PRESIDENTIAL
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ESTABLISHING VIABLE STANDARDS FOR MENTAL HEALTH SERVICES AT THE PENNSYLVANIA STATE UNIVERSITY

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I | EXECUTIVE SUMMARY

As the mental health of students becomes an increasing issue on college campuses, the Pennsylvania State University (Penn State) is dedicated to ensuring quality care for its students through its Center for Counseling and Psychological Services (CAPS). It is clear through patient surveys, the annual monetary endowment from the 2016 Class Gift Committee, and the future implementation of a student health fee by the University Park Undergraduate Association (UPUA), that Penn State is dedicated to improving college student mental health for every student.

Since improving CAPS is the main goal for Penn State and CAPS administrators, it is necessary to hold oneself to the highest possible standard. In order to continue advancing the progress Penn State has made to improve CAPS, it is essential to look beyond campus borders and examine a variety of other universities. Currently, CAPS is compared to other similar, Big 10 universities in order to rank and assess its mental health services. However, this comparative process is done infrequently, resulting in sporadic data accumulation. The issue that needs to be addressed is not just of evaluating current performance, but establishing higher standards in order to ensure quality care to future Penn State students.

This policy elaborates on how to set standards that will improve CAPS. The first approach is through a comparative evaluation technique known as benchmarking. Benchmarking was chosen due to the success it has had in businesses, its relatively low cost, as well as the ease with which it can be performed. Therefore, examining external universities through a benchmarking mechanism will identify the highest standards that are achievable for CAPS. Additionally, it will maximize efficiency and improve its overall performance.

The second part of this policy arose because of the preliminary research performed on a benchmarking mechanism. It would involve the establishment of the first online counseling services offered at any university throughout the country. Initially, this portion of the policy

would apply specifically to Penn State World Campus students, but with time will be available to all Penn State students. Since there are currently no other universities that employ an online counseling program, this policy examines the implementation of an online counseling pilot program at Penn State. The goal of this pilot program is to make Penn State the benchmarking standard – the standard to which other universities should strive to be – for improving mental health care for students.

This policy was developed in response to the pressing question, how can CAPS be improved? In order to address this issue, a benchmarking mechanism was constructed to provide infrastructure for continual assessment of CAPS by comparing it against a variety of different universities across the United States. An online counseling pilot program was developed to assess and improve online counseling services to demonstrate the practicality of this benchmarking mechanism. This policy seeks to not only improve CAPS, but to make it a true leader in the mental health care of college students.

II

INTRODUCTION

2.1 | A BRIEF HISTORY OF MENTAL HEALTH

Mental health has become a major topic of discussion over the past several decades. This is evident through the emphasis that universities and workplaces have begun to place on mental health. The Pennsylvania State University (Penn State) is a major advocate of positive mental health and wellness. It offers various clubs and counseling services that promote well-rounded mental health. The Penn State University Park Campus, as well as the Penn State Commonwealth Campuses, all prioritize mental health. However, mental health has not always been a major concern throughout history.

The earliest instances of societies noticing mental illness date back to 5000 BCE (Foerschner, 2010). In these times, people had no knowledge of the true source of mental health issues. Society often deemed people suffering with mental health problems as deviants that were affected by sorcery, the evil eye, or by a supernatural being (Foerschner, 2010).

People who suffered from various mental health issues were administered treatment in brutal and horrific ways. One of the earliest forms of addressing mental health was called trephining (Foerschner, 2010). This involves drilling a hole in the skull of the individual who was thought to be experiencing some form of supernatural possession. In Neolithic times, this was believed to release the evil spirit that was inhabiting the body or brain of the affected person, therefore curing them (Foerschner, 2010).

In the following centuries, the treatment of people with mental health issues did not improve. Many people were put in hospitals or asylums because doctors felt that they could not cohabitate with non-deviant people. Patients were exposed to dehumanizing treatment that rivaled torture (Farreras, 2016). This mass institutionalization of people led to the invention of the lobotomy by Dr. António Egas Moiz in the early 20th Century (Farreras, 2016). The procedure was originally performed using an ice pick or ice pick-like object that was usually inserted through the eye socket to functionally damage the prefrontal lobe brain. This procedure

mentally infantilized and debilitated approximately 19,000 people in the United States alone (Farreras, 2016).

In the late 20th Century, people and medical professionals began to see the legitimacy of mental health issues as humanely treatable problems. This marked a shift in the culture of the United States that put the country on track to achieve the level of mental health concern and awareness observed in today's world. This change in perspective is evident throughout modern society, including the Penn State University Main and Commonwealth Campuses.

2.2 | COUNSELING & PSYCHOLOGICAL SERVICES AT PENN STATE

At Penn State University Park Campus, mental health services are offered to students through CAPS. CAPS is led by Director Dr. Ben Locke, and it offers a variety of services from group therapy to individual counseling. It also has emergency/crisis services. CAPS has also created a system that offers six free counseling sessions before students have to begin to pay for their counseling via a nominal fee.

The mission statement of CAPS explains that it is a safe space where people's thoughts and concerns are addressed in a "supportive environment" ("Class of 2016 supports fellow students with enduring gift to CAPS," 2015). CAPS is in place to handle a variety of issues that may be as severe as sexual assault counseling or medically diagnosed mental health issues related to stress and the pressures of everyday life as a college student.

Penn State is committed to the improvement of CAPS, and Dr. Locke devotes a significant portion of his time to analyzing how the mental health services offered by CAPS can be modified and improved. One of the catalysts that has made CAPS so successful at Penn State was an endowment nearly a year ago. The endowment was given to CAPS by the Penn State University class of 2016 Class Gift Committee. This endowment ensures that CAPS will have permanent annual funding (Counseling & Psychological Services, 2016). An additional

new source of funding may begin in the Fall of 2017, as a result of the University Park Undergraduate Association (UPUA) introducing changes in the student activities fees that may allocate approximately 15 dollars per student annually to funding CAPS (Shockley, 2016).

Overall, CAPS has developed into a successful center for mental health services at the university level. According to Dr. Locke, the CAPS student experience falls into the satisfaction category of assessment. Random clinical trials and assessments have supported that CAPS mental health services are effective. Through preliminary comparison of CAPS services to other universities' mental health services, CAPS is "average," according to Dr. Locke (personal communication, October 19, 2016). However, CAPS should strive to not just provide average services. It should aim to be the leading mental service unit at the university level. In order to address the question, "how can CAPS be improved?" it requires a system that stresses evaluation and assessment. In the past, CAPS has conducted internal patient surveys to determine what aspects needed improvement, but such surveys were met with little success as students rarely provided substantial feedback to create meaningful change in the organization. Therefore, this policy proposes an alternative evaluation technique known as benchmarking that does not rely on student feedback.

Instead, it provides quantitative data that businesses and organizations can use to draft an action plan for improvement. It serves as an objective measuring process that helps administrations make informed business decisions, develop strategies, create initiatives, and improve various processes. Benchmarking also points out any subtle deficiencies in an organization so they can be correct.

This policy supports the implementation and practicality of benchmarking to improve the performance of CAPS. This policy proposal emphasizes the usefulness and practicality of benchmarking CAPS mental health services to mental health services at other universities throughout the United States. It examines why benchmarking is a superior evaluation

technique, how other universities employ benchmarking, and how a benchmarking mechanism for evaluating CAPS should be organized.

CAPS is only one example of Penn State's dedication to improving mental health in the Penn State Community. Penn State World Campus is an emerging platform that promises students the flexibility and mobility of an online degree, but at the same time, presents the challenge of providing adequate mental health services to students in more geographically isolated locations. In order to provide World Campus students a mental health treatment option and to provide an alternative treatment option for Penn State students at University Park Campus, an online counseling pilot program was developed. This pilot program evaluates the implementation of online counseling as an additional treatment option that provides students increased access to mental health services.

Initially, the benchmarking mechanism gave rise to the idea of online counseling at Penn State. After comprehensive research it was discovered that there are currently no other universities that offer online counseling services. Since there is no established form of online counseling at Penn State, nor any other university, comparison through benchmarking is not applicable at this time. This led to the development of a pilot program that outlines the requirements and logistics for implementing online counseling.

Online counseling is an important aspect of improving Penn State mental health services because it makes it more convenient for students to attend counseling sessions without walking to the University Health Services Building or other mental health counseling locations. It is also beneficial to Penn State World Campus students who are not located close to Penn State Main Campus or any of the Penn State Commonwealth Campuses. Additionally, online counseling assists CAPS by decreasing the wait list for in-person mental health services. In summary, online counseling promises to add to Penn State's dedication to addressing mental health services by providing additional treatment methods that will increase the number of

students that can be treated for mental health issues. Therefore, establishing an online counseling program sets Penn State apart from other universities by being the first university to explore online counseling as a viable treatment method, ultimately setting the standard for future benchmarking by other universities.

This policy examines benchmarking as an assessment tool to improve the performance of CAPS. Within this policy there are two concepts. The first is regarding meeting and achieving standards that are being set by various universities across the country. Benchmarking provides quantitative data that Penn State can use to make informed decisions on developing actionable plans to improve CAPS. The second is regarding setting standards through the developed online counseling pilot program. This program will provide a practical display of how benchmarking can be used as an improvement technique for CAPS by setting Penn State apart from other universities. Online counseling is an unexplored avenue of mental health care at the university level that will assist with treating additional students and offer an alternative treatment option to in-person counseling.

Benchmarking is a tool for the Penn State administration to use to improve the mental health services provided by CAPS. It will achieve this goal by comparing Penn State to other universities and by implementing an online counseling pilot program.

III

POLICY 1:

ADOPTION OF AN INTERCOLLEGIATE BENCHMARKING MECHANISM

3.1 | PREFACE TO BENCHMARKING

Benchmarking can be defined as the identification of comparators and the collection of data to evaluate a level of performance. It is a means of comparing an institution's operations or standards to those of its peers in attempt to improve performance, alleviate weak points, and highlight strengths (Garret, 2016). It is a valuable tool in moving beyond average performance, to best performance. The goal of benchmarking is to provide key personnel in charge of a process or organization with an external standard for measuring the quality of internal activities, and to help identify points in need of improvement (Alstete, 2016). Benchmarking is an ongoing, systematic process for measuring and comparing the processes of one organization to those of another by bringing an external focus to internal activities and operations.

The strategy of benchmarking is currently being used to improve administrative processes as well as instructional models at colleges and universities by examining alternative processes and adapting their techniques and approaches. Benchmarking has been met with great success not only in businesses and corporations, but in higher education universities as well. Purdue University has used benchmarking to increase the success of its sustainability program through assessment of peer institutions ("Peer Benchmarking," 2013). University of Kentucky regularly uses benchmarking to examine areas such as tuition, faculty salaries, diversities, and retention and graduation rates ("Benchmark Comparisons," 2014). Community colleges also use benchmarking as a way to identify ways to improve student involvement since they are largely commuter campuses ("Center for Community College Student Engagement," 2009).

The versatility of benchmarking allows it to be adapted to almost any organization, process, or strategy. Identifying key metrics for the benchmarking purpose, defining a comparison group, and finding data are the three critical components of a benchmarking

mechanism; identify those three areas, and the benchmarking process can easily be applied.

To evaluate the mental health services provided at CAPS, points of evaluation must be identified, schools selected for comparison, and data collected. Treating CAPS as the entity that will be evaluated in the hopes of improving its services, benchmarking can be utilized to answer the following questions:

- How does CAPS compare to counseling services at other universities?
- How does CAPS' performance measures against other universities'?
- How can we adapt practices to make CAPS excel?

3.2 | THE BENEFITS OF BENCHMARKING

Statistical comparative methods have increasingly been used in health care to measure and evaluate performance. More recently, mental health services have started to recognize the potential of these methods and started to consider data driven approaches. In the scope of the mental health care infrastructure development, quality measurement has progressively become essential (Hermann, Chan, Provost, & Chiu, 2006). Conjointly with this trend, general accreditation and certification systems have improved performance (Lovaglio, 2012). Developing a rigorous and customized mechanism for a specific institution has higher potential and can drive quality improvement further. This proposal focuses on developing a comprehensive benchmarking mechanism that can provide a continued effort to maximize resource potential.

To ensure quality mental health care, it is essential for CAPS to strive for improvement in performance, looking at both efficiency and effectiveness. As Ozcan (2014) states, being efficient mostly refers to providing a certain quantity of service at a given standard of quality, using the fewest resources possible (Ozcan, 2014). Dr. Locke's continued efforts and the

redesigning of the clinical system in 2015 to meet overwhelming demand have helped CAPS operate at a high level of efficiency. In addition to efficiency, effectiveness is an important aspect of performance; efficiency and effectiveness are both closely related. This means that a growth approach that focuses mainly on efficiency can in fact overlook a source of growth with significant potential. When considering effectiveness, the questions shift to the consideration of whether the current practices and resources result in the best outcome. (Ozcan, 2014).

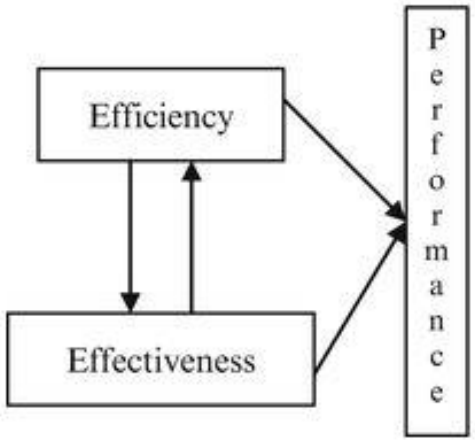

Figure 1: Relationship between Efficiency, Effectiveness and Performance (Ozcan, 2014)

The approach of achieving quality through efficiency is not flawed. Studies have shown clear evidence of quality resulting from an increase in efficiency (Hermann, Chan, Provost & Chiu, 2006). Ideally, both these facets of quality can be improved at the same time (Ozcan, 2009). If CAPS can establish mechanisms that ensure sustained and structured efforts to improve performance, Penn State's provision of mental health services will continually maximize the allocation of scarce resources.

The situation that CAPS is facing is not exclusive to Penn State. Universities across the nation are dedicating tremendous efforts to manage the overwhelming demand and shifting trends in mental health care. This is a situation in which a somewhat unified innovative effort will accelerate the development process and help spread best practices across campus counseling centers.

The introduction of a rigorous benchmarking system can potentially provide great benefits if developed and updated appropriately. Benchmarks would identify high performing counseling centers for measures of interest and provide an improvement guideline. Additionally, it is essential to have a system in place that will allow for the analysis and adoption of practices that contribute success. Benchmarking is a process that involves institutional collaboration to search for and implement best practices at the lowest cost (Ettorchi-Tardy, 2012).

CAPS is completely invested in handling the overwhelming demand for services and maximizing efficiency, causing their ability to see beyond their own operations to become compromised. The distinction between efficiency and effectiveness can begin to blur as waitlists and appointment waiting times increase, so a rigorous system that can remain impassible and provide valuable input on quality improvement is an invaluable asset. Benchmarking avoids the risk of missing out on the progress that counterparts achieve at other counseling centers in universities around the country (Bogan & English, 1994).

A common benchmarking mistake is to compare an organization to industry averages. Truly beneficial benchmarking utilizes the levels of performance of best-performing providers as indicators to develop achievable targets (Hermann et al, 2006). It is not simply a matter of comparison to the best, but one of customizing objectives to make them realistic and informative in regards to decision-making.

Overall, establishing a competent and comprehensive benchmarking mechanism can be an immense step in the scope of performance improvement. Benchmarking would provide CAPS and the Penn State administration a reliable way to ensure ongoing maximization of allocated resources.

3.3 | THE POTENTIAL OF BENCHMARKING: CURRENT EXAMPLES

Benchmarking was first developed in the 1980s and utilized by the business sector. It quickly gained respect from the healthcare community, but has yet to be employed regularly by higher education institutions. Since it has proliferated in the business sector, benchmarking networks, clubs, and resources have become available to provide numerous data sources for organizations that wish to benchmark.

To assist organizations with benchmarking, the American Productivity and Quality Center (APQC) was developed to help organizations work smarter, faster, and with greater confidence. APQC is the world's foremost authority in benchmarking, best practices, process and performance improvement, and knowledge management. APQC's unique structure as a member-based nonprofit makes it unique compared to its competitors in the marketplace. APQC partners with more than 500 member organizations worldwide in all industries. With more than 40 years of experience, APQC remains the world's leader in transforming organizations with respect to improved management and performance ("About Us," 2016). Since the establishment of APQC, benchmarking has been transformed into a legitimate business within the United States.

While APQC is predominantly used by business and corporations for assistance with benchmarking, higher education universities and colleges use the National Association of College and University Business Officers (NACUBO) as their primary agent to facilitate the nationwide collection of sharing information for benchmarking. Founded in 1991, NACUBO's goal is to encourage the cooperative discovery of best practices and use of data to improve operations (Farquhar, 1998).

Another resource for the practical implementation of benchmarking is the Association for Continuing Higher Education and the American Assembly of Collegiate Schools of Business. Similar, to NACUBO, these organizations provide databases and resources for data

collection and university comparison. They do not assist with the benchmarking process, but merely provide the resources necessary for the process (Farquhar, 1998).

Despite the presence of online resources for collection of data, universities currently perform benchmarking independently. The process is undertaken by a single institution that seeks out partners that it believes to excel at a given process. The institution determines what they can do differently to improve their own results and tries to adapt practices to their institution. Because most of this activity is independent of regulation, literature on the success of benchmarking at universities is difficult to find (Farquhar, 1998). While international benchmarking studies have occurred throughout European, South African, and Australian universities, benchmarking within the United States is limited (Farquhar, 1998). One example of a university that has publicly accessible data on their use of benchmarking is the University of Kentucky (UK).

UK, a medium-size public university, employs benchmarking as a means of assessing UK's standing in areas including tuition, faculty salaries, diversity, and retention and graduation rates. The UK's Institution Research and Advanced Analytics branch performs benchmarking analysis and data collection independently. The university review committee meets every 2-3 months and identifies a set of benchmark universities that will help the UK become stronger and more effective in a certain area ("Benchmark Comparisons," 2014).

In 2005, the selection committee gathered to select benchmark universities based on a mandate set forth by the university. According to the Council on Postsecondary Education (2005), this mandate required UK to become a "major comprehensive research institution ranked nationally in the top twenty public universities." The criteria for selecting benchmark universities based on this mandate, were determined by the review committee and consisted of the following:

A comprehensive array of undergraduate, graduate, and professional programs, many

with national prominence;

Attracting and graduating outstanding students capable of making significant contributions to their professions and communities;

A distinguished faculty whose research, service, scholarship, and teaching are exemplary;

The discovery, dissemination, and application of new and significant knowledge;

Diversity of thought, culture, gender, and ethnicity that creates communities of learning and appreciation at the university and beyond; and

Improvements to the health and educational, social, economic, and cultural well-being.

Indicators of universities consistent with these criteria were determined to be:

Total & federal research dollars;

Endowment assets;

Annual giving;

Faculty academies membership;

Faculty awards;

Number of doctoral students produced;

Number of postdoctoral appointments; and

Undergraduate SAT scores (Council on Postsecondary Education, 2005).

In the end, the committee identified a set of 11 benchmark universities. These universities include Michigan State University, Ohio State University, University of Arizona, University of California – Davis, University of Florida, University of Iowa, University of Michigan – Ann Arbor, University of Minnesota – Twin Cities, University of Missouri – Columbia, University of North Carolina at Chapel Hill, and University of Wisconsin – Madison ("Benchmark Comparisons," 2014). Data was collected not through a general database, but from each individual university's website.

University of Louisville employed the same process (overseen by UK). A mandated was set forth by the university, the selection committee identified criteria for benchmark universities, established identifiers for such criteria, and then reviewed and finalized a list of universities to examine (Council on Postsecondary Education, 2005).

Because benchmarking is a versatile assessment tool, universities can employ it to measure any aspect of performance. From a practical viewpoint, benchmarking is successful if the following process is employed:

A clear objective is announced that serves as the basis of the benchmarking evaluation;

This objective can be a process, service, new initiative, or general goal mandated by the university;

Criteria are established for reaching said objective;

Identifiers are selected that assist with selecting benchmark universities;

A committee selects possible benchmark universities; and

Benchmark universities are reviewed and finalized.

As illustrated by UK, benchmarking can be performed individually without aid from a central agency. While benchmarking is a useful evaluation technique, the lack of centrality and uniformity introduces a certain level of variety and error. As universities increasingly employ benchmarking and benchmarking transitions from business to higher education establishments, there is a growing need for a central agency to collect data and establish guidelines. In response to this need, APQC has put together a knowledge base of education best practices that is accessible online. Once members of APQC, universities benefit from shared information that is easy to access. APQC's Benchmarking Portal – accessible only to APQC members – puts critical performance data in one location that can be reviewed and evaluated. Member universities also can upload and submit their own data. This database contains thousands of performance metrics to evaluate, along with several peer group options ("About Us," 2016).

Even though UK does not employ benchmarking to measure mental health services, this example nevertheless illustrates the practical implementation of benchmarking. Benchmarking is not dependent on the objective being evaluated, but the mechanism employed. Currently, both APQC and NACUBOs contain information on universities and metrics for benchmarking, but they do not store data on mental health services on college campuses. Therefore, Penn State would have to implement a benchmarking mechanism independently, like the UK example.

3.4 | DEVELOPING A HOLISTIC BENCHMARKING MECHANISM

3.4.1| Identification of Target Measures and Processes

The success of benchmarking is largely dependent upon the selection pool (often referred to as a collaborative group) that is created. Putting aside the theory, benchmarking is strictly the examination of peers with respect to a topic of interest. To evaluate the performance of CAPS, it is necessary to compose a collaborative group of universities in which to compare mental health services. The identification of this collaborative group would be the foundation of the benchmarking mechanism as it provides the basis for measurement, evaluation, and data collection for analytical reports.

Research has shown that general health care services (such as services provided by hospitals) have been improved through benchmarking by selecting measurements that assess quality. Part of quality is diversity among health care systems (Lovaglio, 2012). Criteria for selecting benchmarking establishments include prevention, access, assessment, treatment, continuity, safety, and outcomes of the provided care (Herman et al., 2006). These criteria were set, established, and evaluated by health care professionals.

Similar to the assessment of health care services, assessment of CAPS depends on the

selection of benchmarking criteria. The collaborative group should ideally be a collection of diverse universities varying in services offered. The purpose of benchmarking is to examine exterior organizations and choose the best service models. This can only be accomplished if the selection pool is large and contains enough variety to offer insight into different types of mental health service models. At the same time, the benchmark universities cannot be too different because the collected data would be rendered inapplicable.

The collaborative pool should be determined based on the benchmarking criteria collected by an internal investigation of CAPS. Only after a clear objective is identified can the benchmarking process begin. This first step – the identification of target measures within CAPS – shall be performed by a panel of stakeholders who have background and knowledge in health care, mental health services, and counseling. This panel should ideally contain CAPS employees, psychologists, faculty members in health sciences, members of the CAPS advisory board, and administrative representatives. With the correct personnel, this group contains the knowledge necessary to make them credible as they evaluate and offer suggestions for the improvement of CAPS.

This body of individuals – described as the panel of stakeholders – would meet annually at the end of the spring semester to evaluate CAPS and offer input on areas that need improvement and suggestions on how to improve those areas. This panel would examine internal information such as input from students, patient evaluations, and personal observations to identify areas in need of improvement. In addition, the panel could bring in external data from other universities to provide contextual evidence of what competitors are doing and discuss if Penn State could offer such services. This panel of stakeholders would essentially be responsible for identifying benchmarking objectives to improve the overall quality of CAPS. They would be responsible for meeting, discussing, and identifying areas requiring improvement at CAPS that would serve as objectives for identifying benchmark universities.

If an objective is identified, then the next step in the benchmarking mechanism (establishing achievable benchmarks) would be employed; however, if nothing was observed as needing amendment or improvement, then progress to the next step would not occur.

Once a clear benchmarking objective is made by the panel of stakeholders, the next step is to establish criteria for identifying potential benchmarking universities. These criteria depend upon the objective, and therefore will vary depending on the consensus of the panel of stakeholders. However, a constant criterion for establishing a group of benchmark universities – independent of the panel consensus – is their excellence in mental health care provision and their dedication to improvement in this area. "Quality of care" is a difficult to define since it is largely subjective. However, identifying indicators for "quality of care" produces tangible criteria that can easily be measured. Examples of criteria for which to identify benchmarking universities include:

- Funding for counseling services;
- Amount of endowments;
- Annual patients seen;
- Number of counselors employed;
- Relative number of counseling sessions offered;
- Commitment to outreach and education programs;
- Methods of advertisement and service promotion;
- Availability of on-line resources;
- Length of waitlist;
- Member of JED Foundation;
- Referral process; and
- Insurance coverage.

While these categories represent criteria for determining a group of benchmark

universities, they only represent a small number of measurable elements. These are merely suggestions and represent a brief sample of the measurable elements of mental health services at universities. It is important to realize that these benchmark criteria are merely suggestions based on general quality of care as the objective. A set of criteria could be further defined with additional research by the panel of stakeholders who are experts in assessing the performance of mental health services on college campuses.

3.4.2 | Establishing Achievable Benchmarks

Before any resources are put into benchmarking efforts for a specific measure or set of measures, it is necessary to identify and rank the potential for improvement in the specific context of Penn State. Therefore, it is crucial that the previous step is not only performed thoroughly, but also updated on a regular basis before the analysis of these measures is carried out. This way, Penn State can ensure relevant, realistic and, above all, actionable benchmarks.

Upon the identification of target objectives to benchmark, the system utilized to develop said benchmarks must provide both an individualized assessment of the objectives and determine a realistic threshold. This is important as it accounts for all factors and the level of control over variables and processes.

Analysis for implementation is preceded by rigorous due diligence. Selecting the service to be improved, collecting internal data, and setting performance achievable benchmarks are necessary steps before developing proposals, implementing them and monitoring their progress (Pitarelli & Monnier, 2000).

The benchmarking mechanism developed will provide the best insight and lead to better recommendations if it is comprehensive in nature. There is a broad spectrum of benchmarking techniques and approaches ranging from purely quantitative – a competitive take – to a purely qualitative – customer-experience based (Ellis, 2006). The proposed mechanisms involve both quantitative and qualitative benchmarking.

The main body working on the process for this stage would consist of a benchmarking committee. Depending on availability of resources as well as on the number and imperativeness of acting on targets identified, this team would be assembled every three to five years. Ideally, its members would have been a part of the panel that continually worked on the identification of targets. It would be integrated by members with complementary skills, including clinical practitioners familiar with campus counseling services, psychologists in academia with extensive research experience, and at least one statistician familiar with statistical evaluation methods.

This team would be engaged in an effort to develop qualitative and quantitative objectives for CAPS in each targeted area. Their primary objective would be to combine statistical benchmarking with process research and analysis efforts to identify realistic and achievable goals.

Quantitative Benchmarks – Statistical Performance Benchmarking

Statistical performance benchmarking will have the underlying objective of determining the desired level for a performance indicator. Performance indicators will be related to a specific process.

Across the mental health service industry, policy makers and oversight organizations have advocated for more use of benchmarking techniques for quality assessment and improvement. Traditional benchmarking takes an average-based approach that demonstrates to be of little use to institutions that perform in the normal ranges for the industry (Kiefe et al., 1998).

The first facet to consider when developing statistical thresholds is that to promote excellence within mental health services provided in our college campuses, it is important to develop benchmarks for quality improvement beyond the industry average. Recognizing that mean results provide little indication of what level is desirable or achievable is the first and

most important step in all benchmarking efforts (Hermann, 2006).

The second facet involves the selection of a provider that demonstrates high performance. It is preferable that this identification involves a predefined data-driven selection system for measures that can be benchmarked quantitatively (Kiefe et al., 1998). Nevertheless, subjective selection can in some cases be valid as well despite its limitations.

Another facet that must be recognized in the development of statistical benchmarks is that setting quantitative standards that do not have a solid empirical basis can be futile, as one single standard does not fit all measures (Hermann, 2006). When looking at a measure and benchmarking it is necessary to account for the fact that different providers will necessarily have different levels of control over certain processes.

Finally, the process of establishing achievable benchmarks requires both an investigation of external and internal statistical data. Therefore, an important part of this stage will also be to include the collection and analysis of internal data in the framework of establishing the desirable level of a given benchmark that CAPS will strive to achieve.

Proposal:

1. The Benchmarking committee initially undertakes a process of collecting administrative data, both internal and external, which is inexpensive and reasonably accurate (Wallgren & Wallgren, 2007) and whose limitations can be minimized during the collaborative benchmarking stage. The establishment of a systematic collection framework is necessary and its specific structure will depend on the measure or procedure in question.
2. Selecting the right approach to take when developing a benchmark is the first task of the benchmarking committee. There are numerous developed statistical benchmarking systems such as the Pared-Mean method (Kiefe et al., 1998) or the ABC (Weissman, 1999) that are quite similar. For the best results, the team can utilize member expertise

to adjust, combine and develop a customized system to determine the relevant statistical benchmarks. It is crucial that variability in the level of control for different processes is considered and accounted for in the development of such a method.

3. When the approach is ready, the committee can gather any additional missing information and proceed with calculating the benchmark. This number will show an attainable numerical benchmark that CAPS can set as a goal.
4. The final step is to identify the underlying processes responsible for each measure.

Qualitative Benchmarking – Patient Experience Benchmarking

It is essential to ensure the framework for the benchmarking mechanism is competent at establishing methods to evaluate both qualitative and quantitative benchmarks. Only then it can be deemed adequate to provide the level of insight required to develop serviceable proposals. An exclusively statistic framework would fail to identify processes behind statistics of success. This is why Penn State should consider the introduction of an effective all-inclusive mechanism involving performance, process, and patient experience benchmarking.

One of the basic principles of health services involves the provision of satisfactory patient experiences. This has increasingly become a challenge for college campus counseling centers as demand for mental health services has spiked. At Penn State, the percentage increase in students serviced by CAPS has grown almost by fifty percent in the past five years compared to an increase in enrollment of about ten percent (Locke and Sims, 2015).

Despite the high reported efficiency of CAPS in its use of allocated resources, anecdotal evidence seems to highlight that there is a certain degree of disenchantment and dissatisfaction among patients. Much of the criticism originates from the shift towards a rapid access model in detriment of full treatment. This is a characteristic that cannot be currently changed due to resource and infrastructure scarcity, CAPS must regenerate patient satisfaction in other ways to ensure maximizing the quality of service.

To attain outcomes that improve subjective patient experiences it is necessary to develop a framework to analyze qualitative benchmarks both externally and internally (Ellis, 2006). Thus, statistical data analysis methods exclusively will not be as useful and the development of a mechanism must take another approach.

The first part of the qualitative approach focuses on internal benchmarking. When considering internal qualitative benchmarking, it is natural to think of patient surveying. This type of data gathering technique can be very useful depending on the design and implementation. Flexible patient satisfaction surveys that strategically highlight possible flaws in the service process are useful to improve performance quality. Thoroughly designed patient surveys can account for patient dissatisfaction with brief intervention models and assess true service quality. The benchmarking committee can create patient surveys based on specific measures with identified potential.

The second part of the qualitative approach involves external benchmarking. Although there have been attempts to fully adapt qualitative benchmarking tools like Essence of Care – developed in the United Kingdom as a clinical practice benchmarking toolkit to support sustained improvement in quality of health care (Ellis, 2006) – full adaptation to mental health services has proven too difficult (McDonnell & Jones, 2010).

For this kind of benchmarking, best practices can be aspirational and descriptively support improvement rather than drawing on data and inferential analysis (Ellis, 2006). At this stage, the benchmarking committee should focus on the provision of a structure for a customizable comparison framework based on internal data. Empirical evidence can be gathered during visits to other institutions in the collaborative benchmarking stage of the process. This would be done by means of descriptive studies and reports as well as opinions and experience of respected authorities (such as the directors of other counseling centers).

Proposal

1. Based on the outcomes of the Identification of Target Measures and Processes stage, the benchmarking committee can decide if measure-targeted patient surveys could play a role in developing an achievable benchmark goal.
2. If deemed appropriate, the committee can work on developing a patient surveying method specifically designed to provide insight on target measure.
3. Finally, the committee can undertake the creation of a comparison framework using gathered internal qualitative data to use during collaborative benchmarking phase.

3.4.3 | Developing Actionable Recommendations

THE COLLABORATIVE APPROACH

Stage one of the overall mechanism regularly identifies the measures that seemingly have the most potential to impact CAPS. Subsequently, the second stage involves the establishment and sporadic updating of customized, realistic, and achievable benchmarks that CAPS should strive for to improve the quality of its service. Once these thresholds and objectives are established, CAPS will be ready to undertake the third stage. Focused on the processes and practices in the industry that are responsible for benchmark success, this stage is crucial in adapting them into actionable recommendations specific to CAPS.

Whereas the other two stages have a somewhat defined timeline, the undertaking of this stage is dependent on the judgement of the stakeholder panel regarding results of the previous two. With achievable benchmark objectives in place it is possible to determine whether investing in a full benchmarking project will be beneficial for quality of service at CAPS. Establishing empirical thresholds that determine the potential of CAPS is essential for organizational quality awareness. Yet, the true benefit arising from benchmarking practices comes from understanding the practices used by others and identifying the specifics of superior performance (Gift and Stoddard, 1994).

The collaborative benchmarking model allows for this to happen and is a cost-effective and more complete approach than independent improvement efforts. Mosel and Gift (1994) identify three phases in collaborative benchmarking: selecting the topic of the project, establishing the benchmarking collaborative, and conducting the study.

To avoid vague objectives, it is essential to select a project before targeting possible collaborators. As the sponsor organization, CAPS will oversee the process, however, when selecting partners, it must be mindful of choosing projects that might also interest other institutions. Collaborative benchmarking projects bring organizations with a common interest in creating breakthrough improvements for a common process (Gift and Stoddard, 1994).

Once a project is chosen, there is a defined set of measures involved that together determine the success level of a common process. Each of this individual measures will have a target benchmark and a list of top performers developed in stage two. The next step is choosing benchmarking partners and convincing them to join the collaborative project. Since it is rare that a single potential partner is to be a top performer in every considered measure, highlighting the benefits of comparing processes with other top performers will be the driving argument for collaboration. A diverse pool of partners will yield the best results when undertaking this sort of project, ideally interested in geographical, size, and service model variety (Gift and Stoddard, 1994).

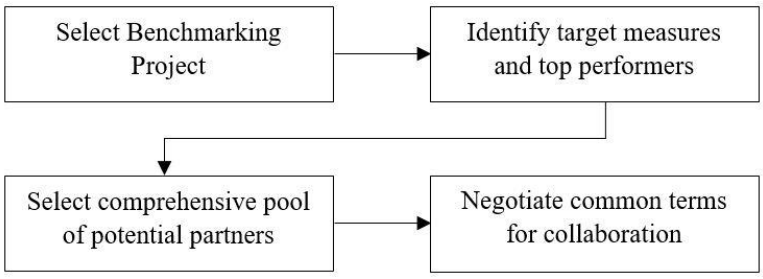

Figure 2: Creating a Benchmarking Collaborative (Adapted from Gift and Stoddard, 1994)

The specific characteristics of the collaborative benchmarking efforts can be determined for each specific project, since potential variability is high. Best practice sharing

methods can have different degrees of formality, and they can be virtual, onsite, or a combination of the two (Dewan, Daniels, Zieman, & Kramer, 2000). The level of flexibility will depend on the nature of the process investigated and the context of participants.

Ultimately, this stage involves the engagement in collaborative benchmarking to examine key processes, innovate, and adapt successful practices to the specific context of CAPS. Collaborative benchmarking is not only beneficial for cost reduction and exposure to a greater sample of process variations. One of the principal benefits of this approach is the potential for sustained quality improvement through long-term cross institutional collaboration agreements (Edwards, Wilkinson, Canny, Pearce, & Coates, 2014).

Procedure

1. The first step is to analyze the developed benchmark thresholds with the objective of selecting the topic for collaborative benchmarking project. The decision to embark in this stage will be free of any regularity constraints and depend on the initial stakeholder panel. To make this decision, a set of specific criteria would need to first be developed to frame the discussion and aid in identifying a project.
2. The Benchmarking committee then selects partners among counseling centers at other university campuses to be part of the collaborative benchmarking process. This involves identifying high performers for the different target measures considered in the overall project.
3. Subsequently, the committee sends requests to potential partners inviting them to join the collaborative. Also, they illustrate the benefits emerging from investigating the processes that lead to high performance at other institutions.
4. As the sponsoring institution, the benchmarking committee can then lead the development of a framework for cross-investigation and process sharing.
5. Finally, through the investigation and analysis of successful processes, the

Benchmarking committee develops a report and adapts findings into actionable recommendations for CAPS at Penn State.

3.4.4 | Evaluation and Setting Guidelines for Implementation

The last step involved in the proposed mechanism involves the evaluation of actionable recommendations proposed by the benchmarking committee and ultimate decision to implement the changes at CAPS. It is fully dependent of a rigorous and sophisticated effort in the previous stage that leads to tailored and pragmatic recommendations. The degree of success of the whole mechanism is highly dependent in the ability to avoid implementing ineffective procedures. The objective of this mechanism is to clarify possible paths to quality improvement and to investigate and adapt innovative procedures; however, it also seeks to reduce the probability of engaging in futile implementations. Ultimately, the final pillar for success will consist of discerning between the value of proposals as possible implementations.

The principal responsible organism involved in this stage will be the CAPS Advisory Board. Their task will be to review reports and recommendations made by the benchmarking committee to assess the possibility of implementation for CAPS. Constituencies of the board must be varied to ensure beneficial perspective diversity and therefore it may be valuable to bring in others to the discussion.

As leaders of an evaluation board it is necessary to have individuals with preeminent decision-making power in the context of CAPS. For this reason, it would be appropriate for the director of CAPS be heavily involved in the strategic planning and conformation of the overall mechanism and thus play a crucial role in final rulings. Including other members of CAPS with a stake in the specific proposal discussed can also be beneficial. Depending on the project, it will be upon the discretion of the advisory board to call in additional attendees to the meetings.

The board also counts with the leadership of high level representatives of the administration, holding resource allocation competences. The administrative and resource

dependency that CAPS has with Penn State deems the presence of high representatives from this constituency essential to ensure functionality.

Student representation would be the third constituency pillar of this board, ensuring that the users of the service have a voice in the decisions that will impact them directly (Jennings, Gray, Sharpe, & Fleischman, 2004). Student government representatives should always be included in these discussions, but depending on the proposal it may be beneficial to identify other groups on campus that can add a useful perspective. This will be based on the nature of proposals and thus evaluated case by case.

Further to the constituency representative backbone of the advisory board, expanding on the board's perspectives and combined expertise can be achieved by drawing on the human capital that the university possesses. For this, it will be constructive to include experts from the departments of Psychology, Educational Psychology Counseling, and Special Education (Penn State College of Education) and potentially others whose perspectives are deemed enriching. Participation would be voluntary but encouraged under the pretext of the importance of bettering college campus mental health services.

The guidelines for operation will follow the established structure of the existing advisory board. The members of the board should all have preliminary voting rights on a proposal. Ultimately, the director of CAPS and a high-level representative from the administration will have the option to veto a resolution. Favorable votes from these constituencies will be necessary for implementation of any proposal. As the chairman of the board, the director of CAPS will have the responsibility of making sure presented proposals are within the accepted guidelines set by the university and the law ("Evaluation Committee Formation & Procedures,"2016). Overall steps in the decision process will include requirement compliance, reporting and clarification process, cost evaluation, discussion and voting (ibid).

Once a proposal is approved for implementation at Penn State, then guidelines for said

process will be decided upon and next steps determined. This phase will be highly dependent on the specific proposal and thus an appropriate and tailored approach must be decided on at the time of approval. Considerations will include an implementation timeline, the discussion of risks and techniques for their mitigation, and finally an appropriate budgetary adjustment if deemed necessary. This will be carried out by the benchmarking committee that proposed the implementation with oversight of the evaluation board to whom they must report back regularly.

After implementation, the progress of the new process will be evaluated continually by the director of CAPS and reporting to the board will be done yearly for three years after implementation to ensure it has provided consistent value.

Proposal

1. The CAPS advisory board reviews reports and process implementation proposals made by the benchmarking committee.
2. Evaluation discussions should include the director of CAPS, a high-level administration officer, and a student government representative, as well as potential additional members from CAPS, the administration, and/or the student body with valuable perspectives or stakes on the topic. Also, bringing in Penn State faculty from academic department such as Psychology and Education would also be beneficial.
3. Upon listening to the reports and proposals, there will be a board discussion with the benchmarking committee for clarification of queries, including expected cost.
4. When the proposal is clear, the board moves to evaluating and discussing its success potential and assess risks and mitigation possibilities.
5. Voting and the proposal take place. The votes from the Director of CAPS and the high-level administration representative must both be in favor to continue.
6. An implementation plan will be developed with considerations to CAPS operations

integration, timeline, risk mitigation and budget adjustment. Its specific structure will be tailored to each case and worked on by the benchmarking committee with oversight from the evaluation board.

7. A yearly report for the first three years after implementation will be drafted to ensure the new process is adding value to mental health services at Penn State and inform future decisions.

3.4.5 | Note: Mechanism Implementation Costs

Considering the extent of accessible research resources in the development of this policy proposal, it is not feasible or even appropriate to come up with a specific monetary value that can accompany the described benchmarking mechanism. The nature of this mechanism is highly variable depending on the focus, as well as conveniently flexible to existing budgetary constraints. Per the International Clearinghouse of the American Productivity and Quality Center, an individual undertaking of benchmarking project could cost around $60, 000 (Gift & Stoddard, 1994), regardless of an arbitrary value, the cost would be significantly reduced due to the cost-sharing nature of the proposed collaborative approach. Considering the possible cost range that can be inferred from this limited data, it is prudent to say that incurring this expense on a three to five-year basis would not outweigh the potential benefits brought on by the proposed benchmarking mechanism.

3.4.6 | Note: Potential Adaptation to Commonwealth System

This proposal focuses on the development and implementation of a rigorous benchmarking mechanism that would provide realistic and achievable benchmark objectives determined empirically. It uses collaborative benchmarking projects to identify best practices and processes behind high performance measures and provides a system to adapt and implement selected processes as a part of quality improvement for CAPS.

The focus of proposal is implementing this mechanism for CAPS at University Park

campus to benchmark against the counseling services of other universities. However, this mechanism could be adapted to implement collaborative benchmarking across the Commonwealth Campus system. The reasoning behind focusing on other university campuses and University Park in advance originates in the fact that it has the highest number of students demanding care and that more radical innovation can be achieved initially looking outside of a single campus system. Despite this initial approach, expansion of the model to the whole university system would eventually help to achieve a high and unified standard of health care quality for all Penn State students.

A more conservative approach can be considered before a complete adaptation of a Commonwealth Campus benchmarking mechanism. Gradually including Commonwealth Campus CAPS representatives in the different stages of the intercollegiate process could potentially result in the implementation of proposals at various campuses across the system.

IV

POLICY 2:

ONLINE COUNSELING PILOT PROGRAM

4.1 | SETTING STANDARDS

Benchmarking is a successful tool to assess and improve the performance of CAPS. It evaluates its current performance and provides tangible data for improvement. But part of improving mental health services at Penn State is improving access to services. This can be accomplished in the form of online counseling. Online counseling promises additional counseling services, assists with depleting the waitlist at CAPS, and provides a platform to reach World Campus students. That is why the second policy outlines how to implement an online counseling pilot program at Penn State CAPS. Currently, there are no clear standards in online counseling among universities in the United States. Rather than using traditional benchmarking and achieving industry standards, the online counseling pilot program will focus on setting standards.

Online counseling is still in early stages of research, so more data collection must be performed by implementing it on a university level. According to Dr. Carolyn Turvey, a Professor of Psychiatry at the University of Iowa and Vice Chair of the American Telemedicine Association's Telemental Health special interest group, much of the demand for online counseling services is to accommodate younger clients (Navotney, 2011). College students today, many of whom are Millennials , incorporate technology into almost every aspect of their lives. Looking at the younger population could yield insightful results on the future of this type of program at Penn State University Park, Commonwealth Campuses, as well as World Campus.

4.2 | COUNSELING IN THE AGE OF TECHNOLOGY

The public launch of the World Wide Web in the 1990s was a turning point in history. It transitioned society into the digital age and created countless opportunities for advancements in most fields of study including the field of psychology. The first instance of technology being

used in conjunction with counseling took place during the International Conference on Computer Communication in 1972. It was not until the rise of the Internet in the 1990s that online counseling, which is also referred to as e-therapy, online therapy, cybercounseling, and more officially telepsychology, began to grow (Hsiung, 2002).

Online counseling is defined as the provision of mental health services via Internet or phone and can be conducted two ways – synchronously or asynchronously. Synchronous cybercounseling occurs when the patient and counselor speak at scheduled times by videoconference, phone, or electronic chat. Asynchronous cybercounseling happens when there is a lag time between responses. This generally happens when the mode of communication is e-mail. This is helpful for patients who have busy schedules and do not have a block of time to dedicate to counseling (Fang, Bogo, Mishna, Murphy, Gibson, Griffiths, & Regehr, 2012). When the Internet was first introduced, online counseling was mostly limited to informal discussion and general advice boards, such as Cornell University's "Ask Uncle Ezra." It is possible that individuals did seek professional help online, but it is uncertain whether they received any one-on-one counseling at the time. It was not until the early to mid-2000s that telepsychology became more popular. Mental health professionals began working on a way to legally, ethically, and competently administer services in nontraditional settings. Almost two decades have passed since then and the prevalence of online counseling has increased, but it remains a complicated topic.

4.2.1 | Licensing Laws as a Problem for Online Counseling

Technology moves forward at a pace too quickly for governing bodies to create laws and regulations that establish appropriate and ethical online counseling. Therefore, there is a large grey area surrounding the implementation of online counseling. Perhaps the biggest obstacle that prevents many practitioners from offering online counseling is the uncertain legality of conducting therapy across state lines. Although licensing laws have been slow to

catch up to incorporate advancements in technology, that does not mean progress has not been made. An article published in 2011 stated that only three states had specific licensing guidelines on psychologists' use of technology in counseling. Since 2013 every state except for Arkansas and Connecticut offer some sort of temporary or guest practice provision for out of state counselors (American Psychological Association, 2013; Navotney, 2011). This progress can be credited to the Joint Task Force on the Development of Telepsychology Guidelines for Psychiatrists (Telepsychology Task Force) which was formed in 2011 (Legal and Regulatory Affairs Staff, 2013). The duration, restrictions, and requirements to obtain a temporary license vary greatly from state to state. Thus, it is important that counselors who wish to practice distance therapy, without going through the lengthy process to attain a second license, are careful and pay close attention in order to avoid receiving a misdemeanor charge (American Psychological Association, 2013).

4.2.1.1 | American Psychological Association (APA) Guidelines for Telepsychology

In 2013 the Telepsychology Task Force, in addition to compiling a 50-state review of telepsychology regulations, developed a set of guidelines for practicing online counseling. Since there are many questions surrounding the practice of telepsychology, the guidelines serve as a framework, which are not mandatory or enforced in any way, for psychologists who wish to provide online mental health services. The focus is primarily on ensuring that the psychologist is competent in the technologies required for telepsychology and that the client is fully aware of the confidentiality risks associated with communicating via technology. The Telepsychology Task Force makes it very clear in the introduction to the guidelines that, "They are intended to facilitate the continued systematic development of the profession and to help ensure a high level of professional practice by psychologists… They are not definitive and they are not intended to take precedence over the judgment of psychologists." All their recommendations are based on case studies and relevant literature (Join Task Force for the

Development of Telepsychology Guidelines for Psychologists, 2013).

4.2.2 | Cyber Safety and Security, and Technological Competence

When conducting therapy online it is important to be cognizant of several factors in regards to technology and its limitations:

- The security of confidential patient files against online threats; and
- Possible technological failures.

While some counselors believe that there is no significant difference in safety and security between online and in person counseling, it is still critical to take precautions (Chester & Glass, 2006). This means having a secure and private internet or phone connection as well as encrypting and password protecting confidential files. It is not enough for the counselor to know this; he or she has a responsibility to ensure that there is informed consent from his or her client. The counselor and client should not engage in online counseling until both parties fully understand and consent to the potential threat to privacy. Also, they both must understand how to use the technology they will be working on and the proper way address any technological issues that may arise (Yeun, Goetter, Herbert, & Forman, 2012).

4.2.3 | Overall Online Counseling Merits and Limitations

One of the main benefits to online counseling is the number of people it can reach:

"Nearly 80 million Americans live in a mental health professional shortage area, according to the U.S. Health and Human Services Health Resources and Services Administration. Even in urban environments where psychologists abound, cost, transportation and time constraints often prevent people from seeking mental health services.

In addition to these structural barriers, a 2009 Substance Abuse and Mental Health Services Administration survey found that less than one-quarter of the estimated 45 million American adults who have a mental illness received treatment. One major reason for the low number: stigma and embarrassment about making contact with a therapist. Telehealth — be it by phone,

> *email or video conferencing — can help solve many of these access problems, says Eve-Lynn Nelson, PhD, assistant director of research at the University of Kansas Center for Telemedicine and Telehealth"* (Navotney, 2011).

A study titled "Telepsychology: Research and Practice Overview" published in 2010 states that preliminary evidence shows that telepsychology increases access to services and is cost effective. Based on numerous telemental health reviews, the authors of this study also note that there have been reports of high satisfaction with online counseling among both counselors and clients across various groups (Nelson, Bui, & Velasquez, 2011). In 2014, a study was conducted to obtain more specific feedback of counselors' opinions on telepsychology: "Specifically, the Technology Acceptance Model (TAM) was developed to assess facilitating and impeding factors in the acceptance and utilization of innovative online systems and software." The researchers' findings helped mental health professionals observe the usefulness of online counseling, and perceived usefulness predicts a greater intent to use technology in counseling (Lazuras & Dokou, 2016).

In addition, clients who have participated in online or phone therapy sessions have had positive experiences. In an Australian study conducted in 2015 on client satisfaction with online counseling, all but one of the participants experienced an increase in satisfaction with telepsychology as time went on. This included the quality of communication, ease of relationship with the counselor, and comfort with the technology, among others. One participant commented that videoconferencing was a happy medium between phone calls. He or she found phone calls too impersonal but face to face sessions too intimidating. Overall, participating individuals were understanding of technological issues and remained optimistic despite them. This study demonstrated that online counseling could provide positive benefits to clients suffering with severe anxiety. One individual in the study explained that the distance allowed him to feel comfortable enough to disclose more than he would have in an in-person

setting. Overall, researchers concluded that online counseling, like traditional counseling, is nuanced and while it requires more research and possibly more advancements in technology, telepsychology has proved to be a satisfactory way of interacting with most clients (Richardson, Reid, & Dziurawiec, 2015).

Although online counseling has received mostly positive feedback, it is important to make the distinction that it is suitable for most, but not all, clients. For example, people suffering from severe mental health issues and those experiencing suicidal ideation would have to meet with a counselor face to face (Barnett, 2014). In order to determine whether or not a patient will benefit from e-therapy, counselors have to conduct initial screenings with each patient, preferably in person. Another aspect to consider is the diminished ability for counselors to gauge emotion through facial expressions and body language when the session is not conducted in-person.

There are many benefits to online counseling, but most important among them is the increased access it provides to individuals requiring mental health services. Whether it's geographical location, embarrassment, or transportation difficulties, online counseling promises a way to improve access to mental health services for students at Penn State. The online counseling pilot program focuses on improving mental health services – similar to benchmarking CAPS – but approaches the concept of improvement differently. Rather than using comparative techniques to meet and achieve standards, the pilot program strives to set standards and make Penn State the industry standard for online counseling

4.3 | IMPLEMENTION OF THE PILOT PROGRAM

The online counseling program at Penn State aims to provide web and phone based counseling services to all Penn State students, but will initially be limited to only students registered in World Campus within the Commonwealth of Pennsylvania. The success of online

counseling in universities is undetermined, so limiting the number of students participating in the pilot program will allow CAPS to ascertain whether it is worth it to invest the resources to expand online services to on-campus students, both at University Park and Commonwealth Campuses. The second limitation – only providing online counseling services in state – is added to avoid the issue of licensing laws, which are the biggest deterrent to the implementation of online counseling.

By offering services online through video conferencing, e-mail, or by phone, students would be able to have greater access to the help they need. This would direct students away from CAPS, which constantly struggles with a lengthy wait list, while also providing World Campus students the option of not having to travel to a different campus for mental health services. After a certain amount of time the pilot program will be analyzed to determine the impact that the implementation of online counseling has on college student mental health, as well as the effect it has on the efficiency and effectiveness of CAPS. If the pilot program proves successful, CAPS will be able to reach more students and relieve the burden on their physical location at the University Health Center.

4.3.1 | Specialized Training for Counselors

Prior to being permitted to administer online counseling, all counselors would have to complete a three-part training process. Training for online counseling is currently provided by both the American Psychological Association (APA) and the American Telemedicine Association (ATA). The APA hosts workshops at its annual convention, while the ATA provides online courses and training at its annual meeting (Navotney, 2011). Because online counseling requires different skills than in person counseling, the time to train an online counselor is largely dependent on the individual counselor. Some counselors will take longer to adjust their habits to be successful in an online setting, while others may be able to adjust more quickly.

This three-part training process requires counselors to first be trained in the technologies being utilized. The counselor should know how to operate the video conference software used for sessions and have an idea of how to deal with system malfunctions during a session. In the case that an issue does arise, IT services should be readily available to resolve the problem. In addition, encryption software should be utilized to ensure security is maintained throughout the sessions. The counselor and student should both have security questions, passwords, or other means of securely accessing the session. The decision on which software to use is up to the university, so long as the chosen system is secure and complies with the Health Insurance Portability and Accountability Act (HIPAA) (*ibid.*). While videoconferencing will be used frequently, email communication is also vital to an online counselor-patient relationship. In order to maintain a secure relationship with a client, it is important to include a confidentiality notice at the end of every email.

Secondly, counselors must be trained to deal with the limits of telepsychology. The inability to read all facial expressions and body language that would be easily seen in a normal session can be a serious limiting factor. Counselors should be aware that this may be an issue and learn to not rely on these factors during a session in order to be as effective as possible. One possible solution for email or text interactions is to instruct counselors to type their exact emotions in parentheses after a statement. This helps the student to understand the way it was intended to be said and not read into what the counselor may or may not have been thinking. Other issues can be more technical. For example, a microphone that is too loud may cause the client to feel uncomfortable, as if someone is shouting at them. Also, loss of eye contact with the screen on the counselor's part as they take notes may cause the patient to feel uneasy (*ibid.*). These issues can be avoided by informing the client in advance of the session what the counselor plans to do, and periodically checking to see if the equipment is operating properly.

The last requirement of this three-part training process is being aware of a client’s

location. In case of an apparent emergency during a session, the counselor may have to make an immediate referral to a resource in the client's vicinity. Knowledge of the area beforehand can allow the counselor to make a quicker and more effective referral. To account for such an extreme case, the client should provide contact information for family members before beginning counseling.

While counselors are effectively trained for online counseling, it's important to recognize that not all patients can be treated with online resources. Not all clients should have online counseling either, whether because of their specific needs and concerns, or simply because the client would have a greater likelihood of a positive experience through face-to-face meetings. An in-person assessment is necessary prior to a patient starting an online counseling program. This would help counselors gauge the severity of the patient's health and assist with the proper treatment method.

4.3.2 | Required Resources

World Campus students currently pay an information technology fee to attend Penn State. This program would be an added expenditure for the university. Since this service would only be utilized by World Campus students in the beginning, it may be reasonable to introduce a fee specific to World Campus that aids in paying for the program, while in effect granting access to the services provided. This fee could fund hiring additional counselors and the purchase of the software needed to operate the program. An appropriate fee for these online resources would be determined by the university after further analysis of the costs for implementing such a program.

4.4 | CRITERIA FOR ANALYSIS

After implementation, it is important to review the program at a set future date. Sufficient data and results for students who used the program should be available after one year. To review the program's success and make amendments, the CAPS Advisory Board should evaluate the program annually. When analyzing these results, it is important to ask three questions:

1. Is the program working?

Students should be utilizing the program in order to have their needs met. The data analysis should yield positive results for students who elected to make use of the program as well as prove that services were readily accessible to students.

2. Is the program worth the cost required to operate it?

The big question here will be the cost-benefit analysis. While expansion of CAPS services online to World Campus students is highly beneficial, the benefits of the program need to exceed the costs. Providing online services could require hiring additional counselors and will require online programs to be purchased. Enough students need to utilize the program and get the desired help to justify maintaining and/or expanding the program.

3. What aspects of the program could be improved for better results and more access for students?

Assessing the services provided and making improvements before moving forward with the program is essential. It is impossible to foresee the exact response to the program and the level of services provided may need to be adjusted depending on the demand. If these three criteria are successfully met, then the program should be considered for further expansion within the university.

4.5 | EXPANDING SERVICES

The online counseling pilot program will provide services to Pennsylvania residents enrolled in the World Campus, but it has the potential to be expanded. The first possible extension of services is to provide online counseling to all students attending a Penn State campus. This could relieve pressure on the demand for in-person counseling sessions and make mental health services more accessible by providing students with the flexibility to work around their schedules. Additionally, online counseling services could be expanded to World Campus students in other states of high enrollment. Under current law, it is not practical nor cost effective to offer services to all of World Campus, but services could be expanded to certain states with large numbers of students enrolled in World Campus.

4.5.1 | Making Online Counseling Available to On-Campus Students

Expanding services to University Park and the Commonwealth Campuses would be a task of much larger proportion than providing services for World Campus students living in Pennsylvania. With 40,000 undergraduates at University Park alone, adapting online counseling services presents a large challenge. That being said, CAPS already serves all of these students through face-to-face meetings. Providing an online counseling option would alleviate the overwhelming demand put on CAPS. Students would also be able to schedule sessions around their unique schedules and connect from their residences rather than visiting CAPS facilities.

The largest issue with extending online counseling to students at University Park would be to ensure that students utilize the program only for more minor issues, such as stress management. Some issues require in person treatment, while other issues can be addressed with online resources. In terms of cost, hiring enough counselors to expand online services throughout the university, buying software, and the cost of training new personnel need to be taken into consideration.

4.5.1.1 | Therapist Assisted Online (TAO) Counseling

While there are currently no existing online counseling services offered by universities in the United States, there have been a few attempts to test such a program. Therapist Assisted Online (TAO) Counseling is a seven-week online program developed at the University of Florida that helps students learn to deal with stress and anxiety, while decreasing the amount of time required with a counselor. Through the program, students receive text reminders and complete homework assignments on a mobile app. At the end of the week, the patient completes a videoconference session with a counselor. The counselor then measures and assesses the student's progress before reviewing it with the student (Benton, Heesacker, Snowden, & Lee, 2016). Baylor University, Texas A&M University, and the University of

North Texas have all adopted a similar program for use on their campuses this fall. If Penn State were to attempt to expand services to all campuses, TAO would be an inexpensive option compared to hiring more counselors. On average, hiring a new counselor costs $50,000 in salary annually, while TAO costs between $4,000 and $25,000 per year, with a large university such as Penn State coming in on the higher end of the scale (Pattani, 2016). While this program would not be applicable to all mental health care needs, the ability to target issues, such as stress management, that do not require as much face-to-face counseling time would help to alleviate the current demand on CAPS.

4.5.2 | Extending Online Services Outside of Pennsylvania

Expanding services to all of World Campus simply is not possible under current law because of the great variety of locations where World Campus students are located. If online mental health services proved successful for Pennsylvania-based students, a possible next step would be to consider expanding into other states with large World Campus enrollment.

If licensing laws do not evolve in the coming years, the university would either have to hire counselors licensed in these states or would have to hire professionals licensed in both

those states and the commonwealth. Once again, the biggest obstacle for expanding services in this manner would be the cost. Hiring counselors outside Pennsylvania is costly enough, while hiring counselors with double licensing would be undoubtedly higher. However, if an online counseling program should prove successful within Pennsylvania, expanding beyond state border is a real possibility given a high success rate.

V

CONCLUSION

5.1 | CONCLUDING REMARKS

CAPS at Penn State has developed into a successful and praised organization that provides support to thousands of students. Dr. Locke has devoted his career to maximizing the quality of mental health services and care that CAPS can provide to the students of Penn State University. This policy revolves around expanding and encapsulating the passion that Dr. Locke and his team has for CAPS.

Benchmarking is an evaluation technique that exposes minor issues and areas that require improvement within CAPS. It allows the CAPS leadership team to institute a new method of organization that can improve the present system. Comparison should not be based upon competition. It is based solely on the desire to improve upon a system that is meant to help as many people as possible. The initial benchmark will allow Dr. Locke and his colleagues to determine if any positive changes can and should be made to CAPS. The system that we have established for benchmarking will allow the university to continually analyze whether CAPS can be improved based upon an aspect or process that another university's mental health center has been practicing. This benchmarking mechanism is a dynamic system that is critical for CAPS to achieve constructive change.

An additional way that CAPS can achieve constructive change is through the implementation of online counseling. Online counseling is a revolutionary tool that should be harnessed by Penn State. With online counseling, CAPS would be able to have more counselors located anywhere in the Commonwealth of Pennsylvania providing additional services for students. Online counseling increases the number of Penn State students that have access to mental health services. It also provides a treatment option for World Campus students. Online counseling is a system that allows CAPS to increase the number of students it can help and support.

In conclusion, students, faculty, and administrators of Penn State University want to see

the mental health service centers succeed for every campus. Benchmarking promises improvement for CAPS by establishing a mechanism to meet and achieve standards, and the online counseling pilot program has the potential to make Penn State the industry standard for online counseling programs at the university level. This policy will help Penn State achieve positive change by improving mental health services and setting industry standards.

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