2021

Counseling System Documentation and the Relationship Between Treatment Plans and Client Outcomes

Moraima N. Frangiosa
Walden University

Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral study by

Moraima Frangiosa

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Raj Singh, Committee Chairperson, Public Policy and Administration Faculty
Dr. David Milen, Committee Member, Public Policy and Administration Faculty
Dr. George Larkin, University Reviewer, Public Policy and Administration Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2021

Abstract

Counseling System Documentation and the Relationship Between Treatment Plans and Client Outcomes

by

Moraima N Frangiosa

MBE, Boise State University, 2013

Professional Administrative Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Public Administration

Walden University

November 2021

Abstract

The purpose of this qualitative study was to provide a method for evaluating counseling services delivered to patients during treatment. The evaluation of the study required the use of methods that are repeatable and effective that would allow a clinic to continue using them over time to grow a database of valuable information about counseling and patient outcomes. The new database would allow the clinic to change counseling methods and approaches of delivery to promote organizational change. The evidence-based practice (EBP) for counseling therapy would encourage the connection between public administration and public policy in the health care system. Public administration using EBP can help advance the lack of knowledge of how human services manage outcomes for health care and will impact service allocation, ethical distribution, and use of services, as well as social/political power. I examined various performance and process factors including duration, type of problem to be solved, type of service, and which outcome indicators will be tracked, as provided by the clinic. Access was given to unique and extensive data sets to best identify counseling healthcare outcomes contained in individual data from 40 randomized files of 540 total client files, in both hard copy and electronic format. The outcomes were characterized and sorted into four outcome indicators based on services: case management, psychotherapy, peer support, and community-based rehabilitation. The feasibility of assessing and comparing performance by providers will allow the organization to incrementally improve services and recognize shortfalls in its counseling services.

Counseling System Documentation and the Relationship Between Treatment Plans and Client Outcomes

by

Moraima Frangiosa

MBE, Boise State University, 2013

Professional Administrative Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Public Administration

Walden University

November 2021

Table of Contents

List of Tables

List of Figures

Section 1: Introduction to the Problem

Counseling services available can be varied even in small clinical settings and such varied services can lead to a breadth of outcomes for patients. Understanding patient outcomes from counseling services and the variables that can affect those outcomes is complicated. Tidwell Social Work Services and Consulting, Inc. (Tidwell) has been offering counseling services in southwestern Idaho for 20 years. During this time, the organization has helped patients from a wide variety of cultural backgrounds with a wide range of problems; many patients had traumatic stress experiences. The vast diversity of clients has made it challenging for the organization to track patient outcomes. Tidwell has determined that mapping out a consistent method of applying outcome indicators and keeping these as an ongoing metric will assist them in continually improving their counseling services. To this end, Tidwell has committed to have a method of defining and cataloging patient outcomes.

According to Srebnik et al. (2010), “outcomes are much more direct indicators of quality than either structure or process indicators” (p. 903), and the quality of indicators will be researched and categorized by direct outcomes of the clients of the clinic. In this study, a series of methodologies were investigated to develop a method that satisfactorily fulfilled the clinic’s needs. Putting together a systematic methodology for expressing and recording these outcomes will assist the clinic’s counselors in improving services and applying for additional grants or resources to aid in treatment.

I reviewed current and existing client files and reported the findings in an outcome indicator sampling to make sure that the outcomes selected were usable and

repeatable for tracking future patient outcomes. These reporting methods assisted Tidwell in developing outcome indicators to be used during and after counseling to allow for comparison of how individuals respond to therapy. Because some patients struggle to reintegrate into society successfully after a significant traumatic event, by tracking their progress, counselors will be able to better treat them. These outcome indicators will make it easier to determine if the client's plan for counseling has been successful. Tidwell will track these indicators throughout future client–counselor interactions to apply them to other incoming clients and create a database.

Problem Statement

Tidwell wishes to have a tool in place to track and review patient outcomes individually. Development of Outcome Indicators for Monitoring the Quality of Public Mental Health Care (Srebnik, et all.,1997). A brief, simple outcome assessment measurement tool that can be used continually to assess counselor treatment plans and patient outcomes would accomplish this goal. Tracking and continually reviewing and discussing the outcomes of patients will allow counselors to assess their services and continue to improve the quality and effectiveness of the counseling provided. Currently, however, therapists only have simple routine measurements documented individually in each patient's file; such measurements are only used during treatment of that individual patient. The organization has no method for documenting and sharing successful outcomes across providers. Tidwell needs to have a method that tracks the treatment outcome for each patient in database that can be used to review and refine services more broadly, not just on a patient-by-patient basis.

Addressing the organization's problem requires a three-step approach: (a) review and agree to outcome indicators to be used, (b) historical review and compilation of a fixed number of files for application of outcome indicators, and (c) documentation in a database of outcomes from the public administration perspective. The implementation is often perceived as a knowledge transfer problem in the study of implementing evidence-based practices and programs in human services (Johansson, 2010). These are the only items within the scope of this study. However, it is noted and was discussed as a group that this is only the beginning of what needs to be accomplished to fully integrate the system throughout the working model for Tidwell. The development of a tool for counselors to use and gather information about counseling services with the patient to understand the outcome more easily will need to be incorporated, as well as the internal methodology for guaranteeing those outcomes are added to the database of outcomes to make a continually growing database of public mental health.

Purpose

The purpose of this study was to define patient outcome indicators, conduct a historical review of current patient files, and begin a database of the findings. Additionally, this study will spur the discussion of a unified method for collection of these indicators in the future to create an ongoing database. I developed a model to separate patient needs into four groups or outcome indicators. The model involved the clinic's counselors to define those indicators and come to an agreement as to those needed for their practice. After the model was vetted, I reviewed existing and current

client records to categorize them into each of the outcome indicators and determine the degree of success measurement within that particular outcome indicator.

Nature of the Administrative Study

This study was qualitative in nature and revolved around the review and analysis of existing and past counseling files to understand patient outcomes and match the data with the degree of success measurement with the appropriate outcome indicator. I worked to provide a rubric of how the data were to be analyzed to define a repeatable method of matching the data with the correct outcome indicator. Then, data from 40 files were reviewed and analyzed to start the ongoing database that Tidwell will use going forward.

Significance

The significance of this study is to provide the organization with information about the services they provide to allow them to have continual development and improvement of those services and to provide the most beneficial services to their clients. Mental health care providers must legally offer the best care for all patients. The standardized instruments in public administration are designed efficiently and are relevant to public health practices and research. Due to time constraints and access to data gathering and personnel due to the COVID-19 pandemic, the data collection process was modified to accommodate circumstances. Decisions were developed with the long-term and short-term in mind. “Good collaborative outcomes stem from effective communication, strong leaders and managers, concrete and focused goals, and trust” (Varda et al., 2012, p. 568). The collaboration depends on the trust that stakeholders have and strategies and incentives to improve outcome indicators in a collaborative process in

public, private, or nonprofit organizations to determine how to structure the service better (Varda et al., 2012).

The study's standardization of reporting outcomes helped to create a common relevant method to make clear what is working within Tidwell's client care program. (Mathei 2015, p. 60). "Built around positive results and evidence of what is working." The aim of the study, and of the clinic's practice, is to have the best result for clients, thus following the law and necessity of the clientele.

The essential goal was to establish measurements to ensure that reporting of outcomes of treatment was standardized. Such standardized routine monitoring will generate relevant variables that validate evidence of measurements in general that capture the phenomenon of interest to clinicians. This measurement approach provides several features that will allow the average routine outcome indicators to be sustainable for data analysis to aid the treatment for individuals.

I gathered quality data that the therapists could use in program evaluation to prove clients are benefiting from treatment. This measurement approach provides the basic features of routine outcome indicators for clients at risk of treatment failure. This research has the potential to impact the wider community in Idaho by helping individuals to better reintegrate in society and become productive members of the community.

Summary

The Tidwell counselors strive toward the restoration of dignity and respect, safety and trust, and power and control for the individuals and families they serve. Tidwell workers and clients collaboratively design individualized treatment plans to promote

growth in a compassionate environment. They provide care to individuals of all ages, cultures, and faiths. The mission is to provide tailored care and quality of life in services that focus on the individual.

With this additional study information and data research, Tidwell could be able to refine their approach with their clientele further and be able to better tailor individual clinical plans to be successful for their clients' outcomes. Proper design of health services and tracking outcome indicators are relevant to any organization for managing how relationships and strategies affect patient outcomes.

It was important to perform these objectives in collaboration with the clinic. Management strategies and outcomes of collaboration with relevant real data are essential to reach an established goal, whether long-term or short-term. Many organizations follow the old style of traditional counseling. Tidwell has a vision of working and placing a network of outcomes to find better solutions for its clientele. Network structure provides lessons on how organizations are organized and managed and how relationships are formed and evolve. Management strategies offer discussions on how collaboration and networking are administered in and among public-sector organizations. Outcomes of collaboration are addressed in this study.

Section 2: Conceptual Approach and Background

Introduction

The role of Tidwell as a counseling service provider in the community is to help people achieve a greater ability to control their emotions and their behavior. It is important within the community for those who work with trauma survivors to provide successful ongoing healing and treatment. All nonprofit organizations (NPOs) in the field of counseling should be implementing sustainable programs to assist individuals, families, and clinicians in understanding outcomes, while providing additional services that collaborate with their healthcare processes and increase the chance of success. For the past few decades, the medical field has started to use evidence-based practices (EBPs) in several areas to improve the understanding of patient outcomes (Johansson, 1997). Tidwell prefers to understand outcomes over a broad spectrum of cases, not just on an individual patient basis. Tracking and adjusting to provide the most successful and complete services for their patients is paramount to the organization. The successful implementation of EBP in the form of tracking outcome indicators is seen by the clinic as a potential solution to monitoring outcomes for the entire clinic.

During the study outcome indicators were developed, a pool of past and current patient files was analyzed and applied to these outcome indicators, and the initial rubrics for continued analysis of these results were completed. To attain the results Tidwell hopes to achieve for this study, understanding and answering the following questions was necessary:

RQ1: Which outcome indicators will be used to start the analysis to find the needed indicators to determine client counseling success?

RQ2: How will the client files be analyzed to ensure proper classification of counselling notes into the correct outcome indicators?

RQ3: How will the outcome indicators be tracked and used to analyze counselor and clinic success?

With the correct implementation and incremental changes to services over time, this style of program could provide Tidwell and its staff with a valuable tool to use in counseling and human services. The proper implementation of this style of EBP in the field of human services could be benefit all, including the patients and the community.

Tidwell's staff's clinical expertise in monitoring individual treatment is presented in this section. Next, the patient's values and expectations are described in detail to align the patients' expectations with the treatment, and the section concludes with a review of Tidwell's output indicators.

Concepts Models and Theories

Research into EBP has recently increased in popularity in the health services fields in public administration. This research has improved the support practices and research analysis of data collected by practitioners to recognize viable intervention treatments for clients. The development and integration of EBP are complicated by several different factors: (a) philosophy and ethics of staff members, (b) the framework used for service delivery, and (c) which treatment components are found to be significant (Johansson, 2010).

EBP is used to help clinicians support treatment goals in mental health social services. EBP has been used on patient victims of trauma, such as child abuse, domestic violence, community violence, kidnapping, accidents, natural disasters, wars, and other events that involve traumatic incidents. The goal of patient-reported outcomes is to measure and compare how clinicians develop patient care plans and then use outcome indicators to improve organizational data to support those plans. Unfortunately, no gold standard exists for patient outcome indicators or measures that should be tracked and analyzed (Srebnik et al., 1997). EBPs, which consider three main areas of observance, are most effective at tracking outcomes in patients. The areas of observance are (a) clinician's expertise, (b) patient values and expectations, and (c) best external evidence for improvement.

Figure 1

Evidence-Based Practices

Source: By SURMEPI. Stellenbosh University (September 17, 2015

Monitoring Individual Clinical Expertise

Individual clinician expertise as well as a clinic's area of expertise will affect the outcome of any given client–counselor therapy. Improving services and clinical expertise can be achieved by monitoring therapy used in each patient case and then auditing patient progress through the course of treatment. Individual providers would note the plan of care used and any outcome through a standard set of indicators, with a standardized methodology of interpreting the results. Data showing the number of times a treatment method is used and its apparent success would be valuable information for the counselors and the clinic in understanding the successes of a particular provider and treatment methods. Once outcome successes are understood, clinicians are more able to share success with others to improve the overall success of the clinic.

Quality of life and family dynamics are most affected with those individuals who have experienced traumatic situations; this indicator is critical to the success of the treatment. A patient's ability to function in society is important in understanding the success of treatment and, therefore, is one of the best indications of their quality of life. One of the methods used by providers to monitor this indicator is to routinely summarize brief observations as they relate to quality of life and family dynamics.

Tools used in recording these indicators include patient-reported outcomes (PROs). PROs are aspects of a patient's health status that are directly reported by the patient (Philip et al., 2019). PROs are expected to be exceptionally reliable feedback on patient outcomes. Patient-reported outcome measures are used in reporting PROs and can be collected using several methods, including simple questioning or patient-completed

questionnaires. Mental and medical health care can benefit an individual and their family. By adding to the understanding the quality of life from the patient's point of view during and after treatment, PROs can provide valuable information to the clinician as well as the overall clinic.

Patients' Values and Expectations

Patients' values and expectations are an integral part of the outcome and how they are reported at the time of service. Patients can feel that the services do not directly relate to their desired outcome and the patient's goals and expectations of that outcome. Patients sometimes have unreasonable or unattainable expectations if a clinician does not define them or handle them properly. Patient values can also change based on the patients' ethnic and cultural backgrounds and experiences, making the determination of expected outcomes more difficult without considering these issues -front in the treatment environment (Srebnik et al, 1997). Because each clinician and patient has varied goals, personalities, and backgrounds, a defined method of tracking and reporting outcomes will help reduce variances and not completely remove them from the equation.

Role of the DPA Researcher

Through extensive self-study by the clinic and several meetings with stakeholders, I determined that the outcomes should be categorized into four indicator areas: (a) health, (b) subjective well-being, (c) safety, and (d) social connections. The data were arranged based on the qualitative analysis of the files provided by Tidwell. The data were further separated by areas of service that Tidwell currently provides: (a) psychotherapy, (b) case management, (c) community-based rehabilitation, and (d) peer

support. For the first method of analysis, demographic characteristics and time were the independent variables, and the ratios of achieved outcomes was the dependent variable. For the second method, the ratios of reported positive versus reported negative outcomes constituted the dependent variable.

I separated these analyses into three time periods: (a) short-term treatments, (b) midterm treatments, and (c) long-term treatments. The newly formed database allowed me and Tidwell therapists to analyze the data from different aspects, including client needs, and to create new viewpoints for adjusting client plans. It also allowed for ease of sharing outcomes and strategies among counselors and stakeholders. The research was motivated by the desire to help patients become productive members of society. To address potential biases, patient selection was randomized and personal data were removed from the files.

Definition of Terms

Adult behavior: A process that can require lots of trial and error and hard reminders from life.

Counseling treatment: A treatment plan is a document that helps to process plan goals and methods for the therapist. This process is vital for the therapist and needs to be continually improved to efficiently treat the clients in treatment.

Reinforcement: Traditionally clinical settings strategies are essential to reinforce knowledge, beliefs, and skills. The currency of intervention is a vital role to encounter recognition based on the range of factors each person has been treating during the intervention strategies from counseling.

Team: A group that plays a role when the group of them needs to be together.

Treatment plan: Counselors, social workers, and other behavioral health professionals use treatment planning as a tool to be effective with their clients. Without a plan in place, it can be hard to track progress, stay organized, and record clients' perception of their own health condition. Every patient needs individually tailored treatment; clinicians must create a compressive plan to design what treatment the patient needs for healing.

Relevance to Public Organizations

Completing this qualitative study for Tidwell will encourage staff involvement in understanding patient outcomes and where improvements can be made. The results of the study could provide the organization's leader with structured data to pursue continued implementation of ongoing EBPs to advance the clinic's ability to provide exceptional service to the community. The implementation of EBPs for counseling therapy will create a connection between public administration and public policy in the health care system. Public administration using EBPs can help close the gap in how human services will manage outcomes for health care and will impact the allocation of those services, ethical distribution and use of services, and social/political power of those in charge of allocating the services. Additionally, the result of this study may improve management's ability to review the clinic's performance, thereby improving outcomes for patients and counselors.

Successful implementation of EBPs will also provide a model for other similar clinical-based medical facilities to continue to implement research and refine the process

for their field of expertise. With so many varied uses for EBP, the continued integration into the medical services field could provide positive changes for patients and clinicians.

Organization Background and Context

Tidwell, as a practice, serves its clients with Medicaid, Medicare, and other client insurance. During the first year of operations, Tidwell, under the management of Kathy Tidwell, established referral sources and training contracts to provide counseling services to individuals and families in Idaho.

Tidwell wishes to give every individual and family the best chance of making this transition successfully. Tidwell organization's concept is to accomplish the vital services to assist families and individuals in transitioning successfully into productive members of society in Idaho. This conceptual mitigation of health counseling is important to challenge communal strategies to achieve the challenges of the basic concept to be healthy. Tidwell was started in 2000 by Kathy Tidwell with the intent to serve all clients, those with Medicaid, Medicare, and other private insurance. During the first year of operations, Tidwell established referral sources and training contracts. These included Head Start and Idaho State University (conducting statewide suicide prevention training). In October 2014, the Clinic started operations as a Non-profit 501(c) under the name Tidwell Social Work Services and Consulting, Inc (Tidwell). Since then, the organization has significantly expanded the community building and healing efforts. This expansion includes initiatives such as Women Empowerment, Family Services, Self-Help, Pay It Forward, and Healing and Rebuilding Our Communities in the state of Idaho (HROC).

The examination of the counselors' summary notes will show the importance of how the driving forces impact health within the varied cultures among families and individuals. According to the American Psychology association Presidential Task Force on Evidence-Based Practice, "Evidence-based practice in psychology is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences." The Evidence-Based Practice Practitioner (EBPP; APA,) Empirical support treatments based on decision making. This study will provide a bottom-up approach of how a clinician will be able to adapt their treatment approach while still ensuring accountability, as necessary (Dozois et al., 2014).

The goal of the therapy is to change aspects of their personality or integrate a vital emotional tool in the treatment process. The client is in the early stages of their emotional development.

Additionally, the study recorded how many cases have continued with counseling services and how many have completed the treatment. Practices on behavioral and sociological models were applied to discuss the information gathered from different journals. During the treatment, clients are trying to develop and improve their self-esteem; at this time, they are more likely to be emotionally manipulated by their environment.

Counseling services should not be limited to institutional facilities; rather, it should be accessible on personal devices to help individuals continuing counseling. Therapists could be more accessible to clients by using digital applications, such as video

conferencing via Zoom, WhatsApp, and other programs to achieve success in the process during a crisis such as the current COVID-19 pandemic.

Summary

Development of a complete and easily implemented method to record, track and preserve data in the form of outcome indicators requires several different, and sometimes competing, aspects of development and integration into the clinical environment. Tidwell's plan is to have a program that is the footprint for an EBP database of outcome indicators which will assist in helping the clinic to better understand and incrementally adjust delivery of their product to the patients to provide for the best possible outcomes for those patients.

Section 3: Data Collection Process and Analysis

Introduction

In this study, I used a qualitative approach to analyzing data. The qualitative portion focused on coding transcripts and progress reports provided by Tidwell. The quantitative method was used to analyze differences in frequencies and proportions of these codes over time. Data from the transcripts and progress reports were used to answer to underlying research questions. Differences in Tidwell's four major treatment methods—peer support, community-based rehabilitation, psychotherapy, and case management—and health, subjective well-being, safety, and social connections as outcome indicators were the primary focus of analysis.

Practice-Focused Questions

RQ1: Which outcome indicators will be needed to determine client-counseling success?

RQ2: How will the client files be analyzed to ensure proper classification of counselling notes into the correct outcome indicators?

RQ3: How will the outcome indicators be tracked and used to analyze counselor and clinic success?

Sources of Evidence

The purpose of this qualitative case study was to provide Tidwell with a database of outcome indicators that could be used in an ongoing EBP to improve outcomes for the clinic. The evidence was gathered from existing client files and was categorized into the proper outcome indicators. In program evaluation and performance measurement,

"typically, when we are doing evaluation and other similar work, we are using multiple lines of evidence, and administrative data sources are a key contribution to many evaluation" (McDavid et al., 2013, p. 163). This collection of data will be provide the basis for any further analysis needed for Tidwell and will be the start of a much larger database once full implementation of the EBP occurs. There are two separate sources of information that the therapists and I will use: (a) historical data and (b) data from existing clients and counselors.

Procedures

I took factors requiring analysis and helped identify the new organizational client outcome indicators from professional counseling literature in journals, newspapers, books, and Walden Library and websites. This information was used to assist in coding the outcome indicators on data collection from closed files. The implementation of EBP provided a specific model to categorize the four outcome indicators and follow the basic medical process for the field. The survey was presented with the purpose of the study and the informed consent form from Tidwell. Participants were recorded either in a hard copy of files or electronic files from their clients. To eliminate the risk of a patient's personal information being exposed, the personal data were deleted from the files before any analysis was performed. The average time to go through the files and record the data was two to three 8-hour sessions to survey of the files. The survey was led by Tidwell employees and me; each person recorded six files each week. The participants searched the data sources to find the correct information from the clients.

Outcome Indicators in Health Care

This section documents the reviewed relevant published findings of researchers and scholars to provide insight about data collection from counseling outcomes. The evaluation assesses how other articles were relevant to this study, such as articles in education and articles in counseling treatment. The information included a review from authors and scholars. Some of the data sources included articles, books, and reports from nonprofit organizations, health organizations, websites, and scholarly journals.

Classification on Data Collection

The study took outcomes from multiple time periods throughout each member's documented treatment. The time periods varied according to whether the client received care in the short term, medium term, or long term. Data collection occurred at Tidwell's office with the help of two assistants and four intern students. Reliability was high, as data collection was conducted as a group with the presence of the researcher and several samples were studied to perform training prior to the data collection.

The overall sample size was 40 randomly selected files from clients, age 18 and older, whose treatment was completed within the last 5 years. The study was flexible, and the sample size was increased from 35 to 40 files. The random selection ensured a representative sample of demographic variables. Counselors and the director of Tidwell assisted in the development of outcome indicators. These indicators were used during and after counseling to better define the success of the treatment used. For the study, I looked back at the historical data for the last 5 years and helped develop an understanding of the outcomes of past patients. Some concerns arose in the data collection; for example, in

some cases, the patient was over the age of 18 at the time of data collection, but the patient had been under 18 when the treatment started, resulting in the invalidation of the file. Previous case studies developed a limited option necessary for improved patient outcomes. Tidwell's current system for therapists does not allow for negotiations about outcomes, and the utility of the instruments threatened counselors and psychological feedback.

Data collection included the preparation of four reports on the four outcome indicators, including 40 patients from the last 9 years of client's counseling sessions. This study accessed issues of service during treatment for clients with Tidwell. Each client's issue in each file was categorized to place the issue into the correct outcome indicator. Below are the concepts for proper categorization of each issue.

Health

Separate Body and Mind

Mind will fall into the category of subjective well-being. To be in this category there will need to be a concrete mention of physical body by the therapist.

- Internal physiological threats
    - "Hurting themselves"; "Suicidal ideology"
- Physical health
    - "Lose weight"
- Exercise
- Diet
    - "Poor diet"

- Routine access to healthcare
    - Checkups, medication, etc.
- Physical violence with strangers

Subjective Well-Being

What goes into answering the question, "How would you rate your life satisfaction on a scale of 1 to 10?"

- Accomplishments
- Confidence
- Activity level
    - Wants to increase activity. "Go out in nature more"; "Hang out with friends/family"
- Spiritual
    - "Going to church for personal religious reasons"; "Meditation"
- What do they care about?
    - Do they want more money? Want more relationships?
- Non-life-threatening mental disorders (life threatening goes to safety)
    - Therapist notation of issue
- Eating disorder
    - Body image

Safety

What is immediately required for physical safety?

- Housing

    - Yes/no; safe housing; location
- Walking outside
- Abuse (physical violence with people close to them)
    - Safety first; could be relationship
- Bills
- Health safety issues (physical immediate access to healthcare)
    - Life alert

Social Connections (Person to Person or Subjective Well-Being)

- Repair relationships
- Establish relationships
    - "Going to church to make friends"
- Eliminate relationships
- Ability to interact healthily with strangers

Each file item or issue was tested and measured against the clarifications of the section and then, if needed, tested against the drill-down section listed below to further clarify and classify each item into the proper outcome indicator section. Each outcome indicator was given a score of 0 to 5 for the basis of degree of success for the outcome in question. Some data were confusing and had to be placed into several areas, such as suicidal tendencies. On the surface this issue seemed to go into the health category, but with further review this issue was a better fit safety. This drill-down approach to find the proper category is shown below and further expanded in the review of the data. Each item in the drill-down section appears as if it could have an impact on each outcome indicator

listed. Placement into the correct indicator needed to be determined by reading and analyzing which indicator is affected the most.

Drill-Down Section

- Income
    - Health
        - Unable to afford health insurance or prescriptions
    - Subjective well-being issue
        - Feelings of inadequacy
    - Safety
        - Housing, bills
    - Social connections
        - Cannot afford to go out and socialize
        - Friction within a relationship
- Job security
    - Health
        - Unable to afford health insurance or prescriptions
    - Subjective well-being issue
        - Doing what they love
        - Feelings of inadequacy
    - Safety
        - Housing, bills
    - Social connection

        - Losing work friends
        - Cannot afford to go out and socialize
        - Friction within a relationship
- Medication purpose
    - Health
        - Diabetes, high-blood pressure, high cholesterol, sleep
    - Subjective well-being
        - Depression, anxiety, sleep
- Reducing stress to help:
    - Health
        - High blood pressure, lack of sleep
    - Subjective
        - Sleep, lack of activity, anxiety, depression, concentration
    - Social
        - Helps repair relationships
- Sleep
    - Health
        - Physical effects of lack of sleep, Health issue causes lack of sleep
    - Subjective
        - Psychological cause and effect
- Substance abuse
    - Health

        - Immediate health risk
    - Subjective
        - Addiction

Methodological Reports

- Report 1 Sample design
- Report 2: Data collection Methods.
- Report 3: Data Collection Procedures.
- Report 4: Weighting and Variance Estimated

The reports are interrelated between the contents and references to each other. To simplify labels, report numbers were given to the clients' files to collect data. The report indicates how data were collected from 2015 to 2020. Client files contain simplified questionnaires filed by the counselors monthly. This was the location in the client's files for most data. Additional data needed to be gleaned from notes in the files. All data were input using a computer and Microsoft Excel to record the data from the questionnaires into a report.

I measured multiple periods throughout each member of the sample's already documented treatment. Tidwell clinicians and I had an overall sample size of 40 randomly selected files from clients whose treatment was completed within the last 5 years. The clinicians and I expanded this timeline to 9 years to increase the sample size. The random selection ensured a representative sample of demographic variables. Due to legal issues, this study only focused on adults ages 18 or older.

Data collection revolved around four major outcome indicators provided by Tidwell: (a) health, (b) subjective well-being, (c) safety, and (d) social connections. I analyzed how these outcome indicators have been structured with reference to the Organization for Economic Cooperation and Development (OECD) 2020 “How’s Life?” report. This report uses several scales from various researchers around the globe to measure well-being and its many facets. One strategy used to quantify these outcome indicators is calculating percent effect of positive versus negative psychological occurrences in the past 24 hours; I used similar methods for this study.

Tidwell case files include detailed reports by the clinicians, which allowed the researcher and clinicians to code words or phrases that coincide with the indicators. These codes were established and agreed upon as a group before data collection began. The base-line data needed for the first method of analysis was frequency counts of client goals coded into the four indicators set at the beginning of therapy. (p,61(1), 4).

From there, the researcher recorded the frequency of indicators that met within a given time frame and create a ratio of indicators met vs. indicators not met. For example, if the client and clinician set four Subjective Well-Being goals at the onset of therapy, and two of them the client met after a year, a ratio of .50 was recorded. The therapist will continue to record data until the completion of the service.

Because of the qualitative nature of the case files, the second method of analysis the researcher ran was on clinician-reported clients’ attitudes and emotions. Qualitative methods are often used in evaluations because they tell the program’s story by capturing and communicating the participants’ stories. “what programs mean to clients and other

stakeholders." (McDavid, el,al,2013). The qualitative evaluation started with the data namely narrative direct and indirect interaction evaluation (198).

In the second method the researcher obtained ratios of reported positive vs. adverse outcomes linked to the four indicators. For example, if between the fifth and sixth month of treatment, the clinician reported that their client joined a church group and began cultivating a community garden, but had lost the support of a friend, then this would be coded as two positive Social Connection outcomes vs. one negative Social Connection outcome. Then the therapist will label the patient's month six with a .67 ratio. Then, the therapist will continue to compile data each month until the end of the client's service. Ratios above .5 indicate an overall positive outcome for that time.

Published Outcomes and Research

This section will be a systematic review of published research noting how they have approached and analyzed evidence data. During the study, the Researcher examined journals, online periodicals, and books on outcome indicators to understand how to best evaluate the outcome indicator data derived from the study. The measurement of these outcome indicators made it possible for the clinic to meet the challenges associated with developing a common tracking system for counseling outcomes, and to allow for incremental improvements to the services provided to the clients.

Figure 2

Example of Tidwell Outcome and Research Log

Functional Problem List	Long Term Goals	Short Term Goals	Time Frame	Service	Frequecy	90 Day Status
Psychiatric:						Sleep problems healthily managed.
Anxiety						
						Client to report lesser fear of the known.
Sleep problems stemming from anxiety.						
						The client will begin to perform menial tasks.
Fear of the unknown.						
Unable to perform certain simple tasks around the house.						
Social:						
Lives alone.						
Refrains from social gatherings.						
Spiritual Goals:						
N/A						
Family:						
Recently moved has no physical contact with immediate family overseas.						
Nature:						
School, Vocational, or Living Situation						
Lives in low-income housing.						
Has a low-paying part-time job						
Has no high school diploma or similar						

Figure 3

Example of Goals and Treatment Chart

Functional Problem List	Long Term Goals	Short Term Goals	Time Frame for Session	**Service	Frequency	Day Status
Alcohol used	365 days	90 days	30/45 mins		2 / Wk	The client has used alcohol over the limited and affects the health condition
Sexual Risk behavior on severed						The client has performed mental risk
Tabaco used						Affect health
Multiple risk behavior						Risk family risk on social integration
Suicide context						The risk for their life

**Key	
PS	Peer Support
PT	Psycho Therapy
CM	Case Management
CBR	Community Based Rehabilitation

Procedures and Protections for the Administrative Study

The researcher presents as completed study and ongoing procedures in a format that is ethical and protects the client, and the Clinic, as well as follow Walden University rules. According to the Manual (Publication of the American Psychological Association,

2016) “Ethical Principles of Psychologists and Code of Conduct” referred to the ethic code for publishing scientific or research data to present information in an easy way to protect others’ ethical and legal principles. The legal ethic is to ensure the protection of the research participant’s rights to ensure the investigation will occur to follow all the ethics codes in the data outcomes (p, 11).

The first step is to derive observations from files examined. The researcher gave a unique file number to keep the client’s identity safe. After these observations were developed, the researcher compiled the organization’s historical data collected on each past client for the overall effectiveness of treatment, based upon the outcome indicators of the past client counseling plans. All files shown directly to the researchers were redacted of names and other identifying information.

During this stage, the researcher used the Pro-Quest Dissertation Abstract Database to meet the general standard before submitting it to IRB for approval. The data was compiled and identified the treatment the client received while at Tidwell. The counseling effectiveness interventions is to evaluate services outcome measures on routine practices to improve counseling services for the clinic and the clients. The researcher provided an analysis at the end of the study on how to create a database with outcome indicators from the services the clinic provided to their clients.

The focus of this study is to establish outcome indicators for Tidwell and then, historically provide feedback for these indicators based upon past clientele. “Routine outcome monitoring (ROM) has been widely endorsed as a means of assuring and improving the quality of psychotherapy treatment” (Sanders, Richards, &

McBride,2018). The standardized instruments that are designed a practical relevant and rigorous in assessing patient progress (p, 925).

(Mantei,2016). “Pressure to prove,” This study will assist Tidwell in establishing an ongoing outcome improvement program to track clients progress as they receive treatment. The information used in this study was challenging to gather due to a variety of factors such as format of the reports, multiple treatments of the same individual, etc. The study must, without directing the client, glean what information is most needed from those trying to work through the system when provided with counseling services. (p. 47).

Protection

The study has the structure in the administrative law to apply the occupational safety and health act (1970). According to Harrington and Cater. In sec. two congressional findings and purpose these act and procedure will act “by provided for a researcher in the field of occupational safety and health, including the phycological factors involved, and by developing innovative methods, techniques, and approaches for dealing with the occupational safety and health problem.” All human rights organizations set codes by which they align their purposes and activities to protect mental health in every person in this process.

Analysis and Synthesis

Data was compiled into a database to manipulate and review the data, not only by the outcome but also by how counselors provided services to the clients and based upon the outcome indicators. The newly formed database allowed the researcher and TSWC therapists to analyze the data from several different aspects, including client needs, create

new viewpoints for adjusting client plans, and share outcomes and strategies between counselors and management.

In terms of the quantitative analysis of these data the four outcomes (Health, Subjective Well-Being, Safety, and Social Connections), the services provided by Tidwell (Psychotherapy, Case Management, Community-Based Rehabilitation, Peer Support, et al.), demographic variables, and time acted as the independent variables. The ratios of achieved outcomes acted as the dependent variable for the first method of analysis with the ratios of reported positive vs. negative outcomes being the dependent variable for the second method.

The researcher analyzed results and descriptive statistics were calculated for all variables. Repeated measures and two-way analyses of variance were conducted to determine if average ratio scores differ significantly over time for the independent variables. The researcher and therapists were able to compare the efficacy of achieving the four outcomes based on which service the client receives and focus on individual outcomes and how each service may or may not provide different results. Multiple linear regressions were used to determine which variables were better at predicting the dependent variables.

Qualitative individual case studies were added depending on each counselor's file notes' completeness. Each type of data recording was developed as part of the research study. Some data recording was found not to be feasible, depending on each counselor's notation habits. "Qualitative evaluation approaches emphasized the importance of

subjectivity in discerning what programs mean to clients and other stakeholders." (McDavid, Huse, Hawthorn, 2013).

Placing good services of practices counseling such as extend the client satisfaction and client relationship of happiness between client and counselor and showed the relationship during the therapy process to benefit clients. The study analyzed the variables to measure social function rate from the client's' initial therapy date. In synthesis, the study helped Tidwell understand and improve the strategies plan to apply in the clinician observation of outcomes concerning counseling services. The consent of treatment explained with clarity in what category the pre-evaluation identified the client before receiving treatment. These concepts were given to Tidwell to determine the client's satisfaction.

- Case Management
- Psychotherapy
- Peer support
- Community-based and rehabilitation

The category specific to individuals showed the differences in demographic characteristics associated with the therapeutic or the clinical methods. These four categories of service were examined in the progress summary review scale on each client during the time they have counseling.

Summary

The study provided a basic, ground floor method in developing a full Outcome Indicator Tracking System for Tidwell and it will also provide a historical perspective on

how Tidwell's counseling services have performed during the sample size selected. Tidwell's counselors and director implemented tracking and development of the outcome indicator database over time into practice.

The study showed how high and low the confidence of the client was during the therapy. The variable determined the client's satisfaction with their personal life. Because some have severe trauma, the counselor and client's relationship challenged the counselor to reach the expected goals. Some of these goals focused on clients who have health, work, emigration, religious faith (spiritual well-being), socialization, family, language, continuing trauma, financial status, and current housing conditions.

Section 4: Evaluation and Recommendations

Introduction

In this project, the research was conducted to addresses the issue of standardized tracking of outcomes to understand historical outcomes and to create a recommendation for a method of ongoing tracking of outcome indicators for patients at a counseling clinic in the southwestern part of the state of Idaho. Multiple issues arose during the research portion of the project that were not foreseen. First, some of the randomly selected files lasted between 7 and 30 days, skewing the data for the short-term treatment group. Some files had no counselor notes or counselor notes with little codable information. Counselor notes in some files were copied from session to session with little or no changes made by the counselor. Some of the notes were handwritten and some were difficult to read to pull sufficient data from. Methods and format of the counseling notes varied during sessions within the same file. Differing 90-day evaluations and tests, as well as intake forms, made it difficult to isolate and determine outcomes for reported issues.

Larger than expected gaps in services were also noted in some of the files that made it difficult to determine if the client ever resolved the issues originally presented to the counselor. Some files were incomplete to the point of not having sufficient information to participate in the study. Other issues were also noted and these files that did not fit the criteria were given back to the clinic and replacements were requested.

The practice-focused questions and the findings were:

RQ1: Which outcome indicators will be needed to determine client-counseling success?

The outcome indicators used in the research were developed by the clinic supervisor with input from the counselors and me. The first unexpected outcome noted was that most of the clinic's services were for the subjective well-being indicator. With a smaller, yet still valid, number reporting in social connections. Only a handful of clients in the files selected had any needs in health and safety. Because of this unforeseen finding, the clinic may decide to reduce their tracking to only two indicators: subjective well-being and social connection. Further tracking and analysis of more than 30 files may be required to make an informed decision.

RQ2: How will the client files be analyzed to ensure proper classification of counselling notes into the correct outcome indicators?

Because of the differences in the files and the variations in treatment length and paperwork, the team set out to determine the minimum required amount of information t needed to have a valid file. During this process, the following issues were noted and files with these issues were determined inadequate and needed to be replaced:

- Client must have attended a minimum of three sessions: one intake session and two counseling sessions;
- Client could not be a minor at any time during the counseling;
- File was missing a significant amount of client demographic information;
- No discharge reason was noted; and
- Counseling notes were lacking or not legible.

Eligible files were then processed for data collection. Files were first organized and reordered by counseling notes, evaluations, testing, and questionnaires with scoring.

All others including data and other clinic and physician referrals were separated from the relevant client treatment data. The notes and evaluations were then put into chronological order starting with the intake date and proceeding to the discharge date.

Next, the files were reviewed for the demographic data. Age categories used were 18–30, 30–45, 45–60, and 60–75. Gender was categorized as either male or female. Ethnicity and race was categorized as Caucasian, Asian, African American, Latino, or Arabic. Other factors that were recorded included preferred language, marital status, and treatment methods used. Student researchers already employed by the clinic were used to collect this data. These data were transferred to a simple shared spreadsheet that all researchers had access to.

Treatment plans were recorded to understand and collect the methods of treatment. Finally, the counseling notes and evaluations were analyzed to determine the indicators present and the success or lack of success during treatment. The analysis of PROs was used during the recording and processing into two methods (Bingham, 2019). *Reporting window* was the daily electronic patient report outcome that captured the daily measurement and was more accurate in the process of data collection.

- Method 1, cumulative treatment balance proportion goal resolution analysis, was based on tracking the client's treatment of issues from start to resolution. This style of tracking was sometimes difficult to determine from the notes whether the client resolved the issue by the end of services.

- Method 2 was clinician reported affect balance proportion analysis. This reporting method was easier to record as clinicians' notes were clearer to understand and, most of the time, detailed.

Several statistical analyses were completed with the data; however, only the analyses deemed valid and relevant to the study were included in the findings and implications section.

RQ3: How will the outcome indicators be tracked and used to analyze counselor and clinic success?

Information for the clinic to help develop their ongoing program and to track these indicators was still found; even with the many difficulties, the findings and implications for the ongoing program are useful. This is discussed further in Section 5.

Findings and Implications

At the start of the study, I selected three files to review to become familiar with the data and to develop a strategy to best extract the data from the files. These were then presented to the research team and reviewed to minimize researcher bias. A consensus on the methods was achieved after discussion. Data were contained in multiple areas of the files, with several notes and data sheets to pull from. Some of the major items within the files noted were: (a) intake paperwork; (b) treatment plan; (c) session notes; (d) 90-day, 120-day, 1-year evaluations; (e) miscellaneous tests and evaluations; (f) various paperwork transferred from other clinic and doctors; (g) discharge paperwork; (h) treatment consent forms; and (i) billing and insurance information. This list is not meant

to be all inclusive as there were multiple files with additional information not relevant to the study.

Based on this limited review of three files, I made several inferences as to the amount of data that would be available, the types of data available, and the length of treatment for the files. These files were used to then strategize the collection procedures and methods to limit bias and keep the integrity of the data.

After the research it was noted that the outcome indicators most noted in clients' files had to directly depend on counseling services. During the work in this field with refugees, I realized that other institutions and NPOs worked closer on the issues of safety and health with certain clients. According to the files, most health issues were referred out to a physician or hospital, while safety issues were referred to housing placement organizations. These two issues were not tracked after referral, and in most cases, the outcome for the client remained unknown. Special attention needs to be made in these areas for the sake of case management.

Some of the secondary findings revealed that the counseling data recorded were missing or not in a standardized format. Therefore, a natural result of the analysis of incomplete data would result in incomplete analysis, directly affecting the results of this study. Additionally, there were several smaller demographic findings present during the analysis of the data. I noted that about half of the subjects were native to the United States, while the other half were from other countries. About 75% of clients were noted as female and only 25% male. Additionally, a large number of sessions were missed due to absence of an interpreter and miscommunication about transportation. I also noted that

age of the client significantly predicted number of social issues resolved by last day of treatment and showed a significant proportion of variance in social issues resolved. However, age did not significantly predict number of subjective well-being issues resolved by last day of treatment.

Lastly, I noted that the rates of predicted number of issues resolved by last day of treatment in the four indicators specified, for subgroups of U.S. clients, were significantly higher than the non-U.S. clients. This would indicate less favorable outcomes in the non-U.S. client group for the number of issues resolved by last day of treatment. In other words, the non-U.S. client group did not experience successful outcomes to the same extent that the U.S. client group did.

Methods of Collection

Data collection was completed in groups, or pairs, in order to increase data collection reliability. Randomly selected eligible files were processed for data collection. Files were first organized and reordered by counseling notes, evaluations, testing, and questionnaires with scoring. All others, including data and other clinic and physician referrals, were separated from the relevant client treatment data. The notes and evaluations were then put into chronological order starting with the intake date and proceeding to the discharge date.

Next the files were reviewed for demographic data: age, gender, and race and ethnicity. Other factors that were recorded included preferred language, marital status, and treatment methods used. Student researchers already employed by the clinic were used to collect this data. These were transferred to a simple shared spreadsheet that all the

researchers had access to. Treatment plans were then recorded to understand and collect the methods of treatment. Finally, the counseling notes and evaluations were analyzed to determine the indicators present and the success or lack of success during treatment.

Table 1

Descriptive Demographic Statistics Recorded

		Count	Column N %
Reported Gender	Male	11	29.7%
	Female	26	70.3%
Marital Status	Single	5	13.2%
	Married	21	55.3%
	Divorced	5	13.2%
	Widowed	3	7.9%
	Other	4	10.5%
Country of Origin	USA	11	30.6%
	Iraq	8	22.2%
	Bhutan	5	13.9%
	Congo	4	11.1%
	Afghanistan	2	5.6%
	Syria	2	5.6%
	Burundi	1	2.8%
	Columbia	1	2.8%
	Egypt	1	2.8%
	Sudan	1	2.8%
Reason for Discharge	Failed to Return	16	48.5%
	Referred	3	9.1%
	Client Request	5	15.2%
	Transferred	4	12.1%
	Goals Met	3	9.1%
	Other	2	6.1%
Preferred/Primary Language	English	12	33.3%
	Arabic	10	27.8%
	Nepali	5	13.9%
	Swahili	3	8.3%
	Other	6	16.7%

Table 2

Continuous Descriptive Statistics

Length of Treatment 2 Groups		N	Minimum	Maximum	Mean	Std. Deviation
Short Term (120 Days)	Age (Begin Year - Year of Birth)	13	24	54	35.85	10.090
	Length of Treatment in Days	14	7	112	51.71	35.608
	Valid N (listwise)	13				
Long Term (121+ Days)	Age (Begin Year - Year of Birth)	16	39	67	53.00	8.025
	Length of Treatment in Days	16	129	1465	639.63	351.910
	Valid N (listwise)	16				

Patterns in Demographic Statistics Noted

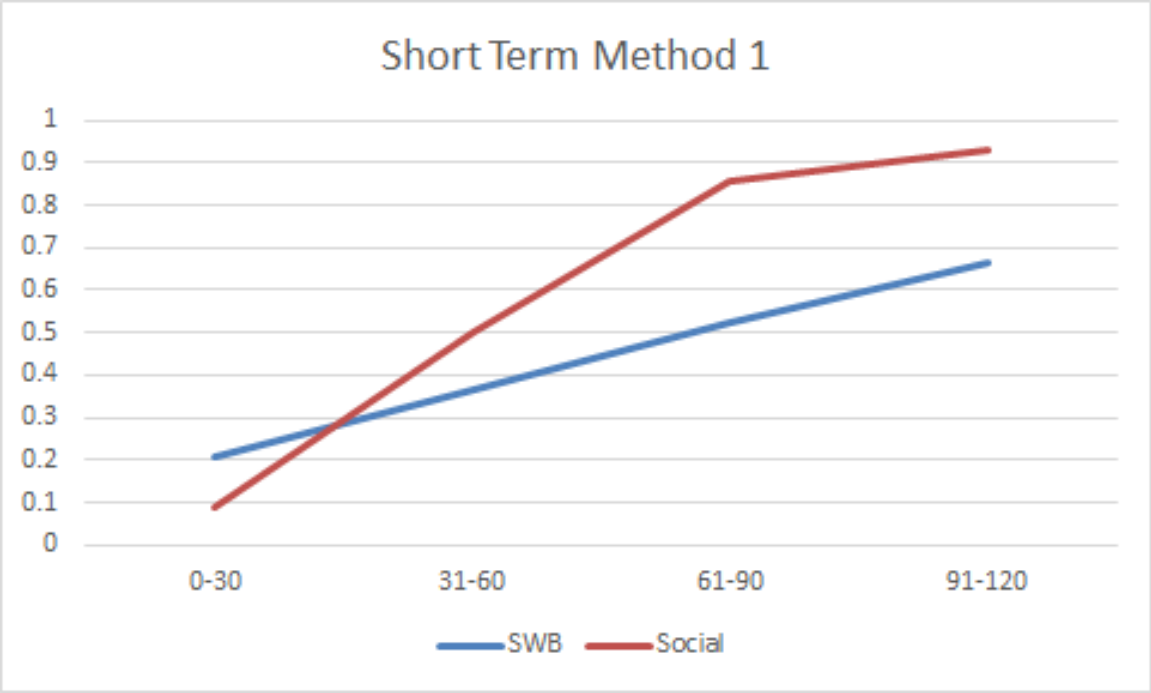
Some of the patterns reflected in the demographic data were not expected. Married individuals comprised 55% of the files, and females comprised 70.3%. The largest percentages for clients' countries of origins were United States and Iraq.

Under *reason for discharge*, the category *goals met* was significantly low at 9.1%; *failed to return* was the highest at 48.5%. This finding indicates that almost half of the clients included in the data did not finish treatment. Incomplete transcription of the clinicians may have caused the low number of *goals met* clients.

In the preferred/primary language, 33% of the clients were English speaking and only one individual was Spanish speaking. This was of notice as the Spanish speaking population in area of Idaho is relatively large at 12.8%, according to the U.S. Census Bureau (2019). The difference in average age between short-term patients and long-term patients was significant. It appears that for older clients, longer treatment is sustained; the average age of short-term patients was 35.85 years, and the average age of long-term patients was 53.62. This difference is statistically significant, $t(27) = -5.104$, $p < .001$.

Figure 4

Cumulative Treatment Balance Proportion Goal Resolution Analysis, Short-Term Method 1



Throughout data analysis, sample sizes for the health and safety indicators were too low to draw any significant conclusions from. They were removed from these descriptive charts and any further analysis. Figure 4 shows the average proportion of resolved subjective well-being and social issues over time (the X axis is treatment length in days) for the short-term patients. Figure 4 is cumulative and values above .5 on the Y axis indicate more resolution than not. For example, within 61–90 days, 75% of social issues were resolved compared to how many were initially brought up at the beginning and throughout treatment. Figure 4 shows that social connection cases were resolved at a higher rate than subjective well-being cases in files that were terminated for whatever reason within 120 days.

Only three subjective well-being and three social issues were reported in the 0 to 120 days range. This made the underlying output too low to draw any significant statistical conclusions from and those results were omitted from the study.

Figure 5

Cumulative Treatment Balance Proportion Goal Resolution Analysis, Long-Term Method 1

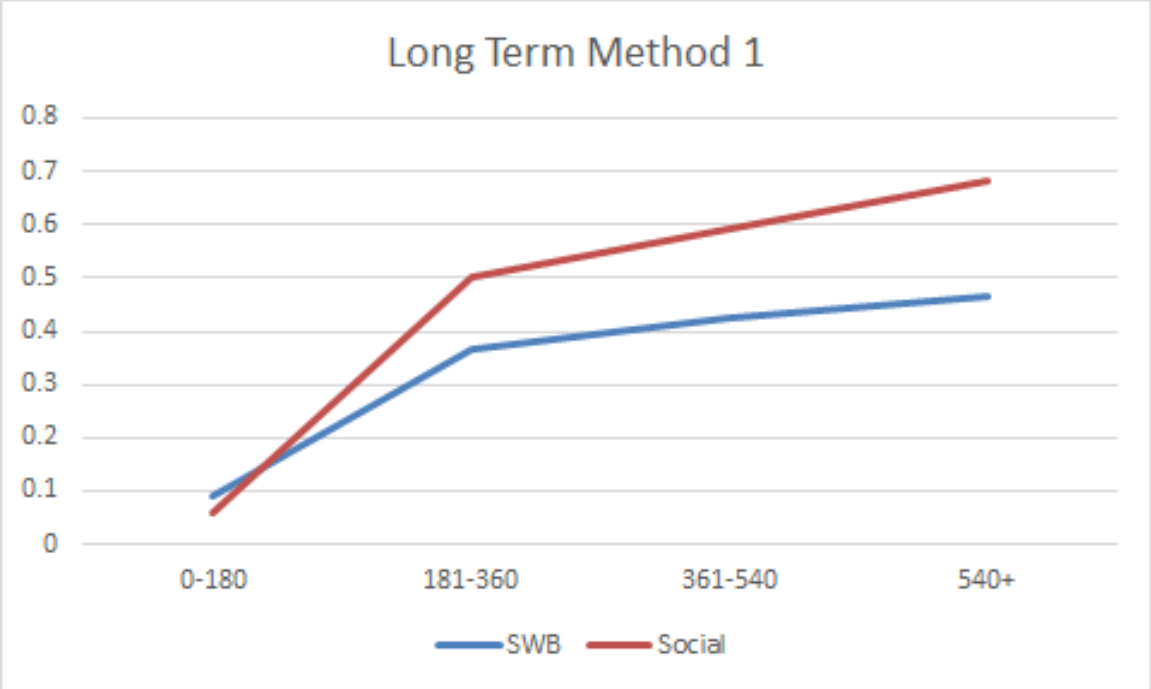


Figure 3 graph is cumulative and values above .5 indicate more resolution than not. Like in the short-term graph, Social issues are resolved quicker than Subjective Well-Being Issues. For example, within 361-540 days, 60% of Social issues were resolved as opposed to approximately 42% of Subjective Well-Being issues.

Figure 6

Cumulative Treatment Balance Proportion Goal Resolution Analysis, Long-Term Method 2

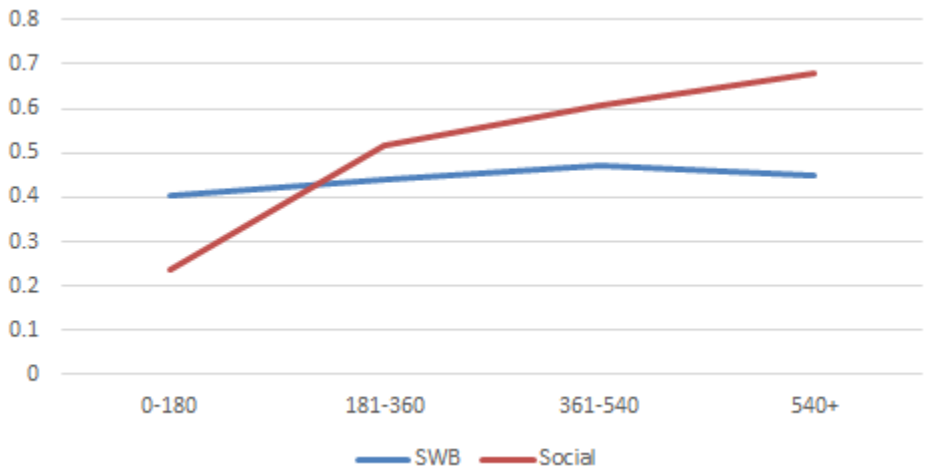


Figure 4 chart depicts our second method over time in the long term. Proportions above .5 indicate the average proportion of positive affect concerning either Subjective Well Being issues or Social issues. For example, between 361-540 days after treatment began, approximately 60% of discourse around Social issues was positive during the sessions. Like the previous charts, Social affect is greater than Subjective Well-Being affect over time.

Table 3

Statistical Analysis

Outcome Indicator	Short Term		Long Term		df	t	*p*	Cohen's *d*	Bootstrap CI	
	M	SD	M	SD						
Subjective Well Being	0.8462	1.1435	1.3333	1.2344	26	-1.077	0.291	1.1933	-1.3313	0.3844
Social	0.6	0.5164	1.3846	0.9608	19.112	-2.511	0.024	0.8011	-1.4083	-0.1818

Outcome Indicator	Americas		Middle East		df	t	*p*	Cohen's *d*	Bootstrap CI	
	M	SD	M	SD						
Subjective Well Being	0.8889	1.2693	1.5	1.1785	17	-1.088	0.292	1.222	-1.633	0.4286
Social	1.2857	0.9512	1.25	0.8864	13	0.075	0.941	0.0357	-0.8333	1.0182

Outcome Indicator	Males		Females		df	t	*p*	Cohen's *d*	Bootstrap CI	
	M	SD	M	SD						
Subjective Well Being	1	1.3093	1.15	1.1821	26	-0.294	0.771	1.2177	-1.125	0.9412
Social	1.2857	0.9512	0.9375	0.8539	21	0.87	0.394	0.8828	-0.5089	1.1696

Several Independent t-tests were run to analyze differences in means of subjective wellbeing and social issues being resolved at the end of treatment. Tests with lower sample sizes or normality issues were bootstrapped.

There was a significant difference between treatment length and social issues resolved by the end of treatment $t(19.112) = -2.511$, $p = .024$. Resolution of subjective well-being issues did not significantly differ between short- and long-term treatment.

Other demographic variables were analyzed, such as males and females and it did not differ for either subjective well-being or social issues resolved. There were no differences between clients from the Americas and clients from the Middle East in resolving either issues as well. The data suggests that Tidwell provides equal service across gender and the two major regions in the sample.

Introduction to Linear Regression

Linear regressions were run to see which ratio-scaled variables were helpful in predicting the frequency of resolved Subjective Well-Being and Social issues by the end of treatment. The two independent variables were age and length of treatment in days.

Table 4

Single Linear Regression 1

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Durbin-Watson
1	.510[a]	.260	.224	.77320	2.986

a. Predictors: (Constant), Length of Treatment in Days

Table 5

ANOVA[a]

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	4.402	1	4.402	7.363	.013[b]
	Residual	12.555	21	.598		
	Total	16.957	22			

a. Dependent Variable: Last_Day_1st_Soc

b. Predictors: (Constant), Length of Treatment in Days

Table 6

Coefficients

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	.540	.246		2.199	.039
	Length of Treatment in Days	.001	.000	.510	2.713	.013

a. Dependent Variable: Last_Day_1st_Soc

Length of Treatment in days significantly predicted number of social issues resolved by last day of treatment, b = .001, t(21) = 2.713 p = .013. Length of treatment also explained a significant proportion of variance in social issues resolved, R2 = .260, F(1, 21) = 7.363, p = .013

Length of Treatment in days did not significantly predict number of subjective well-being issues resolved by last day of treatment, b = .001, t(26) = 1.166 p = .254. Output for this analysis is included in appendix B.

Table 7

Single Linear Regression 2

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.407[a]	.166	.124	.81229

a. Predictors: (Constant), Age (Begin Year - Year of Birth)

Table 8

ANOVA[a]

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	2.622	1	2.622	3.974	.060[b]
	Residual	13.196	20	.660		
	Total	15.818	21			

a. Dependent Variable: Last_Day_1st_Soc

b. Predictors: (Constant), Age (Begin Year - Year of Birth)

Table 9

Coefficients[a]

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	-.219	.679		-.322	.751
	Age (Begin Year - Year of Birth)	.029	.014	.407	1.993	.060

a. Dependent Variable: Last_Day_1st_Soc

Table 10

Bootstrap for Coefficients

Bootstrap for Coefficients

Model			Bootstrap[a]				
						95% Confidence Interval	
		B	Bias	Std. Error	Sig. (2-tailed)	Lower	Upper
1	(Constant)	-.219	-.004	.531	.655	-1.343	.969
	Age (Begin Year - Year of Birth)	.029	.000	.013	.034	.001	.053

a. Unless otherwise noted, bootstrap results are based on 1000 bootstrap samples

Age significantly predicted number of social issues resolved by last day of treatment, b = .029, t(20) = 1.993 p = .034. Age also explained a significant proportion of variance in social issues resolved, R2 = .166, F(1, 20) = 3.974, p = .034

Age did not significantly predict number of subjective well-being issues resolved by last day of treatment, b = .012, t(25) = .564 p = .578. Output for this analysis is included in appendix A.

Power Analysis

The power test was done in order to compare two different methods with respect to the outcome resolution. In the context of this study higher power would increase the likelihood of detecting effects.

Table 11

Power Analysis

Power Analysis - Independent Sample Means

Power Analysis Table

		Test Assumptions					
	Power[b]	N1	Std. Dev1	N2	Std. Dev2	Mean Difference	Sig.
Test for Mean Difference[a]	.664	10	.5164	13	.960769	.78462	.05

a. Two-sided test.

b. Based on noncentral t-distribution.

Power Analysis - Independent Sample Means

Power Analysis Table

		Test Assumptions				
	Power[b]	N1	N2	Std. Dev.[c]	Effect Size	Sig.
Test for Mean Difference[a]	.105	12	13	.449515	.285	.05

a. Two-sided test.

b. Based on noncentral t-distribution.

c. Group variances are assumed to be equal.

When measuring the last day of treatment's proportion of social resolutions vs. social non-resolutions and running an independent t-test on those proportions across the treatment length variable, power was .105. When taking just the frequency of last day social resolutions and running the exact same independent t-test, power was .664. For both power tests, the mean difference was set to the actual mean difference between the

groups. Thus, recording the actual frequencies without converting them to a proportion lends more reliability to statistical analysis.

Strength and Limitations of the Project

The project purposed to determine to perceive effectiveness of the for outcomes indicators that was delivered by the counselor's service. The strength and limitations were based on the rounded files that were requested prior to the research analysis, some of those files contain no valuable data or very limited data. The files needed to at least contain the following information to be valid for the analysis

- A list three session of counseling treatment
- Counseling notes
- No minors
- Reason for discharges.

The review was based on real evidence of the evaluation that was conducted by the professionals' counselors of the clinic. However, the project was limited and that may affect the reliability of the results.

Unexpected Data Collection Outcomes

Affecting Statistical Analysis

The researcher proposed a Two-way Factorial ANOVA and a Two-way Repeated Measures ANOVA prior to the data collected. These were ran and several significant interactions were found. The majority of these interactions centered around gender, however an unforeseen lack of male clients in the sample made the interactions

unreliable. The male sample sizes were too low even to bootstrap the analysis, further collection of data samples would be needed to confirm this interaction.

Another significant interaction in Subjective Well Being resolutions on the last day of treatment was found between length of treatment and the recoded country of origin variable (USA and non-USA born clients). However due to the USA sample being too low the results of the interaction were not reliable, further collection of data samples would be needed to confirm this interaction.

Summary

After data collection, descriptive and inferential statistical analyses were performed. Early on in data analysis the researchers removed the health and safety indicators due to low sample size. Charts show that in the short term and long term, social issues are resolved more readily and rapidly over time than subjective well-being. This pattern held for social outcome indicators when measuring positive affect. After organizing the descriptive statistics for the demographic data an interesting discrepancy emerged, clients who terminated their treatment for whatever reason within the first 120 days were significantly younger than those who terminated treatment after 120 days.

Unfortunately, the statistical tests the researchers proposed to conduct, namely different forms of two-way ANOVA, were not run due to unforeseen major differences in the sample sizes of various important demographic characteristics (males vs. females, country of origin, etc.). Less complex tests such as the independent t-test, correlation, and linear regression were run instead. When using the average proportions of client goal resolution, none of these tests found statistically significant results. The researchers

decided to test a new dependent variable based on data already collected. A power test in SPSS affirmed that using the frequencies of client goals met by the end of treatment, rather than proportions, was more likely to detect real effects in the data. When frequencies were used as the dependent variable, statistically significant patterns emerged. Since the purpose of this study is not to critique but to discover, non-significant results of the higher power tests were also reported.

One interesting finding was that more social issues were resolved for long term clients than for short term. This may not be surprising except this effect did not carry over for subjective well-being issues. There were no differences in either social or subjective well-being resolution for males and females nor for clients from the Americas and Middle Eastern clients. This shows no significant difference in attainment of treatment goals between either group. Linear regression backed up the independent t-test results that duration of treatment (measured in actual days for the regression) was a significant predictor of the number of social issues resolved by the end of treatment. Similarly, the independent t-test, there was no relationship between treatment duration and subjective well-being resolution. Another regression was performed that found age of the client was a significant predictor of social resolution but not subjective well-being resolution. Overall, larger sample sizes suggest that interactions are needed for more complex analysis.

Section 5: Dissemination Plan

This research study was intended to have results and provide variances through the analysis of dependent and independent variables collected in the data. Four outcome indicators—subjective well-being, health, safety, and social connection—were tracked through each client case file. According to Rudestam (2015) addressing each of the research questions one at a time with varied statistical analysis will help to understand the data collected. The dissemination plan has several components that need to be analyzed to influence and better categorize educational intervention in outcomes indicators of quality service. The dissemination of the study results in this case will be focused on the practice-focused questions that guided the study.

RQ1: Which outcome indicators will be needed to determine client-counseling success?

As stated, the outcome indicators used in the research were developed by the clinic supervisor with input from the counselors and me. With only the social and subjective well-being indicators having a large enough pool in the data collected to influence the outcome of the study, it was noted that the clinic may want to only have two indicators to track, rather than four. A larger sample size would help to to ensure the same results hold true. The organization should continue to research more files to determine the validity of the health and safety indicators.

RQ2: How will the client files be analyzed to ensure proper classification of counselling notes into the correct outcome indicators?

This question was answered as part of the overall data collection process. The data had to be combed through and each note, test, intake form, and evaluation had to be read, understood, and transcribed into a format for Method 1 and Method 2. Each issue that was noted in the clients' files had to be understood as something handled by the clinic or something not handled by the clinic. Items not in the clinic's purview were not included in this study of outcomes. Those items that were found to be directly in the purview of the clinic were then categorized into one of the four outcome indicators. These indicators were then analyzed. I noted that a more effective method of recording the issues in one of the categories by the counselor and tracking that issue throughout treatment would lead to more effective analysis of the outcomes for the patients and the clinic.

RQ3: How will the outcome indicators be tracked and used to analyze counselor and clinic success?

The lack of consistency in the clinical assessments made the collection of the appropriate data difficult and sometimes the needed information was unavailable. The clinic should find an appropriate format to track outcomes that is more of a database-driven format or program. This would make it easy for management to pull the data points from the program and create more effective and efficient methods of tracking the outcome indicators. According to Srebnik et al. (2010), outcomes are much more direct indicators of quality than either structure or process indicators. Monitoring quality outcome indicators should be focused on how much quality is delivered through the data

collected for the research analysis. In this area, I found more structure and quality problems than useful indicators.

The effective dissemination of the project depends on how the organization uses the effective structure of data entry to articulate and find client problems. The charge of the clinic is to have a well-defined structure of recording and processing counseling data. This would allow the organization to better develop quality outcomes. The content value, data recorded, is important to ensure the service the clinician provides is valid. In this context, a reflective action practice must continually improve processes for recording quality outcome indicators.

The next component of evaluation would be to include a program process that does not allow copy-and paste-functions in the notes and evaluation sections. Doing so would prevent counselors from copying and pasting notes after each session. It was noted that a handful of files contained this issue. The process would develop an easy method for the counselors to analyze and place specific issues presented by the clients into one of the four appropriate outcome indicators, as well as having an appropriate scale that allows the counselor to update and to show positive or negative changes on a week-by-week or quarter-by-quarter basis.

This database driven program to record the notes and the outcome indicators data needs to be created in a way that is does not affect the quality of the counseling sessions by focusing too much on these indicators. Training in the proper use of the database would then be required for each counselor in “a reflective practice” (Vachon, 2015, p. 2). Short-term goals would be to develop a strategic plan in the administrative act to regulate

the best practices for successful outcomes. This practice must be integrated into the clinic's normal operations to be effective in planning and facilitating an improvement program for quality indicators. The management would be the only one to have the ability to pull the data and create reports. Management oversight seems to have been lacking in some of the files as they were copied and pasted from week to week over a 2-year period. This type of improper documentation could be more easily recognized and the proper correction be implemented with more oversight from management.

This type of a program is not difficult to develop for a database programmer, and it is recommended that the clinic start by taking this first step. It is understood that this is not a final step as this program and database should be kept in an open and malleable format to encourage change and improvement.

Upon the development and use of this new program in the clinic, the clinicians and management should meet on a weekly and quarterly basis to discuss how to record certain client interactions. If the methods are made to be more of a standardized format, it would allow for easier understanding of the notes and evaluations to establish quality. (Waring 2005). Establish quality practical reporting in the organizational learning will exchange professional supervision in term practices and safety. Patient safety is a priority for any healthcare system to have a new way to improve potential of health care service in terms efficacy in public sector management (P, 670).

Efficacy in the semi-annually and annually the counselors and management team should meet to discuss updates to the database and to train to gain further knowledge about the proper use and potential use of the data. Classes could be incorporated on a

professional level to assist them in understanding how to use this tool to further their success as well as their client's success.

Retrospective

If the researchers were to complete this study again to success, the researcher would start with 100 files to allow the researcher to provide more analysis with a greater degree of success. Indicators would be classified into two outcomes and not four, as shown by the files reviewed. This would result in larger amounts of reported data and would allow for additional studies to be done on independent and dependent variables to better understand the relationships.

Summary

Throughout this project the researcher sought to address the organization's requirement to analyze outcomes in the past historical files and begin to formulate an understanding of how the clinic records those outcomes to develop an outcome indicator program for the clinic. This type of program would address the needs of the clinic to evaluate the performance for the clinic and clinicians.

One of the conclusions of this study was to determine that the outcome indicators first selected were in fact the best indicators for the organization moving forward. As stated, prior, Health, Safety, Subjective wellbeing and social, were initially selected. At least two for these four indicators, Subjective Well Being and Social, were determined to be the bulk of the issues presented by the clients in the sampled files. Health and Safety indicators were presented in a relatively low number of times. The organization may want

to evaluate with further research if these two indicators need to be dropped and only track the two that make up the largest percentage of presented issues.

There were several small details that were noted in these files that with small operational corrections could be improved and affect the bottom line of the organization. One key issue was the number of times the client had to cancel due to transportation or interpreter problems. The clinic should incorporate a process to verify the interpreter and the transportation prior to each session.

The primary recommendation of the findings included development of the appropriate policy plan for the organization and then the implementation of these policies, surrounding the methodology and the tracking of clinical data throughout the process of a client's intervention. This would not only improve the way the clinic can retrieve and review patients' outcomes, but it would also provide valuable information allowing the clinic to apply for additional funding. The organization needs to have a standardized tracking method of the outcome indicators, and an appropriate data-driven solution to store it in. This would allow for the clinic to retrieve information quickly and at any time regarding patient outcomes. This could be retrieved by any metrics available such as nationality, sex, age, overall clinic or by clinician, etc.

References

Aström, M., Krig, S., Ryding, S., Cleland, N., Rolfson, O., & Burström, K. (2020). EQ-5D-Y-5L as a patient-reported outcome measure in psychiatric inpatient care for children and adolescents: A cross-sectional study. *Health and Quality of Life Outcomes, 18*(1), 1–14. https://doi.org/10.1186/s12955-020-01366-4

Bingham, C. O., Gaich, C. L., DeLozier, A. M., Engstrom, K. D., Naegeli, A. N., de Bono, S., Banerjee, P., & Taylor, P. C. (2019). Use of daily electronic patient-reported outcome (PRO) diaries in randomized controlled trials for rheumatoid arthritis: rationale and implementation. *Trials, 20*(1), 182. https://doi.org/10.1186/s13063-019-3272-0

Byrom, B., Doll, H., Muehlhausen, W., Flood, E., Cassedy, C., McDowell, B., Sohn, J., Hogan, K., Belmont, R., Skerritt, B., & McCarthy, M. (2018). Measurement equivalence of patient-reported outcome measure response scale types collected using bring your own device compared to paper and a provisioned device: Results of a randomized equivalence trial. *Value in Health, 21*(5), 581–589. https://doi.org/10.1016/j.jval.2017.10.008

Byrom, B., Gwaltney, C., Slagle, A., Gnanasakthy, A., & Muehlhausen, W. (2019). Measurement equivalence of patient-reported outcome measures migrated to electronic formats: A review of evidence and recommendations for clinical trials and bring your own device. *Therapeutic Innovation & Regulatory Science, 53*(4), 426–430. https://doi.org/10.1177/2168479018793369

Coons, S. J., Gwaltney, C. J., Hays, R. D., Lundy, J. J., Sloan, J. A., Revicki, D. A.,

Lenderking, W. R., Cella, D., & Basch, E. (2009). Recommendations on evidence needed to support measurement equivalence between electronic and paper-based patient-reported outcome (PRO) measures: ISPOR ePRO good research practices task force report. *Value in Health, 12*(4), 419–429. https://doi.org/10.1111/j.1524-4733.2008.00470.x

Coons, S. J., Eremenco, S., Lundy, J. J., O'Donohoe, P., O'Gorman, H., & Malizia, W. (2015). Capturing patient-reported outcome (PRO) data electronically: The past, present, and promise of ePRO measurement in clinical trials. *The Patient–Patient-Centered Outcomes Research, 8*(4), 301–309. https://doi.org/10.1007/s40271-014-0090-z

Critical Path Institute. (2018). *Best practices for migrating existing patient-reported outcome instruments to a new data collection mode*. https://c-path.org/wp-content/uploads/2018/09/BestPractices3_Migrating.pdf

Field, A. P. (2013). *Discovering statistics using IBM SPSS statistics: And sex and drugs and rock 'n' roll* (4th ed.). Sage Publications.

Fowers, B. J., Richardson, F. C., & Slife, B. D. (2017). Suffering. In *Frailty, suffering, and vice: Flourishing in the face of human limitations*. (pp. 153–178). American Psychological Association.

Gao, T., & Gurd, B. (2019). Organizational issues for the lean success in China: exploring a change strategy for lean success. *BMC Health Services Research, 19*(1), 1–11. https://doi.org/10.1186/s12913-019-3907-6

García, M. D., Rapado-Castro, M., Fraguas, D., Parellada, M., Arango, C., Castro-

Fornieles, J., Cuesta, M. J., & Bernardo, M. (2019). Functional trajectory in first-episode psychosis based on premorbid IQ and age of onset. *Schizophrenia Bulletin, 45*(Supplement 2), S249. https://doi.org/10.1093/schbul/sbz019.397

Gnanasakthy, A., Mordin, M., Evans, E., Doward, L., & DeMuro, C. (2017). A review of patient-reported outcome labeling in the United States (2011-2015). *Value in Health, 20*(3), 420–429. https://doi.org/10.1016/j.jval.2016.10.006

Johansson, S. (2010). Implementing evidence-based practices and programs in the human services: lessons from research in public administration. *European Journal of Social Work, 13*(1), 109–125. https://doi.org/10.1080/13691450903135691

Manthei, R. (2015). Evaluating counselling outcome: Why is it necessary? How can it be done? *New Zealand Journal of Counselling, 35*(1), 61–85. https://www.nzac.org.nz/assets/Uploads/Journals/4.-Evaluating-Counselling-Outcome.pdf

Manthei, R. (2016). Revealing counselling: Things counseling agencies should know about their services. *New Zealand Journal of Counseling, 36*(1), 47–70. https://www.nzac.org.nz/assets/Uploads/Journals/3.-Revealing-Counselling.pdf

McDavid, J. C., Huse, I., & Hawthorn, L. R. L. (2013). *Program evaluation and performance measurement: An introduction to practice* (2nd ed.). Sage Publications.

Mollica, R. F. (2008). Healing invisible wounds: Paths to hope and Recover in a violent World. Vanderbilt University Press.

Muehlhausen, W., Doll, H., Quadri, N., Fordham, B., O'Donohoe, P., Dogar, N., & Wild,

D. J. (2015). Equivalence of electronic and paper administration of patient-reported outcome measures: A systematic review and meta-analysis of studies conducted between 2007 and 2013. *Health and Quality of Life Outcomes, 13*(1), 167. https://doi.org/10.1186/s12955-015-0362-x

OECD (2020), How's Life? 2020: Measuring Well-being, OECD Publishing, Paris,https://doi.org/10.1787/9870c393-en

Onoruoiza, S. I., Musa, A., Umar, B. D., & Kunle, Y. S. (2015). Using health belief model as an intervention to noncompliance with hypertension information among hypertensives patient. IOSR-Journal of Humanities and Social Sciences, 20(9), 11-16. Retrieved from https://pdfs.semanticscholar.org/8ca0/5f221fc1bd966b6b38e833236b38ff9ee56e.pdf

Oxford University Innovation (2016).Patient-reported outcomes – From paper to ePROs: Good practice for migration Available from: https://innovation.ox.ac.uk/wp-content/uploads/2016/05/ePRO_guide_2016.pdf. Accessed 04/02/2019.

Roller, M. R. (2019). A quality approach to qualitative content analysis: Similarities and differences compared to other qualitative methods. Forum Qualitative Sozialforschung/Forum: Qualitative Social Research, 20 (3), 1-21.

Sanders, P. W., Richards, P. S., & McBride, J. A. (2018). Development of the clinically adaptive multidimensional outcome survey. Psychotherapy Research,28(6), 925–939.

Selohilwe, Arvin Bhana, Emily C. Garman, & Inge Petersen. (2019). Evaluating the role

of levels of exposure to a task shared depression counselling intervention led by behavioural health counsellors: outcome and process evaluation. International Journal of Mental Health Systems, 13(1), 1–15. https://doi-org.ezp.waldenulibrary.org/10.1186/s13033-019-0299-2

Shahraz, S., Pham, T.P., Gibson, M. et al. Does scrolling affect measurement equivalence of electronic patient-reported outcome measures (ePROM)? Results of a quantitative equivalence study. J Patient Rep Outcomes 5, 23 (2021). https://doi.org/10.1186/s41687-021-00296-z

Srebnik, D., Hendryx, M., Stevenson, J., Caverly, S., Dyck, D. G., & Cauce, A. M. (1997). Development of outcome indicators for monitoring the quality of public mental health care. Psychiatric Services, 48(7), 903–909.

Stanley, P., & Manthei, R. (n.d.). Counselling psychology in New Zealand: The quest for identity and recognition. Counselling Psychology Quarterly,17(3), 301–315.

SURMEPI. Stellenbosch University (September 17,2015). Evidence Based Healthcare. Retrieved. From https://blogs.sun.ac.za/surmepi/projects-overview/health-systems/evidence-based-healthcare/

Vachon, B., Désorcy, B., Gaboury, I., Camirand, M., Rodrigue, J., Quesnel, L.,Guimond, C., Labelle, M., Ai-Thuy Huynh, Grimshaw, J., & Huynh, A.-T. (2015). Combining administrative data feedback, reflection and action planning to engage primary care professionals in quality improvement: qualitative assessment of short-term program outcomes. BMC Health Services Research, 15(1), 1–8.

van der Wees, P. J., Eva W. Verkerk, Marjolein E. A. Verbiest, et al. Development of a

framework with tools to support the selection and implementation of patient-reported outcome measures. Journal of Patient-Reported Outcomes. 2019;3(1):1-10. doi:10.1186/s41687-019-0171-9.

Varda, D., Shoup, J. A., & Miller, S. (2012). A systematic review of collaboration and network research in the public affairs literature: implications for public health practice and research. American Journal of Public Health, 102(3), 564–571

Waring, J. J. (2005). Patient safety: new directions in the management of health service quality. Policy & Politics, 33(4), 675–692.

United States Census Bureau. (2019). *Quick facts Idaho: Population estimates*. https://www.census.gov/quickfacts/fact/table/ID/RHI725219

Appendix A: SPSS Output for Linear Regressions Between Age of Client and Subjective Well-Being Resolution

Model Summary[b]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Durbin-Watson
1	.112[a]	.013	-.027	1.21552	2.169

a. Predictors: (Constant), Age (Begin Year - Year of Birth)

b. Dependent Variable: Last_Day_1st_SWB

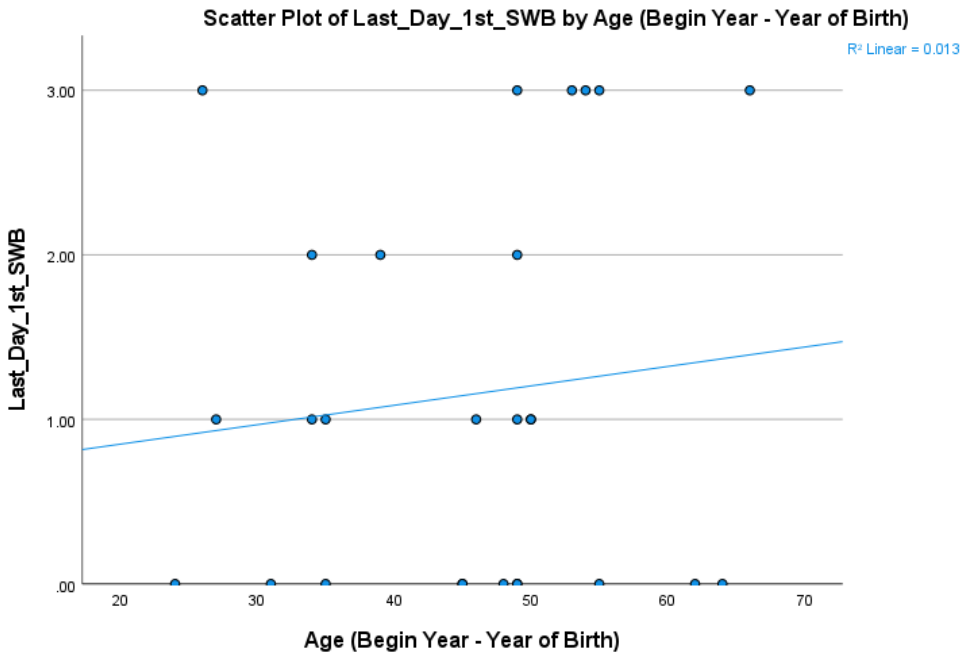
ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	.470	1	.470	.318	.578[b]
	Residual	36.938	25	1.478		
	Total	37.407	26			

a. Dependent Variable: Last_Day_1st_SWB

b. Predictors: (Constant), Age (Begin Year - Year of Birth)

Appendix B: Last Day SWB by Age



Appendix C: SPSS Output for Regression Between Length of Treatment and Subjective Well-Being Resolution

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	1.921	1	1.921	1.359	.254[b]
	Residual	36.758	26	1.414		
	Total	38.679	27			

a. Dependent Variable: Last_Day_1st_SWB

b. Predictors: (Constant), Length of Treatment in Days

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	.842	.320		2.630	.014
	Length of Treatment in Days	.001	.001	.223	1.166	.254

a. Dependent Variable: Last_Day_1st_SWB

Model Summary[b]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Durbin-Watson
1	.223[a]	.050	.013	1.18901	2.121

a. Predictors: (Constant), Length of Treatment in Days

b. Dependent Variable: Last_Day_1st_SWB

Appendix D: Last Day SWB By Length of Treatment in Days