Implementation and Evaluation of a Formal Telephone Counseling Protocol in an Employee Assistance Program

By: Diane Stephenson, David Bingaman, Chris Plaza, Rick Selvik, Brian Sugden, Christopher Ross

Diane Stephenson, PhD, CEAP, is Occupational Health Project Manager, Federal Occupational Health, Program Support Center, Department of Health and Human Ser vices, 233 N. Michigan Avenue, Suite 270, Chicago, IL 60601. David Bingaman, LCSW, CEAP, is Director of Operations, Chicago Regional Division, Office of Performance Review, Health Resources and Services Administration, Department of Health and Human Services, 233 N. Michigan Avenue, Suite 200, Chicago, IL 60601. Chris Plaza, MS, is Sr. Programmer Analyst, Federal Occupational Health, Program Support Center, Department of Health and Human Services, 233 N. Michigan Avenue, Suite 270, Chicago, IL 60601. Rick Selvik, LICSW, MBA, is National EAP Consultant, Federal Occupational Health Program Support Center, Department of Health and Human Services, 233 N. Michigan Avenue, Suite 270, Chicago, IL 60601. Brian Sugden, PhD, is a psychologist with the Federal Occupational Health Program Support Center, Department of Health and Human Services, 6456 Lake Meadow Dr., Burke, VA 22015-3927. Christopher Ross, PhD, is a statistical and analytical consultant, Christopher Ross PhD Consulting, 542 S. Dearborn St., Suite 1060, Chicago, IL 60605.

ABSTRACT. Structured guidelines for conducting telephone counseling were developed and implemented in a large employee assistance program. This study evaluates the telephone counseling service in several areas, including utilization, clinical outcomes, client satisfaction, client reported productivity and absenteeism, counselor feedback, and efficiency. Clients who elect the telephone counseling modality and who are determined by the counselor to be appropriate for telephone counseling show results comparable to those for face-to-face counseling on various measures.

Introduction

The growth of technology-assisted services over the past several years in a range of disciplines is astounding. Although the mental health, substance abuse, counseling and employee assistance fields have traditionally been "low tech," the opportunities for providing in creased access and additional services to clients through technology-enhanced products are now being recognized and more enthusiastically explored by mental health professionals.

Telehealth is defined as "the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision, education, and information across distance. Behavioral telehealth is simply the application of the same technology to provide behavioral health services" (Kirby, Hardesty, and Nickelson, 1998). In most instances, the term telehealth has super ceded the term telemedicine, though sometimes the terms are used inter changeably.

The telephone, the most basic of the technology media, has been utilized by individual counselors, employee assistance professionals, and managed care companies for many years to conduct assessments, make referrals, and to provide consultation, counseling, case monitoring, and follow-up services. Since the 1960s and 1970s, the telephone has served as a critical intervention tool for crisis counseling, such as that provided by suicide and depression hotlines. However, some employee assistance professionals still have fundamental questions about the efficacy of using the telephone for assessment and counseling. A number of major U.S. companies and corporations offer only the telephone counseling option for employee assistance program services with no face-to-face counseling. This service delivery model is not without controversy. Some behavioral health providers offer telephone "consultation," but do not call the service "counseling." Despite the long-time use of the telephone in behavioral health activities and the more recent Internet/ Website/e-mail/video access options, many service delivery programs do not have clearly defined operational policies and procedures to guide mental health professionals in the technology-enabled methods of service delivery and may not have conducted evaluations of their experiences with the various service delivery modalities.

Literature Review

New articles on telehealth appear in journals and on websites daily. Nevertheless, articles reporting the evaluation of the results of the implementation of behavioral telehealth programs are less frequently found than are general informational and theoretical articles. However, the literature on the evaluation of telehealth programs is building. Health Resources and Services Administration's (HRSA) Office for the Advancement of Telehealth (OAT) supports programs involved in the use of video-teleconferencing for medical and behavioral health care in rural communities across the U.S. (Smith and Allison, 1998). Other federally funded programs concern video-teleconferencing in federal prisons, Veterans Hospitals, and similar special populations. Federal programs contain formal

evaluation components, though the scope and breath of the programs covered are highly specific.

There are a limited number of published professional papers and literature specifically related to the evaluation of the efficacy of telephone counseling compared with face-to-face counseling in such areas as utilization, case outcomes, client satisfaction, and/or cost. Two studies re ported results on the effectiveness of telephone counseling in behavioral health treatment. Reese (2002) studied 186 participants who received only telephone counseling and found that the majority of clients believed that telephone counseling was helpful, and they were satisfied with the help they received. These results were consistent with the results reported in the Consumer Reports (1995, November) survey of face-to-face counseling participants. Schneider (2000), in a study of 80 clients randomly distributed into three treatment groups, found that tele phone therapy and the video-teleconferencing therapy provided similar outcome levels in all the outcomes areas cited-clinical outcomes and satisfaction-to face-to-face psychotherapy.

In *A Telemedicine Primer: Understanding the Issues,* Jim Reid (Innovative Medical Communications, 2000) emphasizes that many new telemedicine programs find themselves well into their third or fourth month of operation before even beginning to consider putting evaluation mechanisms in place. He recommends that data should be collected including financial impact, safety and efficacy, user satisfaction, and impact on quality of care.

Impetus for Formal Implementation of the Telephone Counseling Option in the Federal Occupational Health Employee Assistance Program

The Federal Occupational Health telephone counseling program, implemented in an employee assistance program setting, and the evaluation results of the program provide additional information to that currently identified in the published literature. Our information comes from a very high-volume employee assistance program setting and includes data on utilization, outcomes, satisfaction, length of sessions, and affiliate assignment.

Federal Occupational Health is organizationally located within the U.S. Department of Health and Human Services' Program Support Center and has over 55 years of occupational health experience. Its mission is to work in partnership with its Federal agency customers to deliver com prehensive occupational health services to improve the health, safety, and productivity of the Federal and military workforces. Federal Occupational Health's employee assistance program currently provides services to more than 3.2 million Federal employees and their family members.

The reasons that some of Federal Occupational Health's Federal agency customers were ready to pilot a more formal use of technology in employee assistance program service delivery were several:

- other businesses and companies identified successful utilization of some form of telephonic and technology-supported employee assistance program services;
- identification of cost-efficient strategies that retained quality of service delivery;
- the goal to increase "program reach" and timeliness by offering alternative access/service delivery methods;
- reassessment of models requiring face-to-face counseling that felt the need to assess the full scope and depth of the client's problems (i.e., getting at the "underlying issue");
- create a means to address the no-show rate for face-to-face employee assistance program counseling sessions; and,
- greater recognition of the heavily scheduled work/life situations of the employee assistance program clients.

A strategic customer service approach to providing employee assistance program services is to meet the client where he or she is in readiness to access services, and to, at least initially, use the contact modality with which the client is most comfortable. It was determined that moving forward in utilizing technology-supported employee assistance pro gram services would begin with the basic medium-the telephone-and contain an evaluation component to ensure continued service quality. The model developed by Federal Occupational Health for the implementation and evaluation of a formal telephone counseling option could also serve as a model when rolling out more advanced technologies within the service delivery system.

Critical parts of the development of the formal telephone counseling program were:

- gaining input and support from the field staff-the on-site counselors who would be performing the telephonic counseling, and the counselor supervisors;
- gaining input and support from key clinical, administrative, and le- gal consultants;
- developing structured, written guidelines;
- establishing a method for evaluation; and
- evaluating the program.

Policy and Procedure Guidelines Development

It was felt that the process used for developing the guidelines for counseling by telephone was as important as the content of the guide lines themselves, since it impacted the support the on-site staff counselors would lend to the program.

A team comprised of counselor and counselor supervisor representatives, the clinical directors, and Federal Occupational Health employee assistance program

consultants was established by Federal Occupational Health to develop the telephone counseling guidelines. In addition, content representatives (a quality manager and a telephonic mental health consultation manager) gave input at some of the team meetings. Federal customer agency representatives had input and sign-off responsibilities. The team met by telephone weekly over a three-month period, with emails of policy drafts, issues, and articles taking place in between. Representation from these different groups of stakeholders helped as sure that pertinent issues would be addressed. Other clinical, administrative, and legal staff, as well as Federal Occupational Health customer agency representatives, provided constructive input that was incorporated into the guidelines for counseling by telephone.

Philosophically, the team felt that telephone counseling was not and should not be for everyone. Specific criteria were developed to assess client appropriateness for telephone counseling (covering such issues as geographical location and mobility problems) as well as specific criteria for which counseling by telephone is not indicated (covering such is sues as risk factors, administrative proceedings and appropriateness of modality for the counseling focus). If clinical assessments were to be conducted by telephone (an activity that has been done for years by call center access models), pertinent clinical factors that might otherwise be gained through face-to-face observation should be asked to the extent possible (e.g., weight, physical concerns) if additional counseling were to be conducted telephonically. The employee assistance program statement of understanding (SOU) was revised to assure that telephone counseling was covered. The guidelines addressed critical privacy is sues that could arise in telephonic assessments and counseling. Because of state laws pertaining to a health practitioner's interstate practice, the Federal Occupational Health employee assistance program followed the most conservative approach to telephone counseling, that is, counselors would only provide telephone counseling with clients in the same state in which the counselor was licensed.

The telephone counseling guidelines were formally distributed to staff counselors, allowing for discussion of counselor concerns and issues. In addition, counselor feedback on their experiences with telephone counseling was a very important component of the evaluation of the program. A formal feedback mechanism was developed for that purpose.

Program Evaluation

Although the Federal Occupational Health employee assistance pro gram utilizes both staff and affiliate (network) employee assistance pro gram counselors, the telephonic counseling is conducted only by the staff employee assistance program counselors. For all cases, the employee assistance program counselors are responsible for collecting reliable outcome data from clients that includes four pre- and post-employee assistance program health status questions, an absenteeism question, and a counselor-assessed score from the Global Assessment of Functioning (GAF) Scale. Counselors ask the four health status questions and the absenteeism question at case opening and at case

closing. The employee assistance program counselor assesses the GAF score at case opening and again at case closing.

Federal Occupational Health developed structured evaluation criteria to evaluate the formal telephone counseling activities. To the extent possible, we wanted to review both quantitative and qualitative information and feedback, including feedback from our employee assistance program staff counselors.

Components of the structured evaluation were:

- employee assistance program utilization rates;
- Length of counseling sessions;
- Rates of case assignment to affiliate counselors;
- Client satisfaction ratings on access to care and outcome;
- Client satisfaction ratings on services received;
- Counseling clinical outcome (based on Global Assessment of Functioning Scale-GAF);
- Structured counselor feedback on their telephone cases;
- Anecdotal case information from counselors;

Quantitative data were reviewed and divided into categories as follows:

Comparison Time Periods

- Implementation Evaluation Period-Cases opened after 10/1/99 and closed between 1/1/00 and 6/30/00.
- Comparison Period-Cases opened after 10/1/98 and closed be tween 1/1/99 and 6/30/99.

Service Delivery Method

This program evaluation was conducted with over 21,000 face-to-face and telephone counseling cases.

Given that the Federal Occupational Health employee assistance pro gram utilizes staff on-site counselors for telephonic counseling, most telephone cases are not comprised solely of telephone sessions but may include face-to-face session(s) as well (e.g., often the first assessment session may be conducted face-to-face, or a later session may be face-to-face after the client develops trust in the counseling process). Given this difficulty in defining what constitutes a "telephone case," we analyzed the data two different ways, as defined below:

- Face-to-face counseling

    - cases with less than 50% telephone counseling sessions
    - cases with no telephone sessions
- Telephone counseling
    - Cases with 50% or more telephone counseling sessions
    - Cases with any telephone sessions

Findings

A statistical analysis of employee assistance program data for telephone and face-to-face clients, as well as comparison of data for the implementation evaluation time period and the comparison time period covering the same months the previous year, showed the following results.

Utilization. We anticipated counselors would utilize telephone counseling more frequently after the formal guidelines were written than during the comparison time period of the previous year. (It should be noted that our data gathering system always contained a telephone session coding option in addition to a face-to-face session coding option.) The rationale was that this new structured approach to telephone counseling, including the support of formal, written guidelines, would result in counselors considering telephone counseling more often for appropriate cases. However, data did not support our assumptions. There were no significant differences in the number of telephone sessions or the number of "telephone cases" (50% or more sessions being tele phonic) during the implementation period as compared with the com parison period.

Length of Sessions. The average length of telephone sessions in the implementation evaluation period was 32.2 minutes compared with an average length of face-to-face sessions of 59.8 minutes, a statistically significant difference.

Affiliate Case Assignment. During the comparison time period a total of 6,440 of 18,059 cases were assigned to and counseled by affiliate counselors (contracted private practice counselors), while in the implementation evaluation time period a total of 5,972 of 17,587 cases were assigned to and counseled by affiliates. So, a reduction of 5.6% in cases assigned to affiliate counselors occurred from the comparison time period to the implementation time period. This suggests that on-site staff counselors used their own existing capacity to absorb new clients, with no additional affiliate counselor costs. Though several factors may have impacted this reduction in affiliate assignment from the comparison to the implementation time periods (e.g., a general initiative was also in place to decrease affiliate usage while increasing staff counselor usage), the telephonic counseling option certainly helped support the overall initiative.

Client Satisfaction Ratings on Access to Care and Outcomes (Absenteeism and Productivity). An analysis of a total of more than 21,000 cases (telephonic and face-to-face cases from both the comparison and the implementation time frames) was conducted. Results

show that there are no statistically significant differences in client satisfaction regarding access to care or in outcomes (e.g., pre/post employee assistance program self-rating differences in productivity or work absenteeism reductions) associated with telephone counseling as compared with face-to-face counseling in either the comparison or implementation time periods. It must be remembered, however, that the telephone counseling clients were ascertained by the counselors as appropriate for telephone counseling based on the guidelines for telephone counseling, and the clients themselves elected to use the telephone counseling modality. So, both the telephone counseling clients and the face-to-face counseling clients received treatment in the modality that they were comfortable with, and that the counselor judged to be appropriate. Given this, satisfaction rates were equivalent despite the modality of service.

Client Satisfaction Ratings on Quality of Service Received. There were also no significant differences between telephone counseling cases and face-to-face cases on client satisfaction responses regarding quality of service provided by the counselor, and perception of how closely the counselor listened.

Counseling Clinical Outcome-Global Assessment of Functioning (GAF) Scores. The GAF is used in the mental health profession as a standard for counselor/professional rating of client/patient functioning. We found that cases with any telephone counseling sessions produced a statistically significant greater average improvement in GAF scores from the opening to the closing of the case ($p = .05$) compared with the face-to-face counseling cohort. The results raise several possibilities: (a) since telephone clients represented a small group who actively chose telephone counseling, they could have been more motivated and/or receptive to change than face-to-face clients and thus experienced greater results; (b) counselors were enthused about the telephone counseling and its success, resulting in some unintended GAF rating bias; and/or (c) telephone counseling is likely to be more focused than face-to-face, due to the medium, therefore identified goals may be more directly worked towards and evaluated. It would be of interest to see if these GAF results are replicated in further evaluations.

Counselor Feedback. The same team that developed the guidelines for telephone counseling developed a feedback form by which to obtain both structured and unstructured feedback from counselors. Counselors completed the form after closing a telephone counseling case during the six-month implementation evaluation period following the issuance of the formal guidelines.

On a 5-point scale, with 3 being *moderate* and 5 being *high,* the counselors responded with an average rating of 4 asking how they would rate:

- their level of experience with telephone counseling (3.7);
- their level of comfort providing telephone counseling with this case (4.0);
- their perception of client's comfort with telephone counseling (4.2);

- the alliance formed between the counselor and client (3.8);
- the extent to which goals of the treatment plan were met (3.7).

Additional areas of inquiry and counselor ratings were:

- if goals were not met, the extent that counseling by telephone contributed to this (4.0 where 5 is *not at all);*
- the extent to which a telephone counseling session was interrupted (4.5 where 5 is *not at all);* and
- the client's perceived privacy during the telephone counseling (.93 where O = *no* and 1 =*yes)*

In conversations with counselors, some counselors stated it was their perception that telephone sessions adhere to a more structured format (e.g., homework results) and stay on-task more than face-to-face sessions. On the counselor feedback form, in addition to many comments about successful telephone cases, counselors raised several concerns and qualifications about the telephone counseling process: clients with numerous problems seem to do better with face-to-face counseling; counseling by telephone misses the non-verbal messages; and telephone counseling is great for individuals who have insight and are willing to work on their goals.

Anecdotal Case Information. After counselors had counseled employee assistance program clients by telephone under the new Guide lines, counselors were asked to submit case examples of situations in which "telephone counseling had been a user-friendly, efficient, and helpful resource in the repertoire of methods by which we serve our customers." Several categories emerged of client and/or problem characteristics where telephone counseling was not only appropriate but also possibly preferable to face-to-face counseling.

- Stigma and/or concern about seeking mental health counseling be cause of the personal, and/or self-perceived "shameful" or embarrassing nature of the client's issue; or the apprehension of being seen by others entering a counseling office.
- Medical mobility problems making it difficult for a client to get to a counselor's office, either due to a temporary or permanent medical issue.
- Mental health mobility problems such as ruminative anxiety about driving that rendered a client fearful of traveling to a counselor's office.
- Scheduling problems. Many clients have very full and active work and personal lives with employment, childcare, and other responsibilities making it extremely difficult for them to schedule counseling sessions.

The following case characteristics highlight productive uses of tele phone counseling:

- Intervening in situations where the client has had multiple no-shows for face-to-face sessions. This issue often overlaps with those above. Clients know they need and desire some assistance, often scheduling a counseling session, but when the time comes, they feel they cannot attend, often due to the reasons cited here. Initiating the counseling with telephone sessions, and possibly moving to face-to-face, if appropriate, is often a way to provide important services to those who no-show or cancel face-to-face appointments.
- Offering immediate resource, referral, information, and problem solving: Some clients can quickly identify what they need in the work/life or problem-assistance category. Counselors can respond to those needs immediately on the telephone, saving the client time and providing an immediate customer service intervention. Al though mental health professionals have often felt that the client may have more serious or underlying issues than the issue originally presented, completing an appropriate screening and offering immediate information or referrals saves the client time and pro vides good customer service. Immediate service creates a positive experience with the employee assistance program that may result" in continued and/or future use.

These examples help define a classification of client and case characteristics in which counseling by telephone is a helpful modality for pro viding employee assistance program services.

When conducting site visit audits of the on-site employee assistance program offices, Federal Occupational Health employee assistance pro gram consultants were asked to note any problems regarding cases having telephonic sessions. They identified no cases with problems, and in fact, received additional success stories from counselors. The formal program further supported existing patterns of service delivery.

Discussion

The implementation of a formal telephone counseling program met the goal of formally offering another method or modality for providing services to clients. The structured guidelines for counselors provided a consistent, clinically sound policy and procedure.

When used for appropriate clients according to telephone counseling guidelines with client prescreening and in situations where the counselor and client are comfortable with the use of the telephone, telephone counseling resulted in no decrease in clinical outcome, in client satisfaction, or in client productivity outcome measures. Client perceptions of accessibility and convenience of sessions were not impacted by whether telephonic or face-to-face _counseling was the modality of service.

We were expecting the number of telephone counseling cases and sessions to be higher after the formal guidelines were issued, but they were not. It is likely that, with the

issuing of guidelines citing appropriate instances of telephone counseling, situations where counselors were using or coding telephone sessions inappropriately into our data management system were decreased.

There were no significant differences between telephone counseling clients and the face-to-face clients in their perceptions of the ease of get ting through to the counselor by telephone, convenience of appointments, and overall accessibility of the employee assistance program. We had anticipated that telephone clients might rate accessibility and convenience higher, on the expectation that telephone sessions would be easier to arrange. This may not have been the case. Also, because the public expects more immediate action and results from the telephone, accessibility and convenience may have been easier by telephone, but since this pattern fit the clients' expectations, ratings were not impacted. This is in contrast to the Masi and Freedman (2000) study where it was found that 86.4 percent of the respondents believed telephone consultation provided quicker access to services.

There were also no significant differences between telephone counseling cases and face-to-face cases on client satisfaction responses regarding quality of service provided by the counselor, and perception of how closely the counselor listened. This result is of special interest since it indicates no decrement in perceived quality of service when offered by a modality sometimes considered a "lesser" one.

There have been no reports of clients utilizing telephonic counseling instead of affiliate counselor face-to-face counseling with negative results. In addition, the average telephone session is about half the length of a face-to-face session, which results in savings of staff time. If clients make the effort to see the counselor in person, both the client and the counselor may adhere to the traditional, hour-long counseling session. However, since telephone sessions have never had standard length of time associated with them, both counselor and client may end the session at what feels to be its natural close.

Conclusions and Future Directions

After the development and implementation of formal guidelines for conducting telephone counseling, Federal Occupational Health evaluated the impact of the implementation on several service delivery criteria. We emphasize that the telephonic modality was not used indiscriminately. In order to engage in telephone counseling, staff counselors determined that the clients receiving telephone counseling met the specific client characteristics criteria, and the clients themselves chose to receive tele phonic counseling. This group comprised a very small proportion of our total client population. Evaluation results show that telephone clients were satisfied with the services and reported comparable outcomes to the face-to-face counseling cases. Initial indications are that the structured availability of telephonic counseling may be cost effective and result in some savings of both counselor and client time. The availability of telephonic counseling also has resulted in the provision of services to persons who otherwise might not attend face-to-face

sessions. Given the positive outcomes of the Federal Occupational Health program, with no reported negative outcomes, it was strongly recommended that the structured telephone counseling guidelines remain in effect and that counselors be reminded to continue to use it when appropriate. Since some time has elapsed since the initial evaluation period, it would be in formative to review current data to see if results are consistent with those previously reported.

Organizations adding more "high tech" modalities to their existing service delivery models may choose to evaluate the impact of services using a multifaceted approach, as was done in this study, looking at: utilization, counselor feedback, clinical outcomes, client satisfaction and outcome perception, client anecdotal information, follow-up audits, cost, and efficiency impact.

References

American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV).* American Psychiatric Association: Washington, D.C.

Consumer Reports. (1995, November). Mental health: Does therapy help? (11)734-739.

Kirby, K.M., Hardesty, P.H., Nickelson, D.W. (1998, December). *Telehealth and the evolving health care system: Strategic opportunities for professional psychology.* Professional Psychology: Research and Practice, 29, 6, 527-535.

Masi, D. A., Freedman, M. (2000, May/June). *Factors that contribute to the utilization of telephone information/consultation and face-to-face information/consultation services,* Employee Assistance Professionals Association Exchange Research Supplement, 2-6.

Reese, R.J. (2000). *Client Perceptions of the Effectiveness and Appeal of Telephone Counseling.* Unpublished Study. Texas A & M University.

Reid, Jim (2000). A Telemedicine Primer: Understanding the Issues, Innovative Medical Communications.

Schneider, Paul (2000). A Comparison of Outcome Variables in Psychotherapy: Distance Technology Versus Face-To-Face. University of Illinois.

Smith, Henry A. and Allison, Ronald A. (1998). Telemental Health: Delivering Mental Health Care at a Distance. U.S. Department of Health and Human Services, Sub stance Abuse and Mental Health Services Administration, Center for Mental Health Studies, and Health Resources and Service Administration Office for the

Advancement of Telehealth, Rockville, MD.