Shepell·fgi

THE EFFECTIVENESS OF VIDEO COUNSELLING FOR EFAP SUPPORT

VIDEO COUNSELLING COMPARES WELL TO IN-PERSON COUNSELLING

INTRODUCTION

Employee and Family Assistance Program (EFAP) providers are currently being challenged with providing counselling in a highly digital world in which users demand easy access to services. The past decade has seen a significant technological evolution, making things such as video counselling, telehealth, and telemental health possible and feasible support options. It is the expansion of these channels that have created opportunities for more research—to improve not only the method of delivery but also the counselling itself.

This paper focuses on two of these counselling channels: video and in-person. To successfully participate in video counselling, individuals require only modest technical abilities and equipment. An individual and a counsellor communicate using a computer (a personal home computer can be used), webcam, land line, and encrypted Internet software in which both parties can see and hear each other. Participants can also share and create documents in real time. As the name suggests, with in-person counselling, the individual and counsellor meet in person and interact without the use of technology.

The purpose of this document is to provide human resource professionals with insights into video counselling as a capable and accessible delivery channel for EFAP support; one that is as effective as in-person counselling. For the purposes of this paper, although 'video counselling' is the term that is most often used when discussing this form of EFAP service, other terms (e.g., telehealth, telemental health, and videoconferencing) will also be referenced.

BACKGROUND

In response to advances in technology and the changing needs of its clients, Shepell·fgi developed several online counselling platforms, clinical options, and self-directed tools including video counselling, e-counselling, text-based counselling, online programs, and a mobile app to assist:

- People living in remote areas (with access issues due to limited or no transportation);
- Underserved populations (including multicultural minorities); and
- Marginalized populations and differently-abled individuals (with access issues due to mobility).

These digital channels also provide a solution to some of the barriers of in-person counselling, including:

- Perceived challenges: some individuals are disinclined to attend more traditional in-person counselling due to perceived stigma, verbal communication challenges, etc.;
- Convenience and availability: some individuals with child care and family responsibilities prefer the flexibility of online treatment (Mallen et al. 2005); and
- Outcome of online treatment: some individuals receiving online counselling have reported feeling less dependent on their counsellor and experienced "greater equality in the sessions" (Mallen et al. 2005).

While there are a variety of delivery channels—both traditional or digital—to choose from, all requests for EFAP support follow a defined process that assesses the person's issue in order to treat him/her appropriately, and then match him/her with a channel that a) best meets his/her needs, and b) takes into consideration clinical best practices, age, employment status, lifestyle, and learning preference.

ADDITIONAL RESEARCH

In addition to analyzing data from Shepell·fgi's EFAP clients, several other studies and literature reviews were analyzed to corroborate our findings. These studies—conducted on different mental health providers and professions and on a wide range of populations, ages, and various clinical/mental health issues—examine the clinical effectiveness, user satisfaction, and channel equivalency and efficacy of a variety of clinical approaches.

Researchers found that individuals who used video counselling reported high levels of satisfaction, and had similar satisfaction and clinical outcomes to individuals accessing in-person counselling (Richardson et al. 2009). A systematic literature review that focused on therapeutic interventions delivered by videoconferencing for long-term and chronic mental and physical health also reported that the videoconferencing interventions produced similar outcomes, patient satisfaction, and treatment results for patients who received in-person interventions (Steel, Cox, and Garry 2011).

A compelling study published in 2011 examined and compared telehealth with in-person treatment outcomes of US veterans with a diagnosis of post-traumatic stress disorder (PTSD). Twelve therapy sessions were delivered to the veteran patients by means of telehealth or in-person therapy.

The researchers reported effective outcomes from telehealth exposure therapy. However, they also found that therapy delivered via in-person counselling was more effective than if delivered via telehealth. At the same time, they concluded that, "brief telehealth exposure therapy was effective in treating the symptoms of PTSD, depression, anxiety and general impairment in veterans with PTSD," and no significant differences in outcome effects were found across demographic groups (Gros et al. 2011).

A 2012 study representing the largest scale assessment of telemental health services looked at the clinical outcomes of 98,609 US Department of Veteran Affairs patients (VA) over four years (2006 to 2010). Telemental health services were provided to veterans at community based outpatient clinics by a wide range of mental health practitioners, including psychiatrists, psychologists, social workers, and registered nurses. Findings showed that patients receiving telemental health services had not only fewer days of hospitalization but an average of 25 per cent fewer hospitalizations. Although there was no control group, they were able to identify that "the overall VA population of mental health patients did not demonstrate similar decreases during this period". This included VA patients receiving other forms of mental health services (Godleski, Darkins, and Peters 2012).

Summary
Recent literature indicates that, on the whole, there have been similar and comparable clinical outcomes and satisfaction levels between clients and/or patients who received video counselling and those who received in-person counselling.

METHODOLOGY

PROCESS

Data was collected from the closed clinical files of six counsellors (located in Ontario, Quebec, British Columbia, and the Northwest Territories) who provided both video and in-person counselling services. The data from these 2 groups was compared using the following categories:

1. User rating of session helpfulness
2. Goal completion rate
3. User withdrawal (from counselling) rate
4. Pre- and post-counselling user self-assessment rate
5. Presenting issue(s)
6. User demographics
7. Session type
8. Average session duration
9. No show and late cancellation rate
10. User geographic location

TIMEFRAME AND SAMPLE

For the purpose of this study, Shepell·fgi collected and examined the data from 136 closed cases over a 14 month period:

- 68 video counselling cases, opened between July 1, 2011 and September 1, 2012
- 68 in-person counselling cases, opened between June 1, 2011 and October 1, 2012

The sample represents both men and women from various socio-cultural-economic backgrounds, who:

- are located across Canada, in isolated, rural, and urban communities;
- speak English or French;
- are single or in a couple relationship;
- have a wide range of concerns and clinical goals; and
- are qualified for video and/or in-person counselling.

QUALIFIERS FOR SERVICE

Upon contacting the EFAP to request counselling support, individuals are assigned to either in-person or video counselling if he/she specifically requests one of these methods or if the registration counsellor recommends one of these methods after fully assessing the individual's preferences and needs. Ultimately, the decision to accept the referral is made by the individual.

Individuals are assigned to video counselling if he/she:

- Meets the technological requirements
- Is 18 years of age or older
- Has presenting issue(s) that are not of a high-risk nature (i.e., the person reports that he/she is not at risk of harming himself/herself or others, or has low addiction issues). In general, in-person counselling is offered to high-risk clients; however, some high-risk and addiction cases were not disclosed by the individual at the time of registration and the data was used for this study.

The only qualifier for in-person counselling is that the individual be 18 years of age or older.

DATA CRITERIA

In addition to having a representative sample, the following criteria were used for the study data:

- Video or in-person counselling cases that were opened and closed within the timeframe. If a case was opened but an individual did not show for his/her first session or subsequent appointments, or if the case had been recorded as closed but the clinical documentation had not yet been submitted, the file was closed and was not included in the study.
- Individuals who completed both a pre- and post-questionnaire. Clients were given these only when deemed clinically appropriate by the counsellor.
- Clinical files that did not contain identifiable information. During the individual's first counselling session, he/she is informed of and consent to a Statement of Understanding, which states that non-identifiable data may be used for research purposes.
- Cases of which the counsellor completed the (non-mandatory) goal achievement rating.

STUDY LIMITATIONS

A formal research study would include a control group and random assignment. However, the nature of our business, which is to provide the best possible clinical service, prevented this.

Assessment tools were completed in the presence of the counsellor, which could have affected individuals' responses. However, it is important to note that counsellors are trained in presenting the rating scales as a helpful tool for the individual and counsellor (i.e., as an indicator to see if they are moving in the preferred direction, or if different approaches would be more helpful). Therefore, their presence could positively impact rather than detract from completing the assessment.

FINDINGS

Completed client satisfaction surveys indicated that users of video counselling found the service convenient and clinically beneficial. Counsellors also shared positive feedback about their experience using video counselling with clients.

As noted in Methodology, there are 10 categories for data comparison:

1. **USER RATING OF SESSION HELPFULNESS**
   Counselling sessions, whether delivered by video or in-person, were rated as helpful and received high scores (8.5 out of 10 rating for video, 8.6 out of 10 rating for in-person).
2. **GOAL COMPLETION RATE**
   A lower goal completion score was received by video counselling than in-person counselling (91% for video, 96% for in-person).
3. **USER WITHDRAWAL RATE**
   There was a lower percentage of withdrawals and no shows for video counselling than in-person counselling (16% for video, 28% for in-person), as shown in Figure 1.

The occurrence of clients wishing to switch the mode of counselling (i.e., from video to in-person) happened only once in the video counselling sample.

Figure 1: Counselling session ratings by channel of delivery

Dimension	Video counselling (n=68)	In-person counselling (n=68)
Client session rating (on a scale from 0 to 10, with 10 being the most helpful)	8.5*	8.6*
Goal completion rating (using the scale: goals attained, partly attained, not attained)	91% (52)**	96% (48)**
Counselling withdrawal rating	16% (11)	28% (19)

** Only 118 out of 173 video counselling and 134 out of 184 in-person counselling sessions received a client rating.*

*** Refers to goals attained and partially attained.*

4. **PRE- AND POST-COUNSELLING USER SELF-ASSESSMENT RATE**

The following table compares health and mental health questionnaire scores:

Figure 2: Pre- and post-counselling questionnaire scores by channel of delivery

Item	Video counselling (n=30)*	In-person counselling (n=35)*
Cases with improved health rating	8	11
Ave. pre-health rating	3.03	3.14
Ave. post-health rating	3.36	3.45
Cases with improved mental health rating	9	16
Ave. pre-mental health rating	2.89	2.64
Ave. post-mental health rating	3.21	3.21

** The sample size for measuring health and mental health scores was smaller as only questionnaires that were completed both pre- and post-counselling were used (i.e., 30 out of 68 cases for video, 35 out of 68 cases for in-person).*

As shown in Figure 2:

HEALTH SCORES

- Both video counselling and in-person counselling cases showed an improvement in health after counselling (8 out of 30 cases for video, 11 out of 35 cases for in-person).
- Of these cases, video counselling and in-person counselling showed an improvement in users' health after counselling (11% for video, 10% for in-person).
- These results are expected given that most individuals do not access EFAP counselling to deal with physical health issues.

MENTAL HEALTH SCORES

- Both video counselling and in-person counselling cases showed a modest improvement in mental health after counselling (9 out of 30 cases for video, 16 out of 35 cases for in-person).
- Of these cases, video counselling showed an 11% improvement and in-person counselling showed a 22% improvement on users' mental health after counselling.
- These results are expected given that a significant number of these cases consisted of couple/conjoint cases, which historically have poorer outcomes than individual cases, and not all users access EFAP services for mental health concerns.
- Only 8 individual case users rated their pre-counselling mental health as 'poor' or 'fair' and of this group, 6 individuals (75%) reported an improvement after video counselling.
- 14 individuals rated their mental health as only 'fair' or 'poor' in the pre-evaluation, but 11 (78%) reported an improvement after in-person counselling.

5. PRESENTING ISSUE(S)

For this study, users' issues were categorized as follows:

- Addiction related (e.g., alcohol, smoking, drug, etc.)
- Work related (e.g., conflicts, harassment/violence, performance, etc.)
- Individual (e.g., stress, depression, grief, sexuality, etc.)
- Couple and/or family (e.g., relationship, children behaviour, parenting, communication and/or conflict resolution, etc.)

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Figure 3: Presenting issues by channel of delivery

As shown in Figure 3:

- Both video and in-person counselling had a similar distribution of cases across issues.

Issue	Video counselling (n=68)	In-person counselling (n=68)
Addiction	2% (1)	6% (4)
Couple/family	47% (32)	31% (21)
Personal/emotional	44% (30)	59% (40)
Work-related	7% (5)	4% (3)

- Since there was a relatively high rate of conjoint counselling cases for the video counselling sample, couple/family issues were greater in this group than for the in-person counselling group (47% for video, 31% for in-person).

6. USER DEMOGRAPHICS

GENDER

- A slightly higher percentage of females used video counselling than males did (66% of females, 58% of males), as shown in Figure 4.
- This finding is congruent with EFAP gender findings as, averaged across all service channels, women represented 70% of 2012 EFAP cases.

Figure 4: Gender by channel of delivery

Gender	Video counselling (n=68)	In-person counselling (n=68)
Male	34% (23)	42% (29)
Female	66% (45)	58% (39)

AGE

- A younger demographic used both channels of delivery. The average age of video counselling users was 39 years old and in-person counselling users was 38 years old.
- A higher percentage of users 50 years old or older opted for video counselling compared with in-person counselling (15% for video, 13% for in-person), as shown in Figure 5.

Figure 5: Age by channel of delivery

Age	Video counselling (n=68)	In-person counselling (n=68)
18-29	12	13
30-39	25	26
40-49	21	20
50+	10	9
Ave. age	39	38

7. SESSION TYPE

More video counselling cases were for conjoint counselling, than in-person counselling cases (22% for video, 12% for in-person), as shown in Figure 6.

The ease with which people can access video counselling—in terms of location and time—make it easier for conjoint counselling to occur. For video counselling users who live in an Eastern Time zone, there is greater availability for evening appointments with video counsellors in the West (e.g., a client from Toronto may have a 9:00 p.m. ET appointment with a BC counsellor who is working at 6:00 p.m. PT). In-person counselling users are constrained in terms of travel time and must operate in the same time zone as their counsellors, which restricts the availability of evening appointments.

Figure 6: Type of case by channel of delivery

Case type	Video counselling (n=68)	In-person counselling (n=68)
Individual	78% (53)	88% (60)
Conjoint	22% (15)	12% (8)

8. AVERAGE SESSION DURATION

Each case consists of one or multiple sessions that totaled anywhere from one to seven hours. The average case duration (of all totaled sessions) was shorter for video counselling than for in-person counselling (3.91 hours for video, 4.07 hours for in-person).

9. NO-SHOW AND LATE CANCELLATION RATE

More users did not show up or cancelled late for in-person counselling appointments than video counselling appointments (34 cases or 16% for in-person, 21 cases or 11% for video).

10. USER GEOGRAPHIC LOCATION

Although it was initially thought that a key determinant for using video counselling would be location (e.g., people living in remote regions), it was found that this was not the case.

Figure 7: Ease of access of video counselling services

Ease of access	Video counselling (n=68)
Easy access (within 30 minutes of travel)	69% (47)
Moderate access (30 minutes to 1 hour of travel)	25% (17)
Limited or no access (more than 1 hour of travel)	6% (4)

- All in-person counselling users resided in regions with easy access to in-person counselling services.
- However, 70% of the video counselling services were provided to clients located in the easiest to access (in-person) regions, which indicated that *clients chose video counselling even when in-person delivery was readily available,* as shown in Figure 7.

CONCLUSION

As shown in the study:

- Video counselling and in-person counselling had similar outcomes in regards to client session attendance, rate of session helpfulness, pre- and post-counselling self-assessment, and rate of goal completion.
- A greater improvement of pre- and post- self-rated mental health was found for in-person counselling.
- There were lower withdrawal and no-show numbers for video counselling; this may be because employees can access service from the comfort of their home.
- Although it is too early to tell, video counselling appears to also be beneficial for conjoint and family sessions, perhaps because it's easier to get people together from a home environment.
- It is interesting to note that people located in both remote and urban areas chose video counselling. This may be because video counselling removes travel and inconvenience barriers.
- Technology is not a barrier to accessing video counselling. Slightly more individuals over 50 years of age opted for video counselling rather than in-person counselling. This could be another indicator that the convenience of in-home delivery channels like video counselling far outweigh any perceived barriers afforded by setting up the technology.
- Our research appears to support existing literature that suggests similar clinical outcomes between video counselling and in-person counselling, and/or a high rate of video counselling user satisfaction.

YOUR TAKE AWAY

Providing employees with a variety of channels to access EFAP counselling is required in today's digital age. Your employees deserve to be able to avail themselves of EFAP counselling at their convenience so they receive the help they need when they need it in a channel that they find accessible. If your EFAP provider isn't offering video counselling, your employees may not be getting the help they need to be productive, healthy employees.

SHEPELL·FGI EFAP VIDEO COUNSELLING

Shepell·fgi ensured our video counselling program could be accessed by clients who had only modest levels of technical know-how, and that the service remained of the highest technical quality. Therefore, we spent much time recruiting and training video counsellors and providing ongoing support in an effort to provide a clinically sound service to our clients.

Our clinical services are monitored for positive and negative feedback, clinical indicators, and formal or informal complaints. Through the ongoing monitoring of our video counsellors, we received feedback that this program was working well and that clients were satisfied with the service (in fact, video counselling received no complaints or negative feedback from users).

WHY SHEPELL·FGI IS A LEADER IN EFAPS

Shepell·fgi is committed to making EFAPs more accessible by continuing to expand and enhance digital channels while maintaining traditional service delivery.

- Video counselling, launched in 2011, is best for people who may be geographically dispersed but are more comfortable with a face-to-face exchange via video.
- In-person counselling is best for those who are comfortable with a face-to-face exchange and are able to get to a counselling office. Shepell·fgi has over 73 offices across Canada.

- Telephonic counselling is ideal for those who are more comfortable with an audio exchange and who may have some geographic or travel issues.
- E-counselling gives people the opportunity to express themselves in email and is ideal for those more comfortable with written communication.
- First Chat was launched in September 2011 and was added to the My EAP app in November 2012. First Chat provides instant, easy, private, and fast support—highly attractive to busy individuals that don't feel they have time for traditional service deliveries.
- Online programs include Stress Management, Smoking Cessation, Financial Support, Enhancing Your Relationship, and Separation/Divorce, and enable users to access support at their own pace, and when and where they feel the most comfortable
- The My EAP mobile device application was introduced in May 2011 and released with additional value services in 2012—offering mobile access to videos, articles, and support.

Your employees deserve to be able to access counselling at their own convenience, when they need it. Contact us for more information on our EFAP services, how to effectively use video counselling, and for guidance on what makes a successful EFAP: Call 1.800.461.9722, email info@shepellfgi.com, or visit shepellfgi.com.

ABOUT SHEPELL·FGI

Shepell·fgi is the market leader in optimizing employee wellness through our EFAP. With leading-edge technology; the largest EFAP counselling network in Canada; and a personalized, high-touch, people-centered approach, our EFAP services help to proactively prevent and resolve employee health issues. Shepell·fgi is unmatched in the depth and breadth of our EFAP support and counselling offerings, the sophistication of our infrastructure, and the strength of our track record.

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GLOSSARY

Case	A person, couple, or family is given counselling service by an EFAP counsellor.
Conjoint counselling	An individual and their spouse or family member receive counselling simultaneously.
Employee and Family Assistance Program (EFAP)	A service purchased by employers as part of employees' benefits packages; integrated health and productivity solutions that address the mental, physical, and social health issues affecting the workplace, employees, and their families.
Goal completion	Client counselling goals in the clinical file were rated as goals achieved, goals partly achieved or goals not achieved. These ratings are based on the client's reports as documented by the counsellor in the file at time of last session.
In-person counselling	Counselling in which an individual and counsellor meet in person and interact without the use of technology
Pre- and post-user counselling self-assessment rate	Clients are asked to rate their health and mental health at the first session and again at the last session by answering the following: • In general, would you say your health is Poor, Fair, Good, Very Good, or Excellent? • In general, would you say your mental health is Poor, Fair, Good, Very Good, or Excellent? On a scale of 1 to 5 (where 1 = Poor and 5 = Excellent).
Presenting issue(s)	Presenting issues are identified and coded during the registration process when clients request counselling service. For this study, the 53 possible presenting issues are classified into one of four categories: • Addiction related (e.g., alcohol, smoking, drug, etc.) • Work related (e.g., conflicts, harassment/violence, performance, etc.) • Individual (e.g., stress, depression, grief, sexuality, etc.) • Couple and/or family (e.g., relationship, children behaviour, parenting, communication and/or conflict resolution, etc.)
Rating of session helpfulness	At the end of each counselling session clients are asked by their counsellor to rate the session's helpfulness by answering the following question: On a scale of 0 to 10 (where 10 = most helpful), was this session helpful? Due to the clinical content covered in each session, the counsellors have some discretion over when to use the questionnaire.
Telehealth	A free, confidential telephone service you can call to get health advice or general health information from a registered nurse.
Telemental health	Using telecommunications technology to provide mental health services to individuals in locations that are underserviced, typically as a result of geographic isolation.
Traditional services	In-person counselling and telephonic counselling (non-digital services offered to EFAP clients).
User geographic location	Location was categorized in one of the following three categories: • Easy access: A community with existing EFAP counsellors. • Moderate access: A community within one hour of a centre that offers EFAP counsellors. • Limited or no access: A community more than one hour away from a centre that offers an EFAP counsellor.

User withdrawal rate	The number of users who withdraw from counselling after already booking a session.
Video Counselling	A synchronous, confidential counselling service where the client and counsellor communicate using a webcam, land line, and encrypted Internet software through which both parties are able to see and hear each other and are able to share and create documents in real-time. Clients are able to use their own personal computers.

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