

**USE OF CORE-OM AS A BENCHMARKING TOOL FOR PATIENT
OUTCOMES AT COUNSELLING PSYCHOLOGY UNITS IN
MALAYSIAN GOVERNMENT HOSPITALS**

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**FACULTY OF EDUCATION
UNIVERSITI MALAYA
KUALA LUMPUR
2020**

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PSYCHOLOGY UNITS IN MALAYSIAN GOVERNMENT HOSPITALS

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THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR
THE DEGREE OF DOCTOR OF PHILOSOPHY

FACULTY OF EDUCATION
UNIVERSITY OF MALAYA
KUALA LUMPUR

2020

UNIVERSITI MALAYA

ORIGINAL LITERARY WORK DECLARATION

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Registration/Matric No: PHB080008

Name of Degree: DOCTOR OF PHILOSOPHY

Title of Project/Research Report/Dissertation/Thesis "this Work"):

USE OF CORE-OM AS BENCHMARKING TOOL FOR PATIENT
OUTCOMES AT COUNSELLING PSYCHOLOGY UNITS IN MALAYSIAN
GENERAL HOSPITALS

Field of Research: COUNSELLING

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ABSTRACT

The study aimed to use an alternative method of assessing client outcomes, and service performance by using the outcome measure—Clinical Outcomes in Routine Evaluation (CORE-OM). Presently, the counselling psychology unit assesses the clients' outcomes by subjective observations and clients' self-reports. As for service performance, the counselling psychology units are assessed internally by each hospital's management system. In advanced countries, these methods have been replaced or augmented by standardised routine outcome measures. This study used CORE-OM to measure client outcomes, and it was also the benchmarking tool to set service performance standards. It adopted a mixed-method research design using survey and interview as data collection methods. The survey participants were clients from 13 counselling psychology units in selected government hospitals around the country, and the interview participants were the psychology officers (counselling). The data collection methodology had two phases. The first phase entailed the collection of pre- and post-CORE-OM questionnaires from 103 clients and the second phase, involved a semi-structured interview with three psychology officers (counselling). The findings showed that 9% of clients recovered, 66% of clients improved, 16% of clients showed no-change, and 10% of clients had deteriorated. The benchmarking tool—CORE-OM—had determined the service standards of each outcome category. Based on the benchmarking values, one unit achieved the standard for all outcome categories, while the rest showed average performances. The interviews revealed themes on unit evaluation, workforce needs, outcomes concept misunderstood, inappropriate tools, challenging counselling process and low mental health campaigns. These themes had impacted the quantitative findings, and they shed light on the interactions between the variables, which led to the counselling

psychology units' average performance. The study has implications for theory, practice, training, and future research. The study hoped that the Ministry of Health would consider implementing CORE-OM for assessing client outcomes and as a benchmarking tool for assessing service performance.

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**PENGGUNAAN CORE-OM SEBAGAI PENANDA ARAS UNTUK HASIL
KEBERKESANAN RAWATAN PESAKIT DI UNIT PSIKOLOGI
KAUNSELING DI HOSPITAL KERAJAAN MALAYSIA**

ABSTRAK

Kajian ini bertujuan untuk menggunakan kaedah alternatif menilai hasil keberkesanan rawatan klien dan prestasi perkhidmatan dengan menggunakan alat hasil keberkesanan rawatan, Clinical Outcomes in Routine Evaluation (CORE-OM). Pada masa ini, unit menilai hasil keberkesanan rawatan klien dengan pemerhatian subjektif dan laporan diri klien. Untuk prestasi perkhidmatan pula, unit dinilai secara dalaman berdasarkan sistem pengurusan setiap hospital. Di negara maju, kaedah-kaedah ini telah diganti atau ditambah dengan alat hasil keberkesanan rawatan yang standard. Kajian ini menggunakan CORE-OM untuk mengukur hasil pelanggan, dan juga sebagai alat penanda aras untuk menetapkan standard prestasi perkhidmatan. Reka bentuk penyelidikan adalah campuran 'mixed-method' menggunakan kaedah tinjauan dan wawancara untuk pengumpulan data. Peserta tinjauan adalah klien dari 13 unit psikologi kaunseling di hospital kerajaan terpilih di seluruh negara manakala peserta temu duga adalah pegawai psikologi (kaunseling). Metodologi keseluruhan dibahagikan kepada dua fasa. Fasa pertama melibatkan pengumpulan soal selidik pra dan pasca-CORE-OM dari 103 klien, dan fasa kedua melibatkan wawancara separa berstruktur dengan tiga pegawai psikologi (kaunseling). Penemuan menunjukkan 9% klien pulih, 66% klien bertambah baik, 16% klien menunjukkan tidak berubah dan 10% klien telah merosot. Alat penanda aras—CORE-OM dapat menentukan standard perkhidmatan setiap kategori hasil keberkesanan rawatan. Berdasarkan nilai penanda aras, satu unit telah mencapai standard dalam semua kategori hasil keberkesanan rawatan, sementara yang lain menunjukkan prestasi purata. Wawancara mengungkapkan tema mengenai penilaian unit, keperluan tenaga kerja, konsep hasil

keberkesanan rawatan yang disalahpahami, alat yang tidak sesuai, proses kaunseling yang mencabar dan kempen kesihatan mental yang tidak mencukupi. Tema-tema ini telah mempengaruhi penemuan kuantitatif kerana jelas ada interaksi antara pemboleh ubah-pemboleh ubah yang menyebabkan unit psikologi kaunseling berprestasi purata. Kajian ini mempunyai implikasi untuk teori, amalan, latihan, dan penyelidikan masa depan. Kajian ini berharap Kementerian Kesihatan akan mempertimbangkan melaksanakan CORE-OM untuk menilai hasil keberkesanan rawatan klien dan sebagai alat penanda aras untuk menilai prestasi perkhidmatan.

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ACKNOWLEDGEMENT

Praise be to Allah, the Most Merciful and the Most Benevolent.

I am a 63-year-old homemaker with seven children and 12 grandchildren; I really do not need a PhD. Yet here I am! Let me tell you a story:

In 1977, I got married in the second year at Aston University in Birmingham, England. The following year, I got pregnant and had a child, but baby Zaid did not live long. He had a congenital lung defect. I suffered emotionally and lost interest, as a consequence I failed the end of year examination and the following resit, too. After a short stint at 'uni', I became a full-time homemaker.

Allah's Mercy is Dominant; the misfortune did not last long. I returned to the U.K. when my husband enrolled in a PhD programme at Sheffield University in 1989. I took up the challenge to restart my tertiary education. Indeed, it was an enormous undertaking since I had three school-going children and a toddler to manage!

Alhamdulillah, at the end of four years, in 1992, I was awarded a Degree in Education from The Open University, Milton Keynes in the U.K. Thirteen years later, I received a Master's Degree from International Islamic University of Malaysia. The fire was truly lit and would not be extinguished. Why do a PhD? It seemed the logical step to fulfil my potential, but I will only do it at my own pace. Like the tortoise in the classical fable, I plodded on until the finishing line. Along the way, I married off three children, and welcomed nine grandchildren! Finally, with Allah's Grace, the PhD was completed, alhamdulillah.

The people who made this journey possible were many. First and foremost, my supportive and generous husband, Dr Abdul Rahman Bidin, who encouraged and importantly paid all the fees. My mother, Hajah Siti Aidah Hj Abdullah, who

motivated me to be active; my children whom I aspire to inspire to greater heights; and finally to my dedicated supervisors.

In the long and tortuous journey, I had three changes of supervisors for reasons that were out of my control. The first supervisor, Professor Dr Suradi Salim, passed away unexpectedly. May Allah bless his soul. He set the course for counselling in the medical setting. The second supervisor was Professor Dr Haslee Sharil Lim Abdullah. He supervised the candidature defence - Seminar 1. He was promoted to a professorship in another university and left U.M. The final supervisors were two lovely professional ladies, Dr Rafidah Aga Jalaluddin and Dr Noor Aishah Rosli, who led me to the finishing line. Alhamdulillah. No words can express my gratitude to them. May Allah bless them.

I am also indebted to the many PhD friends, without whom the journey would have been lonely and emotionally stressful. The camaraderie, the mutual 'suffering' and laughter in the PhD room, remained my favourite memories of all time!

Moving on, what is next? The world is my oyster, insyaAllah.

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CHAPTER 1

INTRODUCTION

The tool used to measure the effect on a person's mental health as a result of health care intervention is known as an outcome measure (Slade, 2002). The measurement is usually carried out twice or more at specific time points such as baseline, post-intervention, discharge, or follow-up (Hall et al., 2013). It is known as routine outcome measurement when used frequently. Australia, New Zealand, Denmark, United Kingdom and Norway use standardised routine outcome measurement to monitor the quality and effectiveness of their mental health services (Brann & Coleman, 2010; Krageloh, Czuba, Billington, Kersten, & Siegert, 2015; Pirkis et al., 2005; Tasca et al., 2019). The catalyst for such assessment has been the increased importance placed on monitoring quality and effectiveness of service (Happell, 2008).

The questions about the effectiveness of psychotherapy and service are relevant because nowadays the cost of treatment is paid by government bodies, corporate entities, and third-party carriers who need proof that the treatment is cost-effective (Devlin, Appleby, Buxton & Vallance-Owen, 2010). Hence monitoring and benchmarking are part of the arsenal for mental health service evaluation (Kilbourne et al., 2018; Wampold, 2016). However, the psychology counselling units in Malaysia have not started using outcome measures. They are using the non-empirical methods of subjective observations and client self-reports to assess client outcomes. Nevertheless, monitoring the quality and effectiveness of mental health services are essential to the government as evident in the government directives issued in 1996 to implement Malaysian Standards (M.S.) in all government agencies (PKPA 2/1996, 1996).

This chapter introduces the research by first discussing the background of the study, looking at the way the unit assesses clients and service traditionally. Secondly, the discussion centres on the statement of the problem, research purpose, objectives and questions. Thirdly the significance of the study and the organisation of the thesis. Lastly, the chapter provides an operative definition of keywords used in the study.

Background of Study

Mental health problems are one of the leading causes of the burden of disease worldwide, the most prevalent being depression and anxiety (Charlson et al., 2019; Vigo, Kestel, Pendakur, Thornicroft, & Atun, 2019; Vos et al., 2015; Whiteford et al., 2013). Mental illness has two categories: any Mental Illness (AMI) and Serious Mental Illness (SMI). The former is a form of psychological behavioural or emotional disorder (except development and substance use disorders). The illness is current or in the past year and of sufficient duration, which satisfies the criteria set by the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (Dube et al., 2013). It incorporates all recognised mental illnesses while SMI (Chang et al., 2010) is a smaller and more severe subset of AMI.

In the United States (2017), there were an estimated 46.6 million adults aged 18 or older in the United States with AMI. This number represented 18.9% of all U.S. adults. The prevalence of AMI was higher among women (22.3%) than men (15.1%) (Substance Use & Mental Health Services Administration, 2018). In the United Kingdom, one adult in six had a common mental disorder (Mcmanus, Bebbington, Jenkins, & Brugha, 2016). The burden of disease due to mental health is more significant (28%) than cancer (16%) and heart disease (16%) (Ferrari et al., 2013).

In Malaysia, the latest National Health and Morbidity Survey 2017 on adolescent health and nutrition concluded that 1 in 5 adolescents was depressed, 2 in

5 were anxious, and 1 in 10 was stressed. There was suicidal ideation, plan and attempt observed among 10.0%, 7.3%, and 6.9% of students, respectively (National Health and Morbidity Survey 2017, 2018). For the adult sector, the National Health and Morbidity Survey (2015) reported an upward trend in mental health prevalence from 10.7% in 1996 to 29.2% in 2015. This survey revealed that the most vulnerable sector of the population were females, youths, the indigenous people of Sabah and Sarawak, and adults from low-income families. They may be at risk of mental health problems (National Health and Morbidity Survey, 2015).

The current phenomenon of rising mental health problems in its citizenry poses a great concern to the Ministry of Health. It has to find ways to mitigate the situation, at the same time, prevent further deterioration while campaigning for better mental health wellness. The mental health units like the psychology counselling unit has a heavy burden to deliver on mental health care to the people who need it most.

In the late 1990s, there was an epidemic proportion of illicit drug abuse among the youths in Malaysia. It rose to critical proportions causing the Malaysian government to take unprecedented steps to control the situation (Huang & Md Nasir, 2007). The Ministry of Health (MOH) recruited non-medical personnel—counsellors—into hospitals. The researcher managed to speak to one of the recruited counsellors involved. She recounted the event (Hashimah Abdul Rahman, personal communication, June 27, 2011).

Ten years later, in 2001, Hashimah Abdul Rahman became the head of the first counselling psychology unit in a hospital, known locally as Unit Psikologi Kaunseling (UPsK). It was/is a mental health facility that deals exclusively with psychological problems of clients such as government personnel (MOH and other government agencies) and patients (in- and out-patients in MOH hospitals). Doctors will refer to

UPsK the chronic non-communicable disease (NCD) patients who display psychological problems. For example, psychologically disturbed patients with cancer (Heins et al., 2013; Periasamy et al., 2017), diabetes (Hermanns et al., 2013) and other chronic diseases. The psychiatric department also sends patients to UPsK. However, these patients must score more than 61 in the Global Assessment of Functioning Scale, to indicate that they are coherent and cooperative before they can become clients in UPsK (UPsK HQE, 2019).

Assessment of UPsK clients. The UPsK standard operating procedure (Counselling Psychology Services, 2018) refers to a patient as a client; henceforth the study referred to the patient as the client. In counselling psychology practices around the world, the screening of clients is done at the earliest part to determine their suitability for counselling and psychology interventions. Screening ensures the appropriate clients get the help needed (Brown & Wissow, 2010; Davis, Moye, Karel, & Campus, 2002). Thus screening tool is essential to enable early identification of mental health and substance use disorders. The disadvantage of not using a screening tool is the high possibility of misdiagnosis occurring, leading to inappropriate treatment planning (U.S. Department of Health and Human Services, 2014).

Beginning in 2015, most UPsK has a screening tool to use. It was/is Depression Anxiety Stress Scales (DASS) which the psychology officers (counselling) use on clients showing signs of depression, stress, or anxiety. However, they will not use it for non-depressed or anxious clients. Recently, there is a realisation that UPsK should employ a comprehensive mental health screening tool rather than a disorder-specific symptom measure (Deighton et al., 2014; Kwan & Rickwood, 2015). There are efforts underway to introduce a new general mental health outcome measure nationwide. Until that happens, there is not much choice in screening tools available

in UPsK. Therefore psychology officers (counselling) relied heavily on traditional methods of assessment such as intake interview and subjective observations to screen clients. Beutler and Forrester (2015) described the traditional method as the dialogues between the client and therapist, and the proof of efficacy was the subjective assessment of client improvement.

After screening, the eligible client proceeds to undergo counselling and psychological interventions. The client's progress and the outcomes are assessed through the following ways:

- (1) Self-reports on the number of goals achieved; developed alternative ways of thinking, behaving, and managing feelings that are negative (Lambert, 2013; Understanding Psychotherapy, 2017);
- (2) Observations of physical appearance, demeanour, motor activity, general behaviour, speech, and mood of the client (Snyderman & Rovner, 2009);
- (3) Behaviour assessments, such as observing the client's actual behaviour to understand the thoughts and the respective reinforcements behind such actions (Framingham, 2016).

The traditional ways of measuring mental health and the effects of treatment are increasingly accompanied by, or indeed replaced by, outcome measurement such as patient-reported outcome measures (PROM) (Devlin et al., 2010; Krageloh et al., 2015). In broad terms, PROM comprises a series of structured questions that ask clients about their health from their point of view. The purpose of PROM is to get clients' assessment of their health and health-related quality of life (Devlin et al., 2010).

Howard, Moras, Brill, Martinovich, and Lutz (1966) did the first session-to-session measure of client's progress to evaluate and improve treatment outcome. Since

then, many randomised controlled trials (RCT) (Coster, 2013) and several meta-analyses were published (Shimokawa, Lambert, & Smart, 2010). These studies provided strong empirical support for outcome measurement. Now with technological advances practitioners can quickly and efficiently administer outcome measures, track progress and receive individualised feedback for the clients in real-time (Barkham, Mellor-Clark, Connell, & Cahill, 2006; Lambert, 2012). The Ministry of Health Malaysia must not allow the great strides in outcome measurement development pass it by.

In summary, the majority of UPsKs are using non-empirical methods in screening, assessing progress or lack of, and finally in determining client outcomes. Presently, there is no standardised outcome measurement system in any UPsK.

Assessment of UPsK service. The government hospitals use the standards set by the International Organization of Standard (ISO), in particular, ISO 9001:2008 to assess the quality of management in hospital departments and units (Ismail Ahmad & Roslan Johari Mohd Ghazali, 2004). Currently, ISO 9001:2008 is upgraded to ISO 9001:2015. Another standard that applies to hospitals is the standards set by the Malaysian Society for Quality in Health (MSQH). They are the national accrediting body for quality health care facilities and services. The MSQH standard for counselling psychology services (UPsK) is Service Standard 17 I (MSQH, 2012, 2017). Its focus is on the organization, human resource, policies and facilities of the counselling psychology service. However, Standard 17 I does not make references to client outcomes; for example, it does not state the expected targets for outcome categories among clients. Hence, it appears that MSQH is monitoring the UPsK services in terms of structure and process but ignoring the end product of interventions, that is, client outcomes. Table 1.1 shows the Service Standard 17 I and its scope.

Table 1.1

MSQH Standard 17 I for Counselling Psychology Services

MSQH Standard 17 I Counselling psychology	Scope
17 I.1	Deals with organisation and management
17 I.2	Deals with human resource development and management
17 I.3	Deals with policies and procedures
17 I.4	Deals with facilities and equipment and
17 I.5	Deals with safety and quality improvement activities

(MSQH, 2017)

Avedis Donabedian, the foremost proponent of quality evaluation in healthcare, declared that quality evaluation must consider all aspects. Thus quality evaluation takes into account all aspects (Contandriopoulos & Brousselle, 2012; Scriven, 1991; Shadish, Cook, & Leviton, 1990). Anything contrary to this is not quality evaluation. The Donabedian Model (Donabedian, 1988, 1997, 2003) evaluates the quality of health care by looking at three components—structure, process and outcome. This study used the Donabedian Model to examine the three components in UPsK. Figure 1.1 represents the three components of UPsK.

Looking at the outcome column, the patient experienced a reduction in the distress levels as a result of an intervention. Non-empirical method assessed the reduction in distress. As for service, the outputs expected are accessibility, acceptability, equity and efficiency (Quality of Care, 2006) from the UPsK delivery system. The international standards of ISO and MSQH measure these outputs. Looking at the types of measurement tools used, the assessment of client outcome should also use an empirical measurement measure; but it does not.

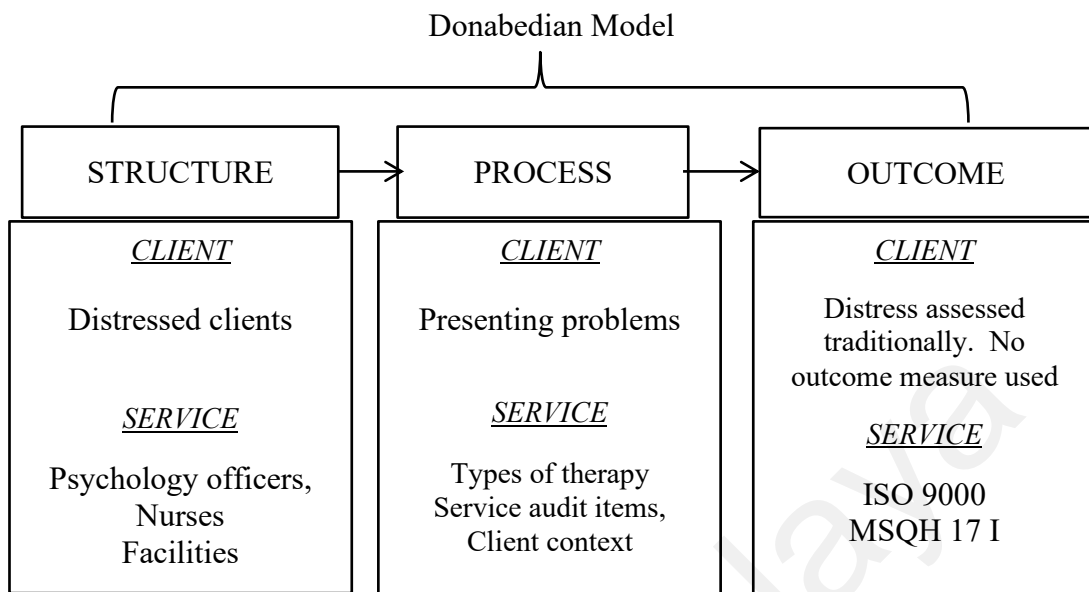


Figure 1.1. Representation of UPsK Components According to Donabedian Model

The MSQH standard 17 I applies to UPsKs whose hospitals are accredited or going for accreditation. However, not many MOH hospitals are accredited or going for accreditation with MSQH hence many UPsKs are not evaluated by any external, independent professional authority. The UPsKs in non-accredited MOH hospitals are accountable to the hospital management, and they are required to present annual reports to the hospital management. The report will show the total number of cases, clients' demographics, the types of cases that come in for treatment and finally, the rate of discharge or referral of the clients. It is an internal administrative exercise, and each hospital may do it differently.

The 60 UPsKs around the country function and perform without external and non-standardised assessment for many years. Without outcome measure and benchmarking tool, each individual UPsK cannot know how well their unit is performing compared to the other.

Statement of Problem

The focus of ISO 9000 is quality assurance in management (Ahmad, 2001) and MSQH sets national standards of performance in health care facilities (MSQH, 2017). In mental health counselling, an essential indicator of a sound management system is client outcomes. Presently both ISO and MSQH ignore this. To date, the effectiveness of UPsK is not known because there is no external evaluation and no standardised routine outcome measurement in place. The common practice is for the individual hospital management system to assess its UPsK via internal reports. This is a local assessment and not nationwide exercise, i.e. no standardised external evaluation.

In 2018, a set of comprehensive guidelines were developed for the governance of all counselling psychology services including UPsK (Counselling Psychology Services, 2018) by the Division of Allied Health Sciences in the areas of individual, group, marital and family counselling. The guidelines streamlined the administrative aspects of governing 149 psychology officers who work in different MOH institutions. The guideline's main thrusts are vision and mission, objectives, organisation, policy and procedures, and quality management. However, there is no mention of client outcomes and how to assess them. For example, what is the mental status of the client after treatment? Presently, UPsKs present subjective anecdotal and idiographic evidence. This non-empirical evidence cannot be used to assess service performance. Thus an essential aspect of quality evaluation of client and service is not possible for the UPsKs for as long as a standardised outcome measure is not used.

Presently only non-empirical methods such as self-report, observations, behaviour and idiographic assessments (Framingham, 2016; Lambert, 2013; Snyderman & Rovner, 2009; Wray, Ritchie, Oslin, & Beehler, 2018) are used in many UPsKs. Without an outcome measure, it is difficult to determine whether the client

has recovered, improved, not showing reliable change or deteriorated (Barkham, Mellor-Clark, et al., 2010; Edbrooke-Childs, Wolpert, & Deighton, 2016; Kendrick et al., 2016) after undergoing interventions. This seminal study attempts to empirically measure the mental status of the UPsK clients after intervention using a known outcome measure, CORE-OM. The CORE system categorises the client outcomes into the above four categories.

Hannan et al. (2005) warned that professional judgement based on traditional assessments, without the use of standardised assessment, cannot identify 100% of clients whose conditions may have deteriorated. Dependency on the subjective professional judgement has been proven by literature (Boswell et al., 2015; Hannan et al., 2005) to be unreliable. Standardised assessment can provide reliable information, and therefore, it is an indispensable tool in assessing change hence the need for this study.

In the local literature, there is no record of empirical studies done on the assessment of UPsK by using outcome measures. However, there is substantial local research on the use of outcome measures in psychiatric care for schizophrenia (Taha, Ibrahim, Rahman, Shafie, & Rahman, 2012; Yoon & Aziz, 2014), depression (Khan, Sulaiman, Hassali, & Tahir, 2011; Firdaus Mukhtar & Oei, 2011), and quality of life (Ibrahim et al., 2016; Periasamy et al., 2017). Also, there are many local studies on outcome measures in the medical field that indirectly affected the psychological state of the patient. For example, survivorship status of cancer clients after two years by Suthahar et al. (2009), breast cancer by Islam et al. (2015). The study on predictors of good functional outcomes in stroke clients six months' post-stroke by Hanun, Azidah and Monniaty (2012).

Many countries have implemented outcome measurement in their mental health services to assess and evaluate clients. Australia has implemented the outcome measurement system as early as the 1990s and acknowledged as one of the world leaders in the use of outcome measures (Eagar, Buckingham, & Coombs, 2001; Pirkis et al., 2005; Slade, 2002). In the U.K. since 1999, the National Health Services (NHS) has established outcome measurement as one of the initiatives for improving the quality of psychological services (Audin, 2001; Barkham, Gilbert, et al., 2005; NIMH(E), 2004). This study is crucial because outcome measure is an essential aspect of assessment that Malaysia is lagging in its implementation.

The lack of a standardised routine outcome measure is problematic. The first problem is in reporting. The psychology officers (counselling) have no empirical evidence to support clients' recovery or deterioration and thus cannot make such claims. In the annual report to the hospital management they can only report on clients' demographics, the total number of clients, presenting cases, discharge and referrals. This lack of empirical evidence puts UPsK in a vulnerable position because it appears that it is not effective in its service. It cannot state the empirical mental status of the clients at the end of interventions or discharge hence doubts about whether psychotherapy works may arise (Campbell, Norcross, Vasquez, & Kaslow, 2013).

The second problematic area is comparisons between the UPsKs cannot be made (Ettorchi-Tardy, Levif, & Michel, 2012; Mellor-Clark & Barkham, 2012). There is no benchmark tool to produce service benchmark values to compare to (Bewick, Trusler, Mullin, Grant, & Mothersole, 2006; Sperlinger, 2002). There are currently 60 UPsKs around the country whose performances have not been assessed, and there is no way to rate their performance against each other. For these reasons, the study on the use of outcome measure as a benchmarking tool is essential and timely.

There is much local research on the evaluation of health services such as multimodal chronic pain service by Abdul Jalil, Sulaiman, Awang and Omar in 2009. They did a retrospective study on managed chronic pain clients in Universiti Sains Malaysia Hospital. In 2013, Noor Azlina and Bahari analysed the quality of a hospital based on clients' satisfaction. No research, however, has been done to assess the performance of UPsKs based on client outcomes.

There are many studies on benchmarking in the counselling psychology field such as standards for waiting times (CORE Partnership, 2011f), improvement in assessment and practice (Delgadillo et al., 2014; Ettorchi-Tardy et al., 2012; Reese, Duncan, Bohanske, Owen, & Minami, 2014). This study used CORE-OM as a benchmarking tool to create service performance benchmarks values based on rates of client outcomes (recovery, improvement, no-change, deterioration) (CORE Partnership, 2011d). A matrix was created to show visually, in a quick and easy perusal, the performance of the individual UPsK in each outcome category as compared to the rest.

In summary, the majority of UPsKs has been in operation for more than ten years. However, it does not have an empirical measure to evaluate client outcomes nor service performance; as a result, three problem areas persist—the first, the uncertainty of the mental status of clients since the traditional assessment method is outdated, and as yet there is no alternative measure. Second, there are lingering doubts about the service provided by UPsK. Finally, without benchmarking tool, the service performance of the UPsKs cannot be assessed.

Purpose of the Study

The purpose of this study is to provide an alternative and current method of measuring and assessing outcomes, notably the assessment of client outcomes and service

performance. These are the two areas that require upgrading. For the former, the study implemented an outcome measure in selected UPsKs to determine the mental status of the clients after the intervention. That is, how many clients have recovered, improved, showed no-change and deteriorated. This information is useful for the psychology officer (counselling) and for the client to know where she/he is along the path to good mental health. For service performance assessment, the study utilised the outcome measure as a benchmarking tool to develop service benchmark values. The UPsK can assess and rank its performance using these service benchmark values. The results will show which UPsK is efficient as well as effective in treating clients with counselling and psychological interventions.

The study chose CORE-OM as the outcome measure because it is an outcome measure that belongs to the practice-based evidence paradigm which possesses components that are useful—routine outcome monitoring and benchmarking. For more details, refer to heading ‘Routine outcome measurement is part of practice-based evidence’, page 64. CORE-OM has all these components. Many mental health services used CORE-OM as a screening tool at the beginning phase, an outcome measure during treatment and discharge; also as a benchmarking tool to create benchmarking values to assess service performance (CORE IMS Ltd, 2014; CORE Partnership, 2011d) Based on these utilities, the study chose CORE-OM as the outcome measure.

As stated earlier, this study wanted to provide an alternative to the traditional method of assessing client outcomes by using outcome measure, CORE-OM, subsequently to use it as a benchmarking tool to assess UPsKs’ service performance. The study came up with three aims and eight objectives to achieve its purpose. The objectives were mainly quantitative except for one qualitative which were in line with

the sequential exploratory design chosen for the study. The research questions were constructed to be incremental, i.e. each one was necessary before continuing to the next. For example, it was necessary to determine the percentage of clients in each outcome categories before determining the benchmark values.

This study has three aims:

1. To describe the mental status of the clients by using CORE-OM.
2. To assess the UPsK service.
3. To assess service performance by using CORE-OM as the benchmarking tool.

Research Objectives

Based on the research aims, the research objectives are as follows:

1. To describe the distress levels, experienced by clients due to psychological problems and risk factors, by using CORE-OM.
2. To ascertain the clients' context (i.e. motivation, working alliance and psychological mindedness) during treatment.
3. To illustrate the service in terms of the type and the frequency of the therapies used.
4. To determine client outcomes according to categories using CORE-OM.
5. To investigate the associations between distress levels, types of therapy, client context and client outcomes.
6. To determine the service benchmark values and the existing UPsKs' performances by using CORE-OM as the benchmarking tool.
7. To create a matrix that will display the UPsKs' performances.
8. To explore the psychology officers' engagement in assessing UPsK service.

Research Questions

1. What are the distress levels experienced by UPsK clients, assessed by CORE-OM, that are caused by psychological problems and risk factors?
 - 1.1. What are the distress levels experienced by UPsK clients before and after intervention?
 - 1.2. How severe do UPsK clients experience psychological problems before and after intervention?
 - 1.3. How severe do UPsK clients experience the risk factors before and after intervention?
2. What are the clients' rating for motivation, working alliance and psychological mindedness during treatment?
3. What are the types and the frequency of the therapies used?
4. What is the percentage of UPsK clients in each outcome category as measured by CORE-OM?
5. Are there associations between distress levels, types of therapy, client context and client outcomes?
 - 5.1. Is there an association between distress level and client outcome?
 - 5.2. Is there an association between types and frequency of therapy with client outcome?
 - 5.3. Is there an association between client context (motivation, working alliance, psychological mindedness) and client outcome?
6. What are the service benchmark values, assessed by CORE-OM as the benchmarking tool, for all outcome categories and to what extent do the UPsKs match up?

- 6.1. What are the service benchmarks at the 25th, 50th, and 75th percentiles for all outcome categories?
- 6.2. To what extent do the UPsKs match up to the service benchmark values?
7. How to create a matrix that will display the performance ranking of the UPsKs?
8. How do the psychology officers (counselling) engage in the assessment of UPsK service?

Significance of the Study

This study aims to provide an alternative and current measurement tool to upgrade the assessment system of UPsK. The parties that benefited from the research are as follows:

Clients — The use of outcome measure gives the client an accurate diagnosis (U.S. Department of Health and Human Services, 2014). The outcome measure can monitor the patient continuously during therapy sessions (Black et al., 2009). By using the outcome measure, the client gets regular updates about progress or lack of in their mental health status (Hawkins, 2004; Wray et al., 2018). The client knows his/her outcome category, i.e. recovered, improved, no-change or deteriorated (Botella, 2006; Evans et al., 2002; Proctor & Hargate, 2012) during treatment and after the intervention. The client receives early detection if gone off track. A red flag is raised. It warns the psychology officer (counselling) that something is not right, and she/he needs to take steps to arrest the decline. However, if the decline continues, the psychology officer (counselling) refers the client to a psychiatrist for further management without delay (Barkham, Mellor-Clark, et al., 2010).

Psychology officer (counselling)—This study boosts their professionalism. CORE-OM provides the officer with three sets of data: psychological (CORE-OM), demographics and client context (TAF & EoT). She/he has sufficient information to see the client's "big picture" and is less likely to misinterpret the standardised assessment results (Mellor-Clark & Barkham, 2006). The officer has empirical evidence of the mental status of their clients during treatment and at discharge (Narang, & Polsa, 2014). The clients with positive outcomes indicate the effectiveness of the therapy conducted by the officer. It is easy for the officer to apply the appropriate treatment plan when he/she knows the baseline distress level of the client (Bickman, 2010; Hatfield & Ogles, 2004). The CORE-OM's easy and straightforward scoring makes it a viable option in a busy UPsK (Elfström et al., 2012). Furthermore, the CORE-OM complements the traditional assessment methods used by all psychology officers in UPsKs.

UPsKs — This study provides UPsK with client outcome data which complements the management and demographic information from ISO 9001:2008 and MSQH. Using CORE-OM as a benchmarking tool, the benchmark values for all outcome categories are produced, which become the standards of best practices among the participating UPsKs. Based on these standards, the other UPsKs can recalibrate their performance (CORE Partnership, 2011d; Mellor-Clark & Barkham, 2012; Mullin, Barkham, Mothersole, Bewick, & Kinder, 2006). The matrix displays all the UPsKs' service performances according to outcome categories, and the colour-coded depiction makes it easy for the management to evaluate them. Green-coloured outcome category indicates a high rate of change in that category,

while the red-coloured outcome category indicates a low rate of change. The UPsK with many green-coloured categories implies high performance and vice versa the UPsK with many red-coloured categories implies low performance.

Hospital management—This study proves the effectiveness of the UPsKs. High rates of positive outcomes show that the UPsK has successfully treated clients' psychological problems in a safe and conducive environment. The hospital may promote UPsK as an attractive mental health option for the public seeking treatment for psychological problems (Creek & Lougher, 2008). Furthermore, due to the excellent track record, the management may consider investing in better manpower allocation and other resources. It augurs well for the future developments of UPsKs

Thesis Organization

There are five chapters. Chapter One introduces the research by summarising the relevant backgrounds to the problem and highlighting the need for this study. It outlines the problem statement, purpose, the research questions, and the significance of the study. Chapter Two reviews the formation of psychology counselling service, the psychology officers, the facilities. Then it goes to discuss mental healthcare and the assessment of quality and how UPsK assessed quality. It then discusses the history of outcome measures and its development globally; and the situation in Malaysia. Finally, the chapter concludes with the theoretical framework, which shows the relationship between the concepts with each other.

Chapter Three describes the research methodology. It discusses and justifies the mixed-method approach and the use of explanatory sequential design; the sites involved; the criteria for participants; the choice of using CORE-OM; the method of

data collection for both quantitative and qualitative samples. In the analysis section, there is a discussion on the research question that will require quantitative input since this is a pivotal point for the explanatory sequential design.

Chapter Four presents the statistical results from the CORE-OM questionnaire. It includes results from the descriptive, inferential and benchmarking questions. The chapter also presents the results of the thematic analysis on the semi-structured interviews by the three psychology officers. The participants' spoke on pre-determined topics such as the need for evaluation, the officers' scope of work, the officers' description of the counselling process, the tools used for client and service assessment, and personal thoughts on counselling. The emergent themes are identified, presented and briefly interpreted.

Chapter Five presents the discussions of the main findings based on the research questions and provides possible explanations from relevant literature. It integrated the information obtained from the interviews to provide context and understanding of the phenomenon discovered in the statistical analyses. The chapter discusses research implications as a result of the study and makes recommendations for better practice and finally gives suggestions for future studies.

Operational Definition

The key terms are discussed and defined:

Benchmarking: A tool to compare a unit's outcome to the best practices among the nine participating UPsKs. The basic unit of analysis is the percentage rate of change of the client (percentile) in each outcome category. The important percentiles are the 25th, 50th and 75th. These will become the benchmarks for recovery, improvement, deterioration and non-reliable change (Mullin et al., 2006) respectively.

These benchmarks are referred to as service benchmarks since it represented the standards for the UPsK (service) in each outcome category.

Clinical sample: Newly registered adult clients are encouraged to become a volunteer in this study. The adult clients who fulfilled the set criteria for this study are the clinical sample. The study required adult clients who are new cases, understand the national language (Malay) or English and has psychological distress. Refer to Table 3.2, page 108, for more details. In UPsK, the patients are referred to as clients according to the rule book in the UPsK standard operating procedure (Counselling Psychology Services, 2018).

Distress: This refers to psychological distress. Psychological distress is the unique discomforting, emotional state experienced by an individual in response to a specific stressor that results in harm, either temporary or permanent to the person (Ridner, 2004). Often co-morbid with other psychological problems. These are the type of clients that seek treatment in UPsK. CORE-OM will measure distress at pre- and post-intervention.

Matrix: A graphical table displaying the performance rankings of the UPsKs according to outcome categories. The matrix applies the 'traffic light' colours found in the thermometer format used by the CORE system to show the benchmarking values. The idea is that thermometer shows the status of the situation (UPsK), whether it is in a desired or undesired based on the benchmark values. CORE used the traffic light colours to do this: green—desirable, yellow and amber—average, red—not desirable (danger must stop). A UPsK that has all its outcome categories in green bands indicate that the UPsK is performing well. That is, it has high rates of positive outcomes and low rates of negative outcomes. All red indicates the UPsK is not

performing well because it has high rates of negative outcomes and low rates of positive outcomes.

Outcome: CORE system identifies outcome as client outcomes that are the changes in distress of the clients according to the formula developed by Jacobson and Truax (1991). Outcomes can be positive or negative. Positive outcomes are recovery and improvement from distress, and negative outcomes are no-change in distress and deterioration, that is an increase in distress. According to Jacobson and Truax (1991), recovery is “when therapy moves someone outside the range of the dysfunctional population to within the range of the functional population” (page 13). That is the client has crossed the cut-off point, and this is clinically significant.

A difference of five or more positive points ($\geq+5$) within the dysfunctional population signifies the client has reliable improvement. A variation of five or more negative points (≥-5) within the dysfunctional population means the client has deteriorated. However, a difference of less than five positive or negative points ($\leq+/-5$) signifies the client has experienced non-reliable change. Refer to Table 4.18 and Table 4.19, page 152, for more details.

Performance: The clients’ positive or negative outcomes are the determinants of the performance of the UPsK. There are three ranks of service performance: high, average and low. The UPsK with high performance is when there are high rates of positive outcomes and low rates of negative outcomes among its clients. UPsK with low performance is when there are high rates of negative outcomes and low rates of positive outcomes (CORE Partnership, 2011d). In the matrix format, the high performing UPsKs will be green in many outcome categories. In contrast, low performing UPsKs will be red in many outcome categories. For more details, refer to Table 4.29, page 179.

Conclusion

Malaysia, along with other South-East Asian countries, is facing increased mental health problems (Steel et al., 2014) among its citizenry. The government has taken many actions; one of them is the setting up of psychology counselling unit (UPsK) in hospitals. UPsK accepts and treats referred clients with psychological problems. The assessment of client outcomes during and after treatment is by the non-empirical methods contrary to the global trend of using outcome measures. The lack of assessment tools has caused problems such as the uncertainty of the mental status of clients, doubts about the service, and many UPsKs' performances are not evaluated.

Many countries have successfully implemented outcome measurement in their mental health services to assess clients routinely and to use outcome measure as a benchmarking tool to assess service (Gilbody, House, & Sheldon, 2002). Malaysia can do too, and many stakeholders such as clients, psychology officers, UPsK and hospital management will benefit from it. This study can contribute to the body of research that will convince the authorities that outcome measurement, in this particular case, CORE-OM can be implemented successfully in government hospitals.

CHAPTER 2

LITERATURE REVIEW

Introduction

Chapter Two begins with a description of the mental healthcare system and in particular, the Malaysian scenario. After the general introduction, the discussion will go into details about the history and establishment of the psychology counselling unit in government hospitals. Then switch back to the mental health care system to review the types of assessments carried out in particular, routinely assessing client outcomes using CORE-OM and using it as a benchmarking tool to assess service performance.

Mental Health Care

Mental health is essential for an individual on the micro and macro levels. On the micro-level, a mentally healthy person is productive in his life. On the macro level, mental health enhances human development and economic growth. The discussion will begin with the macro and then lead to the micro-level. There is no development without health and no health without mental health (World Health Organization, 2014). It is of paramount importance for society and policymakers to pay attention to mental health problems as much as to physical illnesses.

Ritchie and Roser (2018) reviewed the latest estimates of mental health demographics by the Institute for Health Metrics and Evaluation (IHME) as reported in the Global Burden of Disease 2017. This study estimated that in 2017 there were 792 million people, which is approximately 10.7%, slightly more than one in ten people globally, lived with a mental health disorder. Broadly IHME and WHO categorize mental health disorders as mental health and substance use disorders. The category comprises a range of disorders such as depression, anxiety, bipolar, eating

disorders, schizophrenia, intellectual developmental disability, and alcohol and drug use disorders.

Around 4 per cent of the population was estimated to have an anxiety disorder, followed closely by depression at 3%, alcohol use disorders (1.4%), drug use disorders (0.9%), bipolar disorder (0.6%), schizophrenia (0.3%), and eating disorder (0.2%). Generally, in most countries, these disorders are more common among women than man, for example, depression, anxiety, eating disorders, and bipolar disorder are more prevalent in women. However, schizophrenia, alcohol and drug use are typically more common in men (James et al., 2018; Ritchie & Roser, 2018).

In 2001, the World Health Organization (2001) released a report stating that mental disorders were preventable. Literature has shown that psychological interventions have successfully treated most mental and behavioural disorders, and much of this prevention, cure and treatment is affordable (Castelnuovo et al., 2016; Keynejad et al., 2020). For example, over 80% of schizophrenic clients can be free of relapses in one year if treated with antipsychotic drugs combined with a familial intervention (Emsley et al., 2013). Furthermore, 60% of people with depression can recover with a proper combination of antidepressant drugs and psychotherapy. Similarly, 70% of people with epilepsy can be seizure-free when treated with simple, inexpensive anticonvulsants (World Health Organization, 2001).

Despite the hopes given, sixteen years later, the trend of mental health disorders continues to rise. What went wrong? WHO predicted that a lack of investment in mental health would create a “treatment gap”. That is the gulf between the number of people who needed treatment and the small minority who received it. This treatment gap is what went wrong. Only a small percentage of the national health budget goes to mental health (“WHO Highlights Global Underinvestment in Mental Health Care,”

2011). The economic impact of mental disorders is wide-ranging, long-lasting and broad, for example, impact on families, caregivers (indirect costs), lost employment, crime, public safety, premature death and lost productivity. Even if direct treatment costs are low, it is likely that the indirect damages due to “productivity loss” account for a large proportion of the overall expenses (World Health Organization, 2001). Mental health care has not received the level of commitment and resources as warranted by the magnitude of mental health burden, hence the upward trend in mental disorders.

Current knowledge and technologies allow for more effective ways to manage, treat, and prevent a wide range of mental and neurological problems. More than ever, people with psychological, brain or behavioural disorders can become functioning and be productive members of the community and live healthy lives. Therefore, rehabilitation for most people with mental illness is possible (Noiseux et al., 2010; Rössler, 2006; World Health Organization, 2001). Currently, the World Health Organisation (2019) identified mental health for accelerated implementation of the 13th General Programme of Work (GPW13). It seeks to ensure universal health coverage, i.e., access to quality and affordable care for mental health conditions, in 12 priority countries that will affect more than 100 million people, over the next five years from 2019-2023.

Malaysia, as a member state, spent only 1.3% of the total government health expenditure, as stated in the latest Mental Health Atlas 2017 (WHO, 2018). The mental health budget is meagre compared to an international average of 2.8 per cent (Malaysian Health System Research, Ministry of Health, and Harvard, 2016). Countries with established economies put in more because they know that 20% of all health service costs come from mental disorders (World Health Organization, 2001).

The World Health Organization (2007) created a framework for countries to organize their mental health services cost-effectively—“Optimal Mix of Services Pyramid.” The framework puts services that cost the least and most frequently needed, such as self-care and informal community care at the base of the pyramid. While the more expensive services required by a smaller fraction of the mentally ill population, such as long-term in-patient care facilities at the top of the pyramid (World Health Organization, 2007). See Figure 2.1.

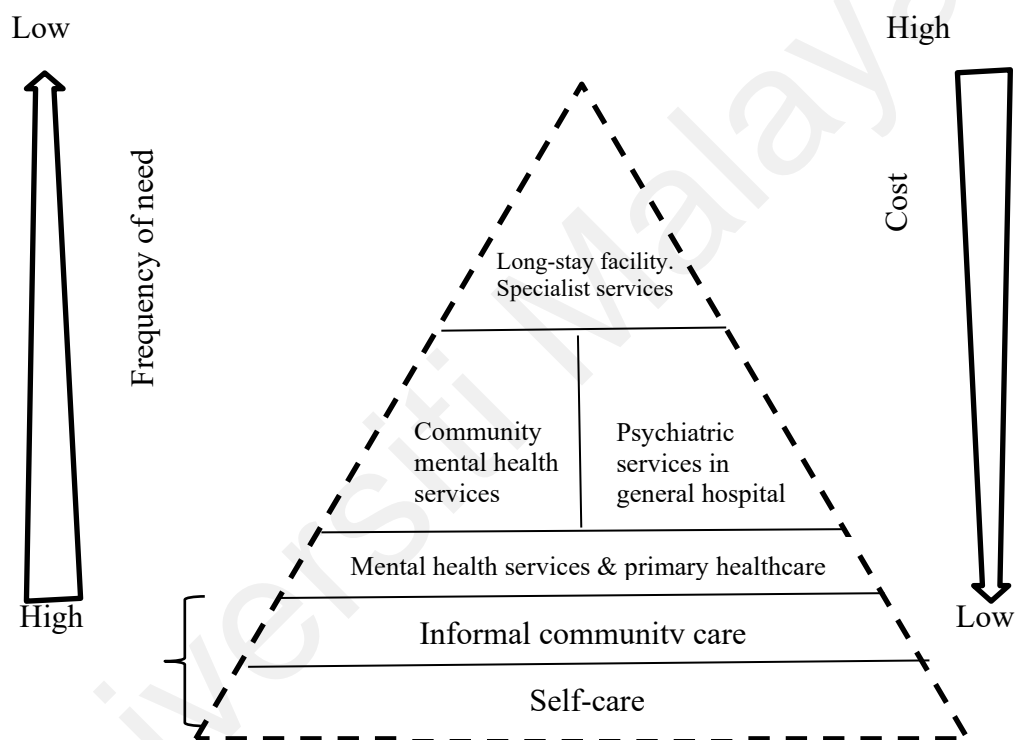


Figure 2.1. WHO Optimal Mix of Services Pyramid Framework

To achieve this combination of services, WHO recommended that countries limit the number of mental institutions instead replace them with community mental health services. Establish psychiatric services in general hospitals to treat clients with acute episodes of mental illness for short term stay. Other mental health services can integrate with primary health care (PHC) since literature showed that treatments for

many common psychological problems are possible at the primary care level (Bruce et al., 2004; Mynors-Wallis et al., 2000).

The informal community mental health services are services provided by the community, outside of the 'formal' health and welfare services, such as services by religious leaders, teachers, police, and non-government organizations. They provide informal support for discharged patients from hospitals with something as simple as "lending a listening ear" to prevent relapse. Also, another crucial benefit of informal community assistance is to encourage patients with psychological problems to seek treatment at the primary level—the earlier the treatment, the better. Thus, avoiding future demands further up the pyramid 'clogging' the system (World Health Organization, 2007).

In the next subheading, the author showed that the Malaysian government did take steps to follow the general trend of deinstitutionalizing mental hospitals, and bring mental health care into the community (Jamaiyah, 2000; World Health Organization, 2007).

Malaysian mental health care. In 1997, the Ministry of Health (MOH) developed the National Mental Health Policy (Chong et al., 2013). It became law in 2001—the Mental Health Act (2001). This Act fulfilled WHO recommendations in 1975 to recognise health as a state of complete physical, mental and social well-being and to foster activities in the field of mental health. Distractors, however, argued that the Act treated mental health as a medical problem rather than a phenomenon triggered by a host of psychosocial factors within the larger society (Crabtree & Chong, 2000). Nonetheless, the Act brought considerable changes to the health professionals, service users, and all those who are directly or indirectly affected by the mental health system in Malaysia (Chong et al., 2013).

The Mental Health Act (2001) provides a framework for the comprehensive care of those with mental disorders. It has provision for the establishment of private and government psychiatric hospitals, psychiatric nursing homes and community mental health (Khan et al., 2015). An example of community mental health care service is the community psychiatric services where the paramedic psychiatric teams visit the patients at their own home. This service hopes to minimize defaulter rate by ensuring the compliance through treatment and counselling to both patients and carers. Another project is the community-based specialist mental health services (MENTARI) which aims to re-integrate patients with severe mental illnesses using work-based therapies; and preventive treatment for individuals having early symptoms (Malaysian Healthcare Performance Unit, 2017).

In the Malaysian mental health care system, there is counselling psychology service that focuses on psychological problems, rehabilitation, and development of clients especially in the soft skills to enable clients to function adequately in the family, at the workplace as well as in leisure activities. Psychology officers (counselling) manage the counselling psychology unit (UPsK), and in many hospitals, it is complementary to the psychiatric service.

The development of the Malaysian mental health services was in line with WHO's optimal mix of service pyramid framework. However, due to monetary constraints, the MOH could not develop a separate comprehensive mental health service system but instead integrated the mental health care with the primary health care services ("Health Facts 2006," 2007; Jamaiyah, 2000; Malaysian Healthcare Performance Unit, 2017). In hindsight, it was a good move because shared infrastructure led to cost-efficiency savings by using existing community resources (Chong et al., 2013). See Table 2.1.

Table 2.1

The Scope of Psychiatric Services in Primary Health Care

Service	Scope
Primary care	Promotion of mental health, early detection and prompt treatment, follow-up of stable cases and defaulter tracing, psychosocial rehabilitation (PSR)
Hospital with no resident psychiatrist	Promotion of mental health, early detection and prompt treatment, follow-up of stable cases and defaulter tracing,
Hospital with resident psychiatrist	Psychosocial rehabilitation (PSR) programmes and in-patient care (optional). Promotion of mental health, early detection and prompt treatment, specialist out-patient care, in-patient care, psychosocial interventions, liaison consultation services, sub-specialised services, e.g., child and adolescent psychiatry, geriatric psychiatry, research and training
Mental institution	Promotion of mental health, early detection and prompt treatment, specialist out-patient care, in-patient care, hospital-based community psychiatry, psychosocial interventions, forensic psychiatry, residential care for hard to place clients and long stay clients, research and training

Malaysian Healthcare Performance Unit (2017), using unpublished psychiatric survey data and other relevant sources from 2015-2016, produced a technical report. The density of psychiatrists serving the Malaysian population is very low, 0.52 per 100,000 populations. The density of clinical psychologists and psychology officers (counselling) combined is even lesser—0.2 per 100,000 populations. The report stated that there are 12 clinical psychologists and 49 psychology officers (counselling) in psychiatric services in MOH hospitals (Malaysian Healthcare Performance Unit, 2017). However, many psychology officers (counselling) are in UPsKs, which, unfortunately, were overlooked in the report which meant the total number of psychology officers in mental health care service is more than that stated in the report.

The counselling psychology service, an essential element in the mental health care delivery system, operated from a unit (UPsK) in Hospital Kuala Lumpur in 2001.

Currently, there are 60 UPsKs around the country including in Sabah, Sarawak and the Federal Territory of Labuan. However, the unit is not as well known as the psychiatric department in providing mental health services.

Counselling Psychology

During the second half of the 20th century, the field of health care faced significant changes and new challenges (Gentry, 1984; Karademas, 2009). For example, one such challenge was that the biomedical model failed to explain health and illness fully. There was a significant change in focus from contagious diseases, which was reliant on the biomedical model, to chronic diseases as the leading health problem of the time. In chronic diseases, there was an increasing awareness that psychology and lifestyle factors played essential parts in the aetiology and may create mental health problems in the patients.

Due to the shift in focus, sophisticated psychological theories about health developed (Wahass, 2005). As a result, health problems, especially chronic diseases, stopped being just a doctor's job; instead many refer their patients to psychologists for treatment and symptom management (Ayers et al., 2007). Thus, the role of counsellor, counselling psychologist and psychologist in health care gradually become more critical (Wahass, 2005). This change was reaffirmed by Layard (2005), who stated that doctors are not ready to identify and address psychological problems posed by the clients. Literature showed that almost 75% of all relevant cases were under-diagnosed for psychological difficulties (Kunen et al., 2005).

Malaysian doctors in the late 1980s were also unable to cope when faced with a psychological-based problem—drug addiction. Unfortunately, the health care system at that time (and now) did not have sufficient psychiatrists or psychologists to go around; hence the urgent call for counsellors from outside the medical field to assist.

Formation of Unit Psikologi Kaunseling (UPsK). The drug epidemic circa 1986 was the reason for the entry of counsellors into the government hospital service. The drug problems had escalated to dangerous levels and eventually became a major social threat to the public. Ministry of Health detected the first case of human immunodeficiency virus infection (HIV) in 1986, and yearly reports of confirmed cases of HIV as well as acquired immune deficiency syndrome (AIDS) steadily increased. In 2000, there were 5,107 new infections, averaging almost 14 cases per day (Huang & Md Nasir, 2007).

The government of the day was concerned with the rising AIDS problem and entrusted the Ministry of Health (MOH) to act on it. In 1992, the MOH chaired an Inter-Ministerial Committee on AIDS to advise the Cabinet on policies and strategies to address the epidemic (Huang & Md Nasir, 2007). The following year, 1993, the Public Service Commission appointed seven people as consultant counsellors (*pegawai perunding cara*) to the Ministry of Health. They came from schools (4), prison service (1), religious department (1) and one psychologist. Their tasks were to manage the influx of AID clients and rehabilitate them in government hospitals. Hashimah, one of the seven recruited counsellors, recounted the early years. She eventually became the first Head of UPsK, HKL from 2002-2005 and again in 2010-2018 (Hashimah Abdul Rahman, personal communication, June 27, 2011).

The counselling profession was considered a strategic resource to combat the menace since the rapid growth and success of counselling services in education, career, and rehabilitation showcased counselling's potential to manage psychological problems (Glamcevski, 2008). Counselling is the only helping profession in Malaysia that has a statute—Counsellor Act 1998—that regulates the profession. It is a first in South-East Asia and Australasian region (Counsellors Act 1998, 1998; Glamcevski,

2008). After the Act, the government introduced counselling services into other government agencies (Public Service Department Malaysia, 1999) to maintain civil servants' morale and high productivity.

The MOH posted the seven 'imported' counsellors to three general hospitals—in Kedah, Kuala Lumpur, Perak, and four mental institutions—Hospital Bahagia in Ulu Kinta, Hospital Permai in Johor, Hospital Sentosa in Sarawak and Hospital Mesra, and Bukit Padang in Sabah. They were absorbed into the psychiatric departments and subsumed into the activities of the psychiatric department. They assisted the psychiatrists by providing counselling to psychiatric clients but not to the drug users. The first counselling service by a counsellor was in 1993 at the Department of Psychiatry, HKL (Psychology counselling unit, 2016).

Despite the passage of time, the seven counsellors were aware they had an unfinished task to do. They persistently drew attention to the need for a separate counselling unit that would serve the psychological needs of clients from non-psychiatric wards such as cancer, diabetic, cardiology and in particular, to help substance abused patients. The unit will be an autonomous unit separate from psychiatry. The rationale is that clients who are experiencing psychological difficulties, as a result of not coping successfully with medical and life stressors are not willing to be associated with clients that had mental illnesses. The common perceptions are the 'mental' clients are dangerous and disruptive. Hence seeking psychological treatments in psychiatric department frightened people away (Kendra et al., 2014; Vogel et al., 2007).

Events outside the hospitals, the enlightened position of the government that endorsed counselling as a means of improving the mental health of staff, all worked in their favour. Finally, in 2001, the first psychology counselling unit/unit psikologi

kaunseling (UPsK) was established in Hospital Kuala Lumpur under the purview of the hospital's management (UPsK HKL, 2013). The Service Circular letters—SPP Bil. 4/1998 and P.P. Bil.1/1999—issued by the Public Service Department (Public Service Department Malaysia, 1998, 1999) reinforced the need for the establishment of UPsK in hospitals. The first service circular was a guideline to manage low performing and troubled civil servants and the following year was the call to establish counselling services in government agencies.

The UPsK has its vision, mission statements, objectives and Client Charter (Counselling Psychology Services, 2018):

Vision: To empower the well-being of individuals and communities through professional counselling services.

Mission: To provide counselling psychological interventions conducted by competent and skilled staff. The service is evidence-based, conducive, therapeutic and effective.

Objectives: To deliver a standard and holistic psychological counselling services for the well-being of individuals, organizations and communities;
To continuously improve the knowledge, skills and competencies of the psychology officer (counselling);
To implement ethical services and related legal provisions.

Client

Charter

Each client, will be referred to the service within five working days from the date the referral is received;
Each counselling session shall be a minimum of 45 minutes while group/family and marriage counselling shall be a minimum of 90 minutes;
Each client will receive an explanation of what to expect from psychological counselling services (page 2).

UPsK provides counselling and psychological therapies for organizations, in particular, the Ministry of Health (MOH). The hospital management refers to UPsK the low performing and troubled personnel of MOH as instructed by SPP Bil.4/1998 (Public Service Department Malaysia, 1998). The personnel may be doctors, nurses, administrative and technical staff. In October 2009 a Service Circular Letter, SPP

Bil.12/2009, provided guidelines on how to implement the Work Culture that Prioritizes Achievement via the application of psychological approaches (Public Service Department, 2009) for all government civil servants. The emphasis on excellence at work may cause weak and troubled civil servants to experience increased stress levels so UPsK must be ready to assist them.

The psychology officers (counselling) follow the 70:30 time rule. That is, 70% of the time for personnel development programmes and 30% for clients. However, the time rule is flexible depending on the availability of psychology officers and the needs of the hospital. The UPsK is a small unit, ideally, comprising the psychology officers (counselling), administrative and health care assistants. However, in many places, there is only one psychology officer (counselling) doing everything (one-person unit) without administrative or health care assistant.

Psychology officer in UPsK. The definition of a counsellor in the Counsellors Act 1998 is “*a person who provides counselling services for a prescribed fee or any other consideration.*”(Counsellors Act 1998, 1998). This Act differentiates counsellors from health professionals. The definition of a health professional is “*a medical practitioner, medical and clinical psychologist, nurse, midwife, medical assistant and any person involved in the giving of medical and health services under the jurisdiction of the Ministry of Health.*” This definition clarifies the position of the health professionals who may in the course of their work offer advice and counsel patients, for example, in genetic or breastfeeding services. In those circumstances, it is clear that health professionals are not giving counselling, i.e. talk therapy. Hence they are not governed by the Counsellors Act 1998 (Counsellors Act 1998, 1998).

The interpretation of the Counsellors Act 1998 (Part 1: Preliminary) poses a problem to UPsK since it states clearly that the Act does not apply to:

- 1.2 (b) any company, society or local authority providing healthcare services such as hospital, nursing home, hospice, blood bank, psychiatric hospital, ambulatory care centre, maternity home, haemodialysis centre, community mental health centre, psychiatric nursing home, medical or dental clinic, or any other healthcare facility. (Page 7)

This statement is causing much confusion amongst psychology officers (counselling) and health professionals. For the former, they assume they do not need to register with the Board of Counsellors. The Ministry of Health, nevertheless, requires all its counsellors to register with the Board of Counsellors to maintain professionalism in conduct. For the latter, the counselling psychology unit appears not to operate under the purview of any Act, neither the Counsellors Act 1998 nor the Mental Health Act 2001. The interpretation of the Act is an ongoing debate between the psychology officers and the relevant authorities to rectify the Act to represent the reality on the ground.

In 2007, a Service Circular P.P. Bil.29/2007 notified the change of name and scheme from counsellor and assistant counsellor's service scheme to psychology officer and assistant psychology officer's service scheme (Public Service Department, 2007). Henceforth a counsellor is called a psychology officer. In the new service scheme, the post of psychology officer includes counsellor, psychologist, and clinical psychologist. Therefore, to differentiate between them, the counsellor becomes the psychology officer (counselling), the psychologist is psychology officer, and the clinical psychologist is the psychology officer (clinical).

The psychology officer is in the management and professional group (S), starting at grade S41 going up to the highest grade of S54. The required qualification for the post of S41 can be a degree in Psychology, Clinical or Counselling (Psychology Officer S41, 2015). The Profession Chief is the person appointed to develop and monitor the service scheme of the psychology officers. One of his/her priorities is to

increase the number of psychology officers (counselling). In some regions, there is a dire lack of workforce, causing the temporary closure of UPsKs.

In 2016, Parliament gazetted the Allied Health Professions Act 2016. The profession of clinical psychologist became a member of the Allied Health Professions; henceforth the psychology officer (clinical) is separate from the other psychology officers in terms of governance.

Psychology officers (counselling) may work in many MOH entities such as the Ministry of Health headquarters in Putrajaya, state health departments, hospitals, mental institutes, district health offices, government health clinics, training institutes, National Heart Institute, and Health Management Institute. About 58% of psychology officers (counselling) work in hospitals around the country. In the hospital, the psychology officer (counselling) is either under the purview of the Deputy Management Director or the Deputy Medical Director. The Deputy Management Director may place the officer in hospital management while the Deputy Medical Director will place the psychology officer (counselling) in UPsK or the psychiatric department depending on the needs of the hospital.

In 2007, the Public Service Circular No. 29/2007 stated the scope of work of the psychology officer in UPsK (Abd.Talib, Abd. Halim, Rosli, & Raja Ahmad, 2011; Public Service Department, 2007). The psychology officer may work within and outside the hospital compound. Outside the hospital means the psychology officers (counselling) have to travel to visit cluster hospitals in the broader catchment area. Table 2.2 shows a simplified version of the Public Service Circular No. 29/2007 that is relevant to the discussion.

Table 2.2

The Scope of Work of A Psychology Officer S41

Scope	Work
Counselling	<p>Implement counselling activities that cover aspects of growth, development, intervention, prevention and recovery.</p> <p>Conduct individual, group, family, marriage, tele-counselling, crisis intervention, and consultancy services.</p> <p>Prepare reports on counselling activities as well as provides monitoring and investigation reports for record and quality improvement purposes of the existing counselling services.</p> <p>Maintain, store, and distribute psychological tests and inventory tools. Also, update the lists of psychological test and inventory tool.</p> <p>Implement training programs on how to administer and interpret the psychological tests and inventory tools.</p>

In 2018 a standard operating procedure (SOP) produced by the Allied Health Division was formulated for individual counselling, group counselling, marital and family counselling. The Head of Unit will monitor and supervise the psychology officers (counselling) based on the relevant SOP as well as ensure the officers (counselling) achieve the key performance indicators. To improve skills and quality service, the psychology officers (counselling) need to follow in-service training for a minimum of seven days annually. In addition to the seven days, the officer takes part in voluntary continuous professional development (CPD) programmes which the officer may have to pay out of his/her pocket (Abd.Talib et al., 2011; Psychological Counselling Services, 2018a).

Facility and Service. According to the operational management plan, a UPsK has these facilities: officer's office, counselling room for an individual session, room for group counselling, room for relaxation therapy, room for art therapy and meeting

room depending on availability (Psychological Counselling Services, 2018a). However, the majority of UPsKs have limited facilities depending on the status of the hospital. Most UPsKs in state hospitals have independent office space with a front counter and therapy room while major and minor specialist hospitals have UPsKs sharing office space with other units.

Van Egeren (2004) noted that mental health practitioners often have to improvise, to adapt and perform under less than ideal conditions while attempting to provide quality service to clients. Any soundproof room with chairs is enough for conducting a therapy session, but Butina (2008) noted that the environment could make a difference in the client's feelings. A comfortable surrounding will make the client feel safe and welcome, allowing the client to open up to the psychology officer.

The UPsK's operating hours are from 8 am - 5 pm Monday to Friday, closed on the weekends and the state's public holidays. The clients come with referral letters from government clinics or hospitals, but referrals from private clinics or hospitals are not accepted. The unit accepts voluntary walk-in by Ministry of Health personnel only. If a client walks in without referral, the psychology officer (counselling) will see the client, however, to continue with treatment, the client has to get a referral letter from the government primary care doctor.

The UPsK gives the client an appointment within the time frame stipulated by the Client Charter, i.e. five working days (UPsK HS, 2018; UPsK HSB, 2016). The waiting time standard for psychological services in the U.K. is two weeks from the referral date to getting an appointment with the psychology officer (NHS England, 2015). Comparatively, the waiting time for UPsK is excellent, indeed.

The UPsKs have psychological tests and inventory tools, but not all UPsKs have the same tests and inventories. Examples of tools available are the Depression

Anxiety Stress Scale (DASS), personality test, self-esteem test, stress test and career aptitude test. Some UPsKs used DASS as a screening test. However, UPsKs do not have standard outcome measure to test clients during and after interventions.

All states' hospitals, many major and minor specialist hospitals offer counselling psychology services, but only a few private hospitals in Kuala Lumpur do that. Even though non-government organizations such as Befrienders and religious-based organizations have a long history of providing counselling services (See & Ng, 2010); but they do not treat psychological distress arising from non-communicable diseases (NCD). Hence the study focused on MOH hospitals to implement outcome measures.

Negative image. It is not easy to seek help for psychological problems, and many studies around the world attest to that. Busiol (2016) conducted a qualitative study on Hong Kong Chinese students and found four main themes of resistance, such (a) as culturally non-inclination to express feelings, (b) limited to one' social network, (c) psychological matters considered small compared to money and career, and (d) misconceptions about counselling. Not much different with Emirati students in UAE in a study by Heath, Vogel, and Al-Darmaki (2016). The Arab students have trouble seeking help due to (a) loss of face for self and family, (b) stigma associated with help-seeking, and (c) discourage self-disclosure outside of the family. In the West, Lynch, Long, and Moorhead (2018) carried out a study on young Irish men. Their resistance came from (a) rejection by peers for being weak, (b) challenges in communicating problems, (c) inhibiting cultural and religious influences, (d) fear of homophobic responses, (e) self-medicate by substance use, (f) goes against traditional masculine ideals.

Two recent local studies confirm almost similar prejudices and resistance. The first was by Ibrahim et al. (2019), whose team conducted a study on students (secondary and tertiary) from the B40 income bracket. They found that the most influential predictor to mental helping seeking was self-stigma. Stigma is behaviours, circumstances, or beliefs that deviate from societal norms and society will dispel or exclude people who do not conform (Goffman, 1963). Self-stigma is the internalisation by members of the negative stereotypes, prejudices, and biases spewed by society. The person with self-stigma developed feelings of low confidence and self-esteem (Corrigan et al., 2009).

Another study in Sabah by Shoemith et al. (2018) found the same factors prevailing in Sabahan society plus an additional factor of spiritual diagnosis. Spiritual diagnosis and treatment are when the client goes to *bomoh* (traditional healer) or religious authorities instead of the medical agency for diagnosis and treatment. Interestingly, the procedures are akin to medical diagnosis, where the spiritual practitioner takes the patient's history and formulate the causes of the illness.

Shoemith et al. (2018) found that spiritual diagnosis is focused on the possession of the person by saka, i.e., a spirit that enters the dead host's descendant; curses and heresy. The treatment by the religious authorities typically included reading a Holy Text or prayer, which are specific to the diagnosis. However, if the treatment is not sufficient, some bomoh and religious authorities advise the client to seek treatment from another religious or spiritual healer with more specialised knowledge in spiritual disturbance or from psychiatric services.

The way forward to make counselling psychology services attractive or relevant requires creative rethinking and actions. Lynch et al. (2018), in their study, suggested direct, positive, and solution-focused advertising that is relevant and

representative of the diversity in the community. Use popular public figures to incorporate non-stereotypical messages such as masculine identity since it is not “a cool behaviour” for men to seeking mental health services. Advertising should be strategically placed, for example, between football matches or on gaming websites, and through social media. This opportunity allows guys who would not typically see a mental health service promotion, see one.

Another suggestion from the Irish participants is that mental health services need to reach out and support families and young men with information that encourages help-seeking behaviours beginning from school. Mental health must start in formal education.

A recent survey study by Wong, Bonn, Tam, C, & Wong (2018) conducted with 409 students from six universities in Malaysia suggest an alternative way forward. The alternative is to use technology, i.e., do counselling online to reach those who are not inclined to meet face-to-face with psychology officers (counselling). The studies by Busiol (2016), Heath et al. (2016), and Wong et al. (2018) conducted on Hong Kong, Emirati and Malaysian students allude to difficulties with self-disclosure, and Asians do not psychologize these problems as compared to those from western societies (Haroz et al., 2017). Thus features that are inherent in online counselling such as relative anonymity, convenience, ease of use, physical distance, and writing down feelings instead of talking may make it an attractive option for many who will otherwise remain untreated (Rodda et al., 2015).

Personal development in the training of psychology officers There are about 23 Malaysian institutions of higher learning (government, private, and private college universities) offering bachelor, and master degrees in counselling, or guidance and counselling. Only a handful (less than five) offer a PhD programme. This study’s

interest in the psychology officer's training is focused on the personal development of the psychology officer since it has a bearing to the way the psychology officers conduct the counselling session with their clients.

There are two purposes for the addition of personal development in counselling curriculum: (1) to appreciate the counselling process and (2) raise self-awareness (Kumari, 2011; Malikiosi-Loizos, 2013). The need for counsellors to have self-awareness goes back to Maslow's concept of self-actualization, Carl Roger also referred to it too. It is moving towards achieving maximum potential by continuously growing self-awareness. The aware psychology officer (counselling) can distinguish different feelings, conscious of their own beliefs, values, and moral principles and their reactions to different stressful situations. Such self-awareness is necessary to become sufficiently trained to conduct this profession (Dryden & Thorne, 2008). How to gain self-awareness? It is through personal therapy and personal development programme.

Kumari (2011) found four major themes in personal therapy. The first was to gain experiential learning on the therapeutic relationship by first-hand experiences, particularly in using techniques and how not to do therapy. Second, to know how it felt to be a client, the third was the development of self-awareness in practice, and finally, personal development is a life long process. Personal therapy enables trainees to be better psychology officers (counselling) and become more integrated individuals in their personal and professional development. However, the set-back is that it costs money and time because to get a genuine experience of counselling, it must be conducted by professional counsellors and not by fellow students (Kumari, 2011).

The next part of the literature review focused on the assessment of health care, mental health care and in particular the UPsK.

Assessing Health Care Quality

In 1990, the Institute of Medicine (IOM) produced a definition of quality of care that has stood the test of time “The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge” (Richardson & Corrigan, 2002, p.1). A decade later, World Health Organization (2000) recommended improvements in six dimensions of quality health service which were similar with IOM’s shared vision called Six Aims for Improvement (Richardson & Corrigan, 2002).

The six dimensions of quality health service (Hanefeld, Powell-Jackson, & Balabanova, 2017; Quality of Care, 2006) are as follows:

1. Efficiency is to maximise resources and to avoid wastage.
2. Effectiveness is when evidence-based care is given and results in improved health outcomes.
3. Access is to give appropriate care in all conditions.
4. Client-centred is care that is considerate to communities.
5. Equity is to give quality care regardless of external factors.
6. Safety is to minimize risk and harm.

Quality of care is still, however, inadequately conceptualized. McQuestion (2006) identified three main healthcare frameworks commonly used in the field. The first is the World Health Organization (WHO) Recommended Quality-of-Care Framework, 2001. It conceptualized the fundamental goals of the health system to three: optimal health for all, the responsiveness of the care provision and adequate financing. The WHO intrinsic goals are, however, too philosophical and aimed at universal rights (McQuestion, 2006).

The second framework is the Bamako Initiative. It identifies four quality of care components: effectiveness, efficiency, sustainability, and equity; and emphasised finance and economy. The Bamako Initiative was the strategy to self-finance primary health care in Africa (McQuestion, 2006).

The third is the Donabedian Model (1980, 1986, and 1988). It conceptualizes three quality of care dimensions: structure, process, and outcomes. The dimensions relate to each other in a linear, unidirectional manner (Donabedian Model, 2013); that is, the structure affects the process and subsequently affects the outcome. These dimensions represent three types of information that are collected to draw inferences about the quality of care in a given system (Donabedian, 2003).

The Donabedian Model was chosen for this study because it could conceptualise and define quality at many levels of the system; and have instrumental goals (Evans, Edejer, Lauer, Frenk, & Murray, 2001; McQuestion, 2006). This study had two instrumental goals: evaluation of client outcomes and the performance of the mental health services at UPsK. Once the quality is defined and goals targeted, then the assessment is possible.

The Donabedian model is the creation of Avedis Donabedian (7 January 1919- 9 November 2000) a physician and researcher at the University of Michigan (Mullan, 2001). He collated the literature on health services research from the 1950s and early 1960s. He presented his results in 1966 in a paper titled "Evaluating the Quality of Medical Care" in which he introduced the Donabedian Model. He later wrote 100 articles and 11 books on this model (Anderson et al., 2007; Donabedian, 2003; Donabedian Model, 2013).

The structure component includes all the variables involved at the beginning of health care delivery. These include the physical facility, equipment, and human

resources, as well as organizational characteristics such as staff training and payment methods. The process component is the sum of all actions that make up healthcare, including diagnosis, intervention/treatment, preventive care, and client education. The outcome component contains the results of the actions taken on the clients such as changes to health status, behaviour, level of knowledge as well as client satisfaction and health-related quality of life (Donabedian, 1980, 2003). It is important to note that outcomes are measured but not manipulated. The variability in outcomes is due to the manipulation of structures and processes. They are the independent variables, while the dependent variable is the outcome.

The Donabedian model fits well with the scientific model, so experiments and quasi-experiments are carried out on this model. It does not have an implicit definition of quality care, so problems of broad or narrow scopes can use the model. At the same time, the model allows researchers to draw connections between the three boxes (structure, process, and outcome) to create a chain of causation that is conceptually useful for understanding systems as well as designing experiments and interventions (Donabedian, 1980, 2003). Hence the value of the model.

Medical science, however, has not verified the relationships of the three-step approach suggested by Donabedian, despite a lapse of 30 years. Nevertheless, Donabedian maintained the three-step approach because of the belief that good structure increased the likelihood of an exemplary process and an exemplary process increased the likelihood of good outcomes (Donabedian, 1997). He supported the assumption suggested by Eislee, Slee, and Hoffmann in 1956 that each component can be a measure of a dimension or ingredient of care so when sufficient amount of information is available, it may permit the reconstruction of the whole (Donabedian, 1966). In other words, the components are either favourable or unfavourable to proper

care. Therefore, it is better to include in any assessment the components of structure, process, and outcomes. Using the three components allow the strength of one to compensate for the other' weaknesses.

Gardner, Gardner, and Connell (2014) cited Donabedian who said in 1988 the knowledge of structure and process should come from organisational sciences, the significance of the process and outcomes should come from behavioural sciences while the structural and outcomes should come from healthcare sciences. He suggested that the answer to this long-standing problem must come from outside the model.

The Donabedian model has evolved over the years. In 1998, Mitchell pointed out the limitation of the Donabedian Model. He proposed an alternative dynamic model, which incorporated the feedbacks that occurred among clients, the system (structure) and interventions (process) leading to the outcome. This model also extended the work of Holzemer, who suggested reciprocal directions of influence (Holzemer & Reilly, 1995; Mitchell, 1998).

In 1999, Coyle and Battles made a conjecture that many studies on the relationship between process and outcome were not conclusive because they did not take into consideration the antecedents of the clients. In 2004, Revere, Black, and Huq integrated Donabedian Model with 6 Sigma while Carayon et al. in 2006 incorporated engineering concepts into the model by introducing System Engineering Initiative for Client Safety (SEIPS).

Much of the past researches explored the Donabedian Model from the perspective of the non-linear model (Kunkel et al., 2007; Mitchell, 1998) while current research reexamined the original unidirectional model operating linearly. For example the study by Kobayashi, Takemura, and Kanda (2011). They used the Donabedian

Model to evaluate the quality of many aspects of nursing. Liu, Singer, Sun, and Camargo (2011) used the model to examine the quality of boarding in the emergency department, and Rademakers, Delnoij and de Boer (2011) used it to assess the client's perception of healthcare.

Malaysian health care quality. In 1991 the fifth Prime Minister, Tun Mahathir Mohamad introduced Vision 2020. It was a blueprint for Malaysia to achieve self-sufficient industrialized nation status by 2020 (Mohamad, 1991). The strategy to achieve Vision 2020 was to privatise, corporatise and decentralise government's held assets, including the health care sector. All these would lead to value for money, that is, the optimum combination of cost and quality to meet the user's requirement. It is possible to use the criteria of economy, efficiency and effectiveness to evaluate the health care facilities and services to see whether it is giving value for money (Jackson, 2012). The underlying assumption was that decreased government involvement would lead to greater efficiency, better quality services, and increased choice for clients (Braithwaite et al., 2011).

The government of the day consciously adopted a systematic approach to monitor and evaluate the quality of facilities and services. Government's commitment to evaluation was evident when in July 1996, the Public Services Department sent a directive to all government agencies to implement ISO 9001:2008, a standard for quality management system from International Organization for Standardization, into their core businesses (Ahmad, 2001; Asli, 1998).

In October 1997, the Ministry of Health with the collaboration of the Association of Private Hospitals Malaysia and Malaysian Medical Association, registered—Malaysian Society for Quality in Health (MSQH)—a non-profit organisation dedicated to improving the quality of the nation's health care through

voluntary accreditation. In 2009, MSQH was recognised as the sole accreditation body for health care facilities and services by Standard Malaysia (MSQH, 2010, 2012, 2016). Interesting to note, the government of Malaysia was proactive in developing quality standards in the health care system even before WHO's recommendation in 2000.

Client's Outcomes

The study focused on clients' outcomes; that is, the mental state of the client after undergoing psychological interventions. The outcome can be positive or negative. Positive outcomes are recovery or improvement from distress, and negative outcomes are no-change in distress level or deterioration (more distress) in the client as a result of the interventions the patients had undergone.

Psychological distress. Clients come to UPsK with psychological distress arising from many factors such as chronic health problems (NCD), socio-economic and stress-related problems. These are the most prevalent factors that explain the aetiology of psychological distress in the general population (Drapeau, 2012).

What is psychological distress, and how is it differentiated from common terms such as stress and distress? In the medical world, stress became well known when Hans Selye in 1956, conducted experiments on rats. He found that when harmful agents come into contact with a living being, a non-specific physiological response syndrome takes place. He called it stress syndrome or general adaptation syndrome (GAS), a biological concept. He coined 'stressor' as the causative agent in GAS and stress as the resulting condition.

In 1974, Selye maintained that stress, good or bad, is always present and without stress, there will be no life. Good stress is eustress, and bad stress is distress.

Murray and Huelskoetter (1987) supported Selye's hypothesis. He defined stress as "a physical and emotional state always present in the person because of living: it is intensified in a non-specific response to an internal or external change or threat, and it is not always negative" (p.374). Life will only be free of stress, on death, so it is an inherent part of life. Therefore, stress does not necessarily result in harm.

According to the online Merriam Webster dictionary, the word distress relates to physical or mental anguish or suffering ("Distress," 2014). Ridner (2004) quoted Cimprich, who in 1999 demonstrated that psychological threats such as anticipated cancer treatment could cause distress as readily as biological threats such as fatigue. Confusion of the meaning of stress and distress has been going on for years. However, as a result of his extensive experiments, Selye was able to define distress as "harmful, unpleasant stress."

Psychological distress is a word used in both lay and health-related literature (nursing, medicine, and psychology). Oncology nursing literature defined it as the "general concept of maladaptive psychological functioning in the face of stressful life events" (Abeloff et al., 2000). It occurs along a positive and negative continuum which means psychological distress can either produced personal growth or caused permanent harm to the individual. Masse (2000) conducted quantitative and qualitative studies on psychological distress. The qualitative results led to the identification of six idioms of distress such as (a) dishearten and pessimistic towards the future, (b) anguish and stress, (c) undervalue oneself, (d) social withdrawal and isolation, (e) somatization, (f) and withdrawal unto oneself. From the quantitative data, he developed the Psychological Distress Manifestation Measurement Scale.

Ridner (2004) made a summary of the working definitions of the terms: -

- Stress—non-specific biological response. The stressor may not be harmful.

- Distress—a non-specific biological or emotional response. The stressor is harmful.
- Biological distress—potentially harmful physiological changes that occur in response to a stressor.
- Psychological distress—emotional state experienced in response to a specific stressor that may result in temporary or permanent harm to the person.

Drapeau (2012) further clarified the definition as “emotional suffering” characterised by symptoms of depression (lost interest, hopelessness) and anxiety (tense, restlessness) and sometimes in the form of somatic symptoms. These symptoms are manifested physically in the form of headaches, lack of energy, or insomnia. Negative states of mind, such as feeling sad, depressed or anxious, are universal. However, the expression may vary in intensity and forms across and within a society based upon the cultural norms.

The clients who come to UPsKs are from diverse backgrounds in terms of ethnicity (Malay, Iban, Kadazan/Dusun, Chinese, Indian and others), socioeconomic status (SES) and age. It is a microcosm of the country – multi-ethnic, multicultural, multilingual society. The many ethnic groups in Malaysia maintained separate cultural identities (Kahn, 1998) and based on their belief systems, the perception of mental health also differs (Chong et al., 2013; Haque, 2005; Ng, 2007):

The Malays belong to the Islamic faith. Islam says the body (physical) and the soul (non-physical) make up the human being, and there are dynamic interactions between them (Haque, 2005). Purification of thoughts and actions bring a person closer to God (*taqwa*) and keep a person mentally healthy, but disobedience to God by doing *maksi'at* will bring mental imbalance.

Centuries-old animalistic beliefs and remnant Hindu traditions nevertheless still influence many Malay Muslims. Such as loss of '*semangat*' or soul substance, which makes them physically weak, '*angin*' or the wind in the stomach and in nerves that causes hallucinations and delusions, possession by the *jinn* that stays in the body, and '*santau*' or black magic leading to psychological problems. These cultural beliefs lead the Malays to seek guidance from traditional healers called *bomoh* or *pawang* who are considered possessors of hidden knowledge and can get rid of the possession and cure psychological illnesses (Haque, 2005).

The Chinese derived their symbol of life '*yin /yang*' from Taoism philosophy. It states that the imbalance between *yin* and *yang* will cause mental illness (Yip, 2005). A weak *yin/yang* makes the body vulnerable to psychological and physical illness, mainly when it affects the circulation of *ch'i* (air or breath). Abnormal emotions affect the *ch'i*, for example, anger causes *ch'i* to rise, joy relaxes it, sorrow dissipates it, and fear makes it go down (Haque, 2005). Another source of the mental illness is rooted in the primary allegiance to parents or family. The material achievement measures a son or daughter's self-worth that she or he brings to the family in terms of education, occupation and monetary gain. When the son or daughter fails to conform to behavioural norms and brings dishonour to the family, it will cause problems in his or her mental health, since there is no one else to blame but the son or daughter (Haque, 2005).

For the believers in Buddhism, a person's suffering is the consequence of previous misdeeds. Thus, the punishment for transgressions done by the person or their family members is the mental illness. Within this orientation, mental illness is declaring to society that a family member has done something immoral or mischievous in this life or the previous life—a shameful label—to the family (Yip, 2005).

The Indians, followers of the Hindu faith, believe that the mind (*sattva*), soul (*atma*) and body (*sharira*) make up the man. Physical and mental health constitutes an appropriate balance among these three entities, but when there is an imbalance in any entity, then diseases may arise (Haque, 2005).

The majority of Ibans in Sarawak are believers of Christianity and others are believers in the Iban religion which is the worship of four categories of being: the god and deities, the holy spirit, the ghost spirit, and the souls of dead ancestors. Other spirits such as *bunsu jelu* (animal spirits), *antu utai tumbuh* (plant spirits), *antu* (ghosts) such as *antu gerasi* (hunter) and *antu menoa* (place spirits like hills or mounts) may cause sickness or even madness. However, some may also be helpful. Even though they are Christians, the old age traditions still hold sway with the Iban community (Thiessen, 2008).

The majority of Kadazan/Dusun of Sabah are Christians (Battandier, 1907), the rests are Muslims and animist worshipers. Nevertheless, the influence of animist traditions, have woven themselves into the fabric of life such as the harvest celebration that gives thanks to the spirit of rice (Bambaazon), are still active and influential in shaping the Kadazan/Dusun life perspectives.

The Christians hold the worldview that mental disorders are due to natural causes such as typical life challenges and the result of wrongdoings by humans over which God has ultimate control, meaning that no illness can inflict man without the will of God. Genuine mental health is not possible without the right relationship with God (Haque, 2005).

The multiracial, multicultural and multi-linguistic composition of clients pose a challenge to the psychology officers who has to consider cultural factors in counselling to engage with clients authentically. The clients who come to UPsK may

present somatic symptoms which the psychology officer (counselling) must link to presenting psychological distress and culture (Drapeau, 2012; Haque, 2005). The understanding of cultural factors will facilitate counselling exploration in determining the emotional suffering, depression, and anxiety, experienced by the multi-ethnic client.

The client undergoes intervention for distress, and at the end, what is the client's outcome, and how was it measured? The CORE system uses Jacobson and Truax (1991) formula to ascertain the outcome. The formula states that a recovered client is one who has moved outside the range of a dysfunctional population into the range of a functional population. He/she is discharged. The client that increases in distress in the dysfunctional population has deteriorated. He/she is referred to a psychiatrist for further treatment. The client who shows improvement, i.e. less distress in the dysfunctional population or shows little change may continue with more sessions with the psychology officer (counselling).

Types of outcomes. In this study, the outcomes were categorized as recovered, improved, no-change and deteriorated. The definition of outcome has evolved throughout the ages, and the above are the current outcome categories. In 1992, Frommer, Rubin, and Lyle wrote the often-quoted definition of outcomes, in New South Wales Public Health Bulletin, as “change in the health of an individual, group of people, or population that is attributable to an intervention or series of interventions.” page 134. The earliest recorded use of outcomes in history was attributed to Florence Nightingale in 1854 during the Crimean War (Lee, 1912).

For Nightingale, the outcome was the deaths of soldiers, but surprisingly, the battle wounds were not the cause of death. To keep the number of deaths low, she imposed an intervention—a strict code of conduct on personal hygiene such as

handwashing (“Handwashing has been a central component of personal hygiene,” 2017) and sanitary environment (cleaned sewers and improved ventilation). The cause of death was unhygienic conditions, and when the standards of hygiene rose, the death rates fell sharply (Cook & Webb, 2002).

Another influential person in the history of outcome was Ernest Amory Codman (circa 1910) who systematically looked at the result of treatment, that is, outcomes. He created a client card that recorded every interaction that took place so that the client and mental health practitioner can evaluate the results of treatments (Kaska & Weinstein, 1998).

Another influential figure was a renowned public health pioneer, Avedis Donabedian (1919-1990), a Professor of Public Health at the University of Michigan. In a classic 1966 paper, he described three distinct aspects of quality in healthcare: outcome, process and structure (in that order in the original paper) and he postulated with some misgivings that "Outcomes, by and large, remain the ultimate validation of the effectiveness and quality of medical care." (Donabedian, 1966, page 169).

Traditionally the list of outcomes comprised the 5 Ds. They were death, disability, discomfort, and dissatisfaction (Bowling, 2002; Elinson, 1987). However, they did not per se show the connection between the process of care with outcomes (Lohr, 1988) since the measures were not specific to illness hence, did not lent insight to changing provider behaviours or improved processes of care.

In its purest form, the measurement of health outcomes requires the identification of the context (diagnosis, demographics) and to measure the health status before and after an intervention is carried out. The result, therefore, has a high probability that the change is related to the intervention. The health care industry must

measure outcomes to identify which treatments are most effective and provide the most benefit to clients (Kuhn, 2016).

Times have changed, and the level of assessment required is more (Lakeman, 2004). For example, the outcomes from an organization must consider variables such as service, product and revenue. Similarly, outcomes must consider service outputs such as length of stay or accessibility of service. The current global concern of outcomes is to incorporate positive indicators such as degrees of wellness, ability, comfort and satisfaction, which reflect the quality of life (Bowling, 2002). Measuring outcomes has returned to the original concept, that is, to measure the well-being of the client at the end of treatment (i.e., the product of medical care).

For this study on UPsK clients, the outcome chosen was the level of distress. The clients come to seek treatment for distress, and the outcome is the reduction in distress by the end of treatment. The client desires freedom from distress or at the very least, be able to manage their distress so they can function normally in daily living. Reduction of distress is the desired client outcome which is a reflection of the efficacy of treatment and the performance of the UPsK service.

The goal of measuring, reporting and comparing health outcomes is to achieve improvement in the client experience of care, improvement in the health of population and reduction in per capita cost of healthcare of outcomes (IHI, 2017). However, in practical quality assessment terms, outcomes are not necessarily better than processes of care. Lohr (1988) noted that in situations where outcomes were indirectly linked to specific medical practices, they offered little guidance for improving quality care. Similar reservations were echoed by Mant (2001) who warned that standardized outcome measures that took into account case-mix adjustments were worth using if they have the power to detect real differences in quality.

Lohr (1988) stated that timing and client-reported information are two critical factors when assessing outcomes. The outcome can be short-term (day, week or month), long-term (5-year) or anything in between. Take note that the longer the period of observation, the lower the connection between outcomes and processes of care because by then other extraneous factors affecting client and providers will weigh more heavily than the known or presumed linkages between outcomes and process.

The other consideration is client-reported information. A review by Davies in 1988 stated that people responded reliably to carefully constructed questionnaires and instruments. The current research maintains that patient-reported outcomes measure (PROM) (Frost, Reeve, Liepa, Stauffer, & Hays, 2007) and patient-reported outcome measurement information system (PROMIS) (Cella et al., 2010) have sufficient levels of reliability and validity to be considered seriously.

A special Journal Integrating Science and Practice edition [November 2012, 2 (2)] entitled *10 Tools for Progress Monitoring in Psychotherapy* showcased the launch of many popular outcome measures from both sides of the Atlantic in the early or late 1990s. Such as the Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM) (Evans, 2012), Integra/COMPASS Tracking Assessment System (Lueger, 2012) and Treatment Outcome Package (TOP) (Kraus, 2012). More than a quarter of a decade later, the usage of the outcome measure is still going strong (Wampold, 2016).

In the early years, there was no health status assessment for children and the elderly. Now there are children's mental health outcome measures such as Child and Adolescent Service Intensity Instrument (CASII) (Fallon et al., 2006), measure for childhood cerebral palsy such as Caregiver Questionnaire (CQ) (Schneider et al., 2007), and head injuries such as King's Outcome Scale for Childhood Head Injury

(KOSCH) (Calvert et al., 2008). For the elderly, there are outcome measures for pain level (Department of veteran affairs, 2003), coping psychologically and spiritually (Pargament et al., 2004) are some examples.

The types of outcome measure used for psychiatric treatment are based on theory and meant to detect specific conditions. The most frequently used outcome measures are Beck Depression Inventory (BDI); Depression Anxiety Stress Scale-21 (DASS-21); Patient Health Questionnaire-9 (PHQ-9), Hamilton Depression Rating Scale (HDRS) and Hospital Anxiety Depression Scale (HADS) (Mukhtar & Oei, 2011; Ng, 2013).

These specific measures are not suitable for screening and treating clients at UPsK. The screening tool to detect global distress (i.e. 'core' of distress) must have the characteristics of a-theoretical (unrestricted to any theory), short, possessing excellent reliability and validity. Only such a measure will fulfil the purposes of screening. Therefore, use appropriate outcome measure for specific assessment objectives.

Local outcome research. The local literature showed there are many medical studies on treatment outcomes. The recent study by Chen, Shafei, Aziz, Sidek and Musa (2019) showed a significant change in stroke outcomes such as declining number of stroke deaths since 2009, increased number of patients achieving functional independence and sex is a significant factor in stroke outcomes. A comparison study by Rajaram et al. (2019) on breast cancer patients from Malaysia and high-income countries showed how cultural and socioeconomic settings caused the differences in perception in critical patient-reported outcomes.

In mental health literature, particularly in psychiatry, many studies looked at psychological outcomes. For example, Mukhtar and Oei (2011) used outcome

measure to assess treatment for depression, schizophrenia (Chee & Abd.Aziz, 2014) and substance use disorders (Chemi et al., 2014) in psychiatric clients. The current practice is to combine pharmacotherapy with psychotherapy. Pharmacotherapy and psychotherapy individually are not able to produce sustainable outcomes (Karyotaki et al., 2016).

Non-psychiatric clients also suffer from distress. Periasamy et al. (2017) studied cancer patients who were distressed due to chemotherapy (oncological treatment), and the patients received therapy to ensure better psychological outcomes. A systematic review conducted by Abdul Khaiyom, Mukhtar and Tian Po (2019) on the treatment of anxiety disorders in Malaysian found this to be true. The combination of selective serotonin reuptake inhibitors and cognitive behaviour therapy was considered as one of the most effective treatment to treat clients with anxiety disorders in Malaysia.

However, there is little literature on the outcomes of patients that seek treatment from the counselling psychology services (UPsK) particularly by using standardized outcome measure such as CORE.

Assessment of quality and patient safety also use outcome measure. Jarrar et al. (2019) examined the effect of hospital nurse shift length and patient-centred care on care outcomes. They found that long shift hours did have an impact on quality and patient safety; however, the practice of patient-centred care mitigated that impact. Hence it was essential to have patient-centred care practice consistently carried out, and at the same time, to restructure the nurses' duty hours to accommodate changes.

Performance outcome was the basis for the evaluation of the medical delivery system. In 2009, Abdul Jalil, Sulaiman, Awang, and Omar did a retrospective study on multimodal chronic pain service which managed chronic pain clients in Universiti

Sains Malaysia Hospital. The study evaluated one-year pain outcomes among all newly referred patients of the multimodal chronic pain service. In 2013, Noor Azlina and Bahari analysed the service quality of a hospital based on patients' satisfaction. They used PLS-SEM to analyse the data. Sethi, Aljunid, and Saperi (2002) made a comparison between trauma services provided by three hospitals at different levels of care: district general hospital, tertiary care and central tertiary care. The outcome used was death or disability.

Similarly, there is little literature on the evaluation of counselling psychology services (UPsK) based on patient outcomes.

Routine outcome monitoring system. In the last decade, the focus has shifted to the implementation of outcome measures regularly, that is, to use it repeatedly many times in a systematic manner (regular intervals) during the treatment process (Boswell, Kraus, Miller, & Lambert, 2013; de Beurs et al., 2011; Wampold, 2016). Routine outcome monitoring (ROM) is an essential component of ongoing service-level quality improvement system by tracking progress so that adjustments are made in the treatment plans when necessary (Kelley & Bickman, 2009). In short, routine outcome measurement improves clinical practice (Bickman, 2010).

ROM benefits clients by improving therapeutic alliance with psychology officer (Carlier et al., 2012; Youn et al., 2012), the accuracy of diagnosis, and maintain the positive effect for more extended periods (Whipple et al., 2003). ROM also benefits psychology officer (counselling) by alerting 'off track' behaviours (Boswell et al., 2013), and outcome measure can accurately identify clients that deteriorate (Hatfield & Ogles, 2007). Refer to Table 2.3 to see the many benefits of using routine outcome measurement.

Table 2.3

Benefits of Routine Outcome Measurement

Benefits of routine outcomes measurement	
1	Can produce large scale aggregated data
2	Can identify hazardous interventions that are only apparent in large datasets
3	Can show differences between clinical services with a similar case mix.
4	Can compare different perspectives from clients and practitioners
5	Can track changes over time
6	Can discuss results with clients to show progress or otherwise

Gilbody, Wahlbeck, & Adams, 2002

Wampold (2016) viewed routine outcome monitoring as the most noteworthy advancement in psychotherapy in the last 25 years. Due to its effectiveness, many children and adolescent mental health services in Australia and New Zealand (Brann & Coleman, 2010; Pirkis et al., 2005; Slade, 2002), United Kingdom (Leach, 2005; Reese, Duncan, Bohanske, Owen, & Minami, 2014), Europe (Skre et al., 2013; Viliū Nienė et al., 2012) and Asia (Uji et al., 2012) adopted the use of ROM in the service.

The standardized outcome measures. Many standardized outcome measures are short, possessing excellent reliability and validity, has normative data from clients and non-clients', and are a-theoretical (unrestricted to any theory). Unlike the Beck Depression Inventory or Patient Health Questionnaire (Lueger & Barkham, 2010), which are outcome measures based on theory.

Many countries have implemented outcome measurement in their mental health services to assess and evaluate clients. Australia is considered one of the world's leaders in routine mental health outcome measurement and one of the early users of the outcome measure since 1992. The Australian health authorities have adopted four instruments; three completed by the mental health practitioner and one by the patient (Basis-32) (Eagar, Buckingham, & Coombs, 2001):

1. Health of the Nation Outcomes Scales (HoNOS).
2. Life Skills Profile (LSP-16).
3. Focus of Care (FOC).
4. Basis-32.

In the United Kingdom, the National Health Services (NHS) in 1999 established outcomes measurement as one of the initiatives for improving the quality of psychological services (NIMH(E), 2004). They used the Health of the Nation Outcome Scale (Audin, 2001; Jacobs, 2009; Wing et al., 1996). Another was the Clinical Outcome in Routine Evaluation (CORE) system (Barkham et al., 1998b; Barkham, Gilbert, et al., 2005; Barkham, Mellor-Clark, et al., 2010).

In the United States, routine outcome measures were 'rolled-out' across mental health services in entire states such as Ohio Mental Health Consumer Outcomes System (Brower, 2003). Other standard outcome measures used are Treatment Outcome Package (TOP) (Kraus, 2012) and Outcome Questionnaire-45 (OQ-45) (Lambert, 2010). In Europe, many countries used a variety of outcome measures suitable to the populace such as CORE-OM, HoNOS, and TOP, to name a few.

Outcome measurement is not a new phenomenon. The lack of an outcome measurement system in UPsK shows that the Malaysian health authority is outdated, lagging in current trends of assessment in the psychological field. It is therefore imperative to research the implementation and utilization of standardized outcome measurement system in UPsK because the evaluation, accountability, and proof of value for money are now international practices in many advanced countries around the world (National Quality Board, 2013; Western Australia Mental Health Commission, 2012). The Malaysian public, as stakeholders will soon demand assessment and accountability in public institutions. Therefore, the evaluation of

UPsK should be implemented sooner rather than later to be at par with international standards,

The researcher compared several standard routine outcome measures (ROMs) used around the world (Drapeau, 2012). Based on four variables: number of items, domains, users and translations. See Table 2.4.

Table 2.4

Comparison of Common Outcome Measures

Outcome Measure	Items	Domain	User	Translation
HoNOS (Health of nation outcome scales)	12	Psychiatric symptoms, physical health, functioning, relationships :	Psychology officer	English, European languages, Korean and Thai
CORE (Clinical outcome in routine evaluation)	34	Subjective well-being, Problem/symptoms Functioning and Risk	Client and psychology officer (CORE Assessment forms)	22 languages
OQ (Outcome questionnaire)-45	45	Anxiety and depression, interpersonal, and life functioning	Client	30 languages
Basis-24	24	Problems/Symptoms, Functioning, Psychosis, Self-harm	Client	5 languages
Integra/COMPASS	68	Subjective wellbeing, Problems/symptoms, Functioning	Client	4 languages
ORS (Outcome rating scale) & SRS (Session rating scale)	8	Functioning, therapeutic alliance	Client	18 languages

Drapeau, 2012

The first characteristic of a good outcome measure is, it must be brief because clients will turn away due to the sheer number of items (Hanley et al., 2011; Reese et al., 2014). Secondly, it can provide context to the client's conditions. Youn et al.

(2012) warned that misinterpretation of the results of the standardized assessment could occur when there is no context given, that is, lack of information about the situation in which change happened. Decisions based on such results may lead to inaccuracies; hence it is prudent to have more than one source of information (Youn et al., 2012). Thirdly, it must have utility features to create benchmarks.

The chosen outcome measure was CORE-OM. This outcome measure is brief and has two sources of information concerning the client—CORE-OM and CORE Assessment forms. CORE-OM collects clients' self-report on past week's emotional and psychological state. At the same time, CORE assessment forms provide the contextual information such as presenting problems, type of therapy given, number of sessions and more. Both CORE-OM and CORE assessment forms complement each other. They presented a detailed and comprehensive evaluation of the mental state of the client during the intervention.

The advantages of CORE-OM over existing outcome measurements were: -

- Brief (34 items), user-friendly, reading ease (fifth grade), and high client compliance (CORE IMS Ltd, 2014)
- Has normative data for clinical and non-clinical populations allowing clinically significant change to be determined (CORE IMS Ltd, 2014).
- Can build up comparative outcome dataset to complement research efficacy data (CORE IMS Ltd, 2014).
- Can supply a range of reports such as individual practitioner feedback, practice feedback, service feedback, domain feedback and symptom group feedback (CORE IMS Ltd, 2014).
- Can compare service with other services who had used CORE-OM because its measures are standardised (like with like basis) (CORE IMS Ltd, 2014).

- Standardized outcome measures have credible psychometric properties (Anker et al., 2009; Kraus et al., 2010; Mazranzouli et al., 2013) and proven track records of monitoring psychological progress.

The next discussion is philosophical concerning the nature of knowledge. It is part of an ongoing debate about whether routine outcome measurement is practice-based evidence or evidence-based practice (Barkham, Hardy, & Mellor-Clark, 2010; Green, 2008)?

Routine outcome measurement is part of practice-based evidence. In psychotherapy, two questions are often asked “does psychological therapy works?” and “which works best?” Many confounding variables are responsible for psychological changes in clients such as treatment, life events, personality development, and many more. The confounding variables make it difficult to put up a single factor responsible for the change because some mental health problems improve without any treatment, that is, they undergo “spontaneous remission” only due to the passage of time. In this case, time is said to be confounded with treatment (Bower & Gilbody, 2010).

It is necessary, therefore, to use experimentation to prove causality where confounders are removed or controlled. Hence randomized controlled trial (RCT) is considered the gold standard for evidence-based practice. In an experiment, the significance of the confounders is diminished by control, comparison, and randomization. The ensuing results point to causality, and because of the rigorous steps that are taken, there is high confidence in its internal validity.

However, Bower and Gilbody (2010) inferred the existence of tensions in evidence-based practice. An example of tension is financing. It requires a substantial financial capability to conduct a random controlled trial (RCT). Only well-known

therapies such as cognitive behaviour therapy (CBT) and interpersonal therapy (IPT) have undergone randomization evaluation. In contrast, many little-known therapies have not been evaluated because of insufficient resources or little professional impetus to fund extensive research.

Another tension is the incongruency between what goes on in RCT (controlled treatment, setting and client) and what happens in a standard healthcare setting. The extensive control imposed in RCT raises doubt that such conditions can be generalized to another context/setting (Cook & Campbell, 1979); hence the external validity of RCT is suspect. There are valid doubts that regular practice may not be able to replicate such controlled conditions.

In a typical health care setting, the client will be self-referred, comes with multiple, complex problems and may also have other treatments at the same time. Therapists with a wide variety of experience and skill will use a variety of therapeutic strategies rather than stick to one approach. The typical characteristics of clients and practitioners in everyday clinical practice are the antithesis of RCT. Therefore external validity remains a crucial weakness of RCT, and it has raised concerns about the limitation of RCT to evaluate the real-world clinical practice (Cook & Campbell, 1979).

A robust counter-response from the community of evidence-based practice has been the “pragmatic RCT” where the inclusion criteria are broadened to reflect the type of participants that will use the intervention in the real world (Bower & Gilbody, 2010). Nonetheless, such RCT is few and far between in psychological therapies, even though when applied, it has been successful (Naylor, 1995).

A complementary paradigm to evidence-based practice which addresses many of the above concerns is that of “practice-based evidence” (Barkham & Mellor-Clark,

2000). This paradigm uses empirical evidence derived from routine practice settings rather than efficacy studies. Empirical evidence comes from the practitioners (in practice settings) who give interventions daily based on their subjective and personal experiences. When these data are collected systematically, it becomes “practice-based evidence” (PBE). In the real world practice, variables are documented and measured, just as it occurs, ‘warts’ and all (Swisher, 2010). Evidence-based practice (EBP) research does not give credence to these uncontrolled interventions. Nonetheless, they have impacted clients’ outcome.

Practice-based evidence does not answer the typical RCT question of “does x cause y” but instead answers another question “how does adding x intervention alter the complex personalized system of client y?” (Swisher, 2010) Hence the process of measurement and tracking matters must be rigorous to make the results reliable and valid so that practice-based evidence can complement the EBP research.

Two key elements become central to the practice-based paradigm: effectiveness and practice. The effectiveness element addresses the generalizability of results across services and settings. It does not provide reliable causal attribution, but it locates the outcome of service within the range of data from other services. The practice element addresses the agenda of analysing results within a service. It can drill down into the data to ascertain individual differences (Evans, Connell, Barkham, Marshall, & Mellor-Clark, 2003).

There are three components of practice-based evidence (PBE). See Table 2.5. Traditionally two components (service audit and routine monitoring) were in the form of narrative reports with self-reflection or cross-linkage to other data or collected in-house quantitative data for local audit and managerial purposes. They were of limited

value, however, since the information was not reported in the research literature and more importantly, they lacked generalizability.

Table 2.5

Components of Practice-Based Evidence

Component	Scope
Service audit	Designed to monitor service activity against service standards and make recommendations
Benchmarking	Benchmark against comparable services Measures used before and after the intervention.
Routine outcome monitoring	Develop methods to 'track change' during the intervention period

The practice-based evidence has incorporated the concept of quantity/mass to increase the value of the data. When many services agree to collaborative activities such as the use of standard measuring tools and utilization of the data (collated) to provide large or national referential datasets (Barkham et al., 1998; Evans et al., 2003), then the mass element is achieved. Having a referential dataset puts things in context and allows services to see which way they differ from other services. The large volume provides better prediction at the level of the individual case; however, be cautious that large databases may produce statistical significance which is of little clinical relevance (Margison, 2000).

The extensive data (e.g., $n=12,000$) from a varied number of primary care-based psychological therapy services create benchmarks (i.e., the second component of PBE). These benchmarks reflect the practice of participating services involved in the data collection (Evans et al., 2003).

Stewart (2009) stated that RCTs are not the only source of evidence (despite being the gold standard for EBP) since it has intrinsic scientific vulnerabilities in the field of psychological therapies. Equally, practice-based evidence (PBE) is limited in

its methodology and implementation. Veerman and van Yperen (2007) stated there need to be a collective effort between practitioners and researchers to yield “the practice-based evidence needed to establish solid evidence-based practice” p 219.

In short, evidence-based practice is the process of disseminating the best information in practice while practice-based evidence asks “has the right thing been done and has it been done right?” (Parry, 1992). The origin and evolution of practice-based evidence are proof that this paradigm is rigorous in its validity and reliability so that it is scientifically credible and a worthy complement to evidence-based practice (Swisher, 2010).

Routine outcome measurement (ROM) and in particular, Clinical Outcome in Routine Evaluation (CORE-OM) comes from within this traditional debate. They lie in the realm of practice-based evidence, and CORE system possesses many of the components of practice-based evidence such as routine outcome monitoring, benchmarking and service audit items.

Clinical Outcome in Routine Evaluation (CORE)

It began with a little-known psychotherapy researcher in 1975, Irene Elkin Waskow. She wrote a seminal work “*Selection of a core battery*” in which a core set of outcome measures could be adopted in all studies of psychological therapies and therefore bring coherence to research in clinical outcomes (Waskow, 1975). The work of Elkin provided the initial impetus for the development of what eventually became the CORE-OM. In contrast, the work of Codman provided the context of quality assurance of psychological therapy service delivery (Barkham, Mellor-Clark, et al., 2010). In the U.K. before 1994, the outcome measures used were either ‘homegrown’ or imported from the U.S., which was an expensive and required adaptation to suit local needs (Barkham et al., 2006). Hence there was a need for a short and ‘free’

outcome measure. The initial funding from the Mental Health Foundation (MHF) yielded a client/client-completed measure called Clinical Outcome in Routine Evaluation-Outcome Measure (CORE-OM). See Appendix A. The CORE-OM was later complemented by the practitioner/psychology officer-completed forms which were funded by Counselling in Primary Care Trust and Leeds Mental Health Teaching NHS Trust. The forms provided additional contextual information about the presentation of the client from the perspective of the practitioner/psychology officer (Barkham et al., 2006).

The combination of the client- and practitioner/psychology officer-completed forms filled up at pre- and post-therapy became a coherent system known as the CORE System. It can profile the delivery of counselling and psychological therapies as well as capture service data that can be combined across services to yield evidences that are relevant to health authorities and researchers.

The CORE-OM was designed as a non-proprietary measure of global distress (CORE IMS Ltd, 2014) and not for specific psychological disorder; therefore, it becomes a flexible tool to measure distress in any capacity. For example, it can be a screening tool and an outcome measure. It is generic, and it measures a pan-theoretical 'core' of clients' distress in four domains. The domains are (1) subjective well-being, (2) symptom/problem, (3) functioning, and (4) risk. In literature, subjective well-being consists of a combination of two broad lines of research on positive emotions and positive functioning (Ryan & Deci, 2001). The four domains are compatible with the Phase Model by K I Howard et al. (1993).

In the Phase model, the client will first experience enhanced subjective well-being. Such as less fearful, less overwhelmed by problems, more optimistic, feel-good. Secondly, the client will be able to handle the symptoms brought by the

problems, such as less tension, anxiety, panic, and intrusive thoughts and memories, respectively. And the definite increase in energy and better sleep. The final phase is to have lasting changes in life functioning such as feel supported, enhanced coping, closeness to others, feeling capable and being able to cope with criticism and shame.

Many studies has proven that CORE-OM is successful in many types of sample: in a general population sample (Connell, Barkham, & Mellor-Clark, 2007), large samples in primary care (Evans et al., 2003), in secondary care settings (Barkham et al., 2001), and with older adults (Barkham, Culverwell, Spindler, & Twigg, 2005).

Determination of change. There is growing recognition that traditional methods of determining reliable and clinically significant changes using standard inferential statistical tests are problematic (Jacobson, Follette, & Revenstorf, 1984). Traditionally the differences in the means indicate treatment effect; however, there is a statistical limitation since it does not show the variability of response to treatment and secondly, the treatment effect is not the same as being clinically significant (Jacobson & Truax, 1991). In short, it may prove that the treatment has an effect but is it clinically significant?

According to Jacobson and Truax (1991), the clinical significance of treatment refers to its ability to meet standards of efficacy set by clients, clinicians and researchers who expect the treatment to accomplish specific goals. There is little consensus, however, on what the standards are. Some of the criteria put forward by researchers are (a) level of change (Jacobson & Truax, 1991), (b) elimination of presenting problems (Wolf, 1978), (c) normative levels of functioning at the end of therapy (Kazdin & Wilson, 1978), and (d) high end-state functioning at the end of therapy (Mavissakalian, 1986).

Conventional statistical comparison between groups tells little of the efficacy of the psychotherapy treatment. Even effect size is not sufficient and may also be misleading (Jacobson, Follette, & Revenstorf, 1984). Jacobson and Truax (1991) proposed a universal method that will define clinical significance in treatment. It serves three objectives: define a clinically significant change in any disorder; can be used by lay and professionals, and finally has a precise method to classify clients as changed or unchanged.

Jacobson and Truax (1991) defined clinical significance as “the extent to which therapy moves someone outside the range of the dysfunctional population to within the range of the functional population” page 13. In other words, the client at the beginning of therapy is in the dysfunctional/clinical population and on leaving therapy is in the functional population. The pivot of Jacobson and Truax (1991) method is the cut-off point.

Cut-off point. The cut-off point is the point where the client crossed over a specified point that differentiates the clinical from the non-clinical. It is then classified as changed to a clinically significant degree. At that point, the changed client lies outside the range of dysfunctional/clinical population into the range of functionality (Nietzel & Trull, 1988). The cut-off point value defines the end of everyday stress and the beginning of unhealthy distress. The client that began in the clinical range, which then crossed over this line/value into the normal range would be classified as having had clinically significant change or in other words, experienced recovery.

Evans et al. (2002) found the cut-off points for male and female are not the same in the clinical and non-clinical population. However, the differences between male and female in the clinical and non-clinical are significant but small. Suggesting that gender is significant in individual scores, but the effect of gender is small when

compared to the effect of clinical versus non-clinical populations. More recent work (Connell, Barkham, & Stiles, 2007) has established a new cut-off score of 10 between the clinical and non-clinical population that applies to both men and women. CORE system uses the clinical score of 10 as the cut-off point (Barkham et al., 2006; CORE IMS Ltd, 2014). This study also used the cut-off score of 10.

The next consideration is reliability, namely the extent of change required in order for someone to make a meaningful improvement and not by chance. Two components are central here: clinically significant change and reliable change.

Reliable and clinically significant change. Reliable change is the extent of change in a measure that is not due to chance or measurement error (Barkham, Mellor-Clark, et al., 2010; Chris. Evans et al., 2002). The client must make changes greater than five clinical scores to be confident of a reliable change. The movement of 5 scores can be in either direction, that is, positive or negative.

Positive direction implies that the client is improving, that is, showing less distress (post score is less than the pre score). Clients with these scores are in the improvement category. On the other hand, a negative direction implies the client is deteriorating because of the increased in distress (post score is > pre-score). Clients with these scores are in the deterioration category. The reliable changed scores of more than 5 points show real change, not fluctuations of imprecise instrumentation. It is essential to have reliable change because without reliability any results produced cannot be trusted because it is not stable. For example, a client scored 12 at pre and nine at post-testing. The client has crossed the cut-off point, but the scores between them were only four positive scores. The number of scores was less than five positive scores expected of a reliable change; hence, this client did not experience reliable

clinical significant change even though he/she has crossed the cut-off point. This client is in the non-reliable change category.

Recovery occurred when the client crossed the cut-off point (clinic score of 10) by more than five positive scores (reliable change). Recovery is a clinically significant change. Recovery occurred when reliable change and clinically significant clinical change happened at the same time. In other words, the client has moved from the clinical band into the non-clinical band by five or higher scores in a positive direction. Such clients are in the recovery category. There are four outcome categories in the CORE system (Mullin et al., 2006). See Table 2.6.

Table 2.6

Categories of Client Outcomes Based on Statistical Change

Value	Change
> +5	Reliable change - Improvement
> -5	Reliable change - Deterioration
< 5	Non-reliable change
Cross cut-off point by > +5	Clinically significant change – Recovery

CORE assessment forms. Two assessment forms complement the CORE-OM by providing information on the client and the service. The psychology officer completes the first form, Therapy Assessment Form (TAF), after the initial session. See Appendix B. It provides information about the client such as demographics, family support, presenting difficulties, and service information such as waiting time, number of sessions, type of termination.

The psychology office completes the second form, End of Therapy form (EoT), at discharge. See Appendix C. It collects information on types of therapy, review risk and presenting problems, as well as client context such as motivation, working alliance and psychological mindedness.

The CORE assessment forms have several advantages over client-reliant methodologies (CORE IMS Ltd, 2014) such as:

- Profiles client. The psychology officer completed two forms (TAF and EoT) for each client.
- The form collects data on audit items. The items collected are waiting times, referral, non-attendance rates (TAF and EoT). To inform and enhance service efficiency.
- The form collects data on psychological problems, that is, the presenting and emerging problems using the International Classificatory system 10 (TAF and EoT) as well as to profile service population.
- The form collects data on the benefits of therapy. (EoT) as well as to profile outcomes for unplanned endings.
- The form collects data on therapy descriptors such as therapy type, duration, and frequency (EoT). To profile service, practitioner-rated outcomes, and to contextualise client self-report.
- Allows CORE-OM to concentrate on clients' psychological state.

The UPsK study focused on specific aspects of the assessment forms that described the service provided by the UPsK as well as documented the clients' context during treatment. It looked at types of therapy, service (waiting time) and client's context.

Types of therapy. The types of therapy used in UPsKs that were recorded by CORE assessment forms were six: (1) structured brief (2) cognitive, (3) behavioural, (4) person-centred, (5) integrative, (6) cognitive-behavioural. Commonly used were brief therapy, cognitive behavioural and person-centred therapy. Out of the three, the most popular is brief therapy. Brief therapy is an umbrella term for a variety of

approaches to short-term, solution-oriented psychotherapy (Bandler, 1993). Its emphasis is on the specific problem but not on the causes of that problem: instead, it focuses on the factors that sustain the problem and prevent change (de Shazer, 1994). In brief therapy, the psychology officer (counselling) works actively with the client to treat the clinical conditions. There are many types of brief therapy, such as single session therapy (Paul & Van Ommeren, 2013) and walk-in counselling session (Slive & Bobele, 2012). Single session therapy (SST) is a specific form of therapy conducted by professionals to address clients' presenting concerns within one session (Paul & Van Ommeren, 2013; Urrego et al., 2009). In emergencies, such as natural disasters and man-made disasters (armed conflicts), this single session may be the only option available, and it has been successful.

The Emergency and Trauma Department, in state and specialist hospitals, has One-Stop Crisis Centre (OSCC) where a sizeable multidisciplinary crisis intervention team help survivors of domestic violence, sexual assault, child abuse and neglect (MOH, 2015). The psychology officers (counselling) from UPsK are part of this team. They provide mental health services and practised single-session therapy (SST).

In the End of Therapy form (EoT) the psychology officer (counselling) will tick the therapies used to treat the clients. Many ticked structured/brief therapy, cognitive behavioural and person-centred therapy; however, none ticked integrative. An American study revealed that few practitioners used a single orientation in the treatment plan (Cook, Elhai, Coyne, Biyanova, & Schnurr, 2010). Karademas (2009) showed counselling psychologists chose an array of intervention strategies and techniques (brief therapies, crisis intervention, stress management, motivational interview, guided imagery, behaviour analysis and modification, cognitive restructuring) to achieve their intervention goals.

In the integrative psychotherapy movement, whose purpose is to develop a new framework for dialogue among different approaches (Feixas and Botella, 2004), there are four possible approaches to integration: theoretical integration, technical eclecticism, assimilative integration and common factors approach (Zarbo et al., 2016). The least theoretical of the four is technical eclecticism. It seeks to select the best treatment for the client and the problem without subscribing to the theories that spawned them (Norcross et al., 2019). The busy psychology officer (counselling) will likely take up the technical eclecticism approach since he/she has no time to dissect theories.

The cognitive-behavioural model is the basis for many of these short-term techniques and strategies since the model is effective in treating mental health conditions. Medical clients are known to be interested in short-term and focused interventions that can facilitate their recovery rather than long-term insight-oriented therapies (Carmin & Roth-Roemer, 1998; Karademas, 2009).

Service. In this study, the general term 'service' includes audit items such as appointment (waiting time), number of sessions, and the manner of terminating treatment (planned or unplanned ending). The number of intervention sessions is a contentious matter, currently being debated among researchers and practitioners, especially with the advent of the popular brief therapy. Many factors contribute to successful therapy, such as therapist-influenced and client-influenced factors. Asay & Lambert (1999) estimated that only 45% could be contributed to therapist-influenced factors (therapeutic relationship, model and techniques) while the remaining 55% comes from the client and extra-therapeutic factors.

For example, a highly motivated client comes for a walk-in counselling session and at the end shows improvement. The client shows improvement because he/she is

ready to change (Slive & Bobele, 2012). Such brief therapy taps into a client's sense of hope, mobilising his motivation and capacity to engage in the therapeutic process (Larsen, Edey & Lemay, 2007). It is common for clients to make dramatic initial improvements at the beginning of therapy experience, but show declining improvement as the number of therapy session continues (Bloom, 2001; Howard et al., 1986).

The literature showed that there is a relationship between service audit items and outcome, for example, the relationship between types of treatment and rehospitalisation (outcome) by Carlson, Speca, Faris, and, Patel (2007). A similar study with screen-detected-type 2 diabetes clients. They found quick appointment dates lead to early treatment, which influenced clients' psychological outcomes (Thoolen et al., 2006). The overall perception is that the service audit item (waiting period) does influence outcomes.

Context. In this study, context refers to the client's motivation, psychological mindedness and working alliance with the psychology officer. These items are at the End of Therapy form (EoT). These items reflect the state of mind of the client during the intervention, such as motivation to change, the willingness to work with the therapist (working alliance) and the ability of the client to self-reflect and gain personal insight (Conte et al., 1996; Hall, 1992).

In 2014, Mason, Goodman, Chabac, and Lehert did a study on the role of motivation in the outcome (abstinence) of alcohol-dependent clients. The experimental group was treated with FDA-approved medication to maintain abstinence following alcohol withdrawal while a control group received standard medication. The study suggested that clients who are motivated to abstinence will find

the FDA-medication useful. Such studies (Peiters & Heilemann, 2010; Ryan et al., 2010) show that motivation affects the outcome.

Psychological mindedness is an abstract construct and requires a complex definition. A person is psychologically minded if she or he can access feelings, open to new ideas, willing to try and understand oneself and others, and has an interest in the meaning and motivation of his or her own and other's behaviour (Rai & Mathew, 2015). Psychologically minded persons are receptive to the self-evaluative process.

McCallum, Piper, OgrodniczU.K., and Joyce did a study in 2003 on the effect of psychological mindedness on the outcome. They found significant direct relationships between psychological mindedness and favourable outcome. In another study by Masuda and Wendell (2010), mindfulness was a partial mediator in the relationship between disordered eating-related cognition and two predicted variables.

There is still much debate on the nature of psychological mindedness, such as is it constitutional or acquired, can psychological mindedness increase through training? Much is still exploratory (Rai & Mathew, 2015). Working alliance is the commitment of the client to have a relationship with the psychology officer to work out his or her psychological problems (Ardito & Rabellino, 2011).

Assessing Service Performance by Benchmarking

The evaluation of hospital services began in 1997 when the Malaysian Society for Quality in Health (MSQH) started accreditation standards for hospital. Later in the early 2000s, the government introduced audit standards by the International Organization of Standardization (ISO) into government hospitals (Ismail Ahmad & Roslan Johari Mohd Ghazali, 2004). In 2017, the 5th Edition of the Malaysian Hospital Accreditation Standards (MSQH, 2017) laid down specific standards for

counselling psychology unit—Service Standard 17 I. Please refer to Table 1.1 on page 6. The table shows Service Standard 17 I has five areas of interests.

Standards 17 I.1 up to 17 I.5 deal with the organisation, management, policies, facilities, safety, and continuous quality improvement of the counselling psychology service. The main focus appears to be structural (I.1 – I.3), processes (I.4) and outcome (I.5). On closer examination, the sub-topic 17 I.5 is not specific to the outcome but rather to activities to ensure quality improvement with some references made to assessing outcome. The statement:

There is tracking and trending of specific performance indicators not limited to but at least two of the following: (a) the percentage of clients registered for counselling and discharged from the programme, (b) percentage of clients requiring for further management—page 19 of 21.

Currently, MSQH does not refer to the client's mental health outcome (MSQH, 2010, 2012b, 2017). There is no reference to the percentage of achievement desired for specific targets, unlike other units such as Radiology. For example, in Standard 14.5.1.8 Radiology part (vii). It states "Percentage of patients with waiting time ≤ 60 minutes for the commencement of ultrasound examination (Target: $\geq 80\%$)." In the latest 2017 MSQH standard 17 I there is no mention of a set target for client outcomes for counselling psychology service.

The psychology officers (counselling) recorded their cases by keying information into KES Management System (KMS). It is a national management system for the psychology officers (counselling) created by the Ministry of Health to monitor the psychological cases attended to by the psychology officers (MOH, 2020). The system recorded client numbers, demographics, presenting and identified/underlying psychological problems, and the number of sessions carried out.

Also, it recorded the psychology officer's work scope in maximizing potential and mitigating distress amongst staff.

Apart from KMS, the psychology officer must also key in clients' information into the hospital patient registration database, i.e. the Hospital Information System (HIS). The psychology officer (counselling) provides updates on the psychological state of clients via HIS. However, only 15% of the Ministry of Health's hospitals have implemented this system, so many psychology officers do not use it (Ismail et al., 2015). They concentrated on KMS.

Staff performance is evaluated based on the annual work targets [*sasaran kerja tahunan* (SKT)] approved by the Head of Unit. There are general and specific targets to accomplish, which then become the key performance indicators (KPI) on how well the psychology officer (counselling) is performing at work. According to the Service Circular Letter, no 8/2011 the officer must reach a minimum 75% to achieve the category "On Target" (OT) and consequently be eligible for annual salary increment. The psychology officers must achieve their KPIs to ensure reasonable performance rating above the minimum of 75%.

SKT does not make any reference to an officer's work performance based on patient outcomes. Even though that is the core business of UPsK, that is, treating the clients to achieve desired outcomes. Having a significant number of patients recovered or improved are reflective of the work of a competent psychology officer (counselling). However, due to the lack of outcome measurement system, it is not possible to link service performance to outcomes, and thus conditions and practices remain as they are. Muthu, one of the psychology officers selected for the interview phase of the study, succinctly summed up the lack of linkage between service performance and client outcomes in UPsK. He said:

The hospital management wants to know how many cases per month. Numbers only. With numbers, how do you expect to improve? Outcomes not asked at all! First, improve and look at the effectiveness of the service. Secondly, what improvement can be made? Thirdly, what new things can we introduce to UPsK? In conclusion, every unit must be assessed for quality management. We should not talk about quantity only. Quantity without quality is not right. At the moment, only quantity is asked (Muthu: 1 page 13).

Benchmark and matrix. The word benchmark in daily use means “A standard or point of reference against which things are compared” (“Benchmark,” n.d.). The concept of benchmarking used in health care comes from industry, and it has a structured approach for the compilation of comparative data between organizations which then support realistic development (Codling, 1992).

Benchmarking has been used in the mental health care system for some time now (Evans et al., 2003; Mellor-Clark, Twigg, Farrell, & Kinder, 2012). In clinical practice, the idea of a benchmark is to provide the structures for comparison and sharing by using all levels of evidence to achieve a professional consensus of best possible practice (Ellis & Morris, 1997). Ellis further elaborated in 2006 that benchmarking in health care involves a sustained effort to measure outcomes, compare these outcomes against those of other organizations to learn how those outcomes were achieved, and to apply best practices (Ettorchi-Tardy et al., 2012).

Benchmarking is best used in an environment that focuses on quality improvement system. It is an essential part of a comprehensive and participative policy of continuous quality improvement (CQI) and the valuable information obtained are acted on by the corporate/management level (Lueger & Barkham, 2010). Benchmarking appears to produce the most positive impact on continuous quality improvement (CQI) (Lueger & Barkham, 2010) and creates a spirit of competition to apply best practices (Ettorchi-Tardy et al., 2012).

Benchmarking as a practice will not feel out of place in the Malaysian hospital environment. The Malaysian government has started, since the 1980s, concerted efforts to improve public service by emphasizing quality management in the public sector (Karim, 1994). The Malaysian Administrative Modernisation and Management Planning Unit (MAMPU) issued directive through the Public Administrative Development Circular No. 1/1992 entitled “Guidelines for Total Quality Management in the Public Sector” to all government agencies. Henceforth the implementation of quality management became mandatory for these agencies, including the government hospitals.

The Ministry of Health (MOH) developed many quality improvement programmes such as Quality Assurance Programme (QAP) in 1985, Clinical Practice Guidelines (CPG), incident reporting, nosocomial infection control, Peri-operative Mortality Review (POMR), Quality Circles, and clinical audit (Noor Hazilah Abdul Manaf, 2009). The current study about benchmarks is in alignment with the efforts of the MOH.

The empirical literature on continuous quality improvement and benchmarks, however, has not always produced positive predictive results. Whether due to limited effect size, the insufficient power of the study, or failure to implement the intervention as designed is not well established (Ackerberg et al., 2006; Lueger & Barkham, 2010; Solberg et al., 2001).

The UPSK study was interested in internal benchmarking, that is, examining the rates of change of each outcome category and determining the benchmarking values for each category. The study followed the work of Barkham et al. in 2001. His study examined the percentage of patients who maintained excellent outcomes from year to year. Although there are many studies done, yet it is difficult to predict the

variables that replicate across studies. One significant predictor is the alliance between psychology officer (counselling) and client; another is the increased sense of hope early in treatment, agreement on therapeutic goals, agreement on termination and the presence of social support from significant other.

In the U.K., the CORE System Trust has aggregated clinical outcomes data on large samples of clients serviced. The data have been used to benchmark a range of service variables such as planned/unplanned endings (Janice Connell et al., 2006; CORE Partnership, 2011c), waiting times (CORE Partnership, 2011f; Trusler et al., 2006), risk assessment (CORE Partnership, 2011e), recovery and improvement rates (CORE Partnership, 2011d; Mullin et al., 2006), and completion rates (Bewick et al., 2006; CORE Partnership, 2011b).

According to Mellor-Clark & Barkham (2012), the benchmark for improvement and recovery rates are reflective of the domain of effectiveness. See Table 2.7. For a long time, researchers and health practitioners have considered outcomes of counselling as one of the factors to evaluate the effectiveness of the intervention (Mullin et al., 2006).

This UPsK study evaluated the quality of service by creating benchmarks based on recovery, improvement, no-change and deterioration rates. It involved pre-and post-therapy changes, statistical definition of change as statistically reliable improvement or deterioration, and clinically significant change. The outcome measurement system used was the Clinical Outcome in Routine Evaluation (CORE).

Table 2.7

Domains and its Relevant Benchmarks

DOMAIN	BENCHMARK
Overall service	Assessment outcomes
Accessibility	Waiting times
Acceptability	Unplanned endings
Effectiveness	Improvement and recovery rates
Safety	The risk to self and others
Efficiency	Quality of outcome data
Equity	Local demographics

Mellor-Clark & Barkham, 2012

There are complex and sophisticated methods for benchmarking such as Nearest Neighbour (NNN) and Growth Mixed Method (GMM) models (Leach & Lutz, 2010) but CORE developed a straightforward method. CORE system defined a common reporting framework that identifies a set of performance indicators (recovery, improvement or deterioration) to compare and contrast relative service performance (Mellor-clark, Jenkins, Evans, Mothersole, & Mcinnes, 2006). CORE system used percentiles to represent the rates of change in the outcome categories—moreover, these percentiles (25th, 50th and 75th)—are colour-coded following the traffic light colours of green, yellow, amber, red.

In 2006, Mullin and her team collected extensive outcome data from multiple settings to establish benchmark values for overall service, effectiveness, efficiency, accessibility and acceptability. The extensive data set comprised more than 11,000 clients/clients from 32 primary care NHS services who completed the CORE-OM at both intakes and discharge. They focused on recovery and improvement categories and calculated benchmarks for individual practitioners by making simple adjustment for case-mix.

CORE Partnership (2011d) published follow-up data to the Mullin et al. (2006). This data set comprised of 26,467 clients from 35 services. In 2006 the benchmark for recovery category was an average rate of 55%, in the top 25% of the service, i.e. high recovery was 58% or more. In 2011, the average was 50%, and high recovery was 57% or more. There was no significant shift in the percentage rate of change in recovery and improvement over the years.

CORE System further created a unique national research database (NRD) where services collectively pool anonymous data. The purpose is to develop and evolve a set of comparative service quality indicators—benchmarks—designed to help members explore the performance of their service and individual practitioners within their service. CORE system displayed the benchmarking indices (i.e. percentiles) in the form of anonymised, traffic-light ‘thermometers.’(Gray & Mellor-clark, 2007).

In the case of Malaysia, the implementation of the national KMS system of reporting client cases can be the beginning of a national research database for counselling psychology services. However, to do that the KMS must incorporate outcome measure into its system. The outcome measure, CORE-OM, will determine the baseline distress levels and the outcome results, i.e. after the intervention. The clients’ mental state at the end of the intervention can be determined as recovered, improved, no-change and deteriorate by following a standard formula of change by Jacobson and Truax (1991). The CORE-OM is the benchmarking tool to determine the benchmarking indices, i.e. the three important percentiles, of each outcome category and thus create standards of service performance for the UPsKs.

The reliability of achieving improvement and recovery is dependent on getting a high rate of measured endings (CORE Partnership, 2007a). The measured ending is the percentage of clients who have completed both a pre- and post-therapy measure.

With 100% measured ending, it is possible to state with certainty the percentage of reliable improvement, which is not possible when the measured ending is low.

If a service had only 14% measured endings, that meant the other 86% unmeasured clients' outcomes are unknown. Some clients may have dropped out of therapy early without completing a 'post' measure because they felt better and do not need any more sessions. However, others may have dropped out early because they felt therapy is not helping, and they are no better. Moreover, others may have their 'post' measure missing for other reasons. Thus without a measured ending, it is not possible to say with certainty the number of clients improved or otherwise (CORE Partnership, 2007a). In real-life settings, it will take about two to three years for service to achieve 70% measured endings (CORE Partnership, 2007a).

The above method to rank services did not take into account the measurement error. For example, the actual recovery estimates for a service ranked as below average (e.g. quartile below 50%) may not be significantly different to that of an "above average service" (e.g. above 50% percentile), and apparent differences may be simply due to variations in sample size or data completeness. Therefore, Delgadillo et al. (2014) and his team decided to use effect sizes (ES) to measure symptom changes.

Effect size (ES) denotes the magnitude of changes observed in any given measure and is independent of diagnostic status at baseline, making it an inclusive measure for service-level data. ES account for symptom changes in either direction: improvement, deterioration or no change. Furthermore, given their prominence in the research literature, ES enable extensive comparisons across studies, and many used Cohen (1998) guideline.

However, in the UPsK study, the researcher did not combine effect size with the clinically significant improvement since the sample size was too small; therefore

the study concentrated on CORE method of using percentiles and quartiles. This UPsK study only accepted cases with measured endings for analysis, so there were 100% measured endings. Measured endings give confidence in the percentage rate of reliable improvement generated.

Since the first UPsK in 2001, there are presently 60 UPsKs in total. However, there has not been an assessment done on the performance of UPsKs based on clients' outcome. With the use of CORE-OM, the researcher attempted to do just that. The researcher chose the CORE-OM system because it had the utility to measure client outcome as well as to measure service quality. CORE benchmarking has a simple mathematical procedure to follow; it uses percentage rates of change, and the critical information is in the 25th, 50th and 75th percentiles with 95% confidence intervals (Mullin et al., 2006). Also, the benchmark is in graphical form—like a thermometer—that summarizes the range of percentages. The first quartile band is the top 25 per cent of service. The second quartile band and third band represent the mid-quartile ranges, i.e. 60-68%. So a service will compare their service profile on a specific benchmark to get an indication of their relative performance (Mellor-Clark & Barkham, 2012).

The overall quality of the service required looking at other variables such as waiting time, risk assessment, planned/unplanned endings and many more, including the client mix. However, due to constraints of time, this study examined client outcomes, that is, positive as well as negative outcome benchmarks only. Also, this study did not consider the client mix since the focus was on the service, not on the individual performance of the psychology officers (counselling).

The UPsK study was a seminal work creating benchmarks for evaluating UPsKs' performance based on client outcomes categories. The benchmarks' percentile values are displayed graphically in a traffic-light 'thermometer' colour

format—green, yellow, amber and red (Mellor-Clark et al., 2006). The colours represent the rate of change in each outcome category: green—high rate of change, yellow/amber—an average rate of change, and red—low rate of change. Subsequently, these percentile values (colours) translate to levels of effectiveness (performance of UPsK). Green represents a high rate of change which indicates high performance, yellow & amber represent an average rate of change which indicates average performance, and red represents a low rate of change which indicates low performance (CORE Partnership, 2011a; Mullin et al., 2006). For more details, refer to Chapter 4, Application of the service benchmarks.

The use of colour coding is not restricted to percentile range but can also represent other concepts. For example, Cross and her team in 2015 used colour coding in a visual format to highlight small incremental changes in responses to each of the 34 items. The colours green, yellow and red help communicate clients' changes quickly. When they see the changes, it fosters hope in clients and thus raises the mutual morale of client and psychology officer alike.

This study further used CORE's existing colour coding to show rates of performance of each UPsK in a matrix. Firstly, the benchmark value will tell a UPsK whether its performance matches up with the standard for the particular outcome category. Secondly, the UPsK can compare itself with others and see where it stands in comparison with the rest in that particular outcome category.

The matrix gave a quick, easy to read and visual assessment of the performance of 9 UPsKs in one diagram. The matrix consisted of columns and rows. See Table 2.8. The columns represented outcome categories; the row represented UPsKs, and each cell represented the rate of change experienced. For example, UPsK 1 showed red in recovery column; yellow in improvement; green in recovery and improvement,

non-reliable change and deterioration. At a glance, it is possible to see that the UPsK was showing low performance in recovery but showing high performance in preventing clients from deteriorating further into distress. Hence the conclusion was that UPsK 1 has the potential to do better in recovery and improvement.

Table 2.8

An Example of UPsK Matrix

UPsK	Recovery	Improvement	Recovery & Improvement.	Non-reliable change	Deterioration
1					
2	*	*	*	*	*
3	*	*	*	*	*
↓	*	*	*	*	*
13.					

* Colour according to levels of effectiveness: green-high, yellow-average, red-low

The expectations for a UPsKs are to achieve high performance: (1) high rates of positive outcomes such as recovery, improvement; and (2) low rates of negative outcomes such non-reliable change and deterioration. A UPsK with high service performance will have all the columns green, and a UPsK with low service performance will have more columns red.

A comparative study of Italian regions used benchmarkings for assessing performances, and used colour coding to show the progress or otherwise of the participating regions in the study. The benchmarking programme was called Performance Evaluation System (PES), designed and developed by the Management and Health Laboratory (MeSLab) of Sant'Anna School of Advanced Studies. The region that achieved the target received a reward for its successful manager. The communities involved were aware of the targets set, so they were conversant of the hard work and sacrifice needed to be successful. A sense of competition to do their best for their community pervaded the competition. (Bevan et al., 2019)

The PES used a “dartboard” diagram which displayed at a glance the underachievement and high performances of each region/district. The study used a national or international standard, where appropriate, to evaluate the indicators. The scores ranged from 1 (poor performance) to 5 (excellent performance), and each score was associated with a colour; red—1, orange—2, yellow—3, green—4, and dark green—5. High performance was when the indicator was closest to the centre of the target and weaker as it radiated outward. The principle of the matrix or the dartboard is to allow public, stakeholders, concerned agencies to assess at a glance the real situation.

These studies showed that the idea of using colour coding in a matrix, to show the performance of the UPsKs, is viable and valid (Bevan et al., 2019; Cross et al., 2015).

Issues of Implementation

The main issues in implementation come from practitioner/psychology officers. The primary barrier is the continued resistance of psychology officers (counselling) to embrace the measures rather than clients' unwillingness to engage (Bickman (2010). To break the resistance and bring positive impact Black et al. (2009) recommended training sessions for psychology officers (counselling) to prepare them on how to use the instrument effectively and to highlight the positive views of clients and carers who have benefitted from outcome measurement. A recent study by Duncan and Murray (2012) also said the same; that is, the organisation must provide training, sufficient administrative support and adequate allocation of resources.

Boswell et al. (2013) showed that the time constraints experienced by practitioners are real. Left to administer the questionnaire, score and interpret results, create reports, provide feedback, benchmarking, risk adjustment, even though the

development of software has alleviated some of these burdens, the expected work is daunting to many.

Also, many practitioners do not want to try anything new (outcome measure) because they assumed that their experience and competency are enough to guarantee outcomes (Bickman, 2010; Blackwood, 2009). Duncan and Murray (2012) further recommended the development of positive team culture to embrace the ethos of evaluation and not to impose measures on practitioner whenever possible. He noted that practitioner with a higher degree (qualification) do better in implementing routine outcome measurement than most.

Another reason for resistance is the differing philosophical views of the practitioners. Lakeman (2004) advised not to lose sight of the personal journey of the client while focusing on the predetermined end and there must be 'talk-up' where debate and reflection are a significant part of the dialogue with nurses and practitioners so that ROM is not merely a bureaucratic exercise. These sentiments are shared by Watson (2003), who stated that routine outcome measurement might satisfy calls for accountability but not at the expense of initiative, reflection, and courage.

In the course of data collection, the researcher faced similar resistance from the psychology officers (counselling). Several UPsKs rejected the offer to participate in the study due to the perception of increased workload, which is unwelcomed. Currently, the UPsKs are operating under limited resources and given a choice they would reject any additional external work. The researcher discussed the type of resistance and her attempts to mitigate the situation in Chapter 3.

Another major issue in implementation is manpower, that is the number of people available to do the work.

Manpower. UPsK can achieve effectiveness in its mental health service when there is a sufficient workforce to do the job. According to Lopes, Almeida, and Almada-Lobo (2015), the equivalent term for the workforce in the medical setting is the human healthcare resource (HHR) HHR planning has been identified as the most critical constraint in achieving the well-being targets outlined in the United Nations' Millennium Development Goals (Dreesh et al., 2005).

The effective use and deployment of personnel will ensure efficient service delivery in terms of cost, quality and quantity (Ozcan et al., 1995). Failure to do so may result in an oversupply or shortage of clinical staff (Robertfroid et al., 2009). The former leads to economic inefficiencies and the latter to negative effects on clients. Clients will face long queues and waitlist when fewer clinical staff provide the necessary services. Inevitably the visits will be shorter (Steinbrook, 2006). Similarly, the UPsKs with the insufficient workforce will not achieve effectiveness in client outcomes.

The Malaysian government's Open Access website has information on the services provided by the Counselling Psychology Unit (UPsK) in government hospitals for the year 2017 (MAMPU, 2017). There were 34,808 clients treated by 89 psychology officers (counselling) in 55 UPsKs around the country. On average, the number of clients per hospital was 633, and the number of psychology officer (counselling) per hospital was two. However, in reality, 65% of UPsKs was manned by one officer only. In 2017, there were 252 working days in 2017, so it was estimated that the average psychology officer (counselling) met with three clients (maximum was five) clients per day.

However, it must be noted that the scope of work of the psychology officer is not confined to meeting client but also to conduct awareness and psychoeducational

programmes for staff and the community according to the annual work targets schedule *Sasaran Kerja Tahunan* (SKT). It has three parts: (1) setting the goals, (2) mid-year review and (3) final performance report and review. The goal-setting included the application of psychology in personnel assessment; personnel development; conduct counselling and psychological interventions such as individual counselling session, group counselling session. Provide psychological First Aid (PFA) at the one-stop crisis centre; do group counselling at the methadone clinic; do an intervention for low performing MOH personnel; conduct programme for financial education and management. They also have administrative work such as attend unit meeting, hospital meeting, become a committee member for hospital projects. The psychology officer (counselling) also has to key-in data into the Kes Management System (KMS) every month.

This lack of workforce poses a problem to the operations of the UPsK. In this randomized study of 13 UPsKs, slightly more than half (54%) were one-person units, and 31% were two-person units. The problem was manifested when the officer takes long leave. There is no replacement psychology officer to replace those on extended leave such as maternity leave (60 days) or study leave (2 years). Maternity or study leave frequently occur since three-quarters of the psychology officers were female of child-bearing age (29-34 years). Many will continue to have children until the age of forty (Billari et al., 2011).

The most popular study leave was to pursue a Masters qualification. Currently, 52% of the psychology officers in the study had a Masters qualification (Zakaria Mohamad & Asyraf Hj Ab Rahman, 2011). They had taken long study leaves, and if they were from the one-person unit, there was a high probability that the UPsK was closed temporarily. The UPsK temporary closure disrupted clients' treatments

indefinitely. It is a recurring problem in all the states. The Ministry of Health must take heed of and take remedial actions urgently.

Most psychology officers in the 13 UPsKs met 56% of new clients on the same day as referral date. The psychology officer will attend to new cases immediately if not, the client is given an appointment date within five working days as in accordance to the Client Charter (UPsk HS, 2018; UPsK HSB, 2016). This study found that 15% of clients met the psychology officer (counselling) within 1-5 working days, and 18% between 6-4 days. However, 12 % of clients had to wait longer than a month, and the range was from 23-36 days waiting period. This long delay in getting an appointment is due to the psychology officers being away from the UPsK to attend courses, out doing consultation work or sick on medical leave. When they return, they have to catch up with existing follow-up clients before getting to new cases. Hence, the delay in giving appointment dates. An obvious consequence of inadequate workforce in the one-person unit.

Despite being low in the workforce, this study showed that psychology officers in the 13 UPsKs had done well to respond quickly to new cases as guaranteed by the Client Charter, unlike the two weeks' standard waiting time for psychological services in the U.K. (NHS England, 2015).

The Lean Civil Service Policy of 2015-2020 froze new posts. Government agencies must redeploy and use trade-off approaches to capitalize on services and deliverables under stretched resources to fulfil the agencies' current needs (Ministry of Health Malaysia, 2018). There is no new post for psychology officers (counselling); nevertheless, the need is there. A possible solution is to hire graduate psychology officers as contract workers for a specific period. This way is cost-effective since it does not come with emoluments and pension or gratuity packages. Contract workers

allow the service to carry on for the benefit of the clients and staff in the hospital. The UPsK in HKL used this strategy successfully in 2018. Puan Ruhana, the current Head of the Unit implemented the strategy successfully and is convinced that it can be replicated by other UPsKs as long as the hospital has financial funds to pay for salary (Ruhana Binti Mahmud, personal communication, November 28, 2019).

In Mental Health Atlas (2014b) the rate per 100,000 for mental health practitioners such as psychiatrists, psychiatric nurses, and psychologists are 0.8, not reported and 0.9 respectively. Many counselling and psychology services in America have the staffing to client ratio to ensure their ability to provide optimum service to clients (Teevan Burke et al., 2013). In 2011, they recommended the maximum student-to-counsellor ratio of 250:1.

The number of mental health practitioners is low in Malaysia due to the limited resources available for health—less than 5%—of the gross domestic product (GDP) is allocated for health and even lesser for mental health. In 2013, the total expenditure on health (public and private) was RM35.4 million, that is, 4.5% of GDP and the mental health budget accounted for approximately 0.28% to 0.39% of the total health budget (ASEAN Secretariat, 2016; “Mental Health Atlas,” 2014). Despite existing low resources, in 2016, there was a further cut of RM250 million to RM300 million in the health budget (Fazleena Aziz, 2016), causing more stress on an already underfunded system.

In 2003, the World Health Organisation recognised that without adequate financing, mental health policies and plans would remain in the realm of rhetoric and good intentions only. Worldwide, policymakers in many countries fail to give sufficient recognition to mental health problems, and the consequences are inadequate efforts to prevent or treat mental disorders. They erroneously believe that funding for

other health services is more beneficial to society and more cost-effective (WHO, 2003).

The above perception is proven wrong by Chisholm et al. (2016) in *The Lancet Psychiatry*. They calculated that for every \$1 spent on mental health for treatment such as counselling and medication, governments could receive a \$4 return on their investment. Investing in mental health is the financial paradigm shift necessary for better mental health care services.

The Malaysian health authorities should take note of this financial paradigm shift in health care. The workforce in mental health services must be given priority in the allocation of financial resources. The Counselling Profession Chief is committed to getting more psychology officers to maintain existing units and to helm newly opened UPsKs by considering other ways to increase the workforce without costing the Ministry additional burden.

Burnout. An indirect consequence of lack of workforce is burnout which according to the assumptions of the job demands-control model of Karasek (1979) the impact of job demands caused great work strain on the employee and control becomes the potential buffer to enhance work engagement. In a study by Morse, Salyers, Rollins, Monroe-DeVita, and Pfahler (2012), estimated that about 21% and 67% of mental health service professionals reported high levels of burnout. Looking at psychologists, in particular, Rupert and Morgan (2005) found that 44.1% reported burnout and work-related stress.

Burnout for the psychology officer (counselling) is when she/he is unable to perform the professional role in full capacity and thus unable to provide adequate care for clients (Baker, 2003). Performing at reduced capacity would mean the officer is unable to expend effort causing suboptimal functioning at work. They often

experience impaired emotional and physical health and a diminished sense of well-being. Poor physical health would include higher reports of flu-like symptoms and symptoms of gastroenteritis. Also, there is a high correlation with substance use (Rohland, 2000).

However, Morse et al. (2012) found no mitigation plans to reduce or prevent burnout among mental health professionals. Mitigation plans should have three main preventive strategies: (1) individual programmes, (2) organisational programmes and (3) programs that combine individual and environmental interventions. The latter shows more considerable promise for sustainable results than the rest. An example of a burnout prevention programme that links individual and organization—the client develops a sense of meaning, gratitude, and fulfilment at work (Awa et al., 2010). Third-generation cognitive-behavioural methods, especially meditation and mindfulness practices, also appear promising.

Finally, the theoretical framework that puts the variables and constructs together to show their relationship with each other

Theoretical Framework

Theoretical framework illuminates the relationship of a model, concept and constructs relevant to the investigation. It is a visual depiction of how they are connected to reach a new understanding (Leshem & Trafford, 2007). Maxwell (2005) likened the conceptual and theoretical framework to a map:

A concept map, like the theory it represents, is a picture of the territory you want to study, not of the study itself. It is a visual display of your current working theory, a picture of what you think is going on with the phenomenon you are studying.” (p.25)

The counselling psychology unit/unit psikologi kaunseling (UPsK) is a significant contributor to mental health services in government hospitals alongside

psychiatric services. The unit treats clients from non-psychiatric and psychiatric wards as well as health professionals who are having psychological problems in their daily lives. This study chose to focus on UPsK because there is little literature on this vital unit despite being in operation for close to 20 years and it is also the place where professional counselling is available in the medical setting.

The unit has structural component (client, psychology officer, counselling room), process component (therapy, psychological tools) and outcome component (reduction in psychological problem) however, there appears to be a weakness in the assessment of the outcome component. There is no standardized outcome measurement in place. Presently the primary way to assess client is by the traditional method of subjective assessment which other countries have left behind. The global trend is a combination of traditional methods and the use of outcome measures for screening and continuous monitoring in the therapy sessions.

This study examined the use of outcome measure, CORE-OM, in assessing client outcomes. This study was the first to use CORE-OM in UPsK. Based on the client outcome data, it was possible to create service benchmarks for each outcome categories. The percentage rates of change in the clients are the cornerstone of the benchmark. The service benchmarks became the standard to compare other UPsKs. See Figure 2.2. The UPsKs were ranked high, average and low performing. The colour scheme of the matrix makes it easy to compare the performance of the UPsKs.

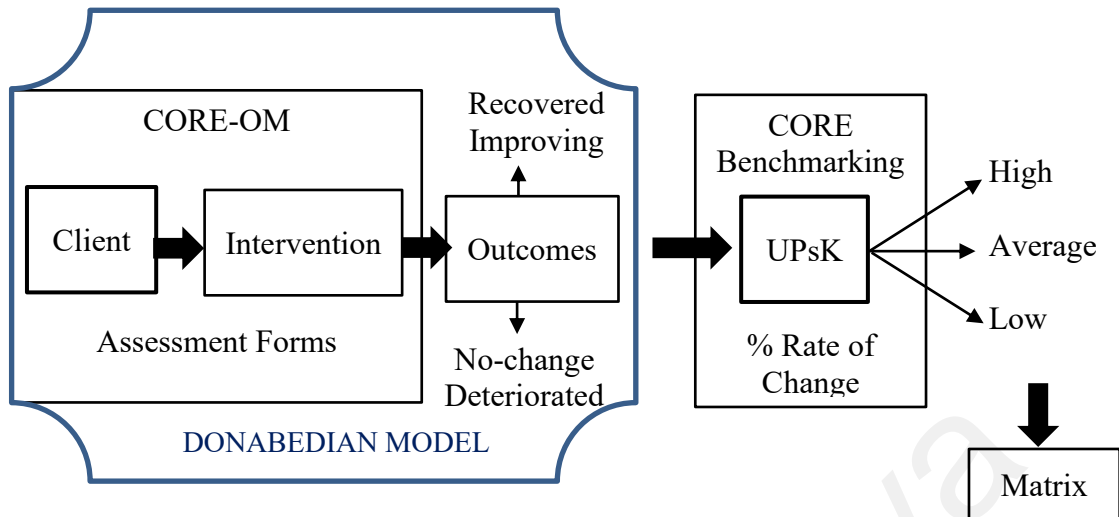


Figure 2.2. The Theoretical Framework

Conclusion

The trend in quality health care and particularly mental health care is to provide the most cost-effective system where the frequently needed service is available to the community (Lokkerbol et al., 2014). Mental health is a serious matter. There are 450 million people worldwide suffering at any given time from some mental or brain disorder, including behavioural and substance abuse (Kim Teng, 2011; World Health Organization, 2001). The situation in Malaysia is no different from the rest of the world. Malaysia faced a major drug epidemic in the 1990s and counsellors were part of the strategic plan to combat the social menace. Counselling gained a foothold in hospitals, and later counselling psychology units (UPsKs) were established to serve diverse populations in the community.

UPsK in the hospital provides psychological interventions for clients in a conducive and safe environment. The UPsK, however, does not have a measurement system to assess client outcomes, and it does not have a basis for evaluating the service performance. The local literature confirmed the lack of research done in this new field—assessment of the counselling psychology services (UPsK). Literature showed

that mental healthcare systems in developed countries are using outcome measurement system routinely to assess and monitor clients' mental health status (client outcomes). Malaysia is lagging in the assessment of client outcomes.

This study attempted to adapt a known outcome measure, CORE-OM, in selected UPsKs and consequently, used CORE as a benchmarking tool to create standards for each outcome categories. The theoretical framework showed the relationships of the many constructs to each other.

Universiti Malaya

CHAPTER 3

METHODOLOGY

Introduction

The purpose of the study was to use outcome measure as an alternative method to assess clients' outcomes and to use it as a benchmarking tool for service performance. The outcome measure for quality improvement is not new (Wampold, 2016) and there are proofs of successful implementations of outcome measures in many countries (Eagar et al., 2001; Krageloh et al., 2015; Slade et al., 2006). However, for Malaysia, it is a novelty, and this study was the first of its kind in the field of counselling psychology.

The gap in the assessment system was exposed in Chapter One and discussed comprehensively in Chapter Two. This chapter describes the methodology used to achieve the aims and objectives of the study. It begins with an overview of the research process and then goes into details of each component such as research design, data collection, ethical considerations and data analysis.

Research Process

This study used a mixed-method approach. It utilised both components of quantitative and qualitative data to understand the research problem better (Creswell & Plano Clark, 2011; Schoonenboom & Johnson, 2017). The research problem was—the counselling psychology services (UPsK) did not utilise standard outcome measure—in its assessment system, despite being in existence for close to twenty years. This study attempted to adapt a standardized outcome measure (CORE-OM) to use in selected UPsKs around the country.

There are presently 60 UPsKs around the country. The study used the survey method to distribute CORE-OM questionnaires to many UPsKs around the country.

The survey gathered data to answer the first part of the study, that is, quantitative questions related to clients' outcomes. The second part of the study on service assessment needed additional input from the psychology officers (counselling) to clarify and provide context to the statistical results obtained. The researcher carried out qualitative interviews with selected psychology officers. Their answers gave insights into questions like "What do they think about outcome measures, is there a need for one? What problems do they face, and how do they feel about it?" Hence the mixed-method approach was appropriate for this study.

There are four dominant research paradigms based on distinct theories of knowledge (epistemology) and the nature of being (ontology). They are positivism/post-positivism, constructivist/interpretivist, critical/transformational and pragmatism (Creswell, 2014; Mackinnon & Dwyer, 1993). Each represents a 'worldview' or a set of assumptions about how things work (Rossman & Rallis, 2003). The epistemological and ontological positions that matched the parameters of mixed-method study is pragmatism. The appropriate paradigm for conducting mixed methods research is pragmatism (Brierley, 2017; J. W. Creswell, 2014; Tashakkori & Teddlie, 2010)

Pragmatism reflects a pluralistic emphasis on both understanding the world and the way to resolve research questions or problems (Kelly et al., 2018; Tashakkori & Teddlie, 2010). In other words, this position acknowledges the strength of both approaches and diminishes their respective weaknesses by reframing the dichotomous views of both quantitative and qualitative research into a continuum.

The overall research process was adapted from Mackenzie and Knipe (2006) and shown in Figure 3.1. The UPsK study involved ten components in its research process, beginning with the research approach and ending with the research report.

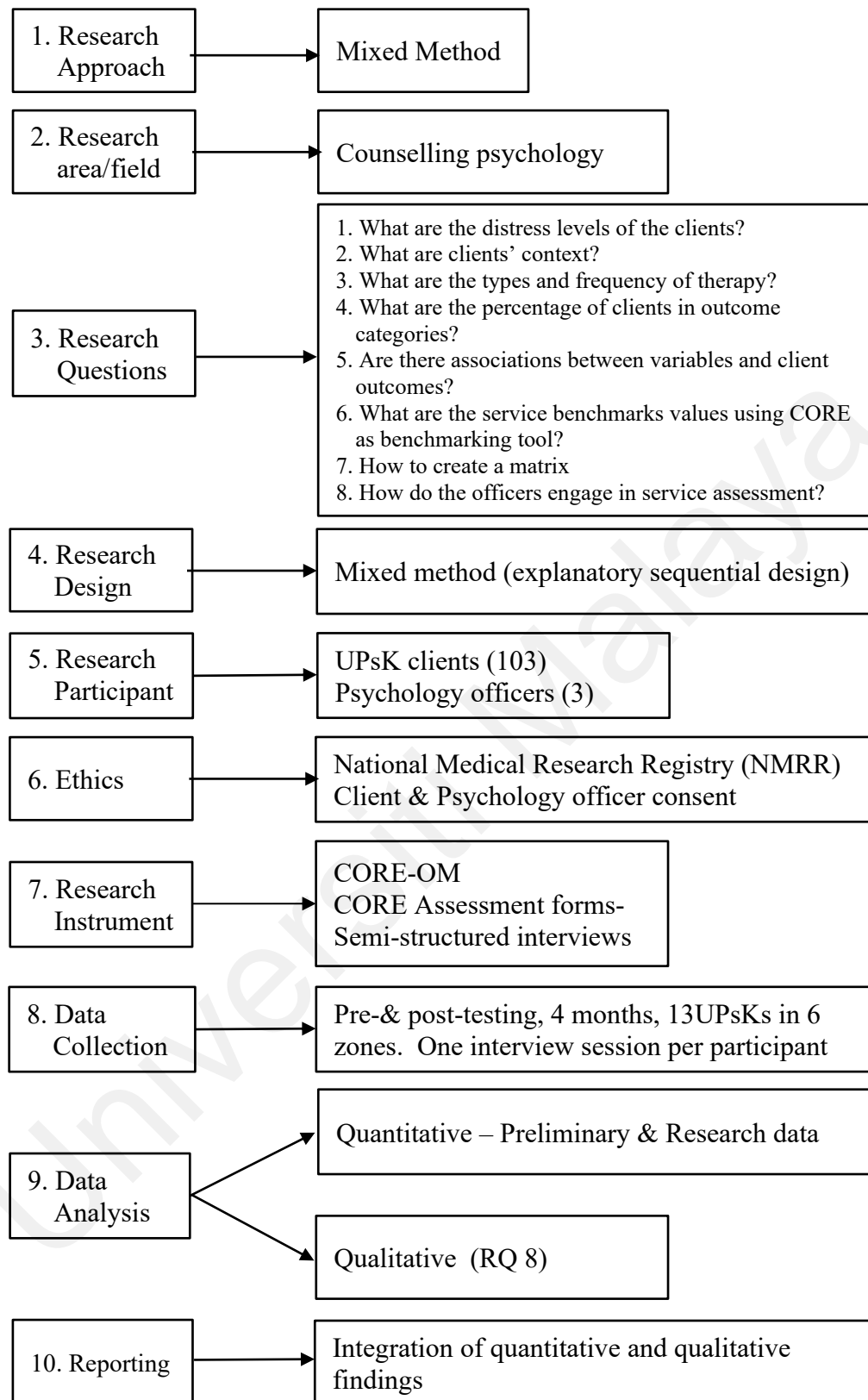


Figure 3.1. Research Process.

Research Design

Johnson and Onwuegbuzie (2007) defined mixed method design as:

Mixed methods research is the type of research in which a researcher or team of researchers combines elements of qualitative and quantitative research approaches (e. g., use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the broad purposes of breadth and depth of understanding and corroboration. Page 123

In this study, the use of the mixed method was to combine the elements of quantitative and qualitative research approaches (e.g. data collection, analysis and inference techniques) for the general purposes of breadth and depth of understanding and corroboration concerning the use of outcome measure in the assessment of UPsKs. There are a few combinations such as concurrent, sequential or parallel mixes in the mixed-method research designs (Creswell, 2014; Tashakkori & Teddlie, 2010). In this study, the researcher chose the sequential design.

The theoretical drive in mixed-method has two components, the core and the supplemental components (J. M. Morse & Niehaus, 2009). The components exist in three forms: (1) core is quantitative, (2) core is qualitative and (3) core and supplemental have equal status. In the sequential design, the core component was quantitative, and the supplemental was qualitative. Closely associated with the theoretical drive is the timing of conducting of the core and supplemental components, that is, are they carried out concurrently or sequentially? In sequential design, the core component (quantitative) preceded the qualitative supplemental component, and in Morse (1991) notation this was written as (QUAN → qual).

The researcher chose the explanatory sequential design because the main study involved many clients from 13 UPsKs, and the resultant quantitative results required a qualitative aspect to support and explain them. Because the CORE-OM was a new outcome measure introduced to the UPsK, and there was no local literature that could

corroborate the findings. So the perspectives of the psychology officers offered great insight into the culture and work context found at the UPsKs during the research period.

The point of the interface was at the presentation of the results. See Figure 3.2. The qualitative aspect provided triangulation; contextual understanding, and it illustrated the quantitative findings. Morse and Niehaus (2009) pointed out at points of interface or integration the quantitative and qualitative are brought together, not mixed but rather integrated carefully. In many ways, the sequential design was like putting “meat on the bones” of ‘dry’ quantitative findings (Bryman, 2006).

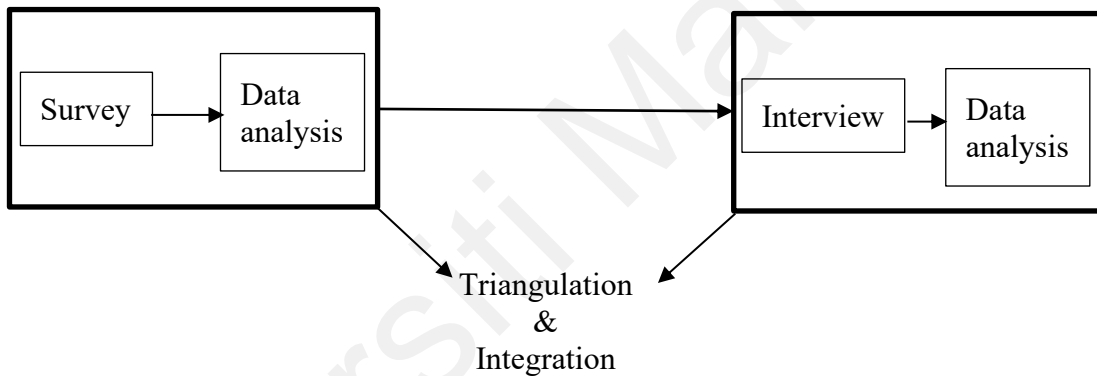


Figure 3.2. Flow Chart for Explanatory Sequential Design

Population and Sample size

In 2015, the clinical population of UPsK clients came from 56 UPsKs in Ministry of Health (MOH) hospitals in 13 states and two federal territories excluding the Federal Territory of Labuan. Generally, UPsKs recorded an average of 15 new clients each month over 12 months (Hashimah Abdul Rahman, personal communication, February 13, 2015). Based on these figures, the calculation showed that the clinical population for UPsK was 10,080 clients (i.e., 15 new patients x 12 months x 56 UPsKs) in 2015.

The study needed a target population since the clinical population was too big. The target population was the estimated number of clients that came to UPsK during

the four months of research. The estimated number was 3360 clients (i.e., 15 new clients x 4 months x 56 UPsKs); children accounted for 10 per cent of the total count. The outcome measure, CORE-OM, is for older teen and adult while children between the ages of 11-16 years use another measure, Young Person CORE (YP-CORE)(O'Reilly et al., 2016). Therefore, children below the age of 17 years old were not eligible for this study. So the target population was cut down to 3024 clients.

From the target population, the researcher derived the sample size. She used the Dillman (2000) sample size table to calculate the clinical sample size needed (Needham & Vaske, 2008). The objective was to get a confidence level of 95%, that is the estimates were within $\pm 5\%$ (or points) of the target population, assuming there was no nonresponse, measurement, or coverage errors (Needham & Vaske, 2008). The sample size is essential to the integrity of the study (Creswell, 2008).

The expectation was that 50% of the clients would answer either way (not at all or all the time); therefore a 50/50 split was the most conservative value possible (Lunsford & Lunsford, 1995). From the Dillman (2000) table, the estimated clinical sample size was 337 clients for a target population of 3024. This estimated sample size produced the power of 0.80 or more higher (Creswell, 2008) and effect sizes between small (0.2) and moderate (0.5) (Zodpey, 2004)

However, it was necessary to prepare for 30% nonresponse from clients and 10% measurement error occurring (Israel, 2009). The collection had to be more than 337 and the estimated number planned was 500 clients, that is about 40% more than the sample size required. In summary, Table 3.1 shows the population and sample sizes for the study.

Table 3.1

Population and Sample Size for UPsK Clients

Population/Sample	Number
Population of registered UPsK clients	10,080
The target population for the study	3,024
The sample size for the study	337
Estimated collection planned (40% increase)	500

Sampling method. The study needed 500 clients that were representative of the population and must come from the length and breadth of the country (comprehensive coverage) so that there will be less error when drawing inferences (Creswell, 2008). The Ministry of Health divided the country into six zones—north, central, south, eastern, Sabah and Sarawak. The majority of the 56 UPsKs are mainly in hospitals in the central and north zones. The study applied a stratified sampling method (Creswell, 2008) to get a randomized number of hospitals with UPsK that will give the researcher the 500 clients needed for the study. A random number generator software (“List Randomizer,” 2018) generated 33 random hospitals with UPsKs from the six zones. To get access to the 33 hospitals, the researcher submitted the list to the National Medical Research Registry (NMRR) for permission. See Appendix D.

In the 11th Malaysian Plan (2016-2020), the Ministry of Health has four types of hospitals: (1) state, (2) major specialist, (3) minor specialist, and (4) special medical institution (Ministry of Health, 2016). The 33 hospitals in the list were mainly from the state, major specialist and minor specialist hospitals. Please refer to Table 4.7, page 138, to see the details of the participating hospitals with UPsK.

Research Participants

There were two types of research participants, clients and psychology officers. The clients participated in the CORE-OM survey, while the psychology officers (counselling) were involved in semi-structured interviews.

Clients. Participants for the study were registered clients who fulfilled the eligibility criteria and voluntarily wanted to be in the study (see Table 3.2). The criteria for client participation were irrespective of race and gender but specific about the case, age, language and distress. The study accepted new cases only. Each new client will have his/her distress level assessed by CORE-OM, and this pre-testing produced the distress baseline score. This score was pivotal in the study. Follow-up cases without distress baseline scores cannot take part in the study.

Table 3.2

Inclusion and Exclusion Criteria for Clients

Inclusion	Exclusion
New case (clients and in-patients)	Follow-up case
All ethnic groups	
Male and female	
≥ 17-years old	< 17-years old
Psychological distress	Psychiatric disorders
Can understand Malay or English	Chinese, Indian languages only

The study only accepted clients who were 17 years and older since young clients below 17 has a separate CORE questionnaire (*CORE-YP*, n.d.) and CORE-OM was not appropriate for them. Clients with psychological problems were accepted but not psychiatric patients. However, if the psychiatric patient had achieved 61 points and more in the Global Assessment of Functioning (GAF) Scale, were cooperative and coherent (UPsK HQE, 2019), they can participate in the study. In-patients (i.e. warded

clients) might participate at the discretion of the psychology officer (counselling). The officer will decide when the patient was emotionally stable to take part in the survey. The CORE-OM questionnaire was bilingual in Malay and English. Clients who had no fluency in either language, only conversant in Chinese or Indian cannot participate. The total number of participants were 103 clients (including in-patients) from 13 participating UPsKs hospitals.

Psychology officers (counselling). In the second phase, selected psychology officers (counselling) took part in semi-structured interviews. The selected officers were from a pool of psychology officers (counselling) from nine hospitals that participated in the benchmarking exercise, and they fulfilled specific criteria (see Table 3.3).

Table 3.3

Inclusion and Exclusion Criteria for Psychology Officer

Inclusion	Exclusion
All ethnic groups	-
Male and female	-
All ages	-
All zones	-
≥ 5-years work experience in the UPsK	< 5-years work experience in the UPsK

The psychology officer (counselling) must have a minimum of five years' work experience at the current UPsK. The officer would then be in a credible position to share her/his perspectives on the evaluation of clients' outcomes and the methods to assess service. It would be advantageous if the psychology officer (counselling) had managerial experiences to add macro-level perspectives to the exploration. Three psychology officers (counselling) were selected: two males and one female; Indian,

Chinese and Malay, respectively. All have worked in their current UPsK for six years, and two of them are in managerial posts. Two are married with families and one single, unmarried.

Research Instrument: CORE-OM

CORE-OM (client-completed) and CORE assessment forms (officer-completed) are part of the CORE system which offers analysis, reporting, benchmarking, performance development and clinical decision aids (Barkham, Mellor-Clark, et al., 2010). The CORE-OM is widely used in the U.K. and extensively translated into many languages (Evans, n.d.).

CORE-OM taps into four domains. They are subjective well-being, symptom/problem, functioning, and risk; each domain has several dimensions except for subjective well-being:

- (1) Presenting problem/symptoms has four dimensions: depression, anxiety, physical, and trauma. Twelve items represent them.
- (2) Functioning has three dimensions: general functioning, social and close relationship. Twelve items represent them.
- (3) Risk has two dimensions: harm to self and others. Six items represent them.
- (4) Subjective well-being is not differentiated. There are four items on subjective well-being.

CORE-OM has 34 items altogether. The risk items are not regarded as a scale but used as clinical flags to trigger further discussions of risk assessment (CORE IMS Ltd, 2014). The items are low, or high-intensity with the purpose to increase the measure's sensitivity; similarly, there are 25% positive items with the purpose to increase the measure's diversity. Table 3.4 shows examples of domains, dimensions, items, severity and item number in the questionnaire.

Table 3.4

Examples of Domains, Dimensions, Items and Severity Intensity in the CORE-OM

Domain/ Dimension	Item	+ve	Severity intensity	Item No.
Subjective- wellbeing	I have felt O.K. about myself	Pos	Low	4
Subjective- wellbeing	I have felt like crying		High	14
Subjective- wellbeing	I have felt optimistic about my future	Pos	Low	17
Symptom-anxiety	I have felt tense, anxious or nervous		Low	2
Symptom-trauma	I have been disturbed by unwanted thoughts and feelings		High	13
Functioning- general	I have been able to cope when things go wrong	Pos	High	7
Functioning-social relationship	I have felt irritable when with other people		Low	29
Risk to self	I have thought of hurting myself		Low	9
Risk to others	I have been physically violent to others		High	6

Pos = positively phrased item. It is adapted from CORE IMS Ltd (2014) page 12.

The CORE-OM assesses global distress (CORE IMS Ltd, 2014) not a specific psychological disorder; therefore, it is a flexible tool to measure distress in any capacity. It measures a pan-theoretical ‘core’ of clients’ distress in four domains, that is, it is generic and not specific to measure a psychological disorder. Therefore it can be a screening tool and an outcome measure in the appropriate situation.

After the establishment of the original CORE-OM, many other versions developed—CORE short forms and special populations. The short forms are administered for repeated use in therapy sessions (Barkham, Hardy, et al., 2010) as well as for screening purposes (Barkham et al., 2013). Population-specific versions were for the following populations (1) the general population (GP-CORE; Sinclair, Barkham, Evans, Connell, & Audin, 2005); (2) adolescent 11-16 years old ((Barkham et al., 2009; Twigg et al., 2016); and (3) learning disability (Brooks & Davies, 2008).

This study chose CORE-OM because it is the original, full 34 items outcome measure with proven psychometric properties. Furthermore, it applies to adults and older teens which constitute the majority of the UPsKs' clientele.

Psychometric properties. The psychometric properties of CORE-OM are reliable, has validity, shows reliable change and has a definitive cut-off point. A summary table, Table 3.5, was created to show the psychometric values that have been tested and proven by many reputable studies.

Table 3.5

Psychometric Properties of CORE-OM

Properties	Values	Citation
Reliability	General population sample = 0.91	Connell et al, 2007b
	Primary care = 0.93	
	Older adult in clinical sample = 0.90	Barkham et al., 2005
	Older adult in nonclinical sample = 0.83	
	Domains: - Well-being = 0.70	Evans et al, 2002
	problem = 0.87	
	functioning = 0.85	
risk = 0.77	Barkham et al., 2007	
Test retest: - 1 month = 0.88		
2 months = 0.81		
	3 months = 0.83	
Validity	Construct=domains intercorrelate strongly except risk scores	Evans et al., 2002
	Convergent = high correlation with the Beck Depression Inventory, Hamilton Rating Scale for depression, Client Health Questionnaire	Lyne et al., 2006
		Evans et al., 2002
		Lyne et al., 2006
Reliable change	Clinical score of 5	Connell et al., 2007b
Clinical cut-off	Clinical score of 10	Connell et al., 2007b

The primary requirement of CORE-OM is to distinguish between the clinical population and non-clinical population samples. There are substantial significance differences in all dimensions ($p \leq 0.0005$), that is, less than a 5 in 10,000 chances

(Evans et al., 2002) of error. Strong psychometric properties confirm the validity and reliability of CORE outcome measure and its other variants.

The evaluation of the scores. CORE-OM has a 5-point scale ranging from 0 (not at all) to 4 (most or all the time). The minimum score is zero, and the maximum is 136. The CORE System (CORE IMS Ltd, 2014) has produced a look-up table for the psychology officer to match their clients' scores to the total scores. Then translate it to a clinical score and finally to the severity level where the client is residing presently. See Table 3.6

Table 3.6

Look-up Table for CORE-OM Scores

Total score	Clinical score (Total score/no of items) x10	Simple score	Severity level	
1-20	0.3-5.9	1-5	Healthy	Non-clinical levels
21-33	6.2-9.7	6-9	Low	
Clinical cut-off				
34-50	10.0-14.7	10-14	Mild	Clinical Levels
51-67	15.0-19.7	15-19	Moderate	
68-84	20-24.7	20-24	Moderate-to-severe	
85-136	25.0-40.0	25-40	Severe	

It is adapted from Barkham et al. (2006) page 8.

The lookup table has four columns. The first column is the total score, i.e. the sum of 34 response values. The next column, the clinical score is the total score divided by the number of items multiplied by 10 (to avoid fractions). The standard deviation is multiplied by 10 to make sure it does not alter any of the psychometric properties of the measure (Barkham et al., 2006). The third column is the clinical score rounded to the nearest ten, the simple score. The fourth column identifies the level of severity experienced by the client, as represented by the scores. The CORE

system designed the domains to operate independently and separately. For example, the risk's scores can be used independently to flag a dangerous situation.

The original cut-off point was 1.19 for men and 1.29 for women; derived from the combined samples of convenience and students (Barkham, Hardy, & Mellor-Clark, 2010a). Later the clinical scores were simplified, and the cut-off points became 12 and 13, respectively. More recent work has established a cut-off point of 10 for the clinical and non-clinical populations, and it applies to both men and women (Connell et al., 2007). The count of 10 is easier to work within a busy routine setting and saves separate calculations for male and female clients. The differences arising from selecting the original or newer cut-off score is relatively small and insignificant. Therefore, this UPsK study used the cut-off point of 10 for both men and women.

The meaning of the scores. CORE-OM is problem-scored; that is, a high score indicates high distress and vice versa. The bands below the cut-off point represent the non-clinical population while above the cut-off point, the bands represent the clinical population. Refer to Table 3.6, page 113. The non-clinical bands are healthy (1-5) and low (6-9). Four bands represent the clinical population: mild (10-14), moderate (15-19), moderate-to-severe level (20-24) and severe level (25-40). It is easy for a psychology officer (counselling) to identify the client's levels of distress by using the look-up table.

Translation of CORE-OM. The researcher got in touch with CORE Information Management System (IMS) to seek permission to use it in this study. Professor Chris Evans from CORE System Trust (CST) replied that CORE was copyleft and that the researcher did not need written permission from CST. Nonetheless, the translation must abide by specific stringent requirements laid out by

CST. Presently there are 22 CORE-OM translations including Italian, Norwegian, Swedish, Japanese, and Gujarati (Evans, n.d.) but none in the Malay language. This study required a Malay language translation of CORE-OM. The UPsK clients, from all walks of life and the length and breadth of the country, use the Malay language as their lingua franca (Ying et al., 2015).

For this study, the questionnaire was bilingual. Both the Malay and English items were on the same page—the Malay item on the top row and the English item underneath it in italics. See Appendix A. Many Malaysians, from pre-school to secondary level, had an average of 11-12 years of English education. However, English is not compulsory to pass at the primary or secondary level; hence there is no guarantee of competent acquisition of the language (Hazita Azman, 2016). Therefore, since the English fluency is uncertain, a bilingual format suited the multicultural and multilingual population in Malaysia better.

Literature has shown that bilingual surveys have been successful in eliciting data from multicultural, multinational and multicultural context (3MC). These surveys are valid and reliable. Take the study by Yeung and team in 2008 that examined the validity of a Chinese Bilingual version of the Client Health Questionnaire (CB-PHQ-9) for screening depression among Chinese Americans in primary care. They found CB-PHQ-9 valid and a useful instrument to use in primary care.

Another example was the English and French interview-format questionnaire by Dufour et al. (2010). They found that the overall equivalence of the English and French versions of the survey was adequate; the agreement measures when administered twice in the same language were not significantly higher than when conducted in each language.

The Malay translation of CORE-OM used the guidelines set by the International Society for Pharmacoeconomics and Outcome Research (ISPOR). (Berger et al., 2012; Evans, 2011). The researcher was not able to abide by the stringent CORE System Trust (CST) requirements due to time and financial constraints so instead used ISPOR guidelines. Table 3.7 sets out the ISPOR steps. These steps were similar to the one used by Mohler, Dorer, Jong, and Hu (2017): translation, review, adjudication, pretesting and documentation (TRAPD) procedures.

Table 3.7

ISPOR Steps for Malay Language Translation

Steps	Checklist	Notes
Forward translation	√	One registered counsellor, one registered translator and one layperson (researcher) translated CORE-OM into the Malay language
Reconciliation	√	Three forward translations reconciled into 1 Malay translation
Back translation	√	One registered translator (no prior involvement) translated the reconciled Malay translation back to English.
Cognitive debriefing interview	√	The final draft Malay translation tested on 35 participants (males, female), young adults to older adults and from all zones.
Review	√	Final Malay translation of CORE-OM
Proofreading	√	Corrected topography and grammar

Three people independently translated CORE-OM into the target language (Malay). One of them was a registered translator with the Malaysian National Institute of Translation. The three forward translations reconciled into one. The reconciled version was given to an independent translator (not part of the first translation team) to translate it back to the source language (English), known as the back-translation. This second translator came from the Malaysian Translator Association, where she

received her training. The team scrutinised the original CORE-OM and the back-translated version for discrepancies in style and content. After much discussion on cultural context, a harmonized Malay translation evolved. This final draft version underwent cognitive debriefing.

The purpose of cognitive debriefing was to examine whether the Malay language version conveyed the same meaning as in English (Wild et al., 2005). Thirty-five participants via convenient sampling took part in the debriefing exercise. They were male and female students from the University of Malaya, ranging from young adults (18-35), middle-age (36-55), and older adults (>55). The changes recommended were (1) chose more definitive Malay words to represent the meaning intended, and (2) some items in English were not apparent in its meanings. The final Malay version incorporated inputs from the cognitive debriefing interviews, especially to get the nearest Malay words to represent the meaning intended. However, the researcher could not make changes in the English items because it is copyleft, and the study did not get permission to amend the original items.

The end-stage of the translation process was proofreading to eliminate grammatical and typographical mistakes. Finally, the Malay translation was ready to use. The researcher incorporated the Malay translation into the bilingual CORE-OM version for this study. The 34 items were in Malay, followed by English written in italics on the next line on the same page.

The complementary CORE assessment forms were in the original version, i.e. not translated into Malay. The reason being the psychology officers' (counselling) English competency was higher than average since they passed the mandatory Malaysian University English Test (MUET) at Band 3. This band is the minimum

required level for most courses in Malaysian universities except for medicine, law and English language subjects like TESL and English literature, for example.

In this study, minor adjustments were made to the CORE Assessment forms to make sure the items were relevant, clear and pertinent so that the busy psychology officer (counselling) completed the forms without much trouble:

Adjustment in TAF. Three categories in the TAF were irrelevant and may create confusion in the psychology officer, hence dropped in the adjusted TAF for the UPsK study. The categories were history of help-seeking, medication, and mental illness status. The study accepted only new cases, so items on the client's previous help-seeking history were not relevant. The researcher removed items on medical prescriptions, and the list of International Classification of Diseases-10 (ICD 10) because psychology officers were not sufficiently knowledgeable about them.

Adjustment in EOT. The UPsK study retained most categories in EoT except for types of therapy. There were 11 therapies listed; the researcher selected the most used while dropping the rest. The popular therapies were brief/structured, cognitive, behavioural, person-centred, integrative and cognitive/behavioural. The less conventional therapies dropped were psychoanalytic, psychodynamic, systemic and art therapy.

Data Collection

Data collection comprised several aspects: (1) ethical consideration; (2) timeframe for research; (3) distribution: (4) preparation for national survey; and (5) procedures for conducting the survey. Included in data collection were the interview sessions for the second phase of the explanatory sequential design.

Ethical considerations. Included in ethical consideration was seeking permission to research in a specific setting. For a hospital setting, the gatekeeper is the National Medical Research Registry (NMRR). It is a web-based service initiated by the National Institutes of Health (NIH), Ministry of Health Malaysia (MOH) to support the NIH guidelines on the conduct of research in MOH facilities that involve MOH personnel. NMRR will vet and later approve the research proposals. If it involves human subjects, there is an additional review by the MOH's Research and Ethics Committee (MREC) (NMRR, 2006).

All researchers planning to research in the Ministry of Health institutions must apply for registration. The researcher registered and received a partial researcher identification number—NMRR ID.1427-12638. With this partial identification number, the researcher contacted 33 hospitals to apply for access to the UPsKs. The hospital's clinical research centre (CRC) vetted the application. It either recommended the Hospital Director to accept or reject the application. When all parties agreed, the Hospital Director signed the Investigator, Head of Department and Organisation Agreement (IA-HOD-IA) form. However, hospitals without CRC caused delays because the overburdened hospital Director would "pass the buck" to the MOH's State Department to do the approval process. After a year of seeking permission from hospital directors, finally, all the IA-HOD-IA forms were signed and submitted to NMRR.

On April 1, 2015, NMRR approved the research proposal and gave the researcher the full identification number—NMRR-12-1427-12638 (IIR)—along with access to eight UPsKs. However, this small number of hospitals were not enough to provide 337 clients (sample size) in four months. Hence, the researcher resubmitted for more add-on sites. The following month, May 22, a new batch of hospitals were

approved. Again, there were technical problems, so another resubmission was made. The approval for the third batch came on September 21, 2015. In total, NMRR/MREC agreed to allow access to 37 UPsKs; however, ten UPsKs declined participation. Finally, 27 UPsKs participated in the study.

Timeframe. The research period was over four months, from August to December 2015. See Figure 3.3. The decision to limit to four months was after considering the literature on the number of therapy sessions, cost and time available. According to literature, clients benefited from any number of psychotherapy sessions, even one. In the classical study by Howard, Kopta, Krause, and Orlinsky (1986), the clients' improvement decreased with treatment length. The classical study was further refined in 1994 by Kopta, Howard, Lowry, and Beutler who found that effective dose varied across different types of symptoms. Hence, time was not a critical factor (Berggren & Josefsson, 2013; Noble, 2015).

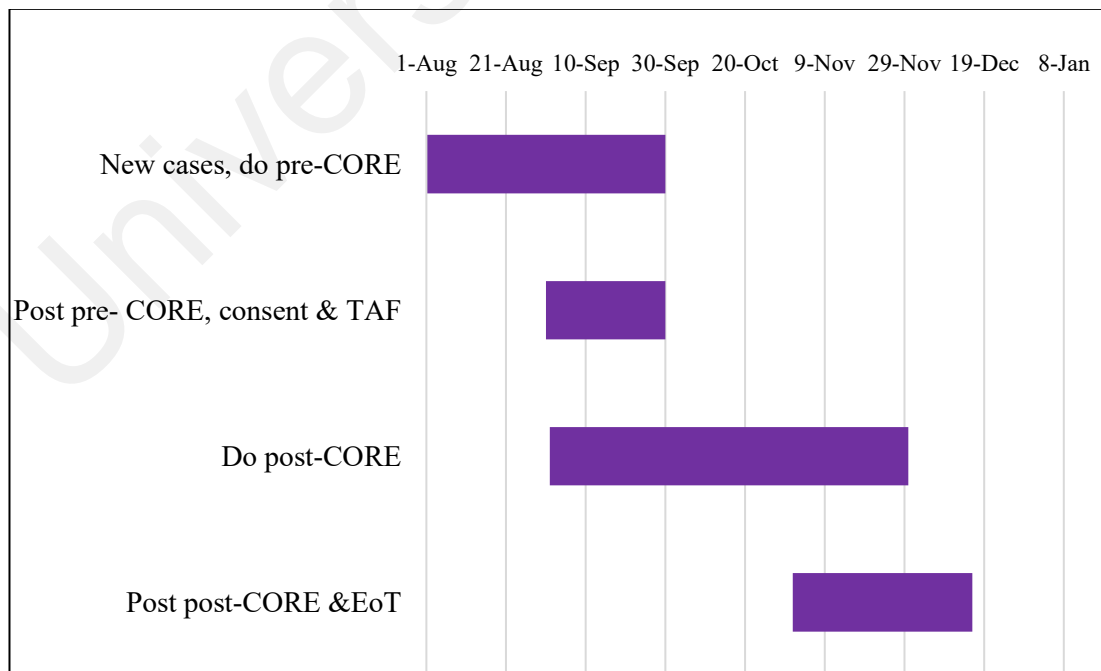


Figure 3.3. Gantt Chart for Distribution, Collection, and Postage of CORE-OM

Nonetheless, the researcher was flexible for practical reasons; for example, some UPsKs had their period extended until middle December to allow them to get new cases. The reality was that new cases did not come regularly. It was seasonal, for example, in the month of Ramadan (Muslims' fasting month), there were no new cases.

Many psychology officers (counselling) did not follow the data collection protocol for posting the packages back to the researcher. Instead, they kept aside the completed pre-CORE questionnaires and waited for the completed post-CORE, then posted pre-and post-collections together to the researcher using the prepaid *poslaju* envelope placed in the research package. The pre-data collection comprised CORE-OM questionnaires, consent and TAF forms while the post-data collection comprised CORE-OM questionnaires and EoT form.

Distribution. The researcher distributed 570 CORE-OM questionnaires to 27 UPsKs around the country, which were more than the required sample size (337) needed. The survey was conducted simultaneously in the 27 UPsKs. The researcher did this with the assistance of psychology officers (counselling) who facilitated the distribution and collection of the CORE-OM questionnaires to the clients.

There was attrition when 12 UPsKs did not participate in the survey. The attrition caused significant loss in completed questionnaires. Other factors such as incomplete sets of CORE-OM (pre/post); and the invalid participation of young person (11-16 years old) compounded the loss further. The final count was 103 cases with completed sets of CORE-OM (pre/post). See Figure 3.4.

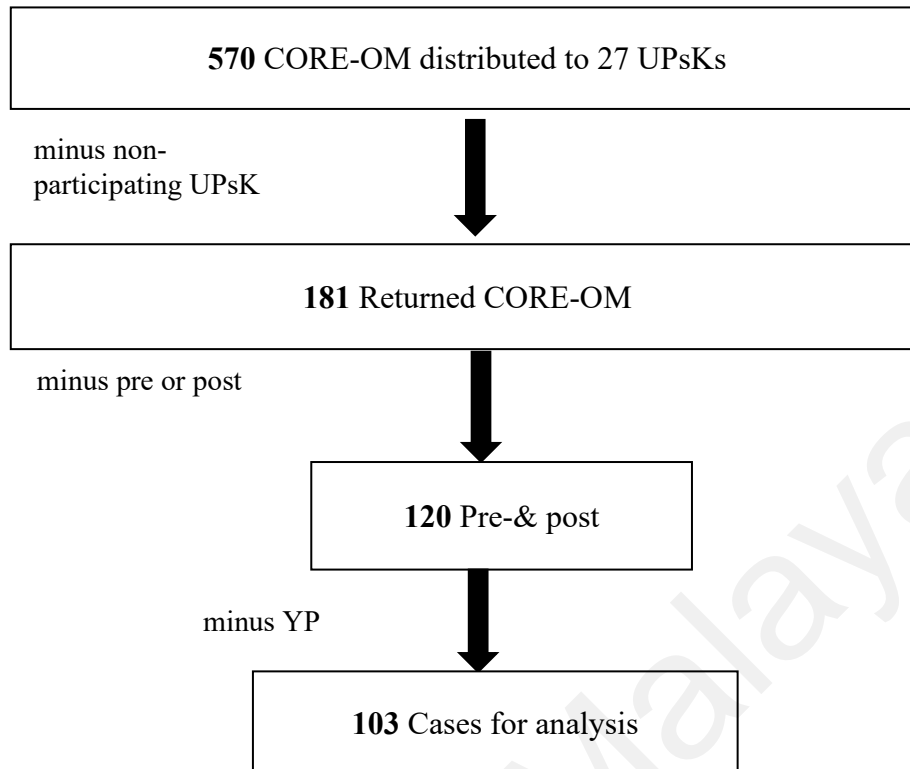


Figure 3.4. Data Distribution and Collection Flow Diagram

Preparation for a national survey. The study was conducted simultaneously in 27 UPsKs over four months. The researcher did not do it alone; she trained the psychology officers (counselling) to facilitate the process of data collection. The training sessions conducted were either face-to-face or virtual sessions. Based on the constraints of time and finances, the researcher conducted face-to-face training session at UPsKs in (1) Kuala Lumpur, Selangor, Negri Sembilan (day trip); (2) Perak and Penang (sister lives in Penang); (3) Johor (son’s hostel in Johor). For the rest of the UPsKs, the researcher conducted virtual training sessions.

There was a total of 25 psychology officers (counselling) who facilitated data collection. At pre-testing, they distributed CORE-OM questionnaires before the counselling session began and collected them back at the end of the session. Similarly,

at post-testing, the same procedure was carried out. The psychology officers had to follow specific procedures to maintain standardization.

The virtual training session also had standard operating procedures to ensure uniformity of action each time. The procedures were (1) PowerPoint presentation emailed to the head of UPsK, (2) research packages posted via registered mail and (3) follow up with the heads of the respective UPsKs. The researcher planned to use technological applications such as conference call or Skype video to communicate with the heads of the UPsKs however, their offices did not have the technical capability to support such technology. At the end, when all else failed the traditional, ubiquitous telephone call worked out well for everyone. The virtual sessions became a series of telephone conversations.

The researcher was aware that the benefits of convenience (i.e. no long, costly trips) were often at the perils of something else and in this case, the inherent weakness in telephone conversations. There was a higher risk of miscommunication and the lack of bonding between psychology officers and the researcher (Blenke, 2013; Ong et al., 2012)

Griffin (2011) said that communication is one of the factors for success. The researcher was aware of the inherent weakness of non-face-to-face encounters (Blenke, 2013) and to mitigate that she came up with the idea of creating a WhatsApp group. This online group could overcome the physical distance and establish communication between the researcher and the psychology officers in real-time. The objectives were to help officers overcome problems in data collection and share acceptable practices; to develop camaraderie so that nobody felt alone or unsupervised during the research period. The WhatsApp group was named 'CORE Research Group', and all participating psychology officers (counselling) became members.

Some became active members frequently sent messages and shared information, but the majority were bystanders, the type that passively read messages only. In the end, it was a failure.

Procedures for conducting the survey. The psychology officer must invite eligible prospective participants (fulfilled the criteria) to join the survey voluntarily. To do that the officer must follow specific procedures to maintain consistency throughout the research period. After registration, the psychology officer began the procedures. First, the psychology officer (counselling) determined the client's eligibility as set out in the criteria in Table 3.2, page 108. Second, eligible clients were given a Participant Information Sheet (Appendix E) with a Consent Form (Appendix F). The psychology officer might assist or give any relevant explanation to the client if required. Third, upon signing the consent form, the client was given the CORE-OM to complete. The client had reasonable time and space given to complete the questionnaire and then to return the questionnaire before the intervention session began.

The second phase of the explanatory sequential design required the researcher to conduct semi-structured interviews with three selected psychology officers (counselling), and she developed an interview protocol.

Interview protocol. The interview protocol guided the whole process (Castillo-Montoya, n.d.; Jacob & Furgerson, n.d.); it was akin to the instrument of research. The interview protocol had the topics, questions, and prompts to facilitate a productive interview between the researcher and the psychology officer (counselling). See Appendix I. Before the interview, the psychology officer (counselling) completed the consent form and read the explanatory research statement. See Appendices G and H.

Pilot Testing of CORE-OM

CORE-OM is a global distress questionnaire that is a screening tool as well as an outcome measure (CORE IMS Ltd, 2014). The researcher used CORE-OM as a screening tool in the pilot study. The pilot study utilised an online survey platform to get as many participants from the community quickly and conveniently. It eliminated the need to distribute and collect the questionnaire from the participants physically.

The number of participants was 341 people comprising of friends, relatives, colleagues, fellow PhD students as well as nursing students. The purpose of the pilot test was to determine the construct validity of the adapted CORE-OM by identifying the underlying factors that explained the interactions between the variables. Refer to Chapter 4, The validity of CORE-OM, page 134 for the results.

Data Analyses

This section describes the steps taken to analyse the specific data according to the method of collection carried out, that is, quantitative and qualitative. Statistical analyses were carried out on the quantitative data first as expected in the explanatory sequential design. Then based on the results of the statistical analyses, it was possible to determine the area that needed qualitative exploration. Qualitative exploration and thematic analyses brought a deeper understanding of the phenomenon—performance of the UPsKs. Refer to Table 3.8 to see the types of analyses carried out.

Quantitative analyses. The analysis and interpretation of the quantitative data used IBM SPSS version 23. The researcher analysed the quantitative data in two stages: (1) preliminary analyses and (2) actual data analyses to address specific research questions. In the preliminary analyses, the data were screened for errors, assessed for normality, checked for outliers, checked for reliability, the validity of

CORE-OM and description of the clients' demographics and characteristics. For the actual study, the CORE-OM scores underwent both descriptive and inferential analyses.

The quantitative questions had four descriptive research questions, one correlational, one on benchmarking and another on matrix. The first descriptive research question described the levels of the distress of the clients due to psychological problems and risky behaviours. Second, described the context of the clients; third described the type and frequency of therapies used; fourth, determined the percentage of clients in the outcome categories. The fifth question was inferential; that is, the determination of associations of several variables with client outcomes. The sixth question was about using CORE-OM as a benchmarking tool to determine the service benchmarks values and how well the other UPsKs matched up to them. The seventh was the creation of a matrix and to see the performance rankings of the participating UPsKs.

Qualitative analyses. The performance of the UPsKs needed further exploration by getting inputs from the psychology officers (counselling) to understand it better. Hence the eighth question was qualitative about the engagement of the psychology officers in the process of assessment. The researcher used Excel and Microsoft Word to conduct thematic analyses on the qualitative data.

The study used a mixed-method approach, applying the explanatory sequential design. The design's core was quantitative (75%), and the supplemental qualitative aspects made up the remaining quarter. In Chapter 5, the researcher discussed the integration of qualitative and quantitative findings of using CORE-OM as the outcome measure and as a benchmarking tool in the UPsK setting.

Table 3.8

Summary of Statistical Tests by Research Questions

Analysis	Statistical tests
<i>QUANTITATIVE:</i>	
Normality	Shapiro-Wilk Test, Z-score
Reliability of CORE-OM	Cronbach alpha
Construct validity	Exploratory Factor Analysis using Principal Component Analysis (PCA)
Demographics & characteristics	Frequency, mean, confidence intervals
RQ 1.1 – 1.3	Descriptive
RQ 2	Mean, Percentage, Effect size
RQ 3	Frequency
RQ 4	Percentage
RQ 5.1 – 5.3	Correlational Cross-tabulation, Chi-square Independent Test, Cramer's V
RQ 6.1 - 6.2	Benchmarking Percentages, Percentiles
RQ 7	Percentage
<i>QUALITATIVE:</i>	
RQ 8	Thematic analysis. Use code, sub-coding, and themes.

Conclusion

This study employed a mixed-method approach to examine the assessment system in counselling psychology services (UPsK) in selected MOH hospitals. It involved UPsK clients and psychology officers who completed the standardized routine outcome measure, CORE-OM, and CORE assessment forms, respectively. The data collection had substantial attrition resulting in a reduced number of cases. The lack of face-to-face contact with the psychology officers may have contributed to the small sample size. Nevertheless, the number of cases was sufficient for analysis.

In the exploratory sequential design, the researcher analysed data in two phases. The first phase analysed the quantitative data. From the analysis, the results identified the area that needed further exploration via a quantitative method. After the

qualitative data was collected, the data underwent thematic analyses. The integration of both the quantitative and qualitative findings gave some insights into the performance of the UPsKs.

Universiti Malaya

CHAPTER 4

RESULTS

Introduction

This chapter presents the overall results from the analyses carried out on the CORE-OM questionnaire, CORE Assessment forms and the qualitative interviews conducted with selected psychology officers (counselling). The results answered the research questions 1-8. This research used the mixed method (explanatory sequential design) approach to explore the diverse perspectives and to explain in depth the phenomenon of using CORE-OM as an outcome measure and as a benchmarking tool.

Preliminary Analysis

The CORE-OM has 34 items with four sub-scales. The first two sets of subscale have 12 items each, and the other two shorter sub-scales with 6 and 4 items respectively. According to the CORE system, the number of missing items allowed for the 12-item subscale was three and only one items for the shorter sub-scales (Skre et al., 2013). The first thing the researcher examined was for any inaccuracy in data entry and to detect missing values (Pallant, 2013). She used the SPSS Missing Value Analysis. See Table 4.1. There were a total of 17 missing counts in the pre- and post-data.

Table 4.1

Pre and Post Missing Variables by Domain and Dimension

	Functioning	Symptom/Problem	Wellbeing	Risk
Pre-	F7, F8, F11, F12	P8	W2, W4	R6
Post	F3, F6, F7, F8, F11	P3, P8	W4	R3

The details of the missing counts were obtained by the Multiple Imputation Analyse Pattern which showed there were 17 missing variables (25%), coming from 7 cases (6.8%) and the total number of values missing was 0.243%. Were the missing

values random? The researcher used Little’s MCAR test to determine that. It showed that the missing pattern was not random ($\chi^2 = 560.8$, $DF = 459$, $p = .001$). See Figure 4.1.

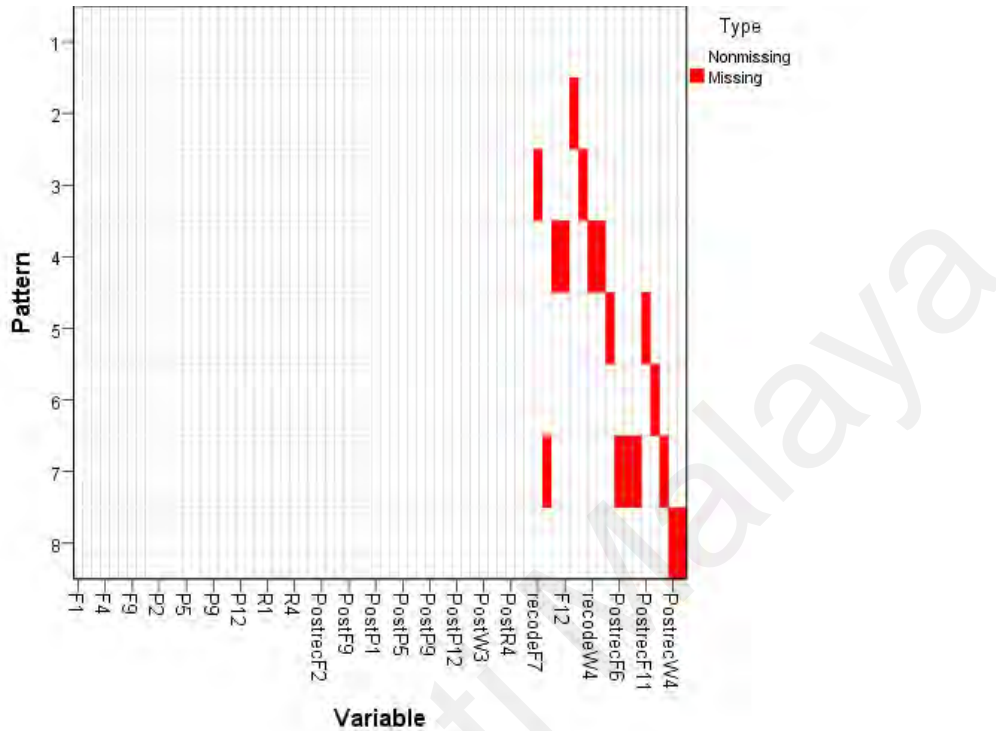


Figure 4.1. Missing Value Pattern Showing Non-Random Distribution

There were seven missing cases which represented 2% of the whole. These cases could be deleted, however, due to the small number of participants (103) it was essential to maintain the sample size to avoid having a larger standard error, lesser power, and the introduction of bias in effect estimates (“Handling missing data,” 2015). Therefore, the missing data were not deleted but replaced by values produced by SPSS Series Means. It is one of the five options of imputation in SPSS (Cokluk & Kayri, 2011).

The percentage of missing values (2%) in this study was comparable to a British study where the overall missing rate was 1.7% (Evans et al., 2002), and a Swedish study where there was 0.44% omitted values (Elfström et al., 2012).

The researcher used SPSS Explore to identify outliers in the individual domains: Functioning, Symptom/Problem, Wellbeing, Risk from both the pre and post data. The variables from the three domains (Functioning, Symptom/Problem and Wellbeing) had no outliers. However, the Risk variables in the post data had outliers. The extreme scores came from clients who displayed risky behaviours (minority) while the majority of clients did not. This disparity caused the scores from the minority to lie beyond the 1.5-3 Interquartile range (IQR). Scores that lie outside this range are considered outliers (Hoaglin & Iglewicz, 1987). The researcher also tested the total scores at pre and post-testing for outliers. Both the total scores at pre- and post-testing had no outliers. Therefore, the researcher used all 103 cases for analysis.

Many psychological variables approximate a normal distribution, so it is essential to determine whether a data has a normal distribution. Equally important to note that data with normal distribution can use many kinds of statistical tests for analysis.

Normality of pre-and post-CORE-OM scores. The study chose the Shapiro-Wilk test over the Kolmogorov-Smirnov (K-S) test because it provided better power than the K-S even after the Lilliefors correction (Steinskog et al., 2007). The Shapiro-Wilk test showed that the pre-scores were not statistically significant, while the post-scores were statistically significant. Histograms and Normal Q-Q plots were also carried out, and both presented the same pre- and post-results. The final test was the z scores for skewedness and kurtosis. See Table 4.2. The results showed the post-scores were at the boundary of a normal distribution, $z = 1.95$, indicating positive skewedness.

Table 4.2

Tests of Normality for Pre- and Post-scores

	Shapiro-Wilk Test		Z-Scores	
	D.F.	Sig.	Skewedness	Kurtosis
Pre-scores	103	.856	-.07	-.30
Post-scores	103	.002	1.95	-1.45

In summary, the UPsK's pre- and post-scores were normally distributed. Take note the post-scores had strong positive skewedness.

Reliability of CORE-OM. Reliability is the ability of CORE-OM to consistently reflect the construct “distress” that it measures (Field, 2013) and the Cronbach alpha value represents the level of reliability (DeVellis, 2012). The desirable Cronbach alpha values adopted by Evans et al. (2002) for CORE studies were between 0.75 and 0.95. Values less than 0.60 indicated lack of internal consistency, more than 0.95 indicated the variables were measuring the same phenomenon, that is, items that were semantically equivalent and therefore did not add anything new.

A pilot study comprising 341 participants, made up of nursing students, university students, professionals and others, completed CORE-OM via an online survey ‘Google Form’. The data collected were analysed for reliability. See Table 4.3. All the domain subscales were within the statistically acceptable values, i.e. more than .6 and not more than .95.

Table 4.3

Cronbach Alpha Values for Domains

Domain	(n=341)	
	Cronbach α	95% Confidence interval
SWB (4 items)	0.65	(0.597-0.768)
Problem (12 items)	0.89	(0.928 -0.959)
Functioning (12 items)	0.76	(0.764 - 0.867)
Risk (6 items)	0.79	(0.794 - 0.885)
All items (34 items)	0.93	(0.932 - 0.961)

Table 4.4 shows the internal reliability of translated CORE-OM in different languages (Evans et al., 2002; Skre et al., 2013; Uji et al., 2012). The Malaysian study was bilingual, and on the whole, its reliability values were comparable with other studies. Looking at the subjective wellbeing domain, the Malaysian and Japanese alpha Cronbach values were much alike in contrast to the values found in the western countries like the U.K. and Norwegian.

Table 4.4

Reliability of Domains in Different Languages

Domains	Bilingual	English	Japanese	Norwegian
Subjective wellbeing	0.65	0.75	0.68	0.7
Problems/symptom	0.89	0.88	0.89	0.87
Functioning	0.76	0.87	0.81	0.84
Risk	0.79	0.79	0.83	0.81
All items	0.93	0.94	0.94	0.94

(Evans et al., 2002; Skre et al., 2013; Uji et al., 2012)

The domain with the lowest internal reliability was subjective well-being, and the domain with the highest internal reliability was the problem/symptom. The Cronbach alpha values obtained from Malaysian participants were consistent with the other CORE studies.

The validity of CORE-OM. Construct validity is the degree to which a test measures what it is supposed to measure (Polit & Beck, 2012). Evans et al. (2002) undertook exploratory factor analysis using principal component analysis for clinical and non-clinical samples to determine the underlying factors that can explain the interrelations between the variables.

This study also used exploratory factor analysis with principal component analysis. According to Tabachnick and Fidell (2013), in their review of PCA and Factor Analysis, concluded: “If you are interested in a theoretical solution uncontaminated by unique and error variability FA is your choice. If, on the other hand, you want an empirical summary of the data set, PCA is the better choice” (page 640). For this study, the purpose of using principal component analysis was to get a summary of the underlying factors for the Malaysian bilingual CORE-OM data set.

The precursor to principal component analysis was to test its suitability. The study used the Kaiser-Meyer-Olkin Sampling Adequacy Test. The expected KMO values ranged from 0-1; the result was KMO .93. The data were thus suitable for principal component analysis.

The first principal component analysis showed that six components had eigenvalues of more than 1; however, the scree plot was unclear. To seek further clarification on the eigenvalues, the researcher carried out a Monte Carlo PCA for Parallel Analysis. The result showed that only three components had the required eigenvalues. Both Kaiser’s criterion and Catell’s scree tests tended to overestimate the number of components (Hubbard & Allen, 1987) while the Monte Carlo test narrowed it down to an accurate estimation.

The data was analysed again using the three extracted factors. The oblique rotation approach was utilised based on the assumption that the components were

related. The Pattern Matrix showed definitive items loading on them. See Table 4.5. The name of the components was according to the main characteristics of the items in them. Component 1 was called negative, component 2 was positive, and component 3 was risk.

Table 4.5

Pattern Matrix of CORE-OM

Item	1(Negative)	2 (Positive)	3 (Risk)
P5 disturbed by unwanted thoughts	.799		
W2 felt like crying	.779		
W3 overwhelmed by problems	.735		
P10 felt unhappy	.728		
F1 very alone	.720		
P6 felt panic	.692		
P4 Tension and anxiety	.692		
P1 felt tense	.684		
P9 felt despairing	.684		
P11 Unwanted images	.674		
P 12 I am to blame	.654		
F9 have no friends	.649		
F12 felt humiliated	.608		
F10 irritable with people	.586		
P2 lacking in energy	.571		
P8 impossible to put aside	.552		
P7 difficulty to sleep	.522		
F8 criticised by other people	.521		
R5 better if I was dead	.483		
W1 recoded	.441	.346	
P3 troubled by aches	.410		
F4 Talking too much	.373		
F11 I have achieved things		.748	
F7 I have been able to do most things		.692	
F3 I have been able to cope		.661	
F5 I have been happy with the things		.656	
F2 I have felt I have someone to turn		.582	
F6 I have felt warmth and affection		.468	
W4 I have felt optimistic		.372	

Table 4.5 (Continued)

Item	1(Negative)	2 (Positive)	3 (Risk)
R4 threatened another person			.739
R1 physically violent			.734
R6 taken dangerous risks			.590
R2 thought of hurting myself	.365		.381
R3 end my life	.366		.367

P=problems/symptoms, W=well-being, F=functioning, R=risk

The matrix showed 22 negative items came from 3 domains—functioning, symptoms/problems and well-being, while eight positive items from domains, functioning and well-being. The risk items were clearly from the domain risk. The Malaysian CORE-OM data showed a pattern matrix that was the same with a similar study by Evans et al. (2002). The UPSK study used the psychometric properties for content and criterion validity from the studies by Lyne, Barrett, Evans, and Barkham (2006), and Evans et al. (2002).

In summary, the CORE-OM used in the Malaysian study was reliable and valid. The domain subscales were within the statistically acceptable values, i.e. between .6 and .95; and the total alpha value of CORE-OM was .93. It had the same robust underlying factor structure similar to the original CORE-OM in a study by Evans et al. (2002).

Clients' demographics and characteristics. Table 4.6 shows the demographics of the clients obtained from the therapy assessment forms (TAF). A third of the participants were in the age range of 26-35 years, and the least number of clients (5.9%) were above 56 years old. Two-thirds were female, predominantly Malay (>50%) followed by Chinese and Indians. There were only a small number of ethnic Sarawakian and no ethnic Sabahan participants. Almost half were employed (full & part-time), and 17% were without jobs. However, 12% of clients did not

answer, which cast doubt on the percentage accuracy of the other components. The majority lived with family members, friends, and only 10% lived alone.

Table 4.6

Demographics of Clients

Demography	Count	Percentage	95% C.I.
Age			
17 – 25 years	25	24.1	16.5 – 32.0
26 – 35 years	32	31.1	22.3 – 40.8
36 – 45 years	26	25.2	16.5 – 34.0
46 -55 years	14	13.6	7.8 – 10.4
>56 years	6	5.9	1.9 – 10.7
Gender			
Female	62	60.2	50.2 – 69.9
Male	41	39.8	30.1 – 49.5
Race			
Malay	54	52.4	42.7 – 62.1
Chinese	22	21.4	13.6 – 29.1
Indian	13	12.6	6.8 – 19.4
Ethnic Sarawakian	10	9.7	3.9 – 16.5
Ethnic Sabahan	3	2.9	0 – 6.8
No answer	1	1	
Employment			
>40 hours per week	42	40.8	31.1 – 49.5
<40 hours per week	7	6.8	2.0 – 11.7
No job	17	16.5	9.7 – 24.3
Student	6	5.8	1.9 – 10.7
Housewife	11	10.7	4.9 – 16.5
Retiree	2	1.9	0 – 2.9
Others	5	4.9	1.0 – 9.7
NA	12	11.7	5.3 – 17.5
Relationship/Support			
Living alone	8	7.8	2.9 – 12.6
Living with partner	46	44.7	35.0 – 53.4
Living with parents	40	38.8	29.1 – 47.6
Living with friends	10	9.7	4.9 – 16.5

Table 4.7 shows the location, type and the number of clients from each of the 13 UPsKs.

Table 4.7

The Participating UPsKs

No. of clients	Centra			East		North			South		Sabah	Sarawak	
	HA	HB	HC	HD	HE	HF	HG	HH	HI	HJ	HK	HL	HM
103	23	8	5	9	8	2	5	26	1	1	4	10	1
Type of hospital	state	state	major	major	major	state	state	state	major	state	major.	minor	major

Quantitative Research Analyses

The central part of the analyses examined the quantitative research questions (RQ) 1-7. Research questions 1-4 used descriptive statistics to highlight the distress, client context, type of therapy and client outcome. Research question 5 examined whether there were any associations between the independent variables (distress, therapy, frequency, client context) and client outcomes. In research question 6, the CORE-OM was the benchmarking tool, and the service benchmark values of each outcome categories were determined. Then the UPsKs' rate of change was matched with the benchmark values. The final quantitative research question 7 was on the creation of a matrix that could display the performance of the participating UPsKs.

Descriptive analyses of RQ 1-4. Research questions 1-4 used descriptive statistics to highlight the clients' distressful experiences, contexts, outcomes, as well as the service offered by the UPsKs. The data came from 103 clients in 13 UPsK around the country.

Clients' distress. The study began with examining clients' distress for which they seek treatment from UPsK. These clients were distressed as a result of many factors that were operating in their lives, for example, psychological, financial, work-related, family matters and many others. They hoped that by undergoing psychological

intervention; they would develop coping skills to alleviate these distresses and henceforth be able to function in their daily lives fully.

RQ 1.1 What are the distress levels experienced by the UPsK clients before and after intervention?

CORE-OM measures the level of distress of the clients in four domains, that is functioning, symptoms/problems, well-being and risk. There are 12 items each in functioning and symptoms/problems, four in well-being and six in risk. CORE-OM uses a scoring system based on a 5-point scale. It ranges from 0 (not at all) to 4 (most of the time). The minimum total score achieved is 0, and the maximum is 136. The overall mean score is the total score divided by the number of completed item response (34 items).

For this study, the total pre-mean score was 1.81, and the overall post-mean score was 1.00. Were there statistically significant differences between the pre and post mean scores? The study conducted a paired-samples t-test, and the result showed that the mean differences of .80 were statistically significant (2-tailed). See Table 4.8.

Table 4.8

Statistical Differences between Pre and Post Mean Scores

	Mean	S.D.	S.E. Mean	95% C.I.		<i>t</i>	D.F.	Sig (2-tailed)
				Lower	Upper			
Mean pre scores - Mean post scores	.8047	.7257	.0715	.6629	.9465	11.25	102	.000

The mean difference was statistically significant but has it any practical relevance? The question was answered by looking at effect size—the analysis used eta squared statistics.

The eta squared formula is $\frac{t^2}{t^2+(N-1)} = \frac{11.254^2}{11.254^2+(103-1)} = 0.6$.

Using the guidelines by Cohen (1988), the result of .6 showed that it had a large effect (.01=small effect, .06=moderate effect, .14=large effect). There was a substantial practical relevance in the differences between the pre- and post scores. The explanation came from the data in Table 4.9. It shows the number and per cent of clients at each severity levels at pre-and post-testing.

Table 4.9

Percentage of Clients in Severity Levels at Pre and Post-Testing

Severity levels	Pre		Post	
	n	%	n	%
Non-clinical: Healthy	5	4.9	30	29.1
Low	9	8.7	23	22.3
Clinical: Mild	16	15.5	27	26.2
Moderate	32	31.1	15	14.6
Moderate to severe	27	26.2	8	7.8
Severe	14	13.6	0	

At baseline (pre), 86% of clients were in the clinical population and 14% in the non-clinical population at all levels of severity. The most number of clients were at a moderate level, with 31% followed by moderate to severe, mild and severe. After the intervention, the post-testing results showed improvement in the overall distress levels. Slightly more than 51% of the clients were in the non-clinical population. The degree of distress had also fallen drastically—there were no clients in the severe level (0%)—after interventions. The drop in the scores accounted for the big mean difference (.80) between pre and post scores. The real-life impact was relevant (effect size) because many clients showed recovery, that is they moved from the clinical population to be in the non-clinical population.

In summary, there was a statistically significant decrease from pre-mean scores to post-mean scores. The mean difference was statistically significant ($M=.81$, $SD=.73$), $t(102)=11.3$, $p<.0$ (two-tailed). The mean decrease was .80 with a 95%

confidence interval ranging from .663 to .947. The eta squared statistic indicated a large effect size of .6. At pre-testing, 86% of the clients lay in the clinical population, however, after the interventions, only 49% remained in the clinical population, and there were no more clients at a severe level.

RQ 1.2: How severe are the psychological problems experienced by the UPsK client before and after intervention?

There are 14 psychological problems listed in the Therapy Assessment Form (TAF) (CORE IMS Ltd, 2014): (1) depression such as the feeling of hopelessness, (2) anxiety such as being irritable and restlessness, (3) psychosis such as having delusions, (4) personality such as lacking empathy, (5) cognitive such as having learning difficulties, (6) eating disorder such as being anorexic, (7) bereavement such as suffering loss, (8) self-esteem such as having confidence, (9) interpersonal such as not having any relationship with others, (10) living such as having sufficient finances, (11) work such performing at work, (12) physical such ailment that is psychosomatic, (13) addiction in substances or gambling and (14) trauma. There is an option 'Others' for psychological problems that are not listed.

The psychology officer (counselling) listened actively to the client's recounting of his/her distress. According to Fritscher (2016), it is the client's self-diagnosis on what is psychologically wrong with him/her. The psychology officer (counselling) ticked as many relevant psychological problems from the list of 13 that matched with the psychological problems presented by the client. The problems could be more than one, that is, comorbid. The note-taking is part of the intake and inquiry section of the assessment (Fritscher, 2016). Then the psychology officer (counselling) diagnosed and determined whether it was the actual problem (Fritscher, 2016;

Hutchings & Virden, 2010) based on many factors, such as duration, circumstances, context, history and prior attempts to resolving it (Hutchings & Virden, 2010).

The pre-testing was at baseline, and the post-testing was after the client had undergone intervention within the four months of research. Was there any difference in the psychological problems between pre-and post-testing? The study analysed the changes, particularly examining the frequency, mean scores, standard deviations and the effect sizes. The results showed that the most common psychological problems were anxiety, self-esteem issues, interpersonal relationship and depression at both pre- and post-testing (see Table 4.10).

Table 4.10

The Changes in Psychological Problems at Pre & Post

	Pre			Post			effect size
	<i>n</i>	mean	S.D.	<i>n</i>	mean	S.D.	
Anxiety	67	1.74	1.39	57	0.78	0.81	0.9
Self-esteem	49	1.21	1.38	43	0.6	0.81	0.6
Depression	40	1.1	1.47	39	0.51	0.74	0.5
Interpersonal relationship	44	1.11	1.35	42	0.56	0.79	0.5
Personality problems	19	0.47	1.03	14	0.17	0.2	0.4
Physical problems	18	0.48	1.07	17	0.26	0.66	0.3
Living/Welfare	20	0.48	1.03	23	0.28	0.57	0.3
Work/Academic	28	0.67	1.19	28	0.4	0.73	0.3
Addiction	16	0.37	0.91	15	0.16	0.39	0.2
Bereavement/loss	9	0.24	0.82	6	0.09	0.37	0.2
Trauma/abuse	6	0.14	0.56	7	0.1	0.38	0.1
Cognitive /learning	3	0.06	0.34	5	0.07	0.32	0.03
Psychosis	3	0.07	0.4	5	0.09	0.42	0.05
Eating disorder	1	0.03	0.3	2	0.03	0.22	0.0
Other	5	0.05	0.22	5	0.05	0.22	0

The least frequent was an eating disorder. The psychological problems were often comorbid, meaning the client had two or more psychological problems co-

occurring at the same time. In this study, anxiety was comorbid with self-esteem and depression in more than half of the clients.

Almost half (43%) of the psychological problems showed changes (improvement) after the intervention. For example, at pre-testing, 67 clients cited symptoms of anxiety, $M=1.74$, $S.D.=1.39$. At post-test, 57 clients mentioned anxiety, $M=0.78$, $S.D.=0.81$. Clients self-reports showed there was a reduction in the number of anxious clients. The effect size calculated showed that the differences in the mean scores of anxiety at pre- and post-testing had a large effect, according to Cohen's d guideline. The large differences between pre and post had a real practical impact on the mental state of the clients, which may be due to the intervention that the clients had undergone in UPsKs.

Some problems showed an increase in the number of clients such as psychosis and living (financial) problems while some did not change, such as addiction and physical problems. Interesting to note that the differences in mean scores were small and that the effect sizes indicated the differences in mean scores had a low impact in real terms (i.e. not statistically significant).

The study examined the severity levels of the 13 psychological problems at pre-and post-testing to understand more about the changes that occurred. The psychological problems were rated from 1 (minimum) to 4 (severe) on the severity range. At Level 1, the problem caused minor difficulty but did not affect day to day functioning, and at level 2, the problem caused mild difficulty in one area of functioning. However, it did not affect day to day functioning. At level 3, the problem began to cause moderately significant difficulty in more areas of functioning and finally, at level 4, the problem caused severe impairment in all areas of functioning (CORE IMS Ltd, 2014).

Table 4.11 shows the severity levels of the 13 psychological problems at pre- and post-testing. The total number of cases in the minimal, mild, moderate and severe columns added to more than 103 because comorbidity occurred. Where did the change occur? Look at the anxiety row. There were a total of 67 clients who experienced anxiety at pre-testing, 37 of them experienced moderate levels of anxiety, and seven were in the severe level. The high anxiety baseline explained the high mean of 1.74 (see Table 4.10, page 142). At post-testing, changes had occurred. The number of anxious clients had dropped to 57, and 35 of them were at the minimum level and none in the severe level. Hence the low mean score of .78.

Table 4.11

The Psychological Problems' Levels of Severity at Pre and Post

	Presenting Problems (Pre-)					Identified Problem (Post-)					No distress
	Min	Mild	Mod	Sev	Total	Min	Mild	Mod	Sev	Total	
Anxiety	2	23	37	5	67	35	21	1	0	57	10
Self esteem	2	22	19	5	47	26	13	2	0	41	6
InterPersonal	1	18	23	2	44	28	13	0	1	42	2
Depression	1	13	18	8	40	26	12	1	0	39	1
Work	3	13	8	4	28	17	9	2	0	28	0
Living	1	11	6	2	20	17	6	0	0	23	-3
Personality	1	8	9	1	19	10	4	0	0	14	5
Physical	0	7	9	2	18	9	6	2	0	17	1
Addiction	1	9	5	1	16	14	1	0	0	15	1
Bereavement	0	4	3	2	9	3	3	0	0	6	3
Trauma	0	4	2	0	6	4	3	0	0	7	-1
Cognitive	0	3	0	0	3	3	2	0	0	5	-2
Psychosis	0	2	1	0	3	2	2	1	0	5	-2
Eating disorder	0	0	1	0	1	1	1	0	0	2	-1
Others	5	0	0	0	5	5	0	0	0	5	0
Total	17	137	140	32	326	200	96	9	1	306	20

Min=minimal, Mod=moderate, Sev=severe.

The table shows that at pre-testing, the most number of clients with psychological problems were in the mild and moderate levels (85%). However, at

post-testing, the majority of clients were at a minimal level (65%), and there were no clients with severe levels of psychological problems except for interpersonal. Most of the UPsK clients showed improvement in the severity of their psychological problems by the end of the research period. Also, the column 'No distress' shows there were clients who were able to overcome the distress caused by the psychological problems and were now distress free (6%).

In summary, the four leading causes of psychological problems were anxiety, self-esteem, interpersonal relationship and depression. Many were co-morbid. At pre-testing, 67% of clients had anxiety, 46% self-esteem issues, 43% interpersonal problems, and 39% had depression. The clients were at all levels of distress: minimal, mild, moderate and severe. More than 85% were in the mild and moderate levels combined. After undergoing intervention, the percentage of clients with psychological problems had gone down: 55% anxiety, 40% self-esteem, 41% interpersonal and 38% depression. The severity levels were also reduced—65% at a minimal level, no clients at a severe level—and 6% were now distress free.

RQ 1.3 How severe are the risk factors experienced by the UPsK client before and after intervention?

CORE Assessment forms (TAF and EoT) collect data on risk variables such as suicide ideation, harm to self, harm to others and risk in terms of a legal requirement (criminal damage to property such as arson). The risk variables have four levels of severity (none to severe) and rated from 0 to 4. Table 4.12 shows the mean scores, standard deviation, and effect size of the risk variables at pre-and post-testing. At pre-testing, 22% of clients had suicidal ideation, 17% inflicted self-harm, 8% caused harm to others, 5% resulted in legal harm. After the interventions, at post-testing, only 6% of clients displayed suicidal ideation, 4% inflicted self-harm, 3% harmed others and

4% legal harm. The reduction in suicide and self-harm had medium effect sizes while the harm to others and legal had low to negligible effect sizes.

Table 4.12

Changes in the Risk Variables

	Pre			Post			Effect Size
	<i>n</i>	Mean	S.D.	<i>n</i>	Mean	S.D.	
Suicide	23	.32	.69	6	.07	.29	.48
Self-harm	18	.20	.47	4	.05	.26	.41
Harm to others	8	.11	.42	3	.05	.29	.17
Legal/Forensic	5	.07	.35	4	.07	.38	0

Table 4.13 shows at post-testing, the two significant contributors to risk, that is, suicidal ideation and self-harm were less influential than before, and many clients were at the lesser levels of severity. Seventeen clients did not have suicidal ideation any more, and the six that had were in the mild and moderate levels, similarly, with self-harm. The number of clients with legal/forensic risk had declined negligibly.

Table 4.13

The Risk Variables' Level of Severity at Pre and Post

	Pre				Post			
	Mild	Mod	Sev	Total	Mild	Mod	Sev	Total
Suicide	16	4	3	23	5	1	0	6
Self-harm	15	3	0	18	3	1	0	4
Harm to others	6	1	1	8	1	2	0	3
Legal	4	0	1	5	2	1	1	4

Mod=moderate, Sev=severe.

In summary, at pre-testing, 52% of clients had experienced risk factors at all levels of severity. The intervention had reduced the severity levels, evident at post-testing when there were only 17% of clients with risk factors, and out of that, only one client remained at a severe level.

The therapies provided in UPsK. The distressed clients that seek treatment at the UPsKs were treated by trained psychology officers (counselling) with appropriate therapies. The End of Therapy form (EoT) listed six types of therapies: structured/brief, cognitive, behavioural, person-centred, integrative and cognitive behavioural.

RQ 2 What are the type and frequency of the therapies used?

In the EoT form, the psychology officer ticked as many therapies that she/he used in the treatment of the client. The frequency of each therapy used was analysed using multiple response analysis. From the data collected, it was clear that the psychology officers (counselling) used combinations of therapies to get the best and enduring change in the clients. The most common therapies used in treatment cases were structured/brief therapy (56%), cognitive behavioural (48%) and person-centred (37%). See Table 4.14. Hence the percentage of cases added to more than 100%.

Table 4.14

Therapies Used in Combination

Type of Therapy	<i>n</i>	Per cent of cases
Structured/Brief	58	56.3%
Cognitive Behavioral	49	47.6%
Person-centred	38	36.9%
Cognitive	29	28.2%
Integrative	16	15.5%
Behavioural	12	11.7%

The study also examined the combination of therapies used on each client. Table 4.15 shows a third of psychology officers (counselling) used one type of therapy exclusively; another third used a combination of two types of therapies on a client. Less than 5% of psychology officers (counselling) used more than three therapies on the same client.

Table 4.15

The Combination of Therapies Used on Each Client

Therapy	Frequency	Per cent
One therapy	38	36.9
Two therapies	36	35.0
Three therapies	26	25.2
Four Therapies	3	2.9
Total	103	100.0

According to the standard counselling procedure, the psychology officer (counselling) and client discuss and agree on the number of therapy sessions needed for the healing process. The EoT form records the number of therapy sessions. The study analysed the frequency of the sessions to determine whether the number of therapy sessions planned by the psychology officer (counselling) corresponded with the number of therapy sessions attended by the clients. The difference between them would highlight any absenteeism or changes made.

The recorded number of sessions planned ranged from one to eight. Table 4.16 shows the number of sessions planned by the psychology officer (counselling).

Table 4.16

Comparison of Planned and Actual Therapy Sessions

Number of sessions	Planned sessions		Actual sessions attended	
	Frequency of case	Per cent	Frequency of case	Per cent
1	8	7.8	8	7.8
2	28	27.2	35	34
3	27	26.2	28	27.2
4	17	16.5	16	15.5
5	12	11.7	6	5.8
6	10	9.7	9	8.7
8	1	1.0	1	1.0

The psychology officers (counselling) often planned for two or three sessions, but the actual attendance showed that the most frequently attended session was two sessions (34%) followed by three sessions (27%). The planned five therapy sessions for 12 clients did not work out as expected. Half of the clients did not attend, i.e. absent for the 3rd-5th sessions. They attended the first two sessions only, which caused an increase in the number of attendance ($n=35$) for the two therapy sessions (planned for 28 clients). However, it was interesting to note that the planned eight therapy sessions went accordingly. There was a low level of absenteeism, 8%. The mean number of therapy sessions attended, $M = 3.09$, $S.D. = 1.44$ and the mean number of sessions planned, $M = 3.31$, $S.D. = 1.50$.

The UPsK conducted the sessions weekly, monthly or no fixed schedule. This study analysed the frequency of the therapy sessions schedule based on the data found in the EoT. It showed UPsK scheduled weekly, monthly and no fixed time fairly evenly at about 33%.

Most psychology officers (counselling) in the 13 UPsKs met 56% of new clients on the same day as per the referral date, 15% of clients were attended to within five working days, 18% between 6-14 days. However, 12 % of clients had to wait longer than a month, and the range was from 23-36 days waiting period.

In summary, the popular therapies were structured/brief (56%) followed by cognitive behaviour (48%) and person-centred (38%). However, 63% of clients received a combination of therapies, and the most common are two therapies (35%). The average number of session attended was three. There was low absenteeism, 8%, suggesting a high correspondence between the number of therapy sessions planned, and the actual number of therapy sessions attended. The UPsKs used the three schedules (weekly, monthly, no fixed time) evenly at 33% of the time. The psychology

officers (counselling) met 71% of clients within the time limit guaranteed by the Client Charter.

The client's context. In the End of Therapy (EoT) assessment form the variables of motivation, working alliance and psychological mindedness represented the client's context. Motivation referred to the client's commitment to engage and ready to change in the therapy process. The working alliance was the bond established between the psychology officer (counselling) and client, for example, when they mutually agreed to the goals of intervention. The psychological mindedness referred to the client's understanding of his/her own and others' feelings, and be able to use that awareness to change their behaviour (CORE IMS Ltd, 2014).

RQ 3 What are the UPsK clients' rating for motivation, working alliance and psychological mindedness?

The psychology officer (counselling) gave a rating to the client's context in the EoT form at the end of the intervention (CORE IMS Ltd, 2014). The EoT data were analysed, and the scale used was poor, moderate and good. The frequency of the three variables was analysed.

The clients had an average percentage of good motivation (56.3%), and only a few had a low motivation (9.7%). Many clients also showed an average rate of good working alliance and psychological mindedness (52.4% and 49.5%) but a much higher percentage of low working alliance and psychological mindedness (16.5%). The results showed that half of the clients had good motivation to do psychological counselling therapy, but 17% of them found difficulty in forming a working alliance and developing psychological mindedness to change their behaviour. See Table 4.17.

Table 4.17

Frequency of the Context Variables

Context	Poor	Moderate	Good
Motivation	9.7 %	34 %	56.3 %
Working alliance	16.5 %	31.1 %	52.4 %
Psychological mindedness	16.5 %	34 %	49.5 %

In summary, about 53% of UPsK clients showed a good level of motivation, working alliance and psychological mindedness.

The percentage of clients in the outcome categories The CORE System developed four client outcome categories: (1) recovery, (2) improvement, (3) no change, (4) deterioration. Every client has one outcome category at the end of intervention or at discharge that indicates his/her mental status as a result of the treatment received at UPsK.

RQ 4 At the end of the intervention, what is the percentage of UPsK clients in each outcome category?

The CORE-OM scoring is problem-based, that is, the higher the scores, the more severe the problems faced. A lesser post-score value indicated a decrease in the severity of the client's problems (positive direction). In contrast, a higher post-score value indicated an increase in the severity of the problem faced (negative direction). Movement of fewer than five scores in either direction indicated chance or uncertainty.

CORE-OM used the mathematical criteria set by Jacobson and Truax (1991) to categorise the client outcomes. Table 4.18 shows the outcome categories and the corresponding criteria. The criteria for recovery is when the client has a lesser post score value compared to pre-testing and importantly, has crossed the cut-off point that divides the clinical from the non-clinical range by five or more scores. The criteria for

improvement is similar to recovery except that it did not cross the cut-off point 10. The criteria for deterioration is the same with improvement, except it is in the negative direction, i.e. a higher post score value compared to pre-testing.

Table 4.18

The Outcome Categories and the Criteria

Category	Criterion
Recovery	Equal to five scores or more in the positive direction, and crossed the cut-off point of 10 [$\geq+5$) & cross cut-off point 10].
Improvement	Equal to five scores or more in the positive direction ($\geq+5$).
Deterioration	Equal to five scores or more in the negative direction (≥-5).
No change	Movement of fewer than five scores in either a positive or negative direction ($<+/-5$)

It was essential to note that the 103 clients had measured endings, that is, they completed pre-and post-testing. With 100% measured endings, the study had greater confidence in the percentage rate of changes taking place.

Table 4.19 shows the four criteria and their matching outcome categories. The researcher set up several dummy scores to show ways to operationalise the criteria. Take case 1; the baseline score was 56, and after the intervention, the post-score was 8. The client moved more than five positive points and crossed over at the cut-off point. Therefore for case 1, the client showed clinically significant change, i.e. recovered. However, for case 4, the reverse happened. The baseline score was 64, but after the intervention, the post-score increased by more than five negative movements. In this case, the client has deteriorated. For case 2, the client moved many points but did not cross the cut-off point, so he/she was still in the range of clinical population even though had made strides in improvement. Finally, in case 3, the client did not make sufficient moves (less than five); hence the movement was attributed to chance. Therefore the client has not changed in mental status.

Table 4.19

Example of Outcome Categories

Case	Pre-score	Post-score	Criterion	Outcome Category
1	56	8	($\geq+5$ & cross 10)	Recovery
2	60	20	($\geq+5$)	Improvement
3	66	68	(<+/-5)	No change
4	64	73	(≥-5)	Deterioration

The analysis began with the creation of two new variables in SPSS—pre-post and client outcome category. Table 4.20 shows by the end of the research period (4 months), the majority of clients (66%) showed improvement. The next highest number of clients was in the no-change outcome category (15.5%). Both recovery and deterioration had low percentages. When the researcher collapsed the four variables into two main categories, i.e. positive outcomes (recovery and improvement) and negative outcomes (no change and deterioration) another perspective opened up. The data revealed 75% positive outcomes and 25% negative outcomes.

Table 4.20

Frequency of Client Outcome Categories

Outcome Categories	Frequency	Per cent
Recovery	9	8.7
Improvement	68	66.0
No-change	16	15.5
Deterioration	10	9.7
Total	103	100.0

In summary, the percentage of the recovered client was 9%. The majority of UPsKs' clients (66%) showed improvement. On the opposite end of the spectrum, the percentage of deteriorating clients was small (9.7%) and no-change was slightly higher

(15.5%). On the whole, 75% of UPsKs' clients showed positive, and 25% showed negative outcomes.

The variables and client outcomes. The next step was to determine whether there were any associations between the variables of distress, therapy and client context and client outcomes.

Client outcome and distress. The CORE System has identified six severity levels of distress. From the descriptive analyses done earlier, there were clients in each of the severity levels from healthy to severe.

RQ 5.1 Is there an association between distress severity levels and client outcomes?

The study analysed the variable, distress, for any association with client outcome. Based on CORE literature, the clients' baseline does influence the client's outcome (CORE Partnership, 2007a, 2011d). The study used the distress total pre-mean scores for analyses. Distress as an independent variable had six levels, and client outcomes as a dependent variable had four levels. Since the variables were categorical, the study used the Chi-squared Independent Test to analyse the association between them. The result will either accept or reject the hypothesis:

The hypothesis: There is no statistically significant association between distress and client outcome, and that each variable is independent of each other.

The initial run of the Chi-squared Test showed that the basic assumption of 'minimum expected cell frequency of 5 or more' was violated. There were 19 cells (79.2%) with an expected count less than 5. To improve the situation, the researcher reduced the variables by combining them, i.e. the variables with small counts

combined with the next related variable (Pallant, 2013). The six distress levels reduced to three—healthy/low, mild/moderate, moderate-to-severe/severe—and the four client outcomes reduced to two—positive and negative outcomes. The study repeated the Chi-squared Independent Test using the new recoded variables.

The Chi-square Test results showed one cell (16.7%) had expected count less than five which was within the allowed range of 20% (maximum allowed for expected count less than 5) (Pallant, 2013). This data was acceptable for further analyses. The resultant analysis showed the value of Pearson Chi-square, $\chi^2 = 22.89$ at $p < .001$ (2-tailed). Therefore the difference between distress and client outcome was statistically significant. The Cramer's V verified the effect size, $\phi = .47$. The effect size indicated there was a strong association between the baseline severity level of the clients and the final client outcome. See Table 4.21.

Table 4.21

Cross-tabulation of Distress Severity Levels Against Client Outcomes

			Client outcomes			
			Recovery/improvement	No change/deterioration	Total	
Pre-severity level	Healthy and low	Count	4	10	14	
		% within Reduced pre-severity level	28.6%	71.4%	100.0%	
	Mild and moderate	Count	35	13	48	
		% within Reduced pre-severity level	72.9%	27.1%	100.0%	
	Moderate-to-severe and severe	Count	38	3	41	
		% within Reduced pre-severity level	92.7%	7.3%	100.0%	
		% within Reduced client outcomes	49.4%	11.5%	39.8%	
			% of Total	36.9%	2.9%	39.8%
	Total	Count	77	26	103	
% within Reduced pre-severity level		74.8%	25.2%	100.0%		

The cross-tabulation table showed clients in the clinical range (mild and moderate) had a high rate of positive outcomes (73%), and clients in the clinical range (moderate-severe and severe) had the highest rate of positive outcomes (93%). Clients in the clinical ranges (mild/moderate and moderate to severe/severe) improved for the better with positive outcomes. However, clients in the non-clinical ranges (healthy and low distress) had high rates of negative outcomes (71%).

Clients in the non-clinical range had high rates of negative outcomes because they had nowhere else to go but down. These clients were mentally healthy (non-clinical range) at the start, i.e. baseline, and after an intervention, they might remain healthy or show signs of distress. In the CORE criteria, no change is a negative outcome. Hence clients that began with baselines in the non-clinical range would have negative outcomes.

In summary, the Chi-Square Test of Independence indicated there was a statistically significant association between distress severity levels and client outcome, $\chi^2(2, n = 103) = 22.89, p < .001$ (2-tailed). The effect size $\phi = .47, p < .001$. The study rejected the hypothesis since there was a statistically significant association between distress and client outcome. Clients that started intervention with distress in the clinical population range ended with positive outcomes; however, clients that began intervention with distress in the non-clinical population range ended with negative client outcomes (CORE Partnership, 2007a, 2011d).

Client outcome and therapy. The study examined two aspects of therapy variable: types of therapy, that is the combination of therapies used to treat clients and the frequency of the therapy carried out.

RQ 5.2 Are there associations between type and frequency of therapy with client outcome?

The study used the data in EoT to determine the types of therapy used. The psychology officers (counselling) ticked multiple response questions concerning types of therapy in the EoT form. Therefore, the researcher used multiple response analysis to either accept or reject the hypothesis:

The hypothesis: There is no statistically significant association between the type of therapy and client outcome, and that each variable is independent of each other.

The study used the Chi-squared Independent Test because the variables were categorical. See Table 4.22. It shows the association between types of therapy and client outcomes. On the whole, the use of therapies produced 75% positive outcomes and 25% negative outcomes.

Structured/brief therapy showed the highest percentage of positive outcomes (66%) in the clients followed by cognitive behavioural (47%) and person-centred (36%). The structured/brief therapy produced the least negative outcomes among the clients (27%); the most was cognitive behavioural (50%).

Table 4.22

The Association of Type of Therapy with Client Outcomes

			Client Outcomes		Total
			Positive	Negative	
Therapies used for treatment	Structured/brief therapy	Count	51	7	58
		% within Outcome	66.2%	26.9%	
		% of Total	49.5%	6.8%	56.3%
	Cognitive therapy	Count	23	6	29
		% within Outcome	29.9%	23.1%	
		% of Total	22.3%	5.8%	28.2%
	Behavioural therapy	Count	11	1	12
		% within Outcome	14.3%	3.8%	
		% of Total	10.7%	1.0%	11.7%
	Person-centred therapy	Count	28	10	38
		% within Outcome	36.4%	38.5%	
		% of Total	27.2%	9.7%	36.9%
	Integrative therapy	Count	12	4	16
		% within Outcome	15.6%	15.4%	
		% of Total	11.7%	3.9%	15.5%
Cognitive behavioural	Count	36	13	49	
	% within Outcome	46.8%	50.0%		
	% of Total	35.0%	12.6%	47.6%	
Total	Count	77	26	103	
	% of Total	74.8%	25.2%	100.0%	

Percentages and totals are based on respondents.

a. Dichotomy group tabulated at value 1.

Interesting to note that many psychology officers did not use one therapy exclusively instead used combinations of therapy (see Table 4.14, page 147). Hence the study examined the combinations of therapies. Similarly, with the first analysis on the association of levels of distress with client outcomes, the underlying assumption of “minimum expected cell frequency of 5” was violated. Hence the variables with many levels collapsed into a smaller number of levels to ensure sensible statistical results. Therefore, the final number of variables used for analysis

was three instead of four. Then the data was subjected to another round of Chi-squared Test analysis.

The results showed no zero cell with expected count less than 5, and the Pearson Chi-square value, $\chi^2 (2, n=103) = 6.12, p = .047$. The cross-tabulation broke down the frequency and percentages of each variable in relation to each other. Table 4.23 shows that 35% of psychology officers (counselling) favoured the exclusive use of one therapy which produced positive outcomes in 31% of clients. The combinations of two therapies produced 35%, and three & four therapies produced 34% of positive outcomes in the clients. Interesting to note that one therapy variable produced the highest percentage of negative outcomes (54%) while the combination of 3 & 4 therapies produced the least number of clients with negative outcomes (12%).

Table 4.23

The Association of Combination of Therapies with Client Outcomes

			Client Outcome		Total
			Positive	Negative	
Combinations of therapy	One therapy	Count	24	14	38
		% within client outcomes	31.2%	53.8%	36.9%
		% of Total	23.3%	13.6%	36.9%
	Two therapies	Count	27	9	36
		% within client outcomes	35.1%	34.6%	35.0%
		% of Total	26.2%	8.7%	35.0%
	Three and four therapies	Count	26	3	29
		% within client outcomes	33.8%	11.5%	28.2%
		% of Total	25.2%	2.9%	28.2%
Total	Count	77	26	103	
	% of Total	74.8%	25.2%	100.0%	

The effect size was determined by Cramer's V, $phi = .244, p = .047$ [Cohen (1988) guideline: $DF=2$: small effect = .07, medium effect = .21 and large effect =

.35]. Therefore, this data showed that types of therapy had a medium effect on client outcomes in real terms.

How many times was the therapy, and did the frequency has an association with client outcomes? The 103 clients participated in several therapy sessions ranging from one to eight sessions (see Table 4.16, page 148). The study used Chi-Square Test of Independence to analyse the association of frequency of therapy to client outcomes. The result can either accept or reject the hypothesis:

The hypothesis: There is no association between the frequency of therapy and client outcome, and that each variable is independent of each other.

The initial run of Chi-square test did not produce a good result, that is, there were seven cells (50%) with an expected count less than 5. Then the number of session variables were reduced from 7 to 3. The reduction in the number of variables ensured that each operational variable had sufficient counts in them. The study tested the new recoded variables with Chi-Square Independent Test. The result was much better—the expected count of less than 5 was one cell (16.7%); hence the data was acceptable, and the analysis proceeded.

The results showed the value of Chi-Square, $\chi^2 (2, n = 103) = 4.067, p = .131$. The p -value was not statistically significant since p was more than .05. Indicating there was no statistically significant association between the number of sessions and client outcomes. Cramer's V test for effect size, $phi = .199, p = .131$.

In summary, the Chi-Square Test of Independence indicated a statistically significant association between the combination of therapy and client outcomes, $\chi^2 (2, n = 103) = 6.12, p = .047$. The effect size, $phi = .244, p = .047$, a medium effect size according to Cohen (1988) guideline. The study rejected the null hypothesis because

there was a statistically significant association between the combinations of therapies and client outcomes.

However, the Chi-Square Test of Independence indicated no statistically significant association between the number of sessions and client outcomes, $\chi^2 (2, n = 103) = 4.067, p = .131$. The effect size, $\phi = .199, p = .131$. The effect size was small, according to Cohen (1988) guideline. The study accepted the null hypothesis because there was no statistically significant association between frequencies of therapy with client outcomes.

Client outcome and context. Client context was represented by several variables as listed at the End of Therapy form (EoT). The variables were motivation, working alliance and psychological mindedness. The descriptive analyses showed that half of the 103 clients had average rates of motivation; working alliance and psychological mindedness (see Table 4.17, page 151). The question now was to determine whether client context as represented by the three variables had a relationship with client outcomes.

RQ 5.3 Are there associations between client context (motivation, working alliance, psychological mindedness) and client outcomes?

The study used Chi-Square Test of Independence to analyse the association between client context (motivation, working alliance, psychological mindedness) and client outcome and to accept or reject the hypotheses:

The first hypothesis: There is no statistically significant association between client context and motivation, and that each variable is independent of each other.

The second hypothesis: There is no statistically significant association between client context and working alliance, and that each variable is independent of each other.

The third hypothesis: There is no statistically significant association between client context and psychological mindedness, and that each variable is independent of each other.

The study examined each context variable separately, and the first variable was motivation.

(1) Motivation. At the initial run of the Chi-square Test, there was no violation of the basic assumption, so the analysis proceeded. The result indicated statistically significant association between motivation and client outcomes, $\chi^2 (2, n = 103) = 17.26, p < .001$. The effect size using Cramer's V test, $\phi = .41, p < .001$. A large effect. The motivation was ranked poor, moderate and good concerning client outcomes. The clients with good motivation contributed 68% to the number of clients with positive outcomes, and unexpectedly, clients with moderate motivation were the highest contributor to negative outcomes (54%). See Table 4.24.

(2) Working Alliance. The study used Chi-Square Test of Independence to analyse the association between working alliance and client outcomes. The data on client context fulfilled the basic assumption of the Chi-square Test. Finally the results of the Chi-Square, $\chi^2 (2, n = 103) = 12.01, p = .002$. The effect size, $\phi = .342, p = .002$. Almost large effect. The Cross tabulation showed the breakdown of working alliance according to the ranks of poor, moderate and good concerning client outcomes. The clients with good working alliance contributed 62% to the number of clients with positive outcomes, and unexpectedly, clients with the moderate working alliance were the highest contributor to negative outcomes (50%). See Table 4.24.

(3) Psychological mindedness. The study used Chi-Square Test of Independence to analyse the association between psychological mindedness and client outcomes. Again the data on client context fulfilled the basic assumption of the Chi-square Test; hence the testing proceeded. The results showed, $\chi^2 (2, n = 103) = 9.82$, $p = .007$. The effect size, $\phi = .309$, $p = .007$. The effect size was medium. The cross-tabulation showed the breakdown of psychological mindedness according to the ranks of poor, moderate and good concerning client outcomes. The clients with good psychological mindedness contributed 58% to the number of clients with positive outcomes, and unexpectedly, clients with moderate psychological mindedness were the highest contributor to negative outcomes (50%). See Table 4.24. Among the three variables, good motivation was the highest contributor to positive outcomes (68%) followed by a good working alliance (62%) and good psychological mindedness (58%).

The highest contributor to negative outcomes was the moderate level of the three variables. It appeared that moderate or in other words, average feelings of motivation, average connection with psychology officer (working alliance) and average insight to psychological mindedness led to negative outcomes.

Table4.24

The Associations of Client Context and Client Outcomes

			Client Outcomes		Total
			Positive	Negative	
Motivation of client	Poor	Count	4	6	10
		% within client outcomes	5.2%	23.1%	9.7%
		% of Total	3.9%	5.8%	9.7%
	Moderate	Count	21	14	35
		% within client outcomes	27.3%	53.8%	34.0%
		% of Total	20.4%	13.6%	34.0%
	Good	Count	52	6	58
		% within client outcomes	67.5%	23.1%	56.3%
		% of Total	50.5%	5.8%	56.3%
Total	Count	77	26	103	
	% of Total	74.8%	25.2%	100.0%	
Working alliance	Poor	Count	10	7	17
		% within client outcomes	13.0%	26.9%	16.5%
		% of Total	9.7%	6.8%	16.5%
	Moderate	Count	19	13	32
		% within client outcomes	24.7%	50.0%	31.1%
		% of Total	18.4%	12.6%	31.1%
	Good	Count	48	6	54
		% within client outcomes	62.3%	23.1%	52.4%
		% of Total	46.6%	5.8%	52.4%
Total	Count	77	26	103	
	% of Total	74.8%	25.2%	100.0%	
Psychological mindedness	Poor	Count	10	7	17
		% within client outcomes	13.0%	26.9%	16.5%
		% of Total	9.7%	6.8%	16.5%
	Moderate	Count	22	13	35
		% within client outcomes	28.6%	50.0%	34.0%
		% of Total	21.4%	12.6%	34.0%
	Good	Count	45	6	51
		% within client outcomes	58.4%	23.1%	49.5%
		% of Total	43.7%	5.8%	49.5%
Total	Count	77	26	103	
	% within client outcomes	100.0%	100.0%	100.0%	
	% of Total	74.8%	25.2%	100.0%	

In summary, the Chi-Square Tests of Independence found the three variables that represented client context—motivation, working alliance, psychological mindedness—were statistically significantly associated with client outcomes. Motivation, $\chi^2(2, n = 103) = 17.26, p < .001, phi = .41, p < .001$. Working alliance, $\chi^2(2, n = 103) = 12.01, p = .002, phi = .342, p = .002$. Psychological mindedness, $\chi^2(2, n = 103) = 9.82, p = .007, phi = .309, p = .007$. The null hypotheses were rejected because there were statistically significant association between client context and client outcomes.

Benchmarking When members of the industry want to produce standards, they create benchmarks. Benchmarks are the standards of best practices among the participating members. Outcome data collected from multiple settings can establish benchmarks against which services can use to make comparisons. This study focused on service benchmarks related to outcomes from UPsKs.

Traditionally the way to analyse change was to use different outcome measures and measure group averages or report the statistically significant difference between intake and discharge (Mullin et al., 2006). However, in this study the service benchmark (CORE Partnership, 2011d; Lueger & Barkham, 2010; Mullin et al., 2006) was derived from the percentage rate of change of clients in each outcome category and then based on the percentiles derived, it was possible to evaluate the performance of the UPsKs.

Service benchmarks values based on percentiles. The study derived benchmarks from the percentage rates of change, and the quartiles hold essential information.

RQ 6.1 What are the service benchmark values at the 25th, 50th and 75th percentiles for each outcome category?

This study aimed to develop service benchmarks for client recovery, improvement, no reliable change and reliable deterioration in the selected UPsKs. However, only 9 UPsKs were used for benchmark analyses since four UPsKs had less than 3 cases each. They were not used for benchmark analyses because they did not fulfil the requirement of three cases needed to calculate the average (Mullin et al., 2006). Finally, the study used a total of 98 cases for analyses. All of them had measured endings; that is, the clients had scores for both pre- and post-testing. The 100% measured endings gave high confidence in the ensuing results (CORE Partnership, 2007a). The nine UPsKs' baseline scores were above the cut-off point of 10, which avoided the danger of influencing the outcome (see Client outcome and distress).

The analysis began with finding the pre- and post-clinical mean scores of nine UPsKs. The clinical mean score was obtained by dividing the total scores by 34 and then multiplying by 10 (Barkham et al., 2006). The pre-mean clinical score for 9 UPsKs was 17.92 (*S.D.* = 6.5). The lowest mean score for UPsK service was 14.24 (HC), and the highest was 26.21 (HM). The mean score for UPsK was comparable to the mean clinical scores obtained by Mullin et al. (2006) from 32 services, $M = 17.7$ (*S.D.* = 1.3).

Figure 4.2 shows that the range of pre-mean scores was mainly in the moderate level with two UPsKs reaching moderate-severe and severe levels. All the mean scores

were in the range of the clinical population, i.e. above the cut-off point of 10. The post-mean scores ranged from mild (in the clinical population) to healthy in the non-clinical population. There was a noticeable change in clients' distress levels as seen from the decrease in the CORE-OM mean scores from pre- to post.

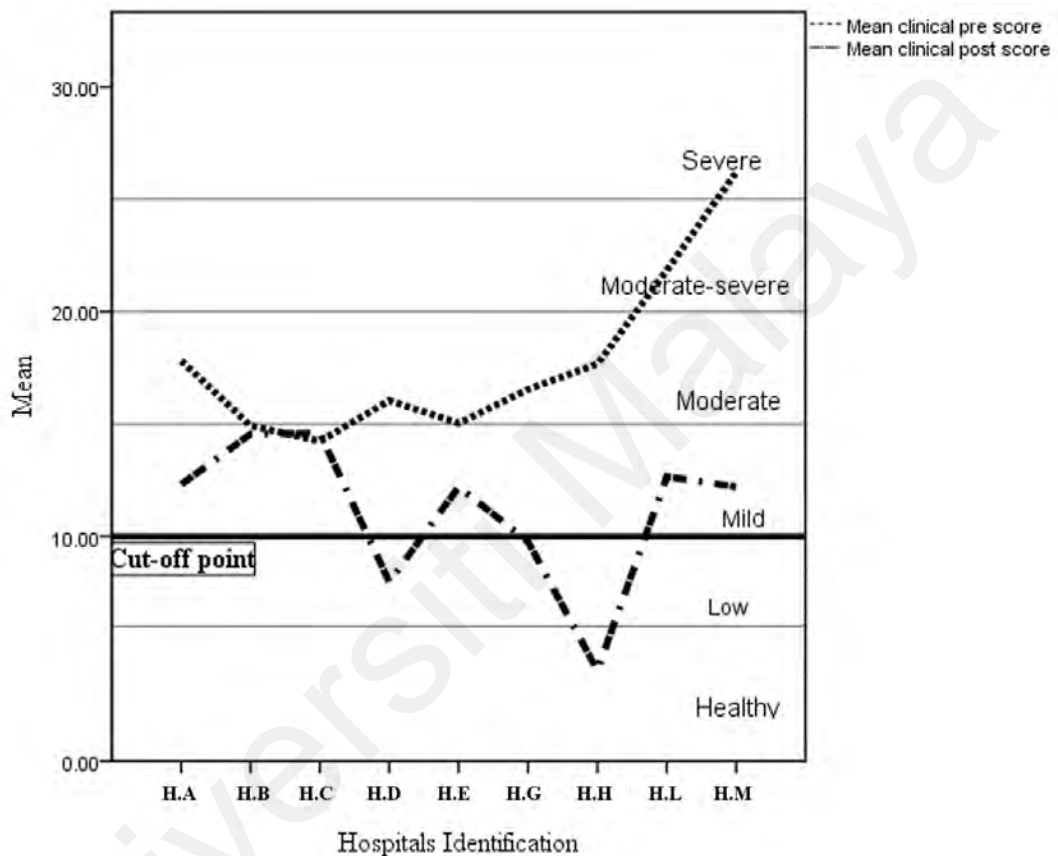


Figure 4.2 Pre- and Post-Mean CORE-OM Scores for 9 UPKs

The study conducted a paired-sample t-test to determine the impact of the intervention on the clients' distress levels at pre-and post-testing. The results showed a statistically significant difference in the distress levels, $M = 27.35$; the p -value is less than .000 (two-tailed).

The study calculated the effect size (magnitude of the differences) by using eta squared formula:

$$\frac{t^2}{t^2 + (N_1 + N_2 - 2)} = .56.$$

The eta-squared valued obtained was a large effect based on Cohen 1988, page 284-7 guidelines. Therefore, there was statistically significant decrease in CORE-OM scores from pre-testing ($M = 60.95, S.D. = 22.09$) to post-testing ($M = 33.60, S.D. = 20.23$), $t(97) = 11.22, p < .000$ (two-tailed). The mean decrease in the CORE-OM scores was 27.35, with a 95% confidence interval ranging from 22.51 to 32.18. The eta squared statistic (.56) indicated a large effect.

What about the percentage rate of change in the outcome categories as set by Jacobson and Truax (1991)? The study obtained the percentage rate of change by determining the percentile values at the 25th, 50th and 75th levels. The quartiles split the data into four groups: the 75th percentile showed a high rate of change in the client, 50th was the average rate of change and 25th was the lowest rate of change in the client.

The study determined the percentiles in each outcome category by using the feature 'Select Case' to look at a specific subset and then subjecting that subset to analysis. The first selection was the recovery sub-set. The researcher used the Explore feature to determine the 25th, 50th and 75th percentiles of the variable pre-post looking only at the subset recovery. She then used Bootstrap in Explore feature to get the confidence intervals for the percentiles. All the other outcome categories were analysed the same way. The 95% confidence intervals (CI) gave an upper and lower limit for the population, providing a range of plausible values for the percentiles and the width of the CI indicated the levels of uncertainty of the value of the percentile (Mullin et al., 2006). Take note that the service benchmarks in Table 4.25 have relatively large CI for the percentiles, indicating uncertainty, which the study must consider when developing the benchmarks.

The percentile levels determine the benchmarks for each category. Look at the recovery column in Table 4.25. At the 50th percentile, the average percentage

rate of change was 48%, so the benchmark was 48. At the 75th percentile, the high percentage rate of change was 50% or more, so the benchmark was 50. Similarly, the 25th percentile will determine the benchmark for low recovery. In other words, in the recovery category, the top 25% of UPsKs have 50% or more clients recovered while the bottom 25% of UPsKs have 25% or fewer clients recovered.

Table 4.25

Percentile Values According to Outcome Category

	Recovery	Improvement	No change	Deterioration
Number of clients	9	66	15	8
Mean	44.2	35.9	2.1	11.4
Stand. Dev.	25.4	17.7	1.5	7.4
Minimum	14	5	0	5
Maximum	97	73	4	29
25 th percentile	25 CI(14.0-48.0)	21 CI(15.0-30.0)	1 CI(0.0-2.0)	8 CI(5.0-10.0)
50 th percentile	48 CI(14.0-52.0)	40 CI(30.0-43.0)	2 CI(1.0-3.5)	10 CI(7.0-11.0)
75 th percentile	50 CI(48.0-97.0)	48 CI(44.0-55.0)	4 CI(2.0-4.0)	11 CI(11.0-29.0)

The CORE system created graphical benchmarks (CORE Partnership, 2011d; Mullin et al., 2006) with a ‘thermometer’ format (Mellor-Clark & Barkham, 2012) to display the percentile values. The idea of the thermometer is to show the status of the situation (UPsK) whether it is in a desired or undesired state based on the percentile values. CORE used the traffic light colours to do this. In common usage the colour green is to go, yellow is proceed with caution, and red stop, it is dangerous to continue. In CORE terminology and particularly in this study, the traffic light colours represented the following:

- Green : desirable state for UPsK, has high performance,
- Yellow/amber: above and below-average performances respectively,

Red: not a desirable state for UPsK, has low performance.
 Give attention to the problems that are preventing UPsK from achieving the best for its clients.

The CORE System used the thermometer format to divide the range of percentages into four bands (quartiles) at the 25th, 50th, 75th percentiles. These percentiles contained critical benchmark values. Each band's 'traffic-light' colour indicates the level of performance. The green band as 'high' and 'desirable,' yellow band as "above average"; amber band as "below average"; and the red band as 'low' or "less desirable." Those placed above and below the 50th percentile are yellow and amber bands, respectively. The 25th percentile is red, denoting a low rate of change. It is not a desirable state (red equals danger, stop) and requires urgent attention.

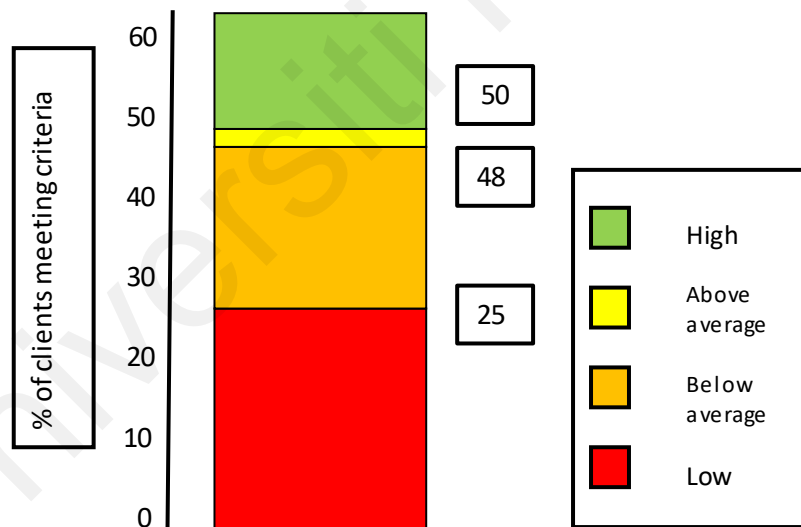


Figure 4.3. Per cent of Clients Meeting the Criteria for Recovery

The percentile values for recovery in Table 4.25 was the basis for the graphical recovery benchmark seen in Figure 4.3. The figure shows that the benchmark for an average rate of recovery was 48. The amber band was the band for below average, that is between 25% and 48%. The yellow band was the band for above average, that

is between 48% to 50%. The 75th percentile was the benchmark for a high rate of recovery. Its value was 50. Therefore, any UPsK with a percentage rate of recovered clients at 50% or more has high performance and was in the top 25% of UPsKs.

Conversely, any UPsK with a rate of 25% or less of its clients achieving recovery status has low performance and was in the bottom 25%. Thus a service could compare its performance for recovery against this service benchmark and determine its status—good or bad.

Figure 4.4 shows the graphical improvement benchmark values. The 75th percentile was the benchmark for a high rate of improvement. The 50th percentile was the benchmark for an average rate of improvement, and the 25th percentile was the benchmark for a low rate of improvement. The amber band (below average) was broad, all clients' with rates of improvement from 21% to 48% were in this band. The low benchmark was at 21.

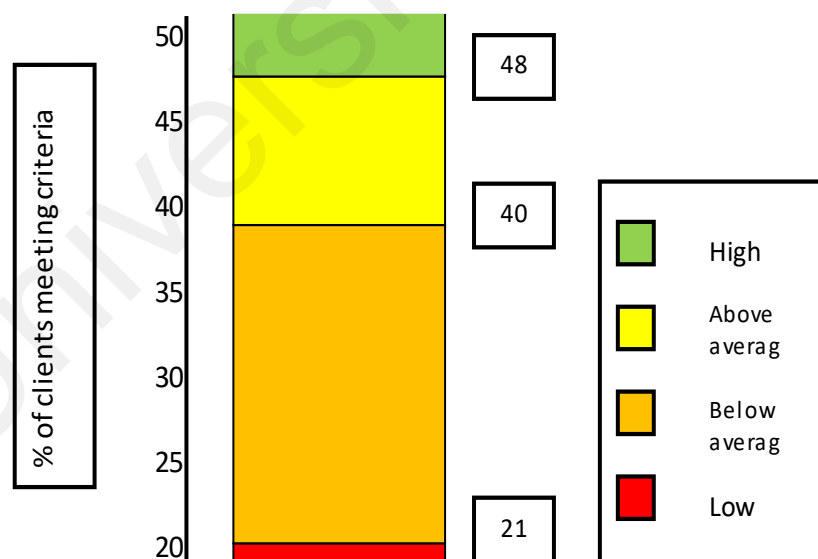


Figure 4.4. Per cent of Clients Meeting the Criteria for Improvement

A UPsK with a rate of 48% or more improved clients has high performance and would be at the top 25% of UPsKs, and conversely, a UPsK with a rate of 21% or

less improved clients has low performance and would be at the bottom 25% based on this criterion. Refer back to Table 4.25, page 169; it showed that the benchmark value at the 75th percentile for recovery was higher compared to improvement. Meaning it required more rates of change for recovery than for improvement.

The service benchmarks for recovery and improvement, i.e. the positive outcomes, had the 75th percentiles in green bands, indicated a high rate of change and thus high performance—the desired outcomes for UPsK. Above and below the 50th percentile were the average rate of change, yellow and amber bands, respectively. There were average performances. The 25th percentile in the red band indicated a low rate of change and thus, low performance. It was not a desirable state for any UPsK to be in, and it needed urgent attention.

The reverse was true for negative categories. The negative categories consisted of no-change or deterioration. The desired state for a UPsK was to have low percentages of no-change and deterioration. Therefore low rates of negative outcomes would indicate high performance for the UPsK. In this situation, the 25th percentile was the benchmark for a low rate of change (no-change/deterioration) and the 75th percentile was the benchmark for a high rate of change (no-change/deterioration) (Barkham, Mellor-Clark, et al., 2010).

The thermometer colours for the desired, high performance is green, and the undesired, low performance is red. Therefore the graphical benchmarks for negative categories had a green band at the 25th percentile and a red band at the 75th percentiles. They indicated high performance due to low rates of negative outcomes at the 25th percentile and low performance due to high rates of negative outcomes at the 75th percentile.

The graphical no-change benchmark in Figure 4.5 demonstrated the reverse reading of the percentiles (Mullin et al., 2006). The 25th percentile was the benchmark value for a low rate of no-change. The benchmark value was one. The 75th percentile was the benchmark for a high rate of no-change, and its value was four. Thus the desired, high performance was green at the 25th percentile. The undesired, low performance was red at the 75th percentile. The above-average band was broader than the below-average band.

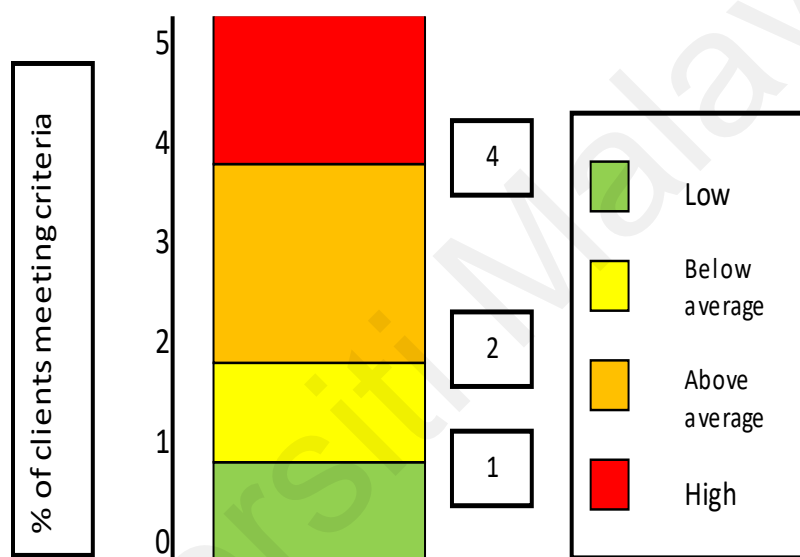


Figure 4.5. Per cent of Clients Meeting the Criteria for No-Change

A UPsK with rates of 1% or less of no-change clients has high performance and was at the top 25% of UPsKs, and conversely, a UPsK with rates of 4% or more of no-change clients has low performance and was at the bottom 25% of UPsKs based on this criterion.

The graphical deterioration benchmark in Figure 4.6 followed the above formula. The 75th percentile was the benchmark for a high rate of deterioration, and the value was 11. The 25th percentile was the benchmark for a low rate of deterioration, and the value was 8. The 75th percentile was red for low, undesired performance while

the 25th percentile was coloured green for high, desired performance. The average percentage rate of deterioration was 10% amongst the clients in the nine selected UPsKs. (Mullin et al., 2006).

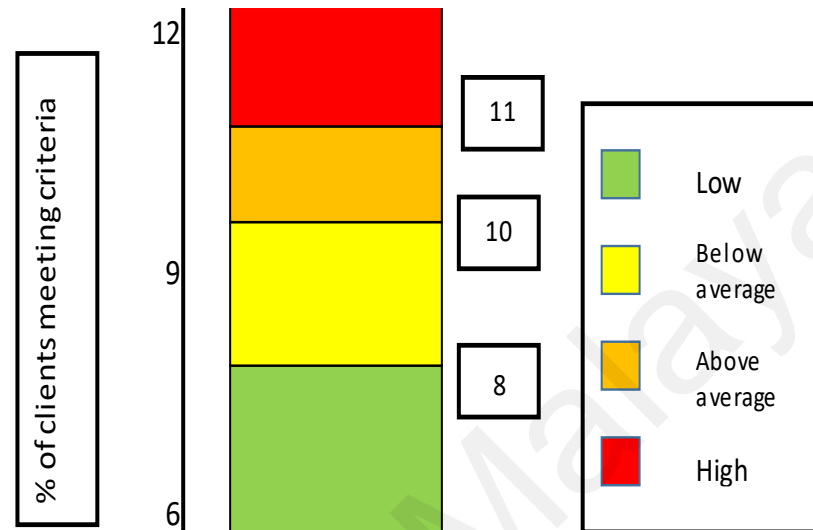


Figure 4.6. Per cent of Clients Meeting the Criteria for Deterioration

A UPsK with a rate of 8% or less of deteriorated clients has high performance and would be at the top 25% of UPsKs, and conversely, a UPsK with rates of 11% or more of deteriorated clients has low performance and would be at the bottom 25% of UPsKs based on this criterion.

Mullin et al. (2006) conducted surveys in 32 primary care NHS services involving 11, 000 clients. There was a follow-up update in 2011 (CORE Partnership, 2011d) involving 26,467 clients in 35 facilities. The UPsK study followed the underlying assumptions in the Mullin et al. (2006) study; however, in terms of quantity of participants, the sample size of the UPsK study was minuscule. Nevertheless, a comparison of the results was possible since the results dealt with means and percentiles values which were not influenced by quantity.

Table 4.26 shows the comparison table of data from UPsK and CORE Partnership, 2011 studies.

Table 4.26

Comparison of UPsK and CORE Partnership (2011) Service Benchmarks

	Recovery	Improvement	No change	Deterioration
UPsK				
25 th percentile	25 CI(14.0-48.0)	21 CI(15.0-30.0)	1 CI(0.0-2.0)	8 CI(5.0-10.0)
50 th percentile	48 CI(14.0-52.0)	40 CI(30.0-43.0)	2 CI(1.0-3.5)	10 CI(7.0-11.0)
75 th percentile	50 CI(48.0-97.0)	48 CI(44.0-55.0)	4 CI(2.0-4.0)	11 CI(11.0-29.0)
CORE Partnership, 2011				
25 th percentile	45 CI(39.8-47.6)	18 CI(15.7-19.7)	22 CI(17.3-22.5)	0.9 CI(0.2-1.1)
50 th percentile	50 CI(44.8-55.6)	21 CI(19.2-21.6)	28 CI(22.1-30.2)	1.3 CI(1.0-1.7)
75 th percentile	57 CI(55.3-67.0)	22 CI(21.2-24.4)	32 CI(29.0-35.9)	2.4 CI(1.7-3.6)

(CORE Partnership, 2011d)

The rate of recovery for the UPsK and Mullin studies showed a high rate of recovery at 50% and 57% respectively at the 75th percentiles. However, at the 25th percentiles, there was disparity—in UPsK, the rate of recovery was low (25%) while the CORE Partnership (2011) was two times higher at 45%. For improvement, the UPsK study showed a higher percentage rate of improvement, double that of the CORE Partnership (2011). However, the UPsK study had very high rates of deterioration but surprisingly very low rates of no change in the clients.

In summary, the study derived graphical benchmark values from the percentile levels for each outcome category. The UPsK graphical recovery benchmark values were high at 50 (75th percentile), average at 48 (50th percentile), low at 25 (25th percentile). The UPsK graphical improvement benchmark values were high at 48 (75th percentile), average at 40 (50th percentile), low at 21(25th percentile). The reverse was true for the negative outcomes. The UPsK graphical no-change benchmark values

were high at 1% (25th percentile), average at 2 (50th percentile), low at 4 (75th percentile). The UPsK graphical deterioration benchmark values were high at 8 (25th percentile), average at 10 (50th percentile), low at 11(75th percentile).

Application of the service benchmarks. The study has graphical service benchmarks for UPsKs in all outcome categories; the next step was to determine how well the individual UPsK matched up to the benchmarks in practice.

RQ 6.2 To what extent do the UPsKs match up to the service benchmarks?

The study determined the percentile values at 25th, 50th, and 75th points for each outcome category from each UPsK. The researcher created two subsets (the identity of the hospital and the outcome category) using Select Cases. Then the pre-post variable was analysed to find the percentiles according to the subsets, i.e. hospital and outcome category. See the results in Table 4.27.

Table 4.27

The UPsKs' Values Matched Against Service Benchmarks in Outcome Categories

UPsK	Recovery % /	Improvement %	No Change %	Deterioration %
H.A.	37% (25-47%)	40% (40-47%)	4% (3%)	11% (11%)
H.B.	0% (0-25%)	16% (0-21%)	4%(3%)	11%(11%)
H.C.	0% (0-25%)	0% (0-21%)	4% (3%)	1% (0-8%)
H.D.	0% (0-25%)	46% (40-47%)	1% (0-1%)	0% (0-8%)
H.E.	0%. (0-25%)	9% (0-21%)	3%(3%)	0% (0-8%)
H.G.	1% (0-25%)	38% (21-39%)	1%.(0-1%)	0% (0-8%)
H.H.	54% (50%)	52% (48%)	0% (0-1%)	0% (0-8%)
H.L.	0% (0-25%)	58% (48%)	0%(0-1%)	1% (0-8%)
H.M.	0% (0-25%)	58%(48%)	0%(0-1%)	0% (0-8%)

The way to understand Table 4.27 was to read it row by row. Take the first row, the UPsK in hospital H.A had a 37% rate of change in recovery. The researcher

matched this value with the percentile values in Table 4.25, page 169. Look at the recovery column. The H.A. value for recovery laid at the percentile range of 25th–50th. Therefore the performance of the UPsK in H.A was below average for the recovery outcome category.

Now, look at H.A.'s deterioration column. It had an 11% rate of deterioration. When compared to deterioration values in Table 4.25, the value for deterioration in H.A. laid in the 75th percentile. Therefore the performance of the UPsK in H.A. was low because it had a high rate of deterioration which was not the desired state

Table 4.27 also highlighted that only one UPsK (in H.H.) matched the service benchmark for recovery with a 54% rate of recovery. Also, there was only one UPsK with a below-average rate of recovery (37%), while the majority of the UPsKs had a low rate of recovery (0-1%). For the improvement category, there were four UPsKs with average rates, three with high rates and two with low rates of improvement. The no-change category had five UPsKs with high performances. They had low negative outcomes (0-1%), i.e. low rates of no-change. Similarly, for deterioration, most UPsKs had high performances, that is, had low rates of deterioration by having low negative outcomes (0-8%), i.e. low rates of deterioration.

In summary, only one UPsK matched the graphical recovery service benchmark—54% of clients recovered. The improvement outcome category had three UPsk, where there were three UPsKs in the top 25%. In the no-change and deterioration categories, many UPsKs matched the service benchmarks.

RQ.7 How to create a matrix that will display the performance ranking of the UPsKs?

The next step was to assign a ranking to the UPsK according to each outcome categories. Refer to Table 4.28.

Table4.28

The Service Benchmarks, Colour Codes and Performance Rank

Percentile	Percentage Rate of Change		Performance Rank	Colour Code
	Recovery	Improvement		
75 th	50%	48%	High	Green
50 th - 75 th	48% - 49%	40% - 47%	Above Average	Yellow
25 th - 50 th	25.1% - 47%	21.1% - 39%	Below Average	Amber
25 th	25%	21%	Low	Red
Percentile	No-Change	Deterioration	Rank	Colour Code
75 th	3%	11%	High	Red
50 th - 75 th	2% - 2.9%	10% - 11.9%	Above Average	Amber
25 th - 50 th	1.1% - 1.9%	8.1% - 9.9%	Below Average	Yellow
25 th	1%	8%	Low	Green

The table shows at the 75th percentile of the positive outcomes (recovery and improvement) there was a high rate of change, thus high performance. They were coloured green symbolizing the desired state (set to go). Those between the 50th to 75th, 25th to 50th and 25th percentiles were above-average performance (yellow), below-average performance (amber) and low performance (red) respectively (Barkham, Mellor-Clark, et al., 2010). Red symbolized danger, requiring attention to arrest the problem.

The reverse was true for the negative outcomes of no-change and deterioration categories. At the 75th percentile, there was a high rate of change of no-change or deterioration. An undesired state for clients to be in; thus, the UPsK has low performance. Hence the colour red; the UPsK must be given attention to arrest the problem that caused clients to deteriorate. Those between the 50th to 75th, 25th to 50th and 25th percentiles were above-average performance (amber), below-average performance (yellow) and low performance (green) respectively (Barkham, Mellor-

Clark, et al., 2010). Green symbolized the desired state and given impetus to continue with the acceptable practices that encourage clients to go through the process of therapy to reach recovery.

All the configurations were put into a matrix table, in Table 4.29, based upon the colour codings in Table 4.28. The matrix shows only one UPsK had overall success in all outcome categories. This UPsK had high positive outcomes and low negative outcomes. On the other end of the spectrum, there was only one UPsK that did not do well—all outcome categories were in the red bands. That meant it had low rates of positive outcomes and high rates of negative outcomes. Generally, for the nine selected UPsKs, there were equal numbers of green (desirable) and red bands (undesirable) at 44% each followed by 11% of yellow and amber.

Table 4.29

UPsKs' Colour Coded Matrix

UPsK	Recovery % /	Improvement %	No Change %	Deterioration %
H.A.	(37%)	(40%)	(4%)	(11%)
H.B.	(0%)	(16%)	(4%)	(11%)
H.C.	(0%)	(0%)	(4%)	(1%)
H.D.	(0%)	(46%)	(1%)	(0%)
H.E.	(0%)	(9%)	(3%)	(0%)
H.G.	(1%)	(38%)	(1%)	(0%)
H.H.	(54%)	(52%)	(0%)	(0%)
H.L.	(0%)	(58%)	(0%)	(1%)
H.M.	(0%)	(58%)	(0%)	(0%)

The recovery column showed that seven UPsKs had low percentage rates of recovered clients (78%). They were all placed in the bottom 25%. Only one UPsK had high rates of recovery. The improvement column showed three UPsKs were in

the top 25%, average, and bottom 25% respectively. The no-change column showed that five UPsKs had low rates of no-change (56%), i.e. placed in the top 25%. For the deterioration column, 7 UPsKs (78%) had low rates of deterioration. They were in the top 25%.

Cross et al. (2015) did a study that used the traffic-light colours to show quickly and simply the changes that had taken place. In the Cross et al. (2015) study, the traffic light system tracked changes in the client's CORE item scores. Briefly, green represented 'improvement', yellow represented 'no change' and red represented 'deterioration' on an individual item.

This UPsK study used the traffic-light colour codes to produce a matrix that could convey quickly at a glance, the performance ranking of the UPsK based on outcomes. The matrix display was a useful way to track the performance of many units. The UPsKs' performances were ranked as high (green), average (yellow & amber) and low (red).

In Summary, the CORE system used traffic-light colours to represent performances based on percentiles. For positive outcomes the 75th percentile, high performance was green, 50th percentile, the above-average performance was yellow, below average was amber, 25th percentile, the low performance was red. The reverse was true for negative outcome categories: 75th percentile, high performance, was red, 50th percentile, above-average performance, was amber, below-average performance, yellow, 25th percentile, low performance, was green.

Only one UPsK achieved the desired state (high positive and low negative outcomes), and only one UPsK had an undesirable state (low positive and high negative outcomes). 78% of UPsK had low rates of recovery, a third had high rates of

improvement, slightly more than half had low rates of no-change, and 78% had low rates of deterioration. Generally, the UPsKs showed average performance.

Qualitative Analysis

The quantitative analyses provided empirical evidence about the assessment of client outcomes and the UPsK service. However, the survey data were unable to give explanations for some of the survey findings. For example, the results on the application of the service benchmarks were mainly benchmark values but without context to explain why they are as they are. It needed additional inputs from psychology officers (counselling) to put matters into perspective and give the situational context to the practices in the UPsK that produced the phenomenon—performance rankings of the UPsKs.

The CORE-OM (client-reported outcome measure) and therapy assessment forms (TAF and EoT) had limited scope to provide context to the UPsK's environment. The former was focused on the client's emotional state, while the latter on the client's demographics, therapy, motivation, presenting and identified psychological problems. Hence the statistical analyses on the quantitative data revealed the phenomenon but were unable to provide any explanation. It was necessary to get further information from an important stakeholder, the psychology officers (counselling). His/her perspectives were crucial to understanding the context of the assessment process in UPsK that produced the phenomenon. The second part of the explanatory sequential design was interviews with the psychology officers. The qualitative data triangulated the findings.

The researcher conducted semi-structured interviews with three UPsK psychology officers (counselling) from the north, central and east zones. The

interviews revolved around the one overarching topic that is the assessment of the UPsK service.

RQ 8: How does the psychology officer (counselling) engage in the assessment of UPsK service?

The study chose three psychology officers (counselling) based on the criteria presented in Chapter Three, page 109 and assigned pseudo names to them to maintain anonymity and to preserve confidentiality. The researcher conducted the interviews in either Malay or English, but many times it was a combination of both languages, and the Malay quotes translated into English.

The thematic analysis of the qualitative data began with the background of the psychology officers (counselling).

The demographics of participants. The psychology officers (counselling) interviewed were representative of the multiracial components of Malaysia: Malay, Chinese and Indian races. The female Malay psychology officer (counselling), Cik Siti, was in her early thirties residing in the east zone. The male Chinese psychology officer (counselling), Ah Chong, also in his early thirties, was working in central zone. While Muthu, the oldest at 57 years old, was a male Indian psychology officer (counselling) in north zone. Muthu has opted for the pension scheme of 2008, i.e. retirement age at 58 (Government of Malaysia, 2005) and the researcher was lucky to have interviewed him before he left for retirement.

Two of them were married with family except for Ah Chong, who was a single young man. Cik Siti was married to a radiographer, and they have a young family, a toddler and a new-born. When the researcher met her for the interview, it was her first day at work after two months of maternity leave. She sent the children to a baby sitter's

house near the hospital before going to work. Muthu had grown-up children who have all left the nest, and he and his wife were like ‘newlyweds’ again.

Muthu came up through the ranks with a Diploma in Counselling from University Kebangsaan Malaysia (UKM) and ended up as Head of Unit at the end of 15 years of a counselling career. Along the way, he acquired a Bachelor Degree in Psychology from his alma mater. He had worked in many hospitals in Negeri Sembilan, Malacca, Pahang and his last posting was in the north zone. He has been in the current UPsK for six years.

Ah Chong had Master in Psychology Counselling from University Kebangsaan Malaysia (UKM) and a bachelor’s degree from University Tunku Abdul Rahman (UTAR) in the same field. He was working as a counselling intern at a central zone UPsK for some time, and then he was upgraded to full-time staff. Counselling was his first job, and he has been here for six years and hopes to continue at this UPsK because he is happy here.

Cik Siti, due to family commitments, has yet to pursue her master’s degree. Her bachelor’s degree was in Counselling from University Sains Islam Malaysia (USIM). The UPsK was her second posting as a psychology officer (counselling) after a short two years stint in a State Health Department. She has been in her current position for the last six years.

All three psychology officers (counselling) were from the UPsK units. The unit is under the purview of the Deputy Director of Medicine. Two of the UPsKs are in state hospitals in central and north zones, respectively, while the other is in a major specialist hospital in the east zone (Saudah Mat Akhir, 2016). The UPsKs in the state hospitals has been operational since the late 1990s while the UPsK in the major specialist hospital started operation in 2009. The UPsKs in the state hospitals have a

separate area with administrative staff, counselling rooms, and psychological tests “*We have two counselling rooms, one playroom, and then office like this one lah*” (Ah Chong: 22 page 5). The UPsK in the specialist hospital shares office space and equipment with the Department of Medical Social Work. The UPsK’s office doubles up as the counselling room when the client meets the psychology officer (counselling).

There was a disparity in the workforce of the three UPsKs. The UPsK in the state hospital in the central zone had nine psychology officers (counselling) while the other two UPsKs had one and two officers, respectively. Nonetheless, the researcher looked at the context of the hospital, especially the sizes of the hospitals to understand the disparity that existed. One state hospital has 2300 beds and 83 wards, the other state hospital has 990 beds, and the major specialist hospital has 498 beds. It appeared that the number of psychology officers (counselling) was proportional to the needs of the hospital.

Ah Chong with eight other psychology officers (counselling) in the large UPsK, provided counselling and psychological services for clients and hospital personnel. They also conducted courses for agencies outside the hospital. The situation was different with Muthu. He had to struggle with the workload because the unit was down to one psychology officer (counselling) instead of two since there was no replacement for the officer who left to continue her studies. Nevertheless, he felt absolved of all the limitations when he received a letter of recommendation from a satisfied client “*Sincerely appreciate your hospital with such a good person*” (Muthu: 40 page 10).

Similarly, it was challenging for Cik Siti as the sole psychology officer (counselling) to provide counselling and psychological services for her hospital, i.e. a major specialist hospital, and also the cluster hospitals in the neighbouring districts.

She also has clients from the district clinics. Under the hospital administration, the psychology officer's (counselling) work scope was to focus 70% of the time on the hospital personnel and 30% on clients. However, the reality is that there are more clients than staff needing psychological assistance. Now 70% of the time was spent on clients and 30% on personnel. Cik Siti described the situation.

Our post is under management, so we are supposed to look after the staff. Focus on 70% of staff and 30% client. But, in reality, there are more clients than the staff. Staff cases are like not coming to work, but conflict not much. For personal problems, they come voluntarily not referred. Staff cases on the disciplinary issue the head of the department will refer to us. But it is reverse now when there are 70% clients and 30% staff cases (Cik Siti:36 page 1).

The year 2019 was particularly challenging for Cik Siti. She was pregnant with a second child, and the UPsK was temporarily closed for two months when she took maternity leave (September and October). When she returned to work, it coincided with the hospital-wide MSQH evaluation period, and she was not ready to present a report on the UPsK's performance for 2019.

The psychology officers' reflection. The purpose of this topic was to allow the psychology officers (counselling) to think beyond assessment and reflect on issues that they felt matter in the counselling field. These ideas or issues would shine a light on their world view and showed the lens through which they viewed the world.

Muthu was at the end of his career. He reflected that counselling has made him a better person compared to who he was at the beginning of his career. He reflected:

I like the job as a counsellor. I like the job very much, that is why I stick to it and not move to do other things. I learnt a lot from this counselling profession. Yes. I experienced lots of changes. This one I can tell significant changes in me, from bad guy to an improved guy (smiling). Not yet good enough, but trying (Muthu: Line 6, page 1).

I try to put myself in my client's place, I cannot take it. So I thank God that He did not give me the suffering, like what they are suffering. Appreciate what

you have. That is why I tell you I changed a lot from these cases. Everyday I change (Muthu: Line 35, page 8).

Thus he has strong opinions about the type of person suited for a career in counselling. The person must have the paper qualification, but more importantly, be people-friendly, has sincerity to help and willingness to serve. He argued:

First of all, the intake of counsellors must follow procedures so that the correct person is in the correct place. If the person is not suited to work with people, then she/he does not qualify even if the person has a degree in counselling or psychology. Cannot accept as a counsellor. (Muthu: Line 30, page 11).

Select the people who want to help other people. Not just come here to earn money from 8-5, then go back. I am not perfect, but if you want to help somebody, you must be sincere. You must be sincere, regardless of race, religion, social status. You help. That is the real counsellor (Muthu: Line 2, page 12).

Being a senior counsellor, he was aware of the limitations of UPsK such as poor access and lack of promotion of the service in society. Thus he formulated a plan that would bring the counselling service to the people in their housing estates. His plans were:

You must have a one-stop crisis centre run by a counsellor or lay counsellors in every neighbourhood (taman). One on-site manager supervises several one-stop crisis centres in the neighbouring tamans. He/she handles the documentation for all reported cases of domestic violence, child abuse, rape, abandonment, suicide in the neighbourhood. The manager will assign a counsellor to the victim. This project is best suited for the Ministry of Women, Family and Community Development to take up. We need to do something to make counselling services accessible to everyone, just like how easy it is to do sports in the tamans. (Muthu: Lines 7, 16, 30, page 10).

The neighbourhood project was Muthu's dream project for the future. After many years of seeing the difficulties clients go through to get counselling treatment in UPsK, he hatched an "out of the box" plan to bring counselling services to the people.

For Ah Chong, counselling presented a continuous learning experience for him. He was never bored at work, enjoyed learning and acquiring counselling competencies even though he had to pay out of his pocket. He explained:

The psychology officer must be knowledgeable. He/she is willing to attend accredited courses that provide certification. I am a licensed practitioner of art therapy drawing. Some Jabatan (Department) will pay the fees, but generally, you pay out of pocket for continuous professional development (CPD) courses. To attend, we have to take leave since it is not part of work.—still, a long way to go. In my UPsK, we have officers specialising in marriage therapy, children, adolescence, geriatric and many others. I specialise in children and adolescents. We try to cover for each other. Make us stronger as a team (Ah Chong: 7, page 8).

The team of psychology officers (counselling) in Ah Chong's workplace has embraced the idea of teamwork as articulated by LePpne, Piccolo, Jackson, Mathieu, and Saul (2008). The objective of teamwork is to bring highly skilled professionals together to work as a team to achieve its purpose successfully.

Ah Chong dealt with resistant Chinese clients and with children daily, so he knew well that it was important to maintain their interest. He put efforts to make the therapy sessions attractive and fun. For example, he chose non-academic personality tests to pique the attention of his clients. He said:

Moreover, to attract clients, who are not fond of the questionnaire, I would say, "Let us do the five love languages. Do you want to know the way you love or be loved?" Do this. "Do you want to know your personality A or B?" Do this. "I have this animal test, as well. From the animals itself, you will know more about your personality." Both to attract and as part of my therapy. To make therapy more fun and lively. Of course, they will also learn something new. Counselling is not just sitting there talking, talk, talk non-stop and go back (laughing). This is a common misunderstanding about counselling. They think everyone can become a counsellor because just sitting there, talking nonsense. It is a very structured kind of therapy, treatment process. (Ah Chong: Line 33 page 4)

Ah Chong is a psychology officer who is young at heart, always learning new things, so he made sure his therapy sessions were not dull. Nevertheless, being a

professional, he thoughtfully chose suitable unpublished, non-referenced personality tests that were simple, captivating and enlightening.

Cik Siti wears two hats: a professional and a mother. She is struggling to find work balance between the two, that is, to find time to complete her workload and have time to be a responsible, loving mother. She lamented:

Administrative work makes me burnt out. We [fellow officers] always share our problems. We find a group to ventilate. All have similar problems. In our workplace, we appear to 'rock' it. People see counsellors as doing great jobs. We appear to be mentally healthy. However, inside we are fragile and very drained. We are tired due to bureaucracy. For myself, I did not fill up the case management system (KMS), but next year I must. I am thinking how to do that? I must fulfil the client quota so when do I find the time to do the administrative work such as keying-in hospital registration, MSQH, State Health Department client registration? Do them on Saturday and Sunday? It is all there but to find the notes and files again, that takes time. Burnt out—emotionally, physically drained! (Cik Siti: Line 7 page 7)

Psychology officers who are dealing with people's emotional and psychological problems are liable to suffer from burnout. Cik Siti was experiencing burnout, not due to her counselling role but to excessive pressure at the workplace, particularly over the administrative work that she has neglected for apparent reasons (McCormack et al., 2018).

In summary, the overarching topic was the exploration of the emic perspectives of the psychology officers (counselling) in assessing the UPsK's service. Understanding the three psychology officers' (counselling) backgrounds, education and work experiences, location and scope of work gave better perspectives to the way they engage in assessing the UPsK's service. Those factors influenced their outlook on work and manifested in their reflections during the interviews.

Themes. The researcher discussed the themes and categories that emerged in the sections below:

The need for unit evaluation. Was there a need to evaluate the UPsK? It was an important question to ask the psychology officers (counselling) who were the practitioners as well as the managers of the psychological counselling service. They could provide the necessary information on practices, cultural context and difficulties that existed in their practice when doing an assessment. Their viewpoints were essential for this study. Literature has shown the active participation and commitment to a system by the psychology officers (counselling) were crucial to the success of the system (Boswell et al., 2015).

The categories found in the unit evaluation theme were as follows: (1) evaluation by MSQH, (2) internal assessment, and (3) quality assurance programmes. Muthu emphasised that external service evaluation should be carried out in the UPsKs with set criteria so that improvements could be carried out based on the assessment. Presently the service was being internally evaluated by the psychology officers (counselling) themselves who used client satisfaction rating as a way of assessing their service. Since it was an internal exercise, there was no improvement plan or development programme taking place in the UPsKs as a result of the assessment. Muthu explained:

An external body should evaluate UPsK, but the criteria must be made known so that the unit is prepared. The evaluation must be made compulsory. Now there is no evaluation. Now I do my work and I evaluate myself. Maybe good, maybe no good. If there is an evaluation, I can improve, perhaps the unit can improve by getting more staff, well-experienced staff. Maybe one is not enough I can ask for experts for some cases. Many things the unit can collaborate in two-ways (Muthu: Line36, page 12).

The hospital, where Muthu worked, used client satisfaction feedback to evaluate the UPsK's service. He explained:

I evaluate from my own clients' improvement and when there is no complaint from any client about the counselling service—received recognition from clients. I read an example to you (he opened a letter and read from it), "Today

I had an appointment with Mr Muthu. Good manners had the patience to explain my problem, well-dedicated person, caring, call me on and off to check my progress. Sincerely appreciate your hospital with such a good person.” The client sent the appreciation letter to the hospital director. Such patient appreciation is more valuable to me than an award worth a thousand ringgits (Muthu: Line 37, page 10).

Many studies have used/are using client satisfaction survey to assess quality service following Donabedian’s recommendation to use client perception as part of quality assessment (Al-Abri & Al-Balushi, 2014; Gardner et al., 2014; Noor Hazilah Abdul Manaf, 2012). It is good practice when client satisfaction is used alongside other outcome measures; however, the situation in UPsK was not the case. He elaborated:

We have a customer complaint form which the client can fill up. That is a form of assessment. By the way, there are items on table and chairs, process and facilities also asked. The items on the UPsK service are mixed with items about other departments too. It is not just about counselling service only. I want to suggest that UPsK has a separate form for itself. Then we can sell our service. Finally, if there are no complaints about UPsK, then there is 100% satisfaction. If there are any then the percentage drop, drop. (Muthu:10 page 13).

Muthu’s hospital used the satisfaction feedback form to get clients’ response concerning the hospital’s facilities such as availability of tables and chairs; waiting time; disabled parking allotments; and other services including the UPsK service. Therefore, technically it was not an assessment of the UPsK service. Nevertheless, it was an indicator of sorts when clients did not complaints about UPsK’s service, therefore, indirectly implying that it has fulfilled its purpose.

Cik Siti’s major specialist hospital did not have a client satisfaction feedback form. Not many government hospitals practice client satisfaction feedback system, and the method of assessing UPsK’s service was dependant on the individual hospital’s

management system. In Cik Siti's hospital, the management used the Malaysian Society for Quality in Health (MSQH) Standard 17 I to monitor the UPsK.

Nevertheless, Cik Siti was not satisfied with the assessment since MSQH 17 I was general and not focused on outcomes. For example, it did not recommend any percentage for the outcome, that is no specific outcome that represented excellent service for UPsK. She elaborated:

For Standard 17 I, the client outcome is the performance indicator here, i.e. the number of clients registered for counselling and discharged; and clients requiring referral. But, it does not indicate the percentage of outcomes. For example, in radiography, the expected outcome is 80%, but there is no percentage outcome for counselling (Cik Siti: Line 18, page 5).

Cik Siti highlighted another aspect that needed attention, that is, evaluation of the psychology officer's (counselling) skills in conducting sessions. She stated:

Yes. Must have assessment. We are afraid that we shall drift away if we evaluate ourselves and say our service is good. The area that most need assessment is my service, "Am I delivering the right way or not?" We need an expert in counselling to assess whether the counselling process is just giving advice (Cik Siti: Line 42, page 5).

The psychology officer giving advice or telling the client what to do was the wrong approach; it is the antithesis to counselling (H., 2013). Cik Siti was brave to bring this up despite the repercussion that would reflect poorly on her. She was sincere in wanting to improve herself, and she wanted an objective expert to show any wrongdoings that had crept into the counselling process.

For a long time, the type of data collected was quantitative, that is the number of clients; demographics; presenting and identified problems; the number of sessions and other technical matters. However, data on clients' outcomes and the quality management practices in the UPsK were not collected. Muthu exposed the gap:

The hospital management wants to know how many cases per month. Numbers only. With numbers, how do you expect to improve? Outcomes not asked at all! First, improve and look at the effectiveness of the service. Secondly, what

improvement can be made? Thirdly, what new things can we introduce to UPsK? In conclusion, every unit must be assessed for quality management. We should not talk about quantity only. Quantity without quality is not right. At the moment, only quantity is asked (Muthu: Line 1, page 13).

Many advanced countries like U.K., Western Australia and Canada have instituted quality management system to ensure clients receive the best available evidence-based care (Boulter & McDonald, 2020; Mental Health Commission, 2013; Wyatt, 2020). They have a continuous routine evaluation system, committed to accredited standards, or have quality assurance programmes. As Muthu succinctly commented, “quantity without quality is not good.” The truth of the matter is that UPsK has not begun this journey of quality assessment. Many UPsKs have remained as they were for the last decade or more because there was no external pressure to evaluate performance. It is time to execute a continuous routine evaluation system such as CORE-OM in the UPsKs.

In 2019, baby steps towards this journey of quality began with the creation of quality assurance systems initiated by the Allied Health Science Division (Psychological Counselling Service, 2018b) for all psychology officers (counselling). Part of the quality assurance system is (1) psychology officers (counselling) must fulfil key performance indicators in the annual work recommendation [*saranan kerja tahunan* (SKT)], and (2) key-in cases into the national case management system (KMS). The KMS organizes and manages data collection from 149 psychology officers (counselling) around the country. Furthermore, the KMS data could be the beginning of a national database on psychology counselling services (UPsK) countrywide. Ah Chong explained:

Entire UPsK, we have SKT so they will assess us based on the SKT. It is about the cases and the sessions too. Of course, our main objective is seeing clients, but we also have another role as well, to the staff. So SKT assesses UPsK in terms of clients but also assesses on how many talks, programmes the

psychology officers contributed, or invited. So it is not just client cases but overall. It is not just the hospital, but we also have the ministry of health (KKM) as well. So sometimes, some of our officers are invited to KKM facilities such as government clinics, hospitals to give talks (Ah Chong: Line 31, page 6).

Muthu described the assessment directive from the Ministry of Health. He said:

We make a report based on the case. [For example] This month the number of client and staff cases are these amount. We have a client charter which we have to fulfil. All cases must receive a minimum of 30 minutes per session. How many cases fulfilled that requirement? This month I saw 50 cases. Did I see them for 30 minutes each? Our target is to get 85% of such cases (Muthu: Line 7, page 14).

The annual work targets (SKT) included the Client Charter. The charter guarantees that the psychology officer (counselling) will see the client within five working days, after referral, for a minimum of 45 minutes or 90 minutes for a group family and marital counselling. Furthermore, the psychology officer will give a brief introduction to the service before the session begins (Psychological Counselling Services, 2018b).

Workforce needs. The thematic analysis revealed that the category “heavy workload” was often quoted at 52%. The exploration began with understanding the work expected from the psychology officer (counselling). Ah Chong explained:

First KPI (key performance indicator) is response time. Response time is five working days; we must respond to the case. Same with the ward cases they sent in the referral letter, we must respond within five days. Not sure whether this is a ministry or just counselling guideline. Last time when I first join, I was required, as an S41 officer, to have 80 new clients per year for each officer and accomplished 400 sessions in a year—about five sessions for each client. Everything adds on, the previous one and the new ones. Terminate the old ones, or it will add up lah. As the rank goes higher, they will do more administrative jobs, so they will [have] less client and fewer cases. The management assesses us by the number of cases we do. Then we have KMS case management system. It is a national system lah. Three minimum cases

per day, but we adjust our time, we may need to go to the wards later. The highest one is 7 cases per day. So, in the end, it depends on our time management. We may need to work overtime (OT). Of course, all the time. The latest I have come back from ward visit was 8.30 at night (Ah Chong: Line 4, page 6).

Ah Chong clarified that the psychology officer's (counselling) work included administrative work such as keying-in the KMS, keeping records of the clients in hospital and state databases, keying-in the KPI's annual target achievements and other administrative works.

Cik Siti shared her work in an MSQH accredited hospital. She said:

MSQH monitors this hospital, and MSQH Standard 17 I audits UPsK. They asked for two things: client registered for counselling and discharged; and client requiring referral. So I must take care of 4 key performance indicators (KPI): (1) give service in 5 working days, must get 80%; (2) MSQH-number of registered and discharged clients; (3) MSQH-number of clients referred; (4) Smart goal, the client, must score minimum 2 points. The KMS System is good, and all officers must use it, but I do not because I do not have time to key-in. We already have the hospital's and state health department's client registration databases to fill up, key-in. Now for KMS, we have to key-in all the same details such as biography, demographics of the clients again. Its double work lah. With so many cases, I do not have time. It is too much burden (Cik Siti: Line 17, page 5).

Cik Siti found it difficult and tedious to key-in patient data into the Hospital Information System (HIS), then into Kes Management System (KMS) and then again into the State Health Department database (*Kumulatif Statistik JKN*). She only managed to jot down notes into the patient personal case file, which was kept under lock and key in UPsK, after the client left. She did not enter the information online because it was time-consuming and energy-draining. She took the unprecedented step to select the database that was critical and to leave the others for later. The workload of the psychology officer (counselling) had detrimental effects on the long term performance of the officer. Cik Siti acknowledged all the difficulty faced. She said:

One other matter is time. Time is an essential factor for clients who come from far. I understand the difficulty of FELDA clients, they come by Grab, or any transport, it is challenging. So I give more time to them, usually one hour or sometimes two hours. The most typical is one and a half to two hours. I consider the first and the second sessions rolled into one visit. During the second visit I do techniques, and the third visit I discharged. If I count the number of hours I spent then many hours. It is like we had five sessions altogether. In one day, I can manage three or four clients, like that. I already burnt out; as it is so heavy. Here is my appointment book (she showed her book). Like this week I am tired. Even three to four clients are too many. By three in the afternoon, I want to do document, but I am tired. I just jot down brief notes, not long sentences. I do that when the management wants a report. I open the file and read the notes jotted down. Then I build up proper sentences for the report (Cik Siti: Line 17, page 1).

Clients from the outlying district hospitals and district clinics go to see Cik Siti as she is the sole psychology officer (counselling) in the area. So another part of her duties is to visit these clients in the small cluster hospitals. However, last year she did not make any visits. She explained:

For cluster hospital I go there. At least once a month but so far it is not possible. I want to give quality service, not quantity. Last year I was pregnant; this year, this issue went up to the management because I did not visit the cluster hospitals. Clients and staff waited for me. I gave excuse I was burnt out, so how? It is a lot of issues (Cik Siti: Lines 9, page 1).

Cik Siti burnt out due to excessive workload compounded by the pregnancy. The phenomenon of burnt out is a concern among those in the caring profession since the workload and work setting contribute to emotional exhaustion (McCormack et al., 2018). Cik Siti was aware of her limitation. She said, *“When there are constraints in work, I play it safe. I do the work that I can do if not I will exhaust myself out. I only take cases that I can manage.”* (Cik Siti: Line 23, page 1)

There is a consistent and robust relationship between burnt out (emotional exhaustion) and workload. The objection to workload is the perceived wrong type of work (e.g., administrative work) added to an individual's role, and made worse when the individual lacks the necessary skills to execute the work (Maslach et al., 2001).

Another set of clients that needed UPsK service are the in-patients. The resident doctor in the ward will recommend clients who appeared to suffer psychologically, to get counselling assistance. Ah Chong discussed in-patients who needed psychology and counselling services. He said:

Clients are in the wards for many reasons, they are having complications, for example, kaki potong or amputation, or are adjusting to cancer diagnosis very anxious, so they refer to us. For ladies, they had miscarriages, so they require counselling. We have burnt wards. Clients may stay for more than half a year in the ward so they will need counselling as well. Downstairs we have rehab (rehabilitation). Rehab clients in the adjustment phase, they cannot walk, they give up, they need motivation. There are many ward cases. (Ah Chong: Line 25 page 6)

The heavy workload caused Muthy and Cik Siti to lament the lack of workforce. Many UPsKs are “one-man show” meaning only one psychology officer (counselling) is managing the unit. When the psychology officer cannot be in the office (for whatever reason), then the unit is closed temporarily for as long as the officer is unavailable.

In Muthu’s UPsK, the designated number of psychology officer (counselling) was two; however, when the officer left to pursue a Master’s qualification, the post was vacant for one year. Muthu had to cope alone. *“Just got an officer. For one year, I was alone. She just came in this month”* (Muthu: Line13, page 11). Cik Siti has been ‘fighting’ for more officers because the UPsK service covered a large area beyond the hospital gates, so one officer was insufficient. *“From 2009, I think, up to now it has always been one post, no development, even though every year I put up a budget for an additional post”* (Cik Siti: Line 4, page 7). Hence, lack of workforce added to the already strained working conditions in one- or two-manned UPsKs around the country.

Challenging counselling process. The counselling process consists of three phases: the beginning phase of pre-counselling and rapport building; the middle phase,

is the in-depth exploration of issues; and the third, is goal setting and finally termination. Similar to the four stages of counselling process (Hackney & Cormier, 2013; Patteson & Welfel, 2005), i.e. establishing relationship, exploration of the problem, goal setting, and solution leading to termination. Thematic analyses revealed the counselling process was challenging (theme) based on categories such as the ambivalent clients and needing action-oriented officers.

The psychology officer (counselling) must be guided by counselling values to do the job of assisting the client. Muthu said:

At the end of the day you want to change a person, there are many strategies, counselling. We talk, caring in the medical part of the hospital. I believe in 3 things – caring attitude, empathy, and non-judgmental. These things already in counselling. Yes? Ha! So caring attitude, for example, a 27-year-old doctor suffering from mental stress and he is trying to serve people. If we can help him, he can help more people! I am not selfish. I take him as my family member. If anything happened to my family member, you think I leave lah? The desire to help. Number two, empathy. Put myself in that fellow's shoes; There are times we are okay and times we are not (Muthu:13 page 5).

The first step was pre-counselling. During this time, the psychology officers (counselling) explained the ethics involved, such as confidentiality and informed consent, followed by an introduction to the counselling session.

Oh yes. I will not tell the client exactly how many sessions but I will tell them precisely what are we going to do in our session. Approximately between 45 minutes to 1 hour, this session is strictly confidential, private and confidential (P&C), structuring lah. Of course, when they fill up the intake interview, they will also come across what are the exceptions that will breach the confidentiality. So we go through all these things (Ah Chong: line 37, page 1).

These steps are of the standard operating procedures for individual counselling, provided by the Allied Health Sciences Division, Ministry of Health Malaysia (Psychological Counselling Services, 2018b), i.e., fill up the Personal Detail Form and sign the Consent Form before the session begins.

A critical category highlighted in the first phase was the ambivalent client. The ambivalent client had come to the UPsK reluctantly, usually coerced by spouse or family members to seek treatment for dysfunctional behaviours. The three psychology officers (counselling) have encountered such clients in their units. Muthu had experienced such clients, and he reported:

At the initial assessment, it is like this - wife brought him to stop drinking. He was already critical. His doctor already ordered him to enter ward for a liver problem. The doctor said his liver was bad must stop drinking. When we speak to him, he said, "I can stop by myself. I do not need counselling. My determination is strong. I know what is good and bad. What can counselling do for me?" He was not ready for change. That is called the pre-contemplation stage. Must read stages of changes to understand. The contemplation stage is when you want to change. For those who do not want to change, we provide health education. Drinking is harmful to you because of this, this and this. Those who want to change we provide counselling. At every step in the process of change, the psychology officer can offer something. (Muthu:30 page 5)

The psychology officers (counselling) would provide motivation, raise awareness and make available health information (give pamphlets) for the clients who were not ready for counselling. There is always something for every client that comes to UPsK.

Ah Chong had children clients. He would play games with them to develop rapport. *"I play with them[kids] for at least one session, ok then they will feel safe to share with me"* (Ah Chong: Line 5, page 2. Once the kids have a rapport with Ah Chong, then it paved the way for them to share their problems, and the psychology officer must listen actively. Muthu said:

Counsellors are in the listening profession. We are expert in listening. While listening, we response minimally. The client would feel his burden has lightened. Good. Then I speak, "Your story is sad. Today you are here with me. We will begin a new chapter." We invite him in (Muthu: Line18, page 4).

Slowly the client would show signs of change for the better when he/she became an active participant by attending sessions, doing assignments, doing activities with family members; gained confidence and thus began to be in control of things (become independent). The expected corollary when there was a reduction in distress levels was the increase in self-confidence. Also, an improvement in the client's physical appearance and demeanour as compared to the first session. *"As sessions go by, you can see the changes. From nervous, he can now sit properly, can say, 'Thank you okay, I will do that.' That is quite good."* (Ah Chong:42 page 3). Muthu described it clearly. He said:

When the client comes to the appointment, that shows a change. The first stage is he/she comes to the appointment or calls me to tell he cannot come then we give another date. These are all positive signs. At stage 2, I give the assignment to do at home after counselling. The client does the assignments, do all the assignments then okay. The words of the client will show he is changing. Also can give test like DASS. The client, themselves will tell me they have changed. For example, if for drug addicts, test the urine for drug use. If he is determined to change, he gives urine for testing. All these show changes lah (Muthu: line 16, page 6).

A significant part of change is the adjustments in the clients' perspectives towards his/her emotional problems. There would be modifications in his/her thought processes. Cik Siti would ask her clients the feelings evoked and behaviour patterns that changed when he/she undertook new ways of doing things. She said:

I will ask, "How do you feel when you do this?" Usually, the client will tell. I ask them again and again. If there are okay changes, then I tell them to continue doing it. I usually ask clients like that (Cik Siti: Line 20, page 4).

Ah Chong stressed the changes in the thought process, which would then lead to changes in the physical activities. He said:

I can see his changes and more importantly, the changes in his thoughts. He has been practising the relaxation methods. I taught him how to breathe, to progressively relax the muscles, then to engage in meaningful activities with his wife (Ah Chong: Line 39, page 3).

The therapeutic relationship Ah Chong developed with his psychiatric client (referred) has enabled the client to open up, be relaxed, and slowly modify his thought processes so that he can handle problems more appropriately (Easterbrook & Meehan, 2017).

Another category that emerged was that the psychology officer (counselling) must be action-oriented. According to Muthu, it was not enough to nod emphatically as the client opened up with his/her problems but to come up with a plan to assist the client. Be ready to suggest things to alleviate the client's problem. The officer must have an extensive network with relevant authorities or private organisations and thus know how to get resources when needed. He said:

Help them! We call welfare to see whether they have any schemes for assistance. Counsellors must be action-oriented not just listen only! Listen only (shaking his head) you must be the action-oriented counsellor. That is why we must have networking. Disabled client says "I want to find work." Have a connection with the unit that finds work for disabled clients. "I have a sick, disabled child that cannot stay at home" On the spot, we have the contact of a nursing home. "The fees are so and so. Put him there for a few months until better." "We want to be with other Malays" Look for it! "We want to find a drug rehabilitation centre that is religious-based." Look for it! We must have all these in our networking. After sending them off, we must follow-up. "How are you?" (Muthu: Line 27, page 4)

In the third phase, the client and the psychology officer (counselling) agreed on the goals after having explored the problems besetting the client, together. Muthu said:

Yes, every counselling session has a goal. The client also understands this. After listening to the client's problems, in the third session, I say to the client, "I hear your story, so now let us discuss the plan and goal for counselling. There maybe one, two or three goals." We discuss. "To achieve the goals, we must work together." Pull the client into the plan (Muthu: Line 26, page 5).

At this stage, the psychology officers (counselling) may have to change the approach to suit the needs of the client. Muthu had a client with third stage cancer,

and her prognosis was poor. The doctors had briefed Muthu on her condition. He described the actions he took:

Cancer, stage 3, okay. Already spread throughout the body. So what to do? Client cried for three days non-stop. Who to complain to? So gave motivation only. Do not expect to change lah. She is suffering, so I referred her to a Muslim priest (Ustaz). Okay, spiritual counselling lah, some spiritual support to be near God (Muthu: Line 7, page 8).

Muthu realised general counselling would not help the client at this point; so he referred her to the relevant authority who can assist her in her current condition of needing spiritual comfort. In this case, Muthu referred her to a Muslim priest (Ustaz). In other cases, Muthu referred his clients to colleagues of the same gender and race when appropriate. It is not uncommon for clients to prefer counsellor to be the same race and gender (Sue et al., 2019). So UPsK unit with two or more psychology officers (counselling) must work collaboratively to ensure the clients received the best intervention for the client. Muthu described such a situation:

I cannot see the client improve, so I ask the client, "Do you want to meet another counsellor? Maybe my colleague can help." Malay client with Malay counsellor, Indian client with Indian counsellor. They want to talk more things about death and related things. The best thing is that we help the client. If I cannot help him/her, maybe my colleagues can help. I cannot be jealous. Ultimately, we want to help the client (Muthu: Line 20, page 8).

Ah Chong also had cases where he had to refer his clients to other colleagues because the case was not in his field of expertise.

I have received some cases which are not in my scope of competency. I am in much dilemma, for example (pause) - homosexuality. Not to say everyone, but many find it harder to gain trust. I discuss with my supervisor, my colleagues, who can deal with this case. Of course, I will not just throw them [client] lah (laughing). The decision is on them. If they are comfortable with me, I will do what I can lah. "If you are not feeling comfortable I will not keep you. Maybe you will feel better with other counsellors" (Ah Chong: Line 24, page 3).

The reality of counselling in Malaysia is not all psychology officers (counselling) are equipped with multicultural skills to handle the controversial issues

of race, culture and sexual orientation delicately (Jaladin, 2011). Therefore, the better approach is to refer to others who have the competencies to do so. The ability to put the interest of the client above self-ego requires a high level of trust and collaboration to exist among the psychology officers (counselling). Muthu and Ah Chong were fortunate to have such teamwork among fellow officers in their UPsK units.

Inappropriate tools used. The thematic analysis revealed resistance by clients and psychology officer (counselling) to the use of tools. Examples of resistance from clients “*Counselling session is one to one meeting. The client does not want to be disturbed at all. When we use the tools, he does not want.*” (Cik Siti: Line 30, page 7). The process of filling up the questionnaire is time-consuming. “*Takes time. The client must read and then answer. Clients like to talk. The client does not like to fill up forms*” (Muthu: Line 23, page 9).

Muthu stressed very emphatically that if the client were resistant or not ready to use the tool, then he would follow the client, that is be pragmatic about it. He said:

After that, we have tools like DASS, BDI, personal Sidek. We use them, but it depends on the case. If the client comes with depression, why want to use the tool. Yes, okay to confirm but if I can identify by her verbal communications, and non-verbal expressions and the clients, they tell me that they are depressed. I follow the clients' way lah (Muthu: Line 14, page 9).

Meier and Davis (2019) wrote to assist clients in self-exploration, listen carefully to what the client has to say and to focus on him/her. Muthu took this approach when faced with a depressed client.

The psychology officers (counselling) also expressed resistance to the indiscriminate use of tools in assessing clients. Muthu expressed this succinctly:

The DASS is short, with only 21 questions. So I do the simple, simple ones. BDI also has 21 questions only. We are willing to do a little bit more work lah, but I will not use the IQ test that is a hundred questions long. I got no time. I

better spend time talking to clients, listen to clients directly (Muthu: Line 19, page 9).

The other problem with the tool was the language. Most questionnaires in Malaysia are in English, and some psychological questionnaires have the Malay version, for example, the General Health Questionnaire (Yusoff et al., 2009), and Center for Epidemiology Study-Depression Scale (Mazlan & Ahmad, 2014). However, for clients who did not understand either language, they were reluctant to use it. Ah Chong described his experiences and the steps he took to overcome the clients' resistance when they encountered language problems in the questionnaire. He said:

For Chinese clients, the problem was the language. I had to do something extra lah to help them. I found a Chinese version of the DASS test. Then it was better lah for uncle and aunty who are not highly educated and cannot read English or Malay. However, strange also lah in Malaysia you cannot read in Malay! Some say I do not know how to read Malay. Seldom I heard they would say not okay. They will say a problem with the language. They cannot understand, could not read. So if there is no test in Chinese, I will translate to them, orally. That is also a challenge, I may translate something [which] is going to be bias already. (Ah Chong: Line 6, page 4).

This study used a bilingual CORE-OM version; that is, the items were in Malay followed by English in italics in the next line. Cik Siti similarly had clients who were resistant to filling up the questionnaire, and she had to assist them. She said:

Clients are not interested in filling up forms [questionnaire]. Even to fill up the simple, smart goal is already tricky. The short 21-items DASS, not too bad, still can tolerate. However, when the client is in an acute condition, and we give the form, he will not answer. Even in stable condition, the client is lazy to do it. Instead, we have to help out. We read, the client answer, and we tick for them. They want to come and talk. Many are like that. (Cik Siti: Line 26, page 7)

An example of a tool used during therapy is a SMART Goal. The purpose of the tool is to set and track the goals of the client. Ah Chong used the SMART form,

as stipulated in the standard operating procedure (Psychological Counselling Services, 2018b) with his client. He said:

Now it is compulsory for every counsellor in the Ministry of Health (KKM) to use SMARTGoal to assess the client's changes and the progress. I try to measure the changes by looking at what they intend to do or achieve. Start by using the SMARTGoal. For example, they need to have a goal. For example, "I have a weight problem. I try to slim down." I ask them, "What plan you have in mind?" I encouraged them to use the SMARTGoal plan. I will follow the progress at every session. From there, I will know whether it is according to our plan. Changes will follow, follow lah (Ah Chong: Line 20, page 2).

Lloyd, Duncan and Cooper (2019) did a systematic review on the use of idiographic goal-focused measures in psychotherapy. Evidence suggests that it may facilitate client/client progress. Nevertheless, they cautioned that there was insufficient evidence to validate the use in population-level evaluation. The researcher considered SMARTGoal as an example of an idiographic goal-focused measure but not the appropriate tool to measure outcomes.

Nevertheless, the SMARTGoal, when used appropriately yielded benefits. Ah Chong had clients who changed through the process of tracking and achieving their goals. The client was initially lost and slowly gained confidence in coping with life's challenges when he was able to achieve his goals. Ah Chong described:

If my clients manage to achieve their own goal, from there, they will start to have confidence, and they will start to have autonomy over their life lah, empowerment over their life. From there, each time they come to counselling, you will know the signs that termination is not far away. Because in the beginning, when they came, they were without direction. They were lost. So as soon as they can achieve something from time to time, then they come here in a relaxed manner, start to joke with you, have a more positive point of view about their future (Ah Chong: 1 page 3).

Outcomes misunderstood. The definition of outcome is the change in the client's distress level as a result of an intervention. CORE system identifies recovery or improvement from distress as positive changes and no-change and deterioration

(more distress) as negative changes. Jacobson and Truax (1991) developed the classification formula for recovery, improvement, no-change and deterioration. However, the thematic analysis revealed that the psychology officers (counselling) do not share the same understanding. To them, client outcome was about discharge and referral of the client, at the end of intervention *“If already gone through sessions, I have done this, the client is okay. He is satisfied then I discharge lah”* (Cik Siti: Line 6, page 5).

Muthu expressed wariness for using a tool since it could be a double-edged sword. He feared that the client may deliberately answer incorrectly for whatever reason and would cause many difficulties for the psychology officer (counselling). Instead, Muthu suggested that the client and officer do the same test. Both results compared to get a fair assessment of the counselling session experienced by both parties.

The client could be arrogant; all his answers were purposely wrong while I have done my best. Assessment tools should not be for client-only but for me too. Give me a tool for me to write about the client. Have you given the time limit? Yes. Have you given the best? Yes. Do you think the client improved? Yes. Then compare the answers. If only the client answered the test, but I did not then not fair to me lah. (Muthu: Line 19 page 12)

Muthu was referring to client reported experience measure (PREM) while the researcher was referring to client reported outcome measure (PROM). They are two different measures. PREM is a questionnaire to measure the client's experiences while receiving care and PROM is a questionnaire to measure the client's health (in this case, mental health) and quality of life. CORE-OM is part of a quality assurance programme to improve the quality of mental health services.

Ah Chong was confused about the words “client outcomes” and ‘termination’. They are different concepts, but he used them interchangeably as though they are the

same. He felt that judging a client on termination was not accurate; hence, client outcome was not the way to assess service. Ah Chong said:

What do you mean by client outcome? Is that the same meaning as to how many cases terminated? We do terminate cases but not that many lah. For me, it is hard for me to determine an outcome based on termination. What I am aware of lah; the UPsK does not use client outcome is not used lah. Because in counselling I think even if terminated it does not mean it is successful. So I think going back to the smart goal analysis is more accurate lah compared to a system that uses termination. And what if referral again? (laughing) So the level of success should be more than that. Not just by termination. Termination—if clients do not come for three consecutive sessions—we also terminate as well. Because without any notice, the client did not come for three consecutive sessions, then it is termination. Maybe we can have a better way, but right now, the SMART [goal] is the most proper lah. (Ah Chong: Line 8 page 7)

The psychology officers (counselling) did not understand the concept of client outcomes. They confused it with termination. Termination is the action by the psychology officer (counselling) to release the client from further treatment. The client may also instigate termination by prolonged absenteeism. Client outcomes, on the other hand, is the mental health changes caused by the intervention. The outcomes may be positive, i.e. recovery and improvement from distress; or negative outcomes, i.e. no-change and deterioration, i.e., increased in distress.

There was no clear definition of the concept of outcome in UPsK hence the confusion in terminologies amongst the psychology officers (counselling). There was no outcome measure used hence the current lack of empirical measurement to assess the mental states of the clients. There were tools used such as DASS (specific distress and anxiety measure) and SMART Goal (a tool to set and track goals), but both are not the right tools in UPsK. The former is an illness-specific measure not appropriate for use as the main tool in UPsK, and the latter is not an outcome measure. Hence the

UPsKs were dependant on the traditional subjective assessments to assess the mental states of the clients.

Mental health campaigns. The final theme was the lack of awareness on the importance of the UPsK service to the community at large. Currently, Malaysian society is experiencing increased psychological problems that are widespread (rural and urban), across racial lines, intergenerational and cuts across the socioeconomic status (SES) (Marret & Choo, 2017). The news channels had a field day dissecting the psychological problems besetting the society as widely as possible (Puteri Nor Ariane Yasmin, 2019; Rakin, 2018). However, despite the attention, there were few solutions in sight. Muthu explained:

Firstly, there are many people with psychological problems, but many are not able to handle emotions. Secondly, people do not know how to find a counsellor. Prevention is better than cure. Go to the nearest bus stop and ask anyone, "If you have a problem who do you see?" Out of ten people, how many will say counsellor? Only those who know will do. So who will do anything about this? (Muthu: Line 28, page 13).

The general idea is that people seek out counselling services when they have psychological problems, but how many people are aware of the existence of UPsK service in hospitals? In contrast, people are more aware of non-profit organisations giving emotional support such as Befrienders or *Talian Kasih* by the Ministry of Women, Family and Community Development (crisis call centre). Ah Chong discussed another aspect of the same problem—access. UPsK is only accessible via a referral letter by a MOH doctor. It is not a simple task to see a primary care doctor in government clinics or hospitals for a referral to a psychology counselling service:

My personal opinion. Firstly, the lack of information. Counselling is much needed but still not known. We need more awareness campaign, more action to be taken to let the public know actually. Not all hospitals, but in most major specialist hospitals, there is already one counsellor. Secondly, I would say the

procedure. I agree that Befrienders is more convenient to access. You can call them for 24 hours. Any time is all right. In UPsK, we follow office hours, and you need a referral letter. Walk-in only for staff, for now. We only accept government official letter, not from a private clinic. It is very troublesome to go to the government health clinic and wait for long hours. Not a conducive environment. I admire the clients who go through this process because they needed psychological treatments. It is a sign that Malaysian are getting more serious on this matter. They are willing to sacrifice time and comfort to get help. That is why I never take things for granted (Ah Chong: Line 20, page 7).

Counselling, just like psychiatry, is poorly understood (Rajagopal, 2013).

People's expectations of counselling are not in sync with the counselling principles. They expect quick solutions and advice-giving (Cowie et al., 2017), which are the antithesis to counselling (Duan et al., 2018). The purpose of counselling is to empower clients with the cognitive and emotional skills to make significant decisions without someone explicitly telling them what to do. Hence clients have to participate actively and work at regaining their full mental capacity for living. The counselling profession must do more to explain the process of counselling and how it equips the client to cope with life's events. It does not give easy and quick solutions. Counselling needs a change of image.

So the fourth point is the misconception of counselling. I do not know about other races, but for the Chinese, when they come here, they asked what I can do to help them (laugh). "What can you do for me? I do not trust you! Just by talking, can you solve my problem?" We, counsellors, need to be more patient, need to explain counselling. Yes, they expect you to give answers. The misconception about counselling, especially if it involves finance, "Can talk solve my money problem? The money will not drop from the sky!" The misconceptions of the Chinese client lah. Then you know they did not come willing but forced to come. Not all the Chinese clients come for a solution, those who are willing to come here, they already understand. They come here to talk. Not necessarily to solve his problem, he has to solve his problems. So this is one way to see whether they come here willing or not (Ah Chong: Line 33, page 7).

The Chinese community is the second-largest ethnic group in Malaysia. They have a relatively low rate of mental health problems compared to the other races in

Malaysia; nevertheless, the ratio is relatively high amongst the Chinese community (Krishnaswamy et al., 2012). Ting and Foo (2018) wrote a chapter titled “The challenges and needs in mental health service deliverance” in a book called “Counselling Chinese communities in Malaysia.” They discovered that some Chinese are reluctant to pay a professional fee to seek help from “talk therapy” and yet they expected “quick fix” or “magic pill” in one session. Ah Chong faced similar problems with his Chinese clients.

Summary. The qualitative assessment of the UPsK service had generated six themes and thirteen categories. Refer to Figure 4.7, page 210. The figure shows the themes and categories. Unanimously the three psychology officers (counselling) saw the need for external standardized evaluation to ensure quality development of the service. The lack of workforce is critical to the one- or two-person units. The units had to close temporarily due to lack of replacement and in turn, had caused undue treatment delays for the clients. The concept of patient outcomes was not well understood by the psychology officers (counselling), causing them to reject the idea of outcome measurement as a means of assessing the service. Also worrying is the early discharge of the patient based entirely on patients’ self-report due to lack of outcome measure. DASS was not the appropriate tool for UPsK, and SMART Goal was not an outcome measure. Hence the UPsKs require a standardized outcome measure; however, the implementation must take into considerations the emerging themes and categories which will impact its rate of success. The UPsK service is unknown due to the low public mental health campaigns to promote UPsK as the treatment centre for positive mental healthcare.

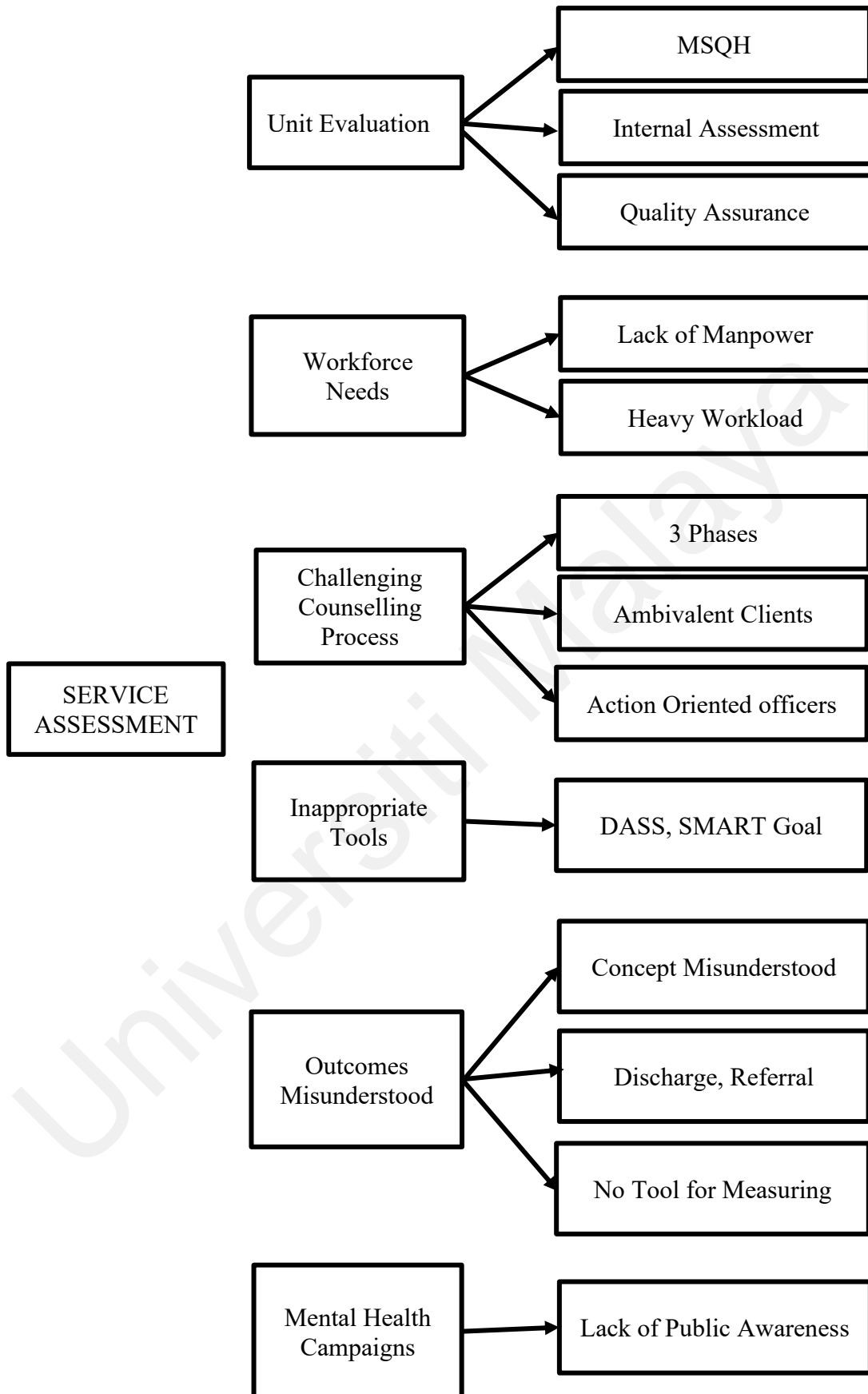


Figure 4.7. The Categories and Sub-categories in the Topic of Service Assessment

CHAPTER 5

DISCUSSION AND CONCLUSION

Introduction

This chapter begins with a summary of the main findings. The findings are discussed in reference to existing literature to keep it in context. In this chapter, the researcher integrated the qualitative and quantitative findings and presented the phenomenon of using CORE-OM to assess client outcomes and to use it as a benchmarking tool in assessing UPsK service. Before the end, the section discusses the limitations and delimitations of the study. It then concludes with some recommendations for future directions.

Summary of the Findings

1. At pre-testing, more than three-quarters of clients had distress scores in the clinical range; at post-testing, more than half of clients have moved to the non-clinical population range, and there were zero clients at the severe level. The main psychological problems experienced were anxiety, self-esteem, interpersonal relationship and depression; and they experienced distress at all levels of severity from minimal to severe, especially in the mild and moderate levels. At post-testing, there was a reduction in the severity levels, most of the clients were in the minimal level of distress, and none in the severe level. At pre-testing, more than half of these clients concurrently displayed risky behaviours such as suicidal ideation, self-harm, and harm to others. However, at post-testing, the risk experienced was similarly reduced, only a third of clients had risk factors, and there were zero clients at the severe level.
2. The three popular therapies were structured/brief, cognitive-behavioural, and person-centred. A third (37%) of psychology officer used one therapy

exclusively, another third (35%) used a combination of two therapies, and 28% used more than three or more therapies combined. A third of the clients met the psychology officer (counselling) for three therapy sessions, and less than ten per cent of clients were absent for these sessions.

3. The psychology officer (counselling) or client did not show a preference for any particular schedule (i.e. monthly, weekly and no fixed time). Almost three-quarters of the clients were met within 1-5 days as guaranteed by the Client Charter.
4. Slightly more than half of the clients had good levels of motivation and working alliance. Slightly less than half had good psychological mindedness.
5. The outcomes of the clients were as follows: (1) less than ten per cent of clients recovered, (2) 66% of client showed improvement. (3) 16% showed no reliable change, (4) ten per cent deteriorated. At the macro level, three-quarters of the clients had positive outcomes (recovery and improvement), and a quarter had negative outcomes (no-change and deterioration).
6. Outcomes were significantly associated with distress levels—clients with baseline in the clinical range showed positive outcomes, but clients with baselines in the non-clinical range showed negative outcomes. Outcomes were significantly associated with therapies—more therapies combined produced better positive and less negative client outcomes. Outcomes were significantly associated with motivation—good motivation was the highest contributor to positive outcomes from among the other client context variables. However, outcomes were not significantly associated with the frequency of sessions.

7. The study established the service benchmarks for recovery, improvement, no-change and deterioration for the top 25%, average and bottom 25% of the selected UPsKs.
8. Only one UPsK matched the service benchmark for recovery. Three UPsKs matched the improvement category, and five UPsKs matched the no-change, and seven matched the deterioration service benchmarks.
9. A matrix was created. It displayed the performance of the UPsKs based on percentiles, ranked by colour codes for all the outcomes categories. The desired UPsK would be green in all the outcome categories. An undesired UPsK would be red in all of the outcome categories. Only one UPsK each achieved the desired and the undesired states. On the whole, the performance of the UPsKs ranked average because there was an equal number of UPsKs with high (16) and low (16) performances which cancelled the effect. The remaining UPsKs had average performances.
10. The main themes that emerged from the qualitative data were as follows: (1) require standardised evaluation, (2) review workforce needs, (3) challenging counselling process, (4) inappropriate tools available, (5) outcome concept misunderstood and (6) increase public mental health campaigns.

Integration of the Quantitative and Qualitative Findings

The exploratory sequential design allowed the qualitative findings from the interviews to shed light on the quantitative findings from the survey done earlier. The qualitative themes had interacted with the quantitative variables to produce the resultant outcome categories. A map was created to show these interactions. The discussion began with the use of CORE-OM to assess client outcomes and later focused on the use of CORE-OM as a benchmarking tool to assess UPsKs' performances.

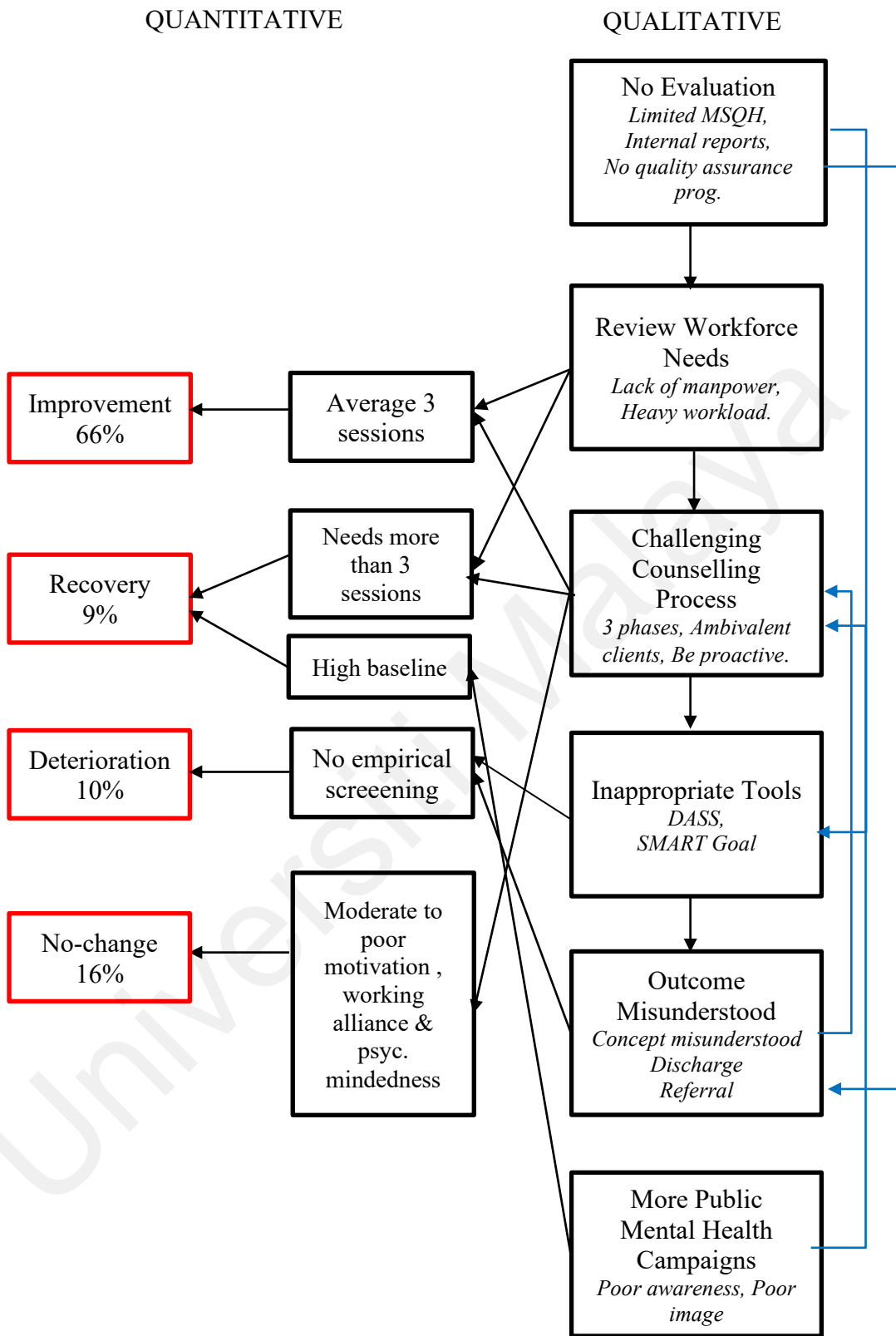


Figure 5.1 The Interactions of the Quantitative and Qualitative Findings

Evaluation of Client Outcomes

As discussed in Chapter One, the goal was to provide an alternative measure to evaluate client outcomes by using an outcome measure (CORE-OM). It would upgrade the UPsK's assessment system. Several UPsKs around the country were selected to use CORE-OM in their practice. This section discusses the main findings with reference to the research questions and current literature.

Client outcomes categories. Client outcome was pivotal in the evaluation of the effectiveness of the interventions carried out in the UPsK. Everyone, especially client and psychology officer (counselling) needed to know empirically whether the client has recovered, was improving, displayed no-change or has deteriorated after interventions. The inability to establish the mental status of the client after having undergone intervention was the primary failure of subjective assessment. Now with outcome measure, CORE-OM, it was possible to measure the client outcomes empirically. At the end of four months, the percentages of clients in each outcome categories were as follows: (a) 9% recovered, (b) 66% clients improved, (c) 16% clients showed no reliable change and (d) 10% clients deteriorated. All the clients had measured endings. In 2013, Gyani, Shafran, Layard, and Clark investigated 19,395 clients over a year and the results showed (a) 40.3% recovered, (b) 63.7% improved and (c) 6.6% deteriorated. The literature on CORE did not give percentages of clients in the outcome categories per se. However, its service benchmarks indicated the standards expected. The CORE service standards set recovery at 57%, improvement at 22%, no-change at 32% and deterioration at 2.4% (CORE Partnership, 2007b, 2011d).

The UPsK study appeared to be consistent with some outcomes, such as high percentage rate for improvement but inconsistent on other outcomes such as recovery

and deterioration. The possible cause for the low rate of recovery was the number of sessions carried out in the UPsKs. The average number of sessions was three. The average client in UPsK met the psychology officer three times for 45-60 minutes per session, a maximum total of 180 minutes, a relatively short period. The UPsK's number of sessions allocated was half to that practised in the U.K. The U.K. national mean is six sessions in a finished course of treatment by diagnosis (HSCIC, 2014).

Gyani et al. (2013) predicted high reliable recovery rates when the client undergoes more than the average number of therapy sessions. Thus a low number of sessions corresponded to a low rate of recovery. Lambert (2013) stated in the sixth edition of the Handbook of Psychotherapy and Behaviour Change, "Therapy is highly efficient for a large minority of clients, perhaps 30% of whom attain a lasting benefit after only three sessions." (p.204). In the same chapter Lambert (2013) continued, "For clients who begin therapy in the dysfunctional range, 50% would achieve recovery after about 20 sessions of psychotherapy. More than 50 sessions are needed for 75% of clients to meet this criterion.". This statement reaffirms the findings of Gyani et al. (2013) that recovery required a higher than the average number of sessions.

Lambert (2013) statements appear contradictory, but they are not. His two statements (1) "...30% of whom attain a lasting benefit after only three sessions." and (2) "...achieve recovery after about 20 sessions of psychotherapy." referred to two different outcomes—reliable improvement and recovery—respectively. For reliable improvement, the number of sessions is not essential (Noble, 2015; Paul & Van Ommeren, 2013; Slive & Bobele, 2012); however, to get reliable recovery requires more sessions. In Lambert's (2017) recent study, he found that low dosage of treatment (average four sessions) would produce an average of 35% rate of improvement and recovery, and 8% rate of deterioration. In contrast, an average of 12–13 sessions of

treatment would produce an average of 57–67% recovered and improved outcomes. Thus the low rate of clients recovered in the UPsK might be explained by the low number of sessions.

Furthermore, the UPsK study showed there was no association between the client outcomes and the number of sessions. The result appeared to support the assumption that reliable change, i.e. improvement, was not dependent on the number of sessions. The widespread use of structured brief therapy, on its own or in combination with other therapies contributed to the high rate of improvement. In structured brief therapy, the psychology officer (counselling) worked actively with the client to focus on the specific problem but not on the causes of that problem. They took the path of direct intervention on the current factors that sustained the problem by utilising the client's strength that she/he was not aware of (de Shazer, 1994). Therefore, it took less time to tackle the presenting problem and to see the benefits on the client. Brief therapy has a shorter number of sessions compared to other therapies, anywhere from 1 session (Bloom, 1997) to 40 sessions (Sifneos, 1987), with the typical treatment lasting between 6 and 20 sessions (Center for Substance Abuse Treatment, 2012).

The 'dose,' i.e. the number of therapy sessions, is not a critical factor (Berggren & Josefsson, 2013; Noble, 2015). In the classical study by Howard, Kopta, Krause, and Orlinsky (1986), the clients' improvement decreased with treatment length. For example, 30% of clients made measurable improvement after two sessions, but only 62% improved after 13 sessions. The dosage was further refined in 1994 by Kopta, Howard, Lowry, and Beutler who found that effective dose varied across different types of symptoms. For example, fewer sessions for distress symptoms but more sessions for characteriological symptoms. Literature seemed to indicate that a large

number of sessions do not guarantee more success; instead, it is dependent on the type of psychological problem involved.

However, there is another point of view expressed by Chorpita, Angeles, Daleiden, and Phillips (2011), who stated that variations in outcomes are more influenced by general severity than by particular diagnoses. For example, severe and complicated cases tend to be long-lasting, and in contrast, the milder cases are short-term treatment (Noble, 2015). There is an ongoing debate on the efficacy of short-term therapy over long-term therapy (Cape, Whittington, Buszewicz, Wallace, & Underwood, 2010; Noble, 2015). The criticism of brief therapy is that its benefits may be short term, that is, over time, the benefits may disappear. In that case, the client is no better than if they had not received help (Bower, Rowland, & Hardy, 2003). Practically, it is difficult to compare long-term and short-term interventions because they are fundamentally different.

The UPsK study showed an association between type of therapy and client outcomes which went against the general resolutions of the American Psychological Association (APA, 2012). In the segment on research effectiveness, a part of the resolution was “—That is, variations in outcome are more heavily influenced by patient characteristics, e.g., chronicity, complexity, social support, and intensity; and by the clinician and contextual factors than by particular diagnoses or specific treatment ‘brands’.” (Beutler, 2009; Beutler & Malik, 2002; Wampold, 2001). In another part of the report, it states “In contrast to large differences in outcome between those treated with psychotherapy and those not treated, different forms of psychotherapy typically produce relatively similar outcomes.” In other words, most psychotherapies are roughly equivalent in effectiveness to treat clients’ psychological problems.

However, recent research by Cuijpers, Reijnders, and Huibers (2019) suggested taking another look at the common factors that run across all therapies. They are saying that “Currently, no common or specific factor meets these criteria and can be considered an empirically validated working mechanism. Therefore, it is still unknown whether therapies work through common or specific factors or both.” So the UPsK results that appear contrary may yet be in the right direction.

The UPsK study also showed an association between client outcomes and distress levels at the baseline. The distress levels at baseline was another factor for low recovery. Two-thirds of the clients were at moderate and moderate to severe levels at the baseline. According to CORE literature, clients in moderate and moderate to severe levels have a high chance of improvement; however, recovery declines quite sharply with the severity of the baseline score (CORE Partnership, 2007b).

Similarly, the low distress levels at baseline before intervention impacted the clients' outcomes. There were 14% of clients treated at UPsKs who were in healthy and low levels. These healthy clients cannot ‘recover’ since they were mentally healthy and therefore, would remain as they were, i.e. no-change or worse would deteriorate after an intervention. Clients in the non-clinical range have four times higher chances of deteriorating, and their chances of improvement were negligible (CORE Partnership, 2007a, 2011d). Clients that started intervention with baselines in the non-clinical range have negative outcomes, i.e. no-change or deteriorate.

This phenomenon of clients in the non-clinical population range coming to seek psychological treatment is not new in CORE literature (CORE Partnership, 2007b). This problem plagued UPsKs because non-distressed clients were not identified and eliminated from receiving treatment due to the inadequacy of subjective observations. Beutler and Forrester (2015) already warned there would be

misdiagnoses and inappropriate treatment planning when using subjective observations only. The two factors—the number of sessions and distress levels at the baseline—might explain the low rate of recovery and high rate of deterioration in UPsKs.

The way to increase recovery rates was to have more sessions planned. In the UPsK study, the average planned number of sessions was three. Nonetheless, there were some psychology officers (counselling) who planned for five, six and even eight numbers of sessions. However, the study revealed that 50% of the clients that had five planned sessions, prematurely dropped off or unilaterally terminated after the second session.

This situation revealed two serious problems that needed attention. The first was the psychology officers (counselling) set a low number of sessions. Below is an excerpt from an interview concerning the usual practice for determining the number of sessions in UPsK:

If there is a need for follow-up I will do. For those not in need, the minimum is three sessions. Three times, we meet and then discharge lah. The client looks okay. By the way he talks, he feels he is okay. Then discharge—typically three sessions lah. In the second session, I have a plan ready for problems that are not acute. The third session I do, or sometimes I do not do, but he feels okay. So I ask him, “Do you want to continue with the service? He says no need.” So I discharge lah (Cik Siti: Line 13, page 2).

Howard et al. (1993) described the steps in the Phase Model of psychotherapy. The first step is a new improvement in the general sense of well-being (remoralization); the second step is the reductions of symptoms (remediation) and finally increased functioning (rehabilitation). In the UPsK, it appeared that the psychology officer (counselling) took the early gains in well-being as recovery. Thus saw little need or benefits from continued sessions and therefore, inadvertently discharged the client prematurely (Swift, Greenberg, Whipple, & Kominiak, 2012).

Early discharge happened when the psychology officer (counselling) ignored the steps in the Phase Model of psychotherapy.

The second problem was premature unilateral termination. It was a significant problem in therapy, and efforts made to minimise its occurrence. For example, 50% of clients attended the five planned sessions. Studies have found that client who dropped out showed negative therapy outcomes and reported greater dissatisfaction with treatment (Knox, Adrians, et al., 2011). The premature termination also had adverse effects on clients' associates (family, friends, employers) since the symptoms and impairments have remained or gotten worse. More importantly, the therapists experienced a sense of failure or rejection when one of their clients dropped out, which affected their work and professional development (Piselli, Halgin, & Macewan, 2011).

Swift et al. (2012) recommended several strategies to reduce premature termination in therapy. They were (1) provide education about duration and patterns of change, (2) explain the different roles of client and psychology officer (role induction), (3) incorporate client's preference, (4) strengthening early hope, (5) foster therapeutic alliance, and (6) assess and discuss treatment progress.

The psychology officer (counselling) can implement the first recommendation that is to brief clients on the duration of treatment and the timing of progress. The briefing will prevent clients from having unrealistic expectations. Swift and Callahan (2008) found that clients expected 25% recovery by the end of two sessions, 44% by four sessions, and 62% by eight sessions. These unrealistically high expectations for duration and recovery are one of the best predictors of treatment drop out (Aubuchon-Endsley & Callahan, 2009; Callahan et al., 2009).

Second, make clear the role of the client and the psychology officer (counselling) at the start of the session. It is important to tell clients that they will do

most of the talking in the session, and the officer only structures and directs the interaction. The briefing will prevent clients from feeling lost or think they are doing things wrong. A study by Reis and Brown (2006) had randomly assigned 125 out-patients to start their intake session by either watching a 12-min psychotherapy induction video or a 17-min control video. The results showed a significantly lower rate of dropout for those who watched the induction video. In UPsK, the best way to give role induction is to conduct a briefing session with the client.

The next recommendation is to give early hope for change. Greenberg (2012) proposed that 15% of the variance in therapy outcomes was due to the anticipation of change; thus, it was a key contributor to success in therapy. Giving hope that treatment will work in the early stage increased the motivation to continue treatment so fewer chances of premature termination. The psychology officer (counselling) and the client should focus on goals that are amenable to change. When the client meets the initial goals, his/her level of hope increases, and thus remain in treatment. Being in treatment will make it possible for the exploration of more complex and deep-seated problem areas.

At the same time psychology officer (counselling) must express confidence in their clients' ability to have a successful therapy outcome and help them move through the first stage, i.e. remoralization in the Phase Model (Howard et al., 1993). The psychology officers (counselling) can facilitate this process by offering empathic understanding, genuineness, trust, and warmth (Swift et al., 2012). As noted earlier moving too fast into actions, techniques, or painful experiences and emotions may overwhelm them and lead to dropping out.

Psychology officer (counselling) works to foster a therapeutic or commonly known to as the working alliance; i.e. the bond between the officer and the client. The

UPsK study showed there was a significant association between working alliance and client outcomes. A study conducted by Horvath, Del Re, Fluckiger, and Symonds (2011) found similar results, that is, therapeutic alliance have a significant relationship to treatment outcomes. In another study by Sharf, Primavera and Diener (2010) it showed that weak therapeutic alliance produced poor outcomes, particularly for clients with a lower level of education, have been in treatments for a longer duration, and at in-patient settings. The UPsK clients had an average rate of working alliance with the psychology officer (counselling), which may explain the low number of therapy sessions and a low rate of recovery.

Psychology officer (counselling) using the SMART goal should focus on achieving manageable goals and tasks to strengthen the therapeutic or working alliance. Encourage the clients to share their opinions, preferences, and reflections about their goals. They will feel the close connection with the officer and believe that they are working together in treatment. It is this type of bond that will help the client move through the phase of remoralization, and increase hope in the possibility of change. Thus fewer chances of premature termination.

The last recommendation is to discuss the progress of treatment with clients. Here the UPsK psychology officers (counselling) were at a disadvantage. They did not have an outcome measure to assess the clients' rates of change for recovery, improvement, no-change or deterioration. They cannot say the mental state of the client empirically. The situation is opposite to those in advanced countries where treatments used outcome measure to monitor the state of the clients routinely (Brann & Coleman, 2010; Krageloh, Czuba, Billington, Kersten, & Siegert, 2015; Pirkis et al., 2005; Tasca et al., 2019).

Although using an objective outcome measure is useful, another beneficial way is to gain feedback from their clients about their progress. Knox, Adrian, Hess, Everton, and Hill (2011) found that premature terminations expressed greater dissatisfaction with treatment. Therefore, psychology officers (counselling) should regularly check in with clients and can make necessary changes. Before the clients' unhappiness about treatment caused them to terminate therapy prematurely.

Evidence of UPsK's efficacy. UPsK clients reported one or more presenting psychological problems. The most prevalent were anxiety (65%), self-esteem (46%), interpersonal (43%) and depression (39%). In a study by Mullin et al. (2006), based on a large national sample of 11,953 clients around the United Kingdom, recorded three major presenting problems. The problems were anxiety (75.1%), depression (69.4%), and interpersonal difficulties (49.5%). This UPsK study was consistent with United Kingdom data except for self-esteem, which was the second most common psychological problem in UPsK clients but not in the United Kingdom. The main identified problems (confirmed psychological problem) experienced by UPsK clients were anxiety (55%), self-esteem issues (40%), interpersonal problems (41%) and depression (38%). Fritscher (2016); Hutchings and Virden (2010) noticed that the identified and presenting problems might not be the same. The difference between them was evident in UPsK, where at the presenting stage, 65% claimed anxiety. However, after assessing the percentage of clients experiencing anxiety, the claim dropped to 55% because many UPsK clients were comorbid with other psychological problems such as depression, self-esteem as well.

Anxiety is the most common mental illness (Kessler, Chiu, Demler, & Walters, 2005; Mullin et al., 2006) in the United States and the United Kingdom. The World Health Organization (WHO) conducted World Mental Health Survey Initiative

(WMHS) in 28 communities involving 142,405 respondents across a range of high, middle, and low-income countries in different geographic regions of the world. They investigated the prevalence, course, impairment, socio-demographic factors, other psychology conditions occurring concurrently with the primary condition, and treatment of social anxiety disorder (SAD) (Stein et al., 2017).

The results show that SAD is common around the world. The lowest occurrence is in low/lower-middle-income countries, Africa and Eastern Mediterranean regions. At the same time, the highest is in high-income countries, the Americas, and the Western Pacific regions. It is consistent with an earlier study by Baxter, Scott, Vos, and Whiteford (2013). This study showed that Malaysia, a middle-income country, has lower anxiety rate at 55% compared to a high-income country such as the U.K at 75.1% (Mullin et al., 2006).

Moreover, interestingly, the UPsK study noted that depression was not as common as anxiety among UPsK clients. It was the fourth frequently cited problem after interpersonal and self-esteem. The UPsK study was contrary to a study by Siti Fatimah, Sherina, Rampai, and Firdaus (2015) that showed depression was comorbid with anxiety and the strongest predictor of anxiety.

There is a perceived close relationship between depression and anxiety; that is, they appeared to "go hand in hand" (Seltzer, 2017). Wu and Fang (2014) cited works by Fava et al., (2008); Wu et al., (2013); Kessler et al., (2007), Lamers et al., (2011) that alluded 70% of individuals with depressive disorders also have anxiety symptoms. Furthermore, 40% to 70% of them meet the criteria for at least one type of anxiety disorder. Many researchers have speculated that the biological connection between anxiety and depression is the same—serotonin imbalance—in the brain. It is the 'key' for both distressed states (Magalhaes et al., 2010). Serotonin is a neurotransmitter that

regulates mood, pain perception, memory, and other brain functions. Low levels of serotonin may lead to anxiety and depression, but current studies are revising this assumption (Frick, Ahs, & Engman, 2015).

To add to the debate on whether anxiety and depression go together; other research from the field of culture-gene coevolution theory may provide some new leads. The Dual inheritance theory (DIT) explains how genetic and cultural evolutions influence and produce human behaviour. Genes and culture continually interact in a feedback loop, that is, changes in genes can lead to changes in lifestyle which can then influence the genetic selection, and vice versa (Dual Inheritance Theory, 2017).

Chiao and Blizinsky (2010) reported that serotonin transporter gene—the S-allele—are found more in individuals living in collectivist cultures than those in individualistic cultures. She also found that people from collectivist societies are less likely to be depressed. The study suggests that collectivism which tends to produce lower levels of negative affect may have co-evolved with the S-allele. Societies of people with the S-allele developed a collectivist culture that reduces stress and risk of depression by emphasising social harmony and social support.

Historical data shows that East-Asian cultures such as Japan, China, and Korea value submissiveness (collectivism) while Western cultures value dominance (individualism) (Numaguchi, 2014). Malaysian culture emphasises social harmony and social support, which is characteristic of collectivism; therefore, it would have a reduced prevalence of depression. This study affirmed that statement.

The second prevalent psychological problem was self-esteem. In this study, the count showed that male and female in UPsK have equal levels of self-esteem. However, the count is not statistically significant. Generally, men have higher self-

esteem than women (Kling et al., 1999) and self-esteem increased with age in Western industrialised countries (Ortho & Robins, 2014).

Self-esteem issues and interpersonal problems were prominent in young UPsK adults (<25 years) and adult age group (25—36 years). Ortho and Robins (2014) stated that the level of self-esteem increased until middle adulthood, becoming less relevant as they mature. According to Maslow's Hierarchy of Needs, the young adult has to fulfil the requirements of the esteem level before he can focus on self-actualisation in adulthood (Koltko-Rivera, 2006). The esteem level parallels Erikson's sixth stage of psychosocial development for early adulthood that is intimacy versus self-absorption at the ages of 20 to 35 years. Erikson's sixth stage is the range in which young adults acquire the capacity for a healthy sense of personal identity (Newman & Newman, 2012). Here they develop intimate relationships, work, and social life. This local study affirmed that young UPsK clients (male and female) were concerned with self-esteem issues, and this was consistent with the literature. However, as they mature, the self-esteem issues decrease with age since self-esteem increases with age.

The results of the UPsK study showed that most clients with psychological problems (anxiety, self-esteem, interpersonal, and depression) had improved in their severity levels after undergoing interventions. It was not dependent on the type of therapy. A study by Pybis, Saxon, Hill and Barkham (2017) found that outcomes from counselling and cognitive behaviour therapy for depression were comparable. Similarly, APA (2012) emphasised that different forms of psychotherapy will produce similar outcomes. It stated:

WHEREAS: for most psychological disorders, the evidence from rigorous clinical research studies has shown that a variety of psychotherapies is effective with children, adults, and older adults. Generally, these studies show what experts in the field consider significant beneficial effects for psychotherapy in comparison to no treatment, confirming the efficacy of psychotherapy across

diverse conditions and settings (Beutler, 2009; Beutler et al., 2003; Lambert & Ogles, 2004; McMain & Pos, 2007; Shedler, 2010; Thomas & Zimmer-Gembeck, 2007; Verheul & Herbrink, 2007; Wampold, 2001). In contrast to significant differences in outcome between those treated with psychotherapy and those not treated, different forms of psychotherapy typically produce relatively similar outcomes. This research also identifies ways of improving different forms of psychotherapy by attending to how to fit the interventions to the particular client's needs (Castonguay & Beutler, 2006; Miklowitz, 2008; Norcross, 2011) Page 1.

Evaluation of the UPsK's Service

As discussed in Chapter One, the goal was to provide an alternative measure to evaluate service by using CORE-OM as a benchmarking tool. It upgraded the assessment system in the UPsK. This section discusses the main findings.

Benchmarks and matrix. The study created service benchmarks (standards of best practices) in the domain of effectiveness (Ettorchi-Tardy et al., 2012; Reese et al., 2014) for the nine UPsKs in the outcome categories: recovery, improvement, deterioration and non-reliable change. The service standards are the basis for comparison among the UPsKs, and every unit aspires to achieve the service standards in the four outcome categories. The result of the comparison will galvanise them to improve their services. This study showed the importance of CORE-OM as a benchmarking tool. CORE system used the rates of change of the clients to set the service benchmark values based on the percentiles obtained.

The study showed that the recovery outcome was relatively low, with only one UPsK reaching the service standard. In contrast, improvement outcome fared better with a third of UPsKs achieving the service standard. For the no-change and deterioration outcomes, most UPsKs achieved the service standards for low rates of negative outcomes. On the whole, the interventions conducted by the psychology

officers (counselling) UPsKs appeared to prevent clients from getting worse but not enough for clients to recover.

Recovery requires the client to go through three phases: the remoralization (increase in subjective well-being), remediation (symptoms reduction) and rehabilitation (gain life functioning) phases according to the Phase Model (Callahan, Swift, & Hynan, 2006). In this study, 66% of clients improved, that is, clients have gone through remoralization and remediation phases, but only 9% recovered, i.e. completed the course until rehabilitation. Recovery was low because of the small number of planned sessions (average of three meetings in UPsK). The number of sessions was insufficient to bring the client to the rehabilitation phase, where the client can resume their former level of functioning. In other words, recover from distress.

Apart from the low number of sessions planned, another factor was the high severity baseline of the clients. The majority of the clients (40%) came to the UPsKs at the moderate to severe and severe levels of distress. Why? During the interview session, the psychology officer (counselling) made references to the reasons of high severity level—little public information and poor access. The psychology officers (counselling) explained that clients who came to UPsKs were those who were already experiencing much distress. They had no other options. They endured long wait and congestion at the government clinics to get a referral from the primary care doctor for the psychology counselling service (UPsK). As expected, their intake baselines were high.

Many Malaysian have a low level of mental health literacy, so they are unaware of mental health providers like UPsK (Ibrahim et al., 2019). An earlier cross-cultural study by Loo, Wong and Furnham (2012) also showed the same. The study comprised British, Hong Kong citizens and Malaysian participants, and it revealed that Malaysian

participants had difficulty in identifying mental health disorders compared to the other nationalities.

Irregular public health campaigns for mental health compounded the low mental health literacy further. The Technical Report by Malaysian Healthcare Performance Unit (2017) declared that “The campaign of a healthy lifestyle and stress management should be stepped up”. The report compared Malaysian lifestyle to other Organization of Economic Cooperation and Development (OECD) countries in the area of lifestyle, Malaysians did not do so well. For example, in addressing the principal risk factors and promoting a healthier lifestyle:

Living an active lifestyle is a known preventive factor for a mental health problem. A recent survey showed that only 33.5% of Malaysian were physically inactive, which is relatively high as compared to other neighbouring countries. Based on registered cases from AADK, the prevalence of drug abuse was increasing in recent years (Page 53).

A study by Yu et al. (2015) in China highlighted the gap between high help-seeking intention but have insufficient knowledge of help-seeking sources. He concluded there is a need for more public campaign and educational activities to close the gap. The public mental health campaign should focus on positive mental health that includes positive emotions such as happiness, gratitude, fulfilment. Increase positive individual traits such as optimism, resilience, character strengths and positive relationships among groups, instead of unduly focusing on mental health illness such as its causes, symptoms and consequences (Seligman, Steen, Park, & Peterson, 2005). In this way, it will avoid or minimise the stigma that comes with mental health (Kobau et al., 2011). Similarly, a study in the U.K. also encourages anti-stigma and anti-discrimination campaigns (Salaheddin & Mason, 2016).

Campaigns must also present a realistic picture of the process of counselling so that clients are not naïve about the duration of therapy and progress. In a study by

Swift and Callahan (2008) found almost 62% of clients expect to be fully recovered by eight sessions and some (25%) idealistically hoped to improve after just two sessions! These unrealistic expectations will cause clients to give up; that is, terminate the session prematurely when it takes longer than expected.

Interestingly, the majority of the UPsKs (67%) were effective in arresting clients' psychological distress from escalating. The clients were affected by the counselling psychology interventions (Barkham, Moller, & Pybis, 2018; Patel et al., 2015). The arrest in escalation is a good sign. It brings back the confidence that psychotherapy is safe (Jarret, 2008). The results dispel the notion that psychology officers' (counselling) incompetence in conducting therapy (Jarret, 2008; Thomas, 2015) caused harm (deterioration) but in the UPsK this was not the case.

The matrix displayed the performance ranking of the UPsKs. At the end of four months, the matrix showed one UPsK achieved the desired state of high performance, and one UPsK had an undesirable state of low performance. In contrast, the rest of the UPsKs had a mixture of high, average and low performances in the outcome categories. Overall the UPsKs achieved average performance. In a study by Clark et al. (2018) found that the implementation of the psychotherapy services was equally important as the development of new and more effective therapies. The characteristics of an excellent service are firstly it can identify the psychological problem. Secondly, it has a shorter waiting period. Thirdly, plans for a high average dose of treatment and finally, excellent service has low rates of absenteeism. All of the above factors would lead to better client outcomes.

The matrix displayed an equal number of green and red bands which meant that half of the UPsKs practised good 'habits', but the same number of UPsKs did not thus the effect cancelled out. Therefore, on the whole, the UPsKs showed average

performances. The good habits referred to are the practices of excellent psychotherapy services as espoused by Clark et al. (2018) rather than emphasising treatment plans.

An interesting study by Bevan et al. (2019) that has relevance to Malaysia is the situation in Zambia. The local details differ, but the principles involved are applicable across national boundaries. That is, public benchmarking can improve poor performance at the national level through “naming and shaming” and enhance excellent performance at the sub-national level through “competitive benchmarking” and peer learning.

The study drew upon ethnographic research such as interviews and observation in Zambia’s Ministry of Health to illustrate how health care managers and workers perceive and respond to public disclosure of information about other countries’ performance. The study asked participants about the Zambian Government’s health care priorities in maternal mortality (publicised by the Millenium Development Goals (MDG). Then compare that to the rapid improvements in other African countries, particularly Zimbabwe. The results showed that the Zambian Government lagged behind their peers, and it shamed them into taking action. One Maternal and Child Health co-ordinator summed it succinctly, “No, Zimbabwe cannot do better than us!”

Sakiko Fukuda-Parr (2014: 123), formerly lead author of the Human Development Reports of the United Nations Development Programme noted that international benchmarking could induce reputational concerns. Zambian civil servants and politicians seemed especially concerned and motivated by the successes of other African countries, which they regarded as peers. Their relative poor performance, compared to the other countries, forced them to do something drastic. Social psychology explained that people would try to conform to the norms of a group with which they identify (Tankard & Paluck, 2016)).

Referring back to the Malaysian situation, not many people know that our system of assessment in the UPsK is lagging behind international standards. Unfortunately, as the saying goes “out of sight out of mind” it is business as usual in the UPsKs. This study hopes to shine a light on this situation for public disclosure to galvanise action.

Manpower. UPsKs can perform when there is a sufficient workforce to do the job. The effective use and deployment of personnel will ensure efficient service delivery in terms of cost, quality and quantity (Ozcan et al., 1995). Otherwise, there will be an oversupply or conversely a shortage of clinical staff (Robertfroid et al., 2009). Based on the information sourced from the government's Open Access (MAMPU, 2017), the estimation is on average that each UPsK treated 633 clients in 2017. There were 89 psychology officers in 55 UPsKs around the country, and the majority of the UPsKs (65%) were one-person units. Considering there were 252 working days in 2017, the 89 psychology officers (counselling) were estimated to have met on average, three clients per day.

At the same time, take note that the psychology officer has a yearly schedule, *Sasaran Kerja Tahunan* (SKT), i.e. annual work targets to follow. The SKT lays out the annual key performance indicators for psychology officers to achieve for the year. Furthermore, there is a constant requirement to key-in data into several databases. In general, each hospital has the Hospital Information System (HIS) database or something equivalent. For the psychology officer, they have their own specific national counselling database (KMS) to use. And also the state department's counselling database. The keying-in of the various databases are part of the administrative workload, which has proven to be burdensome for most psychology

officers. The total workload has led to burnout in some psychology officers (counselling).

Cik Siti declared that she was burnout due to a heavy workload that was repetitive, which was further compounded by her pregnancy and delivery. Burnout was due to emotional exhaustion and depersonalization of the workplace; literature cited them as the two major contributors to burnout (McCormack et al., 2018; Simpson et al., 2019). In a study by O'Connor, Muller Neffand Pitman,(2018) they concluded that work-related factors such as workload and relationships at work are key determinants for burnout. While role clarity, a sense of professional autonomy, a sense of being fairly treated, and access to regular clinical supervision appears to be protective for workers from experiencing adverse occupational hazard.

Maslach (2011) suggested the way forward to prevent burnout before it rears its ugly head is firstly to build engagement among the staff. An engaged workforce is better able to cope with the challenges they encounter. Secondly, organisational intervention is more productive than an individual response. Thus changes in the job conditions will affect and benefit more staff. Cik Siti and many others are in one-person UPsK unit, so they do not have the support of colleagues to share the burden of work. Here is where organisational intervention, as suggested by Maslach (2011), is a better solution than an individual response. In the UPsK case, only the top management level can abolish the one-person unit.

The inherent problem with the one-person unit is the inevitable temporary closure. The unit closes down because there is no replacement staff available to step in when the psychology officer (counselling) takes leave for an extended period (few months). Examples of extended leave are maternity, study, and job transfer. Maternity leave frequently occurs because three-quarters of the psychology officers are female

of childbearing age (29-34 years). A demographic study by Zakaria and Asyraf (2011) using data from the Board of Counsellors and Counselling Association of Malaysia (PERKAMA) revealed that the majority of psychology officers were female under the age of forty. It is inevitable, at one point or other, for the female psychology officer in a one-person unit to temporarily close the unit due to maternity leave.

Another frequently extended leave is the study leave to pursue a Masters qualification. Currently, 52% of the psychology officers in the survey has a Masters qualification (Zakaria & Asyraf, 2011). They had taken 2-years study leave, and if they were from the one-person unit, there was a high probability that the UPsK was closed temporarily. The lack of workforce caused UPsKs' clients to suffer disruption in treatment plans and postponed appointments. For new cases, a long waiting list to get an appointment.

The Client Charter stipulated the maximum number of days allowed for the psychology officer (counselling) to see the client (UPsk HS, 2018; UPsK HSB, 2016). Almost three-quarters of clients saw the officer within the time stipulated. However, 12% of clients had to wait longer than a month. This long delay in getting an appointment is due to the psychology officers (counselling) being away from the UPsK to attend courses, consultation work or sick on medical leave. When they return, they had to catch up with the existing follow-up clients before getting to new cases. Hence, the delay in giving appointment dates (a consequence of the low workforce).

Nevertheless, this study showed that psychology officers (counselling) had done well to respond quickly to new cases as guaranteed by the Client Charter, i.e. within five working days. In the U.K., the standard waiting time is two weeks to get an appointment to see a mental health practitioner in psychological services (NHS England, 2015).

The temporary closure due to no replacement is a recurring problem in all the states which the Ministry of Health must take heed of and take remedial actions. Currently, under the Lean Civil Service Policy of 2015-2020, the creation of new posts was frozen. Instead, management must use redeployment and trade-off approaches to fulfil current needs. By using this approach, the government plans to stretch resources by capitalising services and deliverables (Ministry of Health Malaysia, 2018).

In other words, no new intake for the psychology officer (counselling) post because there is no service warrant for it, even though the need remains. A possible solution to this financial quagmire is to hire psychology counselling graduates as contract workers for a specific period. The strategy is to keep the cost down during low economic growth. The hiring of contract workers is cost-effective since it does not come with emoluments and pension or gratuity packages. Outsourcing allows the service to continue and offer eligible graduates job opportunities, albeit on a contractual basis.

In 2018, Ruhana Binti Mahmod, the Head of UPsK in HKL, successfully employed contract psychology counselling graduates to fill up positions in the service. (Ruhana Binti Mahmod, personal communication, November 28, 2019). The UPsKs in other parts of the country can replicate this strategy as long as the hospital has financial funds to pay for the psychology officer's salary.

The Technical Report 2016 on Malaysian mental health care performance cited the density of psychologist [clinical psychologist and psychology officers (counselling)] as 0.2 per 100,000 population. The ratio is very low (Malaysian Healthcare Performance Unit, 2017). However, the Technical Report only counted the psychology officers (counselling) in psychiatric services, which does not reflect the whole picture. The report did not consider the other psychology officers (counselling)

in UPsK, another Ministry of Health facility that delivers mental health services for non-psychiatric clients for the last 19 years. Therefore, the estimated density of psychologists may be more than the number stated in the report (0.2 per 100,000 population).

Nonetheless, MOH must take action to increase the number of psychology officers to be on par to international standard. Many counselling and psychology services in America are guided by staffing to client ratio to ensure their ability to provide optimum service to clients (Teevan Burke et al., 2013). In 2011, the American Counselling Association recommended the maximum student-to-counsellor ratio of 250:1.

There are limited financial resources available for mental health. In Budget 2020, there is an increase of 10.2% of government spending for healthcare, the highest share ever, from RM28.7 billion previously to RM30.6 billion. The health budget represents approximately 2% of GDP (Khor, 2019). The distribution of money is already specified. The most substantial portion valued at RM1.6 billion goes to infrastructure development and maintenance. The next largest portion is RM500 million for procurement of medicines, followed by RM319 million to upgrade *Klinik Kesihatan* (government clinics), and RM60 million for the National Immunisation Programme. The rest, such as expanding the age range for MySalam, lowering the age range for Peka B40, withdrawal from EPF for fertility treatment and increased maternity leave, do not have a specific budget. Similarly, no specific allocations for mental health, prevention of non-communicable diseases, and old age care. We do not know what is in store (financially) for UPsK as yet.

The Malaysian government is still not cognizant of the WHO (2003) statement. The statement declared that without adequate financing in mental health, all the mental

health policies and plans would remain in the realm of rhetoric and good intentions only. It required the government's commitment to providing financial resources. It is a global phenomenon where policymakers in many countries fail to give sufficient recognition to mental health problems; the consequences are inadequate efforts to prevent or treat mental disorders. Politicians believe that funding for other health services is more beneficial to society and more cost-effective (WHO, 2003). However, this was proven wrong by Chisholm et al. (2016) in *The Lancet Psychiatry*. The study calculated that for every \$1 spent on mental health for treatment such as counselling and medication, governments could receive a \$4 return on their investment. The results prove that a financial paradigm shift is possible and necessary for better mental health care services.

The Malaysian health authorities should take note of this paradigm shift in health care finances. The workforce in mental health services should be given priority in the allocation of financial resources. The Head of Profession for Psychology Officers (Counselling) is pursuing this, along with other mental health heads of the profession.

Conclusion

The oldest counselling psychology unit (UPsK) has been in operation for 19 years, and so too the other UPsKs. However, the ministry has not assessed the UPsKs' client outcomes and the performance of the units. This study used the standardised outcome measurement system, CORE-OM, to assess client outcomes and as a benchmarking tool to evaluate UPsK service. The use of CORE-OM allowed the UPsK to state with certainty the mental status of its clients at the end of intervention or discharge. It also developed a range of service benchmark values to assess and compare the UPsKs' performances.

Client outcomes showed that 75% of clients had positive outcomes, i.e. 9% recovered and 66% improved. In contrast, 25% of clients had negative outcomes, i.e. 15% no-change and 10% deteriorated. Looking at the performance ranking of the UPsKs, it was not inspiring. Only one UPsK achieved high-performance ranking with high positive outcomes and low negative outcomes. On the opposite end, there was one UPsK that had the lowest performance ranking with low positive outcomes and high negative outcomes. The rest had an equal number of high and low results which cancelled the effect out. The overall verdict was that the performance of UPsKs was average.

The reasons for the average performance of the UPsKs may come from the social, cultural and administrative context in which the UPsK operates. Socially and culturally Malaysian have low mental health literacy. Which meant they lacked recognition of mental disorders, little knowledge and poor attitude to help-seeking and treatment. The public campaign on mental health is also intermittent, not sufficient to increase the low level of awareness among the citizenry about mental health resources such as UPsK. The Ministry of Health has not equipped the UPsKs with the necessary instrument (such as CORE-OM) for screening, outcome measures and as a benchmarking tool that will improve the quality of service. Also, there is not enough workforce to ensure the service runs uninterrupted.

Limitations of the Study

This study had methodological strengths and limitations. The methodological strengths enabled it to achieve its aim and objectives within limits imposed by external considerations. The first strength was the mixed-method design which allowed for the collection of data from the clients via survey and collection of data from the psychology officers via structured interviews (Creswell & Plano Clark, 2011;

Schoonenboom & Johnson, 2017). The qualitative aspects contributed to explaining the performance of the UPsKs.

The second was the use of triangulation method to develop a comprehensive understanding of the assessment system in UPsK through the convergence of information from different sources such as CORE-OM, CORE assessment forms and semi-structured interviews. The third was the detailed background information collected from the psychology officers (counselling) concerning their education, place of work (UPsK) and personal thoughts on the profession. The data collected became the basis for understanding the perspective of the psychology officers (counselling) concerning the assessment of the service.

This study has several limitations, which are essential to consider when interpreting the results. The most notable weakness was the small sample size. The strategy was to get 30% more than the sample size required to ensure the generalisation of results and to create a Malaysian norm. However, the nature of the clinical population, especially in-patients (emotionally unstable) made it difficult to predict the number of clients willing to answer the CORE-OM questionnaire (Van Egeren, 2004b). The majority of clients who completed the CORE-OM were outpatients. Hence, the target, of 500 clients coming from the units and hospital wards, was not achieved

The second limitation was that the return rate of CORE-OM was low (32%). The low return rate was due to resistance of the psychology officers (counselling) in some UPsKs. They did not distribute the questionnaire to their clients. Literature has warned that it was a common phenomenon to face resistance from psychology officers (counselling). Lack of consultation was the precursor to fear and opposition among

the psychology officer (counselling) (Duncan & Murray, 2012; Norman, Dean, Hansford, & Ford, 2014; Unsworth, Cowie, & Green, 2012).

Another common problem was lack of training and perception of the excessive workload associated with routine outcome measure (Leff, 2001; McAleavey et al., 2015). To mitigate the fear of the unknown, the researcher created a WhatsApp group (a virtual platform online). To allow real-time interaction between researcher and psychology officers (counselling) to take place, also a venue to communicate and help each other out in the process of data collection. However, it did not work. Their resistance was real, and it left irreparable damage to the study—small sample size. In their defence, the psychology officers (counselling) were working under considerable constraints. Many UPsKs are one-person units, i.e. there is only one psychology officer (counselling) managing the unit. So collaboration in a research project proved too much of a burden to psychology officer in the one-person UPsKs.

In hindsight, many psychology officers (counselling) were not ready for research since they were not familiar with the concept of the outcome measure. Thus cannot appreciate the benefits coming from its utilisation. The short briefing session conducted via telephone or face-to-face meeting was insufficient to impart all the necessary information to convince them of the outcome measure's importance.

Many studies (Beutler & Forrester, 2015; McAleavey et al., 2015; Wampold, 2016) have identified the keys to the successful implementation of outcome measures. First, the involvement of the psychology officers from the onset. Second, to do a needs analysis. Third, to allow psychology officer the choice of outcome measures to use in the UPsK (Duncan & Murray, 2012). Fourth, sufficient training in the use of the measure, and finally to appoint a lead champion among the psychology officer (counselling) to motivate and sustain the use of outcome measures (Boswell et al.,

2013). The MOH must take into account these steps when implementing outcome measures in UPsKs.

The third limitation was the veracity of the benchmarks. A significant limitation was that this study did not go into the benchmark methodology as detailed by Minami, Serlin, Wampold, Kircher, & Brown (2008) for practice-based approaches. Their study estimated the effectiveness of routine practice by the pre-post effect size (ES) and then benchmarking the routine practice ES against the benchmark for trial data. This current UPsK study was limited to showing the trend of positive and negative outcomes of the UPsKs by using the graphical service benchmarks. The graphical benchmarks were dependent on quartiles and percentiles.

The benchmarks produced were based on a single pre/post assessment of nine UPsKs (small sample) around the country over a short period. Thus the benchmark results must be read with caution (Mellor-Clark, Barkham, Mothersole, McInnes, & Evans, 2006). Nevertheless, the service benchmarks indicated the trend and direction of the UPsKs performance ranking on a small scale. Future studies should cover more UPsKs for a year to get sustainable results.

The fourth limitation was the focus on service benchmarks only. Due to time constraint and scope of research issues, the researcher did not examine the psychology officers' (counselling) performance. To be truly comprehensive in evaluating the UPsK service, the performance of the officers is necessary. Future research should assess how well the psychology officer performed according to case-mix, which is the types of patients that the psychology officers have to treat. More challenging or more complicated cases required more time than the more straightforward cases. For a fair comparison, these factors are taken into account when assessing the performance of the service (Mullin et al., 2006).

The fifth limitation was insufficient local literature on counselling psychology unit (UPsK). Thus, this study was dependent on non-local research and used U.K. norms (CORE IMS Ltd, 2014). This study was the first to use outcome measurement system in UPsK and derived benefits from it.

Implications of the Study

This section looked at the implications from three aspects: theory; curricula and pedagogy; and practice.

The implication for theory. The findings of this study seem to suggest several important implications for assessment in psychology counselling. First, the outcome measure, CORE-OM, was adapted into the Malay language. Later 13 UPsKs around the country successfully conducted the bilingual survey among its clients. Second, the adaptability of CORE-OM in the local context. Despite being “foreign” the translated items reflected the emotional state of UPsK clients in all the domains (function, symptoms, well-being, risk) at pre- and post-testing. The CORE system assigns the client to one of the four outcomes categories (recovery, improvement, no-change, deterioration) to indicate the mental state before, during and after an intervention. Now there is empirical evidence of the mental state of the UPsK clients.

Third, the establishment of the service benchmark values using CORE-OM as a benchmarking tool and the creation of the matrix to display the UPsKs performances. Fourth, the UPsK had successfully used the Donabedian Model to evaluate the service, which was a first in this field. Before this study, the Donabedian model was used in the medical field to assess client satisfaction in Malaysian hospitals (Azizan et al., 2013; Rasidah Mohamedd, 2006). Now it has been adapted to assess the counselling psychology field.

The implication for curricula. The study's findings have several significant implications for counsellor training. The first implication for counsellor training is that the trainees must do mandatory personal therapy. The study showed that psychology officers (counselling) do not plan for a sufficient number of sessions for the client to go through the three stages of recovery. The psychology officer (counselling) has learnt the theory but does not appreciate the process until they undergo personal therapy as a client. As a 'client' the trainee becomes sensitive to the interpersonal reactions and needs he or she has as a client. Trainee makes use of the opportunity to observe clinical methods directly (Norcross, 2005). Also, the trainee develops greater self-awareness, acquires knowledge and skills in the counselling process (Grimmer & Tribe, 2001; Malikiosi-Loizos, 2013). Eventually, during personal therapy, the disposition of the person who is suitable or unsuitable for this profession will be exposed (Malikiosi-Loizos, 2013). Muthu expressed the same sentiment when he said. "*If the person is not suitable to work with people, then she/he does not qualify*" (Muthu: Line 30, page 12). The literature recommends that trainees undergo structured self-awareness programmes before working on actual cases. Self-awareness programme consists of doing personal development group work and personal therapy on an individual basis (Dryden & Feltham, 1994; Izzard & Wheeler, 1995). Professionals must conduct personal therapy, not by fellow students. Currently, in the Malaysian counselling training programme, the students conduct the personal therapy voluntary programme. It is not professional and must stop.

Secondly, there are distinct characteristics of counselling in a medical setting compared to other settings. There are certain distinct features, for example, able to use the Diagnostic and Statistical Manual for Mental Disorders, Fifth Edition (DSM-5) and the International Classification of Diseases, Tenth Revision (ICD-10). Must

learn to understand the medical jargons; side effects of medicines on the psychology of clients, and types of brief therapy (Davidson, Ranice, & Thomas, 2001).

Counselling interventions in a medical setting is gaining momentum as an integral part of health service (Karademas, 2009). Thus, it is timely to train psychology officers (counselling) in the specifics of this setting. Soon, more private-owned hospitals will need psychology officers (counselling) in their employment.

The implication for practice. This study's findings have several significant implications for UPsKs' delivery system. The first is the urgent need to upgrade the assessment system. In the four months of study, most UPsKs performed poorly in recovery. Many studies have shown that psychological counselling approach can produce good sustainable results in depressed and anxious clients (Barkham et al., 2018; Cape et al., 2010; Cody & Drysdale, 2013). Therefore, the cause of poor performance is not due to inefficacious therapies but rather a weakness in the delivery system. The leading causes of weakness in the delivery system are the lack of evaluation and the lack of workforce capacity. They are as follows:

1. No outcome measure. Currently, the only form of client assessment is by client satisfaction collected by subjective means not by an empirical measure. The better way to assess is to utilise an outcome measure, CORE-OM, that will determine the mental status of the client. Besides, CORE-OM can also be a benchmarking tool to assess service performance.
2. Lack of workforce. Since 2001, there are 60 UPsKs established around the country involving 149 psychology officers (counselling). Many of them (65%) are one-person unit (MAMPU, 2020). The interviews with the psychology officers (counselling) revealed that many one-person UPsKs

often close temporarily due to lack of replacement when psychology officer has to take leave.

3. Psychology officers (counselling) in one-person units are overworked because the scope of work goes beyond the gates of the hospital. They must visit outlying cluster hospitals to provide psychology-counselling services, *“I have to visit hospitals in J, and J. Hospital J has 33 beds, and Hospital J has 37 beds. Many small district hospitals are considered a cluster. I have to go there”* (Cik Siti: Line 7, page 10). The excess workload has led to burnout (McCormack et al., 2018).
4. Poor access to UPsK. The ordinary man on the street does not know about UPsK; only those who are severely distressed go to government clinics or hospitals to get a referral to UPsK. These distressed clients will take longer to recover, hence the low recovery performance in many UPsKs. The results of this small study may apply to the rest of the UPsKs since they are suffering from the same problems.

The second implication for practice is to devise ways to reduce the resistance of the psychology officers (counselling) to change and in particular, the implementation of outcome measure. The opposition was due to lack of knowledge. The interviews revealed that psychology officers (counselling) have misunderstood what outcome measure is. Many confused outcome measure with termination, thus leading them to reject outcome measure as a means of assessment. Inertia and irrational fear are often present among those who resist. Proper planning from the start can allay their concerns. Hence, there is a need to engage all psychology officers (counselling) before implementing the outcome measures. (Unsworth et al., 2012; Wampold, 2016).

Recommendations

All parties see the benefits of the outcome measure. The clients see the progress or otherwise of their treatment (Boswell et al., 2013). The psychology officers (counselling) have empirical evidence on the amount of distress the patient has and decides on the type of treatment needed (Hatfield, 2006). UPsK can evaluate the performance of their services (Edbrooke-Childs et al., 2016) and finally to prove that UPsKs are successful and worth having.

Therefore, the Ministry of Health must take serious action to implement outcome measure in all UPsKs around the country. So that the local psychology counselling services are comparable with international standards since outcome measurement system is routinely carried out psychology counselling practices in many developed countries (Gyani et al., 2013; Pirkis et al., 2005; Wampold, 2016). Once the psychology counselling services(UPsK) is 'shipshape' the unit can stand tall along with the psychiatric department in delivering mental health services to the public.

Resistance to change is nothing new; the management can overcome officers' resistance with sufficient training and meticulous implementation planning (Hatfield & Ogles, 2007; McInnes, 2006; Norman et al., 2014). Psychology officers (counselling) when involved with the project from the start, understand the need for it, will become committed to see the project through and want to reap the expected benefits.

A successful implementation implies that everyone, from the top management down to the psychology officers, has to 'buy-in' the outcome measurement system. Directives from the top alone (top-down) do not guarantee success because often miscommunications happened, and the team feel alienated and left without a 'voice.'(Ogunlayi & Britton, 2017). The appointment of a lead champion from

amongst the officers will be the bridge between the management and team and help maintain enthusiasm and motivation. Training must impart knowledge and skills (Black et al., 2009). The public needs UPsK service since it is one of the medical facility that handles psychological problems without being associated with the stigma of psychiatry (National Health and Morbidity Survey, 2015). To avoid disruption to the service, the Ministries of Finance and Health must prioritise financial resources for UPsK.

Suggestions for Further Studies

This study has opened up an area that needs further attention. It focused on adult clients; thus, future studies should include children (<18 years old) in the sampling frame, hence making the study more representative of the community. Even though children represented only 10% of the population, their inclusion brings diversity into the research since the outlook and psychological issues of children are different from that of adults (Richards, 2011). The instruments used are also different. Children between 11-17 years old complete Young Person CORE (YP-CORE), and children with learning disabilities complete Learning Disability CORE (LD-CORE).

Another line of research is to collect normative data, which can determine the Malaysian norm for psychological distress. Local norms are distinct from country to country because each country is influenced by different socio-cultural factors that exist in that particular culture and country (Sharma, 2015). Hence, it is better to determine the cut-off point between a clinical and non-clinical range that is unique to Malaysia (Barkham & Mellor-Clark, 2006).

REFERENCES

- Abd.Talib, M. N. K., Abd.Halim, N. H., Rosli, F. H., & Raja Ahmad, R. N. (2011). *Service guide for psychology officer*. http://jknns.moh.gov.my/doc/PANDUAN_PERKHIDMATAN.pdf
- Abdul Jalil, N., Sulaiman, Z., Awang, M. S., & Omar, M. (2009). Retrospective review of outcomes of a multimodal chronic pain service in a major teaching hospital: A preliminary experience in Universiti Sains Malaysia. *The Malaysian Journal of Medical Sciences : MJMS*, *16*(4), 55–65. <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3216138&tool=pmc-entrez&rendertype=abstract>
- Abdul Khaiyom, J. H., Mukhtar, F., & Tian Po, O. (2019). Treatments for Anxiety Disorders in Malaysia. *Malaysian Journal of Medical Sciences*, *26*(3), 24–36. <https://doi.org/10.21315/mjms2019.26.3.2>
- Abeloff, M. D., Armitage, J. O., Lichter, A. S., & Niederhuber, J. E. (2000). *Clinical oncology* (2nd editio). Churchill Livingstone.
- Ackerberg, D. A., Machado, M. P., & Riordan, M. H. (2006). Benchmarking for productivity improvement: A health-care application. *International Economic Review*, *47*(1), 161–201. https://www.jstor.org/stable/3663679?seq=1#page_scan_tab_contents
- Ahmad, Z. (2001). Reengineering public services through ISO 9000. *Asian Review of Public Administration*, 108–120. <http://unpan1.un.org/intradoc/groups/public/documents/eropa/unpan001416.pdf>
- Al-Abri, R., & Al-Balushi, A. (2014). Patient satisfaction survey as a tool towards quality improvement. *Oman Medical Journal*, *29*(1), 3–7. <https://doi.org/10.5001/omj.2014.02>
- Allied Health Professions Act 2016, Pub. L. No. Act 774 (2016). http://www.federalgazette.agc.gov.my/outputaktap/aktaBM_20160218_AKTA776-BM.pdf
- Anderson, R. M., Rice, T. R., & Kominski, G. F. (2007). *Changing the U.S. healthcare system* (Third Edit). Jossey Bass.
- Anker, M. G., Duncan, B. L., & Sparks, J. A. (2009). Using client feedback to improve couple therapy outcomes: a randomized clinical trial in a naturalistic setting. *Journal of Consulting and Clinical Psychology*, *77*(4), 693–704. <https://doi.org/10.1037/a0016062>.
- APA. (2012). *Recognition of psychotherapy effectiveness*. American Psychological Association. <http://www.apa.org/about/policy/resolution-psychotherapy.aspx>
- Ardito, R. B., & Rabellino, D. (2011). Therapeutic alliance and outcome of psychotherapy: Historical excursus, measurements, and prospects for research. *Frontiers in Psychology*, *2*(OCT), 1–11. <https://doi.org/10.3389/fpsyg.2011.00270>

- Asay, T. P., & Lambert, M. J. (1999). The empirical case for the common factors in therapy: Quantitative findings. In *The Heart and Soul of Change: What Works in Therapy* (pp. 23–55). APA.
- ASEAN Secretariat. (2016). *ASEAN mental health systems*. ASEAN Secretariat. <http://asean.org/storage/2017/02/55.-December-2016-ASEAN-Mental-Health-System.pdf>
- Asli, M. (1998). Entire Malaysian civil service adopts ISO 9000. *ISO 9000 News*, 7–10. <http://www.iso.org/iso/livelinkgetfile-isocs?nodeId=15051886>
- Aubuchon-Endsley, N. L., & Callahan, J. L. (2009). The hour of departure: Predicting attrition in the training clinic from role expectancies. *Training and Education in Professional Psychology*, 3(2), 120–126. <https://doi.org/10.1037/a0014455>
- Audin, K. (2001). Value of HoNOS in assessing patient change in NHS psychotherapy and psychological treatment services. *The British Journal of Psychiatry*, 178(6), 561–566. <https://doi.org/10.1192/bjp.178.6.561>
- Awa, W. L., Plaumann, M., & Walter, U. (2010). Burnout prevention: A review of intervention programs. *Patient Education and Counseling*, 78(2), 184–190. <https://doi.org/10.1016/j.pec.2009.04.008>
- Ayers, S., Baum, A., McManus, C., Newman, S., Wallston, W., Weinman, J., & West, R. (Eds.). (2007). Section 1: Psychological aspects of health and illness. In *Cambridge Handbook of Psychology, Health and Medicine* (2nd Editio). Cambridge University Press. <http://www.cambridge.org/catalogue/catalogue.asp?isbn=9780521605106>
- Azizan, N. A., Mohamed, B., Razak, L. T., & Mahkota, B. I. (2013). The effects of perceived service quality on patient satisfaction at a public hospital in the state of Pahang. *Asian Journal of Social Sciences and Humanities*, 2(3), 307–323. [http://www.ajssh.leena-luna.co.jp/AJSSHPDFs/Vol.2\(3\)/AJSSH2013\(2.3-34\).pdf](http://www.ajssh.leena-luna.co.jp/AJSSHPDFs/Vol.2(3)/AJSSH2013(2.3-34).pdf)
- Baker, E. K. (2003). *Caring for ourselves: A therapist's guide to personal and professional well-being*. (1st Editio). American Psychological Association. <https://www.amazon.com/Caring-Ourselves-Therapists-Professional-Well-Being/dp/1557989346>
- Bandler, R. (1993). *Time for a change*. Meta Publications. https://en.wikipedia.org/wiki/Brief_psychotherapy
- Barkham, M., Culverwell, A., Spindler, K., & Twigg, E. (2005). The CORE-OM in an older adult population: psychometric status, acceptability, and feasibility. *Aging & Mental Health*, 9(3), 235–245. <https://doi.org/10.1080/13607860500090052>
- Barkham, M., Evans, C., Margison, F., McGrath, G., Mellor-Clark, J., Milne, D., & Connell, J. (1998). The rationale for developing and implementing core outcome batteries for routine use in service setting and psychotherapy outcome research. *Journal of Mental Health*, 7, 35–47.

- Barkham, M., Hardy, G. E., & Mellor-Clark, J. (2010). *Developing and delivering practice-based evidence* (M. Barkham, G. E. Hardy, & J. Mellor-Clark (Eds.)). Wiley -Blackwell.
- Barkham, M., & Mellor-Clark, J. (2000). Rigour and relevance: Practice-based evidence in the psychological therapies. In N. Rowland & S. Goss (Eds.), *Evidence-based health care in psychological therapies* (pp. 127–144). Routledge.
- Barkham, M., Mellor-Clark, J., Connell, J., & Cahill, J. (2006). A core approach to practice-based evidence: A brief history of the origins and applications of the CORE-OM and CORE System. *Counselling and Psychotherapy Research*, 6(1), 3–15. <https://doi.org/10.1080/14733140600581218>
- Barkham, M., Mellor-Clark, J., Connell, J., Evans, C., Evans, R., & Margison, F. R. (2010). Clinical outcomes in routine evaluation (CORE) - The CORE measures and system: Measuring, monitoring and managing quality evaluation in the psychological therapies. In Michael Barkham, G. Hardy, & J. Mellor-Clark (Eds.), *Developing and Delivering Practice-Based Evidence* (pp. 175–219). Wiley -Blackwell. <https://doi.org/10.1002/9780470687994.ch8>
- Barkham, M., Stiles, W. B., Lambert, M. J., & Mellor-Clark, J. (2010). Building a rigorous and relevant knowledge base for psychological therapies. In M. Barkham, G. E. Hardy, & J. Mellor-Clark (Eds.), *Developing and delivering practice-based evidence*. Wiley -Blackwell.
- Barkham, Michael, Bewick, B. M., Connell, J., Cooper, M., Mulhern, B., & Twigg, E. (2009). The Young Person's CORE: Development of a brief outcome measure for young people. *Counselling and Psychotherapy Research*, 9(3), 160–168. <https://doi.org/10.1080/14733140902979722>
- Barkham, Michael, Bewick, B., Mullin, T., Gilbody, S., Connell, J., Cahill, J., Mellor-Clark, J., Richards, D., Unsworth, G., & Evans, C. (2013). The CORE-10: A short measure of psychological distress for routine use in the psychological therapies. *Counselling and Psychotherapy Research*, 13(1), 3–13. <https://doi.org/10.1080/14733145.2012.729069>
- Barkham, Michael, Hardy, G. E., & Mellor-Clark, J. (2010). Developing and delivering practice-based evidence: A guide for the psychological therapies. *Developing and Delivering Practice-Based Evidence: A Guide for the Psychological Therapies*. John Wiley & Sons Ltd. <https://doi.org/10.1002/9780470687994>
- Barkham, Michael, Leach, C., Lucock, M., Evans, C., Margison, F., Mellor-Clark, J., Benson, L., Connell, J., Audin, K., & McGrath, G. (2001). Service profiling and outcomes benchmarking using the CORE-OM: Toward practice-based evidence in the psychological therapies. *Journal of Consulting and Clinical Psychology*, 69(2), 184–196. <https://doi.org/10.1037/0022-006X.69.2.184>
- Battandier, A. (1907). *Prefectures Apostolic of Borneo*. Catholic Encyclopedia. <https://www.newadvent.org/cathen/02687a.htm>
- “Benchmark.” (n.d.). *Benchmark*. Oxford Dictionaries. Retrieved December 31, 2017,

from <http://oxforddictionaries.com/definition/english/benchmark>

- Berger, M. L., Dreyer, N., Anderson, F., Towse, A., Sedrakyan, A., & Normand, S.-L. (2012). Prospective observational studies to assess comparative effectiveness: the ISPOR good research practices task force report. *Value in Health, 15*(2), 217–230. <https://doi.org/10.1016/j.jval.2011.12.010>
- Berggren, T., & Josefsson, A. (2013). Rate of change in psychotherapy: A matter of patients. *Linköpings Universitet, 47*. <http://liu.diva-portal.org/smash/get/diva2:730552/FULLTEXT01.pdf>
- Beutler, L. E., & Malik, M. L. (2002). Diagnosis and treatment guidelines: The example of depression. In L. E. Beutler & M. L. Malik (Eds.), *Decade of behaviour. Rethinking the DSM: A psychological perspective* (pp. 251–277). American Psychological Association. <https://doi.org/10.1037/10456-010>
- Beutler, Larry E. (2009). Making science matter in clinical practice: Redefining psychotherapy. *Clinical Psychology: Science and Practice, 16*(3), 301–317. <https://doi.org/10.1111/j.1468-2850.2009.01168.x>
- Bevan, G., Evans, A., & Nuti, S. (2019). Reputations count: Why benchmarking performance is improving health care across the world. *Health Economics, Policy and Law, 14*(2), 141–161. <https://doi.org/10.1017/S1744133117000561>
- Bewick, B. M., Trusler, K., Mullin, T., Grant, S., & Mothersole, G. (2006). Routine outcome measurement completion rates of the CORE-OM in primary care psychological therapies and counselling. *Counselling and Psychotherapy Research, 6*(Special Issue 1), 33–40. <https://doi.org/10.1080/14733140600581432>
- Bickman, L. (2010). Measurement feedback system (MFS) is necessary to improve mental health outcomes. *J. Am. Acad Child Adolesc Psychiatry, 47*(10), 1114–1119. <https://doi.org/10.1097/CHI.0b013e3181825af8.A>
- Billari, F. C., Goisis, A., Liefbroer, A. C., Settersten, R. A., Aassve, A., Hagestad, G., & Spder, Z. (2011). Social age deadlines for the childbearing of women and men. *Human Reproduction, 26*(3), 616–622. <https://doi.org/10.1093/humrep/deq360>
- Blackwood, R. (2009). *Study design for assessing effectiveness, efficiency and acceptability of services including measures of structure, process, service quality, and outcome of health care*. Public Health Action Support Team. <https://www.healthknowledge.org.uk/public-health-textbook/research-methods/lc-health-care-evaluation-health-care-assessment/study-design-assessing-effectiveness>
- Blenke, L. R. (2013). *The role of face-to-face interactions in the success of virtual project teams* [Missouri University of Science and Technology]. https://scholarsmine.mst.edu/cgi/viewcontent.cgi?article=3306&context=doctoral_dissertations
- Bloom, B. L. (2001). Focused single-session psychotherapy: A review of the clinical and research literature. *Brief Treatment and Crisis Intervention, 1*, 67–86.

<http://doi.wiley.com/10.1017/aft.2012.4>

- Boswell, J. F., Kraus, D. R., & Lambert, M. J. (2015). Implementing routine outcome monitoring in clinical practice: Benefits, challenges, and solutions. *Psychotherapy Research*, 25(1), 6–19. <https://doi.org/10.1080/10503307.2013.817696>
- Boswell, J. F., Kraus, D. R., Miller, S. D., & Lambert, M. J. (2013). Implementing routine outcome monitoring in clinical practice: Benefits, challenges, and solutions. *Psychotherapy Research*, July 2013, 1–14. <https://doi.org/10.1080/10503307.2013.817696>
- Boulter, L., & McDonald, L. (2020). *Quality at the service of mental health*. Nottingham Counselling Service. <https://www.nottinghamcounsellingcentre.org.uk/news/quality-at-the-service-of-mental-health>
- Bower, P., & Gilbody, S. (2010). The current view of evidence and evidence-based practice. In M Barkham, G. E. Hardy, & J. Mellor-Clark (Eds.), *Developing and Delivering Practice-based Evidence*. Wiley -Blackwell.
- Bowling, A. (2002). Research methods in health: Investigating health and health services. In *Open University Press* (Second). Open University Press. <http://www.mcgraw-hill.co.uk/openup/chapters/0335206433.pdf>
- Braithwaite, J., Travaglia, J. F., & Corbett, A. (2011). Can questions of the privatization and corporatization, and the autonomy and accountability of public hospitals, ever be resolved? *Health Care Analysis: HCA*, 19(2), 133–153. <https://doi.org/10.1007/s10728-010-0152-x>
- Brann, P., & Coleman, G. (2010). On the meaning of change in a clinician's routine measure of outcome: HoNOSCA. *Australian and New Zealand Journal of Psychiatry*, 44(12). <http://journals.sagepub.com/doi/abs/10.3109/00048674.2010.513037>
- Brierley, J. A. (2017). The role of a pragmatist paradigm when adopting mixed methods in behavioural accounting research. *International Journal of Behavioural Accounting and Finance*, 6(2), 140. <https://doi.org/10.1504/ijbaf.2017.10007499>
- Brooks, M., & Davies, S. (2008). Pathways to participatory research in developing a tool to measure feelings. *British Journal of Learning Disabilities*, 36(2), 128–133. <https://doi.org/10.1111/j.1468-3156.2007.00476.x>
- Brower, L. A. (2003). Ohio mental health consumer outcomes system: Reflections on a major policy initiative in the US. *Clinical Psychology & Psychotherapy*, 406(10), 400–406.
- Bruce, M. L., Have, T. R. Ten, Iii, C. F. R., Katz, I. I., Schulberg, H. C., Mulsant, B. H., Brown, G. K., Mcavay, G. J., Pearson, J. L., Alexopoulos, G. S. (2004). Reducing Suicidal Ideation and depressive symptoms in depressed older patients in primary care: A randomised control trial. *JAMA*, 291(9), 1081–1091.

file:///C:/Users/Lenovo/Downloads/JOC32219.pdf

- Bryman, A. (2006). Integrating quantitative and qualitative research: How is it done? *Qualitative Research*, 6(1), 97–113. <https://doi.org/10.1177/1468794106058877>
- Busiol, D. (2016). Help-seeking behaviour and attitudes towards counselling: a qualitative study among Hong Kong Chinese university students. *British Journal of Guidance and Counselling*, 44(4), 382–401. <https://doi.org/10.1080/03069885.2015.1057475>
- Butina, B. (2008). *How to find a good therapist*. CreateSpace. <https://www.amazon.com/How-Find-Good-Therapist-Butina/dp/143825105X>
- Callahan, J. L., Aubuchon-Endsley, N., Borja, S. E., & Swift, J. K. (2009). Pretreatment expectancies and premature termination in a training clinic environment. *Training and Education in Professional Psychology*, 3(2), 111–119. <https://doi.org/10.1037/a0012901>
- Calvert, S., Miller, H. E., Curran, A., Hameed, B., McCarter, R., Edwards, R. J., Hunt, L., & Sharples, P. M. (2008). The King's Outcome Scale for Childhood Head Injury and injury severity and outcome measures in children with traumatic brain injury. *Developmental Medicine and Child Neurology*, 50(6), 426–431. <https://doi.org/10.1111/j.1469-8749.2008.02061.x>
- Carayon, P., Schoofs Hundt, Karsh, B.-T., Gurses, a P., Alvarado, C. J., Smith, M., & Flatley Brennan, P. (2006). Work system design for patient safety: the SEIPS model. *Quality & Safety in Health Care*, 15 Suppl 1, i50-8. <https://doi.org/10.1136/qshc.2005.015842>
- Carlier, I. V., Meuldijk, D., Van Vliet, I. M., Van Fenema, E., Van der Wee, N. J., & Zitman, F. G. (2012). Routine outcome monitoring and feedback on physical or mental health status: evidence and theory. *J. Eval. Clin. Pract.*, 18(1), 104–110. <https://doi.org/10.1111/j.1365-2753.2010.01543.x>
- Carlson, L. E., Speca, M., Faris, P., & Patel, K. D. (2007). One year pre–post intervention follow-up of psychological, immune, endocrine and blood pressure outcomes of mindfulness-based stress reduction (MBSR) in breast and prostate cancer outpatients. *Brain, Behavior, and Immunity*, 21(8), 1038.
- Carmin, C., & Roth-Roemer, S. (1998). Working in medical settings: Diagnostic, practice, and professional issues. In S. Roth-Roemer, S. R. R. Kurpius, & C. Carmin (Eds.), *The emerging role of counselling psychology in health care* (pp. 77–93). W.W. Norton & Company. file:///C:/Users/Prof Muhaya/Downloads/9-24-1-PB (1).pdf
- Castelnuovo, G., Pietrabissa, G., Cattivelli, R., Manzoni, G. M., & Molinari, E. (2016). Not Only Clinical Efficacy in Psychological Treatments: Clinical Psychology Must Promote Cost-Benefit, Cost-Effectiveness, and Cost-Utility Analysis. *Frontiers in Psychology*, 7, 563. <https://doi.org/10.3389/fpsyg.2016.00563>
- Castillo-Montoya, M. (n.d.). *The Qualitative Report Preparing for Interview Research: The Interview Protocol Refinement Framework* (Vol. 21). Retrieved

July 10, 2019, from <https://nsuworks.nova.edu/tqr/vol21/iss5/2>

- Cella, D., Riley, W., Stone, A., Rothrock, N., Yount, S., Amtmann, D., & Bode, R. (2010). The patient-reported outcome measurement information system (PROMIS) developed and tested its first wave of adult self-reported health outcomes item banks:2005-2008. *Journal of Clinical Epidemiology*, *63*(11), 1179–1194. <https://doi.org/10.1016/j.jclinepi.2010.04.011>
- Chee, K. Y., & Abd.Aziz, S. (2014). A review of schizophrenia research in Malaysia. *Medical Journal of Malaysia*, *69*(Supplement A), 46–54.
- Chemi, N., Abdullah, N., Singh, A., & Muhamad Isa, M. F. (2014). A review of substance abuse research in Malaysia. *Medical Journal of Malaysia*, *69*(Supplement A), 55–58.
- Chen, X. W., Shafei, M. N., Aziz, Z. A., Sidek, N. N., & Musa, K. I. (2019). Trends in stroke outcomes at hospital discharge in first-ever stroke patients: Observations from the Malaysia National Stroke Registry (2009–2017). *Journal of the Neurological Sciences*, *401*, 130–135. <https://doi.org/10.1016/J.JNS.2019.04.015>
- Chisholm, D., Sweeny, K., Sheehan, P., Rasmussen, B., Smit, F., Cuijpers, P., & Saxena, S. (2016). Scaling-up treatment of depression and anxiety : a global. *The Lancet Psychiatry*, *0366*(16), 1–10. [https://doi.org/10.1016/S2215-0366\(16\)30024-4](https://doi.org/10.1016/S2215-0366(16)30024-4)
- Chong, S. T., Mohamad, M. S., & Er, A. C. (2013). The mental health development in Malaysia: History, current issue and future development. *Asian Social Science*, *9*(6), 1–8. <https://doi.org/10.5539/ass.v9n6p1>
- Codling, S. (1992). *Best practice benchmarking: A management guide*. Gower.
- Cokluk, O., & Kayri, M. (2011). The effects of methods of imputation for missing values on the validity and reliability of scales. *Kuram ve Uygulamada Egitim Bilimleri*, *11*(1), 303–309. <https://files.eric.ed.gov/fulltext/EJ919903.pdf>
- Connell, J., Barkham, M., & Mellor-Clark, J. (2007). CORE-OM mental health norms of students attending university counselling services benchmarked against an age-matched primary care sample. *British Journal of Guidance & Counselling*, *35*(1), 41–57. <https://doi.org/10.1080/03069880601106781>
- Connell, J., Barkham, M., & Stiles, W. B. (2007). Distribution of CORE–OM scores in a general population, clinical cut-off points and comparison with the CIS–R. *The British Journal of ...*, *190*, 69–74. <https://doi.org/10.1192/bjp.bp.1.05.017657>
- Connell, Janice, Grant, S., & Mullin, T. (2006). Client initiated termination of therapy at NHS primary care counselling services. *Counselling and Psychotherapy Research*, *6*(1), 60–67. <https://doi.org/10.1080/14733140600581507>
- Conte, H. ., Ratto, R., & Karusa, T. (1996). The psychological mindedness scale: Factor structure and relationship to outcome of psychotherapy. *Journal of Psychotherapy Practice and Research*, *5*(3), 250–259.

- Cook, G., & Webb, A. (2002). Reactions from the medical and nursing professions to Nightingale's "reform(s)" of nurse training in the late 19th century. *Postgraduate Medical Journal*, 78(916), 118–123. <https://doi.org/10.1136%2Fpmj.78.916.118>
- Cook, J. M., Elhai, J. O. N., Coyne, J. C., Biyanova, T., & Schnurr, P. P. (2010). What do psychotherapists do in practice? An internet study of over 2000 practitioners. *Psychotherapy (Chicago, Ill.)*, 47(2), 260–267. <https://doi.org/10.1037/a0019788>.WHAT
- Cook, T., & Campbell, D. (1979). *Quasi-experimental - design and analysis issues for field settings*. Rand McNally.
- CORE-YP, (p. 4). (n.d.).
- CORE IMS Ltd. (n.d.). *CORE Translations*. <http://www.coreims.co.uk/Contact.html>
- CORE IMS Ltd. (2014). *Core system user manual* (pp. 1–36). CORE Information Management Systems Ltd. [file:///C:/Users/Lenovo/Downloads/core_system_user_manual\(1\).pdf](file:///C:/Users/Lenovo/Downloads/core_system_user_manual(1).pdf)
- CORE Partnership. (2007a). Assessing the effectiveness of a psychological therapy service. In *CORE Partnership Occasional Paper, No 2*. (Issue 2, pp. 1–4). CORE IMS. http://www.coreims.co.uk/site_downloads/OP1-initial_CORE-OM_
- CORE Partnership. (2007b). Is the initial overall CORE-OM score an indicator of likely outcome? In *CORE Partnership Occasional Paper, No. 1*. (Vol. 1, Issue 1, pp. 1–4). CORE IMS. http://www.coreims.co.uk/site_downloads/OP1-initial_CORE-OM_score.pdf
- CORE Partnership. (2011a). Benchmarks for primary care counselling services assessment outcomes. In *CORE Partnership Occasional Paper*. (Issue May). http://www.coreims.co.uk/Support_User_Benchmarking.html
- CORE Partnership. (2011b). Benchmarks for primary care counselling services outcome measure completion rates. *CORE Partnership Occasional Paper., May*. http://www.coreims.co.uk/Support_User_Benchmarking.html
- CORE Partnership. (2011c). Benchmarks for primary care counselling services planned/unplanned endings. *CORE Partnership Occasional Paper., May*. http://www.coreims.co.uk/Support_User_Benchmarking.html
- CORE Partnership. (2011d). Benchmarks for primary care counselling services recovery and improvement rates. In *CORE Partnership Occasional Paper*. (Vol. 1, Issue May). CORE IMS.
- CORE Partnership. (2011e). Benchmarks for primary care counselling services risk assessment. *CORE P, May*, 8–11. http://www.coreims.co.uk/Support_User_Benchmarking.html
- CORE Partnership. (2011f). Benchmarks for primary care counselling services waiting times. *CORE Partnership Occasional Paper., May*. http://www.coreims.co.uk/Support_User_Benchmarking.html

- Corrigan, P. W., Larson, J. E., & Rüsch, N. (2009). Self-stigma and the “why try” effect: Impact on life goals and evidence-based practices. *World Psychiatry*, 8(2), 75–81. <https://doi.org/10.1002/j.2051-5545.2009.tb00218.x>
- Counselling Psychology Services. (2018). *Operational management plan*. Allied Health Division, Ministry of Health, Malaysia.
- Counsellors Act 1998, Pub. L. No. Act 580, Percetakan Nasional Malaysia Bhd (1998). <http://www.agc.gov.my/Akta/Vol.12/Act580.pdf>
- Cowie, H., Pecherek, A., & Pecherek, A. (2017). *Counselling*. Routledge. <https://doi.org/10.4324/9781315268446>
- Coyle, Y. M. & Battles, J. B. (1999). Using antecedents of medical care to develop valid quality of care measures. *International Journal for Quality in Health Care : Journal of the International Society for Quality in Health Care / ISQua*, 11(1), 5–12. <http://www.ncbi.nlm.nih.gov/pubmed/10411284>
- Crabtree, S., & Chong, G. (2000). Standing at the crossroads: Mental health in Malaysia since independence. In A. Haque (Ed.), *Mental health in Malaysia: Issues and concerns*. University Malaya Press.
- Creswell, J. W. (2014). *Research design: Qualitative, quantitative and mixed methods approaches* (4th Editio). Sage Publication, Inc.
- Creswell, J. W., & Plano Clark, V. L. (2011). *Designing and conducting mixed methods research*. Sage.
- Creswell, John. W. (2008). *Educational research: Planning, conducting, and evaluating quantitative and qualitative research* (Third edition). Pearson Education.
- Cross, S., Mellor-Clark, J., & Macdonald, J. (2015). Tracking Responses to Items in Measures as a Means of Increasing Therapeutic Engagement in Clients: A Complementary Clinical Approach to Tracking Outcomes. *Clinical Psychology and Psychotherapy*, 22(6), 698–707. <https://doi.org/10.1002/cpp.1929>
- Cuijpers, P., Reijnders, M., & Huibers, M. J. H. (2019). The Role of Common Factors in Psychotherapy Outcomes. *Annual Review of Clinical Psychology*, 15(1), 207–231. <https://doi.org/10.1146/annurev-clinpsy-050718-095424>
- Davies, A. R., & Ware, J. E. (1988). Involving consumers in quality care assessment: Do they provide valid information? *Health Affairs*, 7, 33–48. <https://doi.org/10.1377/hlthaff.7.1.33>
- de Beurs, E., den Hollander-Gijsman, M. E., van Rood, Y. R., van der Wee, N. J. a, Giltay, E. J., van Noorden, M. S., van der Lem, R., van Fenema, E., & Zitman, F. G. (2011). Routine outcome monitoring in the Netherlands: practical experiences with a web-based strategy for the assessment of treatment outcome in clinical practice. *Clinical Psychology & Psychotherapy*, 18(1), 1–12. <https://doi.org/10.1002/cpp.696>

- de Shazer, S. (1994). *Words were originally magic*. Norton.
https://en.wikipedia.org/wiki/Solution-focused_brief_therapy
- Delgado, J., McMillan, D., Leach, C., Lucock, M., Gilbody, S., & Wood, N. (2014). Benchmarking routine psychological services: a discussion of challenges and methods. *Behavioural and Cognitive Psychotherapy*, 42(1), 16–30.
<https://doi.org/10.1017/S135246581200080X>
- Department of veteran affairs. (2003). *VHA pain outcome toolkit*.
<http://www.va.gov/PAINMANAGEMENT/docs/Outcomes.doc>.
- DeVellis, R. F. (2012). *Scale development: Theory and application*. (3rd Editio). Sage Publication, Inc.
- “Distress.” (2014). In *Merriam-Webster online dictionary*. In Merriam-Webster Dictionary. <http://www.merriam-webster.com/dictionary/distress>
- Donabedian, A. (1966). Evaluating the quality of medical care. *Milbank Memorial Fund Quarterly*, 44(3), 166–206. <http://www.jstor.org/stable/3348969>
- Donabedian, A. (1980). *Exploration in quality assessment and monitoring vol. 1: The definition of quality and approaches to its assessment*. Health Administration Press.
- Donabedian, A. (1997). The quality of care. How can it be assessed? *Journal of the American Medical Association*, 260(12), 1743–1748.
<https://doi.org/10.1001/jama.260.12.1743>
- Donabedian, A. (2003). *An introduction to quality assessment in healthcare*. Oxford University Press, Inc.
http://neuron.mefst.hr/docs/CMJ/issues/2003/44/5/29_BookRev.pdf
- Donabedian Model. (2013). *Donabedian model*. Wikipedia.
http://en.wikipedia.org/wiki/The_Donabedian_Model
- Drapeau, A. (2012). Epidemiology of psychological distress. In Luciano L’ Abate (Ed.), *Epidemiology of psychological distress - understanding, prediction and control* (pp. 105–135). InTech.
http://www.zums.ac.ir/files/research/site/medical/Mental_and_Behavioural_Disorders_and_Diseases_of_the_Nervous_System/Mental_Illnesses_-_Understanding_Prediction_and_Control.pdf#page=119
- Dreesh, N., Dolea, C., Dal Poz, M. R., Goubarez, A., Adams, O., Aregawi, M., Bergstrom, K., Fogstad, H., Sheratt, D., Linkins, J., Scherpbier, R., & Youssef-Fox, M. (2005). An approach to estimating human resource requirements to achieve Millenium Development Goals. *Health Policy Plan*, 20(5), 267–276.
<https://doi.org/10.1093/heapol/czi036>
- Dryden, W., & Thorne, B. (2008). *Training and supervision in counselling in action*. SAGE Publications Ltd.
- Duan, C., Knox, S., & Hill, C. E. (2018). Advice giving in psychotherapy. In E. L.

MacGeorge & L. M. Van Swol (Eds.), *The Oxford book of advice*. Oxford University Press. <https://doi.org/10.1093/oxfordhb/9780190630188.001.0001>

- Dufour, S., Barkema, H. W., DesCôteaux, L., DeVries, T. J., Dohoo, I. R., Reyher, K., Roy, J.-P., & Scholl, D. T. (2010). Development and validation of a bilingual questionnaire for measuring udder health-related management practices on dairy farms. *Preventive Veterinary Medicine*, 95(1–2), 74–85. <https://doi.org/10.1016/j.prevetmed.2010.02.018>
- Duncan, E. A. S., & Murray, J. (2012). The barriers and facilitators to routine outcome measurement by allied health professionals in practice : a systematic review. *BMC Health Services Research*, 12(96).
- Eagar, K., Buckingham, B., & Coombs, T. (2001). *The Victoria mental health outcomes measurement strategy: Final report on the implementation of outcome measurement in adult area mental health services*.
- Easterbrook, C. J., & Meehan, T. (2017). The therapeutic relationship and Cognitive Behavioural Therapy: A case study of an adolescent girl with depression. *The European Journal of Counselling Psychology*, 6(1), 1–24. <https://doi.org/10.5964/ejcop.v6i1.85>
- Eislee, C. W., Slee, V. N., & Hoffmann, R. G. (1956). Can the practice of internal medicine be evaluated? *Annals of Internal Medicine*, 44(1), 144–161. <https://doi.org/doi:10.7326/0003-4819-44-1-144>
- Elfström, M. L., Evans, C., Lundgren, J., Johansson, B., Hakeberg, M., & Carlsson, S. G. (2012). Validation of the Swedish version of the Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM). *Clinical Psychology & Psychotherapy*. <https://doi.org/10.1002/cpp.1788>
- Elinson, J. (1987). Advances in health assessment conference discussion panel. *Journal of Chronic Disease*, 40(supplement 1), 183S-191S.
- Ellis, J. (2006). All-inclusive benchmark. *Journal of Nursing Management*, 14(5), 377–383. <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3359088&tool=pmc-entrez&rendertype=abstract>
- Ellis, J. M., & Morris, A. (1997). Paediatric benchmarking: A review of its development. *Nursing Standard*, 12, 43–46.
- Emsley, R., Chiliza, B., Asmal, L., & Harvey, B. H. (2013). The nature of relapse in schizophrenia. *BMC Psychiatry*, 13, 50. <https://doi.org/10.1186/1471-244X-13-50>
- Ettorchi-Tardy, A., Levif, M., & Michel, P. (2012). Benchmarking: a method for continuous quality improvement in health. *Healthcare Policy = Politiques de Santé*, 7(4), e101-19. <https://doi.org/10.12927/hcpol.2012.22872>
- Evans, C. (2011). *Translating and “ normalising ” CORE System Trust (CST) position statement*. 1–8. http://www.psycht.org/CORE-OM/Translating_CORE-

- Evans, C. (2012a). The CORE-OM (clinical outcome in routine evaluation) and its derivatives. *Integrating Science and Practice*, 2(2), 12–15.
- Evans, C. (2012b). The CORE-OM (Clinical Outcomes in Routine Evaluation) and its derivatives. In M. Drapeau (Ed.), *Journal of Integrating Science and Practice* (Vol. 2, Issue 2). Ordre des psychologues du Québec. http://www.ordrepsy.qc.ca/pdf/2012_11_Integrating_SandP_10_Tools_for_Progress_Monitoring_in_Psychotherapy.pdf
- Evans, C., Connell, J., Barkham, M., Marshall, C., & Mellor-clark, J. (2003). Practice-based evidence : Benchmarking NHS primary national and local levels. *Clinical Psychology & Psychotherapy*, 10, 374–388. <https://doi.org/10.1002/cpp.384>
- Evans, Chris., Connell, J., Barkham, M., Margison, F., McGrath, G., Mellor-Clark, J., & Audin, K. (2002). Towards a standardised brief outcome measure: Psychometric properties and utility of the CORE-OM. *The British Journal of Psychiatry*, 180(1), 51–60. <https://doi.org/10.1192/bjp.180.1.51>
- Fallon, T. J., Pumariega, A., Sowers, W., Klaehn, R., Huffine, C., Vaughan, T. J., Winter, N., Chenven, M., Marx, L., Zachik, A., Heffron, W., & Grimes, K. (2006). A level of care instrument for children’s systems of care: Construction, reliability and validity. *Journal of Child and Family Studies*, 15(2), 143–155. <https://doi.org/10.1007/s10826-005-9012-y>
- Fazleena Aziz. (2016, August). Health Ministry faces a budget cut of between RM250m and RM300m. *New Straits Time Online*. <http://www.nst.com.my/news/2016/01/122006/health-ministry-faces-budget-cut-between-rm250m-and-rm300m>
- Feixas, G., & Botella, L. (2004). Psychotherapy Integration. *Journal of Psychotherapy Integration*, 142, 192–222. <https://doi.org/10.1037/1053-0479.14.2.192>
- Field, A. (2013). *Discovering statistics using IBM SPSS statistics*. Sage Publication, Inc.
- Fritscher, L. (2016). *What is a presenting problem?* Dotdash. <https://www.verywell.com/presenting-problem-2671638>
- Frommer, M., Rubin, G., & Lyle, D. (1992). The NSW health outcomes program. *New South Wales Public Health Bulletin*, 3(12), 134–137. <https://doi.org/10.1071%2FNB92067>
- Frost, M. H., Reeve, B. B., Liepa, A. M., Stauffer, J. W., & Hays, R. D. (2007). What is sufficient evidence for the reliability and validity of patient-reported outcome measures? *Value in Health*, 10 Suppl 2, S94–S105. <https://doi.org/10.1111/j.1524-4733.2007.00272.x>
- Gardner, G., Gardner, A., & O’Connell, J. (2014). Using the Donabedian framework to examine the quality and safety of nursing service innovation. *Journal of Clinical Nursing*, 23(1–2), 145–155. <https://doi.org/10.1111/jocn.12146>

- Gentry, W. D. (1984). *Handbook of behavioural medicine*. Guildford Press.
- Gilbody, S. M., Wahlbeck, K., & Adams, C. E. (2002). Randomised control trials in schizophrenia: a critical review of the literature. *Acta Psychiatrica Scandinavica*, *105*, 243–251.
- Glamcevski, M. (2008). The Malaysian Counselling Profession, History and Brief Discussion of the Future. *Journal of Counselling, Psychotherapy and Health*, *4*, 1–18.
- Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Prentice-Hall.
- Government of Malaysia. (2005). *New retirement and pension policy*. Department of Civil Service, Malaysia. http://www.jpapencen.gov.my/english/new_policy.html
- Gray, P., & Mellor-clark, J. (2007). *CORE: A Decade*. Penny Gray. http://www.coreims.co.uk/site_downloads/CORE-A-Decade-of-Development.pdf
- Green, L. W. (2008). Making research relevant : if it is an evidence-based practice, where is the practice-based evidence ? *Family Practice*, *25*(December), 20–24. <https://doi.org/10.1093/fampra/cmn055>
- Griffin, E. (2011). *A first look at communication theory*. The McGraw-Hill Companies.
- H., van R. (2013). Advice dilemmas: Managing advice against the competing public health and counselling imperatives that shape VCT in South Africa. *African Journal of AIDS Research*, *12*(4), 211–220.
- Hackney, H. L., & Cormier, S. (2013). *The professional counsellor: A process guide to helping* (7th Editio). Pearson Education. <https://www.pearson.com/us/higher-education/product/Hackney-Professional-Counselor-The-A-Process-Guide-to-Helping-7th-Edition/9780132595148.html?tab=overview>
- Hall, J. A. (1992). Psychological mindedness: A conceptual model. *American Journal of Psychotherapy*, *46*(1), 131–140.
- “Handling missing data.” (2015). *Handling missing data*. EMGO. <http://www.emgo.nl/kc/handling-missing-data/>
- “Handwashing has been a central component of personal hygiene.” (2017). *History handwashing*. Global Handwashing Partnership. <https://globalhandwashing.org/about-handwashing/history-of-handwashing/>
- Hanley, T., Sefi, A., & Lennie, C. (2011). Practice-based evidence in school-based counselling. *Counselling and Psychotherapy Research*, *11*(4), 300–309. <https://doi.org/10.1080/14733145.2010.533778>
- Haque, A. (2005). Mental health concepts and program development in Malaysia. *Journal of Mental Health*, *14*(2), 183–195.

<https://doi.org/10.1080/09638230500059997>

- Haroz, E. E., Ritchey, M., Bassa, J. K., Kohrt, B. A., Augustinavicius, J., Michalopoulos, L., Burkey, M. D., & Bolton, P. (2017). How is depression experienced around the world? A systematic review of qualitative literature. *Society Science Medicine*, 183, 151–162. <https://doi.org/10.1016/j.physbeh.2017.03.040>
- Hatfield, D. R., & Ogles, B. M. (2007). Why some clinicians use outcome measures, and others do not. *Administration and Policy in Mental Health*, 34(3), 283–291. <https://doi.org/10.1007/s10488-006-0110-y>
- Hazita Azman. (2016). Implementation and challenges of English language education reform in Malaysian primary schools. *3L: The Southeast Asian Journal of English Language Studies*, 22(3), 65–78. <https://doi.org/10.1093/mnras/283.3.L95>
- “Health Facts, 2006.” (2007). *Health facts, 2006*. Ministry of Health Malaysia. http://www.moh.gov.my/images/gallery/stats/heal_fact/health_facts_2006.pdf
- Heath, P. J., Vogel, D. L., & Al-Darmaki, F. R. (2016). Help-Seeking Attitudes of United Arab Emirates Students. *Counselling Psychologist*, 44(3), 331–352. <https://doi.org/10.1177/0011000015621149>
- Hoaglin, D. C., & Iglewicz, B. (1987). Fine-Tuning Some Resistant Rules for Outlier Labeling. *Journal of the American Statistical Association*, 82(400), 1147. <https://doi.org/10.2307/2289392>
- Holzemer, W. L., & Reilly, C. a. (1995). Variables, variability, and variations research: implications for medical informatics. *Journal of the American Medical Informatics Association*, 2(3), 183–190. http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=med3&AN=7614119%5Cnhttp://bf4dv7zn3u.search.serialssolutions.com.myaccess.library.utoronto.ca/?url_ver=Z39.88-2004&rft_val_fmt=info:ofi/fmt:kev:mtx:journal&rft_id=info:sid/Ovid:med3&rft
- Howard, K. I., Kopta, S. M., Krause, M. S., & Orlinsky, D. E. (1986). The dose-effect relationship in psychotherapy. *American Psychologist*, 41, 159–164.
- Howard, K. I., Lueger, R. J., Maling, M. S., & Martinovich, Z. (1993). A phase model of psychotherapy outcome: causal mediation of change. *Journal of Consulting and Clinical Psychology*, 61(4), 678–685. <http://www.ncbi.nlm.nih.gov/pubmed/8370864>
- Huang, M. S. ., & Md Nasir, M. T. (2007). HIV/AIDS health care policy and practice in Malaysia. In H. L. Chee & S. Barraclough (Eds.), *Health Care in Malaysia. The dynamics of provision, financing and access*. (pp. 154–169). Routledge.
- Hubbard, R., & Allen, S. J. (1987). An empirical comparison of alternative methods for principal component extraction. *Journal of Business Research*, 15, 173–190.
- Hutchings, P. S., & Virden, T. B. (2010). Presenting problem, history of presenting

- problem, and social history. In D. Segal & M. Hersen (Eds.), *Diagnostic Interviewing: Fourth Edition*.
- Hutchings, Philinda Smith, & Virden, T. B. (2010). Presenting problem, history of presenting problem, and social history. In D. L. Segal & M. Hersen (Eds.), *Diagnostic Interviewing: Fourth Edition* (Fourth edi, pp. 39–59). Springer Science+ Business Media. https://doi.org/10.1007/978-1-4419-1320-3_3
- Ibrahim, N., Amit, N., Shahar, S., Wee, L. H., Ismail, R., Khairuddin, R., Siau, C. S., & Safien, A. M. (2019). Do depression literacy, mental illness beliefs and stigma influence mental health help-seeking attitude? A cross-sectional study of secondary school and university students from B40 households in Malaysia. *BMC Public Health*, *19*(Suppl 4), 1–8. <https://doi.org/10.1186/s12889-019-6862-6>
- IHI. (2017). *The IHI triple aim initiative*. Institute for Healthcare Improvement. <http://www.ihl.org/engage/initiatives/tripleaim/Pages/default.aspx>
- Ismail, N. I., Abdullah, N. H., & Shamduddin, A. (2015). Adoption of Hospital Information System (HIS) in Malaysian public hospitals. *Procedia - Social and Behavioral Sciences*, *172*(January), 336–343. <https://doi.org/10.1016/j.sbspro.2015.01.373>
- Israel, G. D. (2009). Determining Sample Size. *University of Florida, IFAS Extension, PE0D6*, 1–5. <https://doi.org/10.4039/Ent85108-3>
- Jackson, P. (2012). *Value for money and international development: Deconstructing some myths To promote more constructive discussion*. OECD Development Cooperation Directorate. <http://www.oecd.org/development/effectiveness/49652541.pdf>
- Jacob, S. A., & Furgerson, S. P. (n.d.). The Qualitative Report Writing Interview Protocols and Conducting Interviews: Tips for Students New to the Field of Qualitative Research. In *Number 42 Teaching and Learning* (Vol. 17). Retrieved July 10, 2019, from <http://www.nova.edu/ssss/QR/QR17/jacob.pdf>
- Jacobs, R. (2009). *Investigating Patient Outcome Measures in Mental Health*. CHE Publications. www.york.ac.uk/inst/che/pubs
- Jacobson, N., Follette, W., & Revenstorf, D. (1984). Psychotherapy outcome research: Methods for reporting variability and evaluating clinical significance. *Behaviour Therapy*, *15*, 336–352.
- Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology*, *59*(1), 12–19. <https://doi.org/10.1037/0022-006X.59.1.12>
- Jamayah, H. (2000). Community mental health in Malaysia: Marriage of psychiatry and public health. *Jurnal Kesihatan Masyarakat*, *6*, 155–166. <http://journalarticle.ukm.my/4385/>
- James, S. L., Abate, D., Abate, K. H., Bay, S. M., Abbafati, C., Abbasi, N., Abbastabar,

- H., Abd-Allah, F., Abdela, J., Abdelalim, A., Abdulkader, R., Suliankatchi, Abebe, Z., Abera, S. F., Abil, O. Z., Abraha, H. N., Abu-Raddad, L. J., Abu-Rmeileh, N. M. E., Accrombessi, M. M. K., ... Murray, C. J. L. (2018). Global, regional, and national incidence, prevalence, and years lived with disability for 354 Diseases and Injuries for 195 countries and territories, 1990-2017: A systematic analysis for the Global Burden of Disease Study 2017. *The Lancet*, 392(10159), 1789–1858. [https://doi.org/10.1016/S0140-6736\(18\)32279-7](https://doi.org/10.1016/S0140-6736(18)32279-7)
- Jarrar, M., Minai, M. S., Al-Bsheish, M., Meri, A., & Jaber, M. (2019). Hospital nurse shift length, patient-centred care, and the perceived quality and patient safety. *International Journal of Health Planning and Management*, 34(1), e387–e396. <https://doi.org/10.1002/hpm.2656>
- Jette, U., D., Nelson, L., Palaima, M., & Wetherbee, E. (2014). How Do We Improve Quality in Clinical Education? Examination of Structures, Processes, and Outcomes. *Journal of Physical Therapy Education*, 28, 6–12. <http://search.ebscohost.com/login.aspx?direct=true&db=cin20&AN=2012590092&site=ehost-live>
- Johnson, R. B., & Onwuegbuzie, A. J. (2007). Toward a Definition of Mixed Methods Research. *Journal of Mixed Methods Research*, 1(2), 112–133. <https://doi.org/10.1177/1558689806298224>
- Kahn, J. S. (1998). *Southeast Asian identities: Culture and the politics of representation in Indonesia, Malaysia, Singapore and Thailand*. Institute of Southeast Asian Studies.
- Karademas, E. C. (2009). Counselling psychology in medical settings: The promising rise of counselling health psychology. *The European Journal of Counselling Psychology*, 1(1/2), 18–37. <https://doi.org/10.5964/ejcop.v1i1/2.9>
- Karasek, R. A. (1979). Job demands, job decision latitude and mental strain : Implications for job redesign. *Administrative Science Quarterly*, 24(2), 285–308. <https://www.jstor.org/stable/2392498?seq=1>
- Karim, M. R. A. (1994). Changes and trends in Malaysian public administration: A response to national and international challenges. *Asian Review of Public Administration*, 1–2, 149–150.
- Karyotaki, E., Smit, Y., Holdt Henningsen, K., Huibers, M. J. H., Robays, J., de Beurs, D., & Cuijpers, P. (2016). Combining pharmacotherapy and psychotherapy or monotherapy for major depression? A meta-analysis on the long-term effects. *Journal of Affective Disorders*, 194, 144–152. <https://doi.org/10.1016/j.jad.2016.01.036>
- Kaska, S. C., & Weinstein, J. N. (1998). Historical perspective Ernest Amory Codman, 1869-1940. A pioneer of evidence-based medicine: the end result idea. *Spine*, 23(5), 629–633. <https://doi.org/10.1097/00007632-199803010-0019>
- Kazdin, A. E., & Wilson, G. T. (1978). *Evaluating of behaviour therapy: Issues, evidence, and research strategies*. Bellinger.

- Kelley, S. D., & Bickman, L. (2009). Beyond outcomes monitoring: measurement feedback systems in child and adolescent clinical practice. *Current Opinion in Psychiatry*, 22(4), 363–368. <https://doi.org/10.1097/YCO.0b013e32832c9162>
- Kelly, M., Dowling, M., & Millar, M. (2018). The search for understanding: The role of paradigms. *Nurse Researcher*, 25(4), 9–13. <https://doi.org/10.7748/nr.2018.e1499>
- Kendra, M. S., Mohr, J. J., & Pollard, J. W. (2014). The stigma of having psychological problems: Relations with engagement, working alliance, and depression in psychotherapy. *Psychotherapy (Chicago, Ill.)*, 51(4), 563–573. <https://doi.org/10.1037/a0036586>
- Keynejad, R. C., Hanlon, C., & Howard, L. M. (2020). Psychological interventions for common mental disorders in women experiencing intimate partner violence in low-income and middle-income countries: a systematic review and meta-analysis. *The Lancet. Psychiatry*, 7(2), 173–190. [https://doi.org/10.1016/S2215-0366\(19\)30510-3](https://doi.org/10.1016/S2215-0366(19)30510-3)
- Khan, N. N., Yahya, B., Abu Bakar, A. K., & Ho, R. C. (2015). Malaysian mental health law. *BJPsych International*, 12(2), 40–42. <https://doi.org/10.1192/s2056474000000271>
- Kilbourne, A. M., Beck, K., Spaeth-Rublee, B., Ramanuj, P., O'brien, R. W., Tomoyasu, N., & Pincus, H. A. (2018). Measuring and improving the quality of mental health care: a global perspective. *World Psychiatry*, 17, 30–38. <https://onlinelibrary.wiley.com/doi/pdf/10.1002/wps.20482>
- Kim Teng, A. (2011). Current perspectives in mental health. *3rd Asia Pacific Conference on Public Health*, 732–741. <https://doi.org/10.1111/j.1365-2929.2005.02205.x>
- Kobayashi, H., Takemura, Y., & Kanda, K. (2011). Patient perception of nursing service quality; an applied model of Donabedian's structure-process-outcome approach theory. *Scandinavian Journal of Caring Sciences*, 25(3), 419–425. <https://doi.org/10.1111/j.1471-6712.2010.00836.x>
- Kopta, S. M., Howard, K. I., Lowry, J. L., & Beutler, L. E. (1994). Pattern of symptomatic recovery in psychotherapy. *Journal of Consulting and Clinical Psychology*, 62, 1009–1016.
- Krageloh, C. U., Czuba, K. J., Billington, D. R., Kersten, P., & Siegert, R. J. (2015). Using feedback from patient-reported outcome measures in mental health services: A scoping study and typology. *Psychiatric Services*, 66(3), 224–241. <https://doi.org/10.1176/appi.ps.201400141>
- Kraus, D. R. (2012). The treatment outcome package (TOP). *Integrating Science and Practice*, 2(2), 43–45.
- Kraus, D. R., Boswell, J. F., Wright, A. G. C., Castonguay, L. G., & Pincus, A. L. (2010). Factor structure of the treatment outcome package for children. *Journal of Clinical Psychology*, 66(6), 627–640. <https://doi.org/10.1002/jclp.20675>

- Krishnaswamy, S., Subramaniam, K., Jemain, A. A., Low, W. Y., Ramachandran, P., Indran, T., & Patel, V. (2012). Common mental disorders in Malaysia: Malaysian mental health survey, 2003-2005. *Asia-Pacific Psychiatry*, 4(3), 201–209. <https://doi.org/10.1111/j.1758-5872.2012.00180.x>
- Kuhn, J. E. (2016). Why Measure Outcomes? *Instructional Course Lectures*, 65, 583–586. <http://www.ncbi.nlm.nih.gov/pubmed/27049223>
- Kumari, N. (2011). Personal therapy as a mandatory requirement for counselling psychologists in training: A qualitative study of the impact of therapy on trainees' personal and professional development. *Counselling Psychology Quarterly*, 24(3), 211–232. <https://doi.org/10.1080/09515070903335000>
- Kunen, S., Niederhauser, R., Smith, P. O., Morris, J. A., & Marx, B. D. (2005). Race Disparities in Psychiatric Rates in Emergency Departments. In the *Journal of Consulting and Clinical Psychology* (Vol. 73, Issue 1, pp. 116–126). American Psychological Association. <https://doi.org/10.1037/0022-006X.73.1.116>
- Kunkel, S., Rosenqvist, U., & Westerling, R. (2007). The structure of quality systems is important to the process and outcome, an empirical study of 386 hospital departments in Sweden. *BMC Health Services Research*, 7, 104. <https://doi.org/10.1186/1472-6963-7-104>
- Lakeman, R. (2004). Standardized routine outcome measurement : Potholes in the road to recovery. *International Journal of Mental Health Nursing*, 13, 210–215.
- Lambert, M. J. (2010). Outcome Questionnaire System (The OQ System): Development and practical applications in healthcare settings. In M Barkham, G. Hardy, & J. Mellor-Clark (Eds.), *Developing and Delivering Practice-based Evidence* (pp. 141–154). Wiley-Blackwell. [http://books.google.com/books?hl=en&lr=&id=IeiNqsw2khIC&oi=fnd&pg=PT167&dq=Outcome+questionnaire+system+\(the+OQ+System\):+Development+and+practical+applications+in+healthcare+settings&ots=XazWCA2DQg&sig=kW2FH3a7baoVQnAgTiScpLtWA_4](http://books.google.com/books?hl=en&lr=&id=IeiNqsw2khIC&oi=fnd&pg=PT167&dq=Outcome+questionnaire+system+(the+OQ+System):+Development+and+practical+applications+in+healthcare+settings&ots=XazWCA2DQg&sig=kW2FH3a7baoVQnAgTiScpLtWA_4)
- Lambert, M. J., Hansen, N. B., & Finch, A. E. (2001). Patient-focused research: Using patient outcome data to enhance treatment effects. *Journal of Consulting and Clinical Psychology*, 69(2), 150–172.
- Larsen, D., Edey, W., & Lemay, L. (2007). Understanding the role of hope in counselling: Exploring the intentional uses of hope. *Counselling Psychology Quarterly*, 20(4), 401–416. <http://ezproxy.um.edu.my:2664/ehost/pdfviewer/pdfviewer?vid=8&sid=63fc2f44-0852-48f2-89aa-b0ec8386f803%40sessionmgr4007&hid=4112>
- Layard, R. (2005). *Mental health: Britain's biggest social problem?* LSE Research Online. http://eprints.lse.ac.uk/47428/1/_Libfile_repository_Content_Layard_Mental_health_Britain's_biggest_social_problem%28lsero%29_Mental_health%28lsero%29.pdf
- Leach, C. (2005). Assessing risk and emotional disturbance using the CORE-OM and

- HoNOS outcome measures at the interface between primary and secondary mental healthcare. *Psychiatric Bulletin*, 29(11), 419–422. <https://doi.org/10.1192/pb.29.11.419>
- Leach, Chris, & Lutz, W. (2010). Constructing and disseminating outcome data at the service level: Case tracking and benchmarking. In Michael Barkham, G. E. Hardy, & J. Mellor-Clark (Eds.), *Developing and delivering practice-based evidence* (p. 257283). Wiley -Blackwell. <https://doi.org/10.1002/9780470687994>
- Lee, S. (1912). *Nightingale, Florence Dictionary of National Biography* (S. Lee (Ed.)). Smith, Elder & Co. https://en.wikipedia.org/wiki/Florence_Nightingale
- LePINE, J. A., PICCOLO, R. F., JACKSON, C. L., MATHIEU, J. E., & SAUL, J. R. (2008). A META-ANALYSIS OF TEAMWORK PROCESSES: TESTS OF A MULTIDIMENSIONAL MODEL AND RELATIONSHIPS WITH TEAM EFFECTIVENESS CRITERIA. *Personnel Psychology*, 61(2), 273–307. <https://doi.org/10.1111/j.1744-6570.2008.00114.x>
- Leshem, S., & Trafford, V. (2007). Overlooking the conceptual framework. *Innovations in Education and Teaching International*, 44(1), 93–105. <https://doi.org/10.1080/14703290601081407>
- “List Randomizer.” (2018). *List Randomizer*. Random.Org. <https://www.random.org/lists/>
- Liu, S. W., Singer, S. J., Sun, B. C., & Camargo, C. a. (2011). A conceptual model for assessing the quality of care for patients boarding in the emergency department: structure-process-outcome. *Academic Emergency Medicine : Official Journal of the Society for Academic Emergency Medicine*, 18(4), 430–435. <https://doi.org/10.1111/j.1553-2712.2011.01033.x>
- Lloyd, C. E. M., Duncan, C., & Cooper, M. (2019). Goal measures for psychotherapy: A systematic review of self-report, idiographic instruments. *Clinical Psychology: Science and Practice*, 26(3). <https://doi.org/10.1111/cpsp.12281>
- Lohr, K. N. (1988). Outcome measurement: concepts and questions. *Inquiry*, 25(1), 37–50. <http://www.ncbi.nlm.nih.gov/pubmed/2966125>
- Lokkerbol, J., Adema, D., Cuijpers, P., Reynolds, C. F., Schulz, R., Weehuizen, R., & Smit, F. (2014). Improving the cost-effectiveness of a healthcare system for depressive disorders by implementing telemedicine: A health economic modelling study. *American Journal of Geriatric Psychiatry*, 22(3), 253–262. <https://doi.org/10.1016/j.jagp.2013.01.058>
- Lopes, M. A., Almeida, Á. S., & Almada-Lobo, B. (2015). Handling healthcare workforce planning with care: Where do we stand? *Human Resources for Health*, 13(1), 1–28. <https://doi.org/10.1186/s12960-015-0028-0>
- Lueger, R. J. (2012). The Integra / COMPASS tracking assessment system. *Integrating Science and Practice*, 2(2), 20–23. http://www.ordrepsy.qc.ca/pdf/2012_11_01_Integrating_SandP_Dossier_04_Lueger_En.pdf

- Lueger, R. J., & Barkham, M. (2010). Using benchmarks and benchmarking to improve the quality of practice and services. In Michael Barkham, G. Hardy, & J. Mellor-Clark (Eds.), *Developing and delivering practice-based evidence* (pp. 223–256). Wiley -Blackwell. <https://doi.org/10.1002/9780470687994>
- Lunsford, T., & Lunsford, B. (1995). The research sample, part II: sample size. *JPO: Journal of Prosthetics and Orthotics*, 7(4), 137–141. <http://scholar.google.com/scholar?hl=en&btnG=Search&q=intitle:The+research+sample,+Part+II+Sample+size#0>
- Lynch, L., Long, M., & Moorhead, A. (2018). Young men, help-seeking, and mental health services: Exploring barriers and solutions. *American Journal of Men's Health*, 12(1), 138–149. <https://doi.org/10.1177/1557988315619469>
- Lyne, K. J., Barrett, P., Evans, C., & Barkham, M. (2006). Dimensions of variation on the CORE-OM. *British Journal of Clinical Psychology*, 45(2), 185–203. <https://doi.org/10.1348/014466505X39106>
- Mackenzie, N., & Knipe, S. (2006). Research dilemmas: Paradigms, methods and methodology. *Issues in Educational Research*, 16(2), 1–10. <https://doi.org/Retrieved from ERIC>
- Mackinnon, D., & Dwyer, J. (1993). Estimating mediated effects in prevention studies. *Evaluation Review*, 17(2), 144–158. <https://doi.org/10.1177/0193841X9301700202>
- Malaysian Healthcare Performance Unit. (2017). Malaysian mental healthcare performance: Technical report 2016. In the *Ministry of Health Malaysia*. [http://www.mjpsychiatry.org/index.php/mjp/article/viewFile/147/122%0Afile:///C:/Users/Prof Muhaya/Downloads/147-530-1-PB.pdf](http://www.mjpsychiatry.org/index.php/mjp/article/viewFile/147/122%0Afile:///C:/Users/Prof%20Muhaya/Downloads/147-530-1-PB.pdf)
- Malikiosi-Loizos, M. (2013). Personal Therapy for Future Therapists: Reflections on a Still Debated Issue. *The European Journal of Counselling Psychology*, 2(1), 33–50. <https://doi.org/10.5964/ejcop.v2i1.4>
- MAMPU. (2017). *Number of clients receiving treatment from counselling psychology service in government hospital in 2017*. MAMPU. http://www.data.gov.my/data/ms_MY/dataset/bilangan-klien-mendapatkan-perkhidmatan-psikologi-dan-kaunseling-di-hospital-kerajaan-tahun-2017/resource/d1f54c6d-044a-4b4d-85af-b18067af2f05
- Mant, J. (2001). Process versus outcome indicators in the assessment of the quality of health care. *International Journal for Quality in Health Care*, 13(6), 475–480. <http://www.ncbi.nlm.nih.gov/pubmed/11769750>
- Margison, F. R. (2000). Measurement and psychotherapy: Evidence-based practice and practice-based evidence. *The British Journal of Psychiatry*, 177(2), 123–130. <https://doi.org/10.1192/bjp.177.2.123>
- Marret, M. J., & Choo, W. Y. (2017). Factors associated with online victimisation among Malaysian adolescents who use social networking sites: a cross-sectional study. *BMJ Open*, 7(6), e014959. <https://doi.org/10.1136/bmjopen-2016-014959>

- Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job Burnout. *Annual Review of Psychology*, 52(1), 397–422. <https://doi.org/10.1146/annurev.psych.52.1.397>
- Mason, B. J., Goodman, A. M., Chabac, S., & Lehert, P. (2014). Effect of oral acamprosate on abstinence in patients with alcohol dependence in a double-blind, placebo-controlled trial: The role of patient motivation. *Journal of Psychiatric Research*, 40(5), 383–393. <https://doi.org/10.1016/j.jpsychires.2006.02.002>
- Masse, R. (2000). Qualitative and quantitative analyses of psychological distress: Methodological complementarity and oncological incommensurability. *Qualitative Health Research*, 10, 411–423.
- Masuda, A., & Wendell, J. W. (2010). Mindfulness mediates the relation between disordered eating-related cognitions and psychological distress. *Eating Behaviors*, 11(4), 293–296. <https://doi.org/10.1016/j.eatbeh.2010.07.001>
- Mavissakalian, M. (1986). Clinically significant improvement in agoraphobia research. *Behaviour Research and Therapy*, 24, 369–370.
- Maxwell, J. A. (1996). *Qualitative research design: an interactive approach*. Sage.
- Mazlan, N. H., & Ahmad, A. (2014). Validation of the Malay-translated version of the Center for Epidemiological Study- Depression Scale (CES-D). *ASEAN Journal of Psychiatry*, 15(June), 54–65. <http://www.aseanjournalofpsychiatry.org/index.php/aseanjournalofpsychiatry/article/viewFile/210/144>
- Mazranouzouli, I., Brazier, J. E., Rowen, D., & Barkham, M. (2013). Estimating a preference-based index from the clinical outcomes in routine evaluation–outcome measure (CORE-OM). *Medical Decision Making*, 33(3), 381–395. <https://doi.org/https://dx.doi.org/10.1177%2F0272989X12464431>
- McCallum, M., Piper, W. E., Ogradniczuk, J. S., & Joyce, A. S. (2003). Relationships among psychological mindedness, alexithymia and outcome in four forms of short-term psychotherapy. *Psychology and Psychotherapy*, 76(Pt 2), 133–144. <https://doi.org/10.1348/147608303765951177>
- McCormack, H. M., MacIntyre, T. E., O’Shea, D., Herring, M. P., & Campbell, M. J. (2018). The Prevalence and Cause(s) of Burnout Among Applied Psychologists: A Systematic Review. *Frontiers in Psychology*, 9, 1897. <https://doi.org/10.3389/FPSYG.2018.01897>
- McQuestion, M. J. (2006). *Quality of care*. Johns Hopkins Bloomberg School of Public Health; Johns Hopkins University. <http://ocw.jhsph.edu/courses/immunizationPrograms/PDFs/Lecture7.pdf>
- Meier, S. T., & Davis, S. R. (2019). *The elements of counselling* (8th Editio). Waveland. https://books.google.com.my/books?hl=en&lr=&id=ECuODwAAQBAJ&oi=fnd&pg=PR1&dq=counsellor+follow+client+or+client+follow+the+counsellor%3F&ots=TEwWs4s-MG&sig=ZQ9alPo4EuYKDHSxsri7PsrauvY&redir_esc=y#v=onepage&q=cou

nsellor follow client or client follow the c

- Mellor-Clark, J., & Barkham, M. (2012). Using the CORE system to support service quality development. In C. Feltham & I. Horton (Eds.), *The Sage Handbook of Counselling and Psychotherapy* (Third, pp. 210–227). Sage.
- Mellor-clark, J., Jenkins, A. C., Evans, R., Mothersole, G., & Mcinnes, B. (2006). Resourcing a CORE network to develop a national research database to help enhance psychological therapy and counselling service provision. *Counselling and Psychotherapy Research*, 6(march), 16–22. <https://doi.org/10.1080/14733140600581242>
- Mellor-Clark, John, Twigg, E., Farrell, E., & Kinder, A. (2012). Benchmarking key service quality indicators in UK Employee Assistance Programme Counselling: A CORE System data profile. *Counselling and Psychotherapy Research*, 13(1), 1–10. <https://doi.org/10.1080/14733145.2012.728235>
- Mental Health Act 2001, Pub. L. No. Act 615 (2001). file:///C:/Users/Prof Muhaya/Downloads/mental health act 2001 (1).pdf
- “Mental Health Atlas.” (2014). *Mental health atlas country profile: Malaysia*. World Health Organization. http://www.who.int/mental_health/evidence/atlas/profiles-2014/mys.pdf
- Mental Health Commission. (2013). *Quality management framework: Information for community managed organisations* (Issue February 2013). <https://www.mhc.wa.gov.au/media/1665/qmf-info-for-cmos-final.pdf>
- MHSR, & Harvard. (2016). *Malaysia health systems research Vol 1: Contextual analysis of the Malaysian Health System: Vol. I* (Issue March). http://www.moh.gov.my/moh/resources/Vol_1_MHSR_Contextual_Analysis_2016.pdf
- Minami, T., Serlin, R. C., Wampold, B. E., Kircher, J. C., & Brown, G. S. (2008). Using clinical trials to benchmark effects produced in clinical practice. *Quality and Quantity*, 42(4), 513–525. <https://doi.org/10.1007/s11135-006-9057-z>
- Ministry of Health. (2016). Specialty & subspecialty framework of the Ministry of Health Hospitals under the 11th Malaysia Plan (2016-2020). In Medical Development Division. MOH Malaysia (Ed.), *Medical Development Division Ministry of Health Malaysia* (Vol. 16, Issue November 2016). http://www.moh.gov.my/penerbitan/Pelan_Strategik_Bahagian_Perkembangan_Perubatan.pdf
- Ministry of Health Malaysia. (2018). *Ministry of Health Annual Report 2017*. <https://doi.org/10.1360/zd-2013-43-6-1064>
- Mitchell, P. (1998). Quality health outcomes model. *Journal of Nursing ...*, 30(1), 43–46. <http://onlinelibrary.wiley.com/doi/10.1111/j.1547-5069.1998.tb01234.x/pdf>
- MOH. (2015). One-stop crisis centre: Policy and guidelines for hospitals, Ministry of Health Malaysian. In *Ministry of Health, Malaysia*. The Ministry of Health

- Malaysia. file:///C:/Users/Prof Muhaya/Downloads/OSCC_policy (2).pdf
- MOH. (2020). *Ministry of Health psychology officer management system*. KMS Management System. <http://kms.moh.gov.my/v3>
- Mohamad, M. (1991). *Malaysian : The way forward (Vision2020)*. Economic Planning Unit in the Prime Minister's Department, Malaysia. <http://unpan1.un.org/intradoc/groups/public/documents/apcity/unpan003223.pdf>
- Mohler, P., Dorer, B., Jong, J. De, & Hu, M. (2017). *Translation : Overview. August 2016*, 233–377.
- Moore, L., Lavoie, A., Bourgeois, G., & Lapointe, J. (2015). Donabedian's structure-process-outcome quality of care model. *Journal of Trauma and Acute Care Surgery*, 78(6), 1168–1175. <https://doi.org/10.1097/TA.0000000000000663>
- Morse, G., Salyers, M. P., Rollins, A. L., Monroe-DeVita, M., & Pfahler, C. (2012). Burnout in mental health services: A review of the problem and its remediation. *Administration and Policy in Mental Health*, 39(5), 341–352. <https://doi.org/10.1007/s10488-011-0352-1>. Burnout
- Morse, J. M. (1991). Approaches to qualitative-quantitative triangulation. *Nursing Research*, 40(2), 120–123. <https://scholar.google.com/scholar?q=MORSE JANICE M. RN PhD %28Nursing%29 PHD %28Anthropology%29 Nursing Research%3A March-April 1991 - Volume 40 - Issue 2 - ppg 120-123>
- Morse, J. M., & Niehaus, J. (2009). *Mixed method design: Principles and procedures*. Left Coast Press. https://www.crcpress.com/rsc/downloads/9781598742978_chapter_2_final.pdf
- MSQH. (2010). *Hospital accreditation standards 3 rd edition : Philosophy, process and assessment*. 1–36. <http://www.amdi.usm.edu.my/Portals/37/Users/Nota Kursus PBBF 2010/Malaysia Accreditation Standards.pdf>
- MSQH. (2012). Service Standard 17 I: Allied health professional services – Counselling psychology services. In *Malaysian Hospital Accreditation Standards* (4th Editio, Issue January, pp. 1–7). MSQH. <http://www.msqh.com.my/web/images/downloads/S17I.pdf>
- MSQH. (2016). *About MSQH*. Malaysian Society for Quality in Health. <http://www.msqh.com.my/home/2-uncategorised/5-who-are-we>
- MSQH. (2017). Service Standard 17 I: Allied health professional services – Counselling psychology services Title. In *Malaysian Hospital Accreditation Standards* (5th Editio).
- Mukhtar, F., & Oei, T. P. S. (2011). A review of assessment and treatment for depression in Malaysia. *Depression Research and Treatment*, 2011, 1–8. <https://doi.org/10.1155/2011/123642>
- Mullan, F. (2001). A Founder of Quality Assessment Encounters A Troubled System Firsthand. *Health Affairs*, 20(1), 137–141.

<https://doi.org/10.1377/hlthaff.20.1.137>

- Mullin, T., Barkham, M., Mothersole, G., Bewick, B. M., & Kinder, A. (2006). Recovery and improvement benchmarks for counselling and the psychological therapies in routine primary care. *Counselling and Psychotherapy Research*, 6(Special Issue 1), 68–80. <https://doi.org/10.1080/14733140600581515>
- Murray, R. B., & Huelskoetter, M. M. . (1987). *Psychiatric and mental health nursing: Giving emotional care*. Appleton & Lange : US. <http://www.abebooks.com/servlet/BookDetailsPL?bi=12505567680&searchurl=an%3Dmurray%2Bruth%2Bbeckman%2Bhuelskoetter%2Bm%2Bmarilyn%2Bwilson>
- Mynors-Wallis, L., Gath, D., Day, A., & Baker, F. (2000). Randomised controlled trial of problem solving treatment, antidepressant medication, and combined treatment for major depression in primary care. *BMJ*, 320, 26–30. <http://www.bmj.com/content/320/7226/26.pdf%2Bhtml>
- National Quality Board. (2013). *Quality in the new health system - maintaining and improving quality from April 2013* (Issue January). https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213304/Final-NQB-report-v4-160113.pdf
- Naylor, C. D. (1995). Grey zones of clinical practice: Some limits to evidence-based medicine. *Lancet*, 345, 840–842.
- Needham & Vaske. (2008). Survey Implementation, Sampling, and Weighting Data. In *Survey Research and Analysis : Application in Parks, Recreation and Human dimensions* (p. 50).
- Ng, C. G. (2013). Review of depression research in Malaysia. *The Medical Journal of Malaysia*, 69(Supplement A), 42–45. https://umexpert.um.edu.my/file/publication/00000737_113254.pdf
- Ng, W. S. (2007). Psychotherapy in Malaysia. *Mental Health and Learning Disabilities Research and Practice*, 4(2), 206–218.
- NHS England. (2015). *Improving access to psychological therapies (IAPT) waiting times guidance and FAQ's*. NHS England. <https://doi.org/03057>
- Nietzel, M. T., & Trull, T. J. (1988). Meta-analytic approaches to social comparisons: A method for measuring clinical significance. *Behavioural Assessment*, 10, 146–159.
- NMRR. (2006). *National medical research registry*. NMRR. https://www.nmrr.gov.my/fwbPage.jsp?fwbPageId=NMRR_AboutNmrr
- Noble, J. (2015). Exploring the effective length of therapy in a healthcare organisation. *Counselling Psychology Review*, 30(4), 57–65. <http://ezproxy.um.edu.my:2664/ehost/pdfviewer/pdfviewer?vid=8&sid=63fc2f44-0852-48f2-89aa-b0ec8386f803%40sessionmgr4007&hid=4112>

- Noiseux, S., Tribble St-Cyr, D., Corin, E., St-Hilaire, P.-L., Morissette, R., Leclerc, C., Fleury, D., Vigneault, L., & Gagnier, F. (2010). The process of recovery of people with mental illness: The perspectives of patients, family members and care providers: Part 1. *BMC Health Services Research*, *10*(1), 161. <https://doi.org/10.1186/1472-6963-10-161>
- Noor Hazilah Abdul Manaf. (2009). Practice follows the structure: QM in Malaysian public hospitals. *Measuring Business Excellence*, *13*(1), 23–33. <https://doi.org/10.1108/13683040910943027>
- Noor Hazilah Abdul Manaf. (2012). Inpatient satisfaction: an analysis of Malaysian public hospitals. *International Journal of Public Sector Management*, *25*(1), 6–16. <https://doi.org/10.1108/09513551211200258>
- Norcross, J. C., Beutler, L. E., & Goldfried, M. R. (2019). Cognitive-behavioural therapy and psychotherapy integration. In K. S. Dobson & D. J. A. Dozois (Eds.), *Handbook of cognitive-behavioural therapies* (Fourth edition, p. 346). Guildford Press.
- O'Connor, K., Muller Neff, D., & Pitman, S. (2018). Burnout in mental health professionals: A systematic review and meta-analysis of prevalence and determinants. *European Psychiatry*, *53*, 74–99. <https://doi.org/10.1016/j.eurpsy.2018.06.003>
- O'Reilly, A., Peiper, N., O'Keeffe, L., Illback, R., & Clayton, R. (2016). Performance of the CORE-10 and YP-CORE measures in a sample of youth engaging with a community mental health service. *International Journal of Methods in Psychiatric Research*, *25*(4), 324–332. <https://doi.org/10.1002/mpr.1500>
- Ogunlayi, F., & Britton, P. (2017). Achieving a 'top-down' change agenda by driving and supporting a collaborative 'bottom-up' process: a case study of a large-scale enhanced recovery programme. *BMJ Open Quality*, *6*(2). <https://doi.org/10.1136/bmjoq-2017-000008>
- Ong, D., Moors, T., & Sivaraman, V. (2012). Comparison of the energy, carbon and time costs of video conferencing and in-person meeting. *IEEE GreenCom Conference Proceedings*. <http://www2.ee.unsw.edu.au/~vijay/pubs/jrnl/14comcomVC.pdf>
- Ozcan, S., Taranto, Y., & Hornby, P. (1995). Shaping the health future in Turkey: A new role for human resource planning. *International Planning Management*, *10*(4), 305–319. <https://onlinelibrary.wiley.com/doi/pdf/10.1002/hpm.4740100406>
- Pallant, J. (2013). *SPSS survival manual* (5th editio). Open University Press.
- Pargament, K., Koenig, H. G., Tarakeshwar, N., & Hahn, J. (2004). Religious coping methods predictors of psychological, physical and spiritual outcomes among medically ill patients: A two-year longitudinal study. *Journal of Health Psychology*, *9*(6), 713–730. <https://doi.org/10.1177/1359105304045366>
- Parry, G. (1992). Improving psychotherapy services: Applications of research, audit

and evaluation. *British Journal of Clinical Psychology*, 31(1), 3–19.
<https://doi.org/10.1111/j.2044-8260.1992.tb00964.x>

Patteson, L. W., & Welfel, E. R. (2005). *The counselling process: A multitheoretical integrative approach* (6th Editio). Cengage.
<https://www.cengage.co.uk/books/9780534640323/>

Paul, K. E., & Van Ommeren, M. (2013). A primer on single session therapy and its potential application in humanitarian situations. *Intervention*, 11(1), 8–23.
<https://doi.org/10.1097/WTF.0b013e32835f7d1a>

Peiters, H. C., & Heilemann, M. V. (2010). “I can’t do it on my own”: Motivation to enter therapy for depression among low income, second-generation Latinas. *Issues Men Health Nurs*, 31(4), 279–287.
<https://doi.org/10.3109/01612840903308549>

Periasamy, U., Mohd Sidik, S., Rampal, L., Fadhilah, S. M., Akhtari-Zavare, M., & Mahmud, R. (2017). Effect of chemotherapy counselling by pharmacists on quality of life and psychological outcomes of oncology patients in Malaysia: a randomized control trial. *Health and Quality of Life Outcomes*, 15(1), 104.
<https://doi.org/10.1186/s12955-017-0680-2>

Pirkis, J., Burgess, P., Coombs, T., Clarke, A., Jones-Ellis, D., & Dickson, R. (2005). Routine measurement of outcomes in Australia’s public sector mental health services. *Australia and New Zealand Health Policy*, 2(1), 8.
<https://doi.org/10.1186/1743-8462-2-8>

Polit, D. F., & Beck, C. T. (2012). *Nursing research: Generating and assessing evidence for nursing practice* (9th Editio). Lippincott Williams & Wilken.
[https://www.scirp.org/\(S\(i43dyn45teexjx455qlt3d2q\)\)/reference/ReferencesPapers.aspx?ReferenceID=1596228](https://www.scirp.org/(S(i43dyn45teexjx455qlt3d2q))/reference/ReferencesPapers.aspx?ReferenceID=1596228)

Psychological Counselling Services. (2018a). *Operational management plan: Psychological counselling services*. Allied Health Division, Ministry of Health, Malaysia.

Psychological Counselling Services. (2018b). *Standard operating procedures: Service for individual counselling*. Allied Health Division, Ministry of Health, Malaysia.

Psychology counselling unit. (2016). *Psychology counselling unit*. Hospital Kuala Lumpur, Ministry of Health Malaysia.
<http://www.hkl.gov.my/index.php/services/support?id=190>

Psychology Officer S41. (2015). *Psychology officer S41*. Suruhanjaya Perkhidmatan Awam Malaysia. http://www.spa.gov.my/Portal/Deskripsi_Tugas/Ijazah/1152

Public Service Department. (2007). *Public service circular no.29/2007: Change of counsellor and counsellor assistance service scheme to psychology officer and assistant psychology officer service schemes*. (JPA(BPO)(S)328/2Klt.2(29)).
<http://www.jpa.gov.my/pekeliling/pp07/bil29/pp2907.pdf>

Public Service Department. (2009). *Public service circular letter no. 12/ 2009:*

Achievement work culture is preferred.
<http://docs.jpa.gov.my/docs/spp/2009/spp122009.pdf>

- Public Service Department Malaysia. (1998). *Public service circular letter no.4/1998: Guideline on managing low performing and troubled officers*. Public Service Department Malaysia. <http://www.civildefence.gov.my/wp-content/uploads/2015/06/008.pdf>
- Public Service Department Malaysia. (1999). *Public service circular no.1/1999: Guideline to the setting up of counselling services in a public agency*. http://www.eghrmis.gov.my/wp_content2/pekeliling/PP99/PP99Bil01/PP99Bil01.htm
- Puteri Nor Ariane Yasmin. (2019). *A powerful portrayal of mental illness*. New Straits Times. <https://www.nst.com.my/opinion/columnists/2019/10/528470/powerful-portrayal-mental-illness>
- Rademakers, J., Delnoij, D., & de Boer, D. (2011). Structure, process or outcome: which contributes most to patients' overall assessment of healthcare quality? *BMJ Quality & Safety*, 20(4), 326–331. <https://doi.org/10.1136/bmjqs.2010.042358>
- Rai, S., & Mathew, K. J. (2015). Psychological mindedness : An overview. *Indian Journal of Positive Psychology*, 6(1), 127–132. <https://www.questia.com/library/journal/1P3-3655877691/psychological-mindedness-an-overview>
- Rajagopal, M. (2013). Counselling: A misunderstood profession. *IOSR Journal of Humanities and Social Science (IOSR-JHSS)*, 11(3), 30–37. <http://www.iosrjournals.org/iosr-jhss/papers/Vol11-issue3/F01133037.pdf>
- Rajaram, N., Lim, Z. Y., Song, C. V., Kaur, R., Mohd Taib, N. A., Muhamad, M., Ong, W. L., Schouwenburg, M., See, M. H., Teo, S.-H., Saunders, C., & Yip, C. H. (2019). Patient-reported outcome measures among breast cancer survivors: A cross-sectional comparison between Malaysia and high-income countries. *Psycho-Oncology*, 28(1), 147–153. <https://doi.org/10.1002/pon.4924>
- Rakin, E. (2018). *Mental health issues in Malaysia are set to worsen in the coming years - here's what you can do to prevent it*. Business Insider. <https://www.businessinsider.my/mental-health-issues-in-malaysia-are-set-to-worsen-in-the-coming-years-heres-what-you-can-do-to-prevent-it/>
- Reese, R. J., Duncan, B. L., Bohanske, R. T., Owen, J. J., & Minami, T. (2014). Benchmarking outcomes in a public behavioural health setting: Feedback as a quality improvement strategy. *Journal of Consulting and Clinical Psychology*, 83(4), 731–742. <https://doi.org/10.1037/a0036915>
- Revere, L., Black, K., & Huq, A. (2004). Integrating Six Sigma and CQI for improving patient care. *The TQM Magazine*, 16(2), 105–113. <https://doi.org/10.1108/09544780410522991>
- Richards, K. (2011). What makes juvenile offenders different from adult offenders? *Trends and Issues in Crime and Criminal Justice*, 409.

http://www.aic.gov.au/media_library/publications/tandi_pdf/tandi409.pdf

- Ridner, S. H. (2004). Psychological distress: concept analysis. *Journal of Advanced Nursing*, 45(5), 536–545. <http://www.ncbi.nlm.nih.gov/pubmed/15009358>
- Ritchie, H., & Roser, M. (2018). *Mental health*. Our World in Data. <https://ourworldindata.org/mental-health>
- Robertfroid, D., Leonard, C., & Stordeur, S. (2009). Physician supply forecast: better than peeing in crystal ball. *Human Resources for Health*, 7, 10. <https://doi.org/https://doi.org/10.1186/1478-4491-7-10>
- Rodda, S., Lubman, D., & Dowling, N. (2015). *Online counselling for problem gambling*. AGRC Fact Sheets. <https://aifs.gov.au/agrc/publications/online-counselling-problem-gambling>
- Rohland, B. M. (2000). A survey of burnout among health directors in a rural state. *Administration and Policy in Mental Health and Mental Health Services Research*, 27, 221–237. <https://link.springer.com/article/10.1023%2FA%3A1021361419155>
- Rössler, W. (2006). Psychiatric rehabilitation today: an overview. *World Psychiatry : Official Journal of the World Psychiatric Association (WPA)*, 5(3), 151–157. <http://www.ncbi.nlm.nih.gov/pubmed/17139342>
- Rupert, P. A., & Morgan, D. J. (2005). Work setting and burnout among professional psychologists. *Professional Psychology: Research and Practice*, 36(5), 544–550. <https://doi.org/10.1037/0735-7028.36.5.544>
- Ryan, R. M., & Deci, E. L. (2001). On happiness and human potentia: A review of research on hedonic and eudaimonic well-being. *Annual Review of Psychology*, 52, 141–166.
- Ryan, R. M., Lynch, M. F., Vansteenkiste, M., & Deci, E. L. (2010). Motivation and Autonomy in Counseling, Psychotherapy, and Behavior Change: A Look at Theory and Practice. *The Counseling Psychologist*, 39(2), 193–260. <https://doi.org/10.1177/0011000009359313>
- Saudah Mat Akhir. (2016). *Overview of health facility planning in Ministry of Health. National 5 Year Development Plan 2016-2020 (11th Malaysia Plan) : Ministry of Health Malaysia.* file:///C:/Users/Prof Muhaya/Downloads/1_Overview_of_Health_Facility_Planning_in_MOH_-_Dr_.Saudah_(1).pdf
- Schneider, J. W., Gurucharri, L. M., Gutierrez, A. L., & Gaebler-Spira, D. J. (2007). Health-related quality of life and functional outcome measures for children with cerebral palsy. *Developmental Medicine & Child Neurology*, 43(9), 601–608. <https://doi.org/10.1111/j.1469-8749.2001.tb00242.x>
- Schoonenboom, J., & Johnson, R. B. (2017). How to Construct a Mixed Methods Research Design. *Kolner Zeitschrift Fur Soziologie Und Sozialpsychologie*, 69(Suppl 2), 107–131. <https://doi.org/10.1007/s11577-017-0454-1>

- Selye, H. (1956). *Stress of life*. McGraw-Hill Book Company.
- Selye, H. (1974). *Stress without distress*. J.B. Lippincott Co.
- Sethi, D., Aljunid, S., & Saperi, S. (2002). Comparison of the effectiveness of major trauma services provided by tertiary and secondary hospitals in Malaysia. *Journal of Trauma- ...*, 53(3), 508–516. http://journals.lww.com/jtrauma/Abstract/2002/09000/Comparison_of_the_Effectiveness_of_Major_Trauma.19.aspx
- Sharma, G. (2015). *Psychological assessment standardization*. <https://www.slideshare.net/DrGireesha123/psychological-assessment-standardization-evaluation-etc>
- Shoosmith, W. D., Borhanuddin, A. F., Yong, P. L. P., Abdullah, A. F., Nordin, N., Giridharan, B., Forman, D., & Fyfe, S. (2018). Reactions to symptoms of mental disorder and help-seeking in Sabah, Malaysia. *International Journal of Social Psychiatry*, 64(1), 49–55. <https://doi.org/10.1177/0020764017739643>
- Sinclair, A., Barkham, M., Evans, C., Connell, J., & Audin, K. (2005). Rationale and development of a general population well-being measure: Psychometric status of the GP-CORE in a student sample. *British Journal of Guidance & Counselling*, 33, 153–174.
- Skre, I., Friborg, O., Elgarøy, S., Evans, C., Myklebust, L. H., Lillevoll, K., Sørgaard, K., & Hansen, V. (2013). The factor structure and psychometric properties of the Clinical Outcomes in Routine Evaluation--Outcome Measure (CORE-OM) in Norwegian clinical and non-clinical samples. *BMC Psychiatry*, 13(1), 99. <https://doi.org/10.1186/1471-244X-13-99>
- Slade, M. (2002). What outcomes to measure in routine mental health services, and how to assess them: a systematic review. *Australian and New Zealand Journal of Psychiatry*, 36(6), 743–753. <https://doi.org/10.1046/j.1440-1614.2002.01099.x>
- Slade, M., McCrone, P., Kuipers, E., Leese, M., Cahill, S., Parabiaghi, A., Priebe, S., & Thornicroft, G. (2006). Use of standardised outcome measures in adult mental health services: randomised controlled trial. *The British Journal of Psychiatry: The Journal of Mental Science*, 189, 330–336. <https://doi.org/10.1192/bjp.bp.105.015412>
- Slive, A., & Bobele, M. (2012). Walk-In Counselling Services: Making the Most of One Hour. *Australian and New Zealand Journal of Family Therapy*, 33(01), 27–38. <https://doi.org/10.1017/aft.2012.4>
- Solberg, L. I., Fischer, L. R., Wei, F., Rush, W. A., Conboy, K. S., Davis, T. F., & Heinrich, R. L. (2001). A CQI interventions to change the care of depression : A controlled study. *Evaluation Studies*, 4(6), 239–249. <https://www.ncbi.nlm.nih.gov/pubmed/11769296>
- Steinbrook, R. (2006). Private healthcare in Canada. *North England Journal of Medicine*, 354(16), 1661–1664. <https://doi.org/10.1056/NEJMp068064>

- Steinskog, D. J., Tjøstheim, D. B., Kvamstø, N. G., Steinskog, D. J., Tjøstheim, D. B., & Kvamstø, N. G. (2007). A cautionary note on the use of the Kolmogorov–Smirnov test for normality. *Monthly Weather Review*, *135*(3), 1151–1157. <https://doi.org/10.1175/MWR3326.1>
- Stewart, M. (2009). Service user and significant other versions of the Health of the Nation Outcome Scales. *Australasian Psychiatry: Bulletin of Royal Australian and New Zealand College of Psychiatrists*, *17*(2), 156–163. <https://doi.org/10.1080/10398560802596116>
- Sue, D. W., Sue, D., Neville, H. A., & Smith, L. (2019). Counseling the culturally diverse: Theory and practice, 4th ed. In Eight Edition (Ed.), Wiley. Wiley. <https://doi.org/10.1176/appi.ajp.161.6.1137-a>
- Swisher, A. K. (2010). Practice-based evidence. *Cardiopulmonary Physical Therapy Journal*, *21*(2), 4. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2879420/pdf/cptj0021-0004.pdf>
- Tankard, M. E., & Paluck, E. L. (2016). Norm perception as a vehicle for social change. *Social Issues and Policy Review*, *10*(1), 181–211. <https://doi.org/10.1111/sipr.12022>
- Tashakkori, A., & Teddlie, C. (2010). *Handbook of mixed methods in social and behavioural research* (A. Tashakkori & C. Teddlie (Eds.); 2nd Editio). Sage Publication, Inc. https://www.bookdepository.com/SAGE-Handbook-of-Mixed-Methods-in-Social-and-Behavioral-Research-Abbas-M.-Tashakkori/9781412972666?redirected=true&utm_medium=Google&utm_campaign=Base2&utm_source=MY&utm_content=SAGE-Handbook-of-Mixed-Methods-in-Social-and-B
- Teevan Burke, B., Miller, B. F., Proser, M., Bazemore, A. W., Goplerud, E., & Phillips, R. L. (2013). A needs-based method for estimating the behavioural health staff needs of community health centres. *British Health Services Research*, *13*. <https://doi.org/10.1186/1472-6963-13-245>
- Thiessen, T. (2008). *Bradt travel guide - Borneo*.
- Thoolen, B., de Ridder, D., Bensing, J., Gorter, K., & Rutten, G. (2006). Psychological outcomes of patients with screen-detected type 2 diabetes: the influence of time since diagnosis and treatment intensity. *Diabetes Care*, *29*(10), 2257–2262.
- Ting, R. S. K., & Foo, P. L. (2018). The challenges and needs in mental health service deliverance. In *Counseling Chinese community in Malaysia* (Issue September, pp. 23–49). <https://doi.org/10.4018/978-1-5225-6073-9.ch002>
- Trusler, K., Doherty, C., Mullin, T., Grant, S., & McBride, J. (2006). Waiting times for primary care psychological therapy and counselling services. *Counselling and Psychotherapy Research*, *6*(1), 23–32. <https://doi.org/10.1080/14733140600581358>
- Twigg, E., Cooper, M., Evans, C., Freire, E., Mellor-Clark, J., McInnes, B., & Barkham, M. (2016). Acceptability, reliability, referential distributions and

- sensitivity to change in the Young Person's Clinical Outcomes in Routine Evaluation (YP-CORE) outcome measure: replication and refinement. *Child and Adolescent Mental Health*, 21(2), 115–123. <https://doi.org/10.1111/camh.12128>
- Uji, M., Sakamoto, A., Adachi, K., & Kitamura, T. (2012). Psychometric properties of the Japanese version of the Clinical Outcomes in Routine Evaluation-Outcome Measure. *Comprehensive Psychiatry*, 53(5), 600–608. <https://doi.org/10.1016/j.comppsy.2011.09.006>
- UPsK HKL. (2013). *Unit psikologi kaunseling, Hospital Kuala Lumpur*. Hospital Kuala Lumpur, MOH. <http://www.hkl.gov.my/>
- UPsK HQE. (2019). *Operational policy for UPSK HQE*. file:///C:/Users/Prof Muhaya/Downloads/UNIT PSIKOLOGI KAUNSELING.pdf
- UPsk HS. (2018). *Unit psikologi kaunseling*. Hospital Serdang. <https://hserdang.moh.gov.my/index.php/ms/jabatan/sokongan-klinikal/unit-psikologi-kaunseling>
- UPsK HSB. (2016). *Unit psikologi kaunseling*. Hospital Sungai Buloh. <http://hsgebuloh.moh.gov.my/pengurusan2/jabatan-pengurusan/unit-psikologi-kaunseling>
- Urrego, Z., Abaakouk, Z., Roman, C., & Contreras, R. (2009). *Evaluation of results of a single-session psychotherapy intervention in people affected by the Colombian internal armed conflict*. https://www.interventionjournal.com/sites/default/files/Single_Session_Therapy_as_a_framework_for_post.3.pdf
- Van Egeren, L. (2004). Assessment approaches in health psychology: Issues and practical considerations. In P. M. Camic & S. J. Knight (Eds.), *Clinical Handbook of Health Psychology: Practical Guide to Effective Intervention* (2nd Editio). Hogrefe and Huber Publishers. <https://www.amazon.co.uk/Clinical-Handbook-Health-Psychology-Interventions/dp/0889372608>
- Viliū Nienė, R., Evans, C., Hilbig, J., Pakalniškienė, V., Danilevičiūtė, V., Laurinaitis, E., & Navickas, A. (2012). Translating the clinical outcomes in routine evaluation outcome measure (CORE-OM) into Lithuanian. *Nordic Journal of Psychiatry*. <https://doi.org/10.3109/08039488.2012.745599>
- Vogel, D. L., Wade, N. G., & Hackler, A. H. (2007). Perceived public stigma and the willingness to seek counseling: The mediating roles of self-stigma and attitudes toward counseling. *Journal of Counseling Psychology*, 54(1), 40–50. <https://doi.org/10.1037/0022-0167.54.1.40>
- Wahass, S. H. (2005). The role of psychologists in health care delivery. *Journal of Family & Community Medicine*, 12(2), 63–70. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3410123/>
- Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, findings*. Lawrence Erlbaum Associates. <https://psycnet.apa.org/record/2001-00819-000>

- Wampold, B. E. (2016). Routine outcome monitoring: Coming of age—with the usual developmental challenges. *Psychotherapy (Chicago, Ill.)*, 52(4), 458–462. <https://doi.org/10.1037/pst0000037>
- Waskow, I. E. (1975). Selection of core battery. In I. E. Waskow & M. B. Parloff (Eds.), *Psychotherapy Change Measures*. (DHEW Pub. No. (ADM) 78-120 U.S. Government Printing Office.
- Watson, D. (2003). *Death sentence: The decay of public language*. Random House.
- Western Australia Mental Health Commission. (2012). *Mental health outcomes working group 2012* (Issue January).
- Whipple, J. L., Lambert, M. J., Vermeersch, D. A., Smart, D. W., Nielsen, S. L., & Hawkins, E. J. (2003). Improving the effects of psychotherapy: The use of early identification of treatment and problem-solving strategies in routine practice. *Journal of Counseling Psychology*, 50(1), 59–68. <https://doi.org/10.1037/0022-0167.50.1.59>
- WHO. (2003). *Mental health policy and service guidance package: Mental health financing*. World Health Organization Press. http://www.who.int/mental_health/resources/en/Financing.pdf
- WHO. (2018). Member state profile: Malaysia. In *Mental Health Atlas 2017* (p. 68). WHO.
- WHO. (2019). *Thirteenth general programme of work 2019-2023 : Promote health, keep the world safe, serve the vulnerable* (pp. 1–54). WHO. [pps.who.int/iris/bitstream/handle/10665/324775/WHO-PRP-18.1-eng.pdf](https://www.who.int/iris/bitstream/handle/10665/324775/WHO-PRP-18.1-eng.pdf)
- WHO | WHO highlights global underinvestment in mental health care. (2011). *WHO*. https://www.who.int/mediacentre/news/notes/2011/mental_health_20111007/en/
- Wild, D., Grove, A., Martin, M., Eremenco, S., McElroy, S., Verjee-Lorenz, A., & Erikson, P. (2005). Principles of good practice for the translation and cultural adaptation process for patient-reported outcomes (PRO) measures: Report of the ISPOR task force for translation and cultural adaptation. *Value in Health*, 8(2), 94–104. <https://doi.org/10.1111/j.1524-4733.2005.04054.x>
- Wing, J. K., Curtis, R. H., & Beevor, A. S. (1996). *HoNOS: Report of research and development*. July 1993-December 1995. <https://www.rcpsych.ac.uk/traininpsychiatry/conferencetraining/resources/honos/references.aspx#1996>
- Wolf, M. M. (1978). Social validity: The case for subjective measurement or how applied behaviour analysis is finding its heart. *Journal of Applied Behaviour Analysis*, 11, 203–214.
- Wong, K. P., Bonn, G., Tam, C, L., & Wong, C. P. (2018). Preferences for online or face-to-face counseling among university students in Malaysia. *Frontiers in Psychology*, 9(JAN), 1–5. <https://doi.org/10.3389/fpsyg.2018.00064>

- World Health Organization. (2014). *Mental Health Atlas*. World Health Organization. http://apps.who.int/iris/bitstream/10665/178879/1/9789241565011_eng.pdf
- World Health Organization. (2001). *Mental health: A call for action by world health ministers*. http://www.who.int/mental_health/advocacy/en/Call_for_Action_MoH_Intro.pdf
- World Health Organization. (2007). *The optimal mix of services: WHO pyramid framework*. World Health Organization. http://www.who.int/mental_health/policy/services/2_Optimal_Mix_of_Services_Infosheet.pdf
- Wyatt, T. (2020). *Quality assurance in psychotherapy* -. Canadian Counselling and Psychotherapy Association. <https://www.ccpa-accp.ca/quality-assurance-in-psychotherapy/>
- Yeung, A., Fung, F., Yu, S.-C., Vorono, S., Ly, M., Wu, S., & Fava, M. (2008). Validation of the Patient Health Questionnaire-9 for depression screening among Chinese Americans. *Comprehensive Psychiatry*, 49(2), 211–217. <https://doi.org/10.1016/j.comppsy.2006.06.002>
- Ying, H. S., Heng, C. S., & Abdullah, A. N. (2015). Language vitality of Malaysian languages and its relation to identity. *GEMA Online Journal of Language Studies*, 15(2), 119–136. <https://doi.org/10.17576/gema-2015-1502-08>
- Yip, K.-S. (2005). Family caregiving of clients with mental illness in the people's republic of China. *The International Journal of Psychosocial Rehabilitation*, 10(1), 35–42. http://www.psychosocial.com/IJPR_10/Family_Caregiving_in_China2_Yip.html
- Youn, S. J., Kraus, D. R., & Castonguay, L. G. (2012). The treatment outcome package: facilitating practice and clinically relevant research. *Psychotherapy (Chicago, Ill.)*, 49(2), 115–122. <https://doi.org/10.1037/a0027932>
- Yusoff, M. S. B., Rahim, a. F. a., & Yaacob, M. J. (2009). The sensitivity, specificity and reliability of the Malay version 12-items General Health Questionnaire (GHQ-12) in detecting distressed medical students. *Journal of Psychiatry*, 11(June), 1–8. <https://doi.org/10.5959/eimj.2.1.2010.or2>
- Zakaria Mohamad, & Asyraf Hj Ab Rahman. (2011). Counseling practitioners in Malaysia: Socio-demographic profile and theoretical approaches in counseling process. *International Journal of Business and Social Science*, 2(22), 184–188. http://ijbssnet.com/journals/Vol_2_No_22_December_2011/21.pdf
- Zarbo, C., Tasca, G. A., Cattafi, F., & Compare, A. (2016). Integrative psychotherapy works. *Frontiers in Psychology*, 6(JAN), 2015–2017. <https://doi.org/10.3389/fpsyg.2015.02021>
- Zodpey, S. (2004). Sample size and power analysis in medical research. *Research Methodology*, 70(2), 123–128.