



Triage and Clinic Flow

Advanced Topics in College Counseling

Thursday, February 7, 2019
8:30-10am

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Agenda

Introductions

Purpose and Learning Objectives

Definitions and History

From Medical to Mental Health

Motivating Factors

Different Models to Address Clinic Flow

Benefits and Risks

Decision-Making and Implementation

Recent Trends

Examples

Discussion

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Introductions

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Purpose

Triage and Clinic Flow will explore different administrative and clinical structures to help avoid therapist burn out and wait lists as well as maximize clinic efficiency.



Learning Objectives

- Participants will discuss different triage models
- Participants will review key items essential to decision making during triage model selection
- Participants will identify the importance of assessing triage competency




Definition

what are other
words for
triage?



sort, sorting, organize,
prioritize, classify, group,
assortment, emphasize, array,
methodize



 Thesaurus.plus

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History

Originated in the 19th century by a surgeon, Dominique Jean Larrey, in Napoleon's army on the battlefields in France. He implemented triage to treat the most severely injured to save lives, or treat the most superficially wounded first to return them to the battle.



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History

- Larrey's approach [triage] Involved separating patients into one of three categories:
 - ① Those likely to live regardless of the care they received
 - ② Those unlikely to live regardless of the care they received
 - ③ Those for whom immediate care might make a difference
- According to Shotten (2016), [Larrey] “focused finite medical resources where they made the biggest difference, saved thousands of lives.”



Medical Context

“Used in emergency medicine to organize the needs of walk-in patients, dispense services according to patients’ level of medical severity, and help the greatest number of people as efficiently as possible, without losing quality of services.”

(Shaffer et al., 2017)

“In mass casualty situations, triage is used to decide who is most urgently in need of transportation to a hospital for care (generally, those who have a chance of survival but who would die without immediate treatment) and whose injuries are less severe and must wait for medical care.”

(Stoppler & Shiel, 2017)



From Medical to Mental Health

Mental health triage was developed and used in Australia since 1990s and in the UK in the early 2000s

UK Mental Health Triage Scale

Triage Code / Description	Response type / face-to-face contact
A Emergency	IMMEDIATE REFERRAL Emergency service response
B Very high risk of imminent harm to self or others	WITHIN 4 HOURS Very urgent mental health response
C High risk of harm to self or others and/or high distress, especially in absence of capable support	WITHIN 24 HOURS Urgent mental health response
D Moderate risk of harm and/or significant distress	WITHIN 72 HOURS Semi-urgent mental health response
E Low risk of harm in short term or moderate risk with good support/ stabilising factors	WITHIN 4 WEEKS Non-urgent mental health response
F Referral not requiring face-to-face response from mental health	Referral or advice to contact alternative service provider
G Advice, consultation, information	Advice or information only OR More information needed



Origin in the US: Triage for Counseling

Rockland-Miller and Eells (2006) proposed using the clinical triage system in 1999 and 2003 at two conferences resulting in institutions like Harvard University to implement the system.



In their proposed system, college students call the counseling center or services for an initial brief phone screening with a senior staff clinician. This screening is to determine the level of care necessary for the student, whether it is emergent, urgent, or routine.

(Rockland-Miller & Eells, 2006)

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Definition

“In a Triage system, clients receive an initial screening evaluation and those classified as urgent (e.g., a danger to self or others, severe or psychotic symptoms) are given priority appointments and seen quickly. Non-urgent clients may have to wait to begin counseling.”

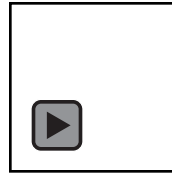
(Blau, DeMaria, & DiMino, 2017)



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Why Consider Triage?

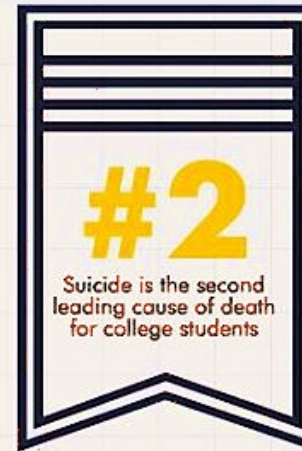


Triage System Helps Colleges Treat Mentally Ill Students

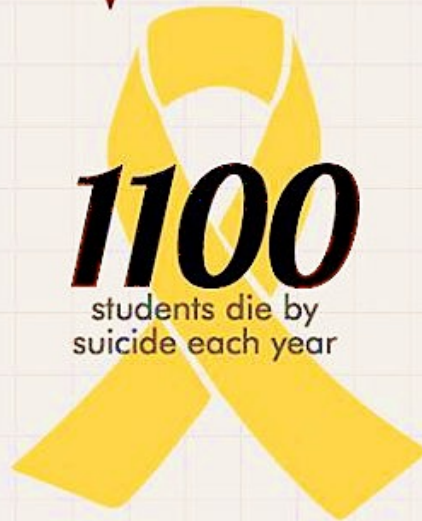


CRISIS ON CAMPUS

SUICIDE & COLLEGE STUDENTS



18% of students going to college counseling centers went for suicidal thoughts/behaviors



1100
students die by suicide each year



1 IN 10 STUDENTS SERIOUSLY CONSIDERED ATTEMPTING SUICIDE AND 1 IN 12 MADE A PLAN



67% of college students tell a peer they are feeling suicidal before telling anyone else

MAJOR RISK FACTORS FOR SUICIDAL IDEATION

- 1) Depression
- 2) Lack of social support
- 3) Conflict with a parent
- 4) Substance abuse problems
- 5) School problems
- 6) Other mood disorders
- 7) Previous suicide attempt(s)

MORE THAN HALF OF COLLEGE STUDENTS HAVE HAD SUICIDAL THOUGHTS

and half of those students with suicidal thoughts never seek help or treatment





From the headlines...

“...the findings indicate that recent generations of young people perceive that others are more demanding of them, are more demanding of others, and are more demanding of themselves”

(Curran & Hill, 2017)

The hidden epidemic of perfectionism in millennials

Is Perfectionism Bad For You? Science Says Millennials Struggle Most With It

Yes, Millennials Really Do Struggle With Perfectionism More

Rise Of Perfectionism Among Millennials May Lead To Depression, Eating Disorders

Millennials Are the Perfectionist Generation

ARE WE CREATING A GENERATION OF PERFECTIONISTS?

The 'irrational desire' driving millennials and Gen Z into depression

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Realities of the Millennials...



- Feel pressure, are less accustomed to spending time alone, and are highly sensitive to peer norms and opinions
- The student who is “different” and unsuccessful in peer connections may feel significant emotional pain
- Social relationships are often digital interactions
- Striving for external acceptance and success results in a high degree of stress



And Their Parents & Families

- Millennial students and their ever-watchful and concerned parents place great demand on college counseling services.
- Parents, often vigilant about their student's well-being, encourage such professional support...they have high expectations of support services on college campuses.
- Student affairs professionals spend much more time dealing with parents than in the past, particularly for students with psychological health issues.





An Exception: Millennial Students of Color

Help-Seeking

Caucasian students are two or more times as likely as African American and/or Hispanic students to say they have ever been diagnosed with or treated for the following conditions.



Anxiety
27% vs.
12%
and 17%



Depression
25% vs.
16%
and 18%



ADHD
13% vs.
5%
and 6%



Self-harm
11% vs.
5%



Bipolar disorder
5% vs.
1%

■ Caucasian
■ African American
■ Hispanic

African American students are more likely than Caucasian students to say they tend to keep their feelings about the difficulty of college to themselves (75% vs. 61%).

African American students are more likely than Caucasian and Hispanic students to turn to a religious figure for support during their first term of college (18% vs. 8% and 5%).



An Exception: Millennial Students of Color



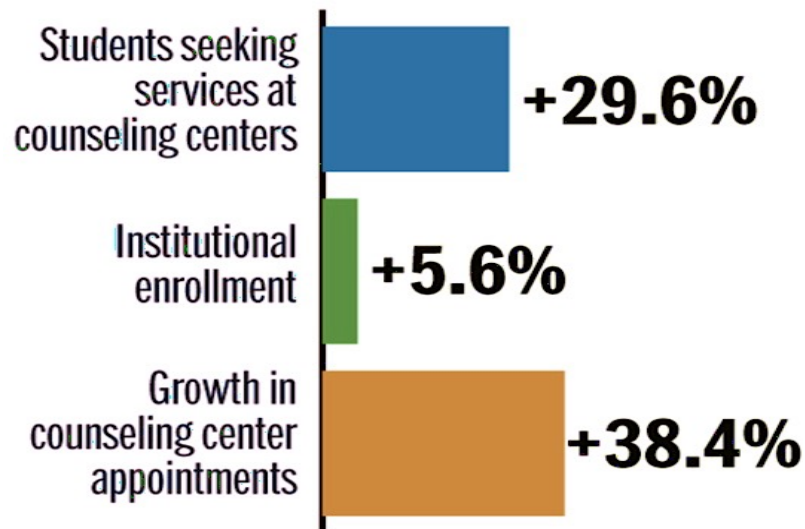
JED FOUNDATION

The graphic above shows how Caucasian, African-American and Hispanic students rated their emotions during their first term in college.



What is the Research Revealing?

Campus counseling growth



According to the CCMH 2015 annual report survey of 93 institutions for 2009-2010 through 2014-2015. See the chart on page 7 of the report

SOURCE: ccmh.psu.edu DESERET NEWS GRAPHIC

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Increasing Pressure

“On campuses around the country, many directors are seeing calls for counseling centers to enhance service, meaning ***immediate responsiveness when needs are expressed, greater availability of routine initial appointments, and requests to handle in-house serious situations***, such as severe eating disorders, borderline personality disorders, non-suicidal cutting, chronic suicidality, and pervasive developmental disorders.” (Meilman,2016)





Financial Necessity

“If students today frequently present with more complex and/or severe problems, they may also **require more resources to support them**. However, despite the increasing demand, college counseling clinics (CCs) have **not seen an equivalent increase in resources** for CCs” (Xiao et al., 2017)



“Because of these strained resources, centers have often **needed to adopt strategies to cope with the clinical pressure**, such as waitlists, implementing clinic-wide session limits, or referring students to external sites” (Xiao et al., 2017)



What are the alternatives?

Most campuses use a combination of approaches to address the increase of students using mental health services

- In-depth initial assessment (intake)
- Waitlists
- Brief behavioral therapy models/interventions, e.g. SFBT, CBT, ACT
- Session limits (3 to 6 per semester)
- Referral to off-campus community providers
- Group counseling
- Consultation in the office or other campus sites, e.g. “Let’s Talk”





What are the Alternatives?

- Stepped Care model – capitalize on students' use and ease with technology
- Therapy-Assisted On-Line (TAO) - phone, text messaging, on-line chat, or videoconferencing
- Self-assessment and interventions - phone apps, on-line or kiosks on campus
- Outreach collaborative prevention programming - residence life, health services



TAO

Therapist Assisted Online



- Relaxation - aromatherapy, TENS, light therapy
- Student organizations - Active Minds
- Peer educators or counselors
- Workshops - stress reduction, test anxiety
- Weekly programs - yoga practice, meditation



Case load model

- Clinicians manage own caseload with set intake expectations weekly
- More clients are seen
- Clients are often seen every 2 weeks
- Availability is based on volume not treatment
- High burnout



Brief time limited services (3 to 6 sessions)

- Gives some contact
- Limits ability to do therapy
- Use of community referrals for more complex problems, e.g. SUDs, eating disorders
- Tendency to want to “use up” sessions
- Risk for relapse
- Some presenting problems take longer to treat
- Not all clients suitable for group therapy

Wait list

- Schedules are filled up then first come, first served
- Does not factor in severity
- Low return rate

Referrals to off-site providers

- Lack of follow-through by students
- 42% of students referred were unsuccessful in connecting with a mental health provider
- Students of color had lower rates of successful referrals vs. White students (43% vs. 58%)
- No longer in-house and be able to follow-up



Strengths/Benefits

- Most urgent students are seen for immediate care
- May avoid a waitlist
- Increased availability in clinical slot times
- Saves intake/crisis time for appropriate student concerns
- Students are seen sooner (shorter wait time) and 4% more likely to return for initial appointments
- Students arriving for their initial consultation after triage are less distressed





Strengths/Benefits

- Relieves pressure on administrative staff having to make clinical decisions when a student is in crisis
- Uses professional staff time more efficiently as 2 to 3 initial contacts (20 to 30 min) can be made during the usual intake interview session (60 min)
- Increased efficiency for staff counselors
- Help screen out concerns inappropriate for the counseling center
- Direct students to more appropriate services, e.g. academic support
- Increased information about students' presenting concerns for intake/first on-going appointment
- Able to better assess how long students may wait for an initial appointment



Limitations/Risks



- Discomfort with and potentially limited ability in making a risk assessment in such a short amount of time
- More work and stress for triage counselor if students who present with imminent risk do not follow-through with clinical recommendations
- Overemphasizing access can lead to treatment shortage and lack of time for consultation with faculty & staff
- Non-urgent (lower risk) students may face a longer wait time for a follow-up intake or counseling appointment especially during the busiest times of the year
- Students miss out on a full counseling session
- Students placed on a waitlist after triage = increased attrition
- Students have to tell “their story” more than once



Limitations

- Therapeutic alliance is difficult to establish during a triage interview (e.g., feels less personal)
 - Consideration of students (e.g., students of color) who already have high rates of early termination or hesitancy to seek services
- Triage interview is usually not conducted by the student's eventual therapist
- Demand for services still exceed supply
- More burnout among counselors who have more crisis coverage
- Optimal triage appointment slots still needs to be determined
- Potentially not enough connection with student to make referrals that will be followed through with, especially via phone
- Philosophical change from counseling to crisis services



One Research Study...



One (1) counseling center implemented a triage system and experienced the following:

- Greater attendance rates
- Higher client satisfaction
- Increase in availability for initial & crisis sessions

BUT

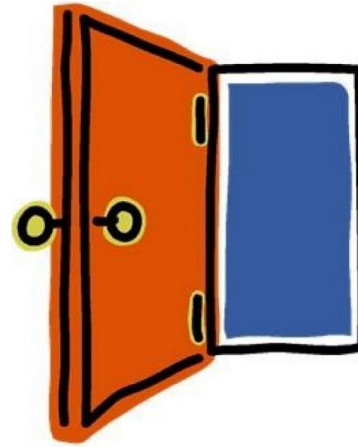
- Did not eliminate the waitlist
 - Still need to hire more counselors

(Francis & Horn, 2017)



Phone vs. Walk-in Triage

Even though triage was originally envisioned and implemented for use via phone, more counseling centers are increasingly setting up or switching to walk-in triage rather than phone triage.



“Some universities (for example Virginia Tech) moved away from a phone triage to an in-person triage system due to worries about whether a sufficient assessment, such as a mental status exam, could occur over the phone”

(Hardy et. al., 2011).



The Decision

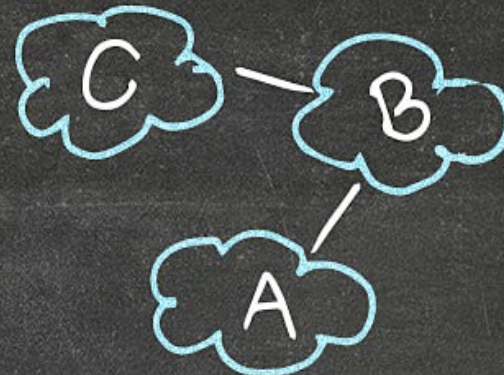
How to decide what is/are the right option(s) for the counseling center/services?

What is the rationale for implementing triage?

What is the quantitative and qualitative data, e.g. usage rate?

"Strategy 101 is about choices: You can't be all things to all people."

- Michael Porter





NEEDS ASSESSMENT

The Campus Community

Departments on campus, e.g. academic services, provost, residence life
Behavioral Intervention Team (BIT), Behavioral Activation Therapy (BAT), etc.

The Greater Community

Parents/Legal Guardians
Hospitals/Mental Health providers

Students

National data
Campus specific

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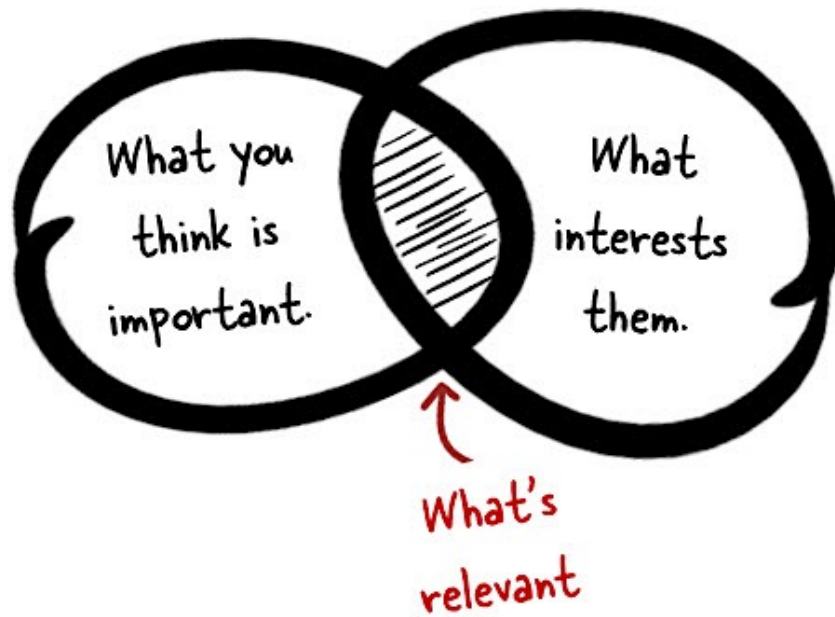
Determine Resources

- Budget
- Staffing
 - Clinical
 - Case manager
 - Wellness Education
 - Administrative
- Physical office space
- Technology – scheduling software, hardware
- On-line presence/social media
- Strength and availability of collaborative relationships on and off campus





Define Scope, Relevance, Expectations



- Mission and Values, i.e. What is the foundational philosophical approach to counseling?
- Division/College Expectations
- Stakeholders Expectations
 - Students
 - Parents
 - Community
 - Others



The Need to Compromise

- Resources will rarely match needs
- Preferred scope of practice may be different than what can be delivered
- Resource acquisition takes time
- Value centric?
- Who will drive the decision making process?
- Is there buy in?





Decisions, Decisions



- Outreach
- Groups
- Private practice silos vs. integration in campus
- Referral criteria

- Long term treatment
- Session limits
- Specialized services
- Follow up after hospitalization
- Case management
- Crisis intervention – in office and on and off campus
- Public health model of prevention
- Number of intakes
- Walk in time



Large Vs. Small Universities/Colleges

- **Considerations**

- Limited size and availability of staff
 - Triage appointments versus on-going appointments
 - Online presence/marketing opportunities
- Availability of community referrals
- Availability of on-campus resources and partners
- Potential financial constraints/ability to successfully advocate for online assisted modules, etc.
- Resource allocation to prioritize which services
- Flexibility “how many hats” for staff



Weigh the Strengths (Benefits) and Limitations (Risks) for Triage



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Different Triage Models: Which is best?

All models cover the following areas:

- Brief sessions ranging from 15-20 minutes
- Demographic Information
- Presenting Problem
- Critical item checklist or Risk Assessment
- Follow up: Emergency, Urgent or Routine

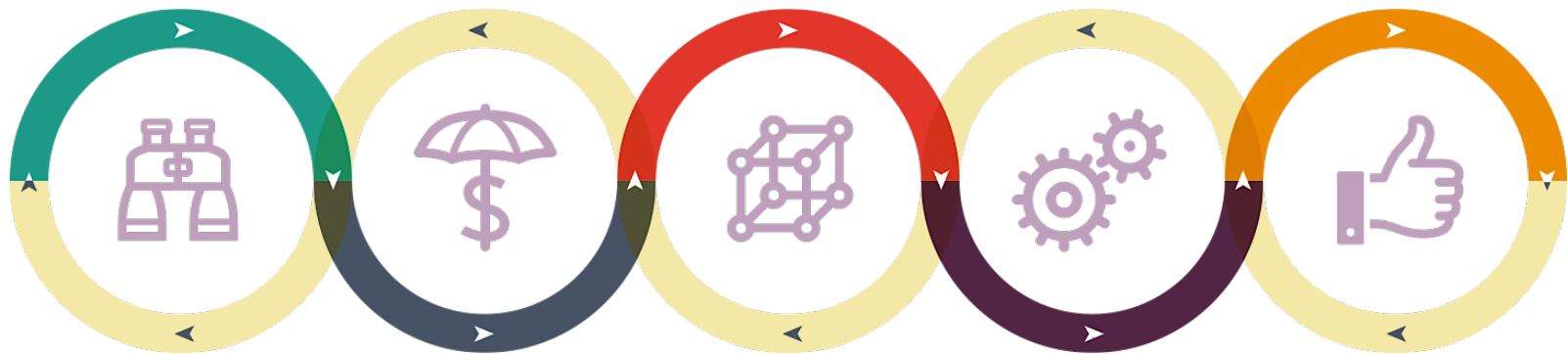




Implementation Process for Triage

This is based on a phone triage system that has been set up for confidential appointments per Rockland-Miller and Eells.

1. Provide an effective rationale.
2. Build a foundation of support, i.e. buy-in among clinical and office staff.
3. Construct a system within current institutional structures to allow for immediate 15-20 min triage appointments.

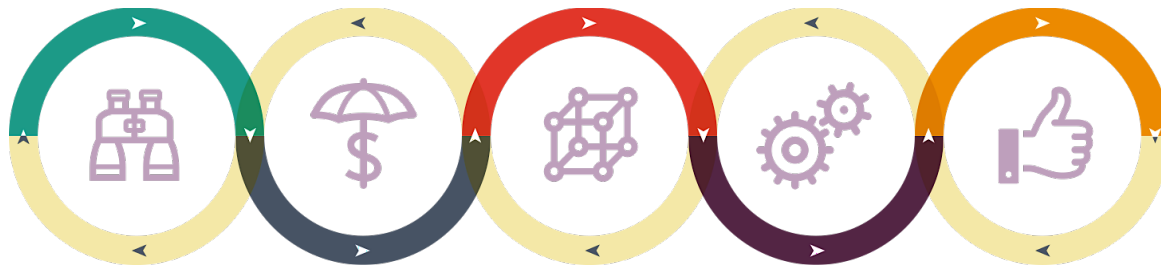


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Implementation Process for Triage

4. Educate the campus community about the triage model and its advantages.
5. Market to students, faculty and staff to increase referrals and attendance, i.e. update webpage, increase online presence, use social media, create posters and fliers for residence halls, etc., collaborate with depts for marketing & education.
6. Offer Mental Health First Aid workshops to faculty, staff and student leaders to increase referrals. Update webpage with workshop information.



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Components for a Successful Clinical Triage System

This is based on a phone triage system that is set up for confidential appointments.

- **Students receive a thorough explanation of the system by administrative staff over the phone, i.e. talk to a senior clinician on the phone, confidentiality.**
- **Students speak to a senior clinician (or a triage coordinator) who will gather basic information to allow for matching of services based on students' needs.**
 - Same-day appointments are set up at the front desk
 - If an emergency/crisis, students are immediately referred to the on-call clinician, bypassing the standard triage system



Components for a Successful Clinical Triage System

This is based on a phone triage system that is set up for confidential appointments.

- **During the triage phone appointment, the conversation covers the following:**
 - Brief description of confidentiality and its limits
 - Demographic information
 - Overview of presenting problem
 - Critical item questions, e.g. past & current treatment, suicidality, substance use, eating disorders, medical concerns, & medication
 - Follow-up, i.e. clinician assign students as emergency/crisis (seen immediately), urgent (appt within 48-72 hrs), or routine level of care (1-2 weeks)
- **Documentation includes:** Client name, date, triage counselor name, phone #, reason for seeking service, SI, outpatient info, etc.



Components for a Successful Clinical Triage System

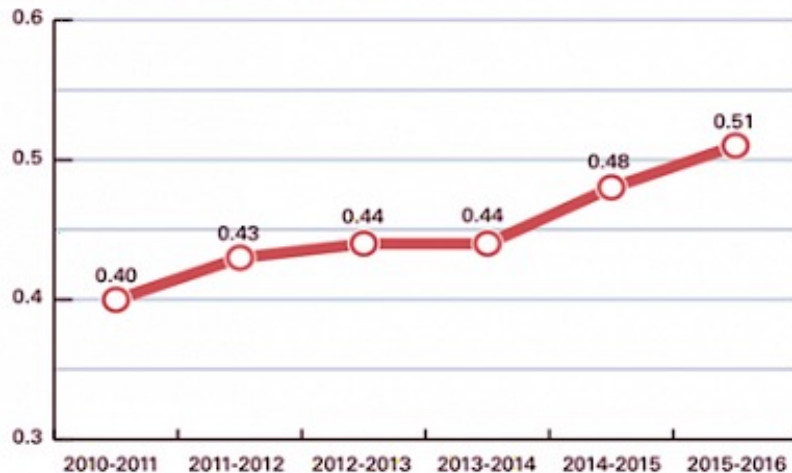
- **To reduce confusion about whether the triage clinician or the intake assessment clinician is responsible for follow-up with students after triage:**
 - Use email reminders for follow-up appointments and contacts
 - Send emails to no-shows for intakes/assessments
- **Develop a mechanism for quality improvement, i.e. assessment, .e.g. Have a team that meets weekly for 30 min to review the week and discuss changes**



Trending...Triage

“Over the last six years, counseling centers have provided 28 percent more “rapid-access” service hours per student, the center found, and devoted 7.6 percent fewer hours to routine services like ongoing counseling.” (New, 2017)

Annual Rapid-Access Hours per Client



Annual Routine Hours per Client



Source: 2016 Annual Center for Collegiate Mental Health Report

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Walk-in Triage: Research Results

- Better assessment – Able to observe nonverbal and behavioral cues
- Stronger connection with the counseling center - Even if the triage counselor was not their follow-up counselor
- Significant increase in attended appointments to overall scheduled appointments
- Number of client no-shows decreased significantly
- Increased efficiency of scheduling
- Clinicians' individual client caseloads did increase significantly
- Clinicians perceived that students found the system more effective for immediate daily services.



Incorporating Technology

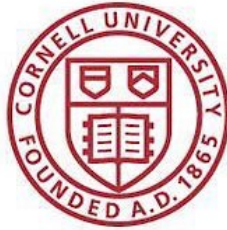
Increasingly, counseling centers are using computer stations or tablets, e.g. iPad for students to do the following:

- Check-in
- Read policies and procedures
- Fill out demographic information
- Fill out contact information
- Give information on presenting problem or fill out the CCAPS (Counseling Center Assessment of Psychological Symptoms) to gather clinical data
- Sign informed consent form(s)





Example



Cornell University

How to get care

First appointment:

- The first step to getting care is to schedule a “brief phone assessment” so we can learn about your needs.
- Phone assessments involve a 10- to 15-minute conversation with a counselor who helps determine the urgency of your concerns, and how we might best help you.
- To schedule your phone appointment, please log in to myCornellHealth and select “Appointments.” Or call us during business hours at 607-255-5155 (press 3 for appointments)



Example



The Process:

1. Contact CTS by calling (940-565-2741) or coming by the office at Chestnut Hall Suite 311.
2. Evaluate which service best fits your needs through one of the four levels of consultation appointments, or tell us if you are interested in Couple's Counseling, Therapy-Assisted Online, Group Counseling, or Workshops. We understand your situation is unique, cannot be fully described and that a feeling of emergency or crisis is defined by you. In our effort to best serve each student, we will respond according to your description of your consultation need. When you call or come in for your consultation appointment you will be asked to indicate the level of appointment you are seeking (see levels below):
3. If at a level 3 or 4 please note that it is important that you **arrive 30 minutes prior to your scheduled appointment** time to complete necessary paperwork, if informed to do so. If you arrive less than 20 minutes prior, your appointment will need to be rescheduled.

Please note, we are unable to provide any mandated services, other than those mandated by the Dean of Students.



Example



Name: _____ Student ID: _____ Phone Number: _____	
Date: _____ Date of Birth: _____	
<i>To help us determine which type of consultation fits your needs, please read the levels and circle number 1, 2, 3, or 4.</i>	
Please mark only ONE Number. Return this to the receptionist when completed.	
<input type="radio"/> 1- <ul style="list-style-type: none">- I am concerned about my ability to keep myself safe.- I have a current plan to attempt suicide.- I have taken recent steps to end my life.- I may physically hurt someone else.- I have a strong desire to harm someone else.- I have been referred by the Dean of Students because I or they are concerned about my ability to keep myself safe.- I have recently been physically or sexually assaulted.- I am hearing voices or seeing things other people do not.	<input type="radio"/> 2- <ul style="list-style-type: none">- Someone close has recently received a serious diagnosis or died.- I have recently been discharged from a psychiatric hospital and need help finding follow-up care in the community.- I am in such emotional distress I have not been able to meet my daily responsibilities.- I have been referred by the Dean of Students to help me find follow-up care in the community.
<input type="radio"/> 3- <ul style="list-style-type: none">- I am experiencing anxiety and/or stress.- I feel depressed and/or have low mood/energy.- I am concerned about my alcohol and/or drug use.- I am having difficulty adjusting to a recent change.- I am having relationship(s) problems.- I am unsure about something significant in my future.- I need to make a major decision and need feedback- I am dealing with a sudden loss	<input type="radio"/> 4- Single Session Consultation <ul style="list-style-type: none">- I have a specific emotional concern or question that can probably be resolved in a single appointment.- I need to make a major decision in the next 2-3 days.- I am concerned about someone else (a friend, roommate, etc.).- I am seeking a referral for medication or counseling elsewhere.

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Example



- **Level 1: Emergency Consultations**
- This level is for students experiencing a crisis and in need of an immediate consultation with a clinician.
- Examples:
 - I am concerned about my ability to keep myself safe.
 - I have a current plan to attempt suicide.
 - I have taken recent steps to end my life.
 - I may physically hurt someone else.
 - I have a strong desire to harm someone else.
 - I have been referred by the Dean of Students because I or they are concerned about my ability to keep myself safe.



Example



- **Level 2: Urgent Consultations**
- This level is for students experiencing significant distress or psychological difficulties in need of an urgent consultation with a clinician.
- Examples:
 - Someone close has recently received a serious diagnosis or died.
 - I have recently been physically or sexually assaulted.
 - I am hearing voices or seeing things other people do not.
 - I have recently been discharged from a psychiatric hospital and need help finding follow-up care in the community.
 - I am in such emotional distress I have not been able to meet my daily responsibilities.
 - I have been referred by the Dean of Student to help me find follow-up care in the community.



Example



- **Level 3: Initial Consultations (ICON)**
- This is the most common level of need for students seeking counseling center services. Common concerns bringing students to an ICON include, but are not limited to:
- Examples:
 - I am experiencing anxiety and/or stress.
 - I feel depressed and/or have low mood/energy.
 - I am concerned about my alcohol and/or drug use.
 - I am having difficulty adjusting to a recent change.
 - I am having relationship(s) problems.
 - I am unsure about something significant in my future.
 - I have been referred by the Deans of Students for behavioral, academic, or personal issues not putting me at immediate risk for safety.
- *ICONS are appointments that will occur within seven days of when you speak with a CTS front desk staff via phone or in person. Upon arrival, you will provide basic information and meet with a clinician for approximately 15-20 minutes to decide how CTS can best meet your needs. Various services may be recommended and scheduled including brief individual, group, or couples counseling, or workshops. Or you may be referred to a more appropriate campus or community resource.*



Example



- **Level 4: Single Session Consultations**
- If you are unsure about your need for or are not interested at this time in on-going counseling at CTS, but want assistance for the following reasons please indicate the reason for the appointment when you call:
 - I have a specific emotional concern or question that can probably be resolved in a single appointment.
 - I need to make a major decision in the next 2-3 days.
 - I am concerned about someone else (a friend, roommate, etc.).
 - I am seeking a referral for medication or counseling elsewhere.



Discussion:

What are you and your staff experiencing on campus?

Do the statistics and research match with what's happening among students?

What are you doing on your campus to address these issues?

Implemented triage? What have you and your staff learned?

How are you assessing triage at your campus? What tools?

Any ideas or suggestions?



Contact Information

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<https://studentaffairs.unt.edu/counseling-and-testing-services>

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