Sustaining Walk-In Counselling Services

An Economic Assessment from a Pilot Study

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Abstract

Introducing single-session walk-in counselling services in a counselling agency virtually eliminated a lengthy wait list and reduced costly no-shows for scheduled counselling. A pilot study found that client distress decreased significantly following the single session, and a high proportion of clients were "ready for change." The service diverts clients from using hospitals and family doctors/walk-in clinics and toward using community social services. It also enables an earlier return to work and usual activities. The social benefits (reduced hospital use and faster return to work) exceed the cost of the service. This information is helping to make the case for sustaining and expanding these services.

In 2007, Kitchener-Waterloo Counselling Services (KWCS) had a waiting list of 981 clients. Delays in access to service led to costly no-shows once a first appointment was finally scheduled. In response to this unsustainable situation, the new executive director initiated consultations that led to the start of single-session walk-in counselling services one afternoon each week. She anticipated that by responding quickly to clients at a time when they expressed readiness to change, counselling would have the greatest effectiveness.

The walk-in counselling service admits clients between noon and 6:00 pm every Thursday. The last client leaves by approximately 8:30 pm. The average wait for service is 20 minutes. There is a 20-minute intake and initial screening, followed by a counselling session of one and a half to two hours. On average, about 30 clients are served per week (range approximately 20–50 clients). Clients are asked to pay on a sliding scale related to income, ranging from $0 to $120 for the session. Sessions can be for individuals, couples or families. The clinic has been so successful that the wait list for traditional counselling has been virtually eliminated, and family service agencies across the province are considering emulating the model.

Despite the success, there have been few evaluations of the effectiveness of single-session walk-in counselling, although client satisfaction is well documented (Hymmen et al. In press). Funding for these services remains precarious: at KWCS, about 13% of the costs are borne by clients and some clients are covered by funding from provincial or municipal governments, but the majority of funding is from charitable sources.

A pilot study was undertaken to evaluate the walk-in counselling services at KWCS to better understand the profile of users, to examine effectiveness and to consider the case for continued funding of these services. No previous study of costs and benefits of walk-in counselling could be identified.

The hypothesis tested here is that single-session walk-in counselling generates economic benefits through the reduced use of hospitals and doctors and the more rapid return to work and usual activities. We describe elsewhere our findings regarding clinical effectiveness and who benefits (Stalker et al. 2012). Briefly, clients report strong improvements in self-reported distress within two to four months of the walk-in session, and a short questionnaire on "readiness-for-change" predicts quite well at the outset who will (or will not) benefit from the session.

Background

The economic costs of mental illness and addiction are high. The Ontario Ministry of Health and Long-Term Care (2009) estimated that provincial spending on mental health and addiction services was $3 billion in 2007–2008, based on data from this ministry and the Ministry of Children and Youth Services. The same study also estimates that the costs outside the health sector were of the order of $39 billion annually (including lost productivity, law enforcement, disability claims, drug costs and employee assistance programs).

Mental health conditions vary considerably in severity. Not surprisingly, the more severe conditions are time consuming and expensive to treat; but, obviously, the economic and social costs of not treating them can be even higher. The most rigorous economic studies (using the double-blind, randomized controlled trial methodology) are of pharmacotherapy. However, according to Bosmans et al. (2008) many patients prefer psychological treatments over medication for treating depression; hence, economic studies of psychotherapy are important.

Walk-in counselling has the potential to fit into the provincial model of "right care, right time, right place."

Systematic reviews of economic studies involving psychotherapy provide some insights. For treating major depression, although it can cost more than usual physician's care, psychotherapy has greater benefits, which may justify its use (Schulberg et al. 2002). Community-based care is both less costly and provides greater benefits than in-hospital care (Roberts et al. 2005). With regard to treating depression, providing training to primary health teams, adding specialized staff and training clinicians to provide specific therapies are all cost-effective, with larger benefits being obtained from the more costly interventions (Glied et al. 2009). One review of counselling in primary care was not able to draw firm conclusions regarding its cost-effectiveness (Bosmans et al. 2008). Another review of counselling in primary care (Bower and Rowland 2006) concluded that it led to better outcomes in the short term but no significant difference in the long run, and found high levels of client satisfaction but no reduction in overall healthcare costs. Cost-effectiveness studies are rare for services provided by social work agencies (Cnaan and McLaughlin 2011; Mullen and Shuluk 2010).

Undertaking an economic analysis of walk-in counselling is a high priority. Walk-in counselling/planned single-session therapy is already available in about 10 other family service agencies in Ontario, and Family Service Ontario is advocating further expansion. Single-session walk-in counselling has been used in the United States, the United Kingdom and Australia for several decades (Slive et al. 2008; Taylor et al. 2010).

Walk-in counselling in Ontario has the potential to fit into the provincial model of "right care, right time, right place" (Government of Ontario 2012). For 75% of clients, one session is enough to give them some tools and confidence to work on their problems, and to identify community agencies that can provide support. Clients presenting with more serious concerns (e.g., suicidality, homicidality, addictions or

intimate partner violence) are referred for additional support, including continued counselling, more specialized agencies and, for a very small group (about 1%; Cindy Jacobsen, KWCS, personal communication, March 17, 2011), in-patient services. Conversely, KWCS regularly receives clients who have been referred by healthcare service providers.

Methods

According to agency statistics from January 2010 to February 2011, 17.6% of KWCS walk-in counselling services clients are aged 20 years or less, 52.1% are between 21 and 40 years old, 26.3% are 41–60 and 4.1% are over 60; 58% are female, and 42% are male. Twenty-nine percent did not report their relationship status, and of those who did, two thirds were single. Just over two thirds reported their income as below $20,000 per annum, and over 90% reported their first language as English. As compared with clients of an agency offering traditional counselling (without a walk-in service) in London, Ontario, just over an hour away, clients at the walk-in services were younger and reported lower incomes, but there was no difference in the gender composition.

Nineteen percent said they would otherwise have sought help from hospital emergency rooms.

The study was originally intended as a quasi-experimental design using, as a control group, clients of a different service at the same agency (clients attending the first session for scheduled counselling). The response rate from the intended control group was very low, most likely because the pilot project was unfunded and it was not possible to have research assistants on site all week to invite participation. The findings are therefore preliminary, but point to the possibility of cost savings. And there are findings regarding the methodology that may be useful for future research.

Details of the research ethics–approved methods are provided elsewhere (Stalker et al. 2012). In summary, baseline data were collected for 13 weeks (the end of May to the end of August 2010), using a self-reported paper questionnaire in English, with consenting clients receiving and returning follow-up questionnaires by post.

At baseline, clients aged 16 years and older were asked to provide brief standard socio-demographic information and to state the problem concerning them most. They were asked to respond to an 18-item questionnaire measuring their readiness to change (Bellis 1994), which has been analyzed elsewhere (Stalker et al. 2012). At baseline and follow-up, clients were also asked to self-report using a widely employed measure of psychological health (the General Health Questionnaire, or GHQ-12 [Goldberg 1972]). They were questioned about their use of health services over the past month and their ability to work and undertake normal activities during that time; these questions were adapted from similar questions used in a range of countries by the World Bank in the Living Standards Measurement Surveys (Grosh and Glewwe 1998).

At baseline, 62.5% of clients (n = 225) returned the questionnaire, and 64.9% of these (n = 146) consented to follow-up. Twenty-eight responses were received at the one month follow-up, but too few responses (eight) were received at the second month to yield useful results. Instead, a research ethics application was approved to mail out an additional questionnaire after four months to all those who had originally consented to follow-up. Respondents were informed that if they chose to mail back the four-month questionnaire, they would receive a small incentive (a $10 coupon valid at a national coffee franchise). Twenty-four individuals responded to this incentive, 15 who had previously responded after one month and nine who had not. Data analysis employed simple t tests, using the 5% level of significance. Resource costs were obtained from published sources (where available) or agency records.

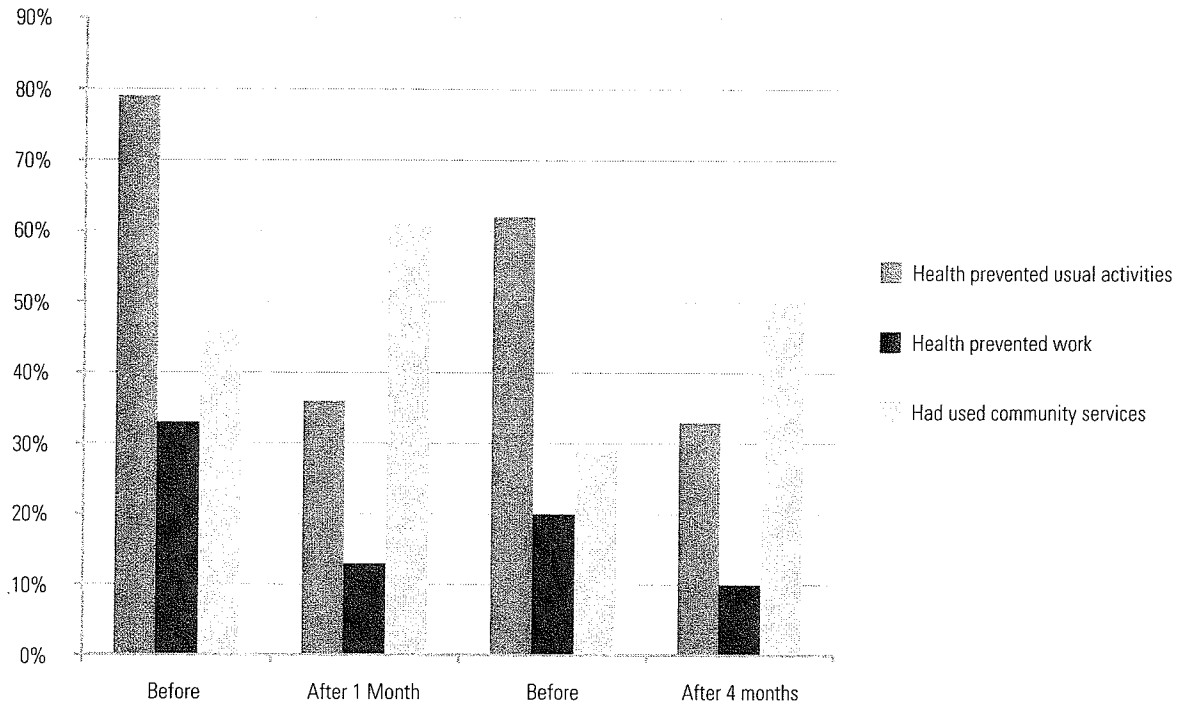
Findings

There were no significant differences at baseline between those who consented to follow-up, those who responded after one month and those who responded after four months, as compared with all those who responded at baseline (Stalker et al. 2012). The sole exception was that those responding after one month were more likely than all those originally surveyed at baseline to state that health prevented their usual activities (79% versus 55% overall; the difference was significant at the 5% level).

At baseline, a large proportion of those who subsequently responded at one month or four months or both reported that health issues limited their normal activities and their ability to work. They also reported a high use of medical and community support services and high levels of distress (the GHQ score ranges from zero to 12, with 12 indicating the highest level of distress; a score of three or higher indicates a "case"). Higher scores on the psychological distress scale (GHQ) are known to be correlated with poorer physical health (Andrews et al. 1977; Corney 1984).

A before-and-after comparison was made for the group who responded after one month and for the group who responded after four months (Figures 1 and 2). There was a significant improvement in the proportion able to undertake their normal activities (see Figure 1). GHQ scores decreased (health improved) significantly after one month, and after four months the average score fell below the level that would indicate a case (a score of three; see Figure 2). Other differences were observed that did not however attain the 5% significance level. Those who reported at baseline that they were employed (full or part time) indicated that they were less likely to have missed work for health reasons in the previous month (see Figure 1), and the average number of days lost per employed person fell (see

FIGURE 1.
Before-and-after comparison of responses by walk-in clients (percentages)



All questions referred to the previous month's experience.

Figure 2). There was an increase in both the proportion using community support services (see Figure 1) and the average number of community services accessed (see Figure 2). There was no trend in use of emergency rooms and doctors' visits (not displayed on the figures).

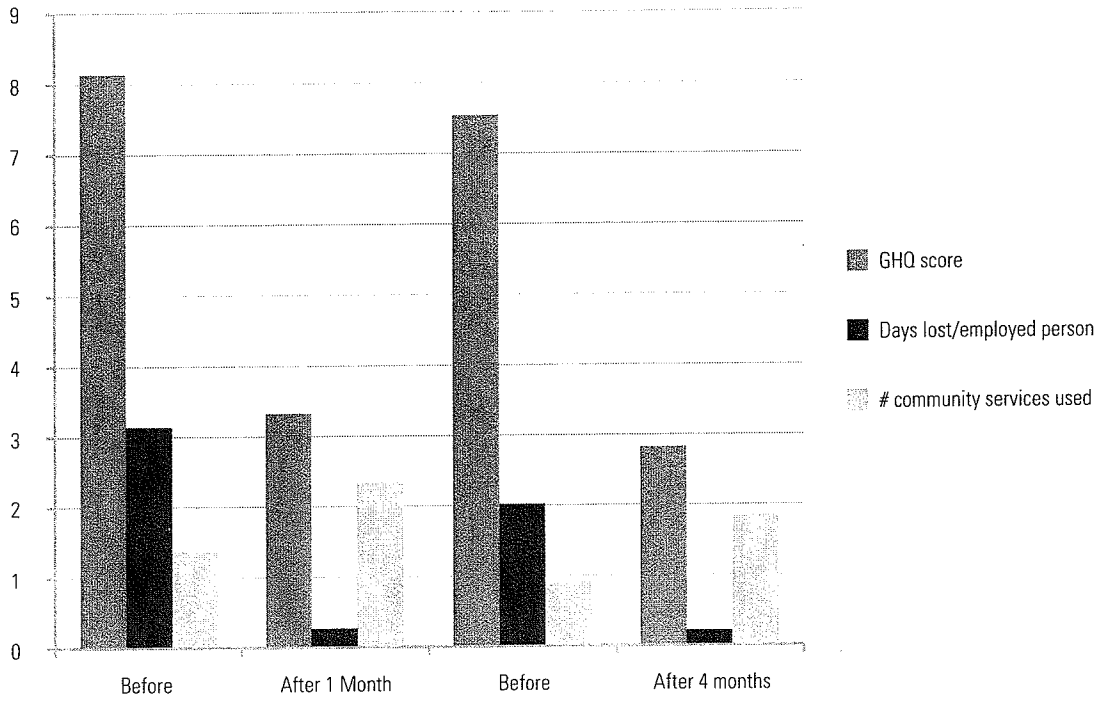
Estimates as to whether there were cost savings in the health-care system and societal cost savings due to earlier return to work were made using published cost data/billing schedules (or, where not available, financial estimates from the agency). We made the conservative assumption that the biggest effect of walk-in counselling occurred in the first month after the visit, and assumed that some improvement would have occurred, even without counselling, after several months.

The use of health or social services did not decrease significantly following the use of walk-in counselling. However, responses to the hypothetical question at baseline, asking where clients would have sought assistance if walk-in counselling services were not available, are suggestive. Nineteen percent said they would have sought help from hospital emergency rooms. Based on an estimated $395 per emergency visit, each visit to walk-in counselling potentially averted $75 (19% of $395) in health system costs. The estimate of $395 is based on the cost of an emergency visit being $260 excluding physician costs (Canadian Institute for Health Information 2010), and a general consultation with a physician being $67.50 (Ministry of Health and Long-Term Care 2011) assuming one consultation in emergency and one follow-up.

There are additional benefits in terms of ability to return to work. On average, for each client, work loss prior to visiting the walk-in counselling exceeded that at follow-up by 1.2 days (based on the respondents at one month). One day's work even at minimum wage represents approximately $80. Economists typically assume that the wage is a measure of the productivity loss to society. The loss of 1.2 days of work (comparing the month prior to the visit with the one immediately after) is therefore valued conservatively at $96.

The cost of walk-in counselling per client is estimated at $120 for one session (financial records, KWCS). In addition, each walk-in session is associated with, on average, 1.0 additional use of community support services per month following the walk-in session, averaged over all clients. It is difficult to cost the community supports since they are heterogeneous and because some are paid whereas others involve volunteers. An educated guess suggests that the cost is at least $10

FIGURE 2.
Before-and-after comparison of responses by walk-in clients (means)



All questions referred to the previous month's experience. GHQ = General Health Questionnaire.

(minimum wage for one hour) but less than the cost of a visit to a family doctor ($67.50); $30 is a reasonable estimate.

Hence, the societal costs savings per client in the first month following a visit to the walk-in session are estimated as being $75 (in averted visits to hospital emergency rooms) plus $96 (in earlier return to work). The cost per client of a visit to walk-in counselling is $120, plus the cost of one additional visit to a community support service (estimated at $30). Accordingly, the societal cost saving per client in the first month is estimated at only $21. The savings might be greater if the benefits continue after the first month and if there are reductions of more serious consequences (suicidality, intimate violence, homicidality, in-patient stays). On the other hand, these benefits may be overstated if patients would have recovered (or partially recovered) spontaneously in the first month in the absence of immediate psychotherapy at a walk-in counselling service.

Discussion

These findings are from a walk-in service that has operated successfully for almost five years, and they lend support for the case that these services provide net social benefits. They are consistent with findings from the literature, which suggest that there are economic benefits to counselling or psychotherapy due to an earlier return to work (de Maat et al. 2007) and treatment being less expensive in the community than in a hospital (Roberts et al. 2005). While the evidence for cost savings in the health sector is mixed (Bower and Rowland 2006), the net benefits from a societal perspective are positive (earlier return to work and usual activities).

Since the sample size was small and efforts to collect data from a control group were not successful, a larger study is now commencing (with a comparison agency), funded by the Canadian Institutes of Health Research. We expect this new study will further allow us to assess the case for expanding and sustaining the use of single-session walk-in counselling services. HQ

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