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Launching a University Telemental Health Counseling Training Clinic: A Case Study

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Abstract

With this article the authors hope to establish a precedent of publishing case studies in technology related implementation in counselor education and supervision with a focus on factors that drive as well as hinder such implementation. This case study described the design, proposal and implementation of a telemental health training clinic at the University of San Diego in San Diego, CA. Additionally, the authors highlight lessons learned and recommendations for other counselor educators seeking to implement similar training clinics at their universities.

Keywords

telemental health; telehealth; clinic; case study

Counselor Education programs have historically prepared and trained trainees for the in person realities of the mental and behavioral health workforce. To aid in that training, counselor education programs in the United States have a long history of conducting clinical instruction in on-campus university counseling training clinics (Meyers & Smith, 1995) and community sites. These programs are typically described as brick and mortar clinics (see Hittner and Fawcett, 2012). While the Council for Accreditation of Counseling and Related Educational Program (CACREP, 1994) at one time developed standards for what were formerly known as counselor education laboratories, current CACREP (2016) standards no longer include such guidance. Holden and Kern (1996) described a case study in the physical design of an on-campus counselor education clinic, and Myers (1994) edited a volume on the topic of developing counselor education libraries. However, this work from the 1990s pre-dates the advent of web-based video conferencing technologies and consequently offers no guidance on the implementation of such technology in a modern counselor education training clinic.

Despite the technology and infrastructure of telehealth being available since the mid 1990s, there was not a wide adoption among counselor educators to train students to utilize telehealth options or for community mental health clinicians in seeing clients virtually. The ongoing global COVID-19 pandemic has literally forced mental health providers to see clients remotely and amplified the need for telehealth training models, as Ortiz and Levine (2021) describe in their recent article. In addition, the COVID-19 pandemic has required that Counselor Education programs teach and provide training to students on effectively utilizing telehealth options.

While many Counselor Education programs heavily rely on community sites to provide the necessary practicum and internship experiences for their trainees, many community sites during the pandemic were not able to provide telehealth options to their clients, supervisors were not trained in telehealth or virtual supervision, and many counselor education programs did not provide comprehensive training needed for students to know how to provide ethical and competent counseling in telehealth long term. However, from March 2020, the need to adopt and increase training in telehealth is no longer an innovative idea or elective, but

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a necessity to provide. As we begin to see the restrictions of COVID-19 lift and more sites getting back to pre-pandemic operations, one thing is certain; telehealth is here to stay. Telehealth has reduced travel time, increased access to care, and improved client safety and provider support. As a result, it is imperative that Counselor Education adapt and incorporate telehealth training in its curriculum and provide clinical opportunities for students to engage with clients remotely.

In this case study, we will describe our experience as counselor educators in designing and implementing a telemental health counseling training clinic at the University of San Diego. We endeavor to focus on aspects of the process that facilitated the implementation, hindered the implementation and lessons learned that may inform other counselor educators seeking to establish their own telemental health counseling training clinics.

Terminology

In this case study, we consider and use the American Counseling Association's (ACA, 2020) definition of telebehavioral health, distance counseling and telemental health counseling as essentially synonymous. The ACA defines telebehavioral health counseling as:

> *Telebehavioral health, or distance counseling, is the use of a digital platform that provides secure, encrypted, audio-video conferencing to communicate with a client in real time. This does not include nonsynchronous (not real time) texts, calls, digital chats, emails to and from counselors and their clients.*

Throughout this case study, we refer to various technology platforms, infrastructure and hardware. These terms include the following:

- Secure web-based video conferencing platform: this refers to any of a number of web-based HIPAA and FERPA compliant video conferencing technologies that may be used for telemental health counseling.
- Secure web-based practice management system: This refers to HIPAA compliant scheduling, intake, assessment, treatment planning, progress note, record storage systems. Many of these systems also offer credit card processing (CCP) for fee payment.
- Technology Infrastructure: This refers to the broadband internet connections, routers and services that connect platforms and hardware to the world wide web. In general terms, download speeds of at least 5Mbps are the minimum requirements for many video conferencing platforms. However, in practical use we have found that download speeds of at least 50Mbps to 200Mbps supports a more stable video conference. This is especially true of wireless connection, as upload speeds will be attenuated by the physical distance from the wireless access point, the number of devices in use on the network and building materials in the physical location.
- Hardware: This refers to the desktop computers, laptop computers, tablet devices, video cameras, headphones and microphones used by clients and counseling trainees. For example, we have configured our counseling rooms at the clinic with iMac desktop computers and headset with microphones.

The Clinic Design Process

The lead authors originally developed the concept of the telemental health training clinic as a primary component of a community-based counseling and educational support initiative for youth and families impacted by homelessness in the San Diego Region. This initiative, called Polaris (Cameron & Callahan, 2019), was submitted as a healthcare grant proposal but was not funded. We subsequently refocused developing and implementing the telemental health counseling aspect of the initiative.

The concept of a university-based telemental health counseling training clinic was based on the following guiding principles:

- High quality training for masters-level counseling graduate students in emerging telehealth service delivery models.
- A "live" supervision model.
- Delivery of high quality, affordable and empowering counseling services to underserved and marginalized populations.
- An approach rooted in community-based counseling.
- A robust and compliant technology platform for telemental health counseling.
- A fiscally self-sufficient operating model.

Once we settled on these guiding principles we set to work on the operational details of the clinic which are described in the sections below. These design principles helped focus the sometimes tedious work of actually bringing the clinic from concept to reality.

The Implementation Process

We designed a four-phase process to structure the clinic implementation and to provide a set of timelines and implementation benchmarks. Our first phase of implementation, or what we called the *Pre Launch*, was a six-month process focused on the clinic staffing plan, fiscal considerations, administrative approvals, working through ethical and legal considerations, consultation with tele-health professionals, contracting and operational plans and onboarding our first cohort of

Table 1

Telemental health training clinic implementation process

Implementation Phase	Timeframe	Implementation Benchmarks
Phase One - Pre Launch	Summer 2019 through Fall Semester 2019 (6 months)	1. Develop staffing & budget plan. 2. Develop clinic fee structure. 3. Develop clinic operating hours schedule. 4. Establish budget account structures and transcation processes to accept credit card payments from clients. 5. Work through ethical and legal issues and obtain University Gener Counsel approval. 6. Secure administrative approvals from unit Dean and University Provost. 7. Secure space and technology for trainees to deliver services. 8. Secure clinic phone lines and email address. 9. Execute contracts for telehealth records and video conferencing platforms. 10. Develop and publish clinic policy and procedures manual. 11. Recruit and train the first cohort of counselor trainees.
Phase Two - Pilot Launch	Winter 2020 through Spring 2020 (6 months)	1. Develop clinic branding and marketing. 2. Seek faculty colleagues input. 3. Develop and launch the clinic website. 4. Disseminate clinic referral and enrollment information to community partners. 5. Develop and implement plans for continuity of operations (ie, leave coverage, shift to fully remote operation in response to pandemic restrictions). 6. Train a graduate assistant to enroll and schedule new clients.
Phase Three - Full Operations	Summer 2020 through Spring 2021 (12 months)	1. Conduct biweekly clinic operations team meetings. 2. Work with the university communications office to inform local media about the clinic, its focus, services available and fee structure. 3. Monitor expenses and inflows. 4. Monthly reports to our Dean and Asst. Dean for Finance. 5. Recruit and select a new cohort of trainees for the upcoming academic year. 6. Submit WACES conference presentation describing the development and launch of the clinic. 7. Publish this case study describing the development and launch of the clinic 8. Meet the goal of 30 active clients.
Phase Four - Growth and Operational Refinement	Summer 2021 through Spring 2022 (12 months)	1. Begin review of clinic operations using SWOT analysis to identify operational Strengths, Weaknesses, Opportunities and Threats. 2. Use results of SWOT analysis to refine clinic operations. 3. Develop a comprehensive evaluation plan. 4. Develop and select a clinic advisory group composed of a clinic operations team as well as representatives from the university community and key community partners. 5. Identify and seek additional funding sources to expand clinic operations.

trainees. Our second phase, or *Pilot Launch*, included our department faculty input, development and launch of the clinic website and clinic branding (ie, what to call the enterprise). This led to the decision to brand the clinic as a university clinic rather than a department or program level clinic. During this period and in response to a COVID-19 pandemic related campus closure, we also developed and implemented a plan to shift from on campus clinic operations to fully remote operations. That is, moving out of counseling rooms at the university that we equipped with iMac desktop computers and secure telehealth conferencing capabilities to fully remote operations via secure telehealth conferencing platforms our students and clinic director ran from their homes. An increase in clinic referrals during this time necessitated the hiring and training of a graduate assistant to help with new client enrollment and scheduling. During this phase we set a goal to concurrently enroll at least 30 active clients, to be attained within 18 months.

A full *operational launch* was the hallmark of our third phase. During this phase what were initially frequent (i.e., more than once a week) implementation meetings, phone calls and other team communications transitioned into regular biweekly leadership team operations meetings. We also initiated work with our university communications team to inform local media about the clinic, its purpose and focus. A reporting and monitoring system for income and expenses was developed and shared monthly with our Dean and Assistant

Dean of Finance. We also submitted a WACES conference presentation describing the clinic, which also led to the development of this case study.

As of this writing, we are entering our fourth implementation phase, which is focused on growth and operational refinement. During this phase we will plan and conduct a SWOT analysis which examines Strengths, Weaknesses, Opportunities and Threats (ie, SWOT) in a two-factor organizational trait model. In this model, strengths and weaknesses are internal attributes of the organization, while opportunities and threats are external attributes of the operating environment (Gürel & Tat, 2017). Results of this analysis will be used for intermediate and long-term planning, and will inform the development of a program evaluation model. During this current phase we are also exploring external funding opportunities to offset operating costs as we expand services. Table 1 outlines our implementation process and includes benchmarks for each phase.

Implementation Drivers

Fixsen and his colleagues (2005) described the role of implementation drivers in the successful launch of innovative educational and human services programs. Indeed, Fixsen et al define implementation drivers as the "engines of change" that can be categorized as competency drivers, organizational drivers and leadership drivers. Competency drivers are supports for new learning and ways of work needed to facilitate the use of an innovation. Organizational drivers are changes in organizational practices and support systems to establish environmental conditions that enhance effective innovations and increase the use of implementation supports for practitioners. Additionally, Fixsen et al (2005) assert that effective implementation requires adaptive leadership characterized by capacity for problem identification and the development of solutions. Such leadership drivers facilitate the initiation of changes in the ways of work and managing change within the organization.

Using Fixsen's et al (2005) model of implementation drivers, we identified competency, organizational and leadership drivers that supported the launch of our clinic. Additionally, we identified implementation barriers that attenuated our implementation process. These drivers and barriers are described in Table 2 below.

Clinic Operations

Table 2

Implementation drivers and barriers

Category	Driver	Barrier
Competency	1. Professional development opportunities sought out and completed by clinic leaders in telemental health. 2. Formal training and onboarding process for counseling student trainees in delivery of telemental health counseling services, use of practice management system and clinic policies and procedures.	1. Variable "starting points" for counseling student trainees' level of competency and background knowledge of telemental health counseling.
Organizational	1. University and academic unit strategic goals aligned with service to marginalized communities and the use of emerging technologies for clinical training. 2. Strong support from fiscal personnel to create fiscal and fee payment processes. 3. Strong support from the university communications office to disseminate information about the clinic with media sources.	1. Lack of consensus from faculty colleagues in support of the launch of the clinic. 2. Lack of internal or external funding to support launch of such pilot projects. 3. The current practice management platform requires clients to use a credit card for fee processing. This is a potential barrier in extending services to extremely economically disadvantaged clients.
Leadership	1. Clinic leadership team developed and adhered to agreements to operate collaboratively to support the launch of the clinic. 2. The Dean and other executive leaders in our academic unit were motivated to support new ways of work and the use of innovative methods. 3. Entrepreneurial skills and orientation.	1. Multiple professional (i.e., faculty, clinician, administrator) roles of clinic leadership team and associated competing professional commitments of time and energy.

Our design principles also helped guide operational aspects of the clinic. These aspects include: training and supervision, our target client population, an approach informed by community-based counseling, robust technology and our fiscal operations. A description of what each of these *look like* in operation is included below.

Training and Supervision

The clinic utilizes individual, group, and live supervision. Weekly group supervision allows for trainee collaboration on cases and for trainings on relevant topics, such as suicide assessment and safety planning for tele-mental health settings. Clinical topics of interest to trainees are also a regular part of group supervision. Weekly live supervision allows for a developmental model of supervision to be employed, with more structure being provided in the early months of training. On the HIPAA compliant web-based platform being utilized, the trainee and the supervisor are able to use the "chat" function to privately message questions or feedback during counseling sessions. Scaffolding is used in supervision; as described by Zimmerman & Schunk (2003), this developmental approach allows for trainees to continue to build on previously learned skills in order to become more confident and independent in their skill as counselors. Outside of live supervision, the clinic director and trainees engage in individual or triadic supervision to develop biopsychosocial, case conceptualization, treatment planning, intervention selection and implementation, progress note, and termination/ discharge planning skills.

Client Population

We conceived the clinic as a community service designed for underserved and marginalized groups. In the clinic we serve a linguistically, age, racially, economically and geographically diverse population. Many of our clients also hold intersecting identities related to gender, race, sexual orientation and disability. In practice, this looks like the clientele of many metropolitan community counseling clinics in the Western United States. On a given clinic day, we may see children, parents, multilingual clients, students, nonbinary, heteronormative, and/or elderly clients, as well as combinations of each of these identifies. It is important to note that because we are a training clinic, we screen all potential clients for serious mental illness and current suicidal ideation. Clients deemed inappropriate to receive counseling services from a trainee are referred to other mental health service providers.

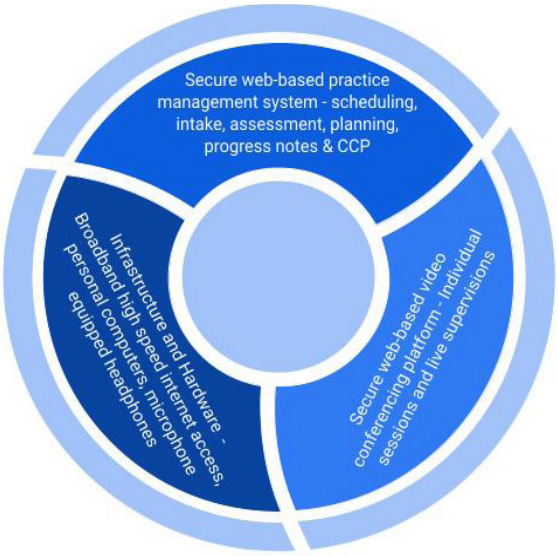
A Community-based Approach

Based on our own clinical training and experiences, we selected an approach embedded in community-based counseling. Informed by Multicultural Counseling Theory (Pedersen et al, 1989) as well as the application of Social-Ecological Theory to counselor training (Lau et al, 2014) the clinic operates as a service provider embedded within and interacting with a larger community. We actively seek out community partnerships and collaborate with partner agencies including local religious groups, community-based clinics, private practitioners and service organizations. Moreover, we appreciate and respect each client as members of their own home communities as well as members of our regional community. Informed by these theories, we are keenly aware of the need to empower clients to enter counseling relationships as a working partner and the expert in their own lived experience, as opposed to a passive patient receiving treatment.

Robust Technology

We intentionally selected technology platforms that are compliant with regulatory requirements and perform reliably in their intended functions. These platforms include a web-based compliant and secure practice management system to enable scheduling, intake/ assessment, treatment planning, progress notes, records storage, credit card processing (CCP) and reporting. Other factors to consider when choosing a system, such as cost, the number of clinicians who may be included in the practice, the number of active clients who may be accomodated, capability for supervisors to access and co-sign trainee case notes, secure email from clinician to client, secure chat capabilities between clinicians, ability to port in client cases from previous systems, etc, were also examined. Figure 1 illustrates technology integration to support the clinic workflow and service delivery. An additional requirement for end user technology was ease of use and/or

Figure 1. Technology integration to support clinic



ease of training end users in their use. Use of tutorial videos as well as our three-hour training/onboarding session for counselor trainees supported mastery of these systems and platforms. Ongoing education sessions for counselors trainees are held regularly, particularly when system updates are made available.

Fiscal Operations

We developed a fee schedule with a regular first session fee of $40.00, and additional session regular fee of $25.00. The fee schedule also includes an 80% fee reduction as well as a 50% fee reduction for both first and additional sessions. Fee reductions are offered as need based scholarships, with clients applying for them using the Fee Reduction Request form.

Clinic fees are processed in the practice management system, which allows clients to set up a credit card for payment processing. Working with our university finance and treasury personnel, we were able to approve the credit card processing service used by the practice management platform to allow receipt of electronic payments in our university account. While securing approvals and compliance verifications for this process to occur, it was essential to be informed by our university's compliance and technical requirements for credit card payment processing systems.

Discussion

This case study documents our experience as counselor educators in the design and launch of a university tele-mental health counseling training clinic. We are intentional in sharing our lessons learned in the hope that a discussion of factors that drive as well as hinder such an implementation might be informative to future colleagues that undertake such an endeavor. Indeed one of the primary lessons learned from this experience is that full implementation takes extended and prolonged commitment of time, energy and resources. We found no off the shelf option for creating and launching a university training clinic. If as Fixsen and his colleagues (2005) assert, implementation drivers are the engine of change then we found that sustained commitment of time, energy and resources is the fuel that drives that engine. Additionally, the source of this fuel is the depth of collaboration, collegiality and mutual respect that develops within the implementation team.

We also learned that an intentional design helps create a vision to guide the implementation. Aligning our vision for the clinic to the strategic goals of our university was perhaps the most critical organizational driver that advanced our implementation. This close alignment of our clinic's mission to the university's and our academic unit's strategic goals for initiatives to provide training experiences in service to marginalized communities shows a high level of consensus in support of the clinic implementation at the executive levels of the university. In turn, this level of support from university leaders helped to drive implementation and minimize the potential barriers to implementation from a lack of consensus support from our department colleagues. That is, had our university leaders not been supportive of the clinic launch and faculty level support remained mixed, it is highly unlikely that we would have launched the clinic at all.

Finally, and perhaps most critically, this clinic would have not materialized had it not been for the intellectual curiosity, motivation and hard work of our counseling trainees. Their commitment to learning new technology, assisting with scheduling, completing assessments and most importantly providing high quality counseling services within their scope as trainees facilitated the growth of the clinic as a provider of effective, client centered services. Each of us have worked as trainees in university counseling centers and we are keenly aware of the vital role trainees play in the success, failure or perhaps even worse, the plodding mediocrity of some endeavors. At the end of the day, we could not have done this without our student trainees.

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