Guidelines for home visits
Appendix F[1]

Malose Langa
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Background

The Trauma and Transition Programme (TTP), one of the programmes at the Centre for Study of Violence and Reconciliation (CSVR), initiated a community project[2] in 2008 aimed at providing services to torture victims. The community work included awareness-raising and capacity-building workshops with relevant stakeholders, and home visits to victims of torture. The home visits took place in townships in Mogale City (a township) to the west of Johannesburg was chosen as a site for the community project because CVSR had been doing Peace Building work with ex-combatants in this community.

Like many other townships, the youth in this community were at the forefront of the struggle against apartheid. They took part in para-military activities and joined military groups such as Umkhonto we Sizwe (MK), Azanian People's Liberation Army (APLA) and Azanian Liberation Army (AZANLA). Many were arrested, tortured and some killed, primarily by apartheid state security forces. Post 1994, many ex-combatants in Mogale City feel marginalised and betrayed by the ANC-led government as they are unable to secure jobs and they live in poverty. Some still struggle with the psychosocial effects of torture. For the past six years, CSVR has worked with ex-combatants to help them deal with the effects of the torture and abuse they suffered under apartheid.

In the past, home visits were conducted as part of a clinical intervention, not as a stand-alone project. The clinical assistant visited clients who received counselling at the TTP Trauma clinic which is based in the inner city suburb of Braamfontein. The purpose of these home visits was to gain further information about the clients, or to follow up if they had not come to counselling.

As part of the TTP community project initiated in 2008 in Mogale City, home visits were undertaken as a stand-alone intervention. Fourth year social work students, a community facilitator, and a qualified psychology counsellor attached to TTP[3] visited ex combatants in Mogale City, resident in the areas of Kagiso and Munsievelle.

Evaluation of the Home Visits Programme

This report discusses the lessons, challenges and ethical dilemmas encountered in conducting home visits. The report covers work that that was done over the two year period from 2008 to 2009. During this period 52

[1] This paper also serves as an appendix to an unpublished *internal* CSVR paper called "Finding our way: developing a community work model for addressing torture. Version 1, 2011". In 2012, a condensed version of the paper which incorporated the appendices was made available with the same title on the CSVR and Dignity websites (by Bantjes, M, Langa, M & Jensen, S)..

[2] The project is funded by Rehabilitation and Research Centre for Torture Victims in Denmark.

[3] These guidelines are based on the work of Pravilla Naicker and Modiege Merafe.

clients were visited at home. In total 305 visits were conducted. Thirty six clients were visited once, while sixteen were visited more frequently on a regular basis, in some cases once a week or twice per month. The frequency of home visits was dependent on the nature of the presenting problem as some clients needed more emotional support and containment than others. Clients who needed more emotional support presented with severe symptoms of major depression and post traumatic stress disorder (PTSD). Ninety five percent of the clients visited were ex-combatants, a large proportion of whom had been tortured under apartheid.

The report is based on interviews conducted with two community facilitators, a review of their process notes, reflections obtained during clinical supervision and on interviews with clients. Eight clients[4] who had been visited were interviewed. They were asked how they felt about being visited in their homes and about the impact of these visits on their functioning.

When this project started there were no formal guidelines for doing home visits. During the process of doing the work important lessons have been identified out of which a set of guidelines for doing home visits have been developed. The following section of the report discusses the benefits of doing home visits as these were articulated in the interviews. Section four and five discuss ethical issues and challenges that were encountered. The final section outlines guidelines for doing home visits.

Benefits of home visits

The following benefits of home visits[5]were identified.

Minimizing isolation

Some of the clients were physically impaired and as a result, had limited contact with people outside of their homes. The home visit provided these clients with an opportunity to talk about their experience of torture, life in exile, and minimise their sense of isolation. One ex-combatant who was wheel chair bound and thus had been isolated for a long time put it this way,

> "I really feel like a human being that you guys make time to come and visit me. I really appreciate your support. I felt understood by you".

Another client said,

> "When you come to visit me I feel so happy. You know I spend so much time alone, but when you are here I don't feel lonely. I feel supported comrade".

Giving voice to the voiceless

There were people amongst those visited who said they had never been given a chance to tell their story. Home visits offered them this opportunity. The quotes below illustrate the healing power of talking about trauma and its effects.

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[4] We were not able to do follow-up evaluation interviews with all clients that we visited due to financial constraints.

[5] Pravilla Naicker wrote these points as benefits of home visits.

"It was good to talk about things that have happened. I really found (it) useful to talk about things that have happened to me."

"I had so many things bottled up in me, but talking to Pravilla (one of the community facilitators) helped me realise the importance of talking about one's problems."

"When I talk about things that have happened I feel I'm healing."

Developing understanding

In modern societies social bonds are becoming weaker (Brems, 2001). The distressed and the excluded, who have no family or friends to turn to for help or emotional support need someone who will not only listen to them, but who can help them to understand what has happened to them. Out of this process they can begin to think about and formulate solutions and identify available resources. In some cases home visits were used for this purpose.

One client said,

"We felt like you were parents to us. We wish it was possible to continue visiting us. It was really healing to talk to you".

Increased sense of self -worth

A well-documented effect of torture is that survivors are unheard (Reeler, 2009). They feel that there is nobody out there who cares about them which negatively affects self esteem. By showing that there are people who take their concerns and needs seriously, their sense of self-worth is re-established. This was one of the major benefits reported by clients as illustrated in the quotes below.

"Yeah, you see you feel so special that these people (referring to community facilitators) travel all the way to come and see you".

"You feel so important they make time to come and see you".

There were some clients who expressed the wish that the community facilitators were local social workers who could be available 24 hours, because they treated them with respect and dignity.

"I felt so special that you guys will always come to my house and ask me, how are you? How have you been feeling? I wish our social workers here were like you".

Safety

Torture destroys people's sense of safety. In contrast to unfamiliar environments such as clinics or hospitals, people feel safer to talk about their private and painful problems in their homes. Clients confirmed this. They pointed out that being visited in their homes made it easier to connect with and trust the community facilitators. Many argued that opening up and trusting would not have been easy if they were seeing community facilitators in formal settings such as clinics or hospitals, which they described as "pathetic" in terms of service delivery.

One client shared her experience of seeing a social worker at the local Child Welfare Offices who failed to keep confidentiality. The social worker told other people in the community about her problems. She felt betrayed and humiliated by this experience. She went on to say that she felt more at ease talking to the community facilitators because they showed a genuine interest in assisting her as well as her younger sister's children, to the extent that her sister's children were emotional when their relationship with the community facilitators came to an end.

She said,

> "It was painful when Pravilla and Modiegi said goodbye to us. It was a big loss. We were used to talking to them about our problems. For example, W (her sister's child) was suicidal, but Pravilla managed to talk to him and now he is fine, although he still needs some support".

There was evidence in the interviews that many clients had a established positive working relationship with the community facilitators and it was not easy for them to deal with termination. The ethical challenge this raises is discussed later in this report.

Getting an insider perspective

Kadushin (1990, p. 107) argues that "home visits give the worker the opportunity to supplement what people say, by seeing what they do. Home visits also simplify the need to ask some questions for information. The unasked questions are answered by observation". Home visits gave community facilitators an opportunity to see the conditions under which clients live. One community facilitator said this in a supervision meeting:

> "It was an eye-opening experience for me to go and visit people in their homes. I learned so much in this process to observe and be aware of the conditions under which our clients live. I remember going to this house in which this woman lived with her children. The conditions of the house were very bad. This family was really living in abject poverty. They had nothing. I was touched emotionally to see their living conditions. I couldn't believe my eyes that 16 years after democracy people still live under these conditions."

It is reasonable to argue that such living conditions exacerbate the psychological distress victims of torture experience, delay recovery and break down any sense of agency, making it even more difficult to access available resources.

Ethical dilemmas in doing home visits

Staff involved in this project encountered a range of ethical dilemmas. Existing codes of ethics were by and large developed for psychologists and social workers who work within a clinical paradigm in clinics, hospitals and private practices. These ethical codes are important, but don't cover alternative situations such as doing home visits which pose unique ethical dilemmas. These are discussed below.

Lack of Privacy

The home setting is not always conducive to intervention due to the fact that many people share the same house making it difficult to meet the ethics of privacy and confidentiality. Some of the clients that were

visited live in one room shacks with the result that there is no available space to hold a private discussion. Community facilitators had to find creative ways of dealing with this ethical dilemma. For example, some clients were seen in cars to allow for a private discussion to be held. In the example below, community facilitators reflect on the ethical dilemmas posed by lack of privacy and the ways is which they dealt with this.

CASE 1

Majority of the meetings that we have with clients in the community take place in a client's living room with many other people being present. In cases where the client is immobile due to a physical injury or other health related reason, there is almost always a caretaker who is present. It is important in these instances to establish a good rapport with the care-givers as they are the "gatekeepers" to the client. In this way they can grant you access to the client without any hesitations as you have already established a rapport with them. One is forced to constantly think of innovative and novel ways in which to gain maximum benefit out of the session.

CASE 2

We had to visit a particular client who lives in a four roomed home. There was always someone present in the home whenever we went. We realised early on in the meetings with the client that there was very little privacy, as the other members of the household always sat with us. My colleague and I thought about how best we could handle this situation. Eventually we reached consensus that the only way that we could get any privacy with the client was if we held the meeting in the car. We spoke to the client about our decision. She agreed very readily. Later she admitted that she too felt very uncomfortable in the house and was glad to speak in a more private setting, even if it meant sitting in the car.

Premature Termination

As a result of financial constraints and a change in strategy TTP terminated sessions with all the clients in the community. Termination with clients who were still in crisis was a major ethical dilemma. For example, one client mentioned it was not easy to accept the termination. She said, "We have accepted the loss, but we miss you especially when we have problems because you were our shoulders to lean on. We were always looking forward to your visit". Although the participant asserts that they have accepted the termination it is clear that the termination was premature as they were not yet ready deal with their problems without support.

Dependence

The converse of early termination is the danger of creating dependency. By seeing clients indefinitely or for extended periods dependence rather than agency or empowerment may result.

Practical challenges in doing home visits

Lack of services

The limited, or indeed the lack of services, to which clients can be referred constitutes a significant challenge. There are very few places that deal with torture and cruel or inhumane and degrading treatment in the

country. So, at a community level, people who are not mobile and therefore cannot travel to available services are left with nothing.

Poor services

Some clients complained that they were not satisfied with the quality of the service that they got at the place to which they were referred. For example, as mentioned earlier, one client complained about a social worker who broke confidentiality following our referral. Other clients mentioned the places to which they had been referred take too long to address their queries and needs. One client gave an example in which it took two to three months before her case was dealt with. Furthermore, the client was not happy with the way in the case was dealt. It was difficult for the community facilitators to liaise with service agents about the quality of their services. This challenge put the community facilitators in an awkward position.

Fluid client population

Some of our clients, due to financial problems or lack of resources, moved homes several times and changed phone numbers, so it became difficult to keep track and make follow-up appointments with them.

Language barriers

The problems that arise when the community facilitator did not speak the same language as the client are illustrated by the case below.

CASE 3

Being an Indian female from Kwa-Zulu Natal, I have only ever been exposed to isi-Zulu and very rarely to any of the other indigenous languages. On the first day that I went to visit a client, I was amazed at how quickly one can get "lost in translation". I was accompanied by my colleague whose home language is Tswana, the same as that of the client. When we arrived the introductions were done and before long we were seated in the comfortable living area of the client's home. As we started talking, the client started finding it very difficult to communicate with me in English, and switched to Tswana every so often. As this was the first real exposure to the language, I had to constantly turn to my colleague to interpret for me. Soon I realised that this can become a cumbersome exercise, as my colleague would constantly have to stop the client midway, to explain to me in English what has been said. At times, I would ask him to let the client speak and we would discuss what has been said on the drive home, so as not to continuously disrupt the client. However, when the conversation is being carried out, it is very easy for the mind to slip away from the current situation, as you no longer feel part of the discussion. One has to deal with feelings of being sidelined due to the lack of understanding of the other's language. This can sometimes prove to be a deterrent and one can very easily lose interest in the conversation.

Safety

Townships are known to have high rates of crime. As a result, home visits raise issues of safety especially for a person who has never been to a particular community and can obviously be identified as an outsider in terms of race or class.

Direct versus indirect survivors

Where resources, both human and time, are limited it is difficult to deal with the needs and expectations of both direct and indirect victims of violence.

CASE 4

> *In this other case, we were seeing the father who was an ex-combatant for emotional support, but it emerged in our interactions with the family that his two daughters were also experiencing various emotional difficulties due to their father's long history of trauma. So we had no choice but to also see them for emotional support and containment. Balancing the needs of the father and his daughters was not an easy process because there were so many family dynamics that needed our attention.*

Unfamiliar environments

For community facilitators not familiar with the area in which they were working it was difficult to locate the homes of clients because many of the houses did not have numbers. As a result, facilitators spent a lot of time trying to find the homes of clients. For example, on two occasions facilitators spent almost two weeks trying find the houses of two clients.

Scope of intervention

It is inevitable when doing community based work that facilitators will be exposed to problems that are beyond the scope of their intervention but nevertheless demand attention. Conflicts within and between families are a common example. The family dynamics implicit in case 4, could result in conflict. Community facilitators reported on another case in which family members were fighting over a house. Without the requisite knowledge and skills it is difficult for facilitators to intervene in an effective way and yet these issues impact on their work. In the latter case TTP referred the family for pro-bono legal assistance.

Burnout

The risk of burn–out amongst community facilitators is very high. This work involves a lot of travelling in unfamiliar environments. Listening to trauma stories, and seeing the poverty-stricken conditions under which people live, can and does evoke sad and angry feelings amongst the community facilitators. Lack of skills can be an additional source of stress for community facilitators because they feel helpless. This is illustrated in the above paragraph in which community facilitators felt unable to deal with family conflict. Supervision can be used to process these feelings and thereby provide support.

Lack of clarity on number of sessions

As noted above when this project started there were no guidelines for doing home visits. The lack of clarity on the number of sessions allocated for each client, resulted in some clients being seen for extended periods raising once again the issue of creating dependence rather than facilitating empowerment.

Lack of clear goals for our home visits

Similarly, community facilitators felt stressed by the fact that they didn't have a clear purpose or goal for doing home visits.

Guidelines for home visits

It is interesting to note that except for limited references in Social Work books and journal articles little has been written about home visits. In most cases, this literature refers to home visits done by Social Workers or Social Welfare officials as an adjunct to other services, rather than as an intervention in and of itself. Given this gap in the literature, TTP has relied on the field work experience and the lessons learned to develop guidelines for home visits.

TTP's four session home visit model

Reflecting on the ethical dilemmas and challenges encountered while conducting home visits has generated clarity of thinking on the purpose of the home visits, the number of sessions and guidelines on how to conduct these visits.

The purpose of home visits will be to assess clients' needs and refer them to relevant resources as it is not possible for community facilitators to address all the needs of clients. The **main goal of doing home visits is to provide basic emotional support, containment, and to connect people with relevant resources in their respective communities**, even though there is awareness that quality of services may not be adequate and in some communities may not be available.

The number of sessions for home visits will be limited to four. This is a response to two factors. Firstly, there are limited resources for doing this work. Secondly, limiting the number of sessions avoids the problem of creating dependency amongst clients as reported above.

Home visits should be provided weekly, although this may vary from one case to another. In some cases home visits may be conducted bi-weekly or once a month. In some cases, once off home visits may be sufficient. This will depend on the nature of the presenting problem. In addition the client's social support system will be taken into account in making the decision on the number sessions required within the limit of four sessions.

It is important that thorough preparation is done before each visit. Community facilitators should ask themselves the following questions before doing a home visit:

- Is it really necessary to visit this client?
- What is the purpose of my visit?
- What do I want to achieve with this visit?

Community facilitators must make appointments to establish a time that is convenient for the person or the family. They must take into account language barriers which may require making arrangements to work with interpreters.

Community facilitators must be professional in their interaction with clients - be on time for their appointments; dress appropriately, not too casual and not too formal which may be intimidating for people being visited.

As a general rule each session should last for 1-2 hours. Again this may vary from client to client depending on the nature of the presenting problem. Some sessions may be shorter or longer than this, but as a general rule sessions should be kept to below 3 or 4 hours. This will help to maintain boundaries and ensure that facilitators are on time for other appointments on the day.

There are four phases to the home visit intervention/prcoess – **the introduction, follow up, assessment of impact, and termination phases**. The sections below provide guidelines for how to conduct each phase of TTP's four session home visit model.

Session 1: Introductory phase

Introductions and ground rules

- Introduce yourself (who are you, CSVR and the work it does).
- Give a brief introduction about the purpose of the home visit.
- Check that client's expectations of the service are realistic. Your role must be clearly explained to avoid any unrealistic expectations.
- Assure the client that everything shared in your meetings will be treated as confidential.
- Explain that information collected may also be used for research purposes, but that privacy will be protected and maintained.
- Explain that participation is voluntary, not mandatory.
- Ask them to sign all the relevant consent forms giving us the permission to use their information for research purposes. However, be clear that our visits are not about research, but to provide emotional support and information about places that they can go to for assistance.
- Explain that your visits will be limited to four meetings.

Assessment, support and containment

- Facilitate story-telling, but make sure that people feel contained in the process of sharing their story.
- Try and avoid deep interpretations. Remember home visits are not therapy sessions, although we acknowledge the difficulty in separating the two processes.
- Use micro-counselling skills such as questioning, clarifying, listening and reflection to acknowledge their pain. Try and gather as much information as possible about the client without making her or him feel intruded upon in their home. Use your clinical or counselling skills to gauge and assess whether the client is comfortable sharing all the material. Allow your client to freely express emotions, for example anger at the police; frustrations about the criminal justice system and so forth.
- Assess the protective and risk factors. Is the person coping with his or her stressors?
- Suicide risk assessment may be necessary if you feel the person is severely depressed. Recommend hospitalisation if you feel the person is at risk of suicide or not coping at all.
- It is important that you have contact details of all referral resources in the community, for example clinics, hospitals, paramedics, police, Social Development offices and so forth.
- Substance dependence assessment may also be necessary if you suspect that the person is dependent on any substance. Your questioning around this should not make the client feel that his or her privacy is being invaded. Use this information to do some psycho-education about the relationship between trauma and substance abuse. You may refer a person to places such as SANCA, only if the person agrees to seek help.

- Use the session to assess whether follow-up session(s) will be necessary. Some families may only need one visit bi-weekly or once a month. Explain your assessment to them and the way forward.
- **Referral**
- Contact details of all relevant agencies may be given, but explain possible difficulties that they may encounter in accessing these agencies.
- Get permission from the client before making any referral.
- Explain the processes and steps that the person may need to follow in accessing some of the agencies.
- Use referral forms to refer your client. A template form should be used.
- Confidentiality should never be broken by passing on more information than is strictly necessary. A very brief description should be given to the referral agency about the nature of the presenting problem.
- Make sure that the client is comfortable with the information shared in the referral form.
- Use this phase to discuss a possible termination date and that you will only have three sessions following this first session. It is important, to explain at the outset that your visits will be limited to four.

Document and report

- A detailed assessment report should be written following your first visit. A template should be used.
- Try and summarise the most urgent issues that need to be attended to.
- Discuss all these key issues with your supervisor before your next visit as part of treatment planning.

Sessision 2: Follow-up phase

- Do a temperature check. How has the individual and or the family been since your last visit?
- Check whether they have managed to contact the agencies to which you referred them? Did they get any help? If not, what were the difficulties? Again use the time and space to contain their frustrations about lack of services in their community.
- Use the meetings to identify family strengths, needs, goals, and necessary resources to support.
- Use the session to do some psycho-education about torture and its effects.
- Use the session to brainstorm additional services and resources that could be accessed.
- Providing information may show the client the problem in a new perspective or may provide new possibilities.
- Help the client to identify and establish a link with relevant support systems.
- Help the client to plan short-term goals that may be achieved within a limited period of time.

Session 3: Impact Assessment Phase

- Follow-up session.
- Evaluate the impact of your home visits. How is the client progressing? Are the symptoms subsiding or getting any better? Monitoring and Evaluation instruments could be used to do this.
- It is important to also use this session to assess and monitor ongoing quality of the support that the person is receiving from referral agencies.
- Evaluate the effectiveness of agency's intervention.
- Provide ongoing information about other possible resources that could be accessed.
- Evaluate and decide on the way forward.
- Remind the client about the termination date.

Session 4: Termination Phase

- This is a very important phase. The ending time should have been agreed upon at the outset of your meetings. Use the two sessions in between to remind clients about the termination date. This will give clients ample opportunity to prepare themselves for termination.
- Preparation of termination at the beginning is very important.
- Termination should be negotiated very carefully to avoid any harm.
- For some clients, termination may evoke feelings of loss and abandonment.
- Help the client to reflect on and process some of these feelings and fears they might have about your working relationship coming to an end.
- Use the termination phase to consolidate goals that have been achieved.
- Arrangements should have been made with other local agencies to continue helping the client.
- A form evaluating the service can also be given to the client.
- Thank clients for having welcomed you into their home. Also thank them for their willingness to talk to you about difficult emotions and feelings.
- Provide them with your contact details for further update about their progress, but be clear about the limitations of the service you can offer.
- You may also do one or two post home visit contacts by telephone to get an update about progress following the termination.

Conclusion

The evidence presented in this report shows home visits are beneficial. In a country like South Africa where the majority of the population does not have access to mental health services, limited session home visits conducted by community facilitators may be a way of providing some people with psychosocial interventions. For torture victims many of whom are immobile and cannot access the very limited services dedicated to dealing with the impact of torture, home visits, as some have said, can be a life-line. However, it is clear from the ethical dilemmas and challenges that community facilitators encountered, that guidelines are needed. Clear guidelines are particularly important if this is to become an effective stand alone intervention, in working with individual victims of torture and cruel, inhumane or degrading treatment.

TTP envisages that the process notes kept by community facilitators will be used not only for supervision but also to provide data with which to assess the strengths and limitations of the TTP Home Visit Model in future.

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