EFAP Video Counselling: A Retrospective Comparison of Video and In-Person Clinical Cases

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ABSTRACT. *In May 2010, video counselling was added to the counselling services offered through the Employee and Family Assistance Program (EFAP) at Shepell as a pilot project with a full operational launch in September 2011. This retrospective study examined clinical outcomes of video and in-person counselling modalities. A sample of 68 video counselling (VC) cases and 68 in-person (IP) counselling cases were collected from a pool of client clinical files closed in 2012. The study compared the two counselling modalities on: (1) client demographic factors (age, gender), (2) session type (individual vs. conjoint sessions with couples or families), (3) type of presenting issue, (4) average total session hours, (5) client ratings of session helpfulness, (6) client reported goal completion, (7) client session no show rates, (8) client withdrawal rate, and (9) improvement in pre/post client self-assessments of mental health and health. Results indicated that the two modalities had largely similar clinical experience and outcome profiles. However, VC cases were also less likely to cancel their scheduled appointments and less likely to withdraw from counseling than IP cases. In addition, most of the VC cases (69%) lived within a half-hour drive to a local counselor's office and yet chose to use the video conferencing option for the EFAP service. These findings offer evidence for the appeal and clinical effectiveness of technology-based counseling.*

Introduction

The past decade has seen a significant technological evolution in providing clinical psychological services.[1] In particular, the use of video counselling (VC) has become increasingly feasible and available to different client populations and types of clinical providers, including providers of Employee and Family Assistance Programs (EFAP).[2]

This study is one of the first to explore the use of VC technology in the EFAP context. At one year post-launch, we now have enough data to examine our program. The study was done to gain a greater understanding of the client experience with VC and to contribute to the current VC literature.

We compared VC and traditional in-person (IP) EFAP services on a variety of measures, including several client demographic, clinical process and self-reported outcomes collected two month after conclusion of the service. The clinical files used for this study were drawn from the closed clinical records of six counsellors who provided both VC and IP services. Other outcome measures collected

from a follow-up survey process are also examined for the smaller subset of cases in each modality with this data.

Hypotheses

We expected to find the VC and IP modalities to be similar for most of the measures in the study, including most of clinical process measures, the clinical outcomes, and client satisfaction with the service. Differences were anticipated, however, in the following three aspects.

H1 = With regard to client gender, we hypothesized that more women than men would be represented in both the IP and VC samples, as Shepell's annual data shows that more women than men typically access clinical services across all modalities.

H2 = Concerning geographic access, we hypothesized that the VC clients would predominantly be living in locations far away from the closest EFAP clinical office.

H3 = A higher rate of conjoint counselling (i.e., two or more clients, such as couple or family counseling) was expected for IP versus VC.

Methods

Sample Selection

For the purposes of this study, Shepell staff collected and examined a retrospective sample of 68 VC cases, opened between July 2011 and September 2012, and 68 IP cases, opened between June 2011 and October 2012, for comparison. The case files came from six EFAP counsellors from Ontario, Quebec, British Columbia, and the Northwest Territories who provided both IP and VC counselling. The cases represented a wide range of ages, geographic locations across Canada, and presenting issues. The clients were predominantly English-speaking; however, there were French-speaking clients in both counselling modalities.

The following types of cases were removed from the list of cases assigned to these counsellors: cases where the client did not attend the first or subsequent appointments, and consequently the file was closed; and cases that were recorded as closed, but clinical documentation had not yet been submitted.

Inclusions and exclusions of clients for the sample were based on the referral process for the modalities. Upon contacting the EFAP to request counselling support, clients were assigned to either the IP or VC modality based on two factors: (1) they specifically request one of the modalities; or (2) intake recommends IP or VC after assessing the client's preferences and needs. The decision to accept the referral recommendation for either service modality is made by the client.

Clients were assigned to the VC modality only if: (1) their presenting issue was not high-risk (e.g., risk of harming self or others; addiction issues), (2) they met the technological requirements for use of VC (web cam, private location, etc.), and (3) they were 18 years of age or older.

Clients assigned to the IP modality did not need to meet these same exclusion criteria. However, for this study, IP clients under 18 and those presenting with high-risk issues were excluded.

Measures

The study compared the two modalities on measures collected both during the treatment period and at post-treatment follow-up. The measures of interest included: (1) client

demographics factors of age and gender, (2) session type (individuals or conjoint), (3) presenting issues, (4) average session hours, (5) client rating of session helpfulness, (6) client reported goal completion, (6) client no shows/late cancellations for sessions, (7) client withdrawal rates, and (9) pre/post client self-assessments on outcome measures of mental health and overall health.

Also, specific to VC, we examined the client geographic location and distance from the counsellor location, as improving client accessibility to clinical service for clients lacking close proximity to counsellors was a key rationale in the development of VC.

Data Analysis

Statistical analysis of the data was done using SPSS software. Comparisons of the two study groups were conducted with either chi-square tests or *t*-tests and featuring a 95% chance level of statistical significance (i.e., a $p < .05$ level).

Results and Discussion

Data from the Full Sample

Demographic Factors. The two samples were compared on age and gender. The groups were similar in age, with an average age of 39 for VC cases and 38 for IP cases. For gender, there was a slightly higher, although not statistically significant, percentage of female users of VC than there female users of IP (66% vs. 57%). This finding of a majority of female users in both modalities is congruent with our book of business experience, in which women represented 70% of all cases, averaged across modalities in 2012.

See Table 1 for summary of findings from all of the comparative analyses in the full sample.

Table 1. Comparison of Clinical Profile in Full Sample

	Video Conference Counselor (n = 68)	In-Person Counsellor (n = 68)
Age (average years)	39	38
Gender (% Female)	66%	57%
Geographic Distance from EFAP Counsellor*		
Easy Access (< half hour)	69%	100%
Moderate (< 1 hour)	25%	0%
Limited/None (> 1 hour)	6%	0%
Total	100%	100%
Session Type		
Individual Person	78%	88%
Conjoint (2 or + people)	22%	12%
Total	100%	100%
Presenting Clinical Issue		
Couple/Family	47%	31%
Personal/Emotional Adj.	44%	59%
Work	7%	4%
Addiction	2%	6%
Total	100%	100%
Clinical Hours per Case	3.91	4.07
Missed Appointments*	12%	19%
Withdrawal from EFAP*	16%	28%
Modality Redirect	0%	1%
Session Helpfulness (Ratings on 1-10 Scale)	8.5	8.6
Clinical Goal Completed[a]	91%	96%

a = sample sizes of VC = 57 and IP = 50.
* significant difference at $p < .05$.

Geographic Distance. It was expected that the VC clients would predominantly be from hard-to-serve regions located far away from the EFAP counselor centers. However, this was not true as less than 1 in 3 VC cases lived more than an hour away from the closest counselling office locations. In fact, 25% of the VC cases lived within an hour away and

were classified as "moderate access" and only 6% of VC cases lived more than an hour away and were classified as "limited/no access." In contrast, most of the VC cases (69%) lived within 30 minutes of an IP EFAP counselor and were classified as "easy access" to the counselor. As expected, all 68 of the IP cases lived in urban settings and thus could access an EFAP counsellor with less than 30 minutes of travel. Thus, contrary to our hypothesis, the majority of clients chose VC even when IP was in close proximity to where they lived. Further research outside the scope of this study is needed to clarify this finding.

Session Type. Typical of EFAP service use in general, both study groups had a majority of users of the individual case type (see Table 1). A higher rate of the conjoint counselling type was predicted for the IP condition versus the VC condition. However, the data did not support this hypothesis. Almost twice as many cases in the VC modality were for conjoint counselling compared to this type among the IP cases (22% vs. 12%). Although the overall mix of the two case types was not statistically different between the two modalities, this finding hints at something interesting. Perhaps the ease of access to VC in terms of location and times makes it easier for clients to schedule it for conjoint counselling. The IP clients are relatively more constrained in terms of travel time, and they must operate in the same time zone as the counsellors, which can restrict the availability of evening appointments. For example, a VC client from Toronto may have a 9:00 p.m. Eastern Standard Time appointment with a Vancouver-based counsellor who is working at 6:00 p.m. Pacific Standard Time. In addition, as VC typically takes place in the client's home, some practical barriers to access are reduced with regard to coordinating conjoint clients' schedules and child care arrangements in order to physically go to the counselor's office for the session.

Presenting Clinical Issue. The presenting issue refers to the type of clinical problem that a client presents with when first seeking assistance from the EFAP. For this study, the presenting issues were divided into four main types: (1) addiction, (2) couple/family relations, (3) personal/emotional adjustment, and (4) workplace issues. The results show that the VC and IP groups overall had a similar distribution of cases among the four kinds of issues. Personal and emotional adjustment issue category accounted for about half of the total cases in both groups (VC = 44% vs. IP = 59%). The work related issues and addiction issues categories were only a small part of the case mix in the both the VC and IP groups (combined VC = 9% vs. IP = 10%). However, as the finding of a relatively high rate of conjoint counselling for the VC sample would indicate, the category of couple/family issues was a slightly higher number of cases in the VC sample than the IP sample (47% vs. 31%).

Number of EFAP Sessions. The total duration of clinical contact hours per case ranged from one to seven sessions. The average duration was similar for the two groups, with 3.91 hours per case for the VC and 4.07 hours per case for the IP.

Clinical Session Attendance and Withdrawal. There was a significant difference between the modalities in how many clients did not show up for scheduled appointments and the rate of withdrawal from counselling before the counselor considered it to be appropriate. For the no show rate, it was 12% (20/173) for VC and 19% (35/184) for IP. The withdrawal rate from VC was 16% (11/68) was less than the IP withdrawal rate of 28% (19/68). Thus, the VC modality had lower levels of both session attendance and client withdrawal from therapy.

Clinical Modality Redirects. A change in the counseling contact modality during the

treatment phase occurred only once during the study and this was for a case in the VC sample who switched to IP. Thus, the two groups did not differ on this issue.

Ratings of Clinical Session Helpfulness. At the end of each clinical session, a rating was obtained of the helpfulness of the session to the client. This data was collected on a rating scale ranging from a low of 1 to a high of 10. While not all sessions received a client rating, it was provided in about two-thirds of the total number of sessions for these cases. More specifically, for the 68 VC cases, 117 out of 173 total sessions received a client rating and for the 68 IP cases, 131 out of 184 total sessions received a client rating. Tests showed there was no difference in the average rating of session helpfulness between the VC and IP modalities, with 8.5 and 8.6 averages for the two groups, respectively.

Clinical Goal Completion. At the end of the each case, the clients self-reported whether or not their goals for using the EFAP were achieved. This measure was obtained in about three-fourths of the cases in each modality condition. Tests revealed no differences in the rate of goal completion in the two samples, as VC had a goal completion percentage of 91% (yes in 52 of the 57 cases) and IP had a goal completion percentage of 96% (yes in 48 of 50 cases).

Pre and Post Follow-up Survey Data

The sample size for the outcome measures collected on the follow-up survey (which was done at an average of 60 days post case close) was only about half of the other clinical session process data. Complete data with pre and post measures on the two items of interest was available for 30 of the 68 VC cases and 35 of the 69 IP cases. The test results with this data are now presented.

Outcome of Improvement in Mental Health. This item asked: "In general, would you say your mental health is: poor, fair, good, very good or excellent." The degree of change in the average mental health rating (on a 1-5 scale) increased by 11% for VC clients and by 22% for IP clients. Examining this same data another way, both IP and VC groups had a similar percentage of the total cases with an improvement on the measure of mental health. Only 30% VC cases and 46% IP cases had a 1-5 rating that was higher at the follow-up than it was at the start of treatment.

See Table 2 for summary of findings from all of the comparative analyses in the full sample.

Table 2. Comparison of Outcome Profile in Follow-up Sample

	Video Conference Counsellor (*n* = 30)	**In-Person Counsellor (*n* = 35)**
Rating of Mental Health		
Pre EFAP Use (1-5)	2.89	2.64
Post EFAP Use (1-5)	3.21	3.21
Average Improvement in mean rating over time	0.31 or 11%	0.57 or 22%
% of individual cases with higher rating at Post EFAP when starting at any level	30%	46%
% of individual cases with higher rating at Post EFAP when starting at low level of *poor* or *fair* in mental health[a]	75%	79%
Rating of Health		
Pre EFAP Use (1-5)	3.03	3.14
Post EFAP Use (1-5)	3.36	3.45
Average Improvement	0.33 or 11%	0.30 or 10%
% of individual cases with higher rating at Post EFAP	27%	31%

a = sample sizes of VC = 6 and IP = 14.

A possible reason for these somewhat low average ratings is that only about of half of these clients accessed the EFAP services for help with mental health concerns (e.g., they

used it instead for workplace issues, marital issues, family concerns, etc. – see the results on presenting issues). If the clients did not rate mental health as much of a concern at the case outset, the seeking improvement in this outcome area is moot. Therefore, this outcome is more meaningful when examined only for those cases with a problem in the area of mental health when first accessing the EFAP. When tested this way, the outcomes are indeed much stronger. Among those in the VC sample who rated their pre-counselling mental health as only "poor" or "fair," 6 of the 8 cases reported improvement at follow-up with a higher rating. Similarly, of the individuals using IP counseling who rated their pre-counseling mental health as only "poor" or "fair," 11 of the 14 improved at the follow-up. Although this subset of cases was only about a third of number of the total cases in the study [and too small to test for statistical significance], these findings are consistent with the hypothesis that the VC modality would show similar clinical outcomes to IP modality (75% vs. 79%).

Outcome of Improvement in Overall Health. This item asked: "In general, would you say your health is: poor, fair, good, very good or excellent." When tested as a change in mean ratings, the cases in the two modalities did not differ in the average health rating (on a 1-5 scale), which increased by 11% for VC and 10% for IP (see Table 2). Looking at the data another way as individuals with change rather than group mean averages, there were 27% of the VC cases (8/30) and 31% of the IP cases (11/35) with an improvement in their health rating after use of the EFAP services compared to their rating at the start of the services. These results were acceptable given that most of the clients did not access EFAP counselling to get help managing physical health issues.

Study Limitations

The sample size in this study is modest with regard to conducting tests of statistical significance. Using larger sample sizes in future studies would be consistent with other current VC research, provide more insight, and potentially offer interesting outcomes.

Lack of a control group of non-users of EFAP services and the self-selection (non-random assignment) of cases to the VA and IP conditions are other limitations. The applied nature of the EFAP as a setting for research is limited by the clients self-referral into the program and how we offer services to clients relating to the client modality preference, described lifestyle and/or recommendations based on the client's stated issue. Random assignment of matched cases to the IP or VC modalities was simply not feasible in the normal business environment of the EFAP.

The pre/post assessment survey and session rating helpfulness scale are both subjective rating tools based on client self-report. Clients complete the session helpfulness rating in the presence of the counsellor (and only when deemed clinically appropriate by the counsellor), which may affect the client's response. In an effort to avoid such a bias, counsellors are trained to present the scales as a helpful tool for the client and the counsellor, an indicator to see if they are moving in the preferred direction or if a different approach would be helpful, and clients are encouraged to actively co-create session direction and focus.

Conclusions

The EFAP, through its capacity to offer multi-modal clinical services to thousands of clients a year across different client demographics, locales, and presenting issues, is in a unique

position to add to the current literature in the video counseling area of study. For many working people in Canada, the EFAP is the easiest and most effective way to access timely and confidential counselling. This study shows that the VC modality of service is a useful and tested modality. A sizeable number of clients preferred the VC modality for convenience (even though they lived close enough to easily visit a local counselor) availability, and other personal reasons. Clients were shown to attend the video counseling sessions more consistently and drop out less often than the clients in the IP modality. Most of the counseling process and activity characteristics were similar between the two modalities. Pre- and post-counselling questionnaires showed modest improvement in mental health response and physical health for both VC and IP cases. With comparable results to traditional IP counselling, VC holds great promise as an effective alternate modality of service delivery for employee and family assistance programs.

References

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