The Center for Victims of Torture

Telehealth Evaluation Report

MENA Region

Evaluation and Research Department (E&R)

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Terminology Definitions

In order to support the reader in better understanding some of the content throughout this evaluation report, some key definitions are provided below.

Complex mental health needs: Complex mental health needs are defined as severe and multifaceted mental health difficulties that may require coordinated or specialist in-person support beyond tele-mental health. While *complex trauma* and *severe mental health symptoms* are commonly observed contributors, the defining feature is the interaction of symptom severity, functional impairment, trauma history, and social, psychological, or physical factors.

Complex trauma: "Complex psychological trauma is referred to as direct harm with or without neglect and abandonment brought about by caregivers or apparently responsible adults in developmentally vulnerable period of an individual… Exposure to complex trauma leads to significant impact and malfunction in various domains of human existence which can be listed as follows: (a) Attachment and relationships (b) physical health of body and brain (c) affect regulation (d) dissociation (e) behavioral regulation (f) thinking and learning (g) concept of self."[1]

Severe mental health symptoms: Severe mental health symptoms, often categorized under the term Serious Mental Illness (SMI), or severe disability mental health issues (SDMHI) are defined as diagnosable mental, behavioral, or emotional disorders (typically excluding developmental and substance use disorders) that result in serious functional impairment, substantially interfering with or limiting one or more major life activities.[2,3]

Specialized services at CVT can be defined as clinically intensive interventions that require advanced, discipline-specific training and trauma-informed/trauma-focused expertise to assess and address complex physical, functional, and psychological needs. Services are intended to deliver targeted treatment for persistent moderate or severe impairments within a structured clinical framework.

Non-specialized services at CVT can be defined as time-limited, supportive interventions designed to stabilize distress, provide psychoeducation, strengthen coping, and provide an entry point to care, rather than deliver intensive or specialized clinical treatment. They are not intended to provide in-depth clinical treatment or address complex trauma through intensive therapeutic modalities.

Counselor (Mental Health): Under the CVT telehealth intervention, a counselor refers to an individual who provides telemental health services to clients.

Therapist (Physiotherapy): Under the CVT telehealth intervention, a therapist refers to an individual who provides tele-physiotherapy services to clients.

Trauma-informed approach: "is a framework designed to acknowledge and address the impact of traumatic experiences on individuals' lives".[4] ***This approach focuses on how care is delivered.***

Trauma-focused approach: An intentional therapeutic approach that focuses on directly addressing trauma symptoms, trauma memories, or trauma-related patterns in the body or behavior.[5,6] **This approach focuses on what is being treated.**

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Acronyms

ADMSP	Association of Detainees and the Missing in Sednaya Prison
ARC	Adaptive Resilience for Civil Society Project (CVT program covering the MENA region)
CSOs	Civil Society Organizations
CVT	Center for Victims of Torture
GSF	Global Survivors Fund
HRDs	Human Rights Defenders
I&E	Inclusion and Exclusion Criteria
MHPSS	Mental Health and Psychosocial Support
PSFS	Patient Specific Functional Scale
PT	Physiotherapy
SGBV	Sexual and Gender-Based Violence
SOTI	The Survivors of Torture Initiative (CVT program in Syria)
SMI/SMH	Serious Mental Illness/Severe Mental Health
TMH	Tele-Mental Health
TPT	Tele-Physiotherapy
WOV	War or Organized Violence

Executive summary

This evaluation examined the Center for Victims of Torture's (CVT) telehealth services — telemental health (TMH) and tele-physiotherapy (TPT) — to assess effectiveness, implementation pathways (including inclusion/exclusion criteria, referral mechanisms), and readiness for scale within the MENA region and beyond.

The evaluation aimed to collect information to identify opportunities to strengthen quality, accessibility, equity, and scalability. TMH was assessed as a specific intervention – that uses a remote modality, while TPT was evaluated as the standard CVT physiotherapy approach, adapted from an in-person format for a remote modality.

A mixed-methods approach was used for this evaluation. Quantitative analyses examined pre- and post-assessment data on mental health symptoms (n=69) and physiotherapy functioning outcomes (n = 18 at 3-month follow-up; n = 15 at 6-month follow-up). Qualitative interviews were conducted with CVT staff (n=4) and a partner organization implementing the TPT model (n=2), the Association of Detainees and the Missing in Sednaya Prison (ADMSP). Client feedback was incorporated to contextualize engagement and service experience (n=10). A structured desk review of the literature on remote mental health and rehabilitation services was conducted to assess evidence-informed practices, particularly regarding appropriate client eligibility selection, target population, and intended outcomes.

Findings are positive, suggesting that the telehealth model, both TMH and TPT, is generally responsive to client needs, seems to produce meaningful improvements within a brief intervention framework, and offers an important access point for survivors and human rights defenders who may otherwise be unable to engage in care. However, these conclusions are tentative, given limitations associated with data quality and a lack of control comparison group. Future evaluations could consider a waitlist control, set up at the start of new services, to better establish causality and isolate outcomes attributable to TMH and TPT separately.

The report concludes with strategic recommendations in the following categories: inclusion/exclusion criteria, assessment tools and processes, intended outcomes and theory of change, and operational considerations. Recommendations result from data findings and are designed to strengthen TMH and TPT and better position both for scale-up and expansion within and/or beyond CVT.

This evaluation was led by Noor Saleem, Program Evaluator at CVT. Courtney Welton-Mitchell, Director of Evaluation and Research at CVT, was involved in all stages of the process. The resulting report is a product of the Evaluation and Research Department.

1. Introduction

1.1 CVT Background

The Center for Victims of Torture (CVT) is an international non-governmental organization founded in the United States in 1985. CVT works toward a future in which torture ceases to exist and victims have hope for a new life. CVT offers rehabilitation services to those who have been tortured, trains partners around the world who can prevent and treat torture, and advocates for human rights and an end to torture. CVT provides direct and indirect services, with offices in the United States, Ethiopia, Jordan, Kenya, Uganda and Iraq, and partner networks in many more countries. Learn more about CVT here: https://www.cvt.org/

1.2 Overview of the Project Landscape within which Telehealth is Situated

The "MENA telehealth model" is implemented in various contexts. A brief explanation of SOTI and ARC is provided below as these are two examples of programs implementing the model. While SOTI is the primary focus of this evaluation, important information has been gleaned from supplemental information that has been collected from ARC.

SOTI is one of CVT's largest projects in Syria, operating since 2016. The program fosters collaboration among Syrian civil society organizations (CSOs) to support justice-related efforts as well as to provide specialized and non-specialized mental health services to survivors in need. SOTI has progressed through three phases, with 2024 marking the launch of the third phase (SOTI 3.0). Building on the successes of earlier phases, SOTI 3.0 focuses on sustaining and expanding impact by refining effective approaches, enhancing adaptability, and strengthening sustainability. This phase also introduces new partnerships in resilience and rehabilitation activities, and aims to refine, manualize, and expand training for previously developed innovations such as telehealth (inclusive of tele-mental health and tele-physiotherapy) and the Trauma-Resilience Workshop (TRW).

During the various stages of the SOTI project, CVT worked closely with the Association of Detainees and the Missing in Sednaya Prison (ADMSP)—a survivor-led organization supporting former detainees, families of the missing, and survivors of detention—to document violations in Sednaya Prison and expand survivor engagement across the Syria region. Between 2022 and 2024, under the Global Survivors Fund (GSF) Interim Reparative Measures project, CVT provided technical assistance to ADMSP to support the delivery of mental health and psychosocial support (MHPSS) and physiotherapy services for survivors. As part of this collaboration, CVT staff delivered targeted training and ongoing clinical supervision to ADMSP therapists to strengthen their capacity to provide remote counseling, telemental health, and remote physiotherapy services, tele-physiotherapy.

The Adaptive Resilience for Civil Society Project in the Middle East and North Africa (ARC MENA) is another CVT project that supports at-risk activists in the MENA region to receive training in three domains: psychosocial safety, digital safety, and physical safety. ARC is currently providing ad-hoc support for incoming inquiries from activists/organizations in the MENA region. One of the many services ARC offers for activists is the telehealth service.

1.3 Overview of Interventions

Associated with the COVID-19 pandemic, the MENA region experienced a rapid expansion of telehealth services, driven by factors such as increased internet connectivity and widespread smartphone

adoption[7,8]. Telehealth models are typically considered well suited to those who may have limited access to in-person care (for various reasons). Despite this growth in telehealth, individuals living in fragile or low-resource settings continue to face significant barriers to accessing even remote care, particularly trauma-informed and trauma-focused services.

While mental health stigma (including low mental health literacy and social norms), is a factor that discourages people from engaging with mental health services (including tele-services), access challenges are also important to consider. For example, limited infrastructure, connectivity, devices, healthcare workforce shortages – including mental health providers, economic hardship, and privacy and technological skill barriers — all shape whether individuals can and will use telemental health in Syria. Despite such barriers (especially for some subgroups), telehealth services are generally well-received.

Evidence on the use and acceptability of telehealth suggests that tele-mental health services are generally perceived as acceptable across diverse contexts, particularly when logistical barriers limit face-to-face care[9]. In humanitarian settings, telephone-delivered psychological interventions have been found feasible and acceptable when displacement, insecurity, or infrastructure limitations restrict traditional service delivery[10]. Similarly, digital health interventions in fragile MENA states have been identified as promising strategies for improving access in conflict-affected and health system–constrained environments[11]. Telepsychiatry services were further expanded during the COVID-19 pandemic, with many countries adopting hotlines, phone-based support, and messaging technologies to sustain mental health care[12]. In northwest Syria, the World Health Organization (WHO) reported the implementation of mental health tele-sessions in partnership with the Union of Medical Care and Relief Organizations (UOSSM), documenting sustained remote consultations as a strategy to maintain continuity of care where in-person services are limited[13]. However, this documentation remains descriptive rather than evaluative, and rigorous program-specific outcome data from northwest Syria are limited.

Similarly, evidence on the use and acceptability of tele-physiotherapy and telerehabilitation indicates that remote rehabilitation services are generally feasible and can achieve clinical outcomes comparable to in-person care, particularly when logistical or health system barriers limit face-to-face rehabilitation. A rapid overview and a meta-analytic evidence of telerehabilitation in physical therapy found that, across multiple conditions, remote interventions “could be comparable with in-person rehabilitation or

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[7] Shamiyah, K. A., Whitebridge, S., Kumar, N., Aljenaee, K., Atkin, S. L., & Ali, K. F. (2023). The impact of COVID-19 on the prevalence and perception of telehealth use in the Middle East and North Africa region: survey study. JMIR formative research, 7(1), e34074.

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[9] Abuyadek, R. M., Hammouda, E. A., Elrewany, E., Elmalawany, D. H., Ashmawy, R., Zeina, S., ... & Ghazy, R. M. (2024). Acceptability of tele-mental health services among users: a systematic review and meta-analysis. BMC Public Health, 24(1), 1143.

[10] McEwen, F. S., El Khatib, H., Hadfield, K., Pluess, K., Chehade, N., Bosqui, T., ... & Pluess, M. (2024). Feasibility and acceptability of phone-delivered psychological therapy for refugee children and adolescents in a humanitarian setting. Conflict and health, 18(1), 7.

[11] El-Jardali, F., Bou-Karroum, L., Jabbour, M., Bou-Karroum, K., Aoun, A., Salameh, S., ... & Sinha, C. (2023). Digital health in fragile states in the Middle East and North Africa (MENA) region: a scoping review of the literature. PloS one, 18(4), e0285226.

[12] El Hayek, S., Nofal, M., Abdelrahman, D., Adra, A., Al Harthi, M., Al Shamli, S., AlNuaimi, N., Bensid, L., Cheaito, M. A., Emberish, A. M., Larnaout, A., Radwan, A., Slaih, M., Kobeissy, F., & Bizri, M. (2020). Telepsychiatry in the Arab World: A Viewpoint Before and During COVID-19. Neuropsychiatric disease and treatment, 16, 2805–2815. https://doi.org/10.2147/NDT.S277224

[13] World Health Organization. (2022, February 24). Following the success of mental health tele-sessions by WHO and UOSSM partnership, tele-medicine reaches northwest Syria. WHO Regional Office for the Eastern Mediterranean. https://www.emro.who.int/eha/news/following-the-success-of-mental-health-tele-sessions-by-who-and-uossm-partnership-tele-medicine-reaches-northwest-syria.html

better than no rehabilitation for various conditions" such as improving pain, function, and quality of life[14, 15]. Systematic reviews of real-time video telerehabilitation similarly report comparable or higher satisfaction, and similar or better attendance and adherence, relative to in-person physiotherapy[16], with telehealth-based physiotherapy assessments demonstrating acceptable validity and reliability for many musculoskeletal and neurological presentations[17]. Studies in rural LMIC contexts are limited, but some (e.g., Nepal) have found remote rehabilitation can achieve outcomes comparable to conventional care for conditions such as stroke, musculoskeletal disorders, and postural balance, and low-cost models are being tested for feasibility and effectiveness in underserved populations, although rigorous program-specific evaluations remain limited[18, 19].

History and evolution of telehealth within CVT. To promote equitable access to care, CVT, guided by its mission to support survivors of gross human rights violations, began offering telehealth services, starting with telemental health (see section 1.3.1), in 2021. Since that time, CVT has leveraged its expertise in trauma rehabilitation to adapt its in-person physiotherapy model for remote delivery (see section 1.3.2). In 2022, CVT partnered with Jordan University of Science and Technology and Global Brain Health Institute to co-design resources (i.e., educational videos and online exercises) for the remote delivery of CVT's in-person physiotherapy intervention. Over time, CVT's trained professionals have refined these clinical models and built the capacity of other CVT staff and partner organizations (including ADMSP) to expand and strengthen this service modality across the MENA region.

Telehealth has been an integral part of the SOTI project since 2021 and the ARC project since 2022. Both projects were funded by the U.S. government to expand accessible services to torture survivors and human rights advocates in the MENA region. Within these projects, telehealth encompasses two main services: tele-mental health (TMH) and tele-physiotherapy (TPT). While telehealth was introduced to ARC in 2022, it primarily focused on TMH until TPT was incorporated into the project in 2024. Both services are provided by therapists trained in these areas: mental health counselors for TMH, and physiotherapists for TPT to support survivors of torture and gross human rights violations—including former detainees and survivors of conflict-related sexual violence—as well as to support human rights defenders (HRDs).

1.3.1 Telemental Health (TMH) – *"SOTI TMH – Individual Psychosocial Support Sessions"*

TMH is an individual-level specific intervention (not just a modality for delivering standard services), that is considered to be *non-specialized* and of brief duration (3-5 sessions). The current TMH model is considered appropriate for some community members, those who meet eligibility criteria and for whom

[14] Seron, P., Oliveros, M. J., Gutierrez-Arias, R., Fuentes-Aspe, R., Torres-Castro, R. C., Merino-Osorio, C., ... & Sanchez, P. (2021). Effectiveness of telerehabilitation in physical therapy: a rapid overview. Physical therapy, 101(6), pzab053.

[15] Krzyzaniak, N., Cardona, M., Peiris, R., Michaleff, Z. A., Greenwood, H., Clark, J., ... & Glasziou, P. (2023). Telerehabilitation versus face-to-face rehabilitation in the management of musculoskeletal conditions: a systematic review and meta-analysis. Physical Therapy Reviews, 28(2), 71-87.

[16] Simmich, J., Ross, M. H., & Russell, T. (2024). Real-time video telerehabilitation shows comparable satisfaction and similar or better attendance and adherence compared with in-person physiotherapy: a systematic review. Journal of Physiotherapy, 70(3), 181-192.

[17] Zischke, C., Simas, V., Hing, W., Milne, N., Spittle, A., & Pope, R. (2021). The utility of physiotherapy assessments delivered by telehealth: A systematic review. Journal of global health, 11, 04072.

[18] Dhakal, A., & Chowdhury, M. S. (2026). Tele-rehabilitation in rural Nepal: a systematic review of effectiveness, barriers, and strategic directions for digital health equity. Frontiers in Digital Health, 7, 1681313.

[19] Gatica-Rojas, V., & Cartes-Velásquez, R. (2023). Telerehabilitation in low-resource settings to improve postural balance in older adults: a non-inferiority randomised controlled clinical trial protocol. International Journal of Environmental Research and Public Health, 20(18), 6726.

the outcomes and objectives are a fit with their needs/presenting concerns. THM is not however, considered appropriate for some community members, as noted in the exclusion criteria section.

Intervention overview: TMH, developed and implemented in 2021 under SOTI 1.0 is titled *"SOTI Telemental Health – Individual Psychosocial Support Sessions."* However, it is informally referred to as 'Tele-mental health' or 'TMH'. Its objectives, intervention-specific eligibility criteria, session structure, assessment forms, and intended outcomes have been utilized in both the SOTI program and the ARC MENA program, with key differences between SOTI and ARC related to subpopulations/ program-specific eligibility criteria:

1. *SOTI* primarily serves Syrian survivors of torture and other forms of trauma (including Syrian human rights defenders) residing inside Syria and in the diaspora.
2. *ARC* serves human rights defenders residing in and/or from the MENA region.

Intervention vs modality: TMH is conceptualized as a standalone intervention, with defined objectives, eligibility criteria, session structure, and intended outcomes. As indicated earlier in this section, TMH is not merely a remote modality for varied types of mental health intervention service delivery. It is a unique intervention that is delivered remotely rather than in-person.

Non-specialized service: TMH is considered a 'non-specialized' intervention by CVT. According to design:

1. The intervention prioritizes stabilization, psychoeducation, coping strategies, and self-care primarily, noting the brief duration of services (up to 5 sessions).

2. The intervention excludes in-depth trauma processing, as this type of work is assumed to carry higher clinical risk when delivered remotely than in person and is therefore not considered something that can be offered safely and effectively within the limited number of remote sessions.

3. The intervention involves 3–5 sessions. Such time-limited service may be seen by some as an entry point for clients seeking mental health support (who do not have previous experience). It is assumed that a comprehensive (also known as intensive and specialized MH service) treatment can't be provided in so few sessions.

Intended Outcomes/Objectives: Although a formal theory of change with intended outcomes does not exist, TMH sessions—through their combination of targeted problem-solving and foundational support—are designed to achieve the following identified outcomes based on document review and conversations with clinical staff:

1. Reduction in psychological distress and symptom severity (e.g., depression, anxiety, PTSD)
2. Reduction in client-rated problem severity (based on presenting problems identified during the process of developing the treatment plan)
3. Increased coping skills and self-efficacy to manage distress
4. Strengthened family and community relationships
5. Enhanced daily functioning

Referral pathway: The TMH service has been widely promoted across both projects (SOTI and ARC) and partner organizations through multiple outreach channels. Information about the service is shared during organizational trainings and through other services offered by CVT and partner organizations.

Outreach is typically conducted verbally by CVT TMH counselors and through the distribution of hard-copy flyers, as well as by sharing digital flyers via organizational Signal/WhatsApp groups. Referrals are accepted from these organizations, as well as from beneficiaries who self-refer or are otherwise identified as requiring the service. Referral to TMH serves as an entry point for clients who may later be referred to telephysiotherapy (TPT) if they are assessed as requiring this service.

Assessment criteria, process, and form: Once receiving a referral from partners and other organizations, counselors complete an initial assessment to determine the client's mental health needs, risk factors, and their suitability for TMH (eligibility). The clinician-created assessment, designed in 2020, draws from CVT tools, relevant tele-mental health literature, and includes contextual adaptations. It is designed to collect information on demographics, presenting concerns, current daily functioning, challenges faced, and strategies used to manage difficulties. Clinicians also assess symptom levels using clinician-created/adapted mental health items that map partially onto constructs such as anxiety, depression, and trauma-related distress or post-traumatic stress disorder (PTSD). Lastly, the assessment asks clients whether they have any current accessibility concerns related to seeking psychosocial support services, as well as their access to the internet and technology (See Annex 1 for TMH intake assessment form). The overall assessment was intentionally designed to be brief and not burdensome for beneficiaries, enabling completion within a single session and aligning with the nature of this brief intervention.

**Clients are followed up with once, one month after their final session and this data is used as a standalone and for comparison with the initial assessment.*

Eligibility: In addition to overall program eligibility as stated earlier for SOTI and ARC projects, a client is considered eligible for tele-mental health services if ***all*** of the following criteria are met:

1. *Impaired level of functioning*, which is determined by clinicians based on anyone with mild, moderate, or high mental health symptom scores on the "Symptom Scales" section G of the assessment form and/or presenting issues (C2), quality of relationships (E3), and a client's family member expressed concerns about their mental health (F7).
2. Psychological and physical stability sufficient to engage safely in tele-mental health services, as determined from questions C2, C3, F2, F3, F6, and F7 in the intake form, which inform clinical judgment (see the *Ineligibility* section for more details).
3. Lack of access to alternative appropriate local psychological support services, as determined from question F8 in the intake form, which informs subsequent clinical judgment on this criteria.
4. Access to a secure communication platform and a private, confidential space.
5. Willingness and ability to commit to the scheduled appointments (note, this is coordinated between the counselor and the client), which are up to 5 sessions (if needed), excluding the intake and follow-up assessment sessions.

Ineligibility: Clients are ***not*** considered eligible if they:

1. Lack access to confidential/private space or the required technology as determined from section H "Telemental health access" in the form;
2. Lack of access to appropriate medical or other support services in case of emergency, as determined from question F9;
3. Demonstrate low motivation for engagement with this type of service determined by clinical observation and judgment;

4. Present with “complex mental health needs” including complex trauma-related symptoms, informed not only by symptom severity, otherwise known as “severe disabling mental health issues (SDMHI), but also by the presence of “additional social, psychological, or physical challenges that fall beyond the scope of the service” as determined by responses on specific assessment sections. Below is a combination (e.g., comorbidities, co-occurring symptoms, multiple contextual challenges) of factors, drawn from questions in the current intake assessment form, that counselors use to help determine whether a client may have complex mental health needs, warranting exclusion from services:
    a. Symptom severity, indicated by a response of “Often” (4) across multiple items;
    b. Pose a ‘high risk’ of harm to self or others (e.g., suicide ideation, homicidal ideation, self-harm, suicide attempts, abuse, or extreme social isolation that significantly impairs the individual’s ability to meet basic daily needs or ensure personal safety). This is determined from questions E2-E5, F6-F7, & C13 and clinical judgment;
    Note: The formally written criteria indicate that “high risk” of harm to self or others is a standalone exclusion criterion; however, no definition is provided specifying what constitutes “high risk.” In separate discussions with the TMH clinical team about how eligibility is applied in practice, it became clear that risk is assessed in combination with other complex mental health factors rather than as an automatic exclusion. For that reason, it is included under this section #5.
    c. Needs related to neurological impairments, substance use, psychosis, thought or mood disorders, or similar (e.g., F6 & F7). Please note that this list is not exhaustive and may include other conditions where counselors may apply clinical judgment to determine eligibility;
    d. Significant physical conditions requiring in-person medical intervention, such as cardiovascular problems, seizure disorders, severe diabetes, etc. (e.g., F1 & F2). When a client is receiving medical treatment for such conditions, eligibility is determined based on how the condition and its management affect the client’s functioning and ability to safely and effectively engage in online sessions;

    Note: Once a client is deemed eligible, TMH counselors typically share relevant information about the client’s physical condition with the tele-physiotherapist early in the process to determine appropriateness for TPT services. However, determinations regarding exclusion due to complex trauma and/or complex mental health needs are generally made by TMH counselors without consultation with TPT therapists.

    e. Severe functional impairment, such as an inability to engage in work or primary relationships, unable to get out of bed or take care of basic hygiene due to severe mental health symptoms (e.g., qualitative open-ended questions C2-3);
    f. Current psychiatric medication requiring monitoring for severe mental health issues such as schizophrenia or bipolar disorder (e.g., F3). Medication management for mild depression or anxiety would typically not be included under this ineligibility criterion, as clients taking such medications would remain eligible for TMH service;
    g. Safety risks to self or others (e.g., E4);
    h. Extreme social isolation or lack of any supports to ensure basic needs are met (e.g., E3-5).

Note: There are currently no criteria that automatically classify clients an ineligibility criterion listed. The factors above are considered collectively and may include further follow-up inquiries during the initial intake session with the client beyond what is captured in the assessment form. Eligibility/ineligibility in these situations is determined on a case-by-case basis through clinical discussion between the counselor and the clinical supervisor.

5. Geographic location-related in/eligibility. In the past, those inside Syria were considered ineligible for THM due to internet-based and other security concerns and lack of referral mechanisms to CVT or to additional care, but that has recently changed. This eligibility criterion has evolved over time in response to contextual changes, including shifts in the security and organizational landscape in Syria following the fall of the regime. These criteria have been revised to allow for expanded eligibility, while ongoing challenges related internet access and client safety continue to be actively assessed by the clinical and program team.
6. When alternative in-person or virtual services are available, therapists assess whether those services are accessible and suitable for the client, considering factors such as cost, waiting lists, language, trust, and perceived safety. Clients may be deemed ineligible for TMH if another service are available and may be more appropriate to meet their needs, based on clinical judgment and further discussion with the client.

Session focus: The TMH intervention typically consists of 3–5 sessions focused on addressing a client's primary 1–2 presenting concerns, which are identified during the second session following the intake and consent session. While the initial intake assessment gathers general information about the client's history, needs, and presenting symptoms, the second session allows the client and counselor to prioritize two pressing problems and collaboratively set specific goals for targeted intervention. This is documented in the "treatment plan" form (See Annex 2). In addition to working toward these individualized goals, the sessions include:

1. Connecting clients to available resources
   - Primary outcomes linked:
     (1) Reduction in psychological distress and symptom severity
     (4) Strengthened family and community relationships
     (5) Enhanced daily functioning
2. Providing psychoeducation on the impact of trauma
   - Primary outcomes linked:
     (1) Reduction in psychological distress and symptom severity
     (3) Increased coping skills and self-efficacy
3. Supporting stress management and coping strategies tailored to clients' identified problems
   - Primary outcomes linked:
     (2) Reduction in client-rated problem severity
     (3) Increased coping skills and self-efficacy
     (5) Enhanced daily functioning

Follow-up: Clients are followed up once, one month after their final session (both initial and follow up assessment are administered by the same person providing the telehealth services). The follow-up assessment includes questions on symptomology (using the same measures as the intake assessment), reassesses the severity of the client's two identified priority problems, and examines the perceived impact of the TMH service on coping with life difficulties, relationships within the family or household,

and relationships within the community. The assessment also captures any ongoing psychosocial needs and client feedback on the service. These data are used both as a standalone follow-up assessment and for comparison with intake findings (See Annex 3).

Who can administer: TMH can be administered by individuals who are required to hold an advanced degree (Master's or equivalent) in clinical psychology, counseling, or a related discipline, with extensive experience delivering individual and group psychotherapy to survivors of torture and conflict-related trauma using culturally appropriate approaches. Relevant professional licensure or certification as a mental health clinician, psychologist or psychotherapist is preferred, as is experience delivering tele-mental health services. Additional experience includes providing training and supervision to MHPSS providers, working with human rights defenders, and collaborating with civil society organizations, particularly in the MENA region. Fluency in English and Arabic is required given these settings.

1.3.2 Tele-physiotherapy (TPT)

TPT is a trauma-focused individual-level physiotherapy (PT) using a remote modality. It is a guided self-help and goal-oriented approach that includes health education, therapeutic exercise and coping strategies to help manage pain, stress and emotional regulation. Although some elements are adjusted for the remote administration, it is not a separate intervention like TMH. TPT is a specialized service of brief duration that is considered appropriate for some community members who meet eligibility criteria and for whom the outcomes and objectives are a fit with their needs/presenting concerns. It is not considered appropriate for some community members, as noted in the exclusion criteria.

PT within CVT incorporates three types of practices, strategies, and techniques that TPT has adapted into its model. These include self-regulatory and body-based strategies for arousal regulation, such as planning coping responses, self-monitoring, pacing, breathing, progressive muscle relaxation, mindfulness, yoga based postures, use of body narratives and posture; practice of exercises to improve musculoskeletal resilience, such as aerobic exercise, balance training, muscle strengthening, joint range of motion exercise, muscle and myofascial stretching, graded functional activities, and postural education-biomechanics; and cognitive learning strategies to challenge and influence unhelpful beliefs and behaviors, such as health and trauma education, goal setting, reducing avoidance behaviors, enhancing safety learning, cognitive restructuring, problem solving, guided practice, reinforcement, enactive mastery experiences, graded exposure, consolidating gains, and behavioral activation.

These examples illustrate core components of sessions but do not represent an exhaustive list. Given the variability in client presentation and needs, additional PT practices may be incorporated as clinically indicated and may differ across in-person and remote modalities. For example, in-person manual therapy, such as massage or joint mobilizations, may require modification in a remote setting, with therapists identifying appropriate alternative strategies to achieve similar therapeutic goals.

Modality/intervention definition: TPT is implemented as a remote modality version of CVT's in-person individual physiotherapy intervention. Although earlier documentation describes TPT as being delivered through both individual and group-based models, implementation by CVT and ADMSP has evolved to focus on *individual-based TPT*.

Current TPT delivery is characterized by the following:

1. Individual-based sessions.
2. Session numbers can vary depending on the client's needs (but the typical duration is 5 sessions).
3. Focused on one or more specific PT-relevant presenting concerns identified by the client during assessment (chief complaints, such as chronic pain, persistent headache or migraine, numbness or tingling, etc.), guiding the therapist to prioritize certain assessment sections within the intake form, rather than completing all sections.
4. More targeted in scope than the in-person PT model. TPT relies on a purpose-driven assessment that requires early prioritization of the clinical question, resulting in a narrower, hypothesis-led approach. For example, rather than conducting a full shoulder screen, the therapist uses a *Look–Point–Move* format to identify key movement characteristics directly related to the client's pain when reaching overhead, as these findings directly inform exercise selection.

Specialized service: Unlike TMH, TPT is categorized as a *specialized service*, based on the following:

1. Successful delivery requires advanced training and familiarity with CVT trauma-focused TPT approaches. According to senior PT staff in-person experience at CVT is generally recommended to orient PTs to these approaches, particularly for assessing movement, identifying physical and functional limitations and comorbidities (e.g., balance disorders such as vertigo, or cognitive impairments such as dementia), and safely guiding exercises remotely. However, PTs who have prior experience working with the same population, are familiar with CVT's assessment and treatment models, and have telehealth experience may be able to deliver TPT safely without an in-person orientation. In other words, within TPT, the only PTs considered qualified to administer the service are those trained in CVT's approaches and experienced with the population served.
2. The core component of PT specialized intervention is not necessarily the manual therapy, but rather the clinical reasoning that therapists apply in considering the depth and presenting issues of clients' physical and functional symptoms (e.g., persistent back pain and difficulty bending forward), the psychological impact of those symptoms (e.g., feelings of helplessness, fear of movement, catastrophizing), and the severity of symptoms to assess and address PT-related functional impairment remotely.

Intended outcomes/objectives: The theory of change for individual and group in-person PT is similar to that of TPT and aims to achieve the following outcomes:

1. Improved overall mood
2. Improved sleep quality
3. Improved arousal regulation
4. Reduced pain and other body symptoms (sexual dysfunction, incontinence)
5. Improved ability to engage in daily activities
6. Improved physical functioning
7. Increase social participation
8. Increased coping and outlook

Referral: The referral process for TPT is dependent on the TMH counselor's observation of the client's symptoms as well as what the client reported in the physical health-related questions (e.g., F1 & F2). Referral process is initiated as follows:

1. Initial consultation between the counselor and supervisor to review the client's needs and decide if a referral is warranted. At this stage, the counselor might consult with the TPT therapist on the client's symptomology and needs.
2. Counselors complete the Patient Specific Functional Scale (PSFS) with the client prior to making a referral. PSFS is a document used to quantify activity limitations and measure functional outcomes. Within it, clients identify specific daily activities that are important to them and rate their ability to perform each activity on a scale from 0 (unable to perform the activity) to 10 (able to perform the activity at the same level as before the problem). For each client, single activity scores and an average score are recorded based on the change in scores between the initial and follow-up assessments. The results are considered as a referral criterion; clients whose PSFS scores show less than the minimum detectable change—that is, less than 2 points on the average score or less than 3 points on a single activity score—are referred for TPT. Individuals with higher scores remain eligible for TPT; however, they're placed on a waitlist until the team can accommodate them. In summary, the PSFS scores are primarily used to help prioritize cases when there is a high number of referrals, with clients who have lower scores being given higher priority.
3. TMH counselor and TPT therapist meet to discuss the client's case. A brief referral form is completed that captures information on the client's need for TPT, symptoms severity for anxiety, depression, PTSD, behavioral functioning, physical symptoms; whether they are receiving or have access to psychosocial support services; any concerns in participation in TPT service; and any barriers to participation, such as internet connectivity or availability of a confidential space for video calls.

   Note: TMH intake assessment form does not necessarily capture all of these symptoms (anxiety, depression, PTSD, behavioral functioning, physical symptoms in full). The symptom scale section of the intake form draws select items from validated measures (adapted) rather than using the full composite scales. As a result, the referral form provides an initial clinical impression of symptom severity, but the exact method or criteria used by the counselor to determine these ratings is not explicitly documented in the form.
4. After the referral form is completed, the counselor and TPT therapist may discuss the case again to identify appropriate interventions for the client's needs and coordinate the scheduling of the initial TPT intake assessment call.

*Clients who remain engaged in TMH sessions and could be suitable for TPT may receive both services concurrently. The counselor is expected to complete the PSFS form to determine functional outcomes prior to submitting a TPT referral form; however, in practice, this has varied, with some referrals submitted without a PSFS form.

Assessment criteria, process, form: Upon receiving a referral from a TMH counselor, PTs complete an assessment that screens for medical and physiological symptoms (e.g., circulatory, neurological, respiratory systems) to identify *red flags*—risk factors requiring urgent medical attention, such as cauda equina syndrome or unstable vital signs—and determine the need for external referrals. The assessment also considers yellow flags, which are physical symptoms assumed to be influenced by emotional or cognitive factors, such as fear of movement or catastrophizing pain. These *yellow flags* are assumed to be often associated with trauma and it is therefore believed that these can be addressed within a trauma-focused physiotherapy framework (e.g., targeting the following - catastrophizing, unhelpful

beliefs about pain, preservation, fear of movement, uncertainty about the future, and passive approach to rehabilitation).

Beyond screening for medical issues and identifying red and yellow flags, the assessment also evaluates the client's functional ability, body functions and physicality (related to pain, sleep, urination, sexual activity (if relevant), social participation, and self-efficacy and coping towards their health. Rather than focusing only on biomedical outcomes such as pain intensity or range of motion, TPT assessments also examine biopsychosocial outcomes. For example, in addition to measuring changes in physical pain, the assessment may explore how pain affects daily functioning, the onset of pain, confidence in movement, emotional wellbeing, and the client's ability to participate in work, family, or community activities. The final section of the intake form focuses on establishing short-term SMART goals to guide the treatment plan (See Annex 4 for TPT intake assessment form).

Within CVT, therapists may complete partial assessments, prioritizing specific sections based on the client's chief complaints and needs. ADMSP, as a partner organization trained by CVT to deliver TPT to its clients, typically completes full assessment forms.

**Clients are followed-up at 3 months, 6 months, and 12 months post-intervention to measure comparison with the initial assessment, similar to the in-person intervention (*See Annex 5 for the in-person follow-up assessment form that is utilized for TPT).

Eligibility: While most TPT clients are referred from TMH and have already undergone TMH inclusion/exclusion screening (see TMH Eligibility section), TPT has its own formally established eligibility criteria. In general, clients who cannot access in-person PT or rehabilitation services—due to geographic, safety, mobility, or infrastructure constraints—are considered particularly suitable for TPT.

As stated earlier, TMH typically serves as the primary entry point to telehealth services. As a result, many clients receive at least one TMH session prior to initiating TPT. This sequencing has often supported treatment planning by promoting psychological stabilization and readiness to engage in TPT. However, service delivery is flexible and context-dependent. In some settings, ADMSP has provided in-person counseling alongside remote TPT, or in-person PT alongside remote TMH, depending on client needs and available resources.

TPT accepts clients with all levels of mild, moderate, and severe physical functioning and/or somatic symptoms as determined from the assessment form and clinical judgement; however, in cases where there is a high number of referrals, the TPT team focuses on clients with more severe functioning symptoms (based on scores identified in the PSFS form), while others are placed on a waitlist. Options for these waitlisted clients include referral to another organization or provision of relevant PT client resources.

Similar to TMH, TPT also expanded its services to accept clients from within Syria following the fall of the regime.

Reminder: TPT clients go through the TMH screening for eligibility process first. As a result, some clients that may have been accepted for TPT are likely screened out during the TMH eligibility determination process.

Ineligibility: exclusions apply to the following scenarios:

1. Red flags or comorbidities requiring in-person care, such as cardiovascular disease, neurological movement disorders, cognitive impairment, diabetic complications, fall risk;
    - This is determined from the medical checklist in the first section of the intake form.
    - Early identification also protects the therapist by ensuring that clients do not begin treatment before they are ready or when the service may not be suitable for their needs.
2. Clients without reliable access to technology, unable to afford the costs of data necessary for audio and visual calls – particularly for the initial assessment (see #5 Note in this *Ineligibility* section)– and lack access to a confidential/private space with enough room for evaluative tasks;

    Note(a): Although clients have already responded to questions about technology access and private space in the TMH assessment form, TPT therapists reconfirm this information and check for any changes since the client last received services from a TMH counselor.
3. If the client's care would remain the same or be negatively impacted by tele-physiotherapy: This criterion primarily reflects clinical reasoning: tele-physiotherapy is excluded if it cannot safely inform assessment, treatment planning, or clinical decisions—such as when hands-on evaluation is required to assess joint stability, neurological change, or wound integrity. However, in CVT's remote contexts, TPT may still provide value by maintaining engagement and continuity of care, even if some hands-on assessments are limited, provided that client safety is not compromised.
4. Clients who pose risks to themselves or others (e.g., suicide ideation, homicide, self-harm, suicide attempts, or abuse), as the service is not equipped to provide intensive crisis management. This is determined by clinical observation and client self-report during the intake assessment in addition to recommendations from the MH assessment;

    Note: this criterion mirrors TMH ineligibility criteria; clients meeting this criterion are excluded during the TMH assessment process and therefore are not referred to TPT services.
5. TPT is also not appropriate if the therapist determines that the client's condition cannot be adequately assessed (e.g., if the client lacks a camera for initial assessment) or supported remotely to ensure a safe, private, and effective care plan.

    Note: If the client chooses to continue their treatment sessions via audio only, without turning on their camera, the therapist can accommodate this, but only if the client has already completed a full assessment with their camera on. Note that in this situation with audio only, clinical reasoning and interpretation of the client's condition and progress would still require specialized expertise. However, the absence of visual input during treatment sessions may limit the PT's ability to fully assess performance and provide tailored guidance on continued progress. As such, these sessions may involve a combination of specialized and non-specialized approaches.
6. Predominant need for a hands-on technique as part of a goal that cannot be accomplished by therapeutic exercise or other means.

*Clients may present with multiple physical and mental health conditions, including complex trauma, and TPT may yield benefits beyond clients' presenting concern(s). For example, while a client may initially focus on one or two primary issues, the treatment, including education and guided exercises, may increase awareness of other psychological and bodily symptoms that could also benefit from the intervention. However, TPT excludes individuals with severe mental health needs or psychiatric conditions, given the limitations of remote delivery in not effectively meeting clients' needs. See the Complex Trauma and Severe Mental Health Symptoms definitions in the Terminology definitions page.

*Although prior consultation with a medical professional is not an exclusion criterion, therapists may occasionally have limited access to relevant medical history if clients do not disclose prior care. Without provider notes or the ability to liaise with medical professionals, therapists may have incomplete information about conditions flagged in the medical screener of the assessment, requiring a more cautious clinical approach.

Session focus: In alignment with the intended in-person individual PT outcomes and trauma-focused principles, TPT follows a phased approach adapted from trauma recovery framework by Judith Herman[20]. These 3 phases include:

1. Safety and stabilization: Focuses on helping clients move from vulnerability to a sense of emotional and physiological control by regulating trauma responses. Physiotherapists support this by creating a safe therapeutic environment, teaching arousal regulation techniques, providing psychoeducation on trauma, and helping clients connect thoughts, emotions, and bodily sensations;
2. Process of integration: Once safety is established, clients begin to address the impact of trauma by understanding its holistic effects on their functioning. The focus then shifts to working toward identified goals and using physical strategies to strengthen the mind–body connection and restore balance across body systems;
3. Reconnection to self and others: clients begin to look toward the future and reconnect with themselves and their communities by consolidating goals and activity plans. The focus is on maintaining a healthy mind–body connection and fostering meaning and purpose after trauma.

Physiotherapists within CVT use different techniques that can be broadly grouped into three categories: arousal regulation techniques, cognitive behavioral techniques, and physical resilience.

Who can administer: TPT uses the CVT approach administered by persons with a degree in physiotherapy, training in CVT trauma-focused physiotherapy approaches, and experience with CVT's in-person assessments and treatments when available. Structured supervision is provided to ensure service quality, particularly when staff have varying levels of experience.

Note: *This evaluation primarily examines TPT as a modality of the in-person physiotherapy intervention, focusing on how effectively the intervention translates to a telehealth context.*

1.3.3 TMH and TPT

Specialized vs. non-specialized services:

- Across both TMH and TPT, specialization is determined by CVT based on:
    - ❖ Provider training, education/certificate and clinical expertise
    - ❖ Depth and intensity of treatment, including clients' presenting physical, functional, and psychosocial needs and the level of clinical judgment required to address them remotely.

Trauma-informed vs Trauma-Focused Practice

[20] Herman, J. L. (1992). *Trauma and recovery*. Basic Books/Hachette Book Group.

TMH and TPT differ in their level of engagement with trauma. TMH is implemented as a trauma-informed intervention, emphasizing safe, supportive, and responsive care that acknowledges the impact of trauma on clients' mental and psychosocial well-being. It does not directly target trauma processes. In contrast, TPT is a trauma-focused intervention, in which physiotherapists actively assess and address the biopsychosocial effects of trauma on physical functioning within their scope of practice.

Neither intervention is designed for in-depth verbal trauma processing. TMH focuses on psychosocial and mental health symptoms, while TPT targets trauma-related impacts on the body, including pain, movement, and functional limitations. Although TPT incorporates psychological dimensions such as body awareness and regulation, it does not provide psychological treatment; TMH remains the primary intervention for focused mental health support within telehealth service.

Clinical Judgment – State of the Literature

Clinical judgment plays a central role in both TMH and TPT at CVT, shaping decisions about client eligibility, treatment planning, and care adaptation. The purpose of this section is to contextualize how clinical judgment functions within CVT's telehealth model—not to critique clinicians.

While structured protocols and standardized tools guide practice, much of the care relies on clinicians' professional expertise, experience, and ability to integrate client-reported trauma history, cultural context, and therapeutic relationships to determine the most appropriate course of action. This allows clinicians to respond flexibly to complex or nuanced situations, considering observable behaviors, client-reported concerns, and contextual factors that may not be fully captured by the current standardized protocols.

While this approach applies across different clinical care contexts within and outside of CVT, studies indicate that clinical judgment can be subject to variability and cognitive biases, such as confirmation bias or anchoring, even among experienced providers[21, 22, 23]. Therefore, research suggests that it can benefit from additional structure and feedback[24]. Studies further suggest that combining clinical expertise with structured decision-making tools—such as diagnostic checklists, standardized assessments, or treatment algorithms—can improve accuracy and consistency, particularly in complex or high-risk cases[24, 25]. These findings highlight the value of reflective practice, supervision, and supportive systems that enhance judgment without replacing the clinician's expertise.

The evaluation findings in this report reflect the reality that decision-making is shaped by training, experience, and the constraints of remote delivery. Strengthening supportive tools and processes outlined in the findings section (see section 2) can help ensure that clinical judgment remains both flexible and well-supported across TMH and TPT services.

[21] Garb, H. N. (2021). Race bias and gender bias in the diagnosis of psychological disorders. Clinical psychology review, 90, 102087.

[22] Van Der Heijden, P. T., Cefo, I., Witteman, C. L., & Grootens, K. P. (2022). On the use of positive test strategies when diagnosing mental disorders. Comprehensive Psychiatry, 116, 152325.

[23] Yager, J., Kay, J., & Kelsay, K. (2021). Clinicians' cognitive and affective biases and the practice of psychotherapy. American Journal of Psychotherapy, 74(3), 119-126.

[24] Cwik, J. C., Papen, F., Lemke, J. E., & Margraf, J. (2016). An investigation of diagnostic accuracy and confidence associated with diagnostic checklists as well as gender biases in relation to mental disorders. Frontiers in Psychology, 7, 1813.

[25] Lilienfeld, S. O., Ritschel, L. A., Lynn, S. J., Cautin, R. L., & Latzman, R. D. (2014). Why ineffective psychotherapies appear to work: A taxonomy of causes of spurious therapeutic effectiveness. Perspectives on Psychological Science, 9(4), 355-387.

1.4 Evaluation Goals

This evaluation was designed to examine the implementation and outcomes of CVT's telehealth services, including TMH and TPT, with the overarching purpose of generating learning to inform service refinement and future scale-up. Specifically, the evaluation sought to assess the extent to which the current telehealth model is achieving its intended objectives, understand the experiences of clients and providers, and examine whether existing assessment tools, assumptions, and protocols are aligned with intervention goals and current evidence, including from the broader literature.

The evaluation pursued five interrelated aims:

1. **Aim1:** To assess the efficacy of telehealth for clients who have received TMH, TPT, or both.
    a. *TMH:* This includes changes in mental health symptoms and self-rated severity of clients' primary and secondary problems.
    b. *TPT:* includes changes in functional ability, body functions and physicality (e.g., pain, sleep, urination, and sexual activity where relevant), social participation, and self-efficacy and coping related to health.
2. **Aim2**: To examine how the telehealth model is being experienced from the perspective of service providers and clients.
    a. Client experiences: Gather qualitative and quantitative feedback from clients on service utilization, accessibility, perceived impact, satisfaction, and overall quality of therapy. This includes retrospective interviews with a small sample of clients and qualitative feedback collected at follow-up.
    b. Provider experiences: Conduct key informant interviews with service providers to understand the strengths, challenges, and limitations of delivering TMH and TPT, as well as the perceived alignment of current assessment tools with intervention goals.
3. **Aim3**: To determine if appropriate assessment tools are being utilized, consistent with the stated aims and outcomes of the intervention.
    a. Examine whether current TMH and TPT assessment forms reflect the objectives of each intervention.
    b. Identify potential gaps or misalignments in the assessment forms that may warrant further consideration in future refinements (without testing or proposing new measures in this evaluation).
4. **Aim4**: To determine if the current protocols are justified and working well including inclusion and exclusion criteria and frameworks.
    a. Assess the relevance, consistency, and adequacy of existing protocols, including inclusion and exclusion criteria and referral pathways, in relation to intervention objectives.
    b. Conduct a desk review of relevant literature to evaluate alignment of current inclusion and exclusion criteria with evidence-based recommendations.
    c. Gather provider perspectives to clarify how clients are referred to TMH and understand the functioning of referral processes.
5. **Aim5**: To inform the further development and scale-up of telehealth (TMH and TPT) services more broadly at CVT.
    a. Assess the relevance, consistency, and adequacy of existing protocols, including inclusion and exclusion criteria and referral pathways, in relation to intervention objectives.

b. Conduct a desk review of relevant literature to evaluate alignment of current inclusion and exclusion criteria with evidence-based recommendations.
c. Gather provider perspectives to clarify how clients are referred to TMH and understand the functioning of referral processes.

1.5 Methodology

This evaluation combines multiple data sources, including clients' demographic information, mental and physical health outcomes, feedback and insights from key informant interviews with CVT and ADMSP staff. The evaluation primarily focuses on TMH clients served by CVT. While ADMSP also conducts TMH, their clients were not included due to capacity constraints. For TPT, CVT had a limited number of clients (n = 6), so it was deemed appropriate to include ADMSP's TPT clients (n = 25) to provide a more comprehensive understanding of outcomes.

Six staff members were interviewed from CVT (n=4) and ADMSP (n=2) in December 2025 and January 2026. The interviews lasted between one hour to 1.5 hr. Additional meetings with CVT staff were held as needed to clarify information, and remaining questions were addressed via email.

A desk review and literature review were conducted to examine the alignment of inclusion and exclusion criteria, intended outcomes, and assessment forms.

All client data (assessment forms, treatment plan, client feedback) from CVT and ADMSP were entered/stored into Alchemer Software, and both quantitative and qualitative data were analyzed using SPSS. Some qualitative data from treatment plans were coded and analyzed using Excel, with themes focused on clients' reported problems, goals, and progress.

For client feedback, a random sample of approximately 45% of 142 clients was selected for follow-up (note: only 142 clients out of 168 consented to be contacted, and those with only an intake assessment were included). All CVT TPT clients who consented (n = 4) were contacted. Follow-up surveys were conducted by the TMH counselor via WhatsApp or Signal, leveraging established trust and safety protocols. The counselor shared the survey link, which was accessible only to the evaluator to maintain confidentiality.

Data cleaning included addressing duplicates and missing data. Three clients had a re-intake of the baseline assessment, and to avoid double-counting, either the initial intake or the re-intake record was excluded based on which service the client spent more time on after assessment. One TMH client was excluded due to a duplicated form; only their treatment plan was included in the analysis. Additionally, three TMH clients had follow-up documents that could not be opened due to file errors and were therefore excluded from outcome analysis.

2. Findings

2.1 Strengths and challenges of TMH and TPT

Four CVT staff were interviewed, TMH counselor and clinical advisor, TPT therapist and clinical advisor and 2 from ADMSP, a case worker and TPT therapist.

2.1.1 Strengths

Staff interviews indicated several strengths that overlaps across TMH and TPT:

1. TMH and TPT provides a critical avenue for individuals who may not otherwise have access to in-person services due to geographic, security, or mobility constraints. This increases the reach of CVT's interventions to survivors and HRDs in remote or high-risk areas.

2. Both services are adaptable to clients' schedules, accommodating HRDs who travel frequently or, generally, clients who may have complex personal commitments. Staff can tailor session timing and focus to client needs, supporting ongoing engagement.
3. The services currently have sufficient capacity, and client demand is manageable and has not exceeded available resources.
4. Clients and partner organizations value telehealth services, appreciating the opportunity to continue care remotely. Staff noted that even clients who initially preferred in-person services can benefit from the structured, brief telehealth model as an entry point to their healing journey.
5. TMH initially excluded trauma-processing as a primary focus during its first year of implementation, while the intervention was being tested and refined. Subsequently, the service was expanded to include trauma-focused support, demonstrating that remote delivery can address certain trauma-related needs within a brief therapeutic framework.
6. Recruitment and engagement are strongest when telehealth is introduced in conjunction with workshops or trainings on self-care, team-building, or other relevant topics. Brief introductions by counselors/therapists and the provision of resource lists during workshops help clients understand and access services.

2.1.2 Challenges

Despite these strengths, staff identified several challenges and limitations:

1. Internet connectivity and platform access vary significantly across regions. Some clients, including older adults and those unfamiliar with digital tools, specifically those who were detained for many years, require additional support to participate effectively. Variability in connectivity, particularly in regions such as Syria, despite the fall of the regime, and Palestine, limits access and session quality.
2. Remote delivery constrains nonverbal communication and empathy conveyance, making rapport-building, safety, and clinical boundary explanation more time-consuming than in-person interactions. Some clients may engage in sessions while commuting or in distracting home environments, reducing session focus.
3. Survivors find it challenging to prioritize self-care due to many reasons, including stigma, guilt, low self-awareness, family commitments, and preferences for in-person services can affect remote service engagement.
4. HRDs' frequent travel requires flexible scheduling from providers, which can extend the time between consecutive sessions.
5. Referral waves complicate capacity planning, and staff absences temporarily pause service delivery.
6. Long-term service recruitment and sustainability are also sensitive to donor funding stability.
7. TPT is limited for clients who need hands-on guidance for physical exercises or whose conditions require more direct, in-person therapeutic support. Risk assessment is particularly challenging when clients are in locations with few alternative services.
8. The TPT assessment tool was adapted from the in-person PT form and may not fully capture information relevant to the telehealth modality needed for clinical decision-making. Combined with inconsistencies in data collection across measures, this limited the ability to fully assess the impact of TPT over the years.

9. Safety concerns have historically prevented direct remote delivery in certain regions, like Syria. TMH and TPT have relied on training local partner organizations to extend reach indirectly, highlighting the importance of partnerships in overcoming access limitations.
10. Limited information on how ADMSP's delivery of TPT, following training on CVT's model, has functioned in practice, including what has worked well or less well, particularly given ADMSP's larger TPT caseload and greater experience serving Syrian clients in Syria and outside.

2.2 Telemental Health (TMH) Data Findings

2.2.1 Client Characteristics and Demographics

This evaluation includes baseline data from 168 SOTI and ARC clients who received TMH services at CVT between February 2021 and September 2025, with the most recent follow-up assessments completed in November 2025. Clients ranged in age from 19 to 67 years, with a relatively balanced gender distribution (81 male and 87 female).

The majority of clients identified as Syrian nationals (n = 136), followed by smaller numbers of Yemeni (n = 10), Lebanese (n = 7), Libyan (n = 4), Tunisian (n = 3), Sudanese (n = 2), Egyptian (n = 2), Saudi (n = 1), Bahraini (n = 1), Palestinian (n = 1), and one dual Syrian–Palestinian citizen. At the time of intake, most clients were residing in Turkey (n = 104), with others living across a wide range of countries, including Austria, Bahrain, Egypt, France, Germany, Iraq, Ireland, Italy, Lebanon, Libya, Qatar, Saudi Arabia, Switzerland, Tunisia, the United Arab Emirates, the United Kingdom, the United States, and Yemen. This geographic dispersion reflects the transnational displacement contexts in which TMH services are delivered.

2.2.2 Client Reported Reasons for Seeking TMH Service

Clients were asked an open-ended question during the intake assessment about the reasons that led them to seek TMH services. A review of responses indicates that many clients are survivors of detention under the former Syrian regime, have witnessed the killing of family members or friends, experienced physical, psychological, and emotional torture, or been subjected to threats by governmental or external actors. Others reported secondary trauma related to their work as human rights defenders, including repeated exposure to traumatic narratives and documentation of abuses.

These experiences were commonly described as contributing to psychological distress, including symptoms related to anxiety, persistent rumination or overthinking, sleep disturbances, and emotional dysregulation (*see 2.2.8 for further analysis of clients' identified problems*).

2.2.3 Safety, Risk, & Support

When asked how they manage their challenges, many clients identified family members as their primary source of support, along with faith and prayer, reading, watching television, and engaging in outdoor activities such as walking. However, social support outside the household was more limited. Nearly one-third of clients (32%, n = 54) reported not having supportive relationships outside their home.

At intake, 14 clients reported that they or someone in their household was currently at risk or in danger. Reported risks included house arrest, direct threats to clients or family members, residence in areas dominated by opposition groups, exposure to physical violence, risk of deportation, being wanted by authorities in Syria, and living in conflict-affected areas with the possibility of bombardment. Human rights defenders (HRDs) reported additional layers of concern related to their advocacy roles.

2.2.4 Physical Health and Co-Occurring Conditions

A substantial proportion of TMH clients self-reported significant physical health challenges. Seven clients rated their physical health as *"poor"* or *"very poor,"* and 41% (n = 69) reported having medical or health problems that negatively impacted their daily functioning. Some of these reported conditions included persistent musculoskeletal pain (e.g., back, neck, joints, shoulders, knees, and feet), mobility limitations related to prior injuries, burns, fractures, and ligament tears, as well as chronic fatigue and exhaustion. Several clients described physical health problems linked to prior detention, torture, or conflict-related injuries, such as nerve damage, chronic muscle tension, headaches, hearing or vision impairment, and urinary incontinence. Others reported chronic non-communicable conditions, including diabetes, hypertension, cardiovascular disease, anemia, kidney and gastrointestinal disorders, hormonal or autoimmune conditions, and reproductive health concerns. Many clients noted that these conditions interfered with sleep, concentration, mobility, ability to work, and participation in daily or social activities, even when medically managed.

Medication use was also common. Seventy-eight clients reported taking medications for physical and/or mental health conditions. Pain relievers were the most frequently reported medications, followed by treatments for chronic conditions such as diabetes and hypertension. Thirteen clients reported using psychotropic medications, including antidepressants and sedatives. Additionally, approximately 16 clients reported taking multiple medications for co-occurring conditions, indicating the presence of complex, multi-morbid health profiles among TMH clients.

When examined more closely, approximately 13 clients of 79, assessed by TMH from November 2023 onward, reported medical or health problems at intake that impacted their daily functioning and included symptoms that could potentially be addressed by TPT within the scope of the intervention. However, these clients did not receive TPT services during the period when TPT was offered (November 2023 onward). Reported medical and health problems included sexual and urinary issues related to torture, chronic muscle tension, and joint pain (e.g., neck and back), which limited daily functioning; a subset of these conditions (n=3) were explicitly identified as resulting from torture. It remains unclear whether these 13 clients were formally referred to TPT or whether their cases were reviewed by providers to determine eligibility or appropriateness for physical therapy services.

2.2.5 Mental Health History, Family Concerns, and Service Concerns

More than one-quarter of clients (27%, n = 43) reported that a family member had expressed concern about their mental health. In addition, 56 clients (33%) reported having previously seen a mental health professional prior to the TMH intake assessment. These findings suggest that a substantial fraction of clients entered TMH services with pre-existing mental health needs and prior engagement with care.

Regarding concerns about seeking TMH, overall, few clients expressed concerns about engaging in TMH services at intake. Among those who did, concerns were primarily related to the perceived effectiveness of remote services compared to in-person care (n = 4) and privacy or confidentiality when sharing personal information remotely (n = 2).

2.2.6 TMH Inclusion and Exclusion Criteria

The current I&E criteria list several potential exclusion factors for TMH services—such as high risk of harm to oneself or others, cognitive impairment, low motivation, lack of emergency supports, or lack of

private space or technology. These were initially interpreted by the lead evaluator as standalone reasons for exclusion. The current criteria are listed below:

> *Beneficiaries of this service undergo an assessment appropriate to the intervention being offered, including an assessment of mental health needs, risk factors, and their suitability for telemental health. Factors that may mean that this is not an appropriate service include, high risk of harm to self or others, complex mental health needs including impaired cognitive ability, lack of access to confidential/private space or relevant technology, lack of access to appropriate medical or other support services in case of emergency, or low motivation for engagement with this type of service.*

Further consultation with the clinical advisor and counselor, however, clarified that exclusion is not based on any single criterion in isolation. Instead, decisions are made through a holistic clinical assessment of whether the beneficiary's overall presentation allows for safe, effective engagement in TMH.

Staff indicate that indicators like high risk of harm, cognitive limitations, or social isolation only warrant exclusion when they combine to create significant barriers to safety, engagement, or appropriateness for remote care. A single factor, such as a previous suicide attempt, should not automatically disqualify someone.

This distinction is ethically important. It prevents unnecessary or discriminatory exclusion and ensures that beneficiaries who are socially isolated but clinically stable can still access TMH. At the same time, it supports clinical responsibility by identifying when multiple interacting factors indicate the need for higher levels of care or in-person services, such as referring beneficiaries who may not be suitable for TMH to accessible CVT in-person services, or, when unavailable, to other organizations or networks that can provide the needed care. To ensure consistent decision-making across counselors, key indicators such as high risk, cognitive impairment, social isolation, and other complex mental health needs must be clearly defined and operationalized. This clarity is essential for determining, for example, when extreme social isolation is compatible with TMH participation and how many additional risk factors, when combined with it, would indicate that a beneficiary is not appropriate for tele-mental health services.

In contrast, certain non-clinical factors—such as lack of private space, inadequate internet, or absence of required technology—can serve as standalone exclusion criteria because they directly affect feasibility, confidentiality, and quality of care.

Overall, the I&E criteria should clearly distinguish which clinical indicators require a combination of factors to justify exclusion and which clinical and non-clinical factors function as definitive, standalone exclusion criteria. This clarification will ensure consistent, transparent, and clinically sound decisions about beneficiary eligibility for TMH services.

2.2.7 Literature on Inclusion and Exclusion of Individuals with Complex Mental Health Needs in Tele-Mental Health

As outlined in the Terminology Definitions page, complex mental health needs within CVT are used to operationalize inclusion and exclusion criteria for TMH service. This concept does not refer to a single diagnosis or standalone risk indicator; rather, it reflects a combination of interrelated clinical, functional (e.g., work, study, social engagement), and contextual factors (e.g., isolation or expressed concerns,

exposure to harm, exposure to prolonged and repeated trauma) that may exceed the scope of a brief, time-limited TMH intervention. These factors are assessed across multiple sections of the intake process and are considered collectively to support clinical judgment, in consultation with a clinical supervisor.

Consistent with this approach, findings from the literature align with this multidimensional conceptualization, indicating that complex mental health needs are commonly described not solely in terms of symptom severity, but as involving multiple, interlocking mental health, functional, and social challenges, often accompanied by comorbidity, instability, or unmet basic needs[26]. At the same time, some studies highlights a critical limitation of the existing digital mental health literature: telemental health or digital mental health interventions exclude individuals with complex presentations, such as those with comorbid conditions, acute risk, high self-harm risk, significant socioeconomic adversity, suicidal ideation, which might be referred to "minimizing risks", though these exclusion may not have been justified by efficacy concerns[27,28]. These exclusions are often based on, for example, for suicide ideation/attempt medical management, inability to provide informed consent, and inpatient hospitalizations[29]. While reasons for exclusion of this group is limited in the literature, some speculate that it mitigates risk in untested modalities[30]. As a result, the current evidence base provides limited guidance on the effectiveness of brief digital interventions for individuals with complex mental health needs, not because such interventions are necessarily inappropriate, but because these populations are underrepresented in research[27].

Conclusions: Notably, the literature frequently infers that individuals with complex needs, such as substance use and homelessness, may stand to benefit substantially from tele-mental health services due to improvements in access, continuity of care, and reduced barriers to engagement[31,32]. The literature also highlights that there is little evidence that suggests individuals with comorbidities (e.g., severe symptoms and suicide ideation) present an increased risk of adverse events[33]. It is important to note that the existing literature of digital mental health interventions is primarily focused on models that differ from CVT's TMH service, including interventions with longer duration, higher session counts, or integration within broader systems of ongoing care (e.g., in-person care). None-the-less this should provide food for thought and further reflection for CVT related to telehealth.

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2.2.8 Symptom Outcomes

A note of caution: The data findings described here may not be reliable due to inconsistencies in how clients' self-reported information was documented, potential bias or subjective judgment by clinical staff in recording responses, limitations in the design of the measurement tool itself (e.g., unvalidated measures and lack of standardized scoring), and low responses rates, These factors collectively reduce confidence in the accuracy and comparability of the findings and limit their representativeness of the full population of clients who engaged with the service but did not receive follow-up.

Of the 168 clients enrolled in TMH services, 69 clients (n = 55 from SOTI and n = 14 from ARC; 31 male and 38 female) completed both baseline and follow-up assessments and were included in symptom outcome analyses (overall response rate is 41% : 47% from the ARC project, and 40% from SOTI project). Across this subgroup, client data indicate overall improvements (100%) in self-reported symptoms of anxiety, depression, and trauma-related distress over the course of TMH participation, as measured on a four-point frequency scale ranging from *Not at all* to *Often (see Annex 1 for the intake assessment and Annex 3 for the follow-up assessment symptom scale measurement section)*.

The largest improvements were observed in depression-related symptoms, including feeling sad, self-blame, loneliness, hopelessness about the future, feelings of worthlessness, feeling everything is an effort, not thinking about or planning for the future as much as before, and thoughts of ending one's life. Client data indicates 100% reported improvement in at least one depression symptom from baseline to follow-up. Improvements were also reported in anxiety-related symptoms—such as nausea, difficulty breathing, chest tightness, and heart palpitations—with 97% of clients reporting improvement. Data indicated trauma-related distress, including feeling upset or nervous when reminded of past traumatic events, improved for 90% of clients. Overall, these findings suggest the greatest symptom reduction occurred in depression, followed closely by anxiety, with meaningful improvements also observed in trauma-related distress *(see Figure 1).*

At the item level, the greatest mean improvements were observed for the following statements:

- "Feeling everything is an effort?" (mean change = 1.90, SD = 0.71)
- "Blaming yourself for things?" (mean change = 1.86, SD = 0.94)
- "Feeling hopeless about the future?" (mean change = 1.77, SD = 0.89)
- "Feeling a tightness or heaviness in the chest?" (mean change = 1.62, SD = 0.81)

Symptom Domain	Pre-mean (SD)	Post-mean (SD)	Mean difference	P-value	Cohen's D	% Improved
Depression	2.7024	1.3595	1.34291	<.001	3.456	100%
Anxiety	2.6957	1.3732	1.32246	<.001	2.461	97%
Trauma Distress	3.0435	1.7826	1.26087	<.001	1.858	90%

Figure 1. TMH symptom outcomes.

While the symptom outcomes reported above appear promising, they should be interpreted with caution. The symptom scale used is not based on a fully validated measure; rather, it consists of selected items extracted from existing validated measures, with language modified by the clinical team. Examples of these measures include select items from the Hopkins Symptoms Checklist-25 (HSCL-25), PHQ-9, and PCL-5. The domain categories: anxiety, depression, and 'trauma-related distress' (not PTSD), were determined based on clinical judgment, and the clustering of symptom profiles was not formally established. Given this, for the purposes of this evaluation, the evaluator assigned each item to a symptom domain. The items included under each of the three symptom domains are listed below:

- **Anxiety:**
    - Feeling nauseous or sick to the stomach?
    - Finding it hard to breathe?
    - Feeling a tightness or heaviness in the chest?
    - Heart pounding or racing?

- **Depression:**

    - Feeling sad?
    - Blaming yourself for things?
    - Feeling lonely?
    - Feeling hopeless about the future?
    - Feeling everything is an effort?
    - Feelings of worthlessness?
    - Thoughts of ending your life?
    - Not thinking about or planning for the future as much as you previously did?

- **Trauma distress symptom:**
    - Feeling unhappy, nervous, or upset by things that remind you of bad things that have happened to you?

Given the positive overall symptom outcomes, an exploratory analysis examined whether clients who began the intervention with higher symptom severity demonstrated greater improvement at the 1-month follow-up. A linear regression analysis indicated that baseline symptom severity significantly predicted symptom change, such that clients with higher initial symptoms (n=15 who had pre- and post-data) experienced greater improvement from pre- to post-TMH (standardized coefficient = 0.70). This pattern suggests that individuals entering the intervention with more pronounced symptoms may benefit more substantially from the TMH support provided.

The symptom indicators used in this analysis section were derived from selected items within the 3 domains (anxiety, depression, and trauma distress) rather than full, validated clinical scales. As a result, the data may not fully capture the complexity or nuance of clients' symptom trajectories over time. Because the complete psychometrically validated measures were not part of the assessment design to keep the intervention concise and avoid burdening beneficiaries, it is not possible to determine how these change patterns would compare if standardized, validated measures had been used in their entirety. Thus, while the observed relationship is meaningful, it should be viewed as preliminary and descriptive rather than definitive.

2.2.9 Client Identified Problems, Goals, and Progress

A note of caution: The data findings described here may not be reliable due to inconsistencies in how clients' self-reported information was documented, potential bias or subjective judgment by clinical staff in recording responses, and low response rate. These factors collectively reduce confidence in the accuracy and comparability of the findings.

While symptoms can provide information about mental health outcomes of clients before and after receiving TMH, it is also important to consider what progress the client has made on their 2 identified problems and goals toward these 2 problems. The problems identified by clients were initially documented in the treatment plan completed during the first TMH session following the assessment (see Annex 2). In this plan, the counselor asks each client to identify up to two problems they would like to focus on over the 3–5 sessions, report the severity of these problems, and outline their goals for addressing them. At the follow-up assessment, the counselor copies these initial problems and asks the client to report the current severity and describe their progress toward the goals associated with each identified problem. The information of the identified problems, severity, goals and progress are documented by the counselor, which may have introduced documentation bias.

Among the 69 clients who completed both baseline and follow-up assessments, nearly all (68/69) demonstrated changes in the severity of their primary and secondary problems as identified in their treatment plans. Problem severity was measured on a scale ranging from *Not at all, A little, A lot, to Very much*, capturing client-reported difficulty related to the issues they sought to address through TMH services.

To help identify the types of problems and goals established by clients, with guidance from the counselor, a thematic and process-based analysis was conducted on the problems and goals clients reported in their treatment plans in the first TMH session. The coding approach followed a narrative sequencing framework, in which:

1. **Primary codes** reflected the initial problem documented in the treatment plan.
2. **Secondary codes** captured the broader internal impact or meaning of the problem.
3. **Tertiary codes** described the external functioning consequences of the problem.

Although both the primary and secondary problems identified by clients were intertwined, distinct patterns emerged. The first problem typically clusters around immediate internal cognitive and emotional difficulties leading to functional struggles, such as difficulty managing intrusive thoughts, regulating emotions, and coping in daily life. The second problem also focused on internal struggles but presumably highlighted trauma-related distress impacting multiple life domains, including sleep, relationships, daily functioning, and social engagement.

Problem 1 primary codes: Cognitive-Emotional Difficulties

- Excessive overthinking, rumination, loss of cognitive control (42 clients)
- Anxiety and persistent worries (32)

- Trauma-related intrusive memories and triggers (16)
- Concentration difficulties and cognitive impairment (14)
- Emotional dysregulation and irritability (10)
- Stress from responsibilities and work-related exposure (9)
- Social withdrawal and relationship difficulties (8)
- Sleep disturbances (7)

Secondary codes reflected the narrative consequences, such as emotional exhaustion, functional impairment, relational strain, and unresolved grief. *Tertiary codes* captured external functioning impacts, including reduced productivity, interpersonal conflicts, physical illness, identity disruption, and loss of control.

This pattern may suggest that clients tend to describe distress initially in terms of cognitive-emotional symptoms, followed by broader internal and external consequences. However, these observations are based on counselor documentation and may not fully reflect the actual sequence or emphasis of what clients shared.

Additional observations:

- HRDs under ARC reported anxiety related to recent events, triggering overthinking connected to political views (2 clients).
- Physical and psychosomatic effects were noted by 8 clients (e.g., fatigue, pain, breathing difficulties, negative effects of prolonged stress). Four additional clients reported sleep disruption and low daily energy. These findings are notable for TPT, as only a subset of these clients received TPT services, reflecting the timeline before TPT implementation at CVT.

Problem 1 Goals and Progress:

Given the first primary problem of cognitive control and overthinking, most frequently identified goals focused on cognitive/thought control, reducing overthinking, and learning coping strategies. In terms of progress, clients who were followed up with reported meaningful progress, based on the counselor's documentation in the follow-up assessment form. Clients reported meaningful progress toward these goals, including greater control over thoughts, reduced anxiety, improved emotional regulation, and increased awareness of trauma-related impacts.

Problem 2 Codes

The second problem primarily involved trauma-related distress affecting emotions, thoughts, sleep, relationships, and daily functioning. Clients reported intrusive memories, nightmares, emotional numbness, overthinking, emotional dysregulation, burnout, and sleep disturbances, which collectively impaired daily routines, decision-making, productivity, and interpersonal relationships.

Problem 2 Goals and Progress:

Clients' goals focused on increasing trauma awareness and strengthening coping strategies, including understanding trauma symptoms and reducing intrusive memories, anxiety, and nightmares. They also emphasized improving emotional awareness and regulation—specifically managing grief, anger,

irritability, and emotional reactivity—while developing safer ways to express emotions. Related goals included strengthening cognitive control, improving sleep, and enhancing social functioning, all of which were closely tied to daily routines, productivity, and interpersonal relationships.

Results: Across these areas, clients who were followed up with reported meaningful progress, based on the counselor's documentation in the follow-up assessment form. They reported increased awareness of trauma and its psychological impact, improved regulation of thoughts and emotions, and greater application of coping strategies in daily life. Many also reported improvements in sleep quality, overall functioning, and interpersonal relationships.

2.2.10 Overall TMH Perceived Impact and Feedback

All 69 clients who completed a follow-up assessment responded to questions assessing the perceived impact of TMH on coping with life difficulties, and relationships with family and the broader community:

1. *"Do you feel that these sessions have changed your ability to cope with difficulties in your life?";*
2. *"Do you feel that these sessions have changed your relationships with your family or household?"*;
3. "Do you feel that these sessions have changed your relationships with people in your community?"

All clients indicated perceived positive effects of TMH services on clients' ability to cope with life difficulties, their mental health symptoms, and their relationships within both the household and the broader community. However, it is important to note that these questions were administered by the counselor, which may have introduced several forms of bias. Clients may have felt inclined to provide favorable responses for a range of potential reasons, such as gratitude toward the provider and perceived power dynamics

When asked about whether the clients are in need of additional psychosocial support, only about 14% (n=10 of 68) of clients expressed the need for ongoing psychosocial support. The counselor has documented in the form that most of these clients have already been looking into continuing care with specialized mental health support outside of CVT to focus on their needs.

Client Feedback from Follow-up Assessment Form

Clients have shared their feedback in the follow-up assessment. Findings indicate that the most frequently reported improvements are awareness and management of thoughts, emotions, and bodily responses, particularly through techniques such as breathing exercises, cognitive restructuring (e.g., the cognitive triangle), grounding, and routine-building.

Many clients described reduced anxiety and panic symptoms, improved emotional regulation, and greater ability to cope with stressors in challenging and unstable contexts, including exposure to traumatic reminders, humanitarian work, displacement, and ongoing conflict. Several clients noted improvements in sleep, energy levels, and daily functioning, as well as reductions in reliance on medications or unhealthy coping behaviors.

Feedback also emphasized meaningful improvements in relationships with family members, spouses, and children, including better communication, boundary-setting, and emotional awareness. Clients

frequently reported achieving a healthier balance between work and personal life, increased engagement in social activities, and renewed participation in work, education, or community life.

Additionally, clients expressed increased self-awareness, self-compassion, and understanding of trauma-related symptoms, which supported more adaptive coping during periods of acute stress (e.g., war, earthquakes, illness, or loss). Several clients shared that TMH services provided a trusted, supportive space for emotional expression and reflection, and many expressed gratitude for the availability of these services and a desire to continue sessions or recommend them to others.

Client Feedback from this Evaluation – Survey Response

Additional feedback was collected from former clients. Out of the 63 former CVT only clients who were reached out to, only 10 clients completed a short survey (response rate of 16%). Two of these clients received both TMH and TPT. The survey assessed clients' experiences with telehealth services, including accessibility, satisfaction, perceived quality, clarity of the overall process, sense of support, and perceived benefits. It also explored preferences regarding service pathways (TMH and TPT), the potential value of case management or social work support, perceived benefits for individuals with complex mental health needs, and recommendations to improve the telehealth experience (see Annex 6).

Most respondents (90%, n=9) reported that they were able to access telehealth services with ease. Overall satisfaction was high, with nearly all participants indicating that they were satisfied with the services received. When asked to rate TMH services on a scale of 1 (very poor) to 10 (excellent), most ratings ranged between 7 and 10. Approximately 70% of respondents described the overall service process as very clear and helpful.

The most commonly reported benefit was increased psychoeducation and understanding of psychological reactions (60%). In addition, 40% reported improved awareness of the mind–body connection, strengthened coping skills, and increased confidence in managing difficulties. About 70% indicated that telehealth services somewhat helped address the concerns that initially brought them to care.

When asked what they valued most, half of the respondents (50%) highlighted rapport building, including communication, kindness, and the therapeutic relationship with their counselor.

A majority of respondents (90%) believed that individuals with complex mental health needs could benefit from telehealth services. Additionally, 70% indicated that having a dedicated case manager or social worker as a main point of contact would have been helpful.

Some respondents identified areas for improvement. Thirty percent mentioned the need for greater continuity of care, including session duration or number of sessions. One respondent expressed interest in follow-up support after services end, particularly for individuals with ongoing or recurring needs. Another respondent noted that clearer communication during service interruptions, including information about alternative service pathways, would have been helpful.

Half of the respondents suggested that online outreach (e.g., social media or electronic leaflets) would be an effective way to reach potential clients, followed by coordination with NGOs and CSOs. Notably, 50% of surveyed clients reported learning about CVT telehealth services through another organization.

Others heard about services through friends or family (n=2), online sources (n=2), or community outreach events (n=1).

Below are selected quotes shared by clients:

> *It was a meaningful and wonderful experience, and I hope this model continues with others who have the same feelings and experiences that I had.*
>
> *I was suffering from a particular condition due to my arrest, and when I received support from Ms. Nour, who explained the reason for this condition to me, I was able to get rid of 60 percent of the psychological stress.*
>
> *I'm grateful for all the support I've received. Suggestion: Healing Circles. Opportunities for group healing, for example, a group specifically for people with neurodivergent conditions.*

2.2.11 TMH Materials Desk Review

The desk review of TMH documentation, including intake and follow-up assessment tools, referral forms, I&E criteria, theory of change materials, and internal protocol summaries, identified several structural and measurement-related gaps.

Terminology used within TMH documentation, such as “complex mental health needs,” “severe symptoms,” “high risk,” was not formally operationalized within program materials. While these terms are broadly consistent with definitions in the literature (see section 2.2.7), they are not accompanied by clearly defined thresholds, scoring rubrics, or applied decision-making guidance within TMH documentation. As a result, clinicians apply their professional judgment when interpreting these terms, as standardized thresholds or decision-making guidance are not specified.

The PSFS referral form, completed by the counselor when referring a client to TPT service, references levels of severity (e.g., low, medium, high) across symptom domains including: depression, anxiety, PTSD, behavioral functioning, or physical symptoms. However, no standardized scoring system was identified in the TMH assessment form that categorizes these symptom domains into defined ranges to guide how severity should be documented in the PSFS referral form. This limits the ability to systematically classify client symptom severity. Therefore, symptom level documentation appears to rely heavily on the counselor’s discretion rather than structured scoring.

The desk review further identified technical and formatting limitations within the assessment tools themselves. Intake and follow-up forms are currently maintained as fillable Word documents. Across reviewed files, responses were sometimes entered using highlights, inserted shapes, or free-text entries rather than standardized checkboxes or numerical entries. In addition, the integration of Arabic text within English-language documents occasionally affected formatting and alignment. These factors may reduce efficiency, readability, and data consistency.

Follow-up timing also presents measurement constraints. TMH symptom outcomes are assessed at a single one-month follow-up point. While this allows for assessment of short-term change, the absence of additional follow-up intervals limits understanding of longer-term symptom and other outcome trajectories.

Finally, no comprehensive intervention manual or guideline was identified for TMH. Available documents provide high-level summaries of the intervention and brief protocol outlines; however, detailed standardized procedures (where applicable), structured session guidance, defined staff competencies, or documented training pathways were not identified in written form.

Collectively, these findings suggest that while TMH is implemented with strong clinical expertise and overall positive feedback from the clients (as noted in the previous sections in the findings), terminologies, documentation, and measurement systems remain partially informalized, which may affect standardization, comparability, and scalability.

2.3 Tele-physiotherapy (TPT) Data Findings

2.3.1 TPT Client Characteristics

> *A note of caution: The data findings described here may not be reliable due to inconsistencies in how clients' self-reported information was documented, potential bias or subjective judgment by clinical staff in recording responses, deprioritization of measure items, limitations in the design of the measurement tool itself (e.g., unvalidated measures and lack of standardized scoring), and low response rate. These factors collectively reduce confidence in the accuracy and comparability of the findings.*

About 31 clients received TPT (CVT and ADMSP); 18 clients were followed up with at a 3-month timepoint (response rate = 58%), and out of those, 15 also received a 6-month follow-up (48%). The timeframe of intake assessments was from November 2023 to August 2025; however, the last follow-up was in November 2024.

TPT intake assessment included torture categories of clients. Results are as follows: Torture survivor categories:

- 84% (n=26) Primary torture survivors
- 61% (n=19) War Organized Violence (WOV)
- 55% (n=17) Sexual and Gender-Based Violence (SGBV)
- 39% (N=12) Secondary torture survivors

2.3.2 Symptom Outcomes

The TPT assessment forms, extrapolated and modified items from multiple validated constructs (e.g., PSFS, Numeric Rating Scale (NRS-11), WHODAS 2.0, and Pain Self-Efficacy Questionnaire (PSEQ)), captured client outcomes across several domains (see Annex 4 & 5):

- Functional ability: measures the ability to perform daily activities (e.g., dressing, walking, climbing stairs). This is assessed using a 0–10 scale (0 = unable to perform the activity at all; 10 = able to perform the activity with no difficulty) displayed on-screen while the therapist read each item.
- Body functions and physicality: measures pain level, sleep quality, urination, and sexual health are assessed similarly on a 0–10 scale.
    - Pain: 0 = no pain; 10= worst possible pain

    - Sleep: 0 = worst sleep quality; 10 = best sleep quality
    - Urination and sexual activity: 0 = not at all a problem; 10= major problem
- Social participation: measures how health and physical condition influence participation in social like. This is assessed using pictorial "glasses" representing "Not at all," "Rarely," "Sometimes," and "Often," with the therapist reading each item aloud for the client to select the appropriate response.
- Psychosocial well-being (coping and outlook): measures overall physical self-efficacy and coping. This is assessed using a scale from "Strongly disagree" to "Strongly agree," with the therapist reading each item aloud for the client to select the appropriate response.

Clients demonstrated substantial improvements on average across these assessment domains. For body functions and physicality measures—including pain, sleep quality, urination, and sexual health—all clients with available data showed average improvements at both the 3-month (n=18) and 6-month (n=15) follow-ups. Coping and outlook outcomes showed a great improvement, with an average increase in coping and positive outlook observed for nearly all clients at 3 months (94%, 17 of 18) and continuing for all clients with available data at 6 months (100%, 14 of 14). Social participation and functioning also improved on average, with approximately 83% of clients (15 of 18) demonstrating average gains at 3 months and 87% (13 of 15) maintaining these gains at 6 months.

In contrast, Functional Ability slightly worsened over time, with only one client demonstrating measurable gains from intake to both the 3-month and 6-month follow-ups, while the majority experienced worsening scores on average. The average functional ability score decreased by approximately 4 points at 3 months and 6 months compared to baseline. Across the twelve functional ability items, A.1 (dressing without help) and A.9 (light work) had the highest proportion of clients reporting no change at both follow-up points (see Annex 4), indicating relative stability in these domains. The largest mean declines were observed for A.12 (participating in exercise or sports) at both *3 and 6 months*. At *6 months*, additional items with the greatest mean decreases included A.6 (carrying a bag), A.8 (running), and A.11 (lifting heavy objects). Interpretation of these findings should be made with caution, as functional ability items were not consistently completed across participants, potentially affecting the reliability of item-level comparisons.

2.3.3 Intended Outcomes

A desk review conducted by the evaluator, complemented by staff interviews and discussions with the E&R and clinical teams, provided insight into the theory of change currently guiding in-person PT services, which also informs the TPT model. The existing theory of change for PT (regardless of in-person or remote modality or whether providing individual or group services) is primarily based on a group-based delivery model and is grounded in Judith Herman's Trauma Recovery framework. The E&R and clinical teams discussed the current theory of change that PT uses during the evaluation period and determined that a review of each outcome within the existing theory of change was necessary to assess alignment with the overall PT model, encompassing both in-person and remote (TPT) modalities.

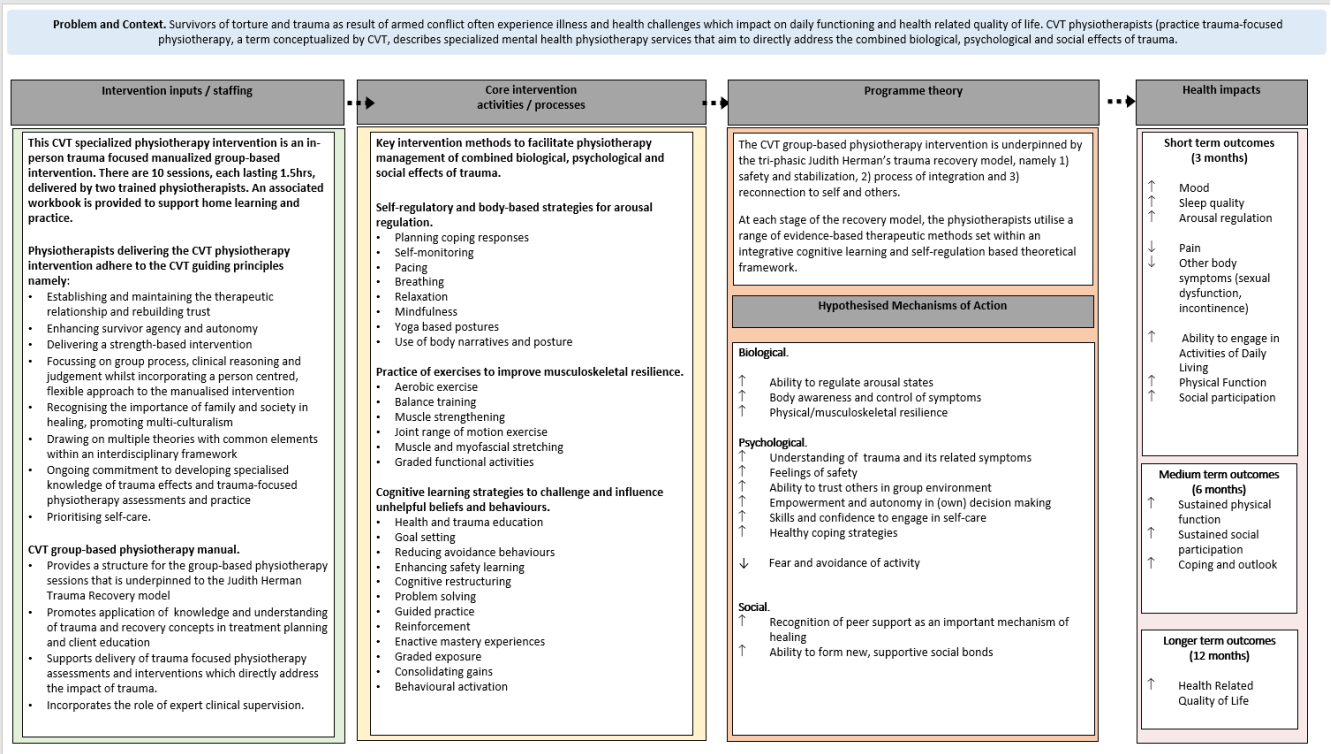


Figure 2. CVT physiotherapy theory of change.

The short, medium and longer-term intended outcomes from the theory of change were reviewed — including improved overall mood, sleep quality, arousal regulation, pain, body symptoms, ability to engage in daily activities, physical functioning, social participation, sustained physical function (e.g., sexual dysfunction, incontinence), sustained social participation, coping and outlook, and health-related quality of life. However, some content was skipped/incomplete in assessment forms (in line with the clinical approach to TPT), making this challenging. Moving forward, full completion of all outcome measures is critical for determination of what outcomes may be changing vs those that are relatively static.

Of note, 'functional ability' means very different things depending on whether focusing on physical health (mobility limitations) or mental health (psychosocial functioning). Functional ability in physical health is typically defined as the capacity to perform specific, observable tasks (e.g., walking, lifting, climbing stairs) and is closely tied to biomechanical impairment, whereas in mental health it refers more to role performance and social, occupational, and cognitive participation (e.g., functional impairment related to ability to engage in tasks associated with work, school, and/or relationship domains due to symptoms of depression). Although conceptually distinct—task-mechanical versus role-participatory—the two domains often overlap in trauma-affected populations, where psychological distress and physical limitations interact to shape overall functioning.

Findings associated with TPT outcomes. As mentioned previously, symptoms and other outcomes were generally positive and in the expected direction (see 2.3.2 Symptom Outcomes), although limitations in how these constructs are currently measured should be taken into account. Furthermore, as a reminder, it is difficult to determine what amount of alleviation in mental health symptoms before and after services can be attributed to specific intervention components - TMH vs TPT.

However, compared to other symptom outcomes, functional ability (physical, change in mobility limitations) showed worsened symptom scores on average. This may be related a variety of factors, including that functional ability (physical, mobility limitations) may not have been a primary complaint for most clients, particularly on items with the highest proportion of unchanged scores, as noted in Section 2.3.2.

Additionally, the theory of change identified the health-related quality of life (HRQOL) as a long term outcome (12 months). There is no validated instrument is currently used to directly measure this construct. Instead, HRQOL is inferred from improvements in shorter and medium-term outcomes (3- and 6-month indicators), which were subsequently consolidated into one list of outcomes (e.g., improvement in mood, sleep quality, arousal regulation) for the purpose of this evaluation. While these domains conceptually align with multidimensional definitions of HRQOL, they do not constitute a validated or standardized composite measure of health-related quality of life. As a result, the evaluation and current standard evaluation practices cannot determine whether the intended 12-month HRQOL outcome is being achieved, nor can they assess sustained long-term impact. Current measurement approaches primarily capture short- and medium-term changes rather than this outcome.

Please see the recommendations table that provides recommendations for TPT including related to the - referral process, inclusion and exclusion criteria, intended outcomes, assessment form, and operational considerations.

2.3.4 Client feedback

While client feedback was collected as part of this evaluation, only two of the surveyed respondents had received TPT in addition to TMH. Both clients reported that TPT helped them learn practical strategies to manage physical discomfort and cope more effectively with bodily challenges.

On a scale of 1 (very poor) to 10 (excellent), both respondents rated TPT services as 8.

One client shared:

> *I felt relatively relieved, I had been experiencing stress, pressure, and fatigue, but thankfully, after receiving guidance from the clinician, my mental state improved significantly.*

Please note that this data is limited. Additional survey results related to telehealth overall and TMH-specific feedback are presented in Section 2.2.10: Client Feedback from this Evaluation – Survey Response.

2.3.5 TPT Literature and Desk Review

A growing evidence base supports TPT and tele-rehabilitation as effective alternatives to in-person physiotherapy for reducing pain, improving function, and enhancing quality of life across several clinical populations, including addressing musculoskeletal conditions, stroke, neurological disorders, and

chronic cardiopulmonary diseases[34, 35, 36, 37]. The current CVT TPT model excludes clients with significant comorbidities (e.g., cardiovascular disease, neurological movement disorders, cognitive impairment, diabetic complications, or high fall risk), which differs from broader TPT research that includes more diverse clinical populations. This exclusion encompasses people with SMH conditions, as PT assumes such cases (e.g., psychosis) may affect engagement and treatment processes, despite the high prevalence of physical comorbidities among individuals with SMH. These overlapping challenges contribute to barriers in accessing PT, including a limited understanding of PT[38] and therapists' awareness or confidence in addressing MH needs[39, 40].

While studies generally show remote delivery can achieve outcomes comparable to traditional care, the literature on the effectiveness of TPT in low-resource settings is limited. Despite this gap in tele-physiotherapy literature among adults, emerging evidence indicates tele-physiotherapy can be feasible and beneficial in pediatric and low-resource contexts. Digital physiotherapy has shown promise to improve children's functional independence and quality of life in low-resource settings[41], improve motor skills in children with cerebral palsy children[42] and neurodevelopmental disabilities[43]. While encouraging, pediatric and low-resource evidence remains sparse.

There is also a critical gap in research on trauma-focused or trauma-informed TPT, despite the growing recognition of trauma-sensitive care, including a trauma-focused approach, as essential in rehabilitation[44,45]. While CVT has already operationalized key trauma-focused, the formal integration and evaluation of these practices and their impact on PT outcomes (e.g., functional ability, pain, quality of life), both within TPT and in-person PT services, remains undefined. Similarly, culturally and context-specific adaptations (e.g., use of culturally relevant metaphors and visuals, attention to gender and

[34] Amarnath, R., Bhatt, P., Darjee, J. P., Sinha, A., Jadhav, R. S., & Jani, H. (2024). Effectiveness of Remote vs. Face-to-Face Physiotherapy in Musculoskeletal Care: The REFORM Study. African Journal of Biomedical Research, 27(3).

[35] Tchero, H., Tabue Teguo, M., Lannuzel, A., & Rusch, E. (2018). Telerehabilitation for stroke survivors: systematic review and meta-analysis. Journal of medical Internet research, 20(10), e10867.

[36] Hawley-Hague, H., Lasrado, R., Martinez, E., Stanmore, E., & Tyson, S. (2023). A scoping review of the feasibility, acceptability, and effects of physiotherapy delivered remotely. Disability and rehabilitation, 45(23), 3961-3977.

[37] Federico, S., Cacciante, L., Cieślik, B., Turolla, A., Agostini, M., Kiper, P., Picelli, A., & RIN_TR_Group (2024). Telerehabilitation for Neurological Motor Impairment: A Systematic Review and Meta-Analysis on Quality of Life, Satisfaction, and Acceptance in Stroke, Multiple Sclerosis, and Parkinson's Disease. Journal of clinical medicine, 13(1), 299. https://doi.org/10.3390/jcm13010299

[38] Lee, S., Waters, F., Briffa, K., & Fary, R. E. (2017). Limited interface between physiotherapy primary care and people with severe mental illness: a qualitative study. Journal of physiotherapy, 63(3), 168-174.

[39] Hemmings, L., & Soundy, A. (2020). Experiences of physiotherapy in mental health: an interpretative phenomenological analysis of barriers and facilitators to care. Physiotherapy, 109, 94-101.

[40] Andrew, E., Briffa, K., Waters, F., Lee, S., & Fary, R. (2019). Physiotherapists' views about providing physiotherapy services to people with severe and persistent mental illness: a mixed methods study. Journal of physiotherapy, 65(4), 222-229.

[41] Estebanez-Pérez, M. J., Martín-Valero, R., Moreno-Morales, N., Liñán-González, A., Fernández-Navarro, R., & Pastora-Bernal, J. M. (2022). Digital physiotherapy intervention in children in a low resource setting in Anantapur (India): Study protocol for a randomized controlled trial. Frontiers in Public Health, 10, 1012369.

[42] Pahwa, P. K., & Mani, S. (2018). Telephysiotherapy as a mode of enhancing motor skills of cerebral palsy children in school settings: a review. Journal of Exercise Science & Physiotherapy Vol, 14(2).

[43] Rangwala, S. (2024). Teletherapy as an Alternate Model for Therapeutic Interventions for Children with Neurodevelopmental Disabilities in a Low-resource Setting in Jharkhand, India. Indian Journal of Physical Medicine & Rehabilitation, 34(2), 94-102.

[44] Heywood, S., Bunzli, S., Dillon, M., Bicchi, N., Black, S., Hemus, P., Bogatek, E., & Setchell, J. (2025). Trauma-informed physiotherapy and the principles of safety, trustworthiness, choice, collaboration, and empowerment: a qualitative study. Physiotherapy theory and practice, 41(1), 153–168. https://doi.org/10.1080/09593985.2024.2315521

[45] Khalil, H., Fricker, I., Nazzal, M. S., Al-Qudah, A., Lababneh, T., Yousef, H., ... & Busse, M. (2025). Delivering trauma-focused physiotherapy interventions for trauma-exposed refugees: a qualitative study exploring perspectives and experiences from Jordan and Kenya. Physiotherapy Theory and Practice, 41(9), 1886-1900.

religious norms, and language translation) are embedded in practice but remain underexamined in the tele-rehabilitation literature. Although limited evidence exists linking such adaptations directly to PT outcome measures[46, 47, 48, 49], they are likely to influence engagement, retention, and equitable access, which are foundational to clinical effectiveness in low-resource and conflict-affected settings. A forthcoming manuscript of a systematic review of culturally adapted PT evidence and practices (authored by CVT) will further explore this topic and can be used as a reference for practitioners moving forward.

Overall, the literature suggests TPT has the potential to improve pain, function, and quality of life, yet significant gaps remain regarding its application in low-resource environments, SMH beneficiaries, and for pediatric groups, and the extent to which integrating trauma-informed, trauma-focused, and culturally responsive approaches influences PT outcomes.

2.3.6 TPT Materials Desk Review

In addition to the intake outcome analysis, literature review and desk review findings related to the in-person PT, theory of change and I&E criteria for SMH conditions, an additional desk review was conducted to examine TPT documentations and protocols. Several structural and measurement-related gaps were identified.

With respect to eligibility criteria, TPT documentation references clinical conditions such as cardiovascular disease, neurological movement disorders, cognitive impairment, and serious mental illness as exclusionary factors. However, the reviewed materials did not clearly articulate the telehealth-specific rationale for these exclusions or define how risk mitigation considerations should be applied in remote delivery settings. This ambiguity is further reflected in the TPT intake assessment, which prompts therapists to determine whether a "sufficient evaluation" has been conducted to establish eligibility. While this question places clinical judgment at the center of the decision-making process, no formal written guidance was identified specifying what constitutes a sufficient evaluation in the context of telehealth. As a result, approaches to interpreting and applying exclusionary conditions, such as cardiovascular or neurological disorders, may vary across providers.

The desk review also did not identify a standardized TPT follow-up assessment template structured to align with the intake form and adapted for remote service delivery. In one reviewed CVT client case involving follow-up services, documentation reflected the use of an in-person PT assessment tool from another CVT program (see Annex 5). The PSFS section included in the TPT intake form (see Annex 4) was not recorded at follow-up in this case, as the in-person template did not incorporate this measure for telehealth use. This limits the ability to assess functional change over time. It is also unclear whether ADMSP consistently administered the PSFS at all intended follow-up intervals (3, 6, and 12 months), as this information was not available for review. These documentation gaps reduce comparability between

[46] Hölzel LP, Ries Z, Kriston L, et al. Effects of culture-sensitive adaptation of patient information material on usefulness in migrants: a multicentre, blinded randomised controlled trial. BMJ open. 2016;6(11):e012008.

[47] Brady B, Sidhu B, Jennings M, et al. The feasibility of implementing a cultural mentoring program alongside pain management and physical rehabilitation for chronic musculoskeletal conditions: results of a controlled before-and-after pilot study. BMC Musculoskelet Disord. 2023;24(1):47. doi:10.1186/s12891-022-06122-x

[48] Brady B, Veljanova I, Schabrun S, Chipchase L. Integrating culturally informed approaches into physiotherapy assessment and treatment of chronic pain: a pilot randomised controlled trial. BMJ open. 2018;8(7):e021999.

[49] Orhan C, Lenoir D, Favoreel A, et al. Culture-sensitive and standard pain neuroscience education improves pain, disability, and pain cognitions in first-generation Turkish migrants with chronic low back pain: a pilot randomized controlled trial. Physiotherapy Theory and Practice. 2021;37(5):633-645. doi:10.1080/09593985.2019.1639231

intake and follow-up measures, and the absence of a telehealth-adapted follow-up template further suggests potential misalignment between remote service delivery and tools originally designed for an in-person service.

Review of client files also indicated that documentation of certain measures was not consistently completed across CVT and ADMSP records. Item-level indicators were sometimes recorded selectively, based on therapist judgment of relevance. While this may reflect a flexible and client-centered assessment approach, inconsistent completion limits cross-client comparability and structured outcome analysis.

As with TMH, TPT assessment tools are currently maintained as fillable Word documents. Review of client files identified formatting inconsistencies and variation in how responses were recorded, which may affect standardization across files. While these issues do not affect the treatment care, they may reduce documentation efficiency and limit data consistency for monitoring and evaluation purposes as well as for ease of clinical review.

Additionally, similar to TMH, no comprehensive TPT intervention manual was identified. Available documentation consists primarily of summary-level protocol descriptions rather than detailed operational guidance, defined staff competencies, structured session frameworks, or documented contingency planning for internet disruptions in low-connectivity settings.

Overall, the desk review findings suggest that while TPT delivery appears clinically grounded and responsive to client needs, greater formalization of eligibility guidance, documentation systems, follow-up measurement tools, and telehealth-specific operational procedures would strengthen consistency, evaluability, and readiness for scale-up.

3. Discussion:

3.1 Overall Responsiveness and Effectiveness

The findings suggest that the telehealth model, including both TMH and TPT, appears to be generally responsive to client needs, producing meaningful improvements within a brief intervention framework, and offering an important access point for survivors who may otherwise be unable to engage in care. Evaluation findings suggest TMH was associated with improvements in non-standardized measures of anxiety, depression, and trauma-related distress (PTSD related symptoms), with the largest gains observed in depression-related symptoms. The findings also showed a pattern that clients with higher baseline symptoms showed greater measurable improvement, suggesting that even a non-specialized, supportive TMH model may provide meaningful benefit to clients presenting with elevated distress. This has implications for possibly shaping and refining inclusion criteria and intended outcomes.

In addition to measurable symptom reduction among all clients, on average, approximately one-third of clients (56 of 168) who completed baseline only reported prior engagement with MH services before enrolling in TMH. In addition, the majority of clients (58 of 68) did not indicate a need for additional psychosocial support at follow-up, suggesting that the intervention was sufficient for many within the scope and duration provided. Although these findings should be interpreted cautiously given data quality limitations, they may suggest that a brief, remote, non-specialized tele-mental health model can be associated with meaningful symptom reduction for a substantial proportion of clients. These results

may support the role of TMH as an effective component within a broader continuum of care, particularly as a short-term intervention that may adequately meet the needs of many survivors and HRDs.

For TPT clients, improvements were reported in body functions and physicality (e.g., pain, sleep quality, incontinence, sexual health), coping and outlook, and social participation and functioning at both 3- and 6-month follow-ups. Functional ability showed minimal change on average, with scores slightly declining over time. Given the inconsistent completion of certain items across time points, this apparent decline should be interpreted cautiously. It may reflect a combination of factors rather than true worsening of functional status. For example, clients may have developed greater awareness of their limitations over time, leading them to report lower scores on the scale.

These outcomes are very encouraging for both TMH and TPT. It is unclear, however, whether the improvements can be attributed solely to TPT, to TMH, to the combined effect of receiving TMH alongside TPT or other factors (given the lack of a control comparison group). Control groups are essential in intervention research because they provide a baseline for comparison, helping to isolate the specific effects of an intervention from other factors such as natural recovery, placebo effects, social desirability in responses, or external variables. Without a control group, it is difficult to establish causality, rule out confounding influences, or validate that observed changes are indeed the result of the intervention. Future evaluations that separate these services and analyze outcomes independently, with a waitlist control comparison, may provide clearer insights.

3.2 Service Pathways and Client Engagement

Although TMH is conceptualized as a gateway to broader psychosocial engagement, most clients did not indicate a need for additional services at completion. This may reflect several factors, including perceived symptom improvement, a preference for short-term support, limited awareness of referral pathways to appropriate remote or in-person services in clients' geographic areas, or broader structural and contextual influences on help-seeking behavior. It is recommended that counselors further explore and document clients' reasons for declining additional support in order to better understand the factors contributing to this pattern.

In addition, it is important to highlight the subset of clients (16%, n=13) assessed by TMH from November 2023 onward who were not referred to TPT, despite reporting medical or health-related concerns that could potentially benefit from TPT services within the intervention's scope. For these cases, it is unclear whether referral discussions between TMH counselors and TPT therapists took place but were not documented. Clients may have been informed about the service but chose not to pursue it, or physical health needs may not have been prioritized during TMH assessments, resulting in limited follow-through on referrals. While the current analysis of treatment plan and follow-up data provides descriptive information, the dataset does not fully capture how clients conceptualize distress and progress, particularly in cases where decisions are guided by clinical judgment that may not be systematically documented.Future data collection that captures direct client reports in a more structured format could allow for more robust analysis. Such data have strong potential to inform clinical focus during the 3–5 session treatment period and could contribute to the development of a structured clinical framework to guide sessions and monitor client progress more systematically.

3.3 Scalability and Expansion of Telehealth (TMH & TPT)

As CVT considers future scale-up and expansion of telehealth service, additional points should be considered:

- Developing a theory of change for TMH is recommended. The TPT theory of change may also require adjustment to better reflect delivery in a remote modality.
- Clarifying and operationalizing inclusion and exclusion criteria (e.g., high risk of harm, cognitive impairment, complex trauma, TPT yellow flags indicators – unhelpful beliefs about pain, preservation, fear of movement, etc. – and feasibility considerations) would promote consistency and equity in service delivery.
- Developing structured clinical guidance or manuals for TMH and TPT would support standardization, facilitate adaptation across programs in MENA and other regions, and help ensure shared understanding of service intent among new and existing staff.
- Integrating and refining validated measures and ensuring full completion of these measures during assessment would allow for more robust conclusions from the data.
- Strengthening outreach beyond existing partner organizations could allow for connections with other groups who could benefit from services.
- Exploring inclusion of additional subgroups (e.g., children and adolescents), while carefully reviewing the evidence base and safety considerations, could be one direction for expansion of the model(s).
- Planning for service adaptation in contexts with limited internet connectivity, including support for populations returning to areas with constrained infrastructure, could be useful in thinking about how to reach more of those in need.

The table below summarizes key recommendations and points to consider for the scale-up and expansion of telehealth (both TMH and TPT).

4. Recommendations

The evaluation identified several areas for refinement across TMH and TPT, particularly related to referral pathways, clarity of inclusion and exclusion criteria, consistency in assessment tools, and alignment between intended outcomes and documented measures. While both interventions demonstrate strong clinical value, gaps in standardized symptom tracking, referral documentation, and operational clarity limit the ability to assess effectiveness and ensure continuity of care.

To address these areas, the following table outlines a summary of the data evidence, results or conclusions of the evidence, and recommendations. It includes a clinical strategy response column for the clinical team to outline how each recommendation will be operationalized (e.g., context-specific adaptations, responsible staff, and other considerations), and a suggested timeline column to be completed by clinicians and reviewed annually. The subsequent table provides the corresponding suggested implementation, outlining recommended actions identified by the evaluator. Each section in both tables is color-coded by the main categories. Clinicians may enter responses directly in this recommendation table in this report or in the accompanying Excel sheet, which mirrors this table. Please note that a suggested timeline for each of the recommendations can be provided by the evaluator upon request.

	Data Evidence	Results/Conclusions	Recommendations	Clinical Strategy Response	Implementation Timeline
A. Referral Process (Internal & External)	Staff interviews and desk review indicate limited awareness of the existing landscape of organizations able to serve clients who are ineligible for TMH and TPT services.	Despite limited referral options in some regions, it remains important for clinical staff conducting assessments to have contingency referral pathways in place for individuals who are determined to be ineligible for TMH or TPT, to ensure access to care through alternative service providers.	**A1. Referral procedures for ineligible beneficiaries:** Establish clear guidance about referral procedures for those deemed ineligible for services, supported by a resource sheet of an external referral network of options, outlining in-country and regional organizations/institutions/entities that can provide services.		
	The majority of clients (85%) who completed the one-month follow-up assessment did not indicate a need for additional psychosocial services at TMH completion (see section 2.2.10 Overall TMH Perceived Impact and Feedback)	Although TMH is conceptualized as a gateway to broader psychosocial engagement, continuation to additional services was limited. This may reflect perceived symptom improvement, client preference for brief interventions, limited awareness of referral options from the counselors' side, or structural/contextual barriers influencing help-seeking behavior.	**A2. Referrals for additional support at Follow-Up:** document clients' reasons for not requiring additional psychosocial support at follow-up to determine whether non-continuation reflects successful brief intervention outcomes, unmet referral needs, or other reasons.		

	TMH intake assessments identified medical and health-related concerns, including physical needs, among approximately 13 clients who may have qualified for TPT service, but did not receive it. For these cases, it is either presumed that no referral to TPT was made or that documentation does not indicate whether any referral discussion occurred between TMH counselors and TPT therapists (see section 2.2.4 Physical Health and Co-Occurring Conditions).	The evidence points to ongoing uncertainty in how TMH counselors determine the appropriateness of referrals to TPT. Assessment and referral documentation does not clearly indicate how referral decisions are made or how cases are coordinated between TMH and TPT. Importantly, clients presenting with complex trauma and/or severe mental health symptoms may still derive benefit from TPT services (as mentioned during staff interviews), even when they are excluded from TMH, indicating that current referral practices may inadvertently limit access to potentially appropriate care.	**A3. TMH ➔ TPT referral pathway:** Establish a clear, shared understanding between TMH counselors and TPT therapists regarding the referral process between these two services, particularly for clients with somatic or physical health needs.		
			A4. Clarify TPT referral for TMH-ineligible clients: Discuss referral pathways for clients deemed ineligible for TMH who may still benefit from TPT (e.g., individuals with a history of complex mental health needs).		
			A5. Therapist-Led Screening/initial determination for TPT Eligibility: Implement a structured approach where TPT therapists, rather than TMH counselors alone, determine and document client eligibility for TPT services. This could include a screening method conducted by a case worker or a joint assessment by both TMH counselor and TPT therapist.		
			A6. PSFS Referral document completion: Ensure documentation is completed for each client prior to referral for TPT services (e.g., PSFS document).		
	Based on staff interviews and discussions, most incoming referrals to CVT's telehealth services originate from advertising efforts, particularly via partner organization trainings or workshops. Staff noted that the most successful approach from their perspective is direct promotion at the end of trainings, where participants are informed about telehealth services and provided with flyers. However, staff also highlighted limitations, including low uptake and limited reach, suggesting that relying solely on partner organization channels does not reach all potential clients or sub-groups who could benefit. A few clients provided feedback from the survey for ways to improve this outreach	Current referral networks may be limited, missing additional persons who could benefits from services, including specific subgroups.	**A7. Outreach strategy:** Expand outreach and referral pathways beyond partner organization trainings to increase awareness and accessibility of telehealth services among underrepresented populations. Consider multiple strategies such as: - Secure electronic leaflets to relevant community leaders, professionals, and human rights networks. - Virtual informational sessions with options for follow-up individualized sessions. - Targeted in-person promotion at community events or trainings.		

	strategy (included in the recommendation cells).				
B. Inclusion/Exclusion Criteria	Staff interviews and desk review, including a review of TMH and TPT I&E criteria and relevant literature, indicated that terminologies (e.g., complex mental health needs, comorbidities, high risks) were used interchangeably, but not formally defined within both services. While these terms are broadly consistent with definitions in the literature, CVT has not clearly operationalized them to align with the specific client populations and service goals.	The current I&E criteria are not fully operationalized, and terms such as "complex mental health needs" or "severe symptoms" remain open to interpretation. This creates variability in client eligibility determinations (such as how such needs might have impacted their functional ability) and may limit access to services for clients who could benefit.	**B1. Define and operationalize TMH and TPT Terminology and Criteria:** Define and operationalize key terminologies used in TMH and TPT within CVT beyond what is listed in the Terminology Definition page (e.g., complex mental health needs, high risks, comorbidities, TPT red & yellow flags, specialized vs non-specialized). For TMH, clarify the rationale for including extreme social isolation within the exclusion criteria, particularly given the literature cautioning against excluding beneficiaries on the basis of social isolation alone. While TMH does not treat social isolation as a standalone indicator, it would be helpful to clearly articulate why and how it is considered in combination with other clinical factors, given that one-third of clients reported not having supportive relationships outside of their home. As services scale or expand, clarity on this rationale will help ensure that eligibility criteria do not inadvertently restrict access for individuals who may still benefit from TMH. As for TPT, the rationale for excluding individuals with cardiovascular disease, neurological movement disorders, cognitive impairment, and serious mental illness should be clarified in light of existing literature, which suggests that TPT can be effective for some of these populations when appropriate safeguards and clinical criteria are in place.		

			B2. TPT to provide structured guidance on applying the "sufficient evaluation" question in TPT: Currently, therapists are asked: "*Have you conducted a sufficient evaluation to confidently create a care plan and initiate tele-physiotherapy?"* To ensure consistent interpretation, guidance should clarify what constitutes a sufficient evaluation (e.g., assessment of physical, functional, and safety considerations), how to document findings, and how to record any ethical considerations. If a therapist determines that the evaluation is insufficient, the client should not proceed with TPT, and the rationale, including ethical considerations, should be clearly documented.		
			B3. Integration of complex mental health individuals: Explore adaptable service models for individuals with complex mental health needs, potentially through a hybrid approach combining remote and in-person support with enhanced case management (e.g., ADMSP model).		
			B4. Expand target population: Conduct a rapid needs assessment to identify sub-groups who could benefit from TMH and TPT services beyond the current I&E criteria.		
	The PSFS and referral forms do not clearly define how mental health symptom levels (low, medium, high) are determined. The intake symptom scale lacks a standardized scoring system to categorize severity for depression, anxiety, PTSD, behavioral functioning, and physical symptoms. Consequently, symptom severity classification is not systematic or easily comparable across clients (please see part 2.2.6 Symptom Outcomes for symptom domain measures & findings).	Clinical staff rely heavily on professional judgment rather than standardized scoring, which may introduce variability in eligibility. The absence of consistently applied and standardized measures in TMH limits the ability to accurately classify clients' mental health needs and may also impact eligibility decisions.	**B5. MH standardize measure:** Develop a standardized approach in TMH assessments to measure and categorize mental health needs as low, medium, or high to reduce reliance on the TMH counselor's clinical judgment.		
			B6. MH and PT measures to inform I&E: Incorporate validated abbreviated measures as appropriate, for TMH and TPT, to better inform I&E decisions.		

	Limited literature and emerging research protocols suggest tele-physiotherapy can improve functional independence, motor skills, and quality of life in children, including in low-resource or remote settings.	While pediatric evidence is sparse, TPT has the potential to deliver meaningful functional gains for children and adolescents when in-person PT is inaccessible.	**B7. Inclusion of children and adolescents in TPT service:** Investigate the feasibility of expanding TPT to include children and adolescents, incorporating structured functional goal-setting and caregiver engagement.		
C. Assessment	TPT functional ability outcomes worsened on average at 3- and 6-month follow-ups (decrease by ~ 4 points) (see section 2.3.2 Symptom Outcomes). Data on functional ability (e.g., dressing, walking, light work) is not consistently completed for clients.	Average scores may not reflect individual client progress because some functional ability items were not the clients' main concern, per clinical judgment, and were therefore not prioritized and completed, potentially skewing results.	**C1. Determine the effectiveness of TPT on functional ability outcomes:** Given the observed modest decline in functional ability scores over time, TPT clinical staff should assess whether the remote PT modality and adapted techniques are sufficiently targeting functional outcomes or whether refinements are needed. Additionally, it may be valuable to explore whether changes in client self-report reflect increased awareness of physical functioning limitations over time rather than true functional deterioration.		
			C2. Ensure complete functional outcome: Ensure all functional ability items are consistently completed for every client, even if some seem less relevant, to enable accurate evaluation and interpretation of outcomes.		
	For TPT, average improvements were observed in coping and outlook, body functions and physicality, and social participation and functioning measures. Because most clients accessed TPT after or alongside TMH services, these outcome gains may reflect the combined or sequential effects of both interventions rather than TPT alone (see section 2.3.2 Symptom Outcomes).	Although TMH and TPT use distinct assessment measures, it is difficult to determine the impact of TPT with the influence of prior or concurrent TMH participation. Improvements observed in TPT domains—particularly coping, outlook, and social participation—may be partially or substantially attributable to skills, symptom stabilization, or therapeutic gains achieved during TMH, limiting the ability to draw	**C3. Assess standalone TPT outcomes vs. TPT combined with TMH:** Conduct a future evaluation using a comparison group design (e.g., TPT only versus TMH + TPT) to assess the effectiveness of TPT as a standalone intervention and better understand the additive or complementary effects of TMH on TPT outcomes.		

		conclusions about TPT as a standalone intervention.	**C4. Torture survivor categories:** Include torture survivor categories within TMH intake assessment form. Clinicians (TMH and TPT) should avoid categorizing HRDs solely under "other" in the torture category. HRD is not considered a torture type on its own. It is recommended that clinicians review and apply the established definitions of torture categories to ensure accurate documentation of the client's experiences (e.g., civil conflict instead of War or Organized Violence).		
			C5. TPT sleep measure scoring: If continuing to use the existing assessment, ensure that all items under the sleep section in the Body Functions and Physicality (B3–B6) are scored consistently before computing section-level averages. Specifically, reverse-code item B4 ("Discomfort while trying to sleep") so that higher scores consistently reflect better sleep. This will provide a more accurate representation of overall sleep quality and ensure that changes over time (e.g., from intake to follow-up) are meaningful and interpretable.		
	A desk review of client TMH and TPT intake and follow-up assessment forms identified inconsistencies and duplication in recorded responses across clients, as well as challenges related to the use of fillable assessments as Word documents. In several cases, responses were entered using highlights, shapes, etc., rather than standardized indicators, reducing the efficiency and readability of the forms for clinical staff. Additionally, the inclusion of Arabic text within an English document, at times affected formatting and alignment.	Such technical limitations reduce the usability of the assessment tools and highlight the need for system-level adjustments to improve data quality and consistency.	**C6. Standardize digital assessments workflow:** Consider alternative approaches to identify and implement a more user-friendly, standardized digital assessment format to replace or improve the usability of current Word-based documents. This should reduce formatting errors, duplication, inconsistent use of highlights or shapes, and challenges related to bilingual (Arabic–English) text entry, while ensuring all fields are point-and-click where possible. Overall, it would improve data quality, streamline clinician workflows, and enhance accessibility of information for program monitoring and evaluation purposes. **C7**. **Data collection and consistency:** whatever revised system is established, use a clean assessment template for each new client and follow-up assessment, rather than adapting or modifying forms from other clients, to minimize data inconsistencies and ensure accuracy and standardization across records.		
	The TMH assessment currently captures symptoms across three non-standardized mental health domains—anxiety, depression, and trauma-related distress.	The current symptom assessment provides useful but partial insight into clients' mental health status. In the absence of broader or more structured and validated symptom	**C8. TMH symptom outcome measure:** Adapt and integrate brief, validated psychological measures within TMH assessments that extend beyond anxiety, depression, and trauma-related distress to include domains in PTSD, behavioral functioning, and physical		

	While these domains are central, they may not fully capture the breadth or severity of clients' mental health presentations when considered alongside co-occurring social, psychological, and physical factors that often characterize complex mental health needs. The limited symptom scope may also constrain counselors' ability to comprehensively assess client needs, develop informed treatment plans, and identify clients who could benefit from referral to TPT.	measures, clinical judgment may vary when determining severity, monitoring change, or making referral decisions. To ensure consistency across CVT interventions and advancing the evaluation framework and alignment with evidence-based practice, symptom measurement should meaningfully capture treatment impact and inform the treatment plan.	symptoms. Using standardized, abbreviated tools would strengthen severity determination, support treatment planning, improve referral decision-making (including to TPT), and enhance comparability of outcomes across CVT services. It is important for TPT to include validated and abbreviated mental health measures, given that TPT is trauma-focused and often serves as a continuation of care for clients who have already received stabilization through TMH. Integrating MH measures into TPT would support monitoring the broader psychosocial context, help capture the interplay between physical and mental health outcomes, and ensure that the trauma-focused intervention addresses both functional and emotional/psychological recovery.		
	Desk review of PT theory of change shows that the health-related quality of life (HRQOL) as a 12-month long-term outcome has no validated instrument that directly measures it, but rather is inferred from short and medium-term outcomes.	Current measurement approaches capture short- and medium-term changes but do not directly assess the intended long-term HRQOL outcome. As a result, the evaluation cannot determine whether sustained improvements in overall quality of life are achieved at 12 months, creating a misalignment between the theory of change and outcome measurement.	**C9. PT HRQOL measure:** Either introduce a validated health-related quality of life measure at baseline and 12 months, or formally define and operationalize structured composite measures aligned with the theory of change.		
	Review of program documentation and discussions with staff indicated that a standardized TPT follow-up assessment template was not developed. Currently, follow-up documentation relies on the in-person PT assessment, which is not adapted for remote delivery. Additionally, the PSFS measure included in the TPT intake assessment is absent from the in-person follow-up form, limiting the ability to track functional progress consistently.	While the use of the in-person follow-up PT assessment allowed for documentation of services, it may reduce alignment between intake and follow-up measures and raises questions about the suitability of administering an in-person tool virtually (e.g., via screen share for client scoring). The PSFS was not documented at follow-up in the reviewed case (CVT client who received 3-month follow-up), limiting the ability to assess functional change over time for that one CVT client. Additionally, it is unknown whether ADMSP completed the PSFS at all timepoints, as such data was not collected from the partner for this evaluation. These gaps limit the completeness and	**C10. TPT Follow-up form:** Develop and store a standardized TPT follow-up assessment template aligned with the intake form and tailored to virtual delivery. Ensure inclusion of the PSFS at all required timepoints and establish clear reporting expectations with partner organizations to support complete and consistent outcome tracking. Additionally, clinicians may benefit from reflecting on the distinct purpose of the PSFS, particularly its client-specific, goal-oriented focus, and how it complements broader functional ability measures in the assessment form. Clarifying the added value of each tool can support intentional measurement selection, strengthen clinical interpretation, and enhance the understanding of the findings regarding the average decline of functional ability scores.		

		comparability of functional change data and highlight the need to clarify how the PSFS complements or differs from other indicators of functional ability included in the TPT assessment (e.g., Section A), particularly in capturing client-specific functional goals.			
	TMH symptom outcomes were assessed only at the 1-month follow-up, whereas tele-physiotherapy conducts follow-up assessments at 3 and 6 months. Because symptom improvement in TMH was evaluated at a single early time point, the data reflect short-term measurable change but do not capture whether improvements continue over time.	The reliance on a 1-month follow-up limits the ability to compare TMH outcomes with other services and constrains understanding of longer-term symptom trajectories. Without a consistent follow-up schedule across programs, it is difficult to interpret whether observed improvements represent early gains, stable change, or temporary effects.	**C11. TMH Follow-up Timepoint:** It may be valuable for the clinical team to reflect on the rationale for this time point and consider whether follow-up assessments should be standardized across services (e.g., aligning with the 3- and 6-month follow-ups used in TPT). Clarifying the purpose and timing of follow-up assessments may strengthen consistency in monitoring outcomes and support more comparable evaluation across programs.		
D. Intended Outcomes & Theory of Change	One-third (56 of 168) of TMH clients had prior mental health service experience; among 69 clients with pre- and post-assessments, all showed measurable symptom improvement, with greater improvement observed among those (n=15) who began with higher baseline symptom severity; and most (58 of 68) did not request additional psychosocial support at follow-up.	These results indicate that TMH can adequately meet client needs, including clients with severe MH measurable symptoms, within its scope and duration, highlighting the potential role of non-specialized, short-term TMH services as meaningful components of a broader continuum of care.	**D1. Reflection on service scope and duration:** Results suggest TMH, as a brief, remote, non-specialized intervention, can serve as an effective intervention, potentially both stand-alone and within a broader continuum of care. These findings highlight the importance of reflecting on assumptions about the type and duration of services required to make meaningful impacts on mental health symptoms and other outcomes. This consideration applies not only to TMH but also to TPT, reflecting on assumptions about what can be achieved with shorter-term remote models vs longer-term in-person services. As a component of this, it may also be useful to examine other assumptions about "specialized" and "non-specialized" within CVT.		
	The findings indicated that increased awareness of trauma and receipt of psychoeducation were key benefits reported by TMH clients within the 3-5 sessions. Clients' reports on this were mentioned in the qualitative follow-up responses regarding their progress toward goals and in the feedback survey, where six of the ten clients who completed this survey identified psychoeducation and	Both client feedback and staff interviews highlight that trauma awareness and psychoeducation are perceived as meaningful benefits of TMH. This suggests that these components are central to the intervention's impact and could be formally incorporated into the intended outcomes to better capture client progress and program effectiveness.	**D2. Psychoeducation/trauma awareness as an added value to TMH intended outcomes:** It is recommended to determine if trauma awareness/psychoeducation can be an added component to the intended outcomes based on the findings from clients and staff.		

	trauma awareness as a benefit of the service (see section 2.2.10 Overall TMH Perceived Impact and Feedback). Staff interviews similarly emphasized trauma education and psychoeducation as central focus areas of the intervention.				
	TPT model currently informed by the in-person, group-based PT theory of change.	TPT outcomes may not fully reflect all intended in-person PT outcomes. Limited changes in functional ability, for example, likely reflect the brief, client-focused nature of TPT, where clients' presenting concerns often differ from functional limitations, rather than indicating a lack of effectiveness. Further data completion and analysis are needed to confirm this pattern.	**D3. Revision to TPT ToC:** Revise the current TPT theory of change, which is based on the in-person group model, to either develop a separate ToC for the individual-focused remote delivery or create a standardized framework that aligns both the remote and in-person (group or individual) models.		
	TPT HRQOL (12-month outcome) is not directly measured; current assessments rely on short- and medium-term outcome measures.	Current evaluation methods cannot determine whether long-term HRQOL outcomes are achieved or sustained.	**D4. Aligning with C9 recommendation regarding integrating a validated measure for health-related quality of life to assess long-term impact:** this will guide the inclusion or exclusion of HRQOL from the PT ToC.		
E. Operational	Evaluation findings indicate that TMH and TPT currently operate in conjunction without a formalized manual outlining standardized protocols, procedures, or defined staff competencies. Staff roles, qualifications, and required training pathways are not consistently documented. Additionally, as telehealth expansion is underway across SOTI, ARC, and other CVT programs, no formal contingency plans were identified to address internet disruptions in settings where connectivity interruptions are common.	The absence of formal protocols, defined staff competencies, and contingency planning for connectivity interruptions highlights operational gaps that could affect service quality and scalability. Establishing standardized competencies, clear procedures, and backup plans is critical to ensure consistent delivery of TMH and TPT, particularly as telehealth expands across MENA and other contexts	**E1. Retain vs. Separate:** Determine whether TPT should remain under the TMH umbrella or function as a standalone service with its own referral and intake pathway. **E2. Develop TMH manual:** Create a comprehensive TMH manual outlining procedures, clinical protocols, and best practices to ensure consistent service delivery. **E3. Staff competency standards:** Define clear competency standards for CVT staff and partner organizations delivering TMH and TPT, including training requirements, supervision structures, and timelines based on partner readiness and implementation needs. **E4: Contingency planning and service continuity in low-resource settings:** Develop guidelines addressing contingencies such as internet disruptions in Syria and planning for future expansion in collaboration with partner organizations, such as ADMSP, ensuring continuity of service and readiness for scaling operations.		

5. Suggested Implementation of Recommendations and Clinical Leadership Response

Recommendation Number	Suggested Implementation
A1	Develop and maintain a clear external referral guidance document and resource sheet of existing in-country service providers (beginning with Syria and Turkey) to support clinical staff—and any future case management roles—in identifying appropriate referral options when clients are deemed ineligible for TMH or TPT. This resource is intended to serve as a contingency support tool, not a replacement for consultation with clinical supervisors, and to ensure counselors and therapists have accessible backup referral pathways when needed.
A2	Inclusion of a structured question in the follow-up assessment for counselors to explore clients' reasons for declining or not requiring additional psychosocial support.
A3	Develop and implement a shared referral protocol between TMH counselors and TPT therapists that clearly outlines indications for TPT referral, with particular attention to somatic, functional, and physical health needs. This protocol should clarify roles, expectations, and referral thresholds to support consistent and clinically informed decision-making across teams.
A4	TMH counselors, in consultation with the clinical supervisor, should initiate early communication with TPT therapists and the TPT clinical supervisor regarding clients who may be ineligible for TMH services but could still benefit from TPT.
A5	Adopt a structured eligibility determination process in which TPT therapists play a primary role in assessing client appropriateness for TPT services. This may include a brief screening conducted by a designated case worker or a joint assessment involving both the TMH counselor and TPT therapist, ensuring that referral decisions are informed by physical therapy expertise rather than counselor knowledge alone.
A6	Completion of the PSFS should be required prior to submitting any TPT referral form to ensure that the client's functional scores and presenting needs are clearly documented and available for TPT therapists to review and follow up on as needed.
A7	Map potential sub-groups and their preferred communication channels for outreach beyond partner organizations.
B1	When establishing the manual/guideline, operationalize terminology related to complex mental health needs, comorbidities (e.g., cardiovascular disease, neurological movement disorders, and cognitive impairment in TPT exclusion criteria, TPT yellow flags indicators), and their association with eligibility criteria (e.g., high risks). Clarify the rationale for including or excluding individuals with these conditions, taking into account the growing evidence of potential benefits and CVT's responsibility to ensure fair access to services.
B2	Provide further clarification, guidance, and ways to operationalize the following assessment questions in the TPT assessment that the therapist completes: "Do you feel you have been able to sufficiently evaluate the client well enough to create a plan of care and initiate treatment?"
B3	Collaborate with ADMSP (in-person operation) or future CVT Syrian office/clinic to pilot a hybrid model combining remote TMH with in-person support for clients with complex needs, ensuring the establishment of clear criteria for when clients qualify for hybrid vs fully remote.
B4	Collaborate with the E&R department to conduct a rapid needs assessment to identify sub-groups who could benefit from TMH and TPT beyond the groups both services are serving.

B5	Collaborate with E&R to establish a scoring system (e.g., low, medium, high) for the symptom scale measure after adapting appropriate validated measures.
B6	Discuss the options regarding including validated measures for intake to identify a clear pathway for inclusion and exclusion (please see recommendation C8 for further information).
B7	Determine the feasibility of developing child-specific TPT protocols with goal-oriented activities, including caregiver participation where needed.
C1 & C2	Discuss and evaluate clinically whether the current remote TPT techniques effectively target functional outcomes, supplemented by future completion and re-analysis of functional ability measures to inform any needed adjustments.
C3	Collaborate with E&R to design a comparison group study of clients who receive TPT alone and TMH with TPT to understand whether observed improvements are attributable to TPT alone or to combined TMH–TPT engagement.
C4	Develop a standardized definition list of torture categories (e.g., primary and secondary survivors, SGBV, WOV, other) to guide TMH and TPT assessments. Incorporate these categories into the TMH intake form, and adjust it in the TPT intake form, to ensure consistent documentation and enable future analysis of outcomes across sub-groups.
C5	If the TPT sleep measure is retained, E&R, in collaboration with clinical staff, should update the assessment to standardize the scoring procedure for this measure by reverse-coding item B4 (“Discomfort while trying to sleep”) so that higher scores consistently reflect better sleep. This will ensure consistency across other items in the sleep measure table. Therapists should be informed of this adjustment and apply the revised scoring consistently during assessments.
C6 & C7	Collaborate with CVT IT team or explore alternative solutions to transition to a standardized, user-friendly digital assessment system and require the use of clean assessment templates for each client and follow-up, in order to reduce formatting errors, duplication, and data inconsistencies—particularly in bilingual (Arabic–English) documentation—and improve overall data quality and usability.
C8	Collaborate with E&R to adjust the assessment tools to add validated mental health symptom measures within TMH and TPT assessment, regardless of whether the interventions remain integrated or operate separately.
C9	Collaborate with E&R to determine whether HRQOL should be measured directly (validated instrument) or operationalized through a standardized composite framework.
C10	Ensure that a standardized TPT follow-up assessment template is available to clinicians and the E&R Program Evaluator/M&E Officer. Additionally, ensure that ADMSP utilizes the same standardized template and consistently includes the PSFS at all required timepoints. Clinicians are also encouraged to discuss the rationale for including the PSFS and how it complements or differs from other measures in the assessment form (e.g., functional ability, sleep hygiene, pain) to support intentional interpretation of client progress.
C11	Clinical team to reflect on the purpose and rationale of the 1-month follow-up used in TMH, including whether this time point adequately captures meaningful change for clients receiving a brief intervention.
D1	Reflect on the assumptions about the scope and duration of TMH and TPT, and reassess these factors across telehealth and other services in light of the findings on symptom outcomes.

D2	Integrate psychoeducation and trauma awareness into TMH intended outcomes and establish a structured approach for delivering these components, including incorporation into the future formal TMH manual.
D3	Identify which TPT outcomes are relevant for individual-focused remote delivery and which require adaptation. Then, develop either a standalone TPT ToC or a harmonized framework aligning both in-person and remote models, ensuring that intended outcomes, measures, and client pathways reflect the modality-specific focus.
D4	Collect HRQOL data using a validated measure to assess whether TPT achieves meaningful long-term improvements.
E1	Discuss telehealth structure involving both of the models to determine dual-pathway system or independent interventions (TMH and TPT operating alone or operating together), ensuring that safety protocols are being followed if both services decide to split (e.g., safety planning for domestic violence, harm to oneself or others)
E2	Create a comprehensive TMH manual detailing procedures, clinical protocols, and best practices, ensuring standardized and consistent service delivery across all staff and partner organizations (including ADMSP and beyond).
E3	While TMH and TPT training materials are available and reproducible, it is important to define the minimum qualifications, skills, and experience required for CVT and partner staff delivering these services within an intervention manual. Establishing supervision and mentoring structures, including frequency and documentation requirements, is essential to support scalability and staff expansion across both TMH and TPT. Additionally, specific guidance should be provided for case manager qualifications, particularly if this role is prioritized in the future based on evaluation findings. Insights from ADMSP's experience with a case manager could further inform CVT's approach.
E4	Develop step-by-step contingency protocols to maintain service continuity during disruptions of the internet or political insecurity or instability.

6. Limitations

1. The evaluation relied primarily on existing program data, and no new outcome measures were introduced. As a result, the assessment of efficacy is constrained to the indicators currently captured in routine TMH and TPT assessments. In the absence of a formal theory of change for either intervention, it was not possible to systematically assess causal pathways between activities and outcomes.
2. The evaluation did not include a comparison group and did not assess differences between TMH and TPT, between telehealth and in-person services, or across country contexts. Consequently, findings should be interpreted as descriptive rather than comparative and cannot be used to draw conclusions about relative effectiveness across service modalities.
3. Limited TPT data were available across CVT and ADMSP, which constrained the depth of analysis and interpretation of findings.
4. While the evaluation reviewed the alignment of assessment tools and protocols with intervention objectives and existing literature, it did not test or validate alternative measures, nor did it assess fidelity, quality, or performance at the individual staff level. Decisions regarding revisions to tools, protocols, or clinical guidelines fall outside the scope of this evaluation.
5. Although the evaluation included a desk review of relevant literature to contextualize inclusion and exclusion criteria and core assumptions, the findings should be interpreted as informative rather than prescriptive, particularly given the evolving evidence base for telehealth services among individuals with complex needs.
6. Client experience data were based on retrospective feedback and a small sample of clients, with only ten clients completing a survey. This limited number may restrict the diversity of perspectives captured and could be influenced by factors such as the lack of compensation or changes in clients' contact information due to migration or relocation to Syria and other countries.
7. Similarly, provider perspectives reflect the views of those interviewed and may not capture all variations in practice or experience across programs or organizations (CVT vs ADMSP).
8. While staff interviews at ADMSP were prioritized during the development of the terms of reference for this evaluation, time constraints and limited capacity meant that the evaluator was only able to speak briefly with one therapist at ADMSP to understand their telehealth process. This limited engagement does not fully reflect ADMSP's experience in implementing TPT or their adaptation of the CVT model. A more in-depth evaluation comparing TPT practice within CVT and at ADMSP is needed, particularly given that ADMSP managed 25 clients during the GSF project and has continued to serve additional clients under CVT supervision and training. ADMSP client data for individuals who received services after the conclusion of the GSF project in 2024 were not included in this evaluation. Future evaluation could help identify challenges, successes, and potential adjustments to enhance client experiences with the service.
9. *TMH client problem severity:* A limitation in the treatment planned follow-up assessment is regarding the problem severity rating. Most of these were documented based on the counselor's observation and interpretation of the clients' descriptions, rather than the clients being consistently asked directly. This approach may have contributed to an overrepresentation of severe baseline ratings and low severity ratings at follow-up, and highlights the importance of asking clients explicit severity questions to ensure accurate and reliable measurement.

10. *TMH client progress:* A potential limitation is related to the quality of the data on client-reported goals. In some instances, the documentation is quite limited and may not fully capture nuanced changes in clients' progress toward their prioritized problems, which could affect the precision of assessing goal-specific outcomes.
11. This evaluation did not include a thorough review of TMH assessments for individuals who were deemed ineligible, nor the specific reasons for ineligibility. While the evaluator briefly reviewed several intake forms of excluded individuals, reasons for exclusion were not consistently documented in the clinical notes section.

7. Conclusion

Results from this evaluation suggest that CVT's remote service delivery models — including Tele-Mental Health (TMH) and Tele-Physiotherapy (TPT) — are feasible and responsive approaches to increasing access to care in low-resource and high-need contexts. Findings suggest meaningful improvements in several client-reported outcomes, particularly in mental health domains, and some TPT outcomes, although functional ability outcomes in TPT were more variable and limited by inconsistencies in item-level data completion. Results suggest that while remote models can effectively address psychological distress and certain rehabilitation goals, outcome measurement processes require strengthening to better determine the efficacy of the interventions moving forward.

Acknowledgment:
The program evaluator extends sincere appreciation to the CVT counselor, Noor Alsagher, physical therapist, Farah Aldweik, and clinical advisors, Justin Hett and Ilona Fricker, who committed to designing and delivering these interventions over the years, and for the valuable time and insights they contributed throughout this evaluation. Gratitude is also extended to our partner organization, ADMSP, for their collaboration, support with data transfer, and valuable insights into intervention implementation. The evaluator further acknowledges the contributions of the Monitoring and Evaluation Officer, Philip Gorgees, whose work in data entry and qualitative analysis strengthened the rigor of this review. Most importantly, deep appreciation is offered to the clients who participated in TMH and TPT services and generously shared their feedback. Finally, the evaluator thanks Dr. Courtney Welton-Mitchell, Director of the Evaluation and Research Department at CVT, for her leadership, guidance, and thoughtful review throughout this process.

Annex 1 – TMH Intake Assessment

SOTI Telemental Health Assessment Form

Administration Box

- ☐ Consent completed
- ☐ Clinical review completed (Initials: _____)
- ☐ Beneficiary **will** be offered services after assessment
- ☐ Beneficiary **will not** be offered services after assessment

Assessment date: _____

Therapist name: _____

Beneficiary name: _____

Beneficiary Signal number: _____

Beneficiary number: _____

AT THE BEGINNING OF THE SESSION:

- Introduce yourself, explaining your position, location, and relevant information about the project.
- Ensure that the client is in a secure and private space and is using the agreed secure platform.
- Check that the internet connection is stable enough for the call, and agree on how to handle connectivity issues.
- Explain that the session will last 60 minutes.

EXPLAIN TO BENEFICIARY:

Today I would like to ask you some questions about your current circumstances and needs. There are no right or wrong answers to these questions. The aim of the conversation is to identify whether this telemental health service is appropriate for you, and if not, to help identify alternative options.

If you have been having bad feelings, some of the questions I ask might make you more aware of them, so please let me know if you are having any difficulties answering questions or if you need to take a break. We also need to let you know that we will not share anything we talk about without your permission unless there is a safety risk that we need to address together.

Is there anything you would like to ask me before we begin?

CONDUCT THE FIRST PART OF THE CONSENT FORM AND OBTAIN VERBAL CONSENT BEFORE PROCEEDING

A. Beneficiary's demographic information:

1. Gender: □ Male □ Female □
2. Age: _____ years / _____ year of birth
3. Nationality: _____
4. Current location (country): _____
5. Current location (town): _____
6. Date of arrival in current location: _____

B. Source of referral:

1. How did the beneficiary learn about this tele-mental health service? (Provide information about CVT/SOTI as appropriate)

   _____

2. Are you currently providing testimony as a witness in legal proceedings?

   □ Yes □ No *If yes specify:*

   _____

C. Beneficiary's main needs and current daily functioning:

1. **What led you to access this service?**

Note: In order to assess eligibility, it is important to determine whether the beneficiary is a torture survivor, former detainee, family member of a missing person, or human rights defender. If this does not come up in the above response, some additional questions may be required.

2. **What challenges you most now?**

3. **What helps you most to manage this?**

D. Economic situation

1. What is your main work or activity right now?

_____

2. *If obvious from the previous response, fill in the following questions without asking the beneficiary. If not, ask:* Do you engage or have you engaged in activities to promote dignity, equality, or the protection of human rights (such as civil, political, economic, social, cultural, or environmental rights) for yourself or others? This can be part of your job, personal time, or through volunteering, even if it's not the main focus of your work. Examples include investigating, documenting, educating, advocating, organizing, or holding violators accountable.
    - ○ I currently do
    - ○ I have in the past
    - ○ I never have

    2b. If *yes:* what type of activities are you doing? *Do not read response options to the beneficiary. Write the beneficiary's response below and then select all that apply.*

    Response:_____
    - ○ Local community organizing
    - ○ Policy advocacy
    - ○ Legal work (investigator, lawyer, etc)
    - ○ Documentation
    - ○ Media, journalism
    - ○ Awareness raising
    - ○ Staff member at a human rights organization
    - ○ Other:_____

3. Do you have any financial needs that you are worried about?

    □ Yes □ No *If yes specify:*

    _____

4. Do you have access to any sources of financial support?

☐ Yes ☐ No *If yes specify:*

_____

E. Relationships and support network

1. What is your social status?

- ○ Single
- ○ Living together as a couple (but not married)
- ○ Married (even if currently apart by circumstance)
- ○ Divorced or separated (married but living apart by choice)
- ○ Widowed

2. Who do you currently live with? *List all other members of the household*

_____

3. How would you describe the quality of your relationships at home?

_____

_____

4. Do you think that anyone in your home (including yourself) is currently at risk or in danger?

☐ Yes ☐ No *If yes specify:*

_____

5. Do you have supportive relationships outside of your home?

☐ Yes ☐ No *If yes specify:*

_____

F. Health

1. How would you rate your physical health overall? *Circle*

Very poor Poor Fair Good Very good

2. Do you have any medical of health problems that negatively impact your daily functioning?

☐ Yes ☐ No *If yes specify:* _____

_____

3. Are you currently taking any medications for your health, including mental health?

☐ Yes ☐ No *If yes specify:* _____

_____

4. Do you drink alcohol?

☐ Yes ☐ No If yes how often*:*

- ○ Never
- ○ Occasionally (less than monthly)
- ○ Monthly (less than once a week)

○ Weekly (some each week)
○ Daily

5. Do you use any drugs for non-medical reasons?

□ Yes □ No If yes how often*:*

○ Never
○ Occasionally (less than monthly)
○ Monthly (less than once a week)
○ Weekly (some each week)
○ Daily

6. Have you or a family member ever been concerned about your alcohol or drug use?

□ Yes □ No *If yes specify:* _____

_____

7. Have you or a family member ever been concerned about your mental health?

□ Yes □ No *If yes specify:* _____

_____

_____

_____

_____

8. Have you ever seen a mental health professional?

□ Yes □ No *If yes give details about type of service, duration and beneficiary perspective on efficacy:* _____

_____

_____

_____

9. Do you have access to medical facilities in the case of an emergency?

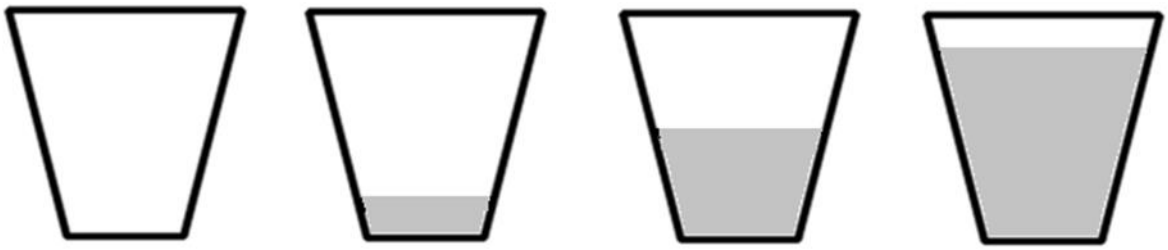
□ Yes □ No *If yes specify:* _____

_____

G. Symptom scales

Explain to the beneficiary that you are going to ask them about how often they experience certain problems. If using video you can show the picture below to help them, explaining that the more full cups mean that they experience these problems more often.

Not at all **Rarely** **Sometimes** **Often**



How much have these problems bothered you in the past two weeks?			Not at all	Rarely	Some times	Often
A	**1**	Feeling nauseous or sick to the stomach?	1	2	3	4
	2	Finding it hard to breathe?	1	2	3	4
	3	Feeling a tightness or heaviness in the chest?	1	2	3	4
	4	Heart pounding or racing?	1	2	3	4
B	**5**	Feeling sad?	1	2	3	4
	6	Blaming yourself for things?	1	2	3	4
	7	Feeling lonely?	1	2	3	4
	8	Feeling unhappy, nervous, or upset by things that remind you of bad things that have happened to you?	1	2	3	4
C	**9**	Feeling everything is an effort?	1	2	3	4
	10	Feeling hopeless about the future?	1	2	3	4

	11	Feelings of worthlessness?	1	2	3	4
	12	Not thinking about or planning for the future as much as you previously did?	1	2	3	4
	13	Thoughts of ending your life?	1	2	3	4

Clinical notes

Are there any identified risk factors such as thoughts of suicide, homicide, self-harm or abuse?

☐ Yes ☐ No ***If yes ask about previous attempts or recent active plans and document below****:*

SAFETY PLAN:

H. Telemental health access

1. Do you have access to other appropriate psychosocial support services?

☐ Yes ☐ No *If yes specify:* _____

_____

2. Do you have concerns about receiving telemental health services?

☐ Yes ☐ No *If yes specify:* _____

_____

3. Do you have the following facilities and accommodations?

I. A reliable internet connection ☐ Yes ☐ No

II. A private and confidential space ☐ Yes ☐ No

III. Access to and ability to use a secure platform for communications

☐ Yes ☐ No *If yes specify:* _____

IV. Video-conferencing ☐ Yes ☐ No

V. Regular time for appointments: ☐ Yes ☐ No *If yes specify:*

_____

NOTE:

The following points should be explained to the client:

- The importance of audio and visual privacy.
- Signal and Zoom are the only platforms that can be used for this service.
- Email will not be used for communication.
- All appointment scheduling will happen via Signal, and this platform should only be used for this purpose. The counselor will not be available for consultation between sessions except in the case of an emergency.
- The importance of keeping mobile devices physically secure and using a strong password.
- For the sake of security, message disappearance will be activated on Signal.

Note any potential challenges identified:

EXPLANATION OF SERVICE:

Explain to the beneficiary the following:

1. Scope of the telemental health service including limitations.
2. Duration of the service (up to 5 sessions).
3. Potential risks of receiving telemental health including:
    a. Experiencing difficult emotions or upsetting memories.
    b. Communication difficulties during calls including the connection being lost during a session.
    c. Loss of confidentiality by conversations being overheard, or information being intercepted.

NEXT STEPS:

Select one of the following:

☐ **If it is clear from the assessment that it would not be appropriate for the beneficiary to receive telemental health**, then explain this and discuss how they could access appropriate alternative services where possible. Document the discussion here, including reasons and advice given: -

_____
_____
_____
_____
_____
_____

☐ **If it is unclear from the assessment whether telemental health would be suitable or not**, then consultation with a supervisor is necessary. In this case arrange for another meeting with the beneficiary, and explain that in the interim you will consult with your supervisor and they can also think about all the information given, and consider if they would like to continue or not.

☐ **If it is clear that telemental health is suitable for the beneficiary**, then arrange for another meeting and explain that in the interim the beneficiary can think about all the information given and consider if they would like to continue or not. Explain also that if they do wish to continue then at the beginning of the first session they will complete the consent process, and also establish an emergency management plan.

End the session by thanking the beneficiary for answering the questions, and ask if they have any further questions for you.

Other notes:

_____

_____

_____

Annex 2 – TMH Treatment Plan

SOTI Tele mental Health Treatment Plan

Beneficiary number: _____

Date of first session _____

Therapist name: _____

A. Beneficiary Concerns and Goals:

Assist the beneficiary to identify 1-2 psychosocial problems that they would like to receive help with, and also goals that they have related to these problems.

First Problem:
How severe was this problem during the past two weeks? ☐ Not at all ☐ A little ☐ A lot ☐ Very much
Beneficiary Goal for this Problem:

Second Problem:
How severe was this problem during the past two weeks? ☐ Not at all ☐ A little ☐ A lot ☐ Very much
Beneficiary Goal for this Problem:

B. Beneficiary Resources:

Identify with the beneficiary, resources that will be useful to them as they work on these goals.

_____ _____

C. Potential Challenges:

Identify with the beneficiary, potential challenges that may arise as they work on their goals, and ways in which these might be addressed.

D. Potential Interventions:

Document here potential interventions, clinical approaches or strategies that could be used during upcoming sessions.

Annex 3 – TMH Follow-up Assessment

SOTI Telemental Health Follow-Up Form

Follow-up date: _____

Therapist name: _____

Beneficiary name: _____

Beneficiary Signal number: _____

Beneficiary number: _____

EXPLAIN TO BENEFICIARY:

Today I would like to ask you some questions about your experience of receiving psychosocial support sessions from CVT. There are no right or wrong answers to these questions, and it is very helpful for us to hear your honest opinion. The aim of the conversation is to understand how you have experienced this service, and any impact it may have had. This will help us improve the service in the future. In addition we will discuss any ongoing needs you might have.

As in all of our previous conversations, we want you to feel comfortable, so if I ask you any question that you don't want to answer, or if you want to take a break, just let me know.

Our conversation will last around 30 minutes.

Is there anything you would like to ask me before we begin?

I. Beneficiary's demographic information:

1. Gender: ☐ Male ☐ Female ☐

2. Are you living in the same place as when you started receiving this service?

☐ Yes ☐ No *If no:*

Current location (country): _____

Current location (town): _____

Date of arrival in current location: _____

J. Impact of services:

	Yes, it has made it **much worse**	Yes, it has made it a **little worse**	No, there has been **no effect**	Yes, it has made it a **little better**	Yes, it has made it **much better**
1: Do you feel that these sessions have changed your ability to cope with difficulties in your life?					
2: Do you feel that these sessions have changed your relationships with your family or household?					
3: Do you feel that these sessions have changed your relationships with people in your community?					

EXPLAIN TO CLIENT:

Now I would like to ask you about whether or not you've told anyone about CVT or the sessions you have participated in. Please remember there is not a right or wrong answer. You are free to respond any way you would like.

	No, I **haven't told anybody**	No, but I **plan to tell at least one person**	Yes, I've **told 1-2 people**	Yes, I've **told several people** (3+)
4: Have you told anyone about services that CVT offers?				
5: Have you told anyone about what you have learned through the sessions?				

K. Treatment plan follow-up

REFER TO THE BENEFICIARY'S INITIAL TREATMENT PLAN. DISCUSS THE 1 OR 2 PSYCHOSOCIAL PROBLEMS THEY MENTIONED. WRITE THESE PROBLEMS IN THE BOXES BELOW AND THE ASK ABOUT PROGRESS TOWARDS THEIR GOALS FOR THESE PROBLEMS.

1. First Problem (copy from treatment plan):

How severe was this problem during the past two weeks?

☐ Not at all ☐ A little ☐ A lot ☐ Very much

Beneficiary's Progress towards Goal for this Problem:

2. Second Problem (copy from treatment plan):

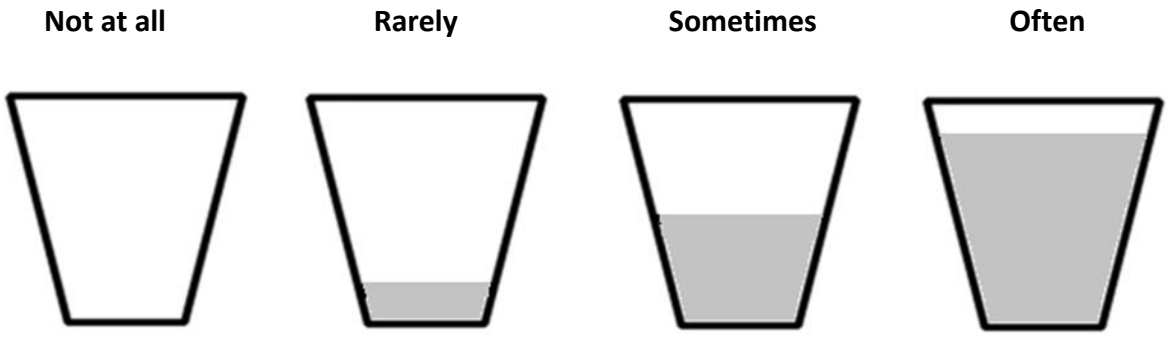
How severe was this problem during the past two weeks?

☐ Not at all ☐ A little ☐ A lot ☐ Very much

Beneficiary's Progress towards Goal for this Problem:

L. Symptom scales

Explain to the beneficiary that you are going to ask them about how often they experience certain problems. If using video you can show the picture below to help them, explaining that the more full cups mean that they experience these problems more often.



How much have these problems bothered you in the past two weeks?			Not at all	Rarely	Some times	Often
A	1	Feeling nauseous or sick to the stomach?	1	2	3	4
	2	Finding it hard to breathe?	1	2	3	4
	3	Feeling a tightness or heaviness in the chest?	1	2	3	4
	4	Heart pounding or racing?	1	2	3	4
B	5	Feeling sad?	1	2	3	4
	6	Blaming yourself for things?	1	2	3	4
	7	Feeling lonely?	1	2	3	4
	8	Feeling unhappy, nervous, or upset by things that remind you of bad things that have happened to you?	1	2	3	4
C	9	Feeling everything is an effort?	1	2	3	4
	10	Feeling hopeless about the future?	1	2	3	4
	11	Feelings of worthlessness?	1	2	3	4
	12	Not thinking about or planning for the future as much as you previously did?	1	2	3	4
	13	Thoughts of ending your life?	1	2	3	4

M. Ongoing needs

1. Do you feel that you have any ongoing psychosocial needs that you would like help with?

☐ Yes ☐ No *If yes specify:* _____

_____

NOTE:

If the beneficiary has ongoing needs, discuss options for how they might access appropriate support. Document here information and advice given.

N. Feedback about the service

1. We are interested to hear your feedback about the service you have received from CVT. Is there anything we could have done differently to improve your experience of receiving support? ☐ Yes ☐ No *If yes specify:* _____

_____

_____

_____

_____

CVT sometimes contacts former beneficiaries to invite them to participate in interviews for different purposes, such as to talk about the impact of CVT programs, for the media, or for attempts to document human rights violations. If we have these opportunities in the future, would you like us to contact you?

○ Yes
○ No

Other notes:

_____

_____

_____

Annex 4 – TPT Intake Assessment

CVT-SOTI
Adult Physiotherapy Intake Assessment
For PT intake assessments conducted remotely

Date of first intake session: Click or tap to enter a date. ☐ *Re-intake? Date:* Click or tap to enter a date.

Client ID #: Click or tap here to enter text.

If the client has an existing Client ID assigned by SOTI PSC/counselor, use this ID.

If not, assign Client ID following CVT Client ID guidelines.

Physiotherapist: Click or tap here to enter text. *PSC/counselor (if applicable):* Click or tap here to enter text.

High risk? Choose an item.

☐ *Consented to services?* ☐ *Consented to data use?*

Client Signal #: Click or tap here to enter text.

How did the client learn about tele-physiotherapy services? Choose an item.

☐ From a family member or friend ☐ From a SOTI staff member (CVT and implementing partners)

☐ From a SOTI partner organization (non-implementing partners) ☐ From another NGO: Click or tap here to enter text.

☐ From a SOTI event ☐ From a former SOTI beneficiary ☐ Other: Click or tap here to enter text.

From psychosocial IDT summary of need for PT services (referral form):

Symptoms: (High, Moderate or Low)

Anxiety: Choose an item. Depression: Choose an item. PTSD: Choose an item.

Behavioral functioning: Choose an item. Physical symptoms: Choose an item.

Main Psychosocial problem(s): Click or tap here to enter text.

☐ Primary torture survivor ☐ Sexual torture / gender-based violence

☐ Secondary torture survivor ☐ War or organized violence (WOV) ☐ Other: Click or tap here to enter text.

Comments: Click or tap here to enter text.

1. Client first name: Click or tap here to enter text.

2. Gender: Choose an item. If non-binary is selected, how does the client identify? Click or tap here to enter text.

3. What is your home country? Choose an item. If other selected, what is the country? Click or tap here to enter text.

4. How old are you? (in years) Click or tap here to enter text.

5. What is your marital status? Choose an item.

6. How many children do you have? Click or tap here to enter text.

(*This should represent children for which the client feels responsible.)*

Explain to client:

- Introduce yourself, explaining your position, location, etc.
- PT at CVT: confidentiality; communication/coordination with PSCs/counselors and mental health trainers, focus on self-management, etc.
- Verbal consent to assessment
- Session will last 60 minutes
- Ensure the client is in a secure and private place, and using a secure communications platform
- Ensure internet connection is stable enough for call, and agree on how to handle connectivity issues

Administration instructions: *This tool should guide your conversation with the client. You should ask the client the questions as they are written on the form, while also being careful to maintain good levels of comfort and trust with the client.*

READ TO CLIENT:

Today I would like to ask you questions about your current health and how it influences your life. This conversation will help me understand more about you. It will help me understand whether tele-physiotherapy is appropriate for you, identify critical medical conditions, and review your physical health goals. It will also help track if your treatment makes/has made any changes for you.

There are no right answers or wrong answers to these questions. If I ask you any question that you don't want to answer or if you need to take a break, just tell me so. I want you to be comfortable throughout this discussion.

Is there anything you would like to ask me before we begin?

Complete the first part of the consent form and obtain verbal consent before proceeding.

History of present condition:

Click or tap here to enter text.

24-hour pattern:

Click or tap here to enter text.

Aggravating factors:

Click or tap here to enter text.

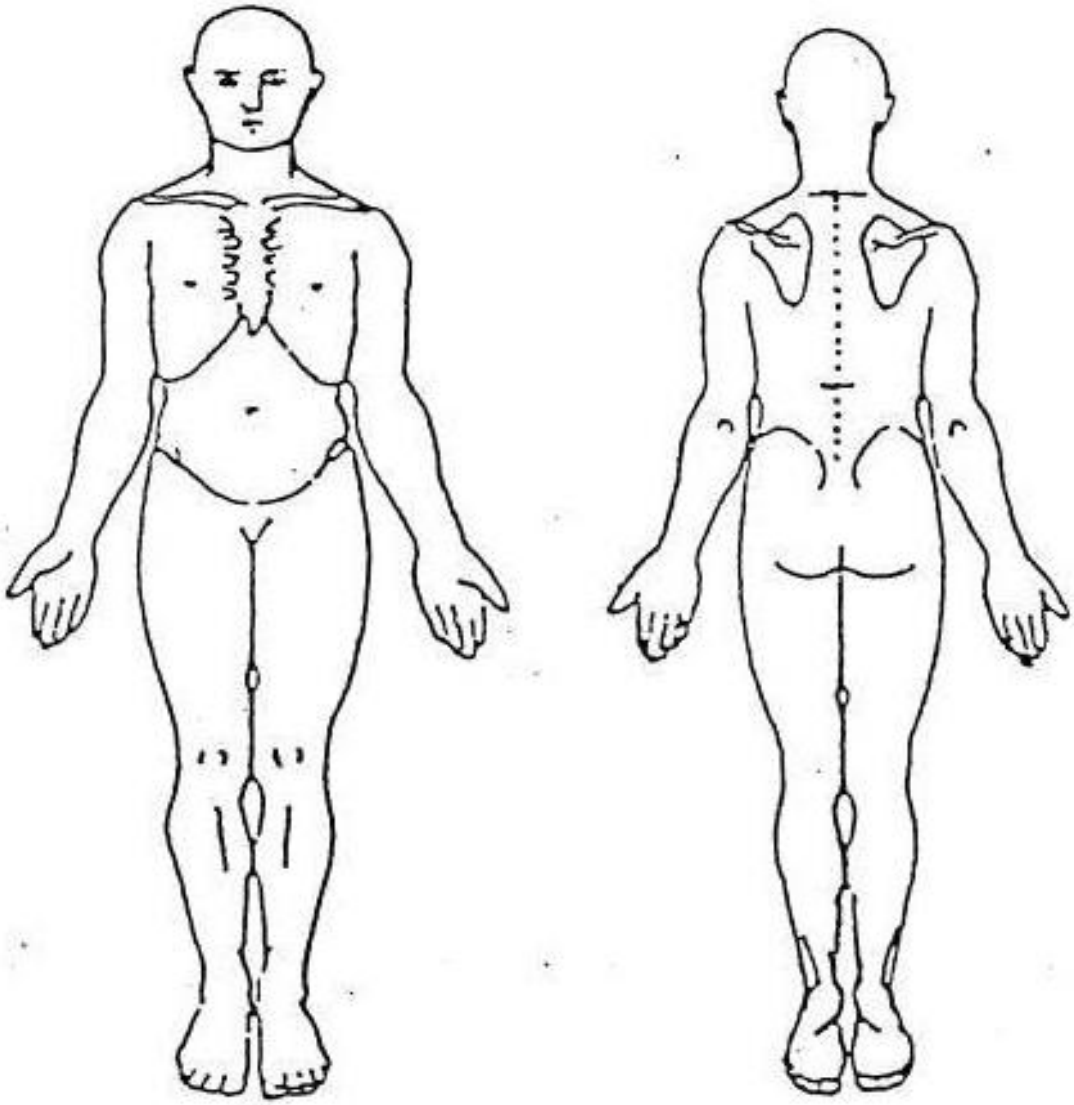
Easing factors:

Click or tap here to enter text.

Instructions: *If the client is not using a computer, direct the client to indicate on their own body affected areas and shade it in for them. Hold the body diagram to the screen afterwards to ensure you have shaded it appropriately and ask if you need to add or take away any shading. If the client is using a computer, ask them to annotate directly on to the screen.*

7a. Indicate the areas on your body that are getting in the way of your life the most.

7b. Indicate on your body the area that is your biggest concern.



SCREENING:

Circulatory system

- ☐ Heart attack
- ☐ Heart disease
- ☐ Heart failure
- ☐ Congenital heart disease
- ☐ Heart murmur
- ☐ Hypertension
- ☐ Varicose veins
- ☐ Deep Vein Thrombosis

Neurologic system

- ☐ Stroke
- ☐ Brain Injury
- ☐ Diagnosed Seizure
- ☐ Other: Click or tap here to enter text.

Respiratory system

- ☐ Asthma
- ☐ Emphysema
- ☐ Other: Click or tap here to enter text.

Skeletal system

- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Previous Fracture
- ☐ Head injury (hit on head)

Digestive system

- ☐ Hernia
- ☐ Ulcer
- ☐ IBS

Skin system

- ☐ Burns or wounds

Area: Click or tap here to enter text.

Bladder/bowel/reproductive conditions

- ☐ Pregnant
- ☐ Pelvic organ prolapse
- ☐ Difficulty starting urination
- ☐ Difficulty controlling urine
- ☐ Painful urination
- ☐ Constipation (<3 BMs per week)
- ☐ Painful bowel movements
- ☐ Painful intercourse
- ☐ Sexual dysfunction
- ☐ Kidney stones
- ☐ Bladder infections
- ☐ Changes in menstruation

Metabolic/Autoimmune conditions

- ☐ Diabetes type I
- ☐ Diabetes type II
- ☐ Rheumatoid Arthritis
- ☐ Thyroid Disease
- ☐ Other: Click or tap here to enter text.
- ☐ Cancer

Type: Click or tap here to enter text.

- ☐ Anemia
- ☐ History of surgery

Type: Click or tap here to enter text.

- ☐ Allergies:

Click or tap here to enter text.

☐ Any additional conditions:

Click or tap here to enter text.

Other Symptoms:

- ☐ Headache
- ☐ Dizziness
- ☐ Fainting
- ☐ Chest pain
- ☐ Chest heaviness
- ☐ Shortness of breath
- ☐ Heart racing
- ☐ Palpitations (skips a beat)
- ☐ Stomach pain

RED FLAGS:

- ☐ Recent PHYSICAL trauma with evidence of fractures or dislocations

Cauda equina symptoms:

- ☐ Sudden onset dermatomal sensation loss or extreme pain
- ☐ Sudden onset myotomal muscle weakness
- ☐ Sudden onset loss of bowel and/or bladder control
- ☐ Sudden onset saddle distribution anaesthesia
- ☐ Sudden onset SEVERE back pain

Uncontrolled medical conditions

- ☐ BP ≥200/110 mm Hg
- ☐ Resting HR >130 or <40 bpm
- ☐ Blood sugar >300 or <70

Suspicion of cancer:

- ☐ Unexplained weight loss
- ☐ Recent fracture without significant trauma
- ☐ History of cancer
- ☐ Severe night pain
- ☐ Constant, unchanging pain
- ☐ Unexplained thoracic pain

PRECAUTIONS:

- ☐ Age over 50
- ☐ Multiple birth history
  - ☐ Vaginal birth
  - ☐ Cesarean section
- ☐ Surgical history
- ☐ Controlled medical condition: Click or tap here to enter text.
- ☐ Diagnosed immunosuppression
- ☐ Smoking
- ☐ Diagnosed or suspected osteoporosis

YELLOW FLAGS:

- ☐ Catastrophizing
- ☐ Unhelpful beliefs about pain
- ☐ Perseveration
- ☐ Fear of movement
- ☐ Uncertainty about the future
- ☐ Passive

Additional details:

Click or tap here to enter text.

Diagnostic tests (with date and details):

Click or tap here to enter text.

If the client is willing to do so, ask them to take a photo of the test results and send them over Signal, or take a Zoom screen shot.

Relevant family medical history:

Click or tap here to enter text.

8. Are you currently taking any medication(s)? Choose an item.

If yes:

What medication(s) and what is it for? Click or tap here to enter text.

Who prescribed the medication(s)? Click or tap here to enter text.

Notes (past medications, difficulty in access, frequency of use, etc.):

Click or tap here to enter text.

If the client exhibits any red flags or has any comorbidities requiring direct, in-person supervision (such as cardiovascular disease, neurological movement disorders, cognitive ability, or diabetic complications), do not continue with the assessment. The client will not be appropriate for tele-physiotherapy. Move directly to "Clinician Assessment" below.

Provide details and examples of any yellow flags indicated above.

Catastrophizing: Click or tap here to enter text.

Unhelpful beliefs about pain: Click or tap here to enter text.

Perseveration: Click or tap here to enter text.

Fear of movement: Click or tap here to enter text.

Uncertainty about the future: Click or tap here to enter text.

Passive approach to rehabilitation: Click or tap here to enter text.

Part A: Functional Ability

READ TO CLIENT:
This first section is about your daily activities and tasks. I'm going to read you a list of activities, and I would like you to rate your ability on a scale of 0 to 10, where 0 is that you cannot do the activity at all and 10 is that you can do it very well (with no difficulty).

How do you manage the following activities?

Instructions: *Share your screen with the client so they can see the scale. Read the items to the client and select one number from 0 to 10. Use a* ***yellow*** *highlight to mark the selected number for each item.*

On a scale from 0 to 10, where 0 is **unable to perform the activity at all**, and 10 is to **perform with no difficulty**, how well do you manage the following activities?												***Not applicable to me***
A.1 Dressing (without help)	0	1	2	3	4	5	6	7	8	9	10	NA
A.2 Walking outdoors	0	1	2	3	4	5	6	7	8	9	10	NA
A.3 Climbing stairs	0	1	2	3	4	5	6	7	8	9	10	NA
A.4 Sitting longer times	0	1	2	3	4	5	6	7	8	9	10	NA
A.5 Standing bent over a sink	0	1	2	3	4	5	6	7	8	9	10	NA
A.6 Carrying a bag	0	1	2	3	4	5	6	7	8	9	10	NA
A.7 Making a bed *(Laying out a prayer mat)*	0	1	2	3	4	5	6	7	8	9	10	NA
A.8 Running	0	1	2	3	4	5	6	7	8	9	10	NA

A.9 Light work	0	1	2	3	4	5	6	7	8	9	10	NA
A.10 Heavy work	0	1	2	3	4	5	6	7	8	9	10	NA
A.11 Lifting heavy objects	0	1	2	3	4	5	6	7	8	9	10	NA
A.12 Participating in exercise or sports	0	1	2	3	4	5	6	7	8	9	10	NA

Part B: Body Functions & Physicality

READ TO CLIENT:
Now I have a few questions about your pain levels and some body functions. These questions ask you to rank your feelings on a scale of 0 to 10.

Instructions: *Share your screen with the client so they can see the scale. Read the items to the client and select one number from 0 to 10. Use a* ***yellow*** *highlight to mark the selected number for each item.*

On a scale from 0 to 10, where 0 is **no pain** at all and 10 is the **worst possible pain**…											
B.1 How much pain or discomfort are you feeling **right now?**	0	1	2	3	4	5	6	7	8	9	10
B.2 How much pain or discomfort have you felt **overall in the past week?**	0	1	2	3	4	5	6	7	8	9	10

Notes: Click or tap here to enter text.

On a scale from 0 to 10, where 0 is the **worst** possible and 10 is the **best** possible, during the **past week**, how would you rate your…											
B.3 Ability to fall asleep in 30 minutes?	0	1	2	3	4	5	6	7	8	9	10
B.4 Discomfort while you're trying to sleep?	0	1	2	3	4	5	6	7	8	9	10
B.5 Ability to sleep through the night?	0	1	2	3	4	5	6	7	8	9	10
B.6 Sleep quality overall?	0	1	2	3	4	5	6	7	8	9	10

Notes: Click or tap here to enter text.

Urination can be sensitive to talk about, but it is an important function of our bodies. It is commonly affected by trauma. Physiotherapy may help improve some conditions related to bladder control.

May I ask you one question about urination? Choose an item.

If no, skip to next question (B.8).
If yes, ask question B.7.

On a scale from 0 to 10, where 0 is **not at all** a problem and 10 is a **major** problem…											
B.7 Is control over your bladder a problem in your daily life?	0	1	2	3	4	5	6	7	8	9	10

Notes: Click or tap here to enter text.

Sexual activity is different for everyone and can sometimes be difficult to talk about. It may or may not be a part of your life right now. Physiotherapy may help improve some physical conditions related to sexual activity. May I ask you one question about how your **physical condition** influences your sexual activity? Choose an item.

If no, skip to Part C.
If yes, ask question B.8.

On a scale from 0 to 10, where 0 is **not at all** a problem and 10 is a **major** problem…											
B.8 How much does your current health cause problems in your sex life?	0	1	2	3	4	5	6	7	8	9	10

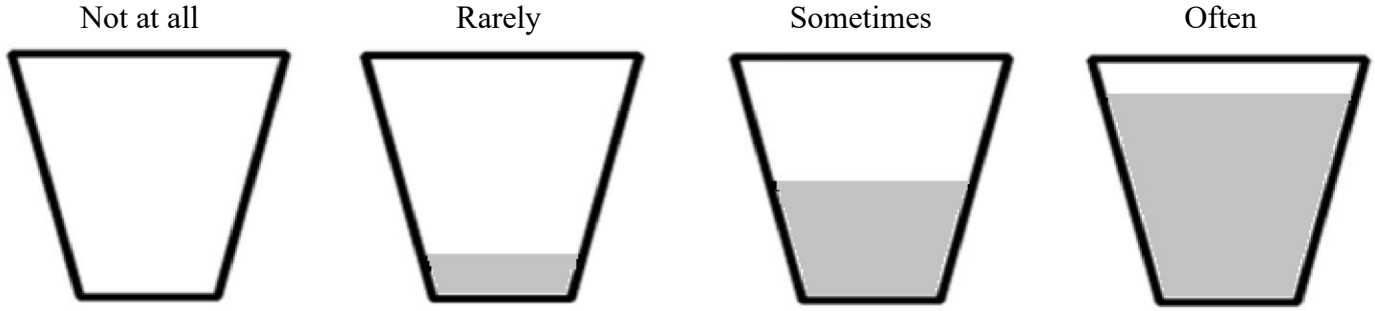
Notes: Click or tap here to enter text.

Part C: Social Participation & Functioning

READ TO CLIENT:
Now I would like to ask about how your health impacts or changes your social life.

In answering these questions, think about **your current health**, which includes your well-being, energy levels, physical difficulties, and discomfort in the **past two weeks**. This picture of glasses of water is an example of your response options. The more full glasses represent something that happens more often.

Instructions: *Show the client the pictures of the glasses. Read items to the client. Select one response for each question, placing an **X** in the box to mark the client's response.*



Considering your current health & physical condition…	**Not at all**	**Rarely**	**Sometimes**	**Often**	***Not applicable***
C.1 …are you able to leave the house and visit friends or relatives?					
C.2 …do you feel you can talk to people about your health and physical condition?					
C.3 …are you able to have positive relationships with people in your house? (such as your children, spouse, or other people living with you)					
C.4 …do you feel connected to your family and friends?					
C.5 …are you able to participate in community events? (such as meetings, sporting events, weddings, religious events)					
C.6					

…do you feel you can talk to people about your life and your story?					
C.7 …are you able to work, look for work, or go to school?					
C.8 …do you feel satisfied with your social interactions and activities?					

Notes on social history:

Click or tap here to enter text.

Part D: Coping & Outlook

READ TO CLIENT:
This is the last section. It is about how you deal with **your current health**, which includes your well-being, energy levels, physical difficulties, and discomfort in the **past two weeks**.

Do you strongly agree, agree, disagree, or strongly disagree with these statements?

Instructions: *Read each statement to the client. Select one response for each, placing an **X** in the box to mark the client's response.*

	Strongly disagree	Disagree	Agree	Strongly agree
D.1 I know specific techniques that help me deal with physical discomfort or pain.				
D.2 Physical pain does not prevent me from doing what I need to do.				
D.3 I am satisfied with my health.				
D.4 I feel confident that I can cope with physical problems in order to function well in my daily life.				
D.5 I do specific activities or movements to help improve how my body moves or feels.				
D.6 I am satisfied with my ability to perform daily living activities.				
D.7 I participate in setting and achieving goals to improve my physical condition.				
D.8 How my body feels and functions is connected to my mental health and what happened to me.				

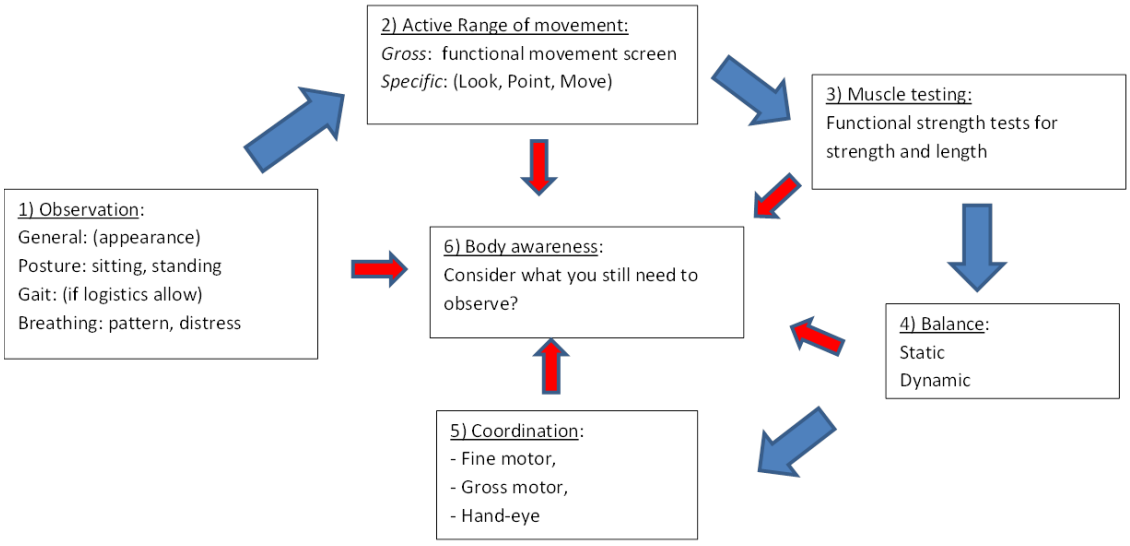
D.9 I can do physical activities, even if they might make my pain worse.				
D.10 I am satisfied with my quality of life.				
D.11 I believe that my current condition is going to improve.				

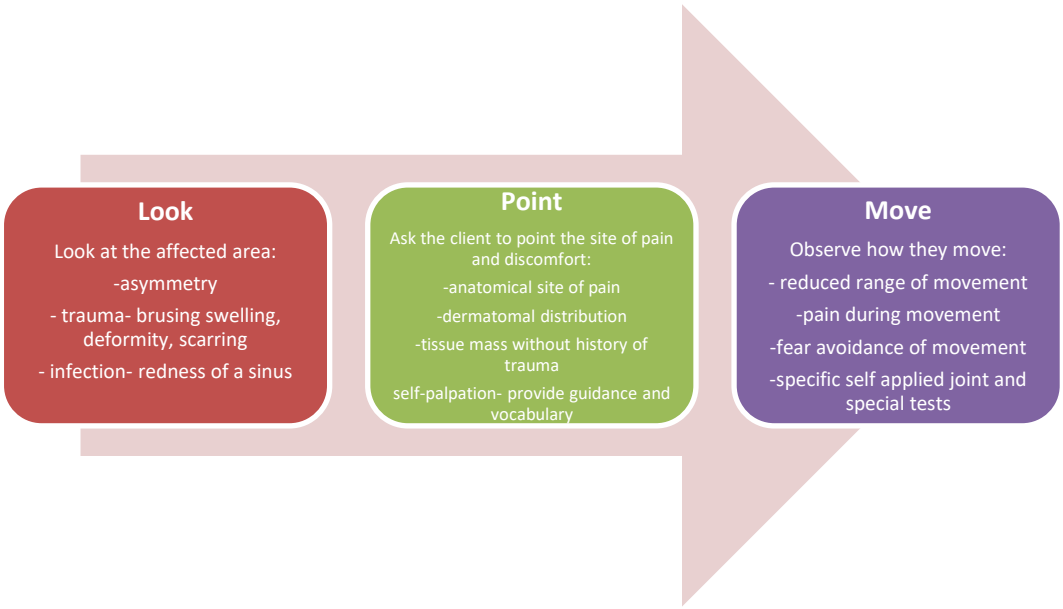
Notes on coping and outlook:

Click or tap here to enter text.

Objective Examination

Remote Objective Assessment Flow chart





Objective examination findings:

Click or tap here to enter text.

In your clinical opinion, to what extent do you feel the client is…? *Select one number from 0 to 10. Use a **yellow** highlight to mark the selected number for each item.*											
B.9 Aware of their body in relation to space and others?	0	1	2	3	4	5	6	7	8	9	10
B.10 Able to localize physical symptoms?	0	1	2	3	4	5	6	7	8	9	10
B.11	0	1	2	3	4	5	6	7	8	9	10

Able to demonstrate smooth and coordinated movements?											

Date that the Problem Rating Scales (Parts A, B, C, and D) were completed*:* Click or tap to enter a date.

Clinician Assessment

This section should be completed in by the physiotherapist without asking the client.

Medical:

Does the client exhibit any red flags? Choose an item.

Does the client have comorbidities requiring direct in-person supervision, such as cardiovascular disease, neurological movement disorders, cognitive ability, diabetic complications, or fall risk? Choose an item.

If yes, please provide details: Click or tap here to enter text.

If you answered "yes" to either of the above questions, the client is not appropriate for tele-physiotherapy at this time for medical reasons.

Ethical:

Would the client's care remain the same or be negatively impacted by tele-physiotherapy? Choose an item.

Do you feel you have been able to sufficiently evaluate the client well enough to create a plan of care and initiate treatment? Choose an item.

Does the client pose a risk to themselves or others by participating in remote services? Choose an item.

Does the client demonstrate a predominant need for a hands-on technique as part of a goal that cannot be accomplished by therapeutic exercise or other means? Choose an item.

If you answered "yes" to any of the above questions, the client is not appropriate for tele-physiotherapy at this time for ethical reasons.

Next steps

Select one of the following:

☐ **It is clear from the assessment that it would not be appropriate for the client to receive individual or group tele-physiotherapy.**

Explain this decision, this and discuss with the client how they could access appropriate alternative services where possible. Document the discussion here, including reasons and advice given:

Click or tap here to enter text.

☐ **It is unclear from the assessment whether tele-physiotherapy would be appropriate or not**.

Consult with your clinical supervisor. Arrange for another meeting with the client, and explain that in the interim you will consult with your supervisor. The client can also think about all the information given, and consider if they would like to continue or not.

☐ **It is clear that tele-physiotherapy is appropriate for the client.**
Continue with the Patient-Specific Functional Scale below.

Patient-Specific Functional Scale (PSFS)

READ TO CLIENT:
I am going to ask you to identify up to five important activities you are unable to do or having difficulty with. Today, are there any activities you are unable to do or having difficulty with? I would like you to rate your ability on a scale of 0 to 10, where 0 is that you cannot do the activity at all and 10 is that you can do it very well (with no difficulty).

Activity	Score Today
1	
2	
3	
4	
5	
Total score	

Explain to client:

- The importance of audio and visual privacy.
- Signal and Zoom are the only platforms that can be used for this service.
- Email will not be used for communication.
- All appointment scheduling will happen via Signal, and this platform should only be used for this purpose. The physiotherapist will not be available for consultation between sessions except in the case of an emergency.

- The importance of keeping mobile devices physically secure and using a strong password.
- For the sake of security, message disappearance will be activated on Signal.

Note any potential challenges identified:
Click or tap here to enter text.

Explain to client:

- Scope of the tele-physiotherapy health service including limitations.
- Duration of the service (number of group sessions and individual sessions).
- Potential risks of receiving tele-physiotherapy health including:
    - Experiencing difficult emotions or upsetting memories connected to movements.
    - Communication difficulties during calls including the connection being lost during a session.
    - Loss of confidentiality by conversations being overheard, or information being intercepted.
    - Frustration that exercises may be more challenging without direct physical guidance.

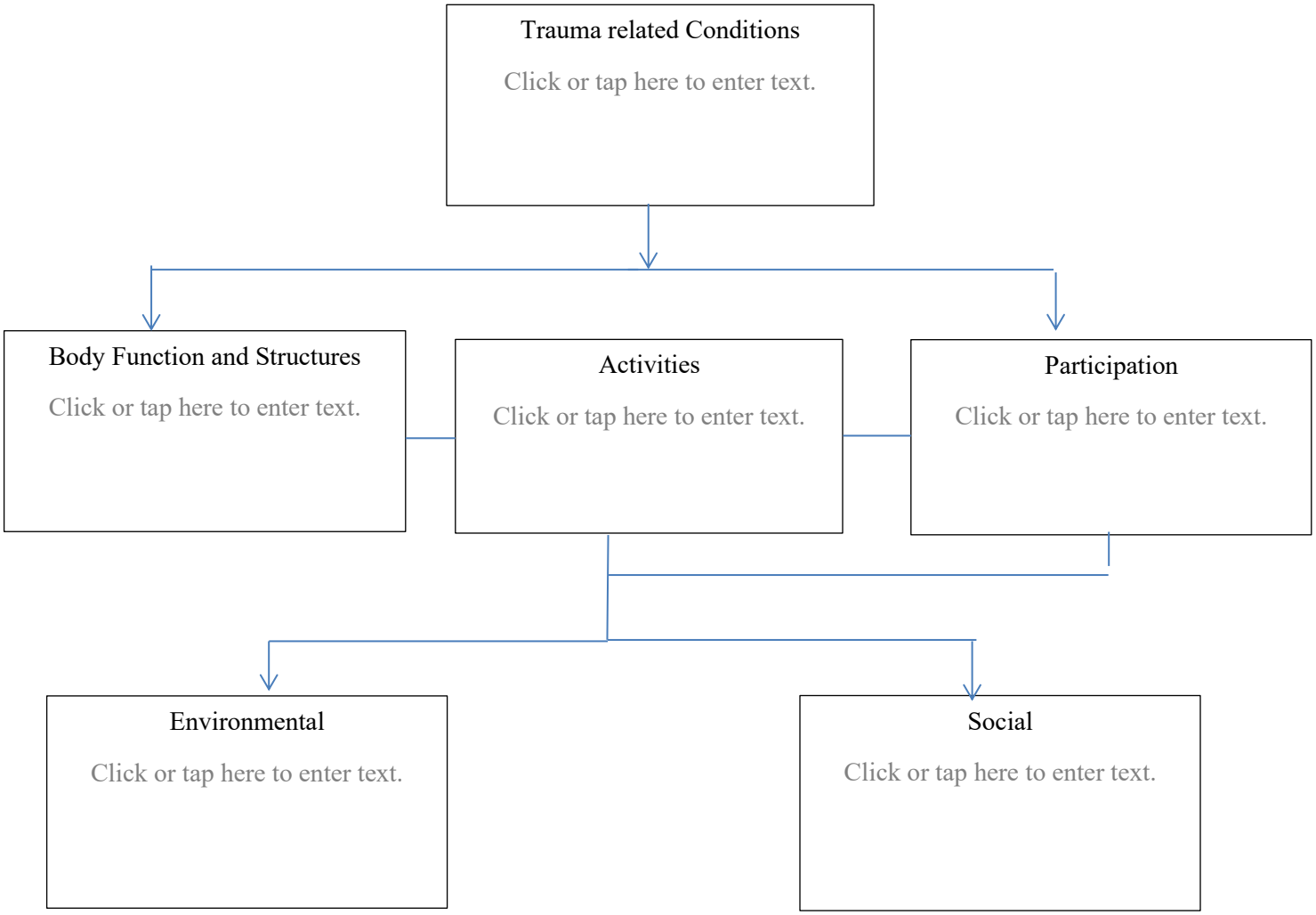
Arrange for another meeting and explain that in the interim the client can think about all the information given and consider if they would like to continue or not.

Explain also that if they do wish to continue then at the beginning of the first session they will complete the consent process, and also establish an emergency management plan.

End the session by thanking the client for answering the questions, and ask if they have any further questions for you.

Clinician Planning

Complete the ICF model based upon the client's assessment. This will help you to plan treatment and review PSFS goals to ensure they are appropriate.



The following short-term SMART goals will be addressed through this client's treatment plan. These should be discussed and agreed with the client at the start of treatment.

Short Term SMART Goals (Steps toward PSFS Goals):

1) Client will be able to Click or tap here to enter text.

in order to Click or tap here to enter text. within Click or tap here to enter text.

2) Client will be able to Click or tap here to enter text.

in order to Click or tap here to enter text. within Click or tap here to enter text.

3) Client will be able to Click or tap here to enter text.

in order to Click or tap here to enter text. within Click or tap here to enter text.

Annex 5 – TPT Follow-up Assessment

TPT Follow-up Assessment

Date: _____

ID #: _____ *Index #:* _____ *Referral #:* _____

Physiotherapist: _____

PSC: _____ _____

Administered at: ○ *3 month* ○ *6 month* ○ *12 month*

Administration instructions: *This tool should guide your conversation with the client. You should ask the client the questions as they are written on the form, while also being careful to maintain good levels of comfort and trust with the client.*

READ TO CLIENT:

Today I would like to ask you questions about your current health and how it influences your life. This conversation will help me understand more about you. It will also help track if your treatment makes/has made any changes for you.

There are no right answers or wrong answers to these questions. If I ask you any question that you don't want to answer or if you need to take a break, just tell me so. I want you to be comfortable throughout this discussion.

1. Client first name: _____
2. Gender: ○ M ○ F ○ _____
3. Are you currently taking any medication(s)? ○ Yes ○No

If yes:

What medication(s) and what is it for? _____

_____

_____

Who prescribed the medication(s)? _____

Notes (past medications, difficulty in access, frequency of use, etc.):

_____

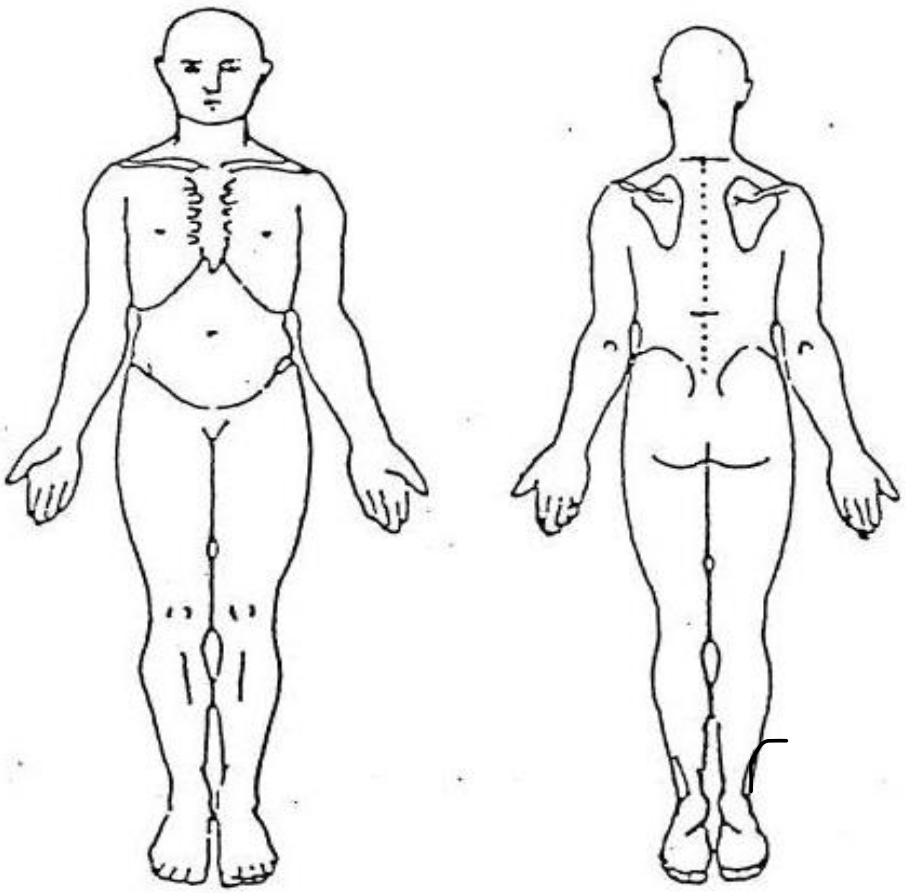
_____

_____

Instructions: *Direct the client to shade and mark the body diagram. Encourage client to mark the diagram as independently as possible.*

4a. Shade the areas on your body where you have concerns (pain, discomfort, heaviness, numbness, etc.).

4b. Put an X on the area that is your biggest concern.



If the client did not mark the diagram independently, please explain why:

_____

_____

Part A: Functional Ability

READ TO CLIENT:
This first section is about your daily activities and tasks. I'm going to read you a list of activities, and I would like you to mark a point on the line to show me if you cannot do the activity at all or if you can do it very well (with no difficulty).

How do you manage the following activities?

Instructions: *Read these items to the client. Allow the client to mark ONE POINT on the line after each question.*

On a scale from 0 to 10, where 0 is to **perform with no difficulty**, and 10 is **unable to perform the activity at all** , how well do you manage the following activities?												***Not applicable to me***
A.1 Dressing (without help)	0	1	2	3	4	5	6	7	8	9	10	NA
A.2 Walking outdoors	0	1	2	3	4	5	6	7	8	9	10	NA
A.3 Climbing stairs	0	1	2	3	4	5	6	7	8	9	10	NA
A.4 Sitting longer times	0	1	2	3	4	5	6	7	8	9	10	NA
A.5 Standing bent over a sink	0	1	2	3	4	5	6	7	8	9	10	NA
A.6 Carrying a bag	0	1	2	3	4	5	6	7	8	9	10	NA
A.7 Making a bed *(Laying out a prayer mat)*	0	1	2	3	4	5	6	7	8	9	10	NA
A.8 Running	0	1	2	3	4	5	6	7	8	9	10	NA

A.9 Light work	0	1	2	3	4	5	6	7	8	9	10	NA
A.10 Heavy work	0	1	2	3	4	5	6	7	8	9	10	NA
A.11 Lifting heavy objects	0	1	2	3	4	5	6	7	8	9	10	NA
A.12 Participating in exercise or sports	0	1	2	3	4	5	6	7	8	9	10	NA

Notes on functional difficulties:

_____
_____
_____
_____

Part B: Body Functions & Physicality

READ TO CLIENT:
Now I have a few questions about your pain levels and some body functions. These questions ask you to rank your feelings on a scale of 0 to 10.

Instructions: *Read the items to the client and select one number from 0 to 10.*

On a scale from 0 to 10, where 0 is **no pain** at all and 10 is the **worst possible pain**…	**No pain at all**										**Worst possible pain**
B.1 How much pain or discomfort are you feeling **right now?**	0	1	2	3	4	5	6	7	8	9	10
B.2 How much pain or discomfort have you felt **overall in the past week?**	0	1	2	3	4	5	6	7	8	9	10

Notes:

_____
_____
_____

On a scale from 0 to 10, where 0 is **worst** possible and 10 is the **best** possible, during the **past week**, how would you rate your…	**Worst possible**										**Best possible**
B.3 Ability to fall asleep in 30 minutes?	0	1	2	3	4	5	6	7	8	9	10
B.4 Discomfort while you're trying to sleep?	0	1	2	3	4	5	6	7	8	9	10
B.5 Ability to sleep through the night?	0	1	2	3	4	5	6	7	8	9	10
B.6 Sleep quality overall?	0	1	2	3	4	5	6	7	8	9	10

Notes:

_____
_____
_____
_____
_____

Urination can be sensitive to talk about, but it is an important function of our bodies. Physiotherapy may help improve some conditions related to bladder control.

May I ask you one question about urination?

- ☐ No → Skip to next question (B.8)
- ☐ Yes → Ask question B.7

On a scale from 0 to 10, where 0 is **not at all** a problem and 10 is a **major** problem…	**Not at all a problem**										**Major problem**
B.7 Is control over your bladder a problem in your daily life?	0	1	2	3	4	5	6	7	8	9	10

Notes:

_____
_____
_____

Sexual activity is different for everyone and can sometimes be difficult to talk about. It may or may not be a part of your life right now. Physiotherapy may help improve some physical conditions

related to sexual activity. May I ask you one question about how your **physical condition** influences your sexual activity?

- ☐ No → Skip to Part C
- ☐ Yes → Ask question B.8

On a scale from 0 to 10, where 0 is **not at all** a problem and 10 is a **major** problem…	**Not at all a problem**										**Major problem**
B.8 How much does your current health cause problems in your sex life?	0	1	2	3	4	5	6	7	8	9	10

Notes:

_____

_____

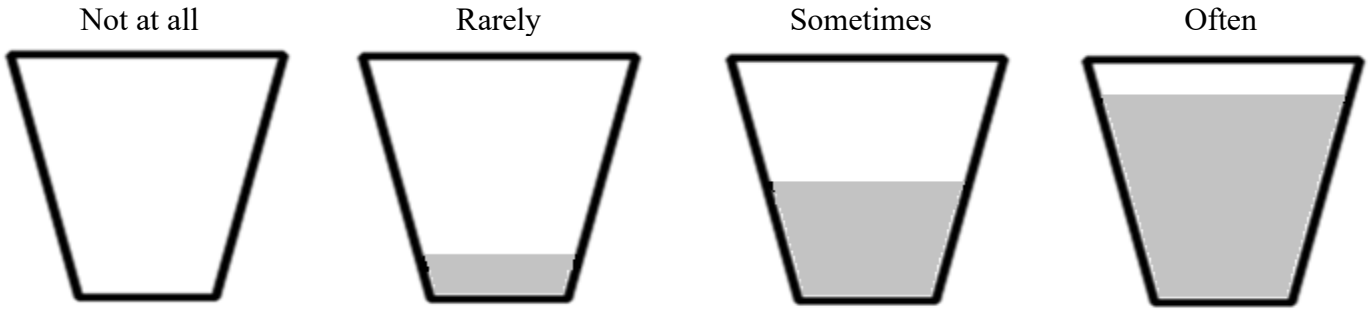
_____

Part C: Social Participation & Functioning

READ TO CLIENT:
Now I would like to ask about how your health impacts or changes your social life.

In answering these questions, think about **your current health**, which includes your well-being, energy levels, physical difficulties, and discomfort in the **past two weeks**. This picture of glasses of water is an example of your response options. The more full glasses represent something that happens more often.

Instructions: *Show the client the pictures of the glasses. Read items to the client. Select one response for each question.*



Considering your current health & physical condition…	**Not at all**	**Rarely**	**Sometimes**	**Often**	*Not applicable*
C.1 …are you able to leave the house and visit friends or relatives?					

C.2 …do you feel you can talk to people about your health and physical condition?					
C.3 …are you able to have positive relationships with people in your house? (such as your children, spouse, or other people living with you)					
C.4 …do you feel connected to your family and friends?					
C.5 …are you able to participate in community events? (such as meetings, sporting events, weddings, religious events)					
C.6 …do you feel you can talk to people about your life and your story?					
C.7 …are you able to work, look for work, or go to school?					
C.8 …do you feel satisfied with your social interactions and activities?					

Notes on social history:

_____

_____

_____

Part D: Coping & Outlook

READ TO CLIENT:
This is the last section. It is about how you deal with **your current health**, which includes your well-being, energy levels, physical difficulties, and discomfort in the **past two weeks**.

Do you strongly agree, agree, disagree, or strongly disagree with these statements?

Instructions: *Read each statement to the client. Select one response for each.*

	Strongly disagree	Disagree	Agree	Strongly agree
D.1 I know specific techniques that help me deal with physical discomfort or pain.				
D.2 Physical pain does not prevent me from doing what I need to do.				
D.3 I am satisfied with my health.				
D.4 I feel confident that I can cope with physical problems in order to function well in my daily life.				
D.5 I do specific activities or movements to help improve how my body moves or feels.				
D.6 I am satisfied with my ability to perform daily living activities.				
D.7 I participate in setting and achieving goals to improve my physical condition.				
D.8 How my body feels and functions is connected to my mental health and what happened to me.				
D.9 I can do physical activities, even if they might make my pain worse.				
D.10 I am satisfied with my quality of life.				
D.11 I believe that my current condition is going to improve.				

Notes on coping and outlook:

_____

Clinician Assessment

This section should be filled in by the physiotherapist without asking the client.

In your clinical opinion, to what extent to you feel the client is…?	**Not at all**										**Excellent / Very Aware**
B.9 Aware of their body in relation to space and others?	0	1	2	3	4	5	6	7	8	9	10
B.10 Able to localize physical symptoms?	0	1	2	3	4	5	6	7	8	9	10
B.11 Able to demonstrate smooth and coordinated movements?	0	1	2	3	4	5	6	7	8	9	10

5a. What treatment did the client receive?

○ Group only ○ Individual only ○ Both group *and* individual

5b. **If group treatment:** How many sessions did the client attend? _____

○ I don't know

Annex 6 – Client Feedback Survey

We would love to hear about your experience with the Center for Victims of Torture (CVT) telehealth services.

By completing this short survey, you are giving your consent for CVT to use your responses to help improve CVT telehealth services for future programs. It will take approximately 15 minutes to complete this survey. Your feedback is voluntary. Nothing you say will affect your relationship with our team or CVT, nor will choosing not to participate. Your responses will be reported to our program team and our funders in aggregate form, without your name attached to your responses.

1) What is your name? *This is collected only to help us confirm who has completed the survey. Your responses will not be linked to your identity.*

1) What is your phone number (e.g., Signal, WhatsApp)? *This is collected only to help us confirm who has completed the survey. Your responses will not be linked to your identity. Please make sure to include the country code first (e.g., +90).*

2) Have you received telehealth service(s) from CVT?
   Telehealth means receiving services from a CVT provider by phone or video, instead of meeting in person. This can include mental health counseling or physical therapy sessions.
   - ○ Yes
   - ○ No
   - ○ I don't know
     a. *(If yes),* Which telehealth service(s) at CVT did you receive?
        - ○ Tele-mental health (with [counselor's name])
        - ○ Tele-physiotherapy (with [therapists' name])
        - ○ Both of the above services

3) How did you first hear about CVT's telehealth services?
   - ○ Family member or friends
   - ○ Another organization (*please specify*_____)
   - ○ Online (e.g., CVT website, social media, or online search)
   - ○ Community events or outreach (*please specify*_____)
   - ○ Other (please specify):_____

4) Overall, how easy was it for you to access and use CVT's telehealth service(s)? (e.g., technology, scheduling, internet, and availability of the therapist)?
   - ○ Very easy
   - ○ Easy
   - ○ Difficult
   - ○ Very difficult

a. If you selected *Difficult* or *Very difficult,* please describe what made access challenging.

5) Thinking back on your experience, how satisfied were you with the tele-mental health service you received from CVT?
(Mental health counseling provided by phone or video)
○ Very satisfied
○ Satisfied
○ Dissatisfied
○ Very dissatisfied
   a. Please tell us what did not work well for you with tele-mental health service.

6) *(SKIP LOGIC)* Thinking back on your experience, how satisfied were you with the tele-physiotherapy service you received from CVT?
(Physical therapy provided by phone or video)
○ Very satisfied
○ Satisfied
○ Dissatisfied
○ Very dissatisfied
   a. Please tell us what did not work well for you with telehealth therapy.

7) Thinking about the telehealth services you received from CVT, how clear and helpful was the overall process?
(This includes how telehealth was explained to you, what happened when you first started services, and how next steps were communicated.)
○ Very clear and helpful
○ Somewhat clear and helpful
○ Not very clear or helpful
○ Not sure

   a. What aspects of the CVT telehealth process were unclear or unhelpful for you?

8) On a scale from 1 to 10, how would you rate the overall quality of tele-mental health service you received? (1 = very poor, 10 = excellent)

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

a. Please share what influenced your rating above.

9) *(SKIP LOGIC)* On a scale from 1 to 10, how would you rate the overall quality of tele-physiotherapy service you received? (1 = very poor, 10 = excellent)

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

a. Please share what influenced your rating above.

10) To what extent did CVT telehealth service(s)help you address the concerns that brought you to care?

○ Very much
○ Somewhat
○ Slightly
○ Not at all

11) To what extent did telehealth allow you to feel supported, understood, and engaged during sessions?

○ Very much
○ Somewhat
○ Slightly
○ Not at all

12) From what you can remember, what benefits did you experience from the tele-mental health service*? (Select all that apply)*

☐ Psychoeducation: I was provided with information and knowledge to help me understand my condition, reactions, or experiences.

☐ Increased awareness of my mind-body connection: learned and practiced how my thoughts, emotions, and mental state affect my physical body, and vice versa.

☐ Improved coping skills and confidence in managing difficulties

☐ Strengthened relationship with family or community

☐ Other (please specify) _____

☐ No benefits.

13) *SKIP LOGIC (If the client received both services from Q3),* During your healing process, how well did the combination of BOTH tele-mental health and tele-physiotherapy meet your needs?
- ○ Very well
- ○ Somewhat well
- ○ Not very well
- ○ Not at all

14) *SKIP LOGIC (If the client received both services from Q3),* Thinking about your experience being referred from tele-mental health (with Noor Alsagher) to tele-physiotherapy (Farah Aldweik) services, what worked well, and what could be improved?
(Please share any part of the process you found helpful or confusing.)

15) *SKIP LOGIC (If the client received both services from Q3),* From what you can remember, what benefits did you experience from the tele-physiotherapy service?
- ☐ Better mood or feeling more positive
- ☐ Improved sleep quality
- ☐ Felt more in control of my body or emotions
- ☐ Easier to do daily tasks (e.g., walking, cooking, cleaning, self-care)
- ☐ Reduced pain or discomfort in my body
- ☐ More engaged in social or community activities
- ☐ Learned ways to manage physical challenges or discomfort (coping with my body)
- ☐ Other (please specify):_____
- ☐ No benefits

16) Would it have been helpful to have a case manager or social worker as your main point of contact for telehealth services?
A case manager or social worker would be someone who helps you schedule appointments, answers your questions, and connects you to other services if needed. This is in addition to the tele-mental health or tele-physiotherapy therapists you worked with.
- ○ Yes, I would have preferred a social worker
- ○ No, I don't think a social worker was needed
- ○ Indifferent
- ○ Not applicable (e.g., I already had a social worker/case manager from another organization who referred me to CVT)

17) Currently, CVT starts with a tele-mental health session, and refers clients to tele-physiotherapy if needed. Based on your experience, which approach works best for clients?

- ○ Current pathway (tele-mental health first, then tele-physiotherapy)
- ○ Offer tele-mental health and tele-physiotherapy as separate, standalone services
- ○ I'm not sure / no preference

18) In your opinion, what is the best way for CVT to reach others in your community who may benefit from telehealth services?

19) Do you think individuals with complex mental health needs could benefit from receiving telehealth?
Complex mental health needs describe situations where a person is experiencing ongoing and serious emotional or psychological difficulties, often linked to repeated or long-term stressful or traumatic experiences. These difficulties affect several areas of daily life and may require more support.
    - ○ Yes
    - ○ No
    - ○ Not sure
        a. If no or not sure, what additional support could help ensure telehealth is effective for individuals with complex mental health needs?

20) What is one thing you would like to change or improve about the services you received?

21) What did you like most about the services you received?

22) Please use the space below to share anything else about your telehealth experience (positive or challenging) or to share any other recommendations you may have.