu	Sometime	Occati	Occa	So	Neve	Neve	Neve	Neve	Occa	Neve	Fre	
15	Ampara	.	Am/0210/259	Female	42	41-50	Married	Tamil	Christia	Frequently	Very O	Occa	Fre	Neve	Neve	Occa	Neve	Som	Som	Occ	
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26	Ampara	.	Am/0210/275	Female	50	41-50	Married	Tamil	Hindu	Sometime	Very O	Very	Nev	Neve	Neve	Freq	Occa	Occa	Som	Ver	
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28	Ampara	.	Am/0210/311	Male	57	51-60	Married	Tamil	Christia	Sometime	Very O	Occa	Fre	Occa	Occa	Occa	Occa	Neve	Freq	So	
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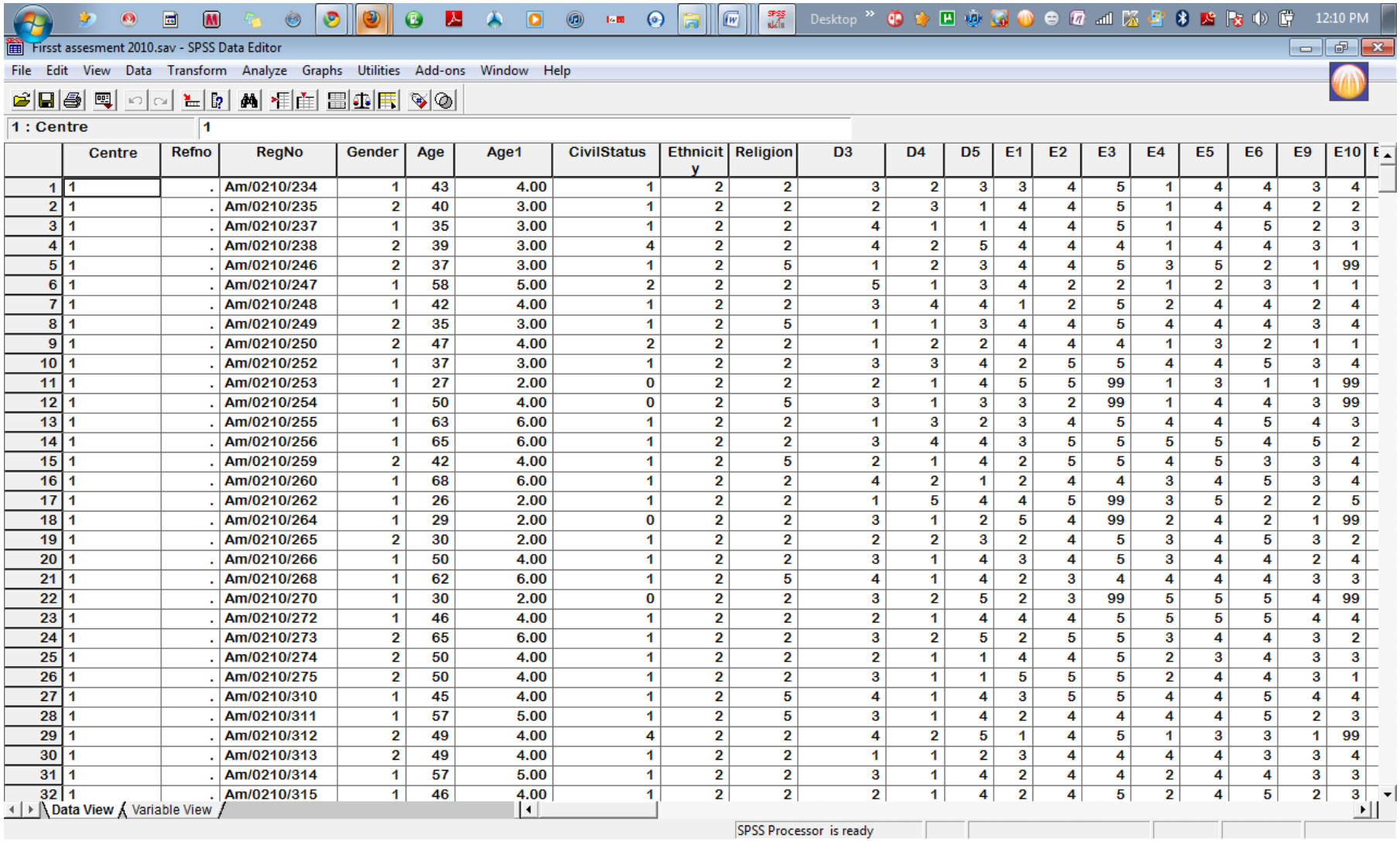
31	Ampara	.	Am/0210/314	Male	57	51-60	Married	Tamil	Hindu	Sometime	Very O	Occa	Fre	Occa	Occa	Freq	Occa	Occa	Som	So	
32	Ampara	.	Am/0210/315	Male	46	41-50	Married	Tamil	Hindu	Frequently	Very O	Occa	Fre	Occa	Neve	Freq	Occa	Neve	Freq	So	

Data View | Variable View

SPSS Processor is ready



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2	1	.	Am/0210/235	2	40	3.00	1	2	2	2	3	1	4	4	5	1	4	4	2	2
3	1	.	Am/0210/237	1	35	3.00	1	2	2	4	1	1	4	4	5	1	4	5	2	3
4	1	.	Am/0210/238	2	39	3.00	4	2	2	4	2	5	4	4	4	1	4	4	3	1
5	1	.	Am/0210/246	2	37	3.00	1	2	5	1	2	3	4	4	5	3	5	2	1	99
6	1	.	Am/0210/247	1	58	5.00	2	2	2	5	1	3	4	2	2	1	2	3	1	1
7	1	.	Am/0210/248	1	42	4.00	1	2	2	3	4	4	1	2	5	2	4	4	2	4
8	1	.	Am/0210/249	2	35	3.00	1	2	5	1	1	3	4	4	5	4	4	4	3	4
9	1	.	Am/0210/250	2	47	4.00	2	2	2	1	2	2	4	4	4	1	3	2	1	1
10	1	.	Am/0210/252	1	37	3.00	1	2	2	3	3	4	2	5	5	4	4	5	3	4
11	1	.	Am/0210/253	1	27	2.00	0	2	2	2	1	4	5	5	99	1	3	1	1	99
12	1	.	Am/0210/254	1	50	4.00	0	2	5	3	1	3	3	2	99	1	4	4	3	99
13	1	.	Am/0210/255	1	63	6.00	1	2	2	1	3	2	3	4	5	4	4	5	4	3
14	1	.	Am/0210/256	1	65	6.00	1	2	2	3	4	4	3	5	5	5	5	4	5	2
15	1	.	Am/0210/259	2	42	4.00	1	2	5	2	1	4	2	5	5	4	5	3	3	4
16	1	.	Am/0210/260	1	68	6.00	1	2	2	4	2	1	2	4	4	3	4	5	3	4
17	1	.	Am/0210/262	1	26	2.00	1	2	2	1	5	4	4	5	99	3	5	2	2	5
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30	1	.	Am/0210/313	2	49	4.00	1	2	2	1	1	2	3	4	4	4	4	3	3	4
31	1	.	Am/0210/314	1	57	5.00	1	2	2	3	1	4	2	4	4	2	4	4	3	3
32	1	.	Am/0210/315	1	46	4.00	1	2	2	2	1	4	2	4	5	2	4	5	2	3

Calculating the percentages

In the DTF for each client, each question is marked with a level in the scale from 1 – 5. Scoring instructions on the DTF are given in the following example:

	Very Often	Frequently	Sometimes	Occasionally	Never
Adaptation	5	4	3	2	1
Distress	1	2	3	4	5
Somatic	1	2	3	4	5

Score 1- Always means the least desired score
Score 5- Always means the most desired score

In the first assessment (intake) the scales are only recorded. In the second assessment after 3 months the scales are compared with those of the previous assessment for the corresponding questions. The former figure is deducted from the latter and is given as a percentage.

This is illustrated in the following example:

Client A
First assessment

	Adaptation	**1**	**2**	**3**	**4**	**5**
E1	Support from family/உமது குடும்பத்தின் ஒத்தழைப்பை பெறுதல்/ පවුලේ අයගෙන් සහයෝගය	✓				
E2	Consult family in Decision making/தீர்மானங்கள் எடுக்கும் போது குடும்பத்தினருடன் ஆலோசனை பெறுதல்/ තීරණ ගැනීමේදී පවුලේ අය සමග සාකච්ඡා කිරීම		✓			

Second assessment

	Adaptation	**1**	**2**	**3**	**4**	**5**
E1	Support from family/உமது குடும்பத்தின் ஒத்தழைப்பை பெறுதல்/ පවුලේ අයගෙන් සහයෝගය	✓				
E2	Consult family in Decision making/தீர்மானங்கள் எடுக்கும் போது குடும்பத்தினருடன் ஆலோசனை பெறுதல்/ තීරණ ගැනීමේදී පවුලේ අය සමග සාකච්ඡා කිරීම			✓		

E1 – level of change – 0
E2 – level of change – 1

This figure could be positive or negative, depending on whether the scale has moved up or down over two assessment periods. This gives an indication on an individual client's change related to each question.

The general percentages for the district office are calculated by adding the scales in each DTF separately for adaptation and for distress. The difference between two mean scores over 2 assessment periods is the numeric indication of the change and this is converted to a percentage to express the level of change that has occurred in the client wellbeing for the district.

At present the FRC derives percentages of the changes in the scales only for each district office, for the overall project intervention and as sex disaggregated percentages. Due to the heavy workload, percentages are currently not calculated for individual clients or for the clients serviced by different counsellors to understand the counsellors' skills and strengths in dealing with particular domains, although the database and the software provides the facility for such extensive analysis.

The percentages are presented in the form of tables or graphs when used in feedback sessions and in documentation of the project intervention. The difference in adaptation and distress scores for males and females, across the 6 FRC offices have been used by the FRC in its reporting documentations. Understanding the impact on adaptation and distress of clients is further discussed in Chapter 4.

The FRC experience

An evaluation in the six FRC offices in Ampara district (Akkaraipattu); Anuradhapura; Batticaloa; Mannar; Trincomalee and Vavuniya, where three full assessments were completed, was conducted in 2008. An overall improvement of 29% was noted in this.

The final report of phase 1 of the RESIST project[19] illustrates how the impact of the FRC counselling service has been quantified.

Actual percentage of improvement in clients scores through April FY 08:
Adaptation score after 3rd assessment: + 72.27
Percent increase in adaptation score from intake to 3rd assessment: 19%

Distress score after 3rd assessment: 47.56
Percent decrease in distress score between intake and 3rd assessment: 18.91%

Combined mean improvement in total score: + 4.56 = 23.9%

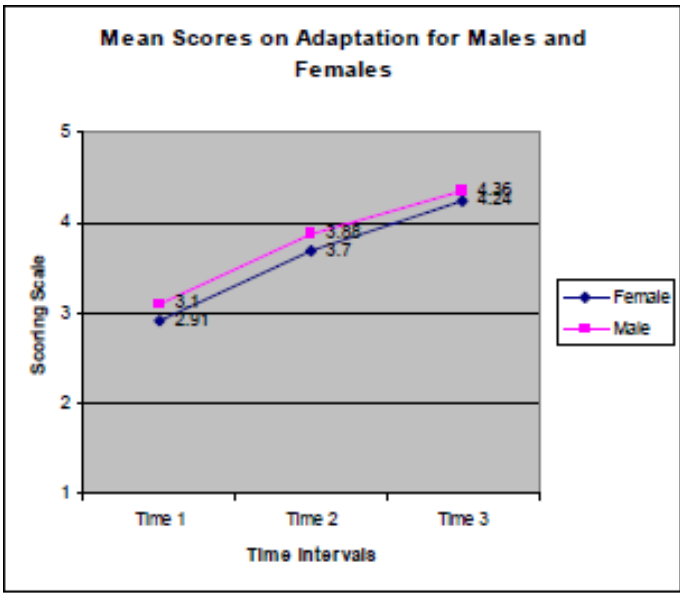
Place	% change between 1 and 2 assessment	% change between 2 and 3 assessment	Total change for period
Akkaraipattu	9.08%	9.74%	18.82%
Anuradhapura	11.89%	6.89%	18.78%
Batticaloa	6.76%	5.28%	12.04%
Mannar	21.97%	7.57%	29.54%
Trincomalee	10.58%	16.23%	26.81%
Vavuniya	25.19%	10.98%	36.17%

During the period January to March 2009[20], the FRC offices across 6 districts counselled 498 new clients. Of this 54% were male and 46% were female. Eighty percent (80%) of the clients were Tamil, 11% Sinhala and 9% Muslim. On completion of the final and 3rd assessment, the assessment scores on the DTFs were analysed to understand the impact of the services on these clients. This was analysed for the district offices, overall scores for the organization and for women and men clients

Analysis of the adaptation scores for males and females highlighted that both women and men are impacted to more or less the same level, with only marginal differences in the adaptation and distress scores for each category. The percentage of change or improvement in female

[19] RESIST Final report of Phase 1 – June 2005 – July 2008
[20] RESIST Quarterly Report No 17 to USAID (July - Sep 2009)

adaptation scores from T_1 to T_2 was 27%. While from T_1 to T_3 there was a 45% improvement. For males the improvement for adaptation from T_1 to T_2 was 25% and from T_1 to T_3 it was 40%.



The SPSS database could be set to extract different categories that an organization would wish to compare to better understand whether the impact is lesser on certain sub populations.

Ensuring smooth data flow from the field

While the CIF and the DTF provides the tools to monitor the impact of their services in a quantifiable manner, the FRC experience indicates that the organization need to discuss and agree on a mechanism to ensure smooth flow of monitoring data from the project sites to the head office for regular and timely analysis.

Initially, the project locations in each district collected and sent the completed DTFs every 3 months resulting in the monitoring staff at the head office in Colombo becoming inundated with DTF statistics! The FRC has been quick to respond to such troubleshoots through discussions with the counsellors and relevant staff at the district offices and the head office. A system has been set up for counsellors to send whatever DTFs they have completed every month. These may be the first intakes or subsequent assessments but it gives the monitoring staff more time and space to enter the data into the SPSS database. The analysis of data entered into the electronic system is scheduled to be done every three months.

The system is being continuously refined so that the organization can draw extensively from the CIF as a monitoring tool while ensuring that the monitoring staff is not overburdened during the periodic assessments.

Chapter 4
The significance and use of the Adaptation and Distress scores

The concept of adaptive functioning

The CIF assessment tool measures impacts on adaptation and distress in a client's life. In the preliminary discussions on developing monitoring mechanisms for the FRC, primary consideration was placed not only on addressing the need to quantify the impacts but also on developing a tool that takes a broader look at clients' recovery. Dr Hubbard highlighted the significance of assessing adaptive functioning which contributes to the healing process while enabling quantified monitoring. Drawing on the notes provided by Dr Hubbard in the introduction of the methodology, the final report[21] of Phase 1 of the RESIST project outlines the concept of adaptive functioning as follows:

"T*rauma research traditionally followed a simple model that looks at the exposure to trauma to predict psychopathology (post trauma psychological symptoms). Treatment planning, outcome and evaluations for survivors of trauma frequently follow the same model and use the same measures.*

Torture survivors, while technically past their experiences of torture frequently experience ongoing traumatic events while they are in treatment, especially if they or their families are in ongoing conflict situations. This raises problems for treatment assessments/research should a new traumatic event bring about symptoms similar (or worse) to those seen at the beginning of treatment. Although this reactive nature provides situational indicators of distress, it does not provide accurate measures of recovery.

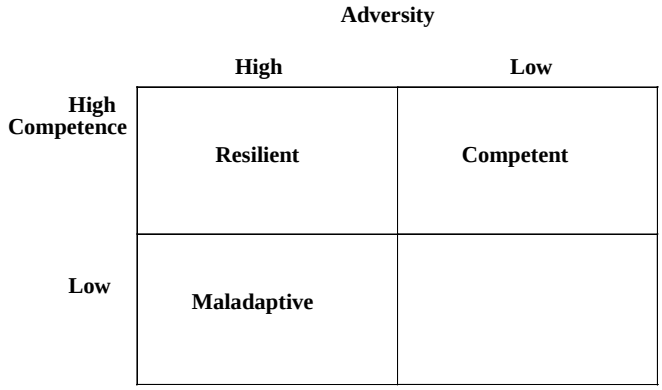
*(*A question that also needs to be asked is*) whether the absence of psychiatric diagnosis indicates that a client has recovered.*

*(*Parallel to this are*) clinicians' experience where clients who no longer report many psychiatric symptoms but they are unable to hold meaningful job, have a romantic relationship or form social relations due to loss of interpersonal trust. The reverse situation is probably more common but is also missed in traditional trauma treatment: Many clients who have ongoing post trauma psychological symptoms are making significant gains in other areas of their lives. They have gotten a job, begun to trust others and build social networks. Again these gains are missed in traditional trauma treatment and assessments".*

The above extracts illustrate the value of recognizing a person's capacity to adapt to adverse circumstances as a measure of healing. Based on this premise, the concept of adaptive functioning is used to assess a clients' ability to function in their daily lives. Assessment measures based on adaptive functioning take a broad view of recovery and incorporate indicators that cover all the important domains of functioning in clients' lives.

[21] RESIST – Final Report - Phase 1 – June 2005 to July 2008

Adaptive functioning also considers a person's resilience and competence. To illustrate these aspects, Dr Hubbard presented the following chart in the introductory workshops held for the FRC and Shanthiham[22].



As illustrated by this, Resilience is described as an individual's ability to adapt well or function on given tasks with competence in times of adversity

Analysis of Adaptation and Distress scores

The CIF looks at a client's capacity to adapt through a set of questions that deals with psychosocial wellbeing, relations with family and community, ability of to perform key life tasks, self satisfaction, self care, future mindedness and religious /social involvement. The stresses in a client's life are looked at through psychosocial problems, social problems and impact of problems on the client's life. The DTF which is used in overall monitoring includes selected measures in both categories that are likely to change with the counselling intervention. Increase in the adaptation and decrease in distresses is aimed at in the healing process.

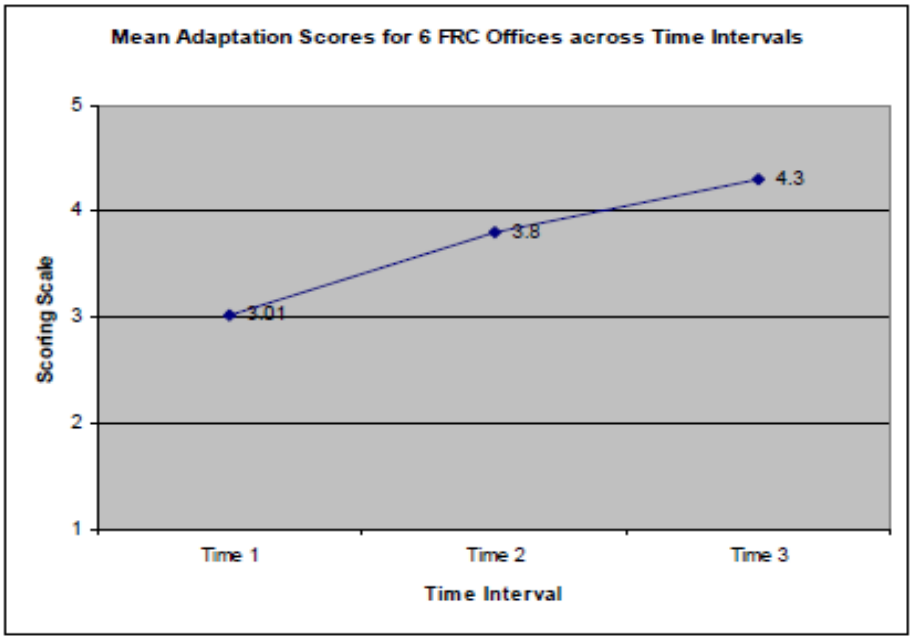
Adaptation and Distress scores are calculated from the ratings marked on the DTFs. The mean score for each of the questions for each district is calculated as well as the overall mean score for all the district offices. These are brought into graphs to map the trends in progress. A point that needs to be noted is that graphs on both Adaptation and Distress have an upward trend. This is due to maintaining a rating scale that always indicates 1 for the least desired status and 5 for the most desired.

In 2009 the FRC analysed CIF monitoring data of 498 new clients who had completed all three assessments (intake, mid-3 month assessment and 6 month assessment which is often the final). This illustrated that the clients, as a total, improved at a percentage of 25% in the second assessment. A progress of 43% was seen between the first and third assessments.

Diagram 1, below, illustrates the progress indicated by the mean rating score while Diagram 2 captures the same impact across assessment times.

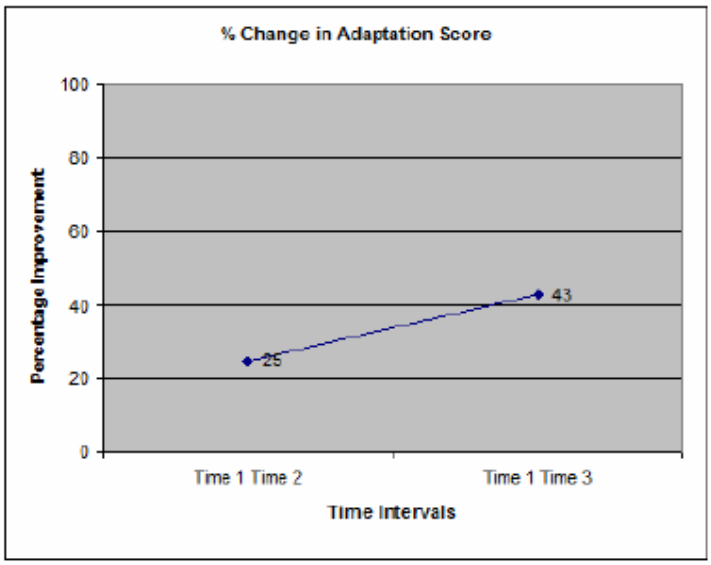
[22] RESIST – Final Report - Phase 1 – June 2005 to July 2008

Diagram 1:



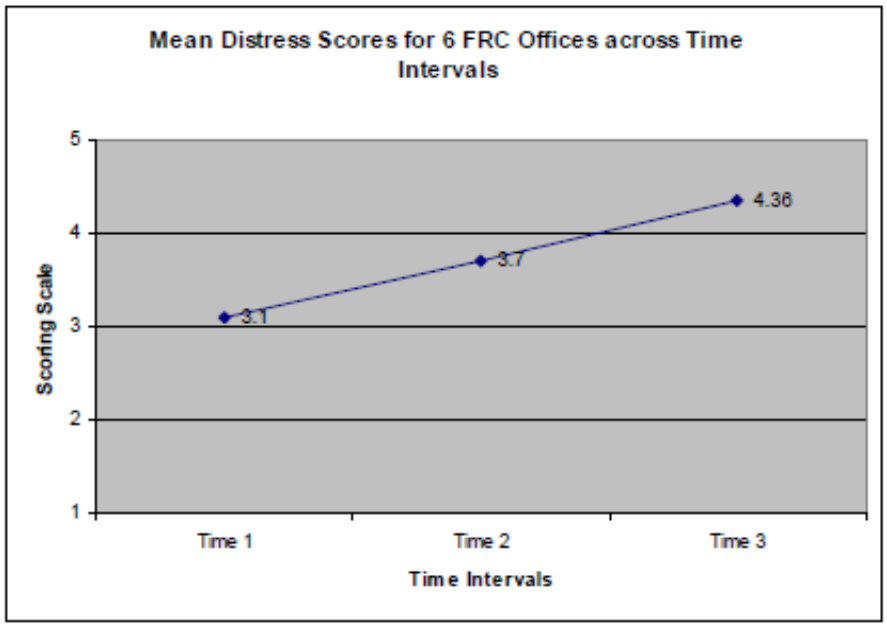
Scoring Scale: 1 (Never); 2 (Occasionally); 3 (Sometimes); 4 (Frequently); 5 (Very Often)
Time Interval (Jan-Sept 09): Time 1 (Client first comes to FRC Clinic); Time 2 (3 month assessment); Time 3 (6 month assessment since Time 1)

Diagram 2



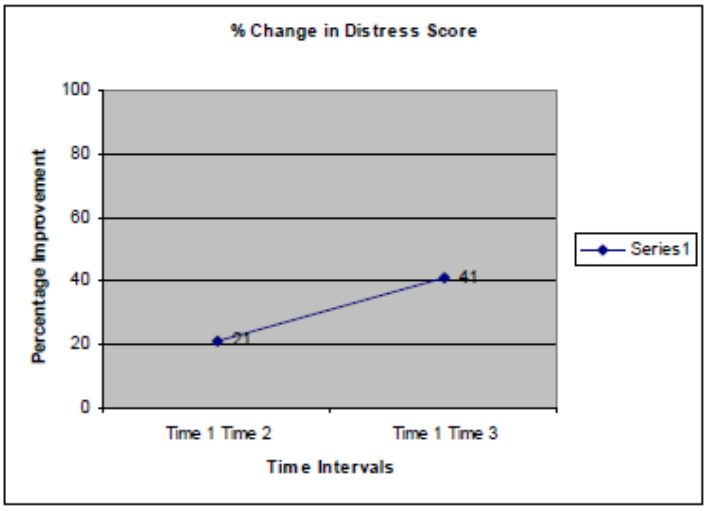
Diagrams 3 and 4 illustrate the distress scores, in similar manner, for the same clients during the same period: Reflecting the positive impact, the distress scores indicate 21% increase (reduction in distress scores) between the 1st and 2nd assessments and 41% between the 1st and 3rd assessment times.

Diagram 3



Scoring Scale: 1 (Very Often); 2 (Frequently); 3 (Sometimes); 4 (Occasionally); 5 (Never)
Time Interval (Jan-Sept 09): Time 1 (Client first comes to FRC Clinic); Time 2 (3 month assessment since Time 1); Time 3 (6 month assessment since Time 1)

Diagram 4:



The statistical data generated through the CIF could be used to understand varying dimensions: For example, adaptation and distress scores of male and female clients highlight that there is no significant gender difference in the impact of the intervention on women and men. Diagrams 5 and 6 depict this.

Diagram 5

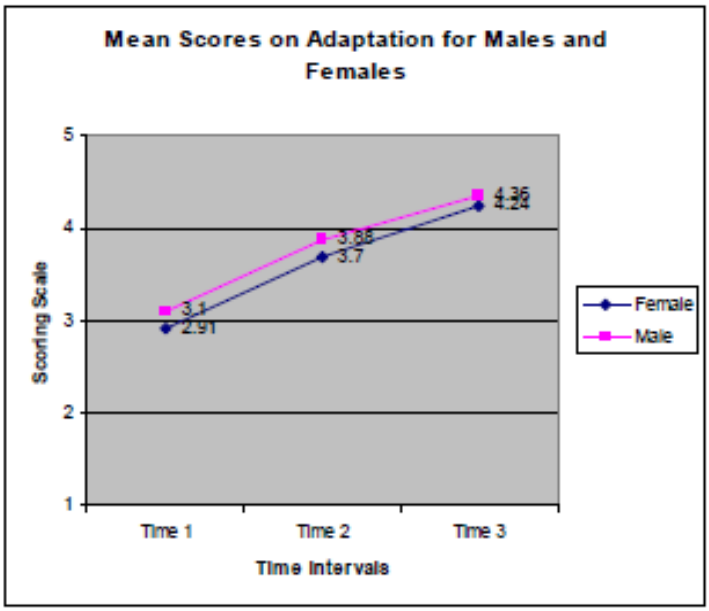


Diagram 6

A range of dimensions could be analysed and compared using the adaptation and distress scores if an organization wishes to draw maximum benefit from the statistical data, given the organization has adequate staff resources and capacity for such detailed analysis. For example, it could be used to understand the level of impact on varying age groups, project locations, civil status, and ethnicity, gender or other significant sub populations in the community.

The analysis could also generate statistical evidence as to which areas in the clients' lives have been most impacted and which are influenced to a lesser degree. For example in some locations, a trend of lesser impact on family and social relations may be visible in the data analysis, which would then inform the organization that greater support is needed to the counsellors of this particular location to deal with such issues.

When the tool is used for research, trends depicted in data analysis could highlight contextual factors that impact on the healing process and would indicate factors/ themes that need more in-depth research using other methodologies such as case studies, focus group discussions, key informant interviews etc.

Chapter 5
The Therapeutic Value of the CIF

As elaborated in Chapter 4, the CIF is a dual purpose tool: Primarily it is a therapeutic tool providing guidance to the counsellors and enabling the client to better understand his/her condition and identify his/her capacity to adapt to life's challenges. The secondary use of the tool is as a mechanism that quantifiably monitors the impact of the counselling intervention.

Often assessment tools that focus on psycho pathological aspects or tools based on unfamiliar socio-cultural norms distance the client from the assessment process: The client has to depend on the counsellor to tell whether he or she is making progress. At times counsellors too may not be clear about the exact meaning of assessment questions that focus heavily on psychopathology. In such instances monitoring could become a mechanical task conducted for project administrative purposes rather than as an inherent part of the counselling process. In developing the CIF assessment tool, such gaps in the existing monitoring mechanisms were discussed.

When introducing the methodology to develop the CIF tool, Dr Hubbard explained the potential of a localised tool that is based on communities' understanding of 'competence', 'resilience' and 'wellbeing'. These abilities/status increase a person's capacity to adapt to challenging situations. Bringing communities' understanding into assessment measures helps the counsellors to track the impact of the counselling with greater involvement of their clients because the indicators of healing are familiar to the clients.

During the feedback meetings on using the CIF, one of the most frequently and expressively stated feedback given by the counsellors was on how the CIF helps the counselling process: According to the counsellors it guides them and helps keep track of all the domains that are significant in a client's life. The detailed questions under each domain prompt the counsellor to talk about these with the client at each time of assessment. The counsellors of the FRC have adopted a practice of filling the self assessment section of the CIF together with the client.

Contribution of the CIF assessment tool to the counselling process

The therapeutic value of CIF has been highlighted by all who participated in the process of developing and using the CIF. As reported by the counsellors and field staff of the FRC as well as explained by the monitoring staff and the psychologist of the FRC, the significant contribution of the CIF to the healing process are as follows:

- It guides the counsellors and provides them with a framework to understand the client's problems
- It broadens the assessment of the client's condition by ensuring that the counsellors probe a clients' ability to manage key life tasks and social aspects along with the psychopathology-somatic focus.
- It brings into discussion the positive aspects (adaptation) in a client's life, not only the distresses and problems the client has. This enhances the healing process.
- It assists in treatment planning by helping the counsellor to better understand which aspects/domains are more affected.
- It helps trace the changes that are visible and which are understood/felt by the client
- It helps to monitor changes in individual clients – the client becomes involved in understanding the changes in his / her life, which contributes to the healing process

- The counsellors are able to better understand what they monitor because the indications of change are what they see in their local communities: The assessment is not dependent on scales that are unfamiliar to them or for which they require medical professional's assistance to interpret.

Ensuring appropriate use of the CIF tool to enhance the therapeutic value

As the primary focus of the CIF should be the therapeutic value, the importance of using the CIF to ensure this was discussed throughout the process of developing the assessment form. The importance of giving priority to listening to the client and using the CIF only as a guide that reminds the counsellors to cover all important domains has been repeatedly highlighted. Measures that would promote the use of the CIF assessment tool with sensitivity were discussed during the training workshops and feedback discussions held for the counsellors.

While the counsellors recognized the importance of such measures of quality assurance, they also pointed out the practical difficulties of adhering to some of these. For example in some distant locations clients have difficulties travelling to the FRC centre or clinic for counselling. In these areas mobile services have to be operated and assessment forms are filled in the client's presence. Counsellors are, however, discouraged from carrying assessment forms with them because, in some locations where high security measures are in place, these may be examined at security check points leading to issues in maintaining confidentiality.

Discussions on application of CIF have highlighted the imperative need for counsellors and the FRC to understand that the primary focus is on the therapeutic value of the CIF and therefore the need to maintain a balance between this and monitoring requirements. Some useful guidelines that were discussed during the feedback meetings are presented below along with how the FRC counsellors have dealt with the practical difficulties of adopting these guidelines:

- Counsellors should avoid reading out the questions to the client. This is discouraged as it may seem like an interrogation and make the client uneasy. The answers to the questions need to be derived from what the client says.

- Counsellors are encouraged to devote undivided attention to the client during the sessions and later rely on carefully taken notes to fill the CIF. However, the counsellors have reported the difficulty of doing this due to the number of questions that need to be probed: Remembering the scales for all these are not practical. The counsellors mostly introduce the form at the second session with a client and take about 2 - 3 sessions to complete the intake form. Some of the sections are filled together with the client. The FRC monitoring team and the technical advisory team recommends that developing counsellors' skill in note taking during the counselling session needs to be improved to address this issue.

- It is important not to introduce the CIF form in the first session thus enabling the counsellor to first establish a good rapport with the client - Although the appropriateness of this is recognized, practical difficulties sometimes have impelled counsellors to use the form in the first session. This is especially noted in the areas where clients are reached through mobile clinics throughout the counselling process because of the clients' difficulties to reach the clinics/ FRC office due to transport issues

- Ensure that space for the client to speak is not limited due to interest to complete the assessment form – while the CIF provides counsellors a focus and a guide they have been encouraged not to let it restrict the counselling process by narrowing the focus only to what is asked in the assessment form.

Concerns

1. Does the CIF restrict the focus of the counselling process to what is examined in the CIF- This has been discussed at many planning, monitoring and feedback meetings. While the CIF gives the benefit of providing a framework for the counselling process, a too heavy focus on it during the counselling session could restrict the counsellors' attention to getting answers for the questions in the CIF rather than understanding the client and empathizing with the client. Over enthusiasm to complete the form could distract the counsellor's attention and could curtail the space the client has to talk freely.

   Some suggestions, by technical support team to address this issue are:
   - Priority should be given to the healing process: Measuring the level of healing should essentially be a secondary concern
   - Ensuring that priority is given to the client during the counselling session is important. The time immediately after the session could be used to make notes to fill the CIF
   - It is important for the management to have an understanding of the counsellors' practical issues and have flexibility in the use of CIF – if some questions are not rated on the CIF, should this be considered as a lapse in a counsellor's duties or should a flexible approach be adopted has to be discussed within the organization.
   - Take initiative to adapt/ shorten the CIF to enhance its practicability so that it guides the counsellors but gives them and the clients the space to talk freely. The flexibility of the process of developing the CIF has a high potential for organizations to review the tool from time to time and adapt it / refine it. The data generated from the CIF could also be complemented with qualitative data generated through case studies/ focus group discussions etc.

2. Inappropriate use of the CIF - If the monitoring function of the CIF is prioritized over the therapeutic aspect it could lead to undue competition and some users marking inaccurate ratings on the CIF. The process of using the CIF is based on trust, integrity, personal skills, capacities and commitment of the user/counsellor. It also respects the confidentiality of the client-counsellor relationship. Therefore access to CIFs for checking is discouraged other than by the psychologist to provide supervision support to counsellors. Similarly micro managing to see how each counsellor completes the CIFs is deemed unnecessary. Therefore the user/counsellor who fills the form is called on to maintain a high standard of accountability: The therapeutic aspect as well as the overall monitoring of the impact of the intervention depends on how accurately the CIF is filled.

   How to ensure responsible and accurate rating of clients on the CIF has been discussed at feedback meetings and during field visits. Some measures that are thought to be useful to address inappropriate use of CIF are:
   - Use of data analysed through the CIF should primarily focus on the therapeutic aspects and be used as a tool for learning about gaps in services. Placing emphasis on the learning aspect would motivate the users / counsellors to identify strengths and gaps in their service rather than aim to superficially record progress.
   - Quantified data should not be interpreted as '*problems of counsellors'* but be seen as areas where service quality needs to improve: there may be other aspects that affect the quality of the service other than the counsellor's skills and capacities.
   - Avoid using data for comparison between counsellors or even different offices. This could unintentionally promote a sense of competition among the counsellors. Assessing the performance of counsellors for management and administrative purposes should, ideally, use a separate mechanism.

- Provide consistent non judgemental support to counsellors so that issues they have could be discussed in a non-threatening environment
- Facilitate skills development opportunities for counsellors in areas where, as a trend, data indicate lack of positive change

Annexes

Annex 1 – Sample questionnaire

Sample

ADULT INTERVIEW

Date: 2 March 2006
Interviewer: Radhika
Community: Nallur
Ethnicity: Tamil
Age of person you are interviewing: 25
Sex of the person you are interviewing: (Woman) Man (circle one)

I. Beginning Question:

"It would be very helpful for us to know how you can tell a person's life is going well. Think of an adult that you know is doing well, but don't tell me who it is. The person doesn't have to be the best person you know, but someone that is doing satisfactorily. Then I'm going to ask you a few questions about this person"

"Are you thinking of a woman or a man?" **Circle one:** (Woman) Man
"How old is this person?" **Enter age:** *32*

"In what ways is this person doing well?"

1. *Her son is first in his class*

2. *She has a successful tailoring business*

3. *Neighbours often come to her for advice*.

4. *She dresses simply and takes care over her appearance*

"Of all these, which do you think is most important?" **Enter Number:** *1.*

Annex 2 – CIF

Reg. No: …….

Family Rehabilitation Centre

ADULT INTAKE AND FOLLOW UP FORM

Client Registration Number : …….

Date of Registration : …….

Name of the Interviewer : ……

Referred By : ……

A. DEMOGRAPHICS OF THE CLIENT

1. Date of Birth : …….
2. Age : …….
3. Sex:

Male		Female	

4. Civil Status

Single		Married		Divorced		Widowed / Widower		Separated		Other	

5. Family Composition

a. Number of Children : …….

6. Ethnicity : ……
7. Religion : ……
8. Highest Level of Education

No Formal Education		Up to Grade 5		Grade 5 -9		O/L		A/L		University		Other	

9. Current Job : ……

10. Other sources of income : ……

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B. IDENTIFYING THE CASE

CLIENT'S SPECIFIC PROBLEMS

1. What are the reasons you came to this centre: (write in detail)

a. Psychological Problems:

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b. Physical Problem: ……

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2. Assist the client in identifying 1 or 2 specific problems that they would like to talk with you.

a. First Problem:

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How severe was this problem during the past week?

1	Very much	**1**	**2**	2	Much	**1**	**2**	3	A little bit	**1**	**2**	4	Not at all	**1**	**2**
		3	**4**			**3**	**4**			**3**	**4**			**3**	**4**

b. Second Problem:

……

……

……

……

How severe was this problem during the past week?

1	Very much	**1**	**2**	2	Much	**1**	**2**	3	A little bit	**1**	**2**	4	Not at all	**1**	**2**

		3	4			3	4			3	4			3	4

c. Other: if any

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……

How severe was this problem during the past week?

1	Very much	1	2	2	Much	1	2	3	A little bit	1	2	4	Not at all	1	2
		3	4			3	4			3	4			3	4

C. HISTORY OF THE CASE

1. Out of the mentioned problems which one do you like to talk about first? No: ...
   (When, how often and how severe)

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D. HEALTH OF THE CLIENT

1. How do you rate your physical health?

1	Very poor	**1**	**2**	2	Poor	**1**	**2**	3	Fair	**1**	**2**	4	Good	**1**	**2**	5	Very Good	**1**	**2**
		3	**4**			**3**	**4**			**3**	**4**			**3**	**4**			**3**	**4**

2. Do you have any physical disabilities? ☐Yes ☐No

   a. If Yes, describe them:

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……

……

……

3. Do you experience headaches?

1	Daily	**1**	**2**	2	Weekly	**1**	**2**	3	Monthly	**1**	**2**	4	Occasionally	**1**	**2**	5	Never	**1**	**2**
		3	**4**			**3**	**4**			**3**	**4**			**3**	**4**			**3**	**4**

4. Do you experience back pains or other body aches?

1	Daily	**1**	**2**	2	Weekly	**1**	**2**	3	Monthly	**1**	**2**	4	Occasionally	**1**	**2**	5	Never	**1**	**2**
		3	**4**			**3**	**4**			**3**	**4**			**3**	**4**			**3**	**4**

   Tick the occasions you get pains among the following:

   ☐ When lifting heavy things
   ☐ While seated
   ☐ While walking
   ☐ While lying down/ sleeping
   ☐ While cycling
   ☐ Other: Specify……..

5. Do you suffer from stomachaches?

1	Daily	**1**	**2**	2	Weekly	**1**	**2**	3	Monthly	**1**	**2**	4	Occasionally	**1**	**2**	5	Never	**1**	**2**
		3	**4**			**3**	**4**			**3**	**4**			**3**	**4**			**3**	**4**

6. Do you smoke?

1	Daily	**1**	**2**	2	Weekly	**1**	**2**	3	Monthly	**1**	**2**	4	Occasionally	**1**	**2**	5	Never	**1**	**2**
		3	**4**			**3**	**4**			**3**	**4**			**3**	**4**			**3**	**4**

7. Do you use alcohol?

1	Daily	**1**	**2**	2	Weekly	**1**	**2**	3	Monthly	**1**	**2**	4	Occasionally	**1**	**2**	5	Never	**1**	**2**
		3	**4**			**3**	**4**			**3**	**4**			**3**	**4**			**3**	**4**

8. Are you currently taking any medicine prescribed for your health? ☐Yes ☐No

   a. If Yes, what for : ……

   b. Who prescribed the medicine: ……

c. Previous Treatments (if any) : ……

9. Do you take any other drugs or medicines not prescribed by a doctor? ☐Yes ☐No

10. Describe if there is any visible illness symptoms: (observation made by the Counselor)

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..……

11. Have you ever been referred to a physiotherapist? ☐Yes ☐No

If Yes,

a. Why: ……..

b. Do you follow physiotherapy regularly?

1	Daily	1	2	2	Weekly	1	2	3	Monthly	1	2	4	Occasionally	1	2	5	Never	1	2
		3	4			3	4			3	4			3	4			3	4

Describe: ……

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……

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……

……

E. PSYCHOSOCIAL WELLBEING

RELATIONS WITH FAMILY AND COMMUNITY

1. Do you get the support of your family for your day to day activities?

1	Never	1	2	2	Occasionally	1	2	3	Sometimes	1	2	4	Frequently	1	2	5	Very Often	1	2
		3	4			3	4			3	4			3	4			3	4

2. Do you discuss with your family members before taking important decisions?

1	Never	1	2	2	Occasionally	1	2	3	Sometimes	1	2	4	Frequently	1	2	5	Very Often	1	2
		3	4			3	4			3	4			3	4			3	4

3. Do you pay attention to your children's education and health?

1	Never	1	2	2	Occasionally	1	2	3	Sometimes	1	2	4	Frequently	1	2	5	Very Often	1	2
		3	4			3	4			3	4			3	4			3	4

4. Do you enjoy in involving with community projects/ activities voluntarily?

1	Never	1	2	2	Occasionally	1	2	3	Sometimes	1	2	4	Frequently	1	2	5	Very Often	1	2
		3	4			3	4			3	4			3	4			3	4

5. Do you maintain friendly relationship with community members/ relations/ friends?

1	Never	1	2	2	Occasionally	1	2	3	Sometimes	1	2	4	Frequently	1	2	5	Very Often	1	2
		3	4			3	4			3	4			3	4			3	4

6. How often do you go to shopping?

1	Never	1	2	2	Occasionally	1	2	3	Sometimes	1	2	4	Frequently	1	2	5	Very Often	1	2
		3	4			3	4			3	4			3	4			3	4

7. Do you feel at ease with the surrounding you are currently living in?

1	Never	1	2	2	Occasionally	1	2	3	Sometimes	1	2	4	Frequently	1	2	5	Very Often	1	2
		3	4			3	4			3	4			3	4			3	4

a. Tick the surroundings you feel at ease at:

- ☐ At ease with the environment/ roads, shops
- ☐ At ease with the people/neighbors
- ☐ At ease with the culture
- ☐ At ease with the language
- ☐ At ease with the way of living

8. Do you feel comfortable traveling alone?

1	Never	1	2	2	Occasionally	1	2	3	Sometimes	1	2	4	Frequently	1	2	5	Very Often	1	2
		3	4			3	4			3	4			3	4			3	4

If not, why? …….

……

……

……

……

SELF SATISFACTION

9. Do you engage in activities in your daily life that make you happy?

1	Never	1	2	2	Occasionally	1	2	3	Sometimes	1	2	4	Frequently	1	2	5	Very Often	1	2
		3	4			3	4			3	4			3	4			3	4

10. Do you feel satisfied with your sexual life?

1	Never	1	2	2	Occasionally	1	2	3	Sometimes	1	2	4	Frequently	1	2	5	Very Often	1	2
		3	4			3	4			3	4			3	4			3	4

11. Do your friends consider you as a pleasant person?

1	Never	1	2	2	Occasionally	1	2	3	Sometimes	1	2	4	Frequently	1	2	5	Very Often	1	2
		3	4			3	4			3	4			3	4			3	4

12. If you are doing a job, do you engage in your job happily?

1	Never	1	2	2	Occasionally	1	2	3	Sometimes	1	2	4	Frequently	1	2	5	Very Often	1	2
		3	4			3	4			3	4			3	4			3	4

13. How often do you engage in recreational activities?

1	Never	1	2	2	Occasionally	1	2	3	Sometimes	1	2	4	Frequently	1	2	5	Very Often	1	2
		3	4			3	4			3	4			3	4			3	4

a. What do you do?

- ☐ Watching Television
- ☐ Reading News Papers
- ☐ Gardening
- ☐ Other:
  Specify…….
- ☐ Listening to Radio
- ☐ Engage in Animal Husbandry

SELF ASSESSMENT

14. Do you stand up for yourself?

1	Never	1	2	2	Occasionally	1	2	3	Sometimes	1	2	4	Frequently	1	2	5	Very Often	1	2
		3	4			3	4			3	4			3	4			3	4

15. Do you face challenges positively?

1	Never	1	2	2	Occasionally	1	2	3	Sometimes	1	2	4	Frequently	1	2	5	Very Often	1	2
		3	4			3	4			3	4			3	4			3	4

FUTURE- MINDEDNESS

16. Do you engage in your day to day activities according to a plan?

1	Never	1	2	2	Occasionally	1	2	3	Sometimes	1	2	4	Frequently	1	2	5	Very Often	1	2
		3	4			3	4			3	4			3	4			3	4

17. Do you save the money you get?

1	Never	1	2	2	Occasionally	1	2	3	Sometimes	1	2	4	Frequently	1	2	5	Very Often	1	2
		3	4			3	4			3	4			3	4			3	4

SELF CARE

18. Do you take care of your clothing and appearance?

1	Never	1	2	2	Occasionally	1	2	3	Sometimes	1	2	4	Frequently	1	2	5	Very Often	1	2
		3	4			3	4			3	4			3	4			3	4

19. Do you take care of your belongings/possessions?

1	Never	1	2	2	Occasionally	1	2	3	Sometimes	1	2	4	Frequently	1	2	5	Very Often	1	2
		3	4			3	4			3	4			3	4			3	4

RELIGIOUS/ SOCIAL INVOLVEMENT

20. Do you usually engage in religious activities? ☐Yes ☐No

    a. If so, what are the activities?

……

……

……

F. PROBLEM RATING SCALE

PSYCHOLOGICAL PROBLEMS

EMOTIONAL STATUS

How often do you feel the following?

1. Afraid:

1	Very Often	1	2	2	Frequently	1	2	3	Sometimes	1	2	4	Occasionally	1	2	5	Never	1	2
		3	4			3	4			3	4			3	4			3	4

a. What causes you fear?

……

……

2. Jumpy

1	Very Often	1	2	2	Frequently	1	2	3	Sometimes	1	2	4	Occasionally	1	2	5	Never	1	2
		3	4			3	4			3	4			3	4			3	4

3. Lack of courage

1	Very Often	1	2	2	Frequently	1	2	3	Sometimes	1	2	4	Occasionally	1	2	5	Never	1	2
		3	4			3	4			3	4			3	4			3	4

4. Sad

1	Very Often	1	2	2	Frequently	1	2	3	Sometimes	1	2	4	Occasionally	1	2	5	Never	1	2
		3	4			3	4			3	4			3	4			3	4

5. Disappointed

1	Very Often	1	2	2	Frequently	1	2	3	Sometimes	1	2	4	Occasionally	1	2	5	Never	1	2
		3	4			3	4			3	4			3	4			3	4

6. Get angry easily

1	Very Often	1	2	2	Frequently	1	2	3	Sometimes	1	2	4	Occasionally	1	2	5	Never	1	2
		3	4			3	4			3	4			3	4			3	4

a. Reasons……

7. Troubled by unpleasant incident /memories

1	Very Often	1	2	2	Frequently	1	2	3	Sometimes	1	2	4	Occasionally	1	2	5	Never	1	2
		3	4			3	4			3	4			3	4			3	4

8. Do you have difficulties falling asleep/staying sleep?

1	Very Often	1	2	2	Frequently	1	2	3	Sometimes	1	2	4	Occasionally	1	2	5	Never	1	2
		3	4			3	4			3	4			3	4			3	4

9. Lack of motivation

1	Very Often	1	2	2	Frequently	1	2	3	Sometimes	1	2	4	Occasionally	1	2	5	Never	1	2
		3	4			3	4			3	4			3	4			3	4

10. Neglect duties

1	Very Often	1	2	2	Frequently	1	2	3	Sometimes	1	2	4	Occasionally	1	2	5	Never	1	2
		3	4			3	4			3	4			3	4			3	4

11. Worn out

1	Very Often	1	2	2	Frequently	1	2	3	Sometimes	1	2	4	Occasionally	1	2	5	Never	1	2
		3	4			3	4			3	4			3	4			3	4

12. Feel Helpless

1	Very Often	1	2	2	Frequently	1	2	3	Sometimes	1	2	4	Occasionally	1	2	5	Never	1	2
		3	4			3	4			3	4			3	4			3	4

13. Mental pressure

1	Very Often	1	2	2	Frequently	1	2	3	Sometimes	1	2	4	Occasionally	1	2	5	Never	1	2
		3	4			3	4			3	4			3	4			3	4

14. Difficulty concentrating

1	Very Often	1	2	2	Frequently	1	2	3	Sometimes	1	2	4	Occasionally	1	2	5	Never	1	2
		3	4			3	4			3	4			3	4			3	4

15. Constant suspicion

1	Very Often	1	2	2	Frequently	1	2	3	Sometimes	1	2	4	Occasionally	1	2	5	Never	1	2
		3	4			3	4			3	4			3	4			3	4

16. Isolated

1	Very Often	1	2	2	Frequently	1	2	3	Sometimes	1	2	4	Occasionally	1	2	5	Never	1	2
		3	4			3	4			3	4			3	4			3	4

17. Lonely

1	Very Often	1	2	2	Frequently	1	2	3	Sometimes	1	2	4	Occasionally	1	2	5	Never	1	2
		3	4			3	4			3	4			3	4			3	4

18. Hatred

1	Very Often	1	2	2	Frequently	1	2	3	Sometimes	1	2	4	Occasionally	1	2	5	Never	1	2
		3	4			3	4			3	4			3	4			3	4

19. Suicidal thoughts

1	Very Often	1	2	2	Frequently	1	2	3	Sometimes	1	2	4	Occasionally	1	2	5	Never	1	2
		3	4			3	4			3	4			3	4			3	4

20. Guilty

1	Very Often	1	2	2	Frequently	1	2	3	Sometimes	1	2	4	Occasionally	1	2	5	Never	1	2
		3	4			3	4			3	4			3	4			3	4

21. Avoidance

1	Very Often	1	2	2	Frequently	1	2	3	Sometimes	1	2	4	Occasionally	1	2	5	Never	1	2
		3	4			3	4			3	4			3	4			3	4

22. Other: state in detail:
Psychological

.....

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23. Have you ever tried to get over from these problems? If yes, in what ways and how successful were you?

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SOCIAL PROBLEMS

24. Feel less interested in engaging with children: (if you have children)

1	Very Often	1	2	2	Frequently	1	2	3	Sometimes	1	2	4	Occasionally	1	2	5	Never	1	2
		3	4			3	4			3	4			3	4			3	4

25. Difficulties in socialization:

1	Very Often	1	2	2	Frequently	1	2	3	Sometimes	1	2	4	Occasionally	1	2	5	Never	1	2
		3	4			3	4			3	4			3	4			3	4

26. Difficulties in rebuilding life:

1	Very Often	1	2	2	Frequently	1	2	3	Sometimes	1	2	4	Occasionally	1	2	5	Never	1	2
		3	4			3	4			3	4			3	4			3	4

27. Feeling unaccepted by the community:

1	Very Often	1	2	2	Frequently	1	2	3	Sometimes	1	2	4	Occasionally	1	2	5	Never	1	2
		3	4			3	4			3	4			3	4			3	4

28. Lessen in social respect:

1	Very Often	1	2	2	Frequently	1	2	3	Sometimes	1	2	4	Occasionally	1	2	5	Never	1	2
		3	4			3	4			3	4			3	4			3	4

29. Face unwanted sexual advances by other people:

1	Very Often	1	2	2	Frequently	1	2	3	Sometimes	1	2	4	Occasionally	1	2	5	Never	1	2
		3	4			3	4			3	4			3	4			3	4

30. Other: state in detail

Social :

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31. Have you ever tried to get over from these problems? If yes, in what ways and how successful were you ?

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G. IMPACT OF PROBLEMS

IF THE CLIENT HAS CHILDREN AND THEY ARE OLD ENOUGH, ASK QUESTION 1

1. Has the problem had a negative impact on children's education? ☐Yes ☐No

   a. If so, in what ways:

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2. Has the problems caused economic difficulties? ☐Yes ☐No

a. If so, in what ways:

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- ☐ Loss of employment/livelihood
- ☐ Loss of property
- ☐ Loss of home

☐ Debt

☐ Other:

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3. Does someone in your family spend more on alcohol or other (illegal) drugs than you can afford? ☐Yes ☐No

4. Has the problem caused problems in family life? ☐Yes ☐No

a. If so, in what ways:

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If the client is employed, ask question 5

5. Has the problem caused difficulties in engaging in employment? ☐Yes ☐No

a. If so, in what ways:

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H. SUPPORT NETWORKS

1. When you have worries, do you involve yourself in activities to get rid of them?

1	Not at all	**1**	**2**	2	Rarely	**1**	**2**	3	Sometimes	**1**	**2**	4	Occasionally	**1**	**2**	5	Always	**1**	**2**
		3	**4**			**3**	**4**			**3**	**4**			**3**	**4**			**3**	**4**

2. When you have worries do you normally talk to someone?

1	Not at all	**1**	**2**	2	Rarely	**1**	**2**	3	Sometimes	**1**	**2**	4	Occasionally	**1**	**2**	5	Always	**1**	**2**
		3	**4**			**3**	**4**			**3**	**4**			**3**	**4**			**3**	**4**

a. If so, tick the following:

- ☐ Talk with family members/spouse:
- ☐ Talk with close relatives:
- ☐ Talk with friends:
- ☐ Talk with elderly persons in the community:
- ☐ Talk with the priest/monk or religious leaders:
- ☐ Talk with counselors :
- ☐ Others: specify:

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I. TREATMENT PLAN

1. Type of the treatment recommended for the client:

Medical		Physiotherapy		Counseling		Referral (Specify):	

Write in Detail:

a. Physical:

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Social:

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b. Psychological :

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c. Material :

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K. TERMINATION FORM

Name of the Client :

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Client Registration Number : ……

Name of the Interviewer : ……

Date of Termination : ……

1. Type of Services:

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2. Duration of Treatment:

Treatment	No of Sessions	Started & ended time period
Counseling		
Medical		
Physiotherapy		
Other		

3. Reasons for Termination:

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4. Follow-Up Plan:

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Annex 3 - DTF

Centre Name :		Client Reg. No :
Sex :	Civil Status:	Religion:
Age :	Ethnicity:	Date :
☐ 1st Assessment	☐ 2nd Assessment	☐ 3rd Assessment

	Description	Rating of Score				
Q.No	Somatic	1	2	3	4	5
D3	Experience Headaches/ தலை இடி/ හිසරදය					
D4	Back pain or body aches/இடுப்பு வலி அல்லது உடல் வலி/ කොන්දෙ රේදනාව හෝ ඇට පත රේදනාව					
D5	Stomach aches/வயிற்று வலி/ උදරාබාදය					
	Adaptation	1	2	3	4	5
E1	Support from family/உமது குடும்பத்தின் ஒத்தழைப்பை பெறுதல்/ පවුලේ අයගෙන් සහයෝගය					
E2	Consult family in Decision making/தீர்மானங்கள் எடுக்கும் போது குடும்பத்தினருடன் ஆலோசனை பெறுதல்/ තීරණ ගැනීමේදී පවුලේ අය සමග සාකච්ඡා කිරීම					
E3	Attention in Children Education/குழந்தைகளின் கல்வி/சுகாதார விடயங்களில் கவனம்/ ළමුන්ගේ අධ්‍යාපන කටයුතු පිළිබඳව අවධානය යොමුකිරීම					
E4	Involve in community projects/சமூக சேவைகளில் ஈடுபடுவதில்/ සමාජ ව්‍යාපෘතීන් සඳහා සහභාගී ඌම					
E5	Friendly relationship with community/ சமூக/ உறவுகளுடன்/ நண்பர்களுடன் நற்புறவை பேணுதல்/ ප්‍රජාව සමග පවත්නා ෆිතුශීලි සඃබන්ධතා					
E6	Shopping/ கடைகளுக்கு செல்தல்/ සාප්පු යෑම					
E9	Activities that make you happy/ நாளாந்த வாழ்கையில் உம்மை திருப்திப்படுத்தல்/ඔබව සතුටට පත්කරන ක්‍රියා					
E10	Satisfied with sexual life/ தாம்பத்திய வாழ்கையில் திருப்தி/ලිංගික ජීවිතය පිළිබඳව සෑහීමකට පත්ඌම					
E12	Engaged in job/ தொழிலில் ஈடுபடுதல்/රැකියාවක නිරත ඌ					
E13	Engage in recreational activities/ பொழுது போக்கு அம்சங்களில் ஈடுபடுதல்/ විනෝදාංශ ක්‍රියා					
E14	Stand up for yourself/ உமது பிரச்சினைக்கு நீரே தனித்து குரல் கொடுத்தல்/ඔබ ඔබ වෙනුවෙන් පෙනී සිඪම					
E15	Face challenges positively/ சவால்களுக்கு முகம் கொடுத்தல்/ අභියෝගවලට සා¾ටකව මුහුණ දීම					
E16	Work according to plan/அழுவல்களை திட்டமிட்டு செயற்படுத்தல்/ සැලැස්මක් අනුව වැඩ කිරීම					
E18	Care in Clothing & Appearance/ ஆடை /வெளித்தோற்றம் என்பவற்றை சிறந்த முறையில் பராமறித்தல்/ඇඳුම් සහ පිටත පෙනුම පිළිබඳව අවධානය					
E19	Take care of belongings/ உமக்குரியவற்றையும் உமக்கு சொந்தமானவற்றையும் பாதூகாத்தல்/ ඔබ සතු දෑ පිළිබඳව අවධානය යොමු කිරීම					

Scoring Instructions

	Very Often	Frequently	Sometimes	Occasionally	Never

Q.No	Description	Rating of Score				
	Distress	1	2	3	4	5
F1	Afraid/பயம்/ භය					
F2	Jumpy/ அதிர்ச்சி/ තිගැස්ම					
F3	Lack of courage/ மன வலிமையை இளத்தல்/ නිර්භීත නොබිම					
F4	Sad/ சோகம்/ දුක					
F5	Disappointed/ எதிர்பார்ப்புக்கள் சிதைந்த நிலை/ බලාපොරොත්තු කඩ වීම					
F6	Angry/கோபப்படுதல்/ තරහ					
F7	Trouble by unpleasant incident/ அனுபவிக்கக் கூடாத சம்பவம் மற்றும் நினைவுகள் மூலம் தொந்தரவுக்கு உட்படல்/ අප්‍රසන්න සිදුවීම් හේතුවෙන් හිරිහරයට පත්වීම					
F8	Difficulties in sleeping/ நித்திரை கொள்வதில் பிரச்சினை/ නිදාවැටීමට තියෙන අපහසුතාවය					

Adaptation	5	4	3	2	1
Distress	1	2	3	4	5
Somatic	1	2	3	4	5

Score 1- Always means the least desired score
Score 5- Always means the most desired score

F9	lack of motivation/ உற்சாகமின்மை/ අභිප්‍රේරණයක් නොමැතිබව					
F10	Neglect duties/ பொறுப்புக்களை அசட்டை செய்தல்/ වගකීම් පැහැර හරිම/ අතපසු ම					
F11	Worn out/ களைப்படைந்த நிலை/වෙහෙසට පත් වීම					
F12	Feel Helpless/ உதவியற்ற நிலை/ අසරණ බව					
F13	Mental pressure/ மன அழுத்தம்/ මානසික පීඩනය					
F14	Concentrating/ மனதை ஒர் முகப்படுத்த முடியாமை/ හිත එක්තැන් කිරීමට නොහැකි බව					
F15	Constant suspicion/ நிலையான சந்தேகம்/ නිරන්තර සැකය					
F16	Isolated / தனிமைப்படுத்தப்படல்/ හුදකලාගත කිරීම					
F17	Lonely/ தனிமையாதல்/ තනිකම					
F18	Hatred/ பழிவாங்கும் எண்ணம்/ වෛරය					
F19	Suicidal thought/ தற்கொலைக்கான எண்ணம்/ සියදිවි නසාගැනීමේ සිතුවිලි					
F20	Guilty/குற்ற உணர்வு/ වරදක් කලායැයි යන හැඟීම					
F21	Avoidance/தவிர்த்தல்/මගහැරීම					

Other Notes:

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PSW Name : .....

Signature & Date: .....

Annex 4 – Sample of Descriptors

DESCRIPTORS

Section D

ii. Do you have any **physical disabilities**?

- Fractures
- Joint dislocations
- Muscle twisting
- Nerve damages, etc.

vi. Do you currently use **alcohol**?

- ra/ arrack/ kasippu/ganja/heroin/drugs

vii. Do you suffer from **stomachaches**?

- Cannot eat food (no appetite)
- Reflux/ regurgitation
- Stomach- burning sensation
- Gastritis

Section E

1. Do you get the support of your family for your **day to day activities**?
    - Employment- agriculture, business etc
    - Mutual understanding and delegation of work

2. Do you discuss with **your family members** before taking important **decisions**?
    - Husband/wife/parents/children
    - Decisions regarding business/household activities/employment etc
    - Respect each other

3. How often you **pay attention** on your children's education and health?
    - Send children to school
    - Spend money on children's necessities/ bring them food
    - Meet teachers/participate for school meetings
    - Give advices/ chat with children
    - Have time for children/ play with children
    - Love children
    - Pay special attention on teenagers

4. Do you enjoy in involving **with community projects/ activities** voluntarily?
    - Social worker
    - Help the helpless
    - Participate actively for funerals and weddings
    - Participate in shramadana
    - Help others materially

5. Do you maintain **friendly relationship** with community members, relations and friends?
    - Exemplary character
    - Unity with others
    - Do not disturb others around him/her
    - Not jealous about others' success
    - Help in others difficulties
    - Talking to everyone in the community
    - Willing to compromise in decision making
    - Values teamwork.

11. Do your friends consider you as a **pleasant** person?

- Smile often
- Enjoyable
- Active
- Honest
- Listen others
- Work with collaboration

13. If you are doing a job, do you engage in your job **happily**?

- Willing to work
- Enjoys in engage in work
- Concern about the income
- Honesty

18. Do you engage in your day to day activities **according to a plan**?

- Think twice before taking decisions
- Good in time management
- Do not rush into decisions
- Spend money according to a plan

19. Do you **save the money** you get?

- Do not waste money
- Spend with control
- Invest on self-employment
- Start self employment

20. Do you follow a **daily routine**?

- Engage in your work/job/employment
- Do domestic chores
- Assist children in their educational activities/ takes care of children
- Regular bathing habits / brush teeth
- Regular food habits
- Follow medication (if taken any)

21. Do you take care of your **clothing and appearance**?

- Wear clean clothes/ Changing clothes
- Wash face and brush teeth
- Comb hair

23. Do you usually engage in **religious activities**?

- Go to temple/kovil/church
- Participates into religious activities taken place in the community.

Section F

31. Get **angry** easily:

- Beat wife/ children/ relatives
- Throw household items

37. **Worn out**:

- Dislike everything
- Lack of motivation

- Lack of interest
- Continuously remembered past incidents
- Deep negative thoughts