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Abstract: *Counseling services were assessed at a non-profit, self-funded, community-based counseling center in the greater Philadelphia area, Daemion Counseling Center (DCC), using the SF-36 health survey. The SF-36 is a multi-purpose health survey documented in nearly 4,000 publications, 50 of which are about depression and psychological disorders. Results of counseling by seven DCC professional counselors, who incorporated different types of industry standard evidence-based therapy models, e.g., Cognitive Behavioral Therapy, were compared to scores for the eight domains of the SF-36 on a 32-client subset of DCC's 206-plus case load over an 18-month period. The 32 clients were assessed at intake and again about four months later; results of the eight domains were analyzed using SAS. Findings indicated a statistically significant improvement for some domains, e.g., Role Emotional ($p < .0236$), but not for others, e.g., Social Functioning ($p < .2198$), which is not unusual, given clients' diagnoses, e.g., depression, and other intervening life factors, e.g., substance abuse. Another domain, Bodily Pain, was statistically significant for non-improvement ($p < .0266$) and provided insights about clients' ability to respond to counseling due to an unobservable source of pain, e.g., DVT. When matched with counselors' assessments over the same time period, SF-36 results were comparable, indicating proficiency of the counseling at DCC and the SF-36's ability to provide helpful insights about clients. The findings also suggest the need for more support of non-profit, community counseling centers by federal, state and local governments.*

Keywords: *Therapeutic counseling, depression, SF-36, evidence-based therapy, non-profit community counseling.*

INTRODUCTION

The need for mental health counseling has been brought to the forefront and recognized nationally as an area of concern. The impact of mental illness upon the lives of people in the United States has been greatly underestimated and under-appreciated. Based on data from the National Alliance on Mental Illness, mood disorders, such as depression, are the third most common cause of hospitalization in the U.S. for youth and adults, ages 18 to 44. Additionally, suicide is the tenth leading cause of death in U.S. and the third leading cause of death for ages 15-24 years of age.¹ Unfortunately, suicide is almost always the result of untreated or under-treated mental illness.

In many cases, suicide can be averted if mental health conditions are treated before they become serious enough to cause limitations in daily living and social activities. For example, behavioral health conditions hinder work productivity and raise absenteeism, resulting in reduced income or unemployment. This generates a substantial economic impact in the U.S. of

¹ NAMI Mental Illness Factsheet, "Suicide" (2016), accessed May 20, 2016, http://www.nami.org/factsheets/mentalillness_factsheet.pdf.

approximately \$100 billion a year in lost productivity.² Furthermore, for those, who are struggling with both their mental health and the inability to pay their bills, therapy seems overwhelming and impossible.

The Patient Protection and Affordable Care Act (PPACA) is helping to provide insurance coverage through extended Medicaid coverage or insurance exchanges for the 3.7 million Americans living with severe mental illness.³ Despite, this increase in coverage, proposed budget increases for the Substance Abuse and Mental Health Services Administration (SAMHSA) may not be granted, leaving many low-income families without treatment.⁴ This is critical because mental illness can interfere with pursuing an education and attaining employment, making it a significant and growing economic burden, one of the five most costly conditions nationwide.⁵

THE BACKGROUND/CONTEXT OF RESEARCH

Mental Illness in Southeastern Pennsylvania

There are approximately a half million people in southeastern Pennsylvania, who have been diagnosed with a mental health condition with an estimated 100,000, who have not yet been diagnosed.⁶ Another 375,000 in southeastern Pennsylvania cannot get access to mental health treatment because they are underinsured (insured but without a mental health benefit) and/or uninsured.⁷ Compounding this is the statistic from a recent NAMI Report that Pennsylvania's public mental health system provides services to only 22 percent of adults, who live with serious mental illnesses in southeastern PA part of the state.⁸

Mental Illness Responds to Treatment but States Slash Budgets

Studies have shown that poverty, the inability to afford housing and healthcare insurance were correlated with a risk of mental illness is consistently linked with mental health problems.⁹ Encouragingly, research has also shown that treatment, to include counseling and pharmacotherapy, not only ameliorates the underlying problem but also has a positive economic impact by reducing employer costs and boosting worker productivity.¹⁰ In one study, work impairment of employees with mental illness—defined as when emotional distress has an impact on day-to-day functioning— was cut nearly in half after three weeks of outpatient treatment.^{11 12}

However, despite the favorable correlation between counseling and patients' responses, many states have slashed their mental health budgets. Twenty-eight states and Washington D.C. reduced their mental health funding by a total of \$1.6 billion between fiscal years 2009 and 2012. As part of these reductions, Pennsylvania cut funding for mental illness programs by about \$6 million.¹³ These same cuts have impacted access to mental health counseling in southeastern Pennsylvania.

² M. DiChristina, "The Neglect of Mental Illness Exact a Huge Toll, Human and Economic," *Scientific American* (2016), accessed on July 5, 2016, <http://www.scientificamerican.com/article/a-neglect-of-mental-illness/>.

³ Ibid.

⁴ SAMHSA, "Department of Health and Human Services Fiscal Year 2017 Substance Abuse and Mental Health Services Administration Budget Justification" (2016), accessed November 27, 2016, <http://www.samhsa.gov/sites/default/files/samhsa-fy-2017-congressional-justification.pdf>.

⁵ AHRQ, "Economic Burden of Mental Illness" (2016), accessed on May 18, 2016, www.ahrq.gov/research/findings/factsheets/mental/mentalth/index.html.

⁶ PennMedicine.org, "Mental Illness in Southeastern Pennsylvania" (2016), accessed May 21, 2016, https://www.pennmedicine.org/~media/documents%20and%20audio/annual%20reports/community/community_report_hup_chna_april_2013_1.ashx.

⁷ Public Health Management Company, "Healthcare Insurance Survey" (2016), accessed May 21, 2016, https://www.pennmedicine.org/~media/documents%20and%20audio/annual%20reports/community/community_report_hup_chna_april_2013_1.ashx.

⁸ NAMI Mental Illness Factsheet, "Suicide" (2016).

⁹ Mental Health, Poverty & Development, "Breaking the Vicious Cycle between Mental-Ill Health and Poverty", Accessed on July 6, 2016, http://www.who.int/mental_health/policy/development/1_Breakingviciouscycle_Infosheet.pdf.

¹⁰ American Counseling Association, "Effects of Treating Mental Illness" (2016), accessed July 6, 2016, https://www.counseling.org/docs/public-policy-resources-reports/effectiveness_of_and_need_for_counseling_2011.pdf?sfvrsn=2

¹¹ Partnership for Workplace Mental Health, "Work Impairment and Counseling" (2016), accessed June 11, 2016, www.workplacementalhealth.org/Business-Case/The-Business-Case-Brochure.aspx?FT=.pdf.

¹² Honberg et al., "State Mental Health Cuts: A Continuing Crisis" (2016), NAMI National Alliance on Mental Illness Report, accessed May 20, 2016, www.nami.org/getattachment/About:NAMI/Publications/Reports/StateMentalHealthCuts2.pdf

¹³ J. Frantz, "State Funding Cuts Proved 'Tipping Point' for Mid-State Mental Health Care" (2016), accessed June 3, 2016, http://www.pennlive.com/midstate/index.ssf/2013/06/tom_corbett_mental_health_penn.html.

Accessing Mental Healthcare in Southeastern Pennsylvania

Patients can access mental health care through primary care providers, psychiatrists, counselors or informal volunteers, which are for-profit or non-profit organizations. For-profit organizations generally exclude the lower or uninsured or underinsured client services offered by non-profit organizations.¹⁴ There are faith-based counseling alternatives, e.g., Catholic Social Services, in addition to several non-profit organizations, such as Deveraux Beneto Center, Family Service of Chester County, Holcomb Behavioral Health, Dayspring Behavioral Health Services and Life Counseling, in addition to DCC.¹⁵ Among these, DCC offers an appropriate range of counseling services to meet the needs of their clients.

A CASE STUDY

Assessing the Quality of Mental Health Counseling at DCC

Given the paucity of non-profit locations, it is reasonable to ask about the quality of care and about how the quality of care is measured. To accomplish this, DCC was selected because it is a non-profit (501c3) outpatient facility with a mission to provide high quality mental health services to the uninsured, underinsured and those who cannot afford traditional therapy fees in southeastern Pennsylvania, e.g., income <\$15,000 per year. Since 1970, DCC has provided counseling for clients with a spectrum of problems, such as depression and bipolar disorder. Seven professional counselors use different types of industry standard, evidence-based therapy models, e.g., Cognitive Behavioral Therapy and Psycho Dynamic Schema Therapy, as part of treating DCC's case load of over 200 clients. Interaction with a client averages about 10 months to a year. During that time, the majority of clients are able to maintain and/or return to a functional daily life, an indication of the quality of care. But, how is the quality of care when assessed by a time-tested instrument, such as the SF-36 Health Survey?

SF-36 Health Survey

To determine whether the counseling center has a positive impact on clients' health-related quality of life (HRQOL), the Short Form (SF), SF-36 Health Survey was utilized. The SF-36 is a multi-purpose, short-form health survey that assesses functioning and well-being in physical, mental and social dimensions of life. It consists of 36 questions that yield an eight-scale profile of functional health and well-being scores as well as psychometrically based physical and mental health summary measures. These measures span across eight (8) domains or operational indicators of health to include; General Health (GH; 5 questions), Physical Functioning (PF; 10 questions), Role Limitations due to Physical Health (RP; 4 questions), Role Limitations due to Emotional Problems (RE; 3 questions), Social Functioning (SF; 2 questions), Bodily Pain (BP; 2 questions), Vitality or energy/fatigue (VT; 4 questions) and Mental Health or emotional well-being (MH; 5 questions).

These 35 questions can be aggregated into two summary measures, the Mental Condition Summary (MCS) and the Physical Condition Summary (PCS). The MCS includes the RE, SF, VT and MH domains while the PCS includes the GH, PF, RP and BP domains. The 36th question asks about health change over a one-year period (HT) is not included in the summary scores. Higher scores in the SF-36 represent better overall health. A breakdown of the SF-36 can viewed in Table 1.

Table 1 – Components of the SF-36

Domains	Physical/ Mental	Questions
1) General Health (GH)	Physical	5 questions - 1, 11a, 11b, 11c, 11d
2) Physical Functioning (PF)	Physical	10 questions - 3a, 3b, 3c, 3d, 3e, 3f, 3g, 3h, 3i, 3j
3) Role Physical (RP)	Physical	4 questions - 4a, 4b, 4c, 4d
4) Role Emotional (RE)	Mental	5a, 5b, 5c
5) Social Functioning (SF)	Mental	6, 10
6) Bodily Pain (BP)	Physical	7, 8
7) Vitality (VT)	Mental	9a, 9e, 9g, 9i
8) Mental Health (MH)	Mental	9b, 9c, 9d, 9f, 9h
Health Transition (HT)	Health Change over one Year	2 (not included in analysis of domains)

¹⁴ Chester County Pennsylvania Counseling Services, "Directory of Care" (2016), accessed July 20, 2016, <http://www.chesco.org/3245/Directory-of-Care>.

¹⁵ Ibid.

8 Domains and 1 HT	4 Mental 4 Physical 1 HT	36 questions
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The SF-36 has been widely used and has been documented in nearly 4,000 publications, which include 50 about depression and psychiatric diagnoses. In 2002, it was determined to be the most widely evaluated health outcome measure in a study of “quality of life” measures published in the *British Medical Journal*.¹⁶ The SF-36 Health Survey has also been extensively utilized in medical disorder treatment studies, such as fluoxetine for treating depigmentation disease, clonazepam for treating panic attacks along with other indications and tetracyclic arylsulfonamide indoles for treating viral infections.¹⁷ Additionally, the SF-36 has been adapted into a format that can more readily report patient-reported outcomes in the Patient-Reported Outcomes Measurement Information System (PROMIS), especially for patients with mental illness.¹⁸

Importantly, the SF-36 has been shown to be a sensitive measure that can demonstrate changes in health due to various therapeutic interventions, such as counseling.¹⁹ Furthermore, the routine use of the SF-36 in an outpatient psychiatry clinic was feasible, and the results were reliable, valid and helpful to clinicians because it measured physical and mental health conditions that were previously unidentified and found to be meaningful.²⁰

Research Question

Given the experience and credentials of the counselors at DCC, qualitative assessment over time indicates that they are meeting and/or exceeding clients’ counseling needs. Notwithstanding that, how does the quality of care compare to independent assessment by the SF-36 Health Survey after a period of counseling?

METHODOLOGY

The Institutional Review Board of DCC approved DCC’s participation in this study, requiring that identification of all participating clients and counselors remain anonymous. Seven (7) participating DCC counselors, who are counselors and/or licensed professional counselors (LPC), randomly selected clients to participate in the case study; see Table 2 for a depiction of the counselors’ credentials.

Table 2 – Credentials and Background of Participating Counselors

Participating Counselor (C)	Counseling Credentials	Years of Experience*	Gender	Ethnicity
C1	Intern	3 years	Male	Caucasian
C2	Therapist, LPC	11 years	Female	Caucasian
C3	Therapist, LPC	10 years	Female	Caucasian
C4	Intern, MA	1 year	Female	Caucasian
C5	Intern, MS	2 years	Female	Caucasian
C6	Intern, MA	4 years	Female	Caucasian
C7	Therapist, LPC	2 years	Female	Caucasian

*at time of study

Participating clients were impacted by problems that ranged from anxiety to depression. Per their normal procedure, clients’ backgrounds to include their gender, age, race along with diagnoses and pharmaceutical use were assessed as part of the intake

¹⁶ SF-36 Health Survey (2016), accessed June 11, 2016, <http://www.sf-36.org/tools/sf36.shtml>

¹⁷ Heiligenstein et. al., 2016.

¹⁸ Choi et al, “PROsetta Stone® Analysis Report A Rosetta Stone for Patient Reported Outcomes PROMIS Depression and SF-36 Mental Health” (2016), accessed August 10, 2016, <http://www.prosetta-stone.org/LinkingTables1/Linking%20tables%20vol1/PROMIS%20Depression%20and%20SF-36%20Mental%20Health%20Full%20Report.pdf>.

¹⁹ Gandek et al, “Psychometric Evaluation of the SF-36® Health Survey in Medicare Managed Care” *Scientific American* (2016) 25 (4): 5-25, accessed July 7, 2016, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4194895>.

²⁰ Adler et al, “Patient-Based Health Status Assessments in an Outpatient Psychiatry Setting,” *Psychiatric Services* (2016) 51 (3): 341-48, accessed July 8, 2016. ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.51.3.341.

process at DCC. The counselors recorded their assessments about each client session. As part of intake, clients completed the SF-36 Health Survey to establish a baseline score for each of the SF-36's eight (8) domains and an overall score for each participating client. The 36th item, which asks about health change or health transition (HT), is not included in the scale or summary scores but was assessed separately.

After about four months of counseling, which was conducted weekly, participating clients took the SF-36 a second time to measure any changes in their overall score and across the eight (8) domains. As is routinely done, clients were evaluated by participating counselors in their notes and with two SF-36 assessments, one at baseline and one as follow-up about four months later. Counselors were not made aware of SF-36 results. Results were analyzed using the Statistical Analysis System (SAS), a software system that outputs quantitative amounts with statistical methods, such as means and t-tests.

RESULTS

Thirty-two (32) clients met the study's inclusion criteria of undergoing counseling with one of seven of DCC's counselors and completed the SF-36 at baseline and again approximately four months into their therapy over an 18-month period between August 2014 and January 2016. The 32 included 19 women and 13 men, who ranged in age between 16 and 63 with the majority in their 40's and 50's. There were two Afro-Americans and 30 Caucasians with 25, who were single. Diagnoses ranged from anxiety and stress to depression as well as social issues, such as marital problems. Counseling was conducted by seven counselors with three counselors completing 24 of the 32 participating clients. This is depicted in Table 3.

Table 3 – Summary of Participating Clients

Client (CL)	Gender	Ethnicity	Age	Family Status	Reason for Counseling	Current Diagnoses	Medications (to be added)	Counselor (C)
CL1	Female	Caucasian	46	Separated	Anxiety, Stress, Marital Problems	Mood/Anxiety	Prescription meds: Ziac 2.5, HCTZ 25mg as needed (HBP meds)	C1
CL2	Female	Caucasian	54	Divorced	PTSD issues	Severe delusion/paranoid	Strattera 100mg for ADHD; Vyvanse 5-mg for ADHD; Cliazepam,	C1
CL3	Male	Caucasian	46	Child with girlfriend	Various Reasons	adjustment disorder w/ depressed mood and anxiety	none	C2
CL4	Female	Caucasian	36	Single	Depression	N/A	None	C1
CL5	Female	Caucasian	53	Divorcing	Divorcing	Mood/Anxiety	Vistril, seroquel	C1
CL6	Female	Caucasian	23	Single	Feels stuck	Anxiety	Lexapro, 20mg; In past: Aderol, Paxil.	C1
CL7	Female	Caucasian	27	Single	Anxiety	Social Situations	Ativan, as needed	C3
CL8	Male	Caucasian	37	Married	Job loss	Mood/Anxiety	In the past: Zoloft	C1
CL9	Female	Caucasian	55	Blended	Relationships	Abuse, Financial Stress	Ativan	C1
CL10	Female	Caucasian	22	Never Married	Post college grad adjustment	Anxiety	None	C4
CL11	Female	Caucasian	25	Single	Relationship	Communication	None	C4
CL12	Female	Caucasian	21	Single	Depression	Depression	Zoloft	C5

CL13	Male	Caucasian	43	Divorced	Divorce/Adjustment	N/A	None	C2
CL14	Male	Caucasian	31	Single	Relationship	Internal Conflict	Paxil, Wellbutrin, Xanax	C4
CL15	Female	Caucasian	31	Single	Relationship	Internal Conflict, Anger	Wellbutrin, Paxil, Prozac	C4
CL16	Male	Caucasian	29	Single	No Change	No Change	Norvasc for blood pressure.	C4
CL17	Male	Caucasian	N/A	Married	Relationship/Family Issues	Marriage Issues	None	C2
CL18	Male	Caucasian	30	Single	Break-up	Depression abt Break-up	None	C5
CL19	Female	Caucasian	29	Single	Anxiety/Trauma	PTSD/Intrusive Thoughts	Zolotoft	C2
CL20	Female	Caucasian	48	Single	Depression, Anxiety, ADHD	Living Situation, Finances	Pristiq, Klonopin	C2
CL21	Female	Caucasian	63	Single	Anxiety, Depression	Health Issues, Work, Interpersonal	Amlodipine-Benaz 5/10mg; Atorvastation calcium 80mg; Glimpiride 1mg; Hydrochloro Thiazide 25mg; Isosorbide Mononitrate 60mg; Kombiglyze 5-1000mg; metorololer succinate 50mg; Sertraline 100mg, prozac	C2
CL22	Male	Caucasian	31	Single	Court Ordered	Anger Management	none	C6
CL23	Male	Caucasian	31	Married	Anger Management, Career Advice	Adjustment with Anxiety, ADD, Anger Management	Omeprazole, Ritalin, welbutrin	C7
CL24	Female	Caucasian	53	Married	Anxiety	Anxiety/Social Anxiety	Paxil, paxilar	C2
CL25	Female	African American	50	Single	Depression	Finances, Medical Issues, Family	elavil	C5
CL26	Female	Caucasian	57	Single	Anxiety, Substance Abuse	Anxiety, PTSD,	Abilify (anxiety)	C2
CL27	Female	Caucasian	N/A	Married	Depression	Mild depression, Procrastination	Zolotoft, Wellbutrin, generic effoxor, venlafaxine	C2
CL28	Male	Caucasian	50	Divorced	Custody Issues	Family Issues	None	C2
CL29	Female	Caucasian	44	Single	PTSD, Life Choices	Career Stuck, Relationship	ativan	C7
CL30	Female	Caucasian	48	Divorced	Relationship, Guidance	Self Esteem	None	C2

CL31	Male	Caucasian	36	Single	Improve Relationship, Anger	Relationship and Anger	None	C2
CL32	Male	Caucasian	16	N/A- Parents-married	N/A	ADHD	Vyvance 70mg	C3

After about four months of counseling, the seven counselors' evaluations indicated that half of their clients showed progress while other clients showed limited progress due to an intervening set back, such as a medical problem. These counselor evaluations are summarized in Table 4.

Table 4 – Counselors Evaluations of Clients after 4 Months

Counselor (C)	Client (CL)	Counselor's Assessment of Client's Progress after 4 Months
C1	CL1	Not Improved
C1	CL2	Not Improved
C2	CL3	Improved
C1	CL4	Improved
C1	CL5	Not Improved
C1	CL6	Not Improved
C3	CL7	Improved
C1	CL8	Improved
C1	CL9	Not Improved
C4	CL10	Improved
C4	CL11	Improved
C5	CL12	Not Improved
C2	CL13	Improved
C4	CL14	Not Improved
C4	CL15	Improved
C4	CL16	Improved
C2	CL17	Not Improved
C5	CL18	Not Improved
C2	CL19	Not Improved
C2	CL20	Improved
C2	CL21	Improved
C6	CL22	Not Improved
C7	CL23	Not Improved
C2	CL24	Not Improved
C5	CL25	Improved
C2	CL26	Not Improved
C2	CL27	Improved
C2	CL28	Not Improved
C7	CL29	Improved
C2	CL30	Not Improved
C2	CL31	Improved
C3	CL32	Improved

The counselors' evaluations were consistent with SF-36 results. When viewed cumulatively, overall SF-36 results indicated no difference between base line and four-month scores; both were 65.6 (p=.9998). However when the domains were viewed separately, there was statistically significant improvement between the base line and second score for one of the domains, RE (from 45.8 to 65.6 or .0236). These results also indicated statistically significant lack of improvement for another one of the domains, BP (from

79.2 to 71.5 or $p < .0266$). Although not statistically significant, four other domains also indicated lack of improvement; GH (67.3 to 63.9, $p = .3311$), PF (86.7 to 80.6, $p = .2198$), RP (73.4 to 69.5, $p = .6455$) and SF (68.8 to 65.8, $p = .6229$). The remaining two domains, although not statistically significant, indicated improvement; VT (46.1 to 48.6, $p = .5431$) and MH (57.8 to 58.8, $p = .7825$). The results are summarized in Table 5.

Table 5 - Comparison of Cumulative SF-36 Assessments

	Intake Assessment	Four-Month Assessment	P-Values
General Health (GH)	67.3	63.9	0.3311
Physical Functioning (PF)	86.7	80.6	0.2198
Role Physical (RP)	73.4	69.5	0.6455
Role Emotional (RE)	45.8	65.6	0.0236
Social Functioning (SF)	68.8	65.8	0.6229
Bodily Pain (BP)	79.2	71.5	0.0266
Energy/Fatigue (VT)	46.1	48.6	0.5431
Mental Health (MH)	57.8	58.8	0.7825
Overall	65.6	65.6	0.9998

When SF-36 assessments for each of the 32 participants were considered, there was also congruence with counselors' evaluations. Half of the clients (16 of 32) showed an overall improvement as illustrated by the difference in SF-36 average scores ranging from 1.1 to 31.4. The other half did not improve as indicated by the difference in SF-36 average scores, which ranged from a -2.9 to -35.9. There was no difference in client improvement among the seven counselors for those same clients. Clients, who did not improve, had psychological diagnoses that were significant and/or had pressing reasons to seek counseling. Examples are Client C2, who had depression/anxiety (-31.5 difference in SF-36 average scores), Client C12, who had depression (-23.3), Client C14, who had relationship problems (-26.1) and Client C19, who had PTSD/intrusive thoughts (-35.9). However, given client-to-client variability in processing a mental illness, two of the clients, who showed improvement, C3 and C10, with 19.7 and 27.6 differences between the baseline and four-month SF-36 average scores, had diagnoses of depression/anxiety and showed improvement. The differences in average SF-36 scores by client are depicted in Table 6.

Table 6 – Comparison of Individual Clients by SF-36 Average Scores

Client (CL)	Counselor (C)	Score 1 Client Average	Score 2 Client Average	Difference between Clients' Averages
CL1	C1	84.3	81.4	
CL2	C1	95.1	63.6	
CL3	C2	72.2	91.9	19.7
CL4	C1	69.4	83.4	14
CL5	C1	75.3	74.3	
CL6	C1	60.9	57.5	
CL7	C3	79.3	84.9	5.6
CL8	C1	60.8	64.3	3.5
CL9	C1	83.5	72.2	
CL10	C4	60.5	88.1	27.6
CL11	C4	79.4	90.7	11.3
CL12	C5	50.1	26.8	
CL13	C2	94.9	96.5	1.6
CL14	C4	58.9	32.8	
CL15	C4	28.2	59.6	31.4

CL16	C4	69.0		78.6	9.6
CL17	C2	40.9		34.4	
CL18	C5	38.4		30.9	
CL19	C2	72.0		36.1	
CL20	C2	62.0		75.3	13.3
CL21	C2	95.4		96.5	1.1
CL22	C6	66.5		52.6	
CL23	C7	21.1		15.5	
CL24	C2	68.4		55.6	
CL25	C5	40.4		70.0	29.6
CL26	C2	86.8		74.5	
CL27	C2	84.0		96.6	12.6
CL28	C2	66.3		45.6	
CL29	C7	40.6		68.8	28.2
CL30	C2	53.2		27.1	
CL31	C2	72.4		77.1	4.7
CL32	C3	67.7		91.4	23.7

The other factor assessed by the SF-36, HT indicated the same results for 17 of the 32 participating clients (CL30, CL28, CL27, CL26, CL24, CL21, CL19, CL18, CL17, CL16, CL15, CL9, CL8, CL7, CL5, CL3, CL1). Nine of clients' scores improved (CL2, CL4, CL6, CL10, CL11, CL12, CL25, CL31, CL32) while six of the clients' scores did not show improvement (CL29, CL23, CL22, CL20, CL14, CL13). There was no correlation between the counselor and the clients' HT results. Again, the clients' diagnosis was the most prominent determinant. It is interesting to note that counselor C2, who had worked with 12 of the 32 clients, had nine (9) clients with HT scores that remained the same, two, with improved HT scores and one with a lower HT score. The HT scores are depicted in Table 7.

Table 7 – Comparison of HT Scores by Individual Clients

Client (CL)	HT at Base Line	HT Four-Month Score	Change Up/Down or No Change	Counselor (C)
CL1	100	100	No Change	C1
CL2	25	100	Up	C1
CL3	100	100	No Change	C2
CL4	50	75	Up	C1
CL5	75	75	No Change	C1
CL6	25	75	Up	C1
CL7	50	50	No Change	C3
CL8	50	50	No Change	C1
CL9	50	50	No Change	C1
CL10	50	100	Up	C4
CL11	50	100	Up	C4
CL12	50	75	Up	C5
CL13	100	75	Down	C2
CL14	50	0	Down	C4
CL15	25	25	No Change	C4
CL16	50	50	No Change	C4
CL17	50	50	No Change	C2

CL18	50	50	No Change	C5
CL19	50	50	No Change	C2
CL20	75	50	Down	C2
CL21	50	50	No Change	C2
CL22	100	50	Down	C6
CL23	50	25	Down	C7
CL24	50	50	No Change	C2
CL25	25	50	Up	C5
CL26	50	50	No Change	C2
CL27	75	75	No Change	C2
CL28	75	75	No Change	C2
CL29	100	75	Down	C7
CL30	50	50	No Change	C2
CL31	25	50	Up	C2
CL32	25	100	Up	C3

DISCUSSION

SF-36 scores aligned with counselors' observations, both for the half of clients, who showed improvement and for the half, who did not. This was regardless of age and, because only two of the clients were Afro-Americans (CL2 and CL25), it is not possible to draw any conclusions about ethnicity. There was also no correlation between the counselors' ethnicity (all were Caucasian) although it can be speculated that DCC may attract more clients of color if they had counselors of color.

While 25 of the 32 clients were single, other factors in a client's life, e.g., history of domestic violence, spiritual beliefs, substance abuse, are all contributory. Additionally, employment status is definitely an intervening factor, especially employment that is accompanied with healthcare benefits because it is acknowledged that the majority of clients come to DCC for counseling because they are uninsured or underinsured by a plan that does not have mental health benefits to include counseling. These intervening life factors seemed to be determinants for clients' responses about HT. The intervening life factors for the participating clients are depicted in Table 8.

Table 8 – Clients' Employment Status and Intervening Life Factors

Client (CL)	Employment/ Income	Medical Insurance	Client's Strengths & Weaknesses	Spiritual Beliefs	Domestic Violence	Suicide Attempts	Substance Abuse
CL1	Employed/ \$15-30	N/A	S: Loyal, Trustworthy W: Naïve	Catholic, Non-Practicing	Parents	Brother	No
CL2	No Information	No Information	No Information	No Information	No Information	No Information	No Information
CL3	Employed/ \$15-30	Yes	S: Attitude, Courage W: Stress, Time Mgmt	Christian	No	No	Brother (Deceased)
CL4	Employed/ \$15-30	No	S: Compassionate, Reliable W:Alcoholism	Christian	No	No	Father, Cousins
CL5	No Information	No Information	No Information	No Information	No Information	No Information	No Information
CL6	Employed/ \$15-30	Yes	S: Friendly, Funny W: Insecurity, Laziness	None	No	No	No
CL7	Employed/ \$40-50	Yes	S: Good Work Ethic, Loyal W: Lack of self-confidence	None	No - Adopted	No	Grandfather

CL8	Employed/ \$30-40	Yes	S: Self-Critical, Intellectual W: Self-Critical	Inner-light in all people	Ex-Husband, Current Husband	No	No – Adopted
CL9	Employed/ <\$15	Yes	S: Caring, Conscientious W: Learning Disabilities	Y	No	No	Brother
CL10	Employed/ \$30-40.	Yes	S: Listens, Organized, Creative W:Self-Doubt	Yes, likes Yoga	No	No	No
CL11	Employed/ \$15-30	Yes	S: Loyal, Honest, W: Too Passionate	None	Grandmother	No	Brother
CL12	Employed/ \$15-30	Yes	S: Outgoing, Determined W: Control Freak	Spiritual		No	Mother, Father, Grandfather
CL13	No Information	No Information	No Information	No Information	No Information	No Information	No Information
CL14	Employed/ <\$15	No	S: Unsure W: too many to list	None	No	No	Yes
CL15	Employed/ <\$15K	No	S: Compassionate, helpful W: Fear of self- injury	None	No	No	No
CL16	Employed/ <\$15	No	No information	None	No	No Information	No Information
CL17	Employed/ >\$60	N/A	S: Insightful kind W: None reported	Christian	Father	No	No
CL18	Employed/ \$40-50	Yes	S: Motivated, Driven W: Handling situations, Goal Oriented	None	Father	No	Father
CL19	Unemployed	No	S: Resilient, Flexible W; Intrusive thoughts	N/A	No	No	Uncle
CL20	Employed	No	S: Caring, Humor W: Not independent	N/A	No	No	No
CL21	Employed	Yes	S: Independent W: Poor social skills	N/A	No	No	No
CL22	Employed	Yes	S: Teamwork/ Leadership W: Tenacity	Agnostic	No	No	No
CL23	Unemployed	N/A	S: Cooking, Education W: Anger, no job	N/A	No	No	No
CL24	Employed	No	S: Friendly, Loyal W: Low self-esteem	N/A	Father	No Information	No
CL25	Unemployed	N/A	S: None reported W: Coping	N/A	No	Yes	Brother, Father
C2L6	Employed	No	S: Responsible	N/A	Yes	No	No

			W: Alcoholism				
C2L7	Unemployed	N/A	S: Intelligent, Humor W: Low self-esteem	Catholic	No	No	No
C2L8	Unemployed	N/A	S: Help Others, Creative W: Relationships	Belief in God, Prayer	Yes	No	No
CL29	Employed	No	S: None reported W: None reported	Catholic	No	No	Yes
CL30	Unemployed	N/A	S: Good Listener W: Low self-esteem	Catholic	No	No	Father, Aunt
CL31	Employed	Yes	S: Generous, Caring W: Anger	Spiritual	No	Yes	No
CL32	Unemployed	N/A	S: Charismatic, Smart W: Unsure	N/A	No	Yes	Father

Note: Meds reviewed if needed, referred to volunteers in medicine or Phoenixville clinic

As mentioned earlier, the SF-36 assessments for each of the 32 participants were congruent with the counselors' evaluations, particularly RE, which statistically significantly improved and is a key indicator of improvement in the counselors' assessments. The same was true for VT and MH. Although they were not statistically significant, improvement in those domains is also considered an indicator of progress by counselors. Another benefit of the SF-36 scores was the insight from the BP domain, which showed a statistically significant lack of improvement. This may not be readily identified by a counselor, especially when the source of BP is not readily observable, e.g., deep vein thrombosis or fractured ribs, but can decidedly alter a client's ability to respond favorably to a counseling session.

While the four other domains, GH, PF, RP and SF, were not statistically significant but indicated lack of improvement, they also served as barometers for counselors to monitor clients' progress.

To understand the findings more comprehensively, an interview was held with the most experienced counselor, C2, who also worked with the most clients in the study (12 of 32 or 37.5%). She felt that her notes assessing clients were consistent with the SF-36 scores and noted that additional insights about the client, e.g., BP, would give her the basis for discussion with a client that she might not otherwise have. She emphasized that the importance of the client's diagnosis or mediating factors in a client's life, can make him/her responsive or unresponsive to counseling session. She also said that, given the client's diagnosis, reassessment using with the SF-36 within four months may be too soon to see significant differences in the client's improvement.

CONCLUSION/RECOMMENDATIONS

Qualitative results of counseling by seven professional counselors using industry standard evidence-based therapy models, such as Cognitive Behavior therapy, at a non-profit, self-funded, community-based counseling center in the greater Philadelphia area, DCC, were comparable to findings using the SF-36 health survey. Clients were assessed at intake and again about four months later on a 32-client subset of DCC's 200-plus case load; results of the eight domains were analyzed using SAS. Findings indicated a statistically significant improvement for some of the domains, e.g., Role Emotional ($p < .0236$), but not for others, e.g., Social Functioning ($p < .2198$). A post-study interview with the most experienced counselor, who counseled the highest number of clients in the study, indicated that the findings were not unusual, given the clients' diagnoses, e.g., depression, and other intervening life factors, e.g., substance abuse, domestic violence. These intervening factors also seem to be determinants of clients' responses for their HT.

The SF-36 assessments for each of the 32 participants were congruent with the counselors' qualitative evaluations, particularly RE, which was statistically significant ($p < .0236$) and a key indicator of improvement in the counselors' assessments. Although they were not statistically significant, VT and MH, showed improvement ($p = .5431$ and $p = .7825$ respectively) and were also indicators of response to counseling. Another benefit of the SF-36 scores was the insight from the BP domain, which showed a statistically significant lack of improvement ($p = .0266$), but alerted a counselor about a physical problem that can impair counseling and was otherwise unobservable, e.g., deep vein thrombosis. The same can be said for the four other domains, GH, PF, RP and SF. Although not statistically significant ($p = .3311$, $.2198$, $.6455$ and $.6229$ respectively), they served as indicators of clients' progress for counselors.

Implications for Counselors

The SF-36 is viable as an external assessment of clients' progress. Additionally, it has the capability to provide insights about clients that might take longer to detect, thereby extending the time before a client shows improvement. Given the relatively small sample size, these results should be evaluated on a larger client population comparable to the one used to assess the uniformity of therapists effectiveness across patient outcomes domains using a methodology comparable to the one used in the recent U.S.-Swedish study.²¹

Finally, it should be noted that, in future assessments of counseling using the SF-36, it may be beneficial for counselors to include their baseline qualitative assessments from their treatment plans for comparison with the base-line SF-36 assessments. Additionally, the time from SF-36 assessment at intake should be increased to greater than four months to give clients more time assimilate the effects of counseling. Lastly, for easier data collection, future studies should incorporate the two PROMIS-derive, four-item summary scores, one for Global Physical Health and Global Mental Health.²²

A Case for Non-Profit Community Counseling Centers – National Perspective

As illustrated by this study, non-profit community counseling centers are useful additions to healthcare delivery in the U.S. They are an alternative point of access to healthcare for youth and adults suffering from mental illness, especially those, who are uninsured or underinsured (have pharmacy but no counseling benefits). Community counseling centers provide intervention that reduces hospitalization related to mental illness. They also provide a frontline interface with clients, who have inclinations toward suicide, especially those in the 15-24 age range.²³

Counseling services by community counseling centers help clients address behavioral health problems resulting in about \$100 billion a year in reduced income and/or unemployment.²⁴ PPACA is helping to provide insurance coverage for the 3.7 million Americans living with severe mental illness,²⁵ using it to access care is more complex than getting assistance at a community counseling center. Furthermore, with the uncertainty of healthcare coverage following the recent presidential election, support of community counseling centers represents a convenient and uninterrupted alternative for those in need.

Favorable Research Results but Continued State/Local Cuts Restrict Access

Research has shown that mental health treatment not only addresses the underlying cause of illness but also reduces employer costs and increases productivity.²⁶ Another study showed that counseling reduced work impairment of employees with mental illness by almost half after three weeks of outpatient treatment.²⁷ Yet, despite these results, states continue to cut their mental health budgets. To date, 28 states and Washington D.C. reduced their mental health funding by a total of \$1.6 billion between fiscal years 2009 and 2012.²⁸ Along with these cuts, Pennsylvania also reduced funding by about \$6 million,²⁹ which impacted access to mental health counseling in southeastern Pennsylvania.

The situation in southeastern Pennsylvania intensifies because about 375,000 of the half million diagnosed with mental illness there cannot get access to mental health treatment at primary care providers, especially when they are uninsured or underinsured.³⁰ Estimates are that over 100,000 uninsured or underinsured adults with mental health diagnoses are excluded from care, particularly by for-profit providers.³¹

A Compelling Case for Non-Profit Counseling in Southeastern Pennsylvania

²¹ Nissen-Lie et al, "Are Therapists Uniformly Effective across Patient Outcome Domains? A Study on Therapist Effectiveness in Two Different Treatment Contexts," *Journal of Counseling Psychology* (2016) 63(4): 367-378.

²² Code Technology, "PROMIS Global-10" (2016), accessed August 13, 2016, <http://www.codetechnology.com/promis-global-10/>.

²³ NAMI Mental Illness Factsheet, 2016

²⁴ M. DiChristina, "The Neglect of Mental Illness Exacts a Huge Toll, Human and Economic."

²⁵ Ibid.

²⁶ Mental Health, Poverty & Development, "Breaking the Vicious Cycle between Mental-Ill Health and Poverty"

²⁷ Partnership for Workplace Mental Health, "Work Impairment and Counseling."

²⁸ Honberg et al, "State Mental Health Cuts: A Continuing Crisis."

²⁹ J. Frantz, "State Funding Cuts Proved 'Tipping Point' for Mid-State Mental Health Care."

³⁰ PennMedicine.org, "Mental Illness in Southeastern Pennsylvania"; Public Health Management Company, "Healthcare Insurance Survey" (2016), accessed May 21, 2016.

³¹ NAMI.org, "Mental Health Coverage in Southeastern PA"; Chester County Pennsylvania Counseling Services, "Directory of Care."

These exclusions to mental health therapy establish a compelling case for support of existing non-profit counseling centers as well as grounds for selective development of new centers. While the current mental health treatment alternatives, many of which are for-profit, are unable to meet the demand of those in need, several non-profit organizations are working to accomplish this. These include faith-based counseling alternatives, such as Catholic Social Services, and several non-profit organizations to include the Deveraux Beneto Center, Family Service of Chester County, Holcomb Behavioral Health, Dayspring Behavioral Health Services and Life Counseling, in addition to DCC.³² Among these, DCC offers an appropriate range of counseling services to meet the needs of their clients and, based on this study's results provides counseling at a high level of efficacy.

DCC – Patient Support beyond Efficacious Counseling

Generally, non-profit counseling centers establish professional relationships with their clients, relationships that not only adhere to HIPPA (Health Insurance Portability and Accountability Act of 1996) but also are truly indicative of caring about their clients' welfare and successful reintegration within the community. For example, one counselor ends her therapy session with clients by taking a 10-minute walk with them. Another, who was counseling a male client, worked with him to complete his immigration paperwork on her own time. This study's most prolific counselor, C2, learned that a former client was recuperating from a severe car accident and visited her at the rehab center. Another non-billable intervention was working with a young man and the judicial system that combined counseling and volunteering to address his underage drinking. From among many others, a final example is the one where a counselor, who learned that a previous client was suffering after the loss of a loved one, contacted her and arranged a no-charge counseling session.

These examples are indicative of quality care and caring for clients, routinely expressed by one very dedicated, non-profit community counseling center. Although data are not available from other non-profit organizations, anecdotal reports indicate similar dedication by counselors and encourage strong consideration by federal, state and local governments to invest more in supporting and establishing non-profit community counseling centers.

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