Athabasca University

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The Development of Outcome Measurement Resources and Tools for Community Counselling Standards for the Northwest Territories

By

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A Final Project submitted to the Campus Alberta Applied Psychology: Counselling Initiative in partial fulfillment of the requirements for the degree of

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CAMPUS ALBERTA APPLIED PSYCHOLOGY:
COUNSELLING INITIATIVE

SUPERVISOR SIGNATURE PAGE

Faculty of Graduate Studies and Research

The undersigned certifies that she or he has read and recommends to the Faculty of Graduate Studies and Research for acceptance, a final project entitled **The Development of Outcome Measurement Resources and Tools for Community Counselling Standards for the Northwest Territories** submitted by **Monique Goerzen** in partial fulfillment of the requirements for the degree of **Master of Counselling.**

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COUNSELLING INITIATIVE

SECOND READER SIGNATURE PAGE

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Abstract

A lack of evidence-based outcome measurements currently exists within the framework of Community Counselling Standards for the Northwest Territories (NWT). The implementation of outcome measurements requires knowledge of the outcome tools that are available and recognition of the value of implementing outcome measurements. Counsellors within the Northwest Territories have an ethical and professional responsibility to ensure that care provided to their clients is both effective and efficient. This project addresses this responsibility through the use of a literature review on outcome evaluation and a manual that provides counsellors with information on the benefits and use of outcome evaluation measures, a practical example of how to implement outcome evaluation measures, and a plain language manual explaining how to measure whether clients are demonstrating change.

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Chapter I

Introduction

An important tenant of counselling is that clients do or at least should experience some positive change as a result of counselling (Lambert, Ogles, & Masters, 1992). Outcome evaluation refers to the tools of measurement for assessing client change. Outcome evaluations provide answers to the basic questions counsellors ask themselves when working with a client: Where am I going with this client and how will I know when I get there? (Corcoran & Fischer, 1987).

As counsellors, it is important to be able to define the client's problems in specific terms so that treatment success can be measured. Measurement procedures can provide important feedback to clients, thereby enhancing the therapeutic relationship and increasing self-knowledge within clients (Allen, Montgomery, Tubman, Frazier, & Escovar, 2003). Outcome measurements also provide a guide to altering a course of treatment if change is not significant. In addition, counsellors are increasingly required to be accountable for monitoring and evaluating their practice and have an ethical responsibility to ensure the services provided are both effective and efficient (Clement, 1999; Sinclair & Pettifor, 2001).

The implementation of outcome evaluations requires a strong belief in the value of the information. In other words, the data needs to be relevant to a particular setting and the benefits of outcome evaluations needs to outweigh the time and cost involved in the process. Benefits of outcome evaluations include greater accountability to clients, accountability as professionals, agency accountability, and the development of a positive therapeutic relationship.

Schalock (2001) emphasizes the inclusion of four key components to include in a comprehensive outcome evaluation program: performance assessment outcomes, functional assessment outcomes, personal appraisal outcomes, and consumer appraisal outcomes. Performance assessment looks at the cost-effectiveness and efficiency of a program and can include such information as waiting times for service and the relationship between cost and treatment outcomes (Cormier & Nurius, 2003). Functional assessment outcomes measure the change in a client's level of functioning or ability to perform day-to-day tasks. Personal appraisal measures include the client's ratings of his or her quality of life. Finally, consumer appraisal outcomes measure client satisfaction with the services provided.

Individual counsellors and counselling agencies must determine the method of assessment. Methods of assessment include interviews, self-report, ratings by others, self-monitoring, and direct observation. Each of these methods has advantages and disadvantages and must be carefully considered prior to implementation. The usefulness of any particular tool depends on the relevance of the data to any particular setting.

Project Description

This project provides an overview of outcome evaluation and provides a resource manual that will be included as a companion resource to the Community Counselling Program Standards for the Northwest Territories (NWT) (Chalmers et al., 2004). The Community Counselling Standards is a document that sets out program standards for community counselling programs throughout the Northwest Territories, as part of mental health and addiction services. Standard Twenty-Two

recognizes the need for evaluation as an important demonstration of accountability of the effectiveness of services provided (Chalmers et al., 2004). This manual will aid counsellors in the implementation of outcome evaluation that will include outcome measurements pertaining to client satisfaction, symptomatology and functioning, and quality of life.

This project begins with a literature review on outcome evaluations to provide the theoretical basis for the development of an outcome evaluation resource manual. The review begins with an introduction and definition of outcome evaluation. Next, the review highlights the benefits of outcome evaluations. The use of outcome evaluation measures requires a commitment and belief in the utility in the chosen measurement tools. Therefore, this section explains the benefits of outcome evaluations in enhancing the quality of counselling services provided to clients.

The next section of the literature review provides an overview of the process of setting up outcome evaluations. Agencies must determine the purpose of the outcome evaluation and should consider the following components: clinical change, client satisfaction, and cost (Cone, 2001). In addition, outcome measurements must include an understanding of the different variables that can influence the outcome.

The literature review then addresses several types of outcome evaluations. Client satisfaction questionnaires are a very quick and efficient means of gaining an understanding of whether clients' expectations of service are being met. Several different outcome measurements also address changes in a client's symptomatology or level of functioning. These changes can be measured through formal assessment or through the use of a simple rating scale. Within outcome measurements,

subjective improvement is also viewed as an essential component of measuring change. A quality of life measurement addresses a client's subjective expression of his or her life, while a working alliance measurement addresses the client's perspective of the counselling relationship. Each of these types of outcome evaluation measurements has an important role in gaining an overall understanding of both objective and subjective change in a client.

One of the key factors to consider when choosing the type of outcome evaluation method is careful consideration of the method of assessment. Methods of assessment can include interviews, self-reports, ratings by others, self-monitoring, and direct observation. The advantages and disadvantages of the various methods are examined. In addition, choosing a specific measurement tool requires an understanding of clinical significance. The collection of data must be purposeful and meaningful and should record changes within a client that have a significant impact on the client's life.

The final section of the literature review looks at specific tools for evaluating outcomes in the areas of client satisfaction, symptomatology and functioning, and quality of life. It is important for counsellors to become familiar with several tools that are available. The use of existing tools allows counsellors to have confidence in the use of these tools where the reliability and validity has already been measured.

The second part of this project includes the resource manual. This manual has three separate components. It begins with a brief overview of outcome evaluations and then highlights the process for meeting the evaluation objectives set out in the Community Counselling Standards for counsellors within the Northwest

Territories. This section reviews the benefits of outcome evaluations and explores the difference between practice-based evidence versus evidence-based practice.

Next, the manual provides an overview of the four factors involved in client change. An important aspect of change involves the ability to articulate clearly defined and measurable goals. Two examples of the process of establishing goals are provided. The final section includes guidelines on how to implement an outcome evaluation program.

The second component of the manual includes recommendations for Family Counselling. This section serves as a model and example for other agencies within the Northwest Territories. Several tools and resources provide practical evaluation measures that can be implemented by counsellors throughout the Northwest Territories. Clients who seek services with Family Counselling also come from a variety of educational backgrounds. The instruments that were chosen as recommendations take into account the fact that many of the clients served may or may not be literate. Therefore, the instruments need to be flexible and adaptable so that the format can be written, oral, or visual.

The third component of the manual includes a very brief manual on outcome evaluations that is written in plain language for the benefit of mental health counsellors within the Northwest Territories. The reality is that mental health counsellors within the Northwest Territories come from a variety of backgrounds and work in a variety of settings. The educational background of mental health counsellors within the Northwest Territories is greatly varied. Therefore, a simplified manual will ensure that the information is available to all counsellors. Upon

discussion with several managers of counselling agencies throughout the Northwest Territories, it became clear that the implementation of outcome evaluations begins with helping counsellors learn the language of outcome evaluations. The terms need to be clearly defined in a way that demonstrates meaning and purpose.

Summary

Counsellors within the Northwest Territories need to acquire knowledge and resources on outcome evaluation in order to meet the objectives that are set within the Community Counselling Standards. To meet these objectives, counsellors require knowledge of outcome evaluation and the tools and resources. The goal of the manual is to provide a quick and easy overview of the literature on outcome evaluation and some examples and tools that counsellors can adapt and implement within their own agency.

Chapter II

Literature Review

Outcome Evaluation Defined

Outcome evaluations are simply a method of assessment for evaluating outcome goals. Ideally, goals are stated in the positive and specify what or how the client will behave, think, or feel differently as a result of treatment. The goals can then be measured through outcome evaluations (Cormier & Nurius, 2003). The goal behaviours are evaluated to determine the level of change that has occurred within a client. The four common dimensions of change are frequency, duration, magnitude (intensity), and occurrence (Cormier & Nurius, 2003). Outcome evaluations can measure the change in how often behaviour is occurring, or the length of time for a response to occur, the degree of intensity of behaviour or symptom, and the presence or absence of particular behaviours (Cormier & Nurius, 2003).

Benefits of Outcome Evaluation

Counsellors have an obligation to ensure that the care they provide their clients is both effective and efficient. However, counsellors often cite the following factors as impacting their decisions regarding the use of formal outcome evaluations: lack of funding, time constraints, lack of reinforcement for research activities, insufficient modeling by supervisors, lack of appropriate instruments, and lack of skill in research design and data analysis (Asay, Lambert, Gregersen, & Goates, 2002).

A client-centred approach to evaluating outcomes focuses on evaluating whether a particular treatment is working for a particular client. The purpose of

outcome evaluations is twofold: counsellors have a means to evaluate progress and alter treatment if change is not significant and they provide counsellor and agency credibility (Asay et al., 2002). Despite the challenges, outcome evaluations are an essential component of counselling. Many of the obstacles can be overcome through the development of outcome tools that are easy and quick to administer. The benefits of outcome evaluations are too great to be ignored.

Accountability to clients. Counselling provides an opportunity to work with an individual for the purpose of improving the client's current level of functioning and satisfaction in life. The counsellor seeks to understand the multiple influences on a client's life, determine appropriate goals, and establish an intervention plan based on this information. Therefore, counselling is interested in the client as an individual with unique personal characteristics and resources. Outcome evaluation can be focused on recognizing unique changes within the individual client.

In order to provide the best care possible to clients, it is essential for counsellors to assess client change and processes through formalized assessment tools that can account for the distortion of information that commonly occurs among clients (Clement, 1999). Counsellors can use continuous assessment measures to determine the effectiveness of a treatment, which will determine the next course of action. If an outcome measurement demonstrates that little or no change is occurring in the client, the counsellor can alter the course of treatment. Frequent measures of change allow counsellors to redirect the course of therapy when the current process is not productive. In addition, when counsellors are vigilant about

providing effective treatment, clients do not waste time and money on ineffective treatment (Barlow, Hayes, & Nelson, 1984).

In addition, a review of outcome measurements can be used to better understand the efficacy of a particular course of treatment. As counsellors, we choose the treatment plan that best suits the needs of our clients. However, we need to ensure that the treatment is delivered in all of its integrity. For example, if a counsellor treats a client with cognitive therapy and the client has been instructed to self-monitor a variety of items, the efficacy of the treatment depends on the delivery of the treatment and on the execution of the plan (Barlow, Hayes, & Nelson, 1994).

Accountability as professionals. Counsellors have both professional and ethical responsibility to ensure that clients are receiving effective treatment. Outcome measurements provide important data on the effectiveness of counselling services. In addition, collecting data from clients enables counsellors to recognize their own strengths and weaknesses. Outcome measurements provide information on a counsellor's personal effectiveness. In particular, the data can be used to inform counsellors as to which diagnostic categories demonstrate high levels of effectiveness, comparisons of effectiveness among different age groups or among a particular gender, and any changes in effectiveness with clients over time. For example, data might reveal a much higher level of effectiveness among certain clients such as adolescents or with particular disorders such as depression or anxiety. Personal effectiveness as a counsellor has been demonstrated to have a high impact on variability in treatment outcomes (Clement, 1999).

Counsellors have an ethical responsibility to ensure that they are selecting interventions that meet the needs of the client and that have “reasonable theoretical or empirically-supported efficacy in light of those needs and characteristics” (Sinclair & Pettifor, 2001, p. 65). Only through relying on empirical evidence can we come close to the ideal of providing the best treatment to clients in the most efficient manner. As counsellors, we make judgments on what clients we will accept, the type and length of treatment, whether the treatment is working, and when to alter the course of treatment to improve effectiveness (Cone, 2001). Ethical practice requires counsellors to base their judgements on reliable research and literature.

Agency accountability. As a service provider, we have to be able to demonstrate effectiveness. Financial responsibility to both the organization and the consumer requires monitoring the effectiveness of treatment. Formal outcome measurements provide evidence of the effectiveness of treatment. Maintaining information on the services provided and the effectiveness of treatment allows service providers to seek financial assistance and to have the information necessary if one is providing services on a contractual basis (Cone, 2001). Counsellors need to strive for the ideal of providing the most effective services with the greatest efficiency.

Therapeutic relationship. Assessment feedback provides both a diagnostic and a therapeutic purpose. Providing clients with feedback regarding their diagnostic assessments provides an opportunity to develop a rapport between the client and the counsellor. In a study by Allen and colleagues (2003), clients reported feeling a stronger rapport with counsellors who reviewed initial assessments with

their clients. In addition, this process promotes the development of trust and openness between the counsellor and client and removes some of the power differentials through the sharing of information.

Second, assessment can be used as a means of enhancing the client's self-awareness. As stated by Allen and colleagues (2003), "assessment feedback has been described as an intervention that enhances self-related processes such as self-understanding, self-verification, positive self-regard, and self-awareness" (p.167). Assessment feedback allows clients to gain an increased awareness of self, which facilitates in the collaborative process of developing treatment goals and interventions. When providing feedback to clients, counsellors should note that clients rate specific feedback regarding an assessment as particularly valuable and that clients who receive feedback following an assessment develop a greater rapport with the counsellor (Allen et al., 2003).

The Process of Outcome Evaluations

The process of outcome evaluation begins with a research question and hypothesis (Bieber, Wroblewski, & Barber, 1999). First, the counsellor or agency must determine what they would like to evaluate. The research question needs to be stated in a clear and concise measure. For example, Family Counselling Agency has determined that they would like to answer the following two questions: Are clients satisfied with the service that they receive? Are the clients that we serve experiencing a reduction in symptoms and an increase in their ability to function?

An optimal outcome for a client considers three components: clinical change, satisfaction with the service received and the outcome produced, and the cost

(Cone, 2001). In addition, outcome measurements need to consider the variables that mediate the effects of the treatment (Cone, 2001). For example, the length of time a client has to wait to receive services will influence the evaluation of satisfaction. The factor of wait time influences the validity of a client's rating of satisfaction with the treatment. When outcome measurements take into account the process variables that influence the outcome, the data reveal information about why change has or has not occurred. In the example of wait time, the data might reveal a positive correlation between the wait time and the dissatisfaction with service.

Outcome measurements can be divided into intrapersonal change (behaviour, affect, and cognition), interpersonal change, and social role dimensions (Lambert et al., 1992). In other words, change is measured within the client, within the client's relationships, and by the individual's contribution to society (Lambert et al., 1992). It is important to choose outcome measurement tools that will identify change in each of these areas in order to adequately understand the specific changes that have occurred within a particular client.

Types of Outcome Evaluations

Client satisfaction. Client satisfaction can be viewed as the gap between client expectations and the actual experience of the client (Stallard, 1996). Therefore, satisfaction is the degree to which the desires and expectations of the client are met. Client satisfaction is an important tool, as it provides information on the counsellor's ability to meet the expectations of the client and the strength of the working alliance (Avis, Bond, & Arthur, 1995; Cormier & Nurius, 2003). In addition,

client satisfaction can be used to predict attendance, treatment compliance, and premature termination (Sabourin et al., 1989).

Client satisfaction surveys have gained popularity as a result of increasing interest in consumer satisfaction, which is a result of increasing pressure to monitor the effectiveness of service (Stallard, 2001). Satisfaction surveys are easy to use, and they place an emphasis on the consumer. In addition, the client serves as a means of reforming current service. In particular, areas of dissatisfaction are important measures of areas that might need to be changed to reflect an acceptable level of consumer satisfaction (Stallard, 2001).

Client satisfaction surveys are a relatively quick and easy means of obtaining data that can be used to measure client satisfaction with the services provided, the quality of the counsellor-client relationship, and the resulting outcome of personal goals (Thiele, 2005). Client satisfaction is often measured through a mail-out survey consisting of several questions designed by a particular agency.

Client satisfaction has also been demonstrated to be correlated with changes in self-reported symptoms. According to a study by Attkisson and Zwick (1982), the Client Satisfaction Questionnaire-8 (CSQ-8) was correlated with client and therapist global ratings of improvement, as assessed by the Client Self-Rating Scale and the Therapist Global Rating Scale. Client satisfaction scales therefore provide some information on how the clients might perceive change of their own symptoms. Client satisfaction questionnaires provide a necessary, but not sufficient means of evaluating client care.

Within the Northwest Territories, a large proportion of the population is of Aboriginal descent. Several studies suggest that racial and ethnic minority clients' ratings of their counsellors' multicultural counselling competence explained significant variance in satisfaction ratings beyond the clients' ratings of their counsellors' expertise, attractiveness, trustworthiness, and empathy (Constantine, 2002). The cultural diversity of clients within the Northwest Territories requires competent multicultural counselling. Therefore, satisfaction surveys might benefit from including a question that asks clients to rate their satisfaction with the counsellors' multicultural competencies.

Despite the many reasons for including client satisfaction questionnaires, there are several problems with agency-developed surveys. The data collected from these surveys are of questionable value due to the fact that the data has not been normed and standardized (Steenbarger & Smith, 1996). In addition, mail-out surveys provide a return rate of between 50 and 60 percent, resulting in potential bias in the respondents (Stallard, 1996). Finally, client satisfaction surveys cannot stand alone as a means of outcome evaluations.

There are several additional concerns with client satisfaction surveys. First, the high levels of satisfaction and the lack of variation in responses suggests that client satisfaction questionnaires have not been adequately researched and validated. According to several studies, "high levels of satisfaction are due to methodological weaknesses in the satisfaction survey social desirability bias, reluctance to express a negative word, the wording of questions, response set bias

and non-specific questions" (Carr-Hall et al., 1989, French, 1981, Locker & Dunt, 1978, Raphael, 1967, as cited in Avis, Bond, & Arthur, 1995, p. 318).

Dansky and Colbert (1996) outline four common problems that can occur in the development of a client satisfaction questionnaire. First, acquiescent response set refers to the tendency to agree with the statements of opinion regardless of the content. Opposition response set is the tendency to disagree with statements, regardless of content. Social desirable response set is the tendency to respond in a way that will please the therapist. Finally, patient characteristics can influence a client's ratings of satisfaction. Clients with a higher level of health status tend to be more satisfied with the health care they receive (Dansky & Colbert, 1996). Many of these concerns can be overcome through the use of valid and reliable client satisfaction questionnaires.

Two of the more popular client satisfaction surveys are the Client Satisfaction Questionnaire-8 (CSQ-8), which measures the general approval of services, and the Service Satisfaction Scale-30 (SSS-30) which assesses the helper's manner and skill, perceived outcome, office procedures, and access (Steenbarger & Smith, 1996).

Symptomatology and functioning. Counselling outcomes measure changes in client symptomatology or the level of client functioning, which refers to the degree in which clients' symptoms interfere with their ability to function with day-to-day tasks and responsibilities (Steenbarger & Smith, 1996). The most commonly used measure of client functioning is the Global Assessment of Functioning Scale (GAF), which rates clients on a 100-point scale (Steenbarger & Smith, 1996).

Symptomatology scales assess the frequency or intensity of specific complaints. The most common measures of symptoms are the Brief Psychiatric Rating Scale, an 18-item checklist, the Brief Symptom Inventory, which is a 53-item short version of the Symptom Checklist-90, and the Outcome Questionnaire-45.(Degogatis & Lazarus, 1994 as cited in Steenbarger & Smith, 1996).

In addition to standardized outcome questionnaires, scaling questions can be used to provide a very quick rating of the client's rating of her or his ability to function. In this approach, the counsellor asks the client to rate her or status on a scale from 0 to 10. Fischer (2004) suggests the use of a standardized description of the Functioning scale. For example, counsellors in one particular family counselling agency describe the Functioning scale to clients as follows:

> How well are you doing the things you need to do in your day-to-day life? Given the issue the client had come in for, how do they feel they are doing in respect to accomplishing the things they need to (e.g., managing the work and family) and want to in his or her routine activities? To punctuate the endpoints of the scale, counselors were asked to say 'where zero is worst – you cannot function at all – and 10 is best – you are doing all the things you need and want to do in your daily life. (Fischer, 2004, p. 105)

These types of questions can then be graphed very easily to provide a quick visual reference to self-reported improvement in functioning.

Quality of life. A quality of life measurement tool moves beyond objective functioning and symptom ratings to a subjective rating of the extent that a client has achieved the best possible life for him or herself (Cone, 2001). An individual with a

high quality of life is an individual who enjoys living, is happy, and feels that life is worthwhile (Cone, 2001). Three common tools for measuring an individual's quality of life are the Quality of Life Inventory, the Satisfaction with Life Scale (SWLS), and the Quality of Life Index (QLI). The quality of life measurement scores measure four subscales consisting of health, social/economic, psychological/spiritual, and family.

Working alliance. A working alliance refers to a collaborative approach between the counsellor and therapist in the development of shared goals and shared treatment plan (Horvath & Symonds, 1991). According to Duncan and colleagues (2003), over a thousand research findings demonstrate that a positive working alliance is one of the best predictors of outcome. When conducting outcome evaluations, it is important to consider that clients attribute positive treatment outcomes to a counsellor's empathy, positive regard, understanding, and acceptance (Ribner & Knei-Paz, 2002). In addition, the following qualities enhanced the relationship: feelings of closeness, enabling an atmosphere that created equality in the relationship and a sense of working together, and accessibility (Ribner & Knei-Paz, 2002). Horvath and Symonds (1991) provide a meta-analysis of the relationship between the working alliance and treatment outcome. Overall, the quality of the working alliance was predictive of treatment outcomes based on clients' assessments (Horvath & Symonds, 1991). Therefore, a valid measurement of outcome will assess the quality of the working alliance. For example, The Working Alliance Inventory is a 12-question measurement that examines the three main components of the working alliance: the relationship and agreement on goals and treatment plan (Horvath & Symonds, 1991).

Methods of Assessment.

Interviews. Interviews are the most common method of assessment. Structured interviews consist of a series of specific questions and are often standardized. Unstructured interviews are more likely to consist of discussions that may be client driven. Most agencies begin with an interview when the client calls for an initial appointment. Initial interviews have the potential to establish a relationship between the potential client and the counsellor as both parties determine the suitability of services. In addition, interviews are also commonly used as a method of following up on clients who have completed treatment.

Interviews have the advantage of allowing for a wide breadth of information. For example, the Structured Clinical Interview for the DMS-III-R has good psychological characteristics and provides information on how to respond to ambiguous responses (Cone, 2001). In particular, the development of computerized interviews such as CASPER provide a range of data such as client functioning, presenting symptoms and severity, and the importance of each of these issues to a client (Cone, 2001).

Self-reports. A self-report measurement usually consists of a set of descriptive statements to which the client responds with either a binary option such as true-false or a Likert scale in which the client chooses the descriptor that best suits (such as always/sometimes/never) (Cone, 2001). Some of the advantages of self-report measures are time and cost efficiency; they are often easy and quick to administer. In addition, the questions are standardized and thus easy to score. One of the disadvantages is the potential for self-presentation bias (Cone, 2001).

Objectivity is more likely to be questioned during self-reports, as individuals are more likely to express themselves in ways that are viewed as positive. Many reported outcome measurements assess perceived improvement. Perceived improvement refers to the change in symptoms and functioning in areas that are most important to the client (Lambert, Salzer, & Bickman, 1998).

Ratings by others. Assessments that are rated by others appear to have the advantage of greater objectivity; however, the ratings are still subject to the perceptions of an individual. These measurements might be completed by a parent, teacher, spouse, or a friend. Common examples include the Conners Parent and Teacher Rating Scales or the Child Behavior Checklist (Cone, 2001). One of the advantages of some of these types of assessments is that the bias can be minimized through the use of multiple raters, such as the parent and teacher.

Self-monitoring. Self-monitoring involves the process of asking a client to record or observe his or her own behaviour. Self-monitoring has been used extensively in monitoring a variety of behaviours, such as smoking, drinking, exercise, feelings of anxiety, and negative thoughts (Cone, 2001). Self-monitoring provides information about a specific behaviour and also serves a purpose in itself. Clients learn to recognize their own patterns of behaviour as part of their overall treatment. One of the problems with self-monitoring is the accuracy of the observations and recording of data. Is the client aware or observant enough to recognize the behaviours consistently? Does the client record every observance of behaviour? Verification of the data can prove beneficial in the process of self-

monitoring. For example, there are circumstances in which a friend or spouse of a client may also record the data and the two records can be compared for accuracy.

Direct observation. Direct observations are assessments that collect data from directly viewing behaviours. A counsellor completing a direct observation assessment must consider the frequency, duration, latency, magnitude, or a combination of these characteristics to observe (Cone, 2001). Many counsellors make frequent narrative recordings in which the data is composed of narrative descriptions. The occurrence of a particular behaviour can also be recorded as an event record or an interval recording might specify how observations will be recorded within a given time period (Cone, 2001). An important factor to consider with direct observations is a principle called reactivity; people are likely to alter their behaviour if they are aware of the observation (Cone, 2001).

Clinical Significance

In order for outcome evaluations to be effective, they need to measure areas of change that are significant to the client. Clinical significance is the effect of a treatment on an individual. Clinical significance demonstrates a meaningful change has occurred in a client that moves them from dysfunctional to functional status (Cone, 2001). The change in the individual needs to be significant, meaning that the client's life has improved in a meaningful way. A study by Ankuta and Abeles (2003) demonstrates the relationship between clinical significance and client satisfaction. In this study, subjects who reported clinically significant change on the Symptoms Checklist-90-Revised (SCL-90-R) also reported greater satisfaction and benefit from

psychotherapy than the group of clients who changed to a moderate degree or not at all.

Specific Tools for Evaluating Outcomes

When choosing specific tools, counsellors and agencies need to consider the psychometric properties of the tools, the feasibility of a particular measure, and the particular clientele that is served by an agency. In simple terms, assessment tools should demonstrate sufficient validity, reliability, and feasibility. Validity refers to the ability of an instrument to measure what it was designed to measure (Corcoran & Fischer, 1987). The following validation methods can be used to determine the ability of an assessment tool to measure what it was intended to measure: content validity, criterion-related validity, construct validity, and face validity. In other words, does the test actually measure the symptoms that it is designed to measure or does the test really portray changes in an individual's ability to function? Validity takes into account the internal factors that might influence the outcomes besides the treatment or the factors that occurred during the studies of a measure or test that make it difficult to apply the findings outside of this study setting (external validity) (Mertens, 1998).

Reliability refers to the level of confidence that you can have with an individual's score (Corcoran & Fischer, 1987). Reliability can be established through the use of the following techniques: test-retest reliability, parallel forms reliability, split-half reliability, and internal consistency. A tool is reliable if similar results are obtained if the test is taken twice at different times, if other tests measuring the same factor yield similar results, and if two individuals gathering the data get the same

results. Despite the validity and reliability of a test, the data obtained from such measurements should be taken as knowledge that builds on the counsellor's clinical judgement obtained through the therapeutic relationship.

Due to the limits in the length of this paper, the list of specific tools is not meant to be an exhaustive list of all available measurement tools. Rather, the list provides an example or two of the tools available for the different types of outcome evaluation.

Client Satisfaction Questionnaire-8 (CSQ-8). The purpose of the client satisfaction questionnaire, designed by Clifford Attkisson, is to provide a simple and efficient tool to assess client satisfaction with treatment (Corcoran & Fischer, 1987). The CSQ-8 is an eight-item questionnaire that uses a four-point Likert scale that asks clients to rate the service of mental health providers from poor to excellent. The norms for the CSQ-8 have been established through extensive studies with a high number of participants from various demographics, ethnicities, and sexes (Corcoran & Fischer, 1987). Therefore, the CSQ-8 can be used with confidence in a setting with a wide variety of clients. The scores are added together for a total within the range of 8 to 32, with higher scores demonstrating higher levels of satisfaction. The CSQ-8 has excellent internal consistency with alpha scores that range between .86 to .94 (Corcoran & Fischer, 1987). In addition, validity is demonstrated through a high correlation with clients' ratings of global improvement and symptomatology and therapist's ratings of clients' progress (Corcoran & Fischer, 1987).

Global Assessment of Functioning Scale (GAF). The GAF scale was introduced in the DSM-III-R in 1987 as the new rating scale for Axis V disorders (Piersma & Boes, 1997). This scale is very commonly used within many counselling agencies as an efficient means of providing a rating of a client's functioning. The score represents the counsellor's opinion of the client's overall functioning in both psychological and social/occupational areas. The GAF is a quick and efficient numerical indicator of a client's level of functioning. However, relatively few studies have examined the GAF's psychometric qualities (Piersma & Boes, 1997).

Outcome Questionnaire-45 (OQ-45). The OQ-45 contains 45 items rated on a five-point Likert scale that ranges from 'never' to 'always' (Lambert, Okiishi, & Finch, 1998). The questions are to be answered by individual clients for the purpose of tracking change over time (Clement, 1999). The OQ-45 measures functioning in the following three domains: symptoms, interpersonal functioning, and social role. Validity studies demonstrate a high correlation with other measures of symptomatic distress, such as the Symptom-Checklist-90-R (Lambert, Okiishi, & Finch, 1998). The OQ-45 has several advantages. It is reliable and valid for a wide range of symptoms, a brief instrument sensitive to changes over short periods of time, inexpensive to administer, and quick to score. In addition, the OQ-45 produces a total score that can be used to quickly assess change.

The Brief Symptom Inventory (BSI). The BSI is a shorter version of the SCL-90-R and it consists of a 53-item self-report inventory (Kelleltt, Beail, Newman, & Frankish, 2003). Each item is scored on a five-point Likert scale ranging from 'not at all' to 'extremely'. The BSI produces nine primary symptom dimensions and three

global indices of psychopathology. The Global Severity Index combines data on both the number and intensity of symptoms and represents a single numerical summary on psychopathology. This makes it a convenient tool to evaluate change in symptomatology. In addition, the Positive Symptom Distress Index measures the symptom intensity corrected for the number of symptoms.

Youth Outcome Questionnaire (YOQ). The YOQ is appropriate for use with clients between the ages of 4 and 17. It includes 64 items rated using a five-point Likert scale ranging from 'never' to 'almost always' and is completed by parents of children and adolescents. The six subscales include intrapersonal distress, somatic, interpersonal relations, critical items, social problems, and behavioral dysfunction (Clement, 1999). One of the advantages of the YOQ is the cost and ease in administration. One licensing fee covers the cost of administering the test.

Child Behavior Checklist (CBCL). The CBCL and the Youth Self-Report (YSR) and the Teacher's Report Form (TRF) were developed by T. Achenbach to create a standardized procedure for assessing children and youth problems and functioning in school, home, and community settings (Crijen & Achenbach, 1999). It provides information regarding a client's mental status, psychiatric disorders, and antisocial behaviour. It is used for clients between the ages of 4 and 18 and is completed by a parent, primary caregiver, or teacher.

Satisfaction with Life Scale (SWLS). The SWLS is a measure of life satisfaction that takes into account the subjective experience of clients. The SWLS is a global measure of life satisfaction that consists of five items that are completed by the individual whose life satisfaction is being measured (Diener, Emmons, Larsen, &

Griffin, 1985). The SWLS has the advantage of being a very brief assessment tool that can be used with a wide range of clients. The instrument has very good reliability and validity.

Barriers to Outcome Evaluation

Although many agencies are requiring outcome evaluation, many counsellors express little interest or desire to participate in the process of ongoing outcome evaluation (Asay et al., 2002). A large study conducted by the American Psychological Association demonstrates that approximately 30% of counsellors conduct outcome evaluations (Clement, 1999). The majority of practicing psychologists do not yet demonstrate the belief that the value and benefits of outcome evaluations outweigh the cost. Studies demonstrate that many counsellors believe that they would recognize change or stagnation within their clients, they do not view the process as a valuable use of time, they question the use of standardized assessment measures for unique clients, and they do not have an agreement or understanding of which tools they could utilize (Cone, 2001; Cormier & Nurius, 2003).

Summary

Outcome evaluations are simply a means of measuring the change that has occurred within clients. Counsellors have both an ethical and professional responsibility to provide effective and efficient treatment. Counsellors can use outcome evaluation measures to evaluate the progress of a client for the purpose of altering the course of treatment. In addition, the data can provide counsellor and agency credibility (Asay et al., 2002).

Providing outcome evaluations has many benefits to both counsellors and clients. Outcome evaluations ensure that counsellors are receiving a clear picture of the change that is occurring within clients and provides information regarding effective or ineffective treatment for any given individual. Outcome evaluations also provide counsellors with the ability to reflect on their own skills in enabling client change. The process of reviewing client change within the environment of the therapeutic relationship provides a basis for increasing client self-knowledge and awareness (Allen et al., 2003).

The process of implementing an outcome evaluation program involves the consideration of several factors such as client change, client satisfaction, and efficiency or cost (Cone, 2001). Within these three factors, counsellors or agencies need to recognize that change can be measured in satisfaction, symptomatology and functioning, quality of life, or the working alliance. Finally, agencies or counsellors need to weigh the benefits and costs of the different types of methods of assessments.

Conclusion

To address the barriers to implementing outcome evaluations, counsellors require an understanding of outcome evaluations and the benefits that these measures will provide to themselves and their clients. Secondly, counsellors need to have the tools for measurement readily available. The sheer volume of outcome measurements can overwhelm beginning mental health counsellors. Therefore, a manual that provides an example of a simple outcome evaluation program can provide a framework for counsellors to begin the process of implementation.

Chapter III

Procedures

This final project included two main components: a literature review on outcome evaluation and a resource manual. A copy of this manual is provided in the appendix. The literature review served two functions: it enables readers to gain knowledge about the topic of outcome evaluations and it provides the theoretical framework for the manual itself (Mertens, 1998). The resource manual provides key information regarding outcome evaluation and provides tools and resources to conduct outcome evaluation

First, I discussed ideas for my project with the manager of Family Counselling. After determining the need for outcome evaluation within the Family Counselling setting, I determined the specific type of tool that would best fit the needs of Family Counselling. I then proceeded to conduct a literature review to gain background knowledge of outcome evaluation and the existing tools for measuring client change.

A preliminary search was conducted through the use of the following databases: Academic Search Premiere, Psychology and Behavioral Sciences Collection, and PsychInfo. A keyword search focused on a variety of combinations of the following terms: outcome, evaluation, measurement, efficiency, efficacy, client satisfaction, symptomatology, functioning, quality of life, and working alliance. My search from these databases yielded approximately 30 relevant articles.

Second, a primary search of articles led to a secondary search for additional articles and references. The initial articles were used to gain knowledge and

information regarding some of the current outcome evaluation tools. An additional search was then completed using Academic Search Premiere, Psychology and Behavioral Sciences Collection, and PsychInfo. The keywords now included some specific tests such as the Outcome Questionnaire-45, the Global Assessment of Functioning, Symptom Checklist-90, Client Satisfaction Questionnaire-8, Brief Psychiatric Rating Scale, Youth Client Satisfaction Questionnaire, The Working Alliance Inventory, and the Youth Outcome Questionnaire. In addition, a search on the web was conducted through the use of search engines such as Google and Yahoo.

Third, the University of Calgary library database was searched for relevant books on outcome evaluation. The reference lists from relevant articles provided a starting point and a keyword search was conducted by using the same keywords that were used in my preliminary search for primary articles. The books were then scanned and the relevant sections were read, summarized, and referenced.

Fourth, an outline was established using the guidelines developed by Campus Alberta. Using the summaries of the books and articles, an outline was developed for the literature review. Next, the literature review was written and an outline for the project was developed.

The outline for the manual was developed through a collaborative process between the writer of the project and the manager of Family Counselling. The manual would include three separate sections: an introductory section on outcome evaluations for Community Counselling Standards, an example of a recommended

outcome evaluation program for Family Counselling, and a brief and condensed version written in simple language.

The introduction section provides a brief overview on outcome evaluation. The objectives and expectations for Community Counselling Standards are provided. Counsellors should be aware that they are expected to evaluate the services offered through the collection of data that demonstrate client satisfaction and change. Second, a clear definition of outcome evaluation is provided, followed by an overview of the benefits of conducting outcome evaluations. A brief discussion of the difference between practice-based evidence and evidence-based practice emphasizes the importance and role of the therapeutic relationship in the process of both client change and client satisfaction. Within the framework of practice-based practice lies the importance of developing measurable client goals.

The recommendations for an outcome evaluation for Family Counselling serve as a model for other counsellors and agencies. At this time, my preliminary and secondary searches on the University of Calgary databases yielded approximately 25 articles pertaining to the use of specific outcome evaluation measures. In addition, a search on Yahoo provided key information on specific measurement tools. I obtained validity and reliability measures on these specific tools and obtained as many samples as I could through the use of the Internet search engines and through the University of Calgary Library collection. I then met with the manager of Family Counselling to review the feasibility of the different measurement tools. The use of specific tools was chosen through a discussion that weighed the factors of validity, reliability, and feasibility. The first two components of

the manual were then used to write a very simplified and brief version of outcome evaluation.

The final step of the project included completion of the simplified or plain language manual. This manual was developed through consultation with a manager of mental health counsellors within another region. The goal was to ensure that the reading level remained at the functional reading level of approximately grade six. In addition, feedback from a variety of counsellors ensured that the manual was easy to understand.

Chapter IV

Synthesis and Implications

The process of developing outcome evaluations can be an overwhelming task for counsellors and counselling agencies. As a result, many counsellors simply rely on their intuition and observations regarding client change. In addition, within the Northwest Territories, many mental health counsellors have little or no training and knowledge on outcome evaluations. The manual on outcome evaluations and the recommendations for Family Counselling provide a clear model for other agencies to follow.

The many mental health counsellors working within the Northwest Territories come from a variety of educational backgrounds. As a result, many of the counsellors do not have a background in research and data collection. Therefore, it is anticipated that the simplified manual on outcome evaluations will provide a clear and easy introduction to outcome evaluation. Counsellors who have limited time and energy have the resources necessary to conduct their own outcome evaluations. The samples of various outcome measurements may provide a starting point for the development of unique outcome instruments or counsellors may use the information to obtain a license to implement the recommended tools.

The different components of the manual ensure that all counsellors will be able to read and understand the foundations for providing outcome evaluations. The manual helps counsellors by providing a model that can be used within their own practice or agency. In addition, the manual clearly highlights the benefits of conducting outcome evaluations. As a result, the project can serve clients better by

monitoring changes that occur so that the treatment can be altered if necessary (Asay et al, 2002). Second, it provides agencies with the necessary data on consumer satisfaction so that agencies can make improvements where needed.

Strengths

This project meets a demonstrated need for counsellors within the Northwest Territories. Upon initial discussion, it was clear that many mental health agencies currently do not collect any data on outcome effectiveness and client change. At the minimal level, some agencies conducted simple client satisfaction surveys. This project clearly defines outcome evaluation and provides a clear foundation for the implementation of various measures of outcome.

One of the benefits of recommending the use of the Outcome Rating Scale and the Session Rating scale is that they provides ongoing assessment that has a direct benefit to clients. Counsellors can include the use of these tools as a means of developing self-awareness in clients and as part of the process of developing and maintaining a clear focus on the goals of therapy. In addition, the manual provides a sample of the instruments and information on how to obtain a license to use these instruments within their own agencies.

The use of the recommended measurements takes into account the culture and context of counselling within the Northwest Territories. The original recommendation was to use the Outcome Questionnaire-45. However, upon consultation and discussion with mental health counsellors at both Family Counselling and with mental health counsellors in Inuvik, it was clear that clients

needed a visual and brief measurement that would take less than five minutes to complete.

Weaknesses

One of the weaknesses of the manual and the recommendations is the inability to apply the tools within the framework of this project. The implementation of the manual and the tools would provide further information on the strengths and weaknesses of the material. In addition, the implementation of the tools would provide vast amounts of information regarding the actual effectiveness of the services provided.

A further weakness of the manual is the inability to track its effectiveness with counsellors and agencies from a wide variety of cultures. The Northwest Territories consists of a mix cultures consisting mainly of Dene, Métis, Inuit, and non-Aboriginals. The recommended tools of measurement do not fully take into account the validity for the cultures specific to this northern region of Canada.

The literature review and the manual place an emphasis on effectiveness. However, a thorough outcome evaluation procedure should also take into account efficiency (Schalock, 2001). The scope of this project simply did not allow for adequate coverage of both effectiveness and efficiency. Therefore, effectiveness was chosen because this tends to have the greatest impact on clients. Within the Northwest Territories, clients are able to access mental health services, regardless of their economics. For example, Family Counselling services offers counselling for clients free of charge for all clients who do not have coverage under an Employee Assistance Plan.

Summary

This project enables counsellors within the Northwest Territories to obtain a basic knowledge of outcome evaluations. The manual provides counsellors with a model that can be quickly and easily implemented within their own agency or setting. The recommended outcome measurement tools that were chosen provide a valid and reliable tool that is feasible. The length of the measurements allows for a minimal amount of completion time and the chosen instruments are cost effective, easy to administer, and quick to score.

The goal of this project was to increase the use of outcome evaluations among counsellors within the Northwest Territories. This project provides the framework and knowledge of outcome evaluations and clearly highlights the benefits for both agencies and the clients they serve. The manual provides a model for agencies to implement and the hands-on tools necessary to begin implementing outcome evaluations.

Conclusion

Although the current state of access to mental health services within the Northwest Territories is very good, there will come a time when agencies are required to demonstrate effectiveness and efficiency of the services provided. In addition, clients have a right to expect that counsellors are meeting their professional and ethical responsibilities of providing an effective service. This project hopes to increase the knowledge and use of outcome evaluation to ensure that clients are receiving the services that will best meet their needs. Ultimately, the purpose of this

project is to increase the effectiveness of mental health services so that clients are meeting their goals of positive change.

References

Allen, A., Montgomery, M., Tubman, J., Frazier, L., & Escovar, L. (2003). The effects of assessment feedback on rapport-building and self-enhancement processes. *Journal of Mental Health Counseling, 25*(3), 165-181.

Ankuta, G., & Abeles, N. (1993). Client satisfaction, clinical significance, and meaningful change in psychotherapy. *Professional Psychology: Research and Practice, 24*(1), 70-74.

Asay, T., Lambert, M., Gregersen, A., & Goates, M. (2002). Using patient-focused research in evaluating treatment outcome in private practice. *Journal of Clinical Psychology, 58*(10), 1213-1225.

Attkisson, C. C., & Zwick, R. (1982). The client satisfaction questionnaire: Psychometric properties and correlations with service utilization and psychotherapy outcome. *Evaluation and Program Planning*, 5, 233-237.

Avis, M., Bond, M, & Arthur, A. (1995). Satisfying solutions? A review of some unresolved issues in the measurement of patient satisfaction. *Journal of Advanced Nursing, 22*, 316-322.

Barlow, D. H., Hayes, S. C., & Nelson, R. O. (1984). *The scientist practitioner: Research and accountability in clinical and educational settings.* Elmsford, NY: Pergamon Press.

Bieber, J., Wroblewski, J., & Barber, C. (1999). Design and implementation of an outcome management system within inpatient and outpatient behavioral health settings. In M. Maruish (Ed.)., *The use of psychological testing for treatment planning and outcome assessment.* (2nd ed., pp. 171-210).Mayway, NJ: Lawrence Erlbaum.

Chalmers, J., Cayen, L., Dutton-Gowryluk, R., Swan, R., Little, S., & Willy, K. (2004).*Community counselling program standards.* Yellowknife, NWT: Northwest Territories Health and Social Services.

Clement, P. W. (1999). *Outcomes and incomes: How to evaluate, improve, and market your psychotherapy practice by measuring outcomes.* New York: Guilford Press.

Cone, J. D. (2001). *Evaluating outcomes: empirical tools for effective practice.* Washington, DC: American Psychological Association.

Constantine, M. G. (2002). Predictors of satisfaction with counseling: Racial and ethnic minority clients' attitudes toward counseling and rating of their counselors' general and multicultural counseling competence. *Journal of Counseling Psychology, 49*(2), 255-263.

Corcoran, K., & Fischer, J. (1987). *Measures for clinical practice: A sourcebook.*New York: Free Press.

Cormier, S., & Nurius, P. (2003*). Interviewing and change strategies for helpers* (5th ed.). Pacific Grove, CA: Brooks/Cole.

Crijen, A., & Achenbach, T. M. (1999). Problems reported by parents of children in multiple cultures: The child behaviour checklist. *American Journal of Psychiatry, 156*(4), 569-574.

Dansky, K. H., & Colbert, C. J. (1996). Developing and using a patient satisfaction survey: A case study. *Journal of American College Health*, *45*(2). 83-88.

Diener, E., Emmons, R. A., Larsen, R. J, & Griffin, S. (1985). The satisfaction with life scale. *Journal of Personality Assessment, 49*(1), 71-75.

Duncan, B. L., Miller, S. D., Sparks, J. A., Claud, D. A., Reynolds, L. R., Brown, J., & Johnson, L. D. (2003). The session rating scale: Preliminary psychometric properties of a 'working alliance measure'. *Journal of Brief Therapy, 3*(1), 3-12.

Fischer, R. L. (2004). Assessing client change in individual and family counseling. *Research on Social Work Practice, 14*(2), 102-111.

Horvath, A. O., & Symonds, D. B. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 38*(2), 139-149.

Kelleltt, S., Beail, N., Newman, D., & Frankish, P. (2003). Utility of the brief symptom inventory in the assessment of psychological distress. *Journal of Applied Research in Intellectual Disabilities, 16*, 127-134.

Lambert, M. J., Ogles, B., & Masters, K. (1992). Choosing outcome assessment devices: An organizational and conceptual scheme. *Journal of Counseling and Development, 70*, 527-532.

Lambert, M. J., Okiishi, J. C., & Finch, A. E. (1998). Outcome assessment: From conceptualization to implementation. *Professional Psychology: Research and Practice, 29*(1), 63-70.

Lambert, M. J., Salzer, M., & Bickman, L. (1998). Clinical outcome, consumer satisfaction, and ad hoc ratings of improvement in children's mental health. *Journal of Consulting and Clinical Psychology, 66*(2), 270-279.

Mertens, D. M. (1998). *Research methods in education and psychology: Integrating diversity with quantitative & qualitative approaches.* New Delhi, India: Sage.

Piersma, H. L., & Boes, J. L. (1997). Brief reports: The GAF and psychiatric outcome: A descriptive report. *Community Mental Health Journal, 33*(1), 35-41.

Ribner, D. S., & Knei-Paz, C. (2002). Client's view of a successful helping relationship. *Social Work, 47*(4), 379-387.

Sabourin, S., Laferriere, N., Sicuro, F., Coallier, J., Cournoyer, L., & Gendreau, P. (1989). Social desirability, psychological distress, and consumer satisfaction with mental health treatment. *Journal of Counseling Psychology, 36*(3), 352-356.

Schalock, R. (2001). *Outcome-based evaluation* (2nd ed.). New York: Kluwer Academic/Plenum.

Sinclair, C., & Pettifor, J. (2000). *Companion manual to the Canadian code of ethics for psychologists* (3rd ed.). Ottawa: Canadian Psychological Association.

Stallard, P. (1996). The role and use of consumer satisfaction surveys in mental health services. *Journal of Mental Health, 5*(4), 333-349.

Stallard, P. (2001). Reducing parental dissatisfaction with a child and adolescent psychology services: A process of quality improvement. *Journal of Mental Health, 10*(1), 63-73.

Steenbarger, B., & Smith, H. (1996). Assessing the quality of counseling services: developing accountable helping systems. *Journal of Counseling and Development, 75*, 145-150.

Thiele, A. (2005). *Outcome evaluations with child and adolescent populations: A manual for developing evidence-based practice*. Unpublished master's project, Campus Alberta, Calgary, Alberta, Canada.

Appendix

A Manual for Outcome Evaluation within the NWT

Outcome Evaluation for Community Counselling Program Standards

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Table of Contents

Tables

Executive Summary

The Northwest Territories Community Counseling Program Standards contains the expectations that counsellors will conduct outcome evaluations to measure the progress of clients. However, there are currently no recommendations or guidelines to aid counsellors in the process of conduction outcome evaluations or the available tools. Counsellors need to have the tools to demonstrate the clients have changed as a result of counselling (Lambert, Ogles, & Masters, 1992).

Most importantly, outcome measurements that are used throughout the course of treatment can be used to assess change and alter the course of treatment if change is not demonstrated (Clement, 1999). Measurement tools can be used to provide feedback to clients as a means of developing the therapeutic relationship (Allen, Montgomery, Tubman, Frazier & Escovar, 2003). In addition, outcome evaluations ensure that counsellors are meeting their professional and ethical responsibility in providing effective services to clients (Sinclair & Pettifor, 2001).

The goal of this manual is to provide the necessary background on outcome evaluations so that counsellors will both recognize the benefits of outcome evaluations and have the tools to implement outcome evaluations. In this way, counsellors can ensure that they are meeting Community Counselling Program Standards set out by the Northwest Territories (NWT).

Objective

NWT mental health and addiction services fall under the umbrella of the Department of Health and Social Services for the NWT. Under the Department, there are currently eight different health and social service authorities that operate within the NWT. The objective of this manual is threefold. First, the goal of this manual is to ensure NWT-wide accountability of counselling programs based on the principle of best practices. This is facilitated through an overview of the literature on outcome evaluations. This manual provides counsellors with knowledge of the benefits and main components of outcome evaluations.

Second, this manual provides recommendations for an outcome evaluation for Family Counselling. This example may be used by other counselling agencies within the NWT or it may serve as a model for the implementation of outcome evaluation.

Third, the manual includes a plain language summary on outcome evaluations in simple and clear language that can be used as an introduction to mental health workers throughout the Northwest Territories who might be new to the process of outcome evaluations.

Introduction

Implementation of outcome evaluation requires basic belief in the value and benefits of outcome measurements. Counsellors within the Northwest Territories have an obligation to ensure that the care provided to their clients is both effective and efficient. Counsellors have a professional responsibility to ensure that they are selecting interventions that meet the needs of the client.

In addition, counsellors need to ensure that the treatment and evaluation of the treatment follows best practice guidelines. Evaluating client outcomes serves a dual purpose. It allows counsellors to guide treatment planning to provide for the best possible treatment outcome and provides a way to evaluate the efficiency of treatment.

This manual provides some standard measurements for implementing the objectives highlighted in Standard Twenty-Two of the Community Counselling Program Standards (Chalmers et al., 2004). It provides readers with the tools necessary to measure changes in a client's symptoms, functioning, and quality of life.

Table 1
Objectives of Standard Twenty-Two: Evaluation

• To evaluate the effectiveness of programs offered by the program including outcome data, client satisfaction survey data and feedback from related services
• To ensure all services of the program are evaluated regularly
• To ensure there are consistent and clearly defined data collection procedures in place
• To make modifications for counselling services and other program components that are identified, planned and implemented jointly by communities and program team
• To ensure regular team and staff meetings are held to discuss program appropriateness, accessibility and effectiveness

Note. From Chalmers, J., Cayen, L., Dutton-Gowryluk, R., Swan, R., Little, S. Willy,K.(2004). *Community counselling program standards and resources*. Yellowknife, NWT: Northwest Territories Health and Social Services, p.56. Adapted with permission from author.

Definition of Outcome Evaluation

Outcome evaluation is simply a measurement of change that has occurred within the client, within the client's environment, or both (Cormier & Nurius, 2003). In addition, outcome evaluation includes what a counselling agency hopes to achieve for its clients and the subjective evaluation of a client's personal goals and expectations of counselling (Schalock, 2001). Therefore, an ideal outcome evaluation program should consist of both objective and subjective measures of change.

Assessments can provide a means of evaluating clients' progress towards their goals as well as changes in symptoms and functioning. Outcome evaluation can be used as a way of evaluating the effectiveness of treatment and to alter the course of treatment if change is not evident. As stated by Hodges (2004), outcome evaluation should be used as a method of continuous quality improvement.

Benefits of Outcome Evaluation

Conducting client-centred outcome evaluations has several benefits for the client. Counsellors who conduct regular outcome evaluations have a means of evaluating the progress of their clients and the ability to change the course of treatment if the current intervention plan is not producing significant change (Asay et al., 2002). In other words, outcome evaluation is used to measure the effectiveness of the current treatment plan.

Second, outcome evaluation provides accountability. Outcome evaluation can be used as a means of helping counsellors recognize their own strengths and weaknesses. As stated by Clement (1999), our effectiveness as counsellors has a tremendous impact on the outcome of a given treatment. In addition, outcome evaluation ensures that counsellors are fulfilling their ethical obligations to provide an effective service that is based on the principles of best practice (Sinclair & Pettifor, 2001).

Practice-Based Evidence Versus Evidence-Based Practice

Although much of the talk in counselling supports evidence-based practice, recent research shifts the focus to practice-based evidence (Miller, Duncan, & Hubble, 2004). Evidence-based practice supports the emphasis on clearly researched and documented therapeutic techniques that have proven reliable. Practice-based evidence demonstrates that significant improvement in client retention and outcomes develops through feedback and monitoring of the client's experience of the therapeutic alliance and progress, rather than through specific intervention techniques (Miller et al., 2004).

The therapeutic alliance provides a significant predictor of treatment outcome (Bachelor & Horvath, 1999). Feedback from clients is an essential element of outcome. As stated by Miller and colleagues (2004), “therapists do not need to know ahead of time what approach to use for a given diagnosis as much as whether the current relationship is a good fit and, if not, be able to adjust in order to maximize the chances of success” (p. 7).

Four Factors Involved in Change

Evidence of change indicates that there are four common factors: client/extratherapeutic factors, the therapeutic relationship, placebo/hope, and the counsellor’s model, technique, or intervention (Lambert, Okiishi, & Finch, 1998). Of the four common factors, the client/extratherapeutic factors account for 40% of the change and the therapeutic relationship accounts for 30% of change. Therefore, it makes sense to focus on the client’s resources to ensure a positive working relationship (Miller et al., 2004).

Bachelor and Horvath (1999) offer the analogy of a three-legged stool to understand a client-directed approach to change in therapy. The stool is set against a backdrop of the client’s strength and resources and each leg of the stool represents one of the main ingredients of a strong therapeutic alliance: shared goals, agreement on the method or tasks of treatment, and an emotional bond. These factors contribute to client retention, or keeping the client comfortably seated on the stool. Therefore, continually monitoring client outcome and alliance information and providing feedback to the clients helps clients remain longer and

such clients are more likely to achieve a clinically significant change (Miller et al., 2004).

Establishing Goals

Treatment goals represent the desired change expressed in a client during assessment. Specific goals are necessary for the evaluation of the outcome of client specified goals. The following steps can be used in helping clients determine goals and accompanying outcome statements: provide a rationale, elicit outcome statements, state the goal in positive terms, define the goal, and weigh the advantages and disadvantages of the goal (Cormier & Nurius, 2003).

Cormier and Nurius (2003) suggest the use of the following types of leading questions to help clients define a measurable goal: If you could change one thing, what might that be? If someone saw you as you would like to be, what would be different? What do you want your life to look like? How would you describe your new self? What do you need to change or do to accomplish this new self? What are some good things that will come from this change? What are some challenges you might face in accomplishing this change? A collaborative process in the development of clear goals forms one of the key elements in the establishment of a positive working alliance (Bachelor & Horvath, 1999).

Counsellors need to evaluate their work on a regular basis and this can be a time-consuming process if completed outside of the therapeutic sessions. Client involvement in the participation of outcome evaluation allows counsellors to work with their clients in understanding which interventions are appropriate and when a different approach may be more effective (Newton, 2002).

The use of individualized outcome measurements provides a way evaluate the extent to which individualized goals are met (Cox & Amsters, 2002). This manual provides two examples of methods used to evaluate individualized goals. Ultimately, counsellors need to be asking their clients: How will you know when you have reached your goals in counselling? How do you define success in counselling? The use of the Counselling Outcome Inventory (Hill, 1975) is used for clients who are unsure of their goals and the use of the Goal Attainment Scale (Newton, 2002) can be used to measure the outcome of clearly defined goals.

Two Examples of Individualized Goal Specific Outcome Evaluation Measures

Counseling Outcome Inventory

The Counseling Outcome Inventory (Hill, 1975) provides a way to measure a client's unique goals and uses behavioural cues as a means of measuring the outcome of the goals. It is suited for clients who are unhappy but uncertain about how they would like to be different. The process can be viewed as a process consisting of three parts: a list of characteristics the client views as important, the client's ranking of the relative importance of these descriptors, and the client's rating of how characteristic these descriptors are of him or her (Hill, 1975).

Table 2

Steps in Developing an Individual Counselling Outcome Inventory Based on Hill's Model

- Ask the client to identify 15 characteristics that the client feels are important or those qualities you would look for in a friend.
- Collaborate with the client to specify at least one behavioural expression of each of these characteristics. (What does someone with this characteristic do, think, or feel?)
- Ask the client to rank the 10 most important characteristics, with the most important item as a 10 and the least important as a 1.
- Ask the client to rate him or herself on each of the 10 characteristics. Possible ratings range from -3 (totally dissatisfied with current level of traits on the particular characteristic) to + 3 (totally satisfied).
- For each of the 10 items, the rank order is multiplied by the self-rating to obtain a weighted score of the client's perception. For example, assume that a client rates self-esteem as a 9th in importance and gives a self-rating score of -2; the weighted score equals -18. The scores are then added to get one total score that represents the client's satisfaction with his or her current state of being.

Goal Attainment Scale

This system of measuring the achievement of specific goals is particularly easy and cost effective to use. The Goal Attainment Scale (GAS) measures the extent to which individualized client goals are achieved (Cox & Amsters, 2002). The counsellor and client work together to determine two or three realistic and individually relevant goals. The GAS is characterized by five levels of achievement. The counsellor and client begin by stating the expected outcome and then proceed to rate this outcome as zero. Next, two better and two worse outcomes are determined. It is important to make each level concrete, realistic, and measurable. The Goal Attainment Scale simply asks clients to rate themselves throughout the course of treatment on a scale that ranges between - 2 and + 2 (see Table 3). One

of the advantages of the Goal Attainment Scale is that it can be constructed as part of the therapeutic process, thereby helping build a stronger therapeutic alliance (Cormier & Nurius, 2003). Clients can rate themselves on the progress of their goal throughout the course of therapy.

Table 3

The Goal Attainment Scale Ratings

-2	Outcome much less than expected
-1	Outcome somewhat less than expected
0	Goal or expected outcome achieved
+1	Outcome somewhat better than expected
+2	Outcome much better than expected

(Cormier & Nurius, 2003)

How to Implement an Outcome Evaluation

Developing an outcome evaluation of a counselling agency begins with determining what outcomes are most significant, how the information be used, and how the data will be collected (Thiele, 2005). In determining what outcomes to evaluate, counsellors need to consider the needs and goals of clients. For example, although Family Counselling serves a wide variety of clients, the majority of clients want a decrease in symptoms and an increase in functioning. In addition, management is interested in client satisfaction as a way to measure the client's perspective on the services provided.

In determining the use and collection of data, an agency needs to consider all of the benefits of outcome evaluation. Data that is collected throughout treatment can be used as a way to determine whether the current course of treatment is

working. Therefore, it is recommended that outcome measurements will be collected prior to treatment, during treatment, upon termination of counselling, and at a set period after counselling (Cormier & Nurius, 2003). Data that is collected at each of these times allows agencies to follow the progress of a client to determine whether change has occurred and when the change occurred.

This type of evaluation is based on the progress of each individual client. Its components include a client and the repeated administration of a given outcome assessment over a period of time (Cone, 2001). Using this type of evaluation allows a counsellor or agency to establish a baseline before treatment, a measurement during treatment, a measurement upon termination, and a measurement at a follow-up (Cormier & Nurius, 2003).

A practice-based outcome approach begins with selecting measurement tools that are valid, reliable, and feasible within a given setting. Validity simply refers to the ability of the test to measure what it is intended to measure (Mertens, 1998). This means that the test is not subject to bias due to gender, race, ethnicity, class, or disability. Reliability can be defined as the extent t which instruments are free from error (Mertens, 1998). Common measures of reliability include test-retest, parallel forms, internal consistency (commonly measured by Cronbach's coefficient), and interrater and intrarater reliability (Mertens, 1998). Brown, Dreis, and Nace (1999) found that feasibility generally refers to measures that take less than five minutes to complete, score, and interpret. Choosing measurement tools that meets these criteria adds support to the data. The recommendations for Family Counselling

Services provides several examples of readily available tools for measuring client change and satisfaction with measures that are valid, reliable, and feasible.

Summary

Counsellors within the Northwest Territories have a professional obligation to meet the objectives set out in Standard Twenty-Two of the Community Counselling Program Standards. Outcome evaluations benefit the client through increased self-awareness, increased rapport with the counsellor through feedback, an ability to evaluate the effectiveness of the current plan of treatment, and an ability to alter the course of treatment as necessary. Conducting ongoing outcome evaluation begins with the development of goals so that counsellors know where clients are going and can measure and understand when clients reach their goals. Measures of change need to take into account the following four areas that are recognized as important factors of change: individuals' level of distress; how they function in relationships; how they perform at work, school, or settings outside the home; and the therapeutic relationship (Miller & Duncan, 2004). Measures of change should be chosen based on the following criteria: validity, reliability, and feasibility.

Recommended Outcome Evaluation for Family Counselling:

A Model for Mental Health

Introduction

This proposal sets out to evaluate the effectiveness and satisfaction with treatment of clients who receive counselling at Family Counselling. Family Counselling is an agency that provides services free of charge to clients who do not have extended medical benefits that would otherwise cover the cost of counselling services.

Family Counselling wishes to collect data that will provide an indication of client change that will enhance treatment practice, improve services, and provide agency accountability. As a government service organization, there is a commitment to providing effective services that meets the needs and satisfaction of its clients.

Assessment measures include both self-reports and other reporting tools. Data is collected at the beginning of treatment, during treatment, and at termination. The specific tools of measurement include a variety of self-reports and other reports. The purpose of this example is to demonstrate how outcome evaluation can become part of an ongoing process of improving services. Simple measurement tools balance the needs of feasibility with reliability and validity.

Method

Setting. Family Counselling has a policy of giving appointments to any clients who ask for an appointment and who do not currently have an Employee Assistance Plan that would cover the services of a counsellor or psychologist. Referrals for Family Counselling come from general practitioners, self-referrals, schools, parents,

mental health, and social services. Staff includes two registered psychologists and four mental health counsellors. In the treatment of clients, there is no particular preference for any one form of therapy. Rather, a client-centred approach focuses on choosing the most effective intervention for the particular needs of a client. However, the staff will be trained in solution-focused therapy in January 2006.

The most common issues at Family Counselling include depression, behaviour, relationships (both couple and family), and benefits of counselling. The average number of intakes per month is 31. The average number of client sessions within the agency is 148. This number includes client sessions in Yellowknife, Fort Resolution, and Lutselke. Over the past 12 months, Family Counselling had an average of 22% no shows.

Sample. The recommendations include the use of consecutive referrals for Family Counselling for any given period. Ideally, all clients will be given the opportunity to complete the assessment measures upon intake, during counselling, and at termination. It is anticipated that the recommended outcome measurements will be used on an ongoing basis, rather than as a one-time evaluation method.

Procedure. During the initial intake assessment, clients will be asked to complete the Satisfaction with Life Scale (SWLS) (Diener, Emmons, Larsen, & Griffin, 1985). During the initial visit and on each subsequent visit, clients will be asked to complete the Outcome Rating Scale (ORS) or the Youth Outcome Rating Scale (YORS) by their counsellor at the beginning of each session (see Appendix). The first session becomes the baseline, while the last session becomes the evaluation phase. Why ask clients to complete these rating scales at each session?

Evidence indicates that counsellors are often unaware of whether clients are or are not progressing in treatment, clients' ratings and therapists' ratings of the alliance are often quite different, and clients' ratings of the alliance have a higher correlation with outcome than the ratings of the counsellor (Bachelor & Horvath, 1999; Lambert, Whipple, Hawkins, Vermeesch, Nielsen, & Smart, 2003).

In addition, counsellors will ask clients to rate themselves on a scale of 1 to 10 on the Functioning Scale and Symptomatology Scale at the beginning of treatment, during subsequent sessions, and upon termination. The use of scaling questions provides a very quick and efficient method of establishing clients' ratings of their ability to function and their ratings of symptom severity. In this approach, counsellors simply ask clients to rate their status on a scale from 0 to10. Specific examples can be found in the Appendix.

At the end of each session, clients are asked to complete the Session Rating Scale (SRS) or the Youth Session Rating Scale (YSRS) (see Appendix) (Miller & Duncan, 2004). Upon termination, clients are also asked to complete either the Client Satisfaction Questionnaire (CSQ-8) or the Youth Satisfaction Questionnaire (YSQ) as well as the SWLS (see Appendix) (Attkisson & Greenfield, 2004; Corcoran & Fischer, 1987). These questionnaires were chosen for their simplicity, efficiency, and feasibility.

As an alternative, counselling agencies may develop their own client satisfaction questionnaires. Although these instruments do not have the data to determine reliability and validity, they may be useful for unique settings and the inclusion of particular questions suitable for a particular population group. Family

Counselling is currently using a client satisfaction questionnaire that has developed over time as particular needs and questions arose (see Appendix).

Design

Measures. The SWLS is a short, five-item questionnaire designed to measure the subjective experience of an individual's satisfaction with life. It only requires about one minute to complete and can be used without charge by any counsellor, as the scale is in the public domain. This scale can be used to measure the difference between the current subjective satisfaction and individuals' expectations of what they would like their life to be (Diener et al., 1985). Repeated measures of the test demonstrate internal consistency and adequate test and retest reliability.

The Outcome Rating Scale (ORS) is a very condensed version of the Outcome Questionnaire-45 and measures the same three factors: individual or symptomatic functioning, interpersonal relationships, and social role performance (work, quality of life) (Miller & Duncan, 2004). Changes in these areas are widely considered to be valid indicators of successful treatment outcome (Miller, Duncan, Brown, Sparks, & Claud, 2003). Due to its brevity, the ORS can be used on an ongoing basis to inform and enhance treatment. The ability to use the ORS as an ongoing outcome measurement provides the basis for joint accountability between the client and the counsellor. The tool can be integrated into the treatment process and provides a process for monitoring change throughout the course of therapy. To view a sample of the ORS, see Appendix 1.

The ORS has also proven to have adequate validity, strong reliability, and high feasibility (Miller et al., 2003). The Pearson correlation yielded a concurrent validity coefficient of .58. Reliability of the measure by Cronbach's coefficient alpha was .93 and test-retest reliability was .66. In addition, construct validity has been shown through studies in which changes in those receiving psychotherapy were evident while the data demonstrated stability for individuals not in treatment (Miller & Duncan, 2004).

Information regarding the use of the ORS can be found on the website www.talkingcure.com. There is currently no fee for the personal use of the ORS and a group fee of $99.00 US for 10 individuals or less. The ORS takes less than a minute to complete. The ORS and the SRS are both visual analog scales in which clients are simply asked to place a hash mark on the line nearest the pole that best fits with their experience (Miller & Duncan, 2004).

The SRS is a four-item self-report measure and can be completed in either a written or oral form. The items reflect the therapeutic alliance and assess the following four elements: the quality of the relationship, the degree of agreement between the client and the counsellor on the goals, methods, and overall approach of therapy (Miller & Duncan, 2004).

The SRS has demonstrates adequate validity, strong reliability, and high feasibility. The reliability and validity were compared to the Revised Helping Alliance Questionnaire (HAQ-II), which is a widely used measure of the therapeutic alliance (Miller & Duncan, 2004). The reliability for the SRS is estimated to be .88, while the test-retest reliability was .74. The feasibility of the SRS is demonstrated by the fact

that it takes less than two minutes to complete. In addition, the cost is also very reasonable, as the SRS can be ordered as a companion to the ORS for a combined licensing fee of $99.00 US.

Both the ORS and the SRS have a version available for children and youth. The series includes a Youth Outcome Rating Scale (YORS), Youth Session Rating Scale (YSRS), and a Young Child Outcome Rating Scale (YCES). Some mental health counsellors may prefer the YORS and the YSRS as a measure for adults whose reading levels may be lower than average. One of the benefits of these tools is that they are a visual analog in which clients are asked to make a mark on a line that best represents their current state along a continuum between a sad face and a happy face. The test can be explained very quickly and is suitable for clients who are unable to understand or read the written language.

Scaling questions on functioning and coping can be used to provide a quick rating of the client's ability to function. In this approach, counsellors can follow a script and rate themselves on a scale from 0-10. Following the rating, counsellors and clients are able to examine levels of change by discussing what an incremental change might look like. These types of questions can then be graphed very easily to provide a quick visual reference to self-reported improvement in functioning. In a study of the use of scaling questions to monitor functioning and coping, Fisher (2004) notes that client decisions to end counselling appeared to coincide with self-ratings in the 6 to 7 point range, meaning that clients do not expect to reach a level of 10 in functioning and coping.

The CSQ-8 is an eight-item questionnaire that uses a four-point Likert scale that asks clients to rate the service of mental health providers from poor to excellent (see the Appendix for a sample of the CSQ-8). The CSQ-8 has excellent internal consistency (Attkisson & Greenfield, 2004; Corcoran & Fischer, 1987). In addition, validity is demonstrated through a high correlation with clients' ratings of global improvement and symptomatology and therapist's ratings of clients' progress (Attkisson & Greenfield, 2004; Corcoran & Fischer, 1987).

In addition:

> The CSQ scales, including the CSQ-8 are copyrighted. Use of these scales is limited to individuals, groups, and organizations who seek permission for the use of the scale(s) prior to written permission to do so. The CSQ web-site (sawww.ucsf.edu/csq) includes information required by potential users who wish to seek permission to use the scales. Use permission includes prepayment of use fees. Email can also be sent to clifford.attkisson@ucsf.edu (Attkisson, personal communications, December 7, 2005; Attkisson & Greenfield, 2004).

The YSQ consists of five questions that are rated on a three-point Likert scale that includes the ratings of yes, somewhat, and no. The YSQ has proven to be a reliable and practical method for assessing children's satisfaction with services (Stuntzner-Gibson, Koren, & DeChillo, 1995). In addition, this questionnaire is considered public domain and can be reprinted without additional cost.

Results. Ultimately, the recording of outcomes and the therapeutic alliance is to facilitate client change. Research demonstrates that change early on in therapy is

a good predictor of overall outcome and early ratings of the alliance are a good predictor of both retention and outcome (Bachelor & Horvath, 1999; Miller & Duncan, 2004). Therefore, counsellors need to be clear in stating the purpose of the assessment measures to solicit active participation in the process. The results can be easily calculated and completed on a simple form (see Appendix).

A Comprehensive Evaluation Program

The tools for measuring outcomes were chosen for their reliability, feasibility, and validity. However, the tools were also chosen to incorporate each of the four key components of a comprehensive evaluation program: performance assessment, personal appraisal outcomes, functional assessment outcomes, and consumer appraisal outcomes (Schalock, 2001). The client satisfaction survey developed by Family Counselling includes a question on waiting time to determine the efficiency as a measure of performance assessment. The SWLS was chosen as a measure of an individual's personal appraisal outcome. The ORS and the SRS (adult and youth versions) were chosen as a measure of a client's functioning and symptomatology, while the CSQ and the YSQ were chosen as a rating of consumer appraisal outcome. Together, these measurement tools provide an excellent overview of outcome evaluation in each of the four areas outlined by Schalock (2001). In addition, the measurements chosen were designed to be easily incorporated into any counselling practice within the Northwest Territories.

Summary

Counsellors working within the Northwest Territories can become easily engaged in the process of outcome evaluation through the use of accessible tools

that are feasible, reliable, and valid. Ultimately, we want to be able to demonstrate that clients are changing as a result of counselling and, if they are not, we need to understand why so that we can alter the direction. The recommended tools provide a framework for individual counsellors and agencies to begin implementing their own unique outcome evaluation program.

Outcome Evaluations: A Plain Language Manual

Introduction

As counsellors, we need to know if we are helping our clients. We need to know what a client wants to change (goals) and how they will know when they get there (indicators of change). We want to know if clients are changing as a result of counselling. If clients are not changing, we need to change the way we are doing things. One way to know if a client is changing is to measure how the client is doing at the beginning of counselling compared to how a client is doing at the end of counselling. However, it is better to measure change at each session so that we can do something different if a client is not producing any change or is not getting any closer to their goal.

Research shows that the factors that produce the greatest amount of change in clients are the client factors and the counsellor/client relationship (Lambert, Okiishi, & Finch, 1998). What are the important client factors? Counsellors need to understand the client's goals for counselling, agreement on how to reach these goals through counselling, and how to develop a positive relationship with clients.

Important Definitions

Outcome: The results of treatment. Did the client change as a result of counselling?
Outcome measurements: The tools or tests that measure change.
Validity: Will the test work for *my* clients in *this* setting?
Reliability: How well does the score represent my client's current level of what I am measuring?
Feasibility: Is this test something that I can see myself using or does it take too much time and energy?

Why Bother Measuring Client Change?

1. Client benefit: If we know if clients are changing, we can continue the same course of treatment, but if clients are not producing the change that they want, we have an opportunity to do something different (Asay et al., 2002).
2. Counsellor accountability: Standardized measures of change demonstrate that we are effective in our work of helping clients to change.
3. Improved counsellor/client relationship: Providing clients with feedback on their change can help develop a stronger rapport (Allen et al., 2003).
4. Improved self-awareness: Providing feedback to clients can improve their self-esteem and self-awareness when the feedback is very specific (Allen et al., 2003).

How to Measure Change

Measuring change begins by developing goals with clients. If we know what or how the client wants to change, we can choose or design a tool or test to measure that change or goal. Begin by asking clients how they would like things to be different and then explore what that change would look and feel like. A very simple way of measuring progress towards a goal is to ask clients to rate themselves on a scale of 1 to 10 in regards to the goal or goals that they have set. Help clients describe what each step of the scale might look or feel like. Once they have given a response, help them move towards a small step by describing the difference between where they are and the next increment on the scale.

Formal Measures of Change

Research shows that successful therapy often shows change in the following three client areas: individuals' level of distress, how they function in close relationships, and how they perform at work, school, or settings outside of the home (Miller & Duncan, 2004). The Outcome Rating Scale (ORS) can be used to measure these three areas. It consists of a simple visual scale on which clients are asked to mark a spot along a line on how they see themselves in each of these areas. This can be used at the beginning of each session and the results can then be reviewed with clients during each subsequent session to assess their progress. The cost of the test is very minimal and clients can complete the questions in less than two minutes. In addition, the test can also be given orally, which can benefit clients who have minimal reading levels.

The second important factor in client change is the relationship between the counsellor and the client. The Session Rating Scale (SRS) is very similar to the ORS in that it is a visual scale on which clients mark a spot along a line to rate important parts of the therapeutic relationship. This measure can be used at the end of the session to determine how the client felt about the relationship during the counselling session. The counsellor can use this information to improve areas that the client feels are not as good as they could be. This test also takes less than two minutes to complete and it can be given orally as well. Both the ORS and the SRS can be ordered from the following website at a minimal cost: www.talkingcure.com.

The third factor that can easily be measured through a formal assessment is client satisfaction. This is important because it tells us whether clients were satisfied with the services and whether counselling met their expectations (Stallard, 1996). Research shows that client satisfaction can predict whether clients will come back to counselling, whether they will follow through with treatment, and whether they will end counselling prematurely (Sabourin et al., 1998). Counsellors can make their own surveys, as in the example of Family Counselling, or they can use a readily available survey such as the Client Satisfaction Questionnaire-8 (CSQ-8).

Finally, the Satisfaction with Life Scale (SWLS) is a very quick and efficient evaluation of subjective change from when a client enters the counselling process until termination.

Summary

Measuring change provides a way to assess whether clients are moving towards their goals. It allows counsellors to evaluate their own work and to change their current plan of treatment if change is not evident. Second, measuring the health of the relationship between the client and the counsellor provides an opportunity for improving areas that are weak. Implementing a plan to measure change does not need to be time consuming or expensive, as several tools are readily available and provide all of the information and support that is needed.

References

Allen, A., Montgomery, M., Tubman, J., Frazier, L., & Escovar, L. (2003). The effects of assessment feedback on rapport-building and self-enhancement processes. *Journal of Mental Health Counseling, 25*(3), 165-181.

Asay, T., Lambert, M., Gregersen, A., & Goates, M. (2002). Using patient-focused research in evaluating treatment outcome in private practice. *Journal of Clinical Psychology, 58*(10), 1213-1225.

Attkisson, C.C. & Greenfield, T.K. (2004). The UCSF Client Satisfaction Scales: I. The Client Satisfaction Questionnaire-8. In M.E. Maruish (Ed.). The use of psychological testing for treatment planning and outcomes assessment (3rd Ed) (pp.799-811). Volume 3. Mahwah, NJ: Lawrence Erlbaum Associates.

Bachelor, A., & Horvath, A. (1999). The therapeutic relationship. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.). *The heart and soul of change: What works in therapy* (pp. 133-178). Washington, DC: American Psychological Association.

Brown, J., Dreis, S., & Nace, D. K. (1999). What really makes a difference in psychotherapy outcome? Why does managed care want to know? In M. A. Hubble, B. L. Duncan, and S. D. Miller (eds.). *The heart and soul of change: What works in therapy* (pp. 389-406). Washington, D.C.: APA Press.

California Department of Mental Health. (2005). Retrieved October 1, 2005, from http://www.dmh.cahwnet.gov/rpod/PDF/csq8.PDF

Chalmers, J., Cayen, L., Dutton-Gowryluk, R., Swan, R., Little, S., & Willy, K. (2004). *Community counselling program standards and resources*. Yellowknife, NWT: Northwest Territories Health and Social Services.

Clement, P. W. (1999). *Outcomes and incomes: How to evaluate, improve, and market your psychotherapy practice by measuring outcomes.* New York: Guilford Press.

Cone, J. D. (2001). *Evaluating outcomes: empirical tools for effective practice.* Washington, DC: American Psychological Association.

Corcoran, K., & Fischer, J. (1987). *Measures for clinical practice: A sourcebook.* New York: Free Press.

Cormier, S., & Nurius, P. (2003). *Interviewing and change strategies for helpers* (5th ed.). Pacific Grove, CA: Brooks/Cole.

Cox, R., & Amsters, D. (2002). Goal attainment scaling: An effective outcome measure for rural and remote health services. *Australian Journal of Rural Health,* 10, 256-26.

Diener, R., Emmons, R., Larsen, J., & Griffin, S. (1985). The satisfaction with life scale. *Journal of Personality Assessment, 49*(1), 71-75.

Duncan, S., Miller, S. & Sparks, J. (2003*). Institute for the study of therapeutic change.* Retrieved October 5, 2005 from http://www.talkingcure.com.

Family Counselling Services (2005). Family counselling client satisfaction questionnaire. Unpublished manuscript.

Hill, C. (1975). A process approach for establishing counseling goals and outcomes. *Personnel and Guidance Journal, 53*(8), 571-576.

Hodges, K. (2004). Using assessment in everyday practice for the benefit of families and practitioners*. Professional Psychology: Research and Practice, 35*(5), 449-456.

Lambert, M.J., Ogles, B., & Masters, K. (1992). Choosing outcome assessment devices: An organizational and conceptual scheme. Journal of Counseling and Development, 70, 527-532.

Lambert, M. J., Okiishi, J. C., & Finch, A. E. (1998). *Outcome assessment: From conceptualization to implementation. Professional Psychology: Research and Practice, 29*(1), 63-70.

Lambert, M. J., Whipple, J. L., Hawkins, E. J., Vermeersch, D. A., Nielsen, S. L., & Smart, D. W. (2003). Is it time for clinicians to routinely track patient outcome? A meta-analysis. *Clinical Psychology*, 10, 288-301.

Mertens, D. M. (1998*). Research methods in education and psychology: Integrating diversity with quantitative & qualitative approaches.* New Delhi, India: Sage.

Miller, S. D., & Duncan, B. L. (2004*). The outcome and session rating scales: Administration and scoring manual.* Chicago: Institute for the Study of Therapeutic Change.

Miller, S. D., Duncan, B. L., Brown, J., Sparks, J. A., & Claud, D. A. (2003). The outcome rating scale: a preliminary study of the reliability, validity, and feasibility of a brief visual analog measure. *Journal of Brief Therapy, 2*(2), 91-100.

Miller, S. D., Duncan, B. L., & Hubble, M. A. (2004). Beyond integration: The triumph of outcome over process in clinical practice. *Psychotherapy in Australia, 10*(2), 2-9.

Newton, M. (2002). Evaluating the outcome of counselling in primary care using a goal attainment scale. *Counselling Psychology Quarterly, 15*(1), 85-89.

Sabourin, S., Laferriere, N., Sicuro, F., Coallier, J., Cournoyer, L., & Gendreau, P. (1989). Social desirability, psychological distress, and consumer satisfaction with mental health treatment. *Journal of Counseling Psychology, 36*(3), 352-356.

Schalock, R. (2001*). Outcome-based evaluation* (2nd ed.). New York: Kluwer Academic/Plenum.

Sinclair, C., & Pettifor, J. (2001*). Companion manual to the Canadian code of ethics for psychologists* (3rd ed.). Ottawa: Canadian Psychological Association.

Stallard, P. (1996). The role and use of consumer satisfaction surveys in mental health services. *Journal of Mental Health, 5*(4), 333-349.

Stunzer-Gibson, D., Koren, P., & DeChillo, N. (1995). The youth satisfaction questionnaire: What kids think of services. *Families in Society, 76*(10), 616-624.

Thiele, A. (2005). *Outcome evaluations with child and adolescent populations: A manual for developing evidence-based practice*. Unpublished master's project. Campus Alberta, Calgary, Alberta, Canada.

Appendix

Outcome Measurement Tools

The Satisfaction with Life Scale

DIRECTIONS: Below are five statements with which you may agree or disagree. Using the 1-7 scale below, indicate your agreement with each item by placing the appropriate number in the line preceding that item. Please be open and honest in your responding.

SCALE:

1 = Strongly Disagree
2 = Disagree
3 = Slightly Disagree
4 = Neither Agree or Disagree
5 = Slightly Agree
6 = Agree
7 = Strongly Agree

_____1. In most ways my life is close to my ideal.
_____2. The conditions of my life are excellent.
_____3. I am satisfied with life.
_____4. So far I have gotten the important things I want in life.
_____5. If I could live my life over, I would change almost nothing.

(Corcoran & Fischer, 1987)

Outcome Rating Scale (ORS)

Name _____ Age (Yrs):____
ID# _____ Sex: M / F
Session # ____ Date: _____

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels.

Individually:
(Personal well-being)

I----Examination Copy Only----I

Interpersonally:
(Family, close relationships)

I----Examination Copy Only----I

Socially:
(Work, School, Friendships)

I----Examination Copy Only----I

Overall:
(General sense of well-being)

I----Examination Copy Only----I

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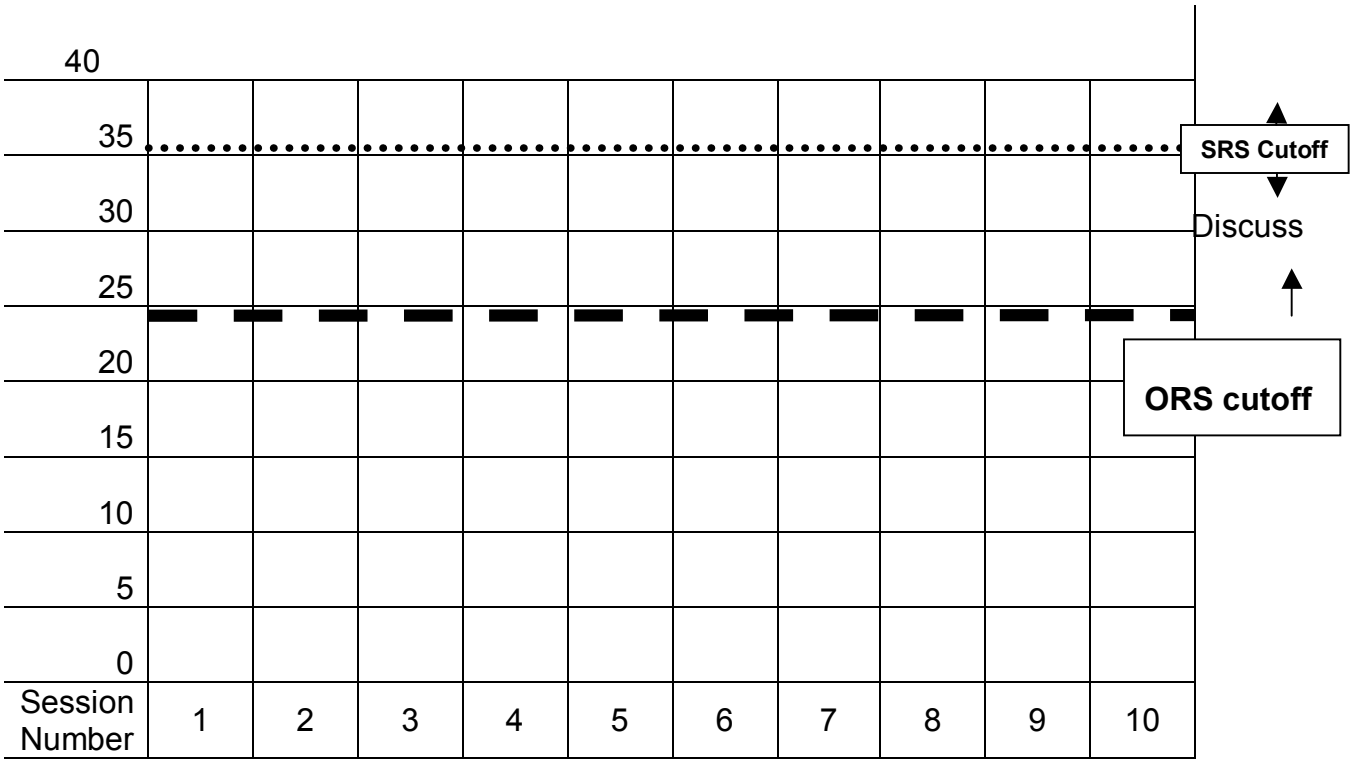
Cutoffs for ORS and SRS



Outcome Rating Scale and Session Rating Scale Used with Permission
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Session Rating Scale (SRS V.3.0)

Name _____Age (Yrs):____
ID# _____ Sex: M / F
Session # ____ Date: _____

Please rate today's session by placing a hash mark on the line nearest to the description that best fits your experience.

Relationship:

I did not feel heard, understood, and respected

I----------I

I felt heard, understood, and respected

Goals and Topics:

We did *not* work on or talk about what I wanted to work on and talk about

I----------I

We worked on and talked about what I wanted to work on and talk about

Approach or Method:

The therapist's approach is not a good fit for me.

I----------I

The therapist's approach is a good fit for me.

Overall:

There was something missing in the session today

I----------I

Overall, today's session was right for me

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Youth Outcome Rating Scale (YORS)

Name _____Age (Yrs):____
Sex: M / F_____
Session # ____ Date:
_____

How are you doing? How are things going in your life? Please make a mark on the scale to let us know. The closer to the smiley face, the better things are. The closer to the frowny face, things are not so good.

Me
(How am I doing?)

I----------I


Family
(How are things in my family?)

I----------I


School
(How am I doing at school?)

I----------I


Everything
(How is everything going?)

I----------I


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_____
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Youth Session Rating Scale (YSRS)

Name _____Age (Yrs):____
Sex: M / F
Session # ____ Date: _____

How was our time together today? Please put a mark on the lines below to let us know how you feel.

Listening

_____ did not always listen to me.

|----------|

_____ listened to me.


How Important

What we did and talked about was not really that important to me.

|----------|

What we did and talked about were important to me.


What We Did

I did not like what we did today.

|----------|

I liked what we did today.


Overall

I wish we could do something different.

|----------|

I hope we do the same kind of things next time.


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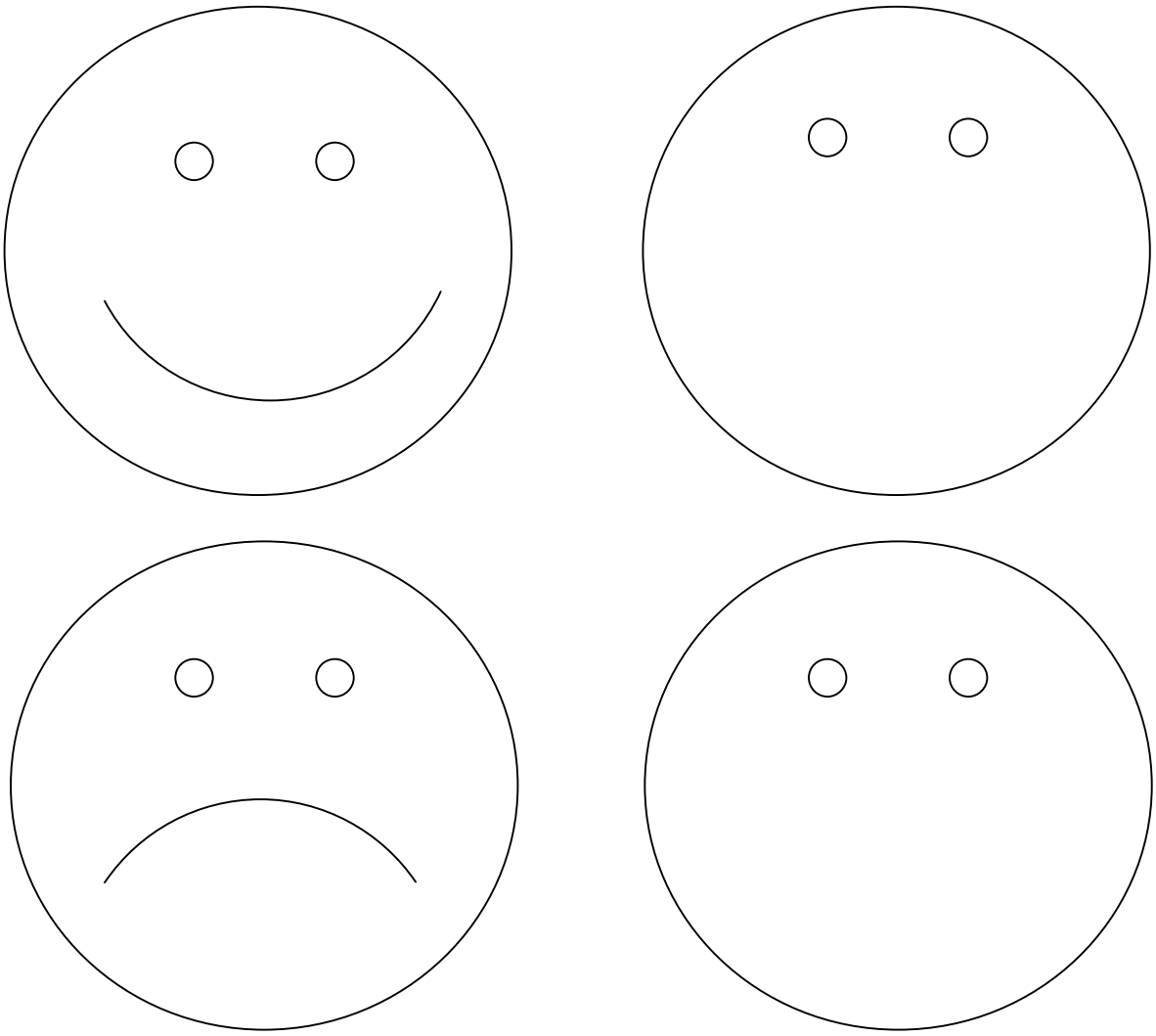
Young Child Outcome Rating Scale (YCORS)

Name _____Age (Yrs):____
Sex: M / F_____
Session # ____ Date:
_____

Choose one of the faces that show how things are going for you. Or, you can draw one below that is just right for you.



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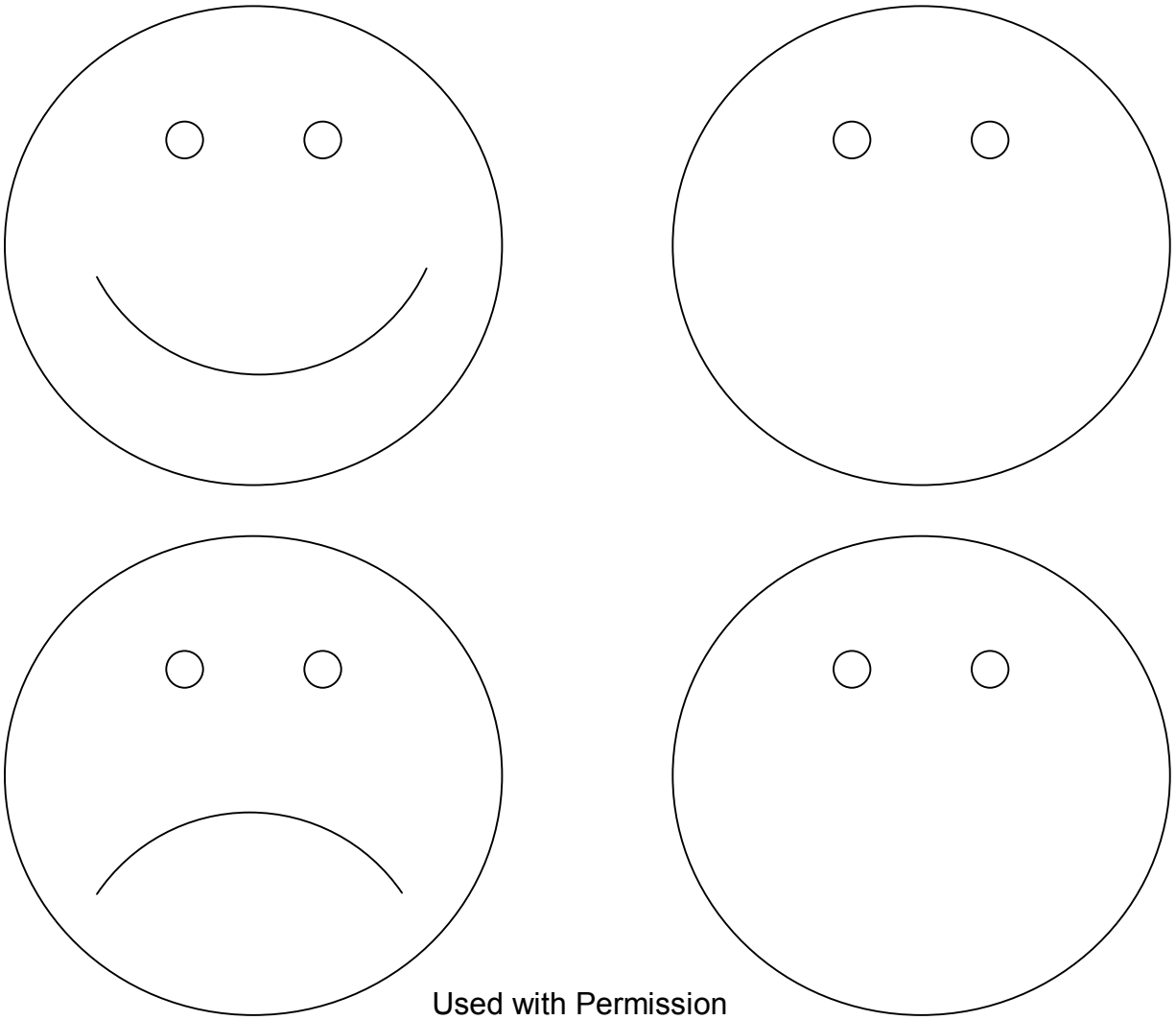
Young Child Session Rating Scale (YCSRS)

Name _____Age (Yrs):____
Sex: M / F_____
Session # ____ Date:
_____

Choose one of the faces that shows how it was for you to be here today. Or, you can draw one below that is just right for you.



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Functioning Scale and Coping Scale

Functioning Scale:

Counsellors might ask the clients to provide a rating on a scale of 1 to 10 where zero is the worst (meaning you can't function at all) and 10 is the best (meaning that you are doing everything you want to do in your daily life). The counsellor might ask the client: 'How well are you able to do everything in your daily life, such as work or school?'

Once the client gives a numerical rating, the counsellor and client explore what the next incremental increase would look like in terms of changes in thinking, doing, and feeling. For example, you stated that you are able to function at a 5. What would it look like to function at a 6? What would you be thinking, doing, and feeling at this point?

Coping Scale:

Counsellors also ask the client to provide a rating on a scale of one to ten where zero is an inability to cope at all with the demands of life and 10 is the best (meaning that you are coping extremely well with all of the demands in your life). The counsellor might ask the client: 'How well are you able to emotionally handle everything in your life?' Again, once the client provides a numerical rating, the counsellor and client can explore what the next incremental rating would look like in terms of changes in thinking, doing, and feeling.

CLIENT SATISFACTION QUESTIONNAIRE ©
CSQ-8

Please help us improve our program by answering some questions about the services you have received. We are interested in your honest opinions, whether they are positive or negative. *Please answer all of the questions*. We also welcome your comments and suggestions. Thank you very much, we really appreciate your help.

CIRCLE YOUR ANSWERS

1. How would you rate the quality of service you have received?

4	3	2	1
Excellent	*Good*	*Fair*	*Poor*

2. Did you get the kind of service you wanted?

1	2	3	4
No, definitely not	*No, not really*	*Yes, generally*	*Yes, definitely*

3. To what extent has our program met your needs?

4	3	2	1
Almost all of my needs have been met	*Most of my needs have been met*	*Only a few of my needs have been met*	*None of my needs have been met*

4. If a friend were in need of similar help, would you recommend our program to him or her?

1	2	3	4
No, definitely not	*No, I don't think so*	*Yes, I think so*	*Yes, definitely*

5. How satisfied are you with the amount of help you have received?

1	2	3	4
Quite dissatisfied	*Indifferent or mildly dissatisfied*	*Mostly satisfied*	*Very satisfied*

6. Have the services you received helped you to deal more effectively with your problems?

4	3	2	1
Yes, they helped a great deal	*Yes, they helped somewhat*	*No, they really didn't help*	*No, they seemed to make things worse*

7. In an overall, general sense, how satisfied are you with the service you have received?

4	3	2	1
Very satisfied	*Mostly satisfied*	*Indifferent or mildly dissatisfied*	*Quite dissatisfied*

8. If you were to seek help again, would you come back to our program?

1	2	3	4
No, definitely not	*No, I don't think so*	*Yes, I think so*	*Yes, definitely*

The *Client Satisfaction Questionnaire (CSQ)* was developed at the University of California San Francisco (UCSF) by Drs. Clifford Attkisson and Daniel Larsen in collaboration with Drs, William A. Hargreaves, Maurice LeVois, Tuan Nguyen, Robert E. Roberts and Bruce Stegner. Every effort has been made to publish information and research on the CSQ for widest possible dissemination. Proceeds from the publication of the CSQ will be used to support postdoctoral training, student academic affairs, and health and human services research activities.

UCSF University of California San Francisco

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Youth Satisfaction Questionnaire (YSQ)

(For Children Age 9 or Older)

Client Name:		Case Number:	County ID:
Gender:	Age:	Date of Administration:	

Type of Administration: ☐ 6 Month ☐ 12 Month ☐ Discharge

Instructions:

Please help us to make this program better by answering the following questions about the services you received over THE LAST 12 MONTHS. We want to know how you felt, good or bad. Please answer all of the questions. Thank you!

Questions	Ratings (Circle your answers)		
Did you like the help you were getting?	Yes	Somewhat	No
Did you get the help you wanted?	Yes	Somewhat	No
Did you need more help than you got?	Yes	Somewhat	No
Were you given more services than you needed?	Yes	Somewhat	No
Have the services helped you with your life?	Yes	Somewhat	No

Now we would like you to grade the specific services YOU RECEIVED OVER THE LAST 12 MONTHS. Write the type of service below and circle a grade to rate how good you felt the service was.

Type of Service	Grade You Would Give The Service (Circle the grade)				
	A	B	C	D	F
	A	B	C	D	F
	A	B	C	D	F
	A	B	C	D	F
	A	B	C	D	F
	A	B	C	D	F

Public Domain

(California Department of Mental Health, 2005)

Family Counselling Client Satisfaction Questionnaire

We value your comments and suggestions regarding our service. Please take a few minutes to complete the survey and mail it to us in the enclosed envelope.

Please circle the most appropriate answer:

1. Counselling helped me to make the changes I wanted in my life.

Strongly Agree Agree Disagree Strongly Disagree

2. Did you get an appointment within?

One week Two weeks Three weeks Other _____

Comments: _____

3. How would you rate the reception services?

Satisfactory Needs Improvement No opinion

4. My counsellor was helpful to me.

Strongly Agree Agree Disagree Strongly Disagree

5. I am satisfied with the service I received at Family Counselling.

Strongly agree Agree Disagree Strongly Disagree

6. I would recommend to others that they use Family Counselling Services.

Strongly Agree Agree Disagree Strongly Disagree

7. If you found anyone particularly helpful, please identify them so we can thank them.

_____

I suggest that the Counselling services could be improved in the following way:

_____

_____

I experienced the following difficulties with the Counselling service:

_____

_____

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