Developing a Clinical Assessment Tool for Counselling Services of the Ministry of Social Empowerment and Welfare

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The Asia Foundation

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The Asia Foundation

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Message from the Country Representative of The Asia Foundation

The Asia Foundation has adopted a psychosocial approach to its development work since 2005, particularly in relation to the Reducing the Effects and Incidences of Trauma (RESIST) project and the Victims of Trauma Treatment Programme (VTTP). The Asia Foundation has found that psychosocial approaches to healing and improving well-being are effective in strengthening existing coping mechanisms that enable individuals, families, and communities to get on with their lives. The Asia Foundation's work in mental health and psychosocial support programming began with the non-governmental sector and currently functions as a collaboration between the non-governmental sector and State mental health and psychosocial support sectors. The partnership with the Ministry of Social Empowerment and Welfare was fostered and developed within this purview

This publication reflects on the process of developing a clinical assessment tool to measure counselling services with a focus to improve the quality of the services provided by the Ministry of Social Empowerment and Welfare (MSEW). This is a continuation of a process the Foundation initiated in 2005 with its non-governmental partners. The same effort was put forward to promote effective monitoring of counselling services by supporting the counsellors of the MSEW through developing a clinical assessment tool. This publication aims to record the process of developing assessment tools for the Ministry as a resource for organizational history and to act as a reference document for future mental health and psychosocial interventions. The publication comprises the following sections: introduction, brief history of the relationship between the Foundation and the MSEW, the rationale and need for the clinical assessment tool, the approach and process employed in the development of the tool, introducing the tool and its salient features; and finally outlines the sustainability and potential of the clinical assessment tool to strengthen the counselling services of the MSEW.

The Asia Foundation is a non-profit international development organisation committed to improving lives across a dynamic and developing Asia. Informed by six decades of experience and deep local expertise, our work across the region addresses five overarching goals—strengthen governance, empower women, expand economic opportunity, increase environmental resilience, and promote regional cooperation.

Dinesha deSilva Wikramanayake
Country Representative
The Asia Foundation

Contents

List of Abbreviations

BEI	Brief Ethnographic Investigation
CIF	Client Intake Form
CSF	Client Screening Form
DS	Divisional Secretariat
FAF	Follow up Assessment Form
FRC	Family Rehabilitation Centre
GN	Grama Niladari – Public administration officer at village level
IDP	Internally Displaced Persons
M & E	Monitoring and Evaluation
MHPSS	Mental Health and Psychosocial Support Services
MSEW	Ministry of Social Empowerment and Welfare – The Ministry, at different times has been known by different names such as the Ministry of Social Services (MSS) and Ministry of Social Empowerment and Livestock Development (MSEWLD). For consistency, this document uses the term currently used, MSEW.
MWCA	Ministry of Women and Child Affairs
NISD	National Institute of Social Development
RESIST	Reducing the Effects and Incidence of Trauma
TAF	The Asia Foundation
TOT	Training of Trainers
VTTP	Victims of Trauma Treatment Programme

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Developing a Clinical Assessment Tool for Counselling Services of the Ministry of Social Empowerment and Welfare

1 Introduction

Developing a clinical assessment tool to monitor the impacts of counselling services was a collaborative initiative by the Ministry of Social Empowerment and Welfare (MSEW) and The Asia Foundation (TAF). The tool is expected to directly benefit over 200 counselling officers/counselling assistants working at divisional/district levels and at the Counselling Division of the MSEW and the counselling processes facilitated by them. The clinical assessment tool consisting of three components i.e. the Client Screening Form, Client Intake Form, and the Follow Up assessment data, was developed and introduced into practice over a period of three years, spanning from 2014 to 2016. For The Asia Foundation, supporting the counsellors of the MSEW to develop a clinical assessment tool was a continuation of a process the Foundation initiated, in 2005, to promote effective monitoring of counselling services. This was through the Reducing the Effects and Incidences of Trauma (RESIST) programme. The current joint intervention with the MSEW, under Phase 2 of Victims of Trauma Treatment Programme (VTTP), has not only generated a clinical assessment tool that encompasses local relevance and practical value: It has also brought forth enriching experience and learning. The Foundation commissioned documentation of this process with the aim of recording the process for organisational history and as a reference document for future Mental Health and Psychosocial Support Service (MHPSS) interventions. The document, in brief, captures the key aspects of the process, outlines the salient features of the assessment tool and discusses the learning gained from this experience.

Introduction to the VTTP Programme of The Asia Foundation (TAF)

Phase 2 of VTTP, implemented by The Asia Foundation and funded by the USAID, aimed to contribute to the goal of 'Improving the capacity of government and non-government actors to provide Mental Health and Psychosocial Support Services for vulnerable and trauma affected communities' . The intervention has three main components i.e. 1) Assessing MHPSS and improving Curricula relevant to MHPSS education and practitioner training; 2) Strengthening MHPSS service delivery through improvement of knowledge and skills of government and non-government MHPSS service providers in post-conflict settings and 3) Building Monitoring and Evaluation mechanisms of key government partners and selected non-government agencies.

Phase 2 of VTTP builds on the outcomes of Phase 1 of VTTP and RESIST programmes. During these two previous interventions the Foundation worked with a range of government and non-governmental agencies and with academia to ensure quality of counselling services through three main initiatives: One was to work with two non-

governmental agencies, Shanthiham and the Family Rehabilitation Centre (FRC) to develop and introduce a locally relevant, culturally appropriate and technically adept assessment tool. The second was supporting curricula development for training of counsellors, which engaged with the National Institute of Social Development (NISD) affiliated to the MSEW and Shanthiham in Jaffna. The third component was developing capacity of counsellors and ground level service providers such as Grama Niladaris (GN – ground level public administration officer) in conflict affected areas.

Phase 2 of VTTP aimed to extend this process and support the counsellors of the MSEW spread throughout the country, to enhance monitoring of their services. Working with a state institution is inherently different to working with non-governmental organisations. This required both the MSEW and the Foundation to collaboratively assess the current context of counselling services provided by the MSEW and adopt a process that is feasible to being operated within a widespread state service provision mechanism. The Asia Foundation's commitment to building and maintaining relationships with the key state agencies was a crucial ingredient that enabled this collaboration. Initially the process of developing the tool also engaged the Ministry of Women and Child Affairs (MWCA). Towards the latter stages of the intervention, the MWCA was more active in the capacity development component while the MSEW took a lead role in developing the assessment tool by setting up the necessary support structures, such as a computerised database for operationalising the tool. This document mainly discusses the development of the clinical assessment tool.

In parallel to the interventions with these two state institutions, under Phase 2 of the VTTP, the Foundation continued to support Shanthiham and the FRC to further refine the monitoring tool introduced during the RESIST programme as well as enhance their technical capacity. This also enabled the FRC to provide technical support to the process of developing the clinical assessment tool with the MSEW, in Phase 2 of the VTTP.

Technical guidance - During both phases of the VTTP, Prof. Gameela Samarasinghe, Senior Lecturer, Department of Sociology at the University of Colombo guided the process as the local Technical Advisor while Dr. Jon Hubbard, Research Director for the Centre of Victims of Torture (CVT), Minneapolis, USA, led the process as the international Technical Advisor. Overall conceptualisation of Phase 2 of the VTTP and its operationalising was managed by Ms. Mihiri Ferdinando, Programme Manager, while Mr. Anjula Jayasundara, Programme Officer of the Foundation, provided monitoring and evaluation (M & E) support. The process was technically supported by Ms. Roshan Dhammapala, Clinical Psychologist; Ms. Prasadi Fernando, M & E consultant; and Ms. Niranjala Somasundaram, M & E officer of FRC.

Introduction to the Counselling Division of MSEW

The Counselling Division of the MSEW, operating under the Director and Deputy Director, has a cadre of approximately 220 counselling officers/counselling assistants.

Ten counsellors, comprising the core team are based at the MSEW, Colombo while approximately 210 counselling officers/ counselling assistants work at divisional level. Counsellors at ground level are located at the Divisional Secretariats (DS) or District Secretariats and thereby have a wide outreach to clientele across the country.

Providing counselling services through a specialised division of the MSEW was initiated in 2005 with a cadre of 60 counselling officers. Subsequently, the staff was strengthened through recruitment of counsellors in 2008, 2011 and 2013. The clientele that seeks support from the counsellors at DS/district offices are varied, requiring the counsellors to have a wide base of technical capacity. This is ensured by recruiting counsellors with appropriate technical and educational qualifications, such as diploma holders of the NISD. Their technical capacity is further strengthened through on-going training programmes. From 2014 onwards, they have also benefitted from capacity building programmes facilitated through the Foundation, under Phase 2 of the VTTP.

Although providing counselling services to clients who visit them at the DS offices is the main component of their work, the counsellors of the MSEW are also required to play a wider role in educating communities on counselling and assisting diverse state initiated projects relevant to psychosocial interventions. For instance, they conduct school and community based educational programmes, visit prisons and assist in rehabilitation programmes, provide counselling and guide psychosocial care giving at elder care and disability care giving facilities and support special programmes of other ministries. Special interventions conducted in the recent past included providing support for trauma counselling to implement recommendations of the LLRC, and conducting programmes on active listening in selected communities as a step towards promoting psychological wellbeing of people.

Documenting the development and features of the clinical assessment tool

Documenting the process of developing the clinical assessment tool was commissioned by the Foundation in November 2016, towards the latter stages of the intervention. The document draws on primary and secondary data. Primary data was gathered through one to one interviews with programme staff of the Foundation (the Senior Programme Manager, Programme Officer and M & E Officer of the Psychosocial Programme), and external consultants (the Clinical Psychologist and M & E Consultant). Key person interviews were also conducted with selected counselling officers based at the MSEW. The selection was based on their availability during the period of data collection. Secondary data was shared by the Foundation (progress reports, discussion notes and documentation of capacity building programmes) as well as two publications jointly produced by the Foundation and the Counselling Division of the MSEW to support the process.

As required by the Terms of Reference and specified time allocation, this document provides only a brief overview of the process and the clinical assessment tool. This

Introduction is followed by Section 2, discussing a brief history of the work relationship between the Foundation and the MSEW which led to the current collaborative initiative. Section 3 of the report outlines the need for the clinical assessment tool. Sections 4 and 5 discuss the Approach and Process while Section 6 briefly outlines the support mechanisms that supported the process. Section 7 introduces the tool and its salient features, followed by Section 8 which discusses, briefly, the sustainability and potential of the clinical assessment tool to strengthen the counselling services of the MSEW as well as impact on ensuring quality standards of monitoring counselling services, in general, in Sri Lanka.

2 Finding Pathways

Pathways that led to the development of a clinical assessment tool for the Counselling Division of the MSEW and the approach it took can be traced along two tracks. One is The Asia Foundation's (TAF) initiatives since mid-2000 to support counselling services, especially in conflict settings, by introducing locally relevant monitoring tools. The second is TAF and the MSEWs long standing work relationship, collaborating through several initiatives to promote availability of quality education and training in counselling. These two pathways often intersected in both short term interventions and longer term ventures and support systems.

Tracing TAF's pathway from CIF to the clinical assessment tool of MSEW

The Asia Foundation's interest in promoting adoption of technically sound, locally relevant tools to measure the impact of counselling services in Sri Lanka was systematically pursued in 2005, through the development of the Client Intake Form (CIF). The CIF mainly aimed to strengthen the counselling services provided for people affected by traumatic experiences of war in the North and East. TAF linked with two non-governmental agencies, Shanthiham and FRC, both organisations which were active in providing psychosocial support for conflict affected communities in these areas during the armed conflict.

The need for such an assessment tool was identified through FRC and Shanthiham's experiences of dealing with donors who were keen to have quantitative evidence of the qualitative impacts of counselling services. It was also underlined by TAF and the two partner organisations' interest to look beyond medically-focused assessment tools to monitor impacts of counselling. This interest reflected the concerns of the MHPSS sector, in general, regarding the inadequacy of medicalised tools to capture the locally relevant nuances of psychosocial issues people faced and impacts of counselling on their lives. At FRC and Shanthiham, this need emerged as a priority concern because counsellors often did not fully understand the medical aspects they were monitoring. When recording monitoring data they also felt restricted by the lack of space to record the changes in people's daily activities and interactions. Furthermore, the medicalised tools based on western cultures, lacked relevance in local cultures with different

lifestyles, norms and value systems. A theoretical perspective that guided the process also highlighted the need to consider the context of on-going violence in people's lives and the need to incorporate people's capacity to adapt to adversities rather than focus heavily on psychopathology of suffering. Discussing the significance of the premise of adaptive functioning, Dr Hubbard noted the usefulness of monitoring all dimensions across the important function of a client's life[1]. Some questions that FRC, Shanthiham and TAF teams collectively probed during the discussions leading to development of the CIF underlined this relevance: For instance, the team discussed whether absence of a psychiatric diagnosis indicated that a client had recovered; how recurrent challenges and traumatic experiences, common in conflict affected settings, could be incorporated into the counselling process based on adaptive functioning; how did people understand and interpret their suffering and the concept of wellbeing; how can an assessment tool be developed to draw on people's understanding of wellbeing.

The interest to develop an assessment tool focusing on adaptive functioning and locating this within affected communities' understanding of wellbeing resulted in TAF, Shanthiham and FRC launching a two-pronged approach. The first step was to conduct a rapid ethnographic study to capture people's understanding of wellbeing, or how they describe a person who is doing well in life. The study was conducted by the counsellors, researchers and assistants affiliated to FRC and Shanthiham and used the Brief Ethnographic Investigation (BEI) method developed by Dr. Hubbard through the Centre for Torture Victims, Minneapolis. The second step was to code and analyse the responses and identify the key characteristics people ascribed to wellbeing and ill-being. Through this, the main domains and aspects that need to be monitored to assess adaptive functioning of clients were identified. The Client Intake Form (CIF) was formulated by drawing on these findings.

Introduction of the CIF into the counselling process as a monitoring tool included developing the capacity of FRC and Shanthiham's M & E staff to use SPSS software to enter data and analyse the synthesis to better understand the nature of service demand and impacts.

The learning gained from the experience of developing the CIF and, especially, the experience of developing staff capacity to work with a SPSS database to record monitoring data formed the basis on which the MSEW's clinical assessment tool was developed. However, there were also fundamental differences of which the Foundation, the MSEW, and the technical resource team supporting the process were aware. The main difference was that the MSEW clinical assessment tool would not be specific to conflict affected experiences: It needed to capture counselling services relevant to a wide range of issues that affect people's day to day lives during peacetime. Therefore, while the concept of adaptive functioning continued to be a primary premise, the domains identified for the CIF of VTTP 1 were not fully relevant in the MSEW counselling

1 The Asia Foundation (TAF) 2010, Handbook: Client Intake Form, Developing an Assessment Tool for Psychosocial Interventions, Reducing the Effects and Incidences of Trauma (RESIST) Project, The Asia Foundation, Sri Lanka, Unpublished document.

services. The process of building on the similarities and reconciling with differences by introducing new perspectives to meet the demands of general counselling service is discussed in Sections 4 and 5.

Tracing TAF and MSEW collaboration

A key strength in the process of developing the clinical assessment tool is the supportive work relationship that TAF and the MSEW had established over the years. This builds on the two organisations understanding each other's strengths and limitations. It has enabled TAF and the MSEW to draw on each other's capacities and complement their services to contribute to the common goal of providing effective counselling services at ground level.

The Foundation's early work with the MSEW to support psychosocial support was in 2009 - 2010, when the MSEW requested TAF to support a psychosocial intervention which the MSEW had started in Vavuniya. The Ministry had appointed over a hundred psychosocial volunteers to work with people affected by the armed conflict in Vavuniya. A priority need was to work with internally displaced communities (IDPs) who were living in temporary welfare camps. The volunteers were untrained in psychosocial work and were ill equipped to deal with the multitude of issues faced by the IDPs. Responding to the MSEW's request, TAF joined with the National Institute of Social Development (NISD), the academic and practitioner-training arm of the Ministry and explored options to train the psychosocial volunteers. Both organisations firmly believed that the training must essentially match the demand in terms of the nature and gravity of issues. Together, TAF and the NISD, supported by the MSEW and local technical advisor, designed a course on counselling. Apart from this, during this period, the Foundation also facilitated short courses on basic counselling skills for GNs and local government officials.

The successful collaboration between TAF and the NISD and the MSEW paved way for the NISD to request the Foundation's support to revise their curricula on counselling and social work diploma programmes. The NISD, recognised by the University Grants Commission (UGC) as a diploma awarding institution, was keen to update and advance its curricula. With TAF's technical support, the NISD was able to re-design its curricula on counselling and social work for the first time in a decade. Simultaneously, TAF also linked the NISD with Shanthiham enabling delivery of the NISD diploma courses on counselling and social work in the North, through Shanthiham's collaboration. Shanthiham has long been recognised as a pioneer organisation in providing quality counselling services and training in Jaffna. The collaboration between the NISD and Shanthiham strengthened both organisations' outreach to a wider student base and greater recognition of their training programmes.

These initiatives, over time, strengthened the trust based work relationship between TAF and the the MSEW. This was collaboration between a non-government agency with greater capacity for flexibility in how they worked and a government institution

which works within state policies, mechanisms and regulations pertaining to public service. Practically, this collaboration also meant that TAF had increased space to collaborate with the state and enhance sustainability of its innovative approaches to promote quality psychosocial support, while the MSEW had increased opportunities to incorporate successfully demonstrated capacity building and monitoring mechanisms to enhance their counselling and psychosocial support systems. Understanding the complementarities of each other's services has helped both TAF and the MSEW to discuss the strengths and current limitations of counselling services provided through the MSEW and the potential to enhance the service by introducing robust monitoring mechanisms.

3 The Need

The need to develop a clinical assessment tool for the MSEW's counselling services was identified at different levels and through different sources: Foremost was a study, conducted in 2013 with TAFs support. The study mapped the role, scope and training needs of counselling assistants and ascertained the varying needs that affect the quality of their counselling services. When formulating Phase 2 of VTTP, TAF decided to respond to three recommendations made by the mapping study. These were, developing a tool to monitor counselling services; clinical supervision for counsellors, which TAF would later facilitate through a mechanism of peer support; and capacity building of counselling officers and counselling assistants. The initiative to support the development of a clinical assessment tool for counselling services delivered through the state mechanism, especially the MSEW and the MWCA was a direct outcome of this.

The MSEW, at ministerial level had identified a need to validate the service of its Counselling Division and its cadre of over 200 counsellors by providing robust evidence on the outreach and impact of the service. At ground level, counsellors of the MSEW felt a need to be better recognised for their technical skills as counsellors. This was especially because of the tendency to engage them in a myriad of other services such as assisting state sponsored programmes. These did not always portray their technical capacity and therefore the counsellors looked for recognition for their professional skills as well as recognition of the Counselling Division of the Ministry. The counselling process itself required more in-depth monitoring, enabling greater insight into impacts on clients healing and wellbeing.

The monitoring tool hitherto used by the counsellors of the MSEW mostly focused on reporting the number of clients seen within a specific time period and lacked sufficient space to record information on clinical assessment. Although the Counselling Division had been in operation for over eight years, the monitoring mechanism of the MSEWs counselling service had not been reviewed until 2014. This underlined that reviewing the monitoring mechanism to identify any gaps and evolving needs was long overdue. Client records and the overall monitoring mechanism of the MSEW counselling service

were reviewed for the first time when, in 2014, TAF and the MSEW jointly initiated the process to develop a clinical assessment tool.

Box 1: Counsellors' suggestion for the structure of the monitoring tool

In one of the early workshops, held in 2014, for 25 counsellors who represented the cadre of counsellors of the MSEW, the participants discussed the limitations of the monitoring tool they were using. They highlighted the need to have an assessment tool that records monitoring data of mainly two types: One was related to the number of people that counsellors of the MSEW see within a given time period and the other, clinical assessment of clients who access counselling services. This two-pronged monitoring, according to the counsellors of the MSEW, was necessary because they often have to speak with a significant number of people who do not necessarily need counselling but who meet counsellors at DS offices to seek support for various issues. Often these clients are referred to the counsellors by other officials of the DS office or by other state or non-state agencies. Although these people do not require counselling services, the counsellors have to invest a considerable amount of time with each visitor to listen to their issues, understand the problem and determine whether they need counselling or any other type of service, and make referrals if necessary. As this was a significant component of their work, the counsellors needed a monitoring mechanism to track the time they invested in this task. The second requirement was the clinical assessment tool to monitor the therapeutic effect on the clients who receive counselling spanning over several sessions.

On establishing the need for a clinical assessment tool, the purpose and parameters of the tool, were determined collaboratively with the core team of counsellors located at the MSEW. The approach that defined this process is discussed in Section 4.

4 The Approach

The approach to developing the clinical assessment tool was largely determined by the fact that the service provision agency was a state institution: this meant working with over 200 counsellors and managing the process within rules and regulations that guide public service. Therefore, it was necessary to work with a representation of counsellors acting as focal points and adopt a method of developing the capacity of the focal points to train the other counsellors spread across the country. Initial workshops, consultations and the latter training of trainer programmes, therefore, directly engaged with the counsellors of the MSEW at two levels. One was the core team of counsellors based at the Ministry. The other was the 25 counsellors selected as the focal persons. These two groups directly interacted with the programme staff and the technical resource team during workshops to develop the tool and to train as trainers who would guide the other counsellors to use the assessment tool and who would also manage the monitoring data.

An inherent component of this approach was establishing and strengthening a tiered link connecting DS level counsellors with focal points who coordinate several districts and similarly linking the focal points with the Counselling Division at the central Ministry and technical consultants of the project. Working with a larger number of counsellors spread across the country also meant that the process of developing the clinical assessment tool would draw primarily on this smaller group of counsellors' experiences and expectations to define the key domains that needed to be monitored. Although TAF's general practice is to adopt participatory approaches that engage with all contributors to a process, in this intervention it was not practically feasible to engage with the full cadre of counsellors. TAF was conscious of the need to be flexible and work within the parameters of public service provision. Similarly the Counselling Division of the MSEW was open to negotiations and learning from TAF's previous experiences of developing a locally relevant assessment tool for counselling.

Prior to meeting the core team of counsellors to design the tool, TAF's technical resource team comprising of the international and local technical advisors, clinical psychologist, M & E consultant and programme staff of TAF discussed the theoretical premise of the clinical assessment tool. It was evident to them that identifying the domains of assessment could not be done by generating community perceptions on healing and wellbeing, as was earlier done when developing the CIF with Shanthiham and FRC. The domains had to be identified through experience of the technical resource team and the counsellors. The preliminary discussions on the design of the tool often turned towards exploring applicability of the tool, which emerged as the foremost consideration. Box 2 captures, in summary, the main discussion points of an early discussion the international technical advisor, clinical psychologist and the programme manager had on the practical value a clinical assessment tool would bring to a counselling process.

Box 2: Outline of a good clinical assessment tool

- A good clinical assessment tool identifies and recognises the clients' needs.
- It recognises which needs can be supported through the counselling process.
- It enables a therapeutic contract between the client and the counsellor, where they agree on which issues they will work together.
- It reaffirms the importance of goal setting.
- It establishes baseline information useful for treatment planning.
- It helps identify areas that need to be referred to other relevant service providers.
- It helps the client and the counsellor focus on the purpose of counselling and how change can be measured.
- It outlines a boundary to the counselling process.

While this set the standards the clinical assessment tool needs to maintain, the content that needs to be covered by the assessment tool were identified through discussions

with counsellors of the MSEW. This was facilitated through a workshop held in early 2014, in which 25 counsellors from the districts and 10 counsellors from the core team at the MSEW in Colombo participated. The 25 counsellors, selected as focal points, represented the cadre of district level counsellors. The participants worked in three groups, with each group exploring issues of three to four selected districts, thereby representing a cross section of the geographical-administrative areas of the country. Feedback from these group discussions outlined the main issues that cause psychological suffering to people. Fifteen key domains emerged as priority areas for which clients seek counselling.

Box 3: Main domains for which counselling is sought, as identified by counsellors of the MSEW

Family and marital problems including domestic violence; mental health and psychological problems; problems related to relationships, sexual dysfunctions and problems with sexuality; learning difficulties and problems related to school attendance and performance; child behavioural problems; child abuse / neglect; suicide risk and self harm; addictions (drug, alcohol, internet, gambling and pornography); disability; issues related to ageing and the elderly; coping with chronic and terminal illnesses; work and occupational problems and socio-economic problems; war related loss, displacements and trauma; and disasters and emergencies.

Based on identification of these key areas, the Foundation, together with the MSEW, later in the process developed a publication outlining work instructions for counsellors to deal with these issues in counselling. However, the publication emphasises that a single counsellor is not expected to be competent in counselling on all these areas. The aim of the publication was to outline the boundary of the counselling process and help counsellors understand the spectrum of interventions.

The clinical assessment tool aimed to capture the impacts counselling services extended to deal with ground level realities as illustrated by the key domains that were determined through practical experience of the counsellors. Simultaneously, it aimed to ensure standards of quality of the counselling process as defined by the technical resource team of TAF. Thereby, the approach to developing the tool was consultative, drawing on the counsellors' experience and engaging their active contribution, whilst facilitating proficient technical guidance to design the tool. The salient features of the process adopted to develop the tool are discussed in Section 5.

5 The Process

The objective of developing a clinical assessment tool was to improve the M & E capacity of counsellors of the MSEW, and through the introduction of an improved client assessment process enhance the quality of clinical services provided for clients. As stated in the Memorandum of Understanding (MoU) between TAF and the MSEW, the tool aimed to assess the counselling process in post conflict settings and in peacetime development. The process consisted of three main components. These were:

1. Review the existing client record information used by the counsellors and develop/revise a clinical assessment tool. This aimed to standardise the clinical assessment process adopted by counsellors of the MSEW spread across the country.
2. Develop training of trainer (TOT) programmes to train counsellors of the MSEW to use the/clinical assessment tool.
3. Develop a database using SPSS to capture information collected through the clinical assessment tool. The counsellors were expected to use the database to synthesise and analyse the outreach and impact of the counselling service. This was deemed to be useful in identifying areas requiring improvement in clinical service provision.

Although these three aspects were outlined as separate components, in implementation these often emerged to be combined activities, enabling time efficient implementation. However, in this document, for convenience of discussion, they are presented as separate components.

1 Reviewing of existing client record information used by the counsellors and developing/revising a clinical assessment tool.

Preliminary discussions on the process of developing the clinical assessment tool happened in early 2014, with the MSEW and the technical advisors. As noted in Section 3, these helped to broadly determine the parameters of the tool. The actual process of developing the tool, however, happened in June 2014, with the participation of the core team and focal point representative counsellors of the MSEW, who met with the technical resource team and TAF at a workshop conducted in Colombo. Over 35 participants from the MSEW attended the workshop and included 10 counsellors of the core team and 25 counsellors from the districts, representing the larger cadre of over 200 counsellors linked to the MSEW. The latter were identified as the District Coordinators in this process.

This workshop aimed to identify the key issues that caused psychological distress to clients and for which they sought counselling services. The counsellors divided into 3 groups, and with each group focusing on selected districts, explored the main issues that were prevalent in different areas. By collating the outcomes of the group discussions,

the counsellors prioritised 15 key domains for which clients sought counselling services (Refer Box 3 for details). This discussion helped to understand the nature of clinical assessment that was needed and the areas in which the counsellors would need capacity building. This was planned to be facilitated through monthly meetings with the Clinical Psychologist. It was also decided that a guide book with instructions for counselling on the identified 15 domains would be compiled to support capacity building of the counsellors. Over the next few months, the core team and district coordinators, working with the Clinical Psychologist would finalise this publication.

Designing the assessment tool

The structure and the format of the clinical assessment tool were developed at a workshop conducted from 27 to 28 November, 2014. The workshop was led by the global technical advisor, with the support of the local technical advisor and the technical resource team. The core team and district coordinators participated in the workshop. A key task of the workshop was to review the existing monitoring mechanisms used by the counsellors. As one counsellor, participating in the interviews for this documentation explained, "We have always systematically monitored the counselling services, and we have used several types of formats over the years. These mainly tracked the number of clients we saw, although some forms we used also recorded the clinical aspects. Two main issues were that the monitoring forms kept changing and that monitoring mostly focused on quantitative data."

Reviewing of the existing monitoring formats helped determine two key expectations from the clinical assessment tool: One was to have a standardised monitoring format that could be used across different locations and over time. The second was to have a monitoring system that gave equal priority to recording quantitative and qualitative data, especially monitoring data that helped track therapeutic quality and changes in clients' emotional and behavioural status.

As discussed in Section 3, illustrating the Need, the counsellors who reviewed the existing monitoring mechanism also highlighted the need to differentiate between the clients with whom they speak once and the clients who are taken in for actual counselling. Due to the amount of time spent on screening people for counselling and determining which services they need, the counsellors were keen to have a monitoring tool that recorded this time input. Simultaneously, clients who were screened and accepted for counselling services had to be assessed clinically at the intake and thereafter at periodic intervals to monitor the progress. Participants also highlighted that, generally, counselling sessions of most clients could be terminated after three to four sessions, although some more complex cases did require more sessions. These pointed towards a monitoring format that includes data on screening as well as a monitoring mechanism that would help assess the clients' status at the intake and across two assessments after three to four sessions.

Based on the parameters established through these discussions, the international technical advisor suggested a framework for the clinical assessment and a draft assessment form. This was discussed in-depth by the core team of counsellors who participated in the workshop, where they raised their concerns and clarified issues after which the tool was modified and finalised for field testing.

The assessment tool, finalised for field testing, consisted of three components:

- Form A – Client Screening Form (CSF) – this enables counsellors to screen whether a person needs counselling or not, and make referrals where necessary.
- Form B – Client Intake Form (CIF) – this enables clinical assessment of the counselling process and helps determine the therapeutic impact of the process on the client. This form includes a problem rating scale which helps track the situation at intake and at periodic intervals during the counselling process.
- Form C – Follow up Assessment Form – (FAF) – this is a form developed to share a summary of the CIF. Data shared through this was to be used to maintain a database of assessment across an individual client's progress as well as identify characteristics of the clientele for overview of the counselling service. On review of its application, Form C was later incorporated into Form B where adaptation and distress rating scales are marked.

(Refer Section 6 for more information on the tool).

Reviewing the assessment tool

The initial review and clarifications, at the workshop, on the clinical assessment tool highlighted concerns counsellors had about the relevance of certain questions and how these could be asked with sensitivity. One of the key concerns raised by some counsellors who participated in the workshop was that demographic data for screening the client would be taken in the initial session when the counsellor has not yet had time to develop sufficient rapport with the client. These questions primarily aimed to access demographic information on the client, while assessing the socio economic status of clients. This information would be useful in intervention planning. Clarifications on these questions underlined the significance of developing descriptors for the questions so that counsellors could be guided on the purpose of asking the questions and how these could be asked sensitively.

Box 4: Asking sensitive questions during client screening

One of the questions that concerned the counsellors reviewing the assessment tool was the question, "On an average day, how many meals does a client eat?" The concerns counsellors had on this were two-fold. One was whether asking this would offend the client. The second was the perception that this question aimed to assess a client's emotional stress that affected his/her inclination to have regular meals. Clarifying the question, the global technical advisor explained that the question aimed to assess the severity of a client's financial difficulties, whether this affected the client's survival. It did not refer to clients who were able to afford sufficient number of meals but chose to eat less. It was suggested that response to this question be probed through general discussion around a client's daily life, functioning and financial situation.

Another concern the counsellors raised, and which is seen to recur as an issue in data entry is the question on the highest level of education a client has achieved. The demographic data related to education has questions on clients' educational participation indicated by the number of years the client has attended school, as well as the highest level of educational achievement. The distinction between the two questions required clarification. The Descriptors for Assessment Tool (2015) explains that the purpose of differentiating between the number of years spent in schooling and the highest level of academic achievement, is to identify

a). information relevant to employment and vocational training,

b). provide appropriate information during psycho-education.

Approximately six months after the clinical assessment tool was developed and introduced into practice, its application was reviewed at a workshop held on 26 - 27 May 2015, at Hotel Janaki, Colombo. This was also an opportunity to present the tool and its initial outcomes to officials such as the Secretary and Additional Secretary of the Ministry and the Director of the Counselling Division of the MSEW as well as the Country Representative of TAF. The technical resource team, including the international Technical Advisor and core counsellors and district coordinators attended the workshop. The field based counsellors responded to queries on the application of the tool, its positive aspects and issues, and whether they wished to make any changes to the tool. The second day of the workshop provided space for more in-depth discussions on the application of the tool, developing competency in using it and clarifications on data recording and ensuring data consistency. Based on these discussions, the tool was further refined.

Reviewing of the clinical assessment tool and developing the counsellors' capacity to use it is an on-going process. Several training of trainer (TOT) workshops conducted with the district coordinators to develop their technical skills in using the tool and to train other counsellors in using it also provided opportunities for further discussion on

ground level application of the tool and how this impacts on intervention planning and the counselling process (Refer section 6 for more information on the assessment tool).

2 Develop training of trainer (TOT) programmes to train counsellors of the MSEW to use the clinical assessment tool

Over a period of approximately two years, TAF together with the technical resource team and the MSEW conducted four TOT programmes for the district coordinators to develop their capacity to provide technical support to other MSEW counsellors. This included a refresher programme after the introduction of the tool and meetings to review the application of the tool. The district coordinators in turn conducted training programmes for the other counsellors working at divisional and district levels. Over a period of three years, from 2014 to 2016, all the counselling assistants got an opportunity to be trained on the tools, the cumulative total of participants who went through these training programmes was 386. Spreading out training in this manner, through TOTs and roll out programmes at district level, enabled space for over 200 counsellors in the cadre to at least access capacity building training to the assessment tool.

This technical support was facilitated in addition to on-going support to develop district coordinators' counselling skills through monthly meetings with the Clinical Psychologist and weekly technical support, by the M & E Consultant, to the core team at the MSEW to use SPSS for data management.

The first refresher workshop, since the introduction of the clinical assessment tool, conducted for the district coordinators was held in the first quarter of 2015. The workshop was conducted by the local Technical Advisor, together with the Senior Programme Manager of TAF, M & E Consultant and with M & E staff of the FRC. The latter's role in the workshop was as a pioneer organisation that had participated in the development of a CIF in a previous collaboration with TAF. Using role play and group work, the participants were engaged in discussions on the application of the tool, competency in using it and skills and capacity development to enhance its effective use. The case scenarios explored during the workshop were also used to illustrate and practice intervention planning, entering data in the assessment forms, sharing and storing data.

Box 5: The place the assessment tool should have in the counselling process

A significant message that was reiterated during the workshop was the primary importance of the quality of counselling. The workshop highlighted that "Using the tool does not replace the counselling process, the importance of note taking and [maintaining] confidentiality"

(Extracts of Quarterly Reports, TAF)

The second TOT programme was conducted from 8 to 9 June, 2015 and was facilitated by the international Technical Advisor and the Clinical Psychologist. The TOT further

reviewed the application of the tool and provided a forum for district coordinators to clarify issues. One of the issues that was further explored was the distinction between the problem the clients present and the problem identified by the counsellor. It was clarified that the actual problem for which the client needs support may not be the presenting problem. The problem identified by the counsellor and verified with the client, forms the basis for the treatment goal and the therapeutic intervention.

Box 6: Link between assessment and intervention plan

Question – What is an intervention plan? How is it different to an assessment?
Answer - Counselling is a continuous process. Assessment is the very first part of counselling. If counselling is done well within the assessment process then the client should be benefited even by just doing the assessment. Asking good questions, caring, listening well, should all be part of the assessment. We use all the information we have, from the intake form (assessment), from our notes and also just by being with the client to develop an intervention plan that will guide the counselling.

Extract from Report on Technical Consultancy, Jon Hubbard, 25 May – 12 June
This is an extract from the summary of proceedings of the TOT

The TOT also outlined the format the district coordinators can use in the roll out programmes they conduct for the other field based counsellors of the MSEW. The group, through discussion and guidance by the technical resource team, decided on a roll out programme plan that included sessions on introduction and purpose; introduction to CSF, introduction to CIF, and data entry and data sharing.

The third TOT conducted in the first quarter of 2016, focused on developing competency to use the CSF and CIF and share data with the Counselling Division of the MSEW for data entry. A refresher programme on SPSS was conducted highlighting the need to maintain data consistency, efficiency in data entry, data recall and use of data for analysis of outreach and impacts. The fourth TOT was conducted in May 2016 to support district coordinators plan for the roll out programme on the assessment tools. The district coordinators trained through these TOTs, in turn, conducted roll out programmes for the other field based counsellors. A consistently highlighted focus of the roll out programmes was the primacy that should be given to the quality of the counselling process and using the assessment tool as an integral part of counselling. A second aspect that was underlined at all TOTs was the significance of ensuring consistency in data that is sent through the CSF and CIF to ensure efficiency in data entry and accuracy of data analysis.

3 Develop a database using SPSS to capture information collected through the clinical assessment tool and identifying outreach, impacts and areas of clinical service provision that need improvements

Use of the clinical assessment tool essentially requires skills to use SPSS software for data entry and data analysis. Developing the capacity of senior counsellors of the MSEW to use SPSS started in October 2014. The core team of counsellors and selected counsellors from the districts were introduced to SPSS software at a workshop conducted on 21 October 2014. The workshop served two purposes. One was to familiarise the counsellors with the software and help them understand how this could be used to track data generated from counselling processes. The second was for the M & E consultant and TAF project team to identify key persons at the MSEW who had the capacity and interest to work with the software and manage the data recording process.

The process of data entry:

The monitoring data recorded in the clinical assessment form is sent to the Counselling Division through a follow up assessment as recorded in the problem rating scale of the CIF. The data is sent after each periodic assessment. The core team members at the Ministry have been allocated districts, and they receive the follow up assessment data of their districts from district coordinators who are also senior counsellors in the cadre. Counsellors located at each DS division send their follow up data to their district coordinators, who are required to review the follow up assessments for data consistency and send these to the core team at the Counselling Division, to enter into the database. This process underlines that core team members and district coordinators, as well as counsellors at DS level need to be familiar with the SPSS software. Without such understanding the field based counsellors would not prioritise the need to ensure data accuracy and consistency, the absence of which would delay data entry and hinder the process.

Based on the needs identified at the workshop conducted in October 2014, TAF team and the M & E consultant decided that, once the assessment tool was introduced, it would be useful to provide regular support to the core team of counsellors at the Ministry to enter the monitoring data and manage the database. This process started from February 2015, with the M & E consultant spending four hours every week with the core team at the Counselling Division, helping them to sort and clean the data to ensure consistency of the data, provide technical support to use the software to enter data and maintain a data base. Apart from weekly technical support sessions, capacity building on using SPSS was also developed through training of trainer workshops conducted for district coordinators. This was followed by supporting the district coordinators to conduct roll out programmes for counsellors at divisional levels, to familiarise them with the SPSS software. These were also combined with technical support sessions to effectively use the clinical assessment tool.

Working with the database:

The M & E consultant identified recurring problems in data entry. These have lessened in frequency over time but indicate a need for district coordinators and counsellors to be alert to data mismatch, especially inconsistencies in dates, and ensure accuracy of demographic data. Some issues also pointed to the need for counsellors to better understand the purpose and nature of information sought by questions included in the assessment tool. Some of the recurrent issues in data entry included the following:

- Incomplete assessment forms – for example not entering some data such as age of client;
- Mismatch of data – for example dates that do not match;
- Negligence – typing mistakes;
- Inadequate understanding of the purpose of asking some questions which caused errors in data entry and analysis – for example questions related to identifying the socio-economic status and assessing severity of poverty/adversity. Three questions have repeatedly generated inconsistent data. These are questions related to number of meals a client is able to have in a typical day; highest level of education; and whether the client lives alone (refer Box 4 for details).

However, the biggest issue that affects the smooth operation of the process and efficiency in using the database for periodic data analysis at national and district levels is the slow pace of data entry. As the core team of counsellors explain, typically each core team member would receive about 400 to 450 assessment forms with follow up data to enter, although this may vary slightly, based on the location. They point out that apart from their duties as core team members contributing to counselling services they are also required to work on other psychosocial initiatives, as directed by the Ministry or other state institutions. This affects their ability to work regularly for several hours on data entry, creating a backlog of follow up data to be entered.

The issue has been discussed with the senior management of the Counselling Division and at TAF, pointing to the need to explore options to hire data entry operators, or develop capacity of district coordinators to takeover data entry. The latter, however, would require greater resource allocation by the Ministry to provide the necessary facilities such as computers for district coordinators to manage databases. Another option that is explored, is to allocate one or two hours daily for data entry rather than postpone it until a full day, undisturbed by other work commitments, is available to perform the task. Although data entry requires keen concentration, the M & E Consultant points out that with training and focusing on the task at hand, the efficiency of data entry can be improved. This is one aspect that is regularly highlighted at training programmes and during on-going capacity building support.

6 Support Mechanisms that Strengthened the Process

Using the clinical assessment tool effectively is reliant on the capacity of the counsellors, having personal integrity to use the tool accurately and as a tool that contributes to learning and self development as a counsellor. TAF recognised this requirement at the planning stages of the process. The need was verified by the MSEW and underlined the importance of developing the counselling skills of the counsellors in parallel to the process of developing the tool. The mapping study, commissioned by TAF in 2013 had also highlighted the need for capacity building as well as the need for clinical supervision for counsellors.

When formulating the process of capacity building, TAF built in these components as affiliated support. Counsellors had access to technical support to develop their knowledge and skills on counselling through the monthly meetings organised with the Clinical Psychologist. The book on Instructions to Counselling Assistants, which provided guidelines for counselling on 15 key domains identified by the MSEW counsellors, was another useful step. The third component was developing technical capacity to use the SPSS software by meeting with the M & E Consultant once a week. On reflection, the technical resource team feels that the opportunities facilitated by the monthly meetings with the clinical psychologist and the weekly sessions with the M & E consultant were not fully utilised by the core team and the district coordinators. Often their participation in these pre-planned technical support sessions were hindered by requirements to attend other programmes or the prioritisation of other work and in some cases the lack of inclination to familiarise themselves with the newly introduced assessment tool and learn the computer software to record the data. However, some counsellors consistently made use of these opportunities and the progress they have made in developing their technical capacity signifies the value of having these affiliated support mechanisms.

A third component that supported the process was to introduce the mechanism of peer supervision for counsellors. This aimed to address the recommendation made by the study on mapping counselling services. Looking for viable and cost effective options that also meet the need, TAF and the MSEW identified peer supervision as the best option to inculcate the practice of accessing clinical supervision by counsellors. As a senior counsellor of the core team highlighted, this has gained ground among most counsellors who bring complex cases they handle for the weekly discussion they have with peer counsellors of the District.

7 The Clinical Assessment Tool

The clinical assessment tool, as discussed in Sections 3 and 5, has three sections i.e. CSF and CIF forms and the problem rating scale in which follow up data is entered for assessment across the counselling process. The tool is introduced as a mode of assessment that needs to be incorporated into the counselling process so as to ensure

the quality of counselling. The guide book, Descriptors for Clinical Assessment Tool (2015)[2], underlines this premise, and emphasises the need to maintain confidentiality when recording and sharing data. To enable this, the assessment form uses a 13 digit client code that facilitates tracking of outreach by province, district and DS division, while also not divulging identification information about the client.

The Client Screening Form – CSF

The Descriptors for Assessment Tool describes the purpose of the CSF as following: "The use of the Client Screening Form (CSF) is to capture work conducted with **all** the clients who access the counselling services of the Counselling Assistants[3]." It is primarily a tool used for screening clients to determine whether they need counselling or whether they should be referred to other services. The CSF has two sections:

Section A - key demographic data.

Section B - summary of the session.

Among the demographic data gathered are client's age; religion and ethnicity; economic status as assessed by the client using four choices; severity of financial difficulties, if any, using a proxy indicator based on the number of meals the client has on an average day; client's education covering level of participation in school education and highest level of academic achievement; clients employment including whether employment matches client's skills and competencies; and information on the client's living arrangements. These demographic data provide insights into the client's issues or factors that could aggravate his/her issues. Thereby, this information provides pointers to determine the treatment plan, if a client is taken in for counselling. Section B of the CSF has space to record the presenting problem briefly, which is followed by a checklist on actions taken such as referrals, single session counselling or whether the client is accepted into a counselling process requiring more than one session. If the client is accepted for counselling, the Client Intake Form is used as an assessment tool.

The Client Intake Form (CIF)

The book, Descriptors on Assessment Tool (2015) states the purpose of CIF as a mechanism to guide the counselling assistants[4] in the counselling process. Its uses are outlined as follows:

1. Provide a guide to clinical intervention i.e. counselling;

2 Ministry of Social Empowerment and Welfare (MSEW), 2015, Descriptors for Assessment Tools: For Counselling Assistants attached to the Ministry of Social Empowerment and Welfare, The Asia Foundation (TAF) and MSEW, unpublished document

3 Counselling Assistants – the counsellors of the MSEW and the MCDWA are known by two designations, counselling officers and counselling assistants, although their work is the same. To avoid misinterpretation regarding status of designation, this document uses the common term Counsellors, which covers both cadres i.e. counselling officers and counselling assistants.

4 As above

2. Provide understanding on the training needs of the counselling assistants;
3. Direct monitoring and supervision;
4. Develop programme evaluations by providing quantifiable assessment data on the clinical intervention.

As with CSF, the form is identified through a client code that is used in the CSF. This is used as a continuation of the CSF, and draws on the demographic data covered in the CSF. The CIF consists of four sections. These are:

Section C – Summary of Client Interview,

Section D – Physical Health of Client,

Section E – Emotional Problems,

Section F – Behavioural Functioning.

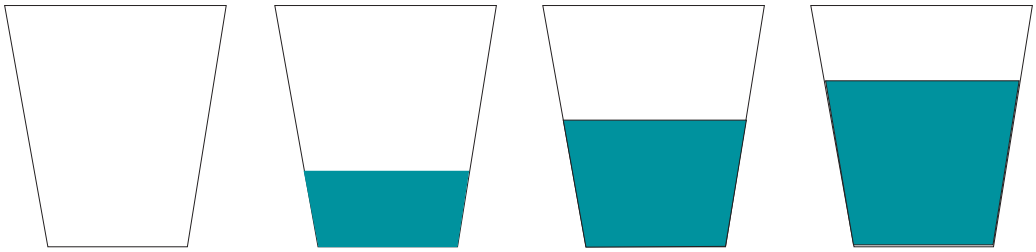
Of these, Sections E and F form the problem rating scale which is the section that is sent to the Ministry for data entry.

Section C is the main section that captures the client's presenting problem, additional challenges or problems faced by the client, personal strengths and resources of the client, family structure and relationships, other social support and community resources, any challenges to the counselling process and initiatives taken by the client in response to the problems. This gives an insight into the client's current situation as well as history of the problem and resources including personal strengths, family and social support available to the client. Probing on barriers and challenges to the counselling process aims to understand any restrictions such as travel and transport difficulties, financial problems, work or family commitments that could hinder the client's access to counselling. Among other factors that could pose challenges to counselling are beliefs, stigma, mental or physical illnesses or unsupportive family members who may restrict the client's access to counselling services.

Section D of the CIF aims to determine whether the client is physically well and has the capacity to come for counselling sessions and engage in the sessions. Descriptors on Assessment Tool (2015) underlines the significance of probing on a client's dependency on alcohol or drugs, which may hinder the counselling process.

Sections E and F provide insight into the client's emotional and behavioural problems. These are assessed using a set of questions related to daily living and functioning. Sample questions on Emotional problems include whether the client is feeling sad, hopeless, anxious, has problems sleeping, has nightmares, feels like ending life, becomes irritable and has difficulty concentrating. Section F, on behavioural problems, has six questions probing difficulties in doing daily activities such as inability to do housework due to emotional problems; difficulty in engaging in income generation activities due to emotional problems; or difficulty in visiting friends or relatives due to emotional

problems. In both sections the frequency of occurrence of these conditions is marked using a rating scale that has four responses ranging from 'Not At All' to [happening] 'Often'. The Descriptors encourage use of a visual image of an empty to near full glass to help the client assess the level to which he or she is disturbed by the condition.



The ratings of these two sections helps to quantify the status of the client at the intake and any progress made at periodic intervals. Discussions during TOT programmes on application of the CIF have highlighted the significance of the problem rating scale in determining the severity of the problem and helping to determine the treatment goal and treatment planning. According to counsellors of the core team at the Ministry, most clients are able to complete the counselling process within three to four sessions. In such cases, the progress is calculated by rating the difference in the scale between the intake and the second assessment. When a counselling process continues beyond this, a third assessment is taken after a further three sessions or at the time of termination. As the counsellors of the core team point out, it is rare for a counselling process of a client to go beyond six or seven sessions. Therefore, typically the clinical assessment is done twice, or at the most, thrice.

8 Impact of the Clinical Assessment Tool on the Counselling Process and on the Counselling Sector

Discussions with the core team of counsellors have highlighted the practical benefit of using the tool. They appreciate that using the tool brings clearer direction to the counselling process; that it brings a system that counsellors with less experience find helpful; that the emphasis on the treatment plan brings greater clarity and focus to the counselling process. As a senior counsellor of the core team pointed out, "The quality of counselling depends on the capacity and experience of the counsellor. If I am not experienced and capable, I may think that talking and listening is what counselling is about. Having the clinical assessment form directs us to focus on different dimensions of the problem. When we see where the problem is, it is easier to work on a treatment plan. The capacity building programmes and peer support programmes that are affiliated components of this process encourage us to work with treatment goals and treatment plans…… Overall this improves our skills in counselling, although working with the SPSS and entering data has been somewhat challenging."

Apart from directly impacting on the counselling process of each client, the assessment tool has also benefited the counsellors of the MSEW in other ways. Foremost among such positive impacts, is the professionalism it has brought to their service. A counsellor of the core team commented, "We are called on to do different types of work. But this helps us to firmly define our role as counsellors. Although we still have to do other work outside counselling, our role as counsellors is now better recognised because this tool has given it a standard."

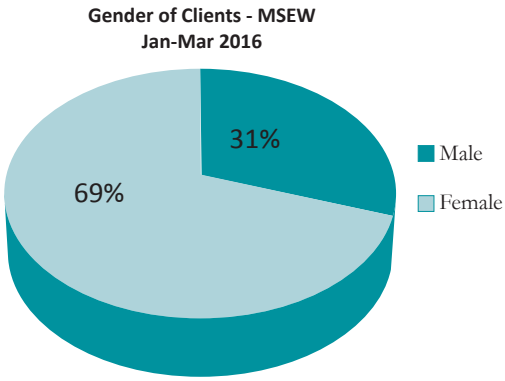
The core team feels that the ability to provide quantifiable data of their service has raised the profile of the Counselling Division within the Ministry. "People who are not aware of counselling don't know what this service is. Therefore when we are able to show that our counsellors see so many clients or that the condition of our clients has improved through our service, it brings recognition to the work we do" was a comment a senior counsellor made.

Challenges

Nevertheless, the application of the clinical assessment tool is not without challenges. The foremost challenge is the delay in entering the assessment data into the database. As the M & E Consultant points out, the evidence of the tool's usefulness can be proven by analysing the data periodically. Delays in data entry hinder this and thereby undermine the benefits the Counselling Division of the Ministry can gain from introducing the tool. As discussed earlier in the document, several options are being discussed to expedite data entry and analysis.

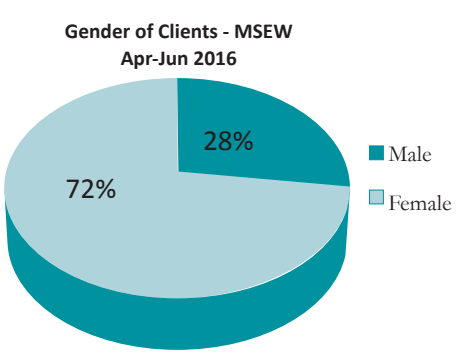
A second challenge, although seen only in a few instances is the reluctance of some counsellors to familiarise themselves with the clinical assessment tool. This is manifested through some counsellors' continued practice of using former monitoring formats. It also manifests as continued negligence in filling the CSF and CIF. However, TAF and the technical resource team view this as a temporary problem that is likely to occur when a new system is introduced into an existing service mechanism.

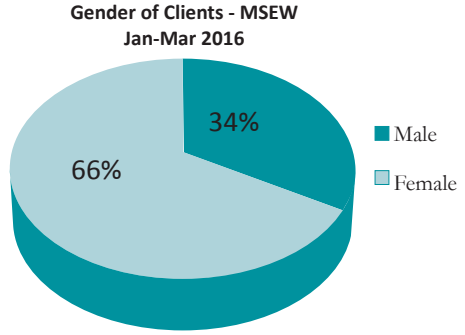
Impact on assessing the progress of counselling services



Given the demographic data captured in the CSF and the insights into the nature of problems and effects of daily living and functioning as denoted by the CIF, the clinical assessment tool has the potential to provide useful overviews on the nature of psychosocial issues that affect different segments of the population. For example, when data entry is up to date, overview at national, provincial or district/DS levels

can trace which problems are prevalent in which areas, which age groups or gender are more affected by which type of problems. This will enable national and provincial resource allocation for mental health and psychosocial services to be directed more specifically and support programmes to be designed more precisely to promote wellbeing of people. However, due to inadequate data from all DS divisions, such analysis is yet to be produced. An indication of this potential is visible in the analysis of recorded data to understand the gendered pattern of accessing counselling services from the MSEW counsellors. The charts illustrate gender disaggregated client participation over the first three quarters of 2016.





Positive impacts on the counselling sector are also likely to be extended to facilitating localised standards for clinical assessment tools. As the Clinical Psychologist points out, discussions around the process of developing the clinical assessment tool has generated some amount of interest in the MHPSS sector to better understand the process and use it as a guide to develop similar tools. Promoting the adoption of relevant and easy to use clinical assessment tools that also enable quantifiable evidence of the nature of counselling services has the potential to increase the overall quality of counselling services in the country. This is all the more relevant when one considers the scattered nature of counselling service provision and the absence of quality assurance mechanisms that are applicable across the country.

Sustainability

Sustainability of the clinical assessment tool as a mechanism used regularly in the counselling services of the MSEW will depend on several factors. Primarily it depends on the effective use of the tool and sharing of SPSS generated data analysis with significant practitioner and policy audiences. Using the tool consistently will ensure quality of the counselling service that will justify the investment made towards developing the tool and the MSEWs commitment to allocate necessary financial and human resources to enable its continued use. A crucial component is ensuring availability of infrastructure and equipment. For example, technically advanced computers to operate the SPSS software, and safe storage at DS levels for counsellors to store the physical copies of the

assessment forms. The latter has become a significant issue for field-based counsellors who have limited access to lockable storage at DS offices. A highly necessary resource that would promote sustainability of using the tool is the allocation of sufficient human resources, both as field based counsellors and for data entry. Supportive infrastructure, human resources and financial backing are often enabled through favourable policy decisions. This points out the need for the counsellors of the MSEW to work more concertedly to expedite the process of data entry, leading to wider sharing of evidence based information on the impact of counselling on communities. This has the potential to enhance recognition of the MSEW's counselling services as a professional intervention and a meaningful service.

Appendix 1 – Client Screening Form

MINISTRY OF SOCIAL EMPOWERMENT AND WELFARE
Counselling Division
Client Screening Form

Client Code: _____

First session location: ..... First session date: DD / MM / YYYY

Counsellor's Name: .....

A. Client's Demographic Information

1. **Sex of Client:** Female ○ ○ Male
2. **Client's age: .....** years

   2a: Client's date of birth (if known): ..... (DD/MM/YYYY)
3. **Client's permanent residence:** Province: ..... District: .....

   Div. Sec: ..... GN. Div (optional): .....
4. **Client's religion:**

   ○ Buddhist ○ Christian/RC ○ Hindu ○ Islam ○ Other.....
5. **Client's Ethnicity**

   ○ Sinhalese ○ Tamil ○ Muslim ○ Burgher ○ Other .....
6. **Client's civil status:**

   ○ Single ○ Widow

   ○ Married ○ Separated

   ○ Divorced ○ Other .....
7. **Client's current economic status:**

   7a: Does the client have enough money for basic necessities?

   ○ Never ○ Rarely ○ Frequently ○ Always

   7b: On an average day, how many meals does the client eat?

   ○ Less than one ○ One meal ○ Two meals ○ Three meals

8. Client's education:

8a: Does the client currently attend school?

○ Yes ○ No

8b: *If yes to 8a*, what grade of school is the client currently in? ……..

8c: *If no to 8a*, did the client attend school in the past?

○ Yes ○ No

8d: *If yes to 8c,* How many years of school has the client attended? …….. years

8e: *If yes to 8c,* Client's highest level of educational achievement

○ Up to grade 5 ○ A/L passed

○ Grades 6 -11 ○ Undergraduate (completed)

○ O/L passed ○ Post graduate (completed)

○ Other ……

9. Client's employment:

9a: Is the client currently working?

○ Yes ○ No

9b: *If yes to 9a*, list the current job: .....

9c: *If no to 9b*, any reasons given: .....

9d: What is/was the client's *primary* occupation / profession *in line with the client's skills or competencies*? ……

10. Is the client currently living alone?

○ Yes, with a house ○ No, with a house

○ Yes, without a house ○ No, without a house

10a. *If not living alone*, who is the client currently living with? (*Check all that apply*)

○ Mother ○ Father

○ Siblings ○ Children

○ Friends ○ Other relatives Specify: ……..

○ Husband/wife ○ Other(s): ……..

11. Who advised the client to come for services? (*Check all that apply*)

○ Own decision ○ Community /Religious Organisations ○ Family /relative

○ Health ○ Legal ○ Police

○ Field Officer ○ Education ○ Other:……

12. Did the client come alone today?

○ Yes ○ No

12a. *If no*, who did the client come with? .....

B. Session Summary

13. Client's presenting problem or concern:

14. Client Referred To (*check all that apply*):

- ○ Medical
- ○ Psychiatric
- ○ Economic/Financial
- ○ Legal
- ○ Clinical Psychology
- ○ Vocational
- ○ Child Services
- ○ Rehabilitation Center
- ○ Counselling
- ○ Other: .....

15. Actions (*check all that apply*):

- ○ Made referrals
- ○ Provided information
- ○ Provided Psycho-education
- ○ Single session counselling
- ○ Intake for counselling
- ○ Other……

16. Any other comments:

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Appendix 2 – Client Intake Form

MINISTRY OF SOCIAL EMPOWERMENT AND WELFARE
Counselling Division
Client Intake Form

Client Code: _____

Session location: Date: DD / MM / YYYY

Counsellor's Name: ……

C. Client Interview Summary

1. Client's presenting problem or concern:

2. Additional problems or challenges:

3. Personal history:

4. Personal strengths and resources:

5. Family structure and relationships:

6. Other social support / community resources:

7. Challenges and barriers for counselling:

8. Actions or initiatives made by client in response to problems:

D. Physical Health

9. How would the client rate his/her overall health?

○ Very Poor ○ Poor ○ Fair ○ Good ○ Very Good

10a. Does the client have any medical or health problems that cause ongoing discomfort, interferes with their daily functioning, or would impact counselling?

○ Yes ○ No

10b. *If yes*, what is (are) the problem(s)?

11. Has the client ever had a problem with drugs or alcohol in the past?

○ Yes ○ No

12. Does the client currently have a problem with alcohol?

○ Never ○ Rarely ○ Frequently ○ Always

13. Does the client currently have a problem with drugs?

○ Never ○ Rarely ○ Frequently ○ Always

Problem Rating Scale

Client Code: _____	Tick as appropriate		Date (DD/MM/YYYY)
	Intake		
	Follow up		

E. Emotional Problems

Emotional Problems	*Not at all*	*Rarely*	*Sometimes*	*Often*
1. Feeling sad?				
2. Feeling hopeless?				
3. Thought of ending your life?				
4. Feeling anxious?				
5. Feeling fearful?				
6. Problems sleeping?				
7. Nightmares?				
8. Feelings of guilt?				
9. Becoming angry or irritable?				
10. Difficulty concentrating?				

F. Behavioural Functioning Problems

Behavioural Functioning Problems	*Not at all*	*Rarely*	*Sometimes*	*Often*
1. Difficulty doing domestic work because of your emotional problems?				
2. Difficulty leaving / being in the house because of your emotional problems?				
3. Difficulty engaging in income generation activities because of your emotional problems?				
4. Difficulty engaging in religious or spiritual activities because of your emotional problems?				
5. Difficulty doing things for pleasure of fun because of your emotional problems?				
6. Difficulty visiting friends or relatives because of your emotional problems?				

Notes

Notes


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