Evidence Compass

Summary Report

Is online video counselling at least equally acceptable and equally as effective as in-person counselling?

A Rapid Evidence Assessment

March 2017

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This project utilised a rapid evidence assessment (REA) methodology. An REA streamlines traditional systematic review methods in order to synthesise evidence within a shortened timeframe. The advantage of an REA is that rigorous methods for locating, appraising and synthesising evidence from previous studies can be upheld. Also, the studies reported can be at the same level of detail that characterise systematic reviews, and results can be produced in substantially less time than required for a full systematic review. Limitations of an REA mostly arise from the restricted time period, resulting in the omission of literature such as unpublished pilot studies, difficult-to-obtain material and/or non-English language studies. A major strength, however, is that an REA can inform policy and decision makers more efficiently by synthesising the evidence in a particular area within a relatively short space of time and at less cost..

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Executive Summary

- This report reviews current research on the acceptability and outcomes of online video counselling (OVC) as an alternative to the traditional approach of delivering counselling in-person.
- New innovations in computer technology are opening the door for mental health practitioners to provide high quality services to a broader population of clients than ever before.
- Face-to-face communication is no longer restricted to those occupying the same room. Through the use of OVC, mental health professionals have the ability to see and treat clients from a distance, thus overcoming some of the limitations of traditional in-person counselling.
- The adoption of such services is important for addressing the significant access-to-care issues affecting not just residents living in rural areas of Australia, but also those who are unable to attend in-person sessions due to their other commitments, the nature of their illness or stigmatisation concerns.
- While there is a growing body of research demonstrating the potential of OVC to treat clients effectively, the efficacy of this treatment modality is yet to be rigorously established.
- The aim of this review was to explore the literature on OVC as a medium for the treatment of adults with a broad range of mental health problems, including depression, anxiety, and posttraumatic stress disorder. In particular, it investigates the efficacy of one-to-one OVC for the treatment of adults with mental health concerns and compares this treatment with traditional in-person counselling in terms of clinical outcomes, therapeutic alliance, client satisfaction and attrition.
- This literature review used a rapid evidence assessment (REA) methodology. The search identified two high quality recent systematic reviews of the literature relevant to the research aims. The first of these reviewed studies published between 1997 and 2010 and was conducted by Backhaus et al. (2012). This review focused on the types of psychological disorders investigated, clinical outcomes, satisfaction ratings, therapeutic relationship and attrition rates for OVC. The second, by Simpson and Reid (2014a), reviewed studies published between 1990 and 2013, with a focus on the therapeutic

alliance in OVC. These reviews were complemented with a literature search of later papers published before July 2016.

- These studies were collated to determine an overall ranking for level of support for OVC's equivalence to in-person counselling for (i) the treatment of depression and anxiety and PTSD, (ii) the establishment of a therapeutic alliance (iii) client satisfaction and (iv) attrition. The ranking categories were 'Supported' with clear, consistent evidence of equivalence with in-person counselling; 'Promising' with equivalence suggested but further research required; 'Unknown' or 'Not Supported' with insufficient evidence of equivalence or clear consistent evidence of inferiority.

- The search identified fourteen studies that considered the efficacy of one-to-one OVC for the treatment of depression and anxiety, four for the treatment of PTSD, fifteen that considered therapeutic alliance from the perspective of the client and four from the perspective of the therapist, and fourteen that considered the level of client satisfaction with one-to-one OVC. In all thirty-four papers were included in this REA.

- The key findings were:

    - Research has consistently demonstrated that despite the doubts of mental health professionals, a strong therapeutic alliance can be developed over OVC.

    - Both clients and practitioners tend to report positive experiences engaging in OVC, with satisfaction ratings typically high.

    - Importantly, the limited number of studies comparing OVC to traditional in-person counselling have shown that the clinical outcomes, therapeutic alliance and satisfaction ratings achieved in OVC are similar to those achieved in traditional in-person counselling settings.

    - Furthermore, there appears to be no significant difference in attrition rates between the two treatment modalities.

- Overall, the previous literature indicates that OVC may be at least as effective as traditional in-person counselling in achieving positive clinical outcomes for a broad range of mental health difficulties and disorders, however, these findings are often the outcome of uncontrolled, non-randomised trials with small sample sizes. A category rating of 'Promising' was therefore assigned for the level of overall support for the equivalence of OVC and in-person counselling. In order to validate these results, further, larger, randomised controlled trials are required.

- It is hoped that further validation of these findings will increase practitioners' awareness of, and confidence in, the benefits of OVC, leading to the increased utilisation of these services.

Background

In 2014-15 approximately 4 million Australians (17.5% of the population) were reported to have a mental or behavioural condition (ABS, 2015). The most commonly reported mental health problems were anxiety-related disorders (2.6 million people or 11.2% of the population) followed by mood disorders, which includes depression (2.1 million people or 9.3% of the population). However, not everyone lives within reach of a mental health professional, as the Australian population is quite geographically dispersed with approximately one third of Australians living in rural or remote areas (ABS, 2008). People living in these areas may find it difficult to access in-person care with studies showing significant disparities in regards to access to mental health care for rural residents compared to those living in urban areas (Schopp, Demiris, & Glueckauf, 2006). Furthermore, travel-related costs often make attending in-person counselling a costly experience for rural residents as they are often forced to take up to an entire day off work and pay for child care and travel expenses.

Needing to travel even short distances to receive in-person treatment can be difficult for many client groups (e.g., those with a disability, the terminally ill, the elderly and other groups unable to leave their homes) (Backhaus et al., 2012; Chester & Glass, 2006). Additionally, the very nature of some mental illnesses can make travel impractical (Bee et al., 2008), and such barriers may be inhibiting Australians from accessing mental health services and receiving the help they need. This is concerning considering that a delay between the onset of a mental health issue and treatment initiation is strongly associated with poorer mental health outcomes (Perkins, Gu, Boteva, & Lieberman, 2005).

One strategy that may help overcome these issues is the provision of mental health services over the internet (Barak et al., 2009; McFarlane et al., 2011) . Current internet technologies allow real-time video communication from many devices, including computers, laptops, tablets, and mobile phones. It is through such technology that the opportunity to reach more clients has been afforded.

Online video counselling (OVC) has been used since the 1950s with an increase in its use in the late 1990s (Rees & Haythornthwaite, 2004) and continuing through to

today as the technology becomes more accessible and inexpensive (Frueh, 2015; Richardson & Simpson, 2015; Simpson & Reid, 2014b).

This review aims to examine the efficacy of one-to-one OVC for the treatment of adults with mental health concerns and focuses on the use of OVC to treat adults suffering from depression, anxiety and PTSD disorders. In addition, this review examines the key process variables of treatment – the therapeutic alliance, satisfaction ratings, and attrition – and compares these OVC outcomes with those achieved in traditional in-person counselling.

Evaluating the evidence

There were five key components that contributed to the overall evaluation of the evidence:

1. The **strength of the evidence base**, in terms of the quality and risk of bias, quantity of evidence, and level of evidence (study design)
2. The **direction** of the study results
3. The **consistency** of the study results
4. The **generalisability** of the body of evidence to the target population (i.e., adults with a psychological disorder)
5. The **applicability** of the body of evidence to the Australian context.

Ranking the evidence

After the evidence was evaluated, the studies were ranked as follows:

Figure 1: Categories within the intervention ranking system

SUPPORTED	PROMISING	UNKNOWN	NOT SUPPORTED
	OVC equivalence to traditional in-person counselling for: • Depression and anxiety • Client Perceptions Therapeutic alliance • Client Satisfaction • Consistency across groups • Other outcomes and attrition	OVC equivalence to traditional in-person counselling for: • PTSD • Therapist perceptions of therapeutic alliance	

'**Supported'** means there was clear and consistent evidence of a beneficial effect of the intervention; '**Promising'** means the evidence was suggestive of beneficial effect, but requires confirmation with additional evidence/research; '**Unknown'** is defined as insufficient evidence at present on whether or not to support the use of this intervention, or additional evidence is required to determine efficacy of intervention; '**Not supported'** is defined as evidence suggesting that the intervention does not have an effect, or produces a harmful effect when implemented.

Implications for policy makers and service delivery

The findings of this REA build upon those of the Backhaus et al. (2012) and Simpson and Reid (2014a) systematic reviews, in concluding that the evidence base for OVC is largely 'Promising'. Despite evidence of a beneficial effect, this evidence has come mostly from non-randomised studies and underpowered RCTs. Therefore, these encouraging findings remain largely unsubstantiated.

Additional studies are needed to determine the true efficacy and acceptability of OVC and to determine whether OVC is truly equivalent to in-person treatment. This need

is clear when considering the prevalence of mental health problems among veterans and the general population, as well as the significant access-to-care barriers that may be preventing these individuals from seeking and receiving needed mental health care.

Moving forward, it is essential that new innovative ways to meet the mental health care needs of Australians are explored and tested (Simpson & Reid, 2014b). As stated by Simpson and Reid (2014b) in their 2020 vision for telehealth in Australia, more Australian-focused research evaluating the efficacy and effectiveness of OVC is “overdue”. Thus, in order to increase the utilisation of OVC among mental health professionals in Australia and begin to enhance access to care for veterans and the general population, further research empirically examining the OVC modality is required.

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