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To cite this article: Harry S. Rockland-Miller PhD & Gregory T. Eells PhD (2006) The Implementation of Mental Health Clinical Triage Systems in University Health Services, Journal of College Student Psychotherapy, 20:4, 39-51

To link to this article: [https://doi.org/10.1300/J035v20n04\\_05](https://doi.org/10.1300/J035v20n04_05)



Published online: 22 Sep 2008.



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# The Implementation of Mental Health Clinical Triage Systems in University Health Services

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**ABSTRACT.** The increase in the level of severity of student psychological difficulties and the growing need for psychological services in higher education settings has placed considerable pressure on college and university mental health services to respond effectively to this demand. One way several of these services have responded has been to implement clinical triage systems. Though these systems have been well developed in physical health settings, their use in mental health services, especially higher education mental health settings, are still novel. The present article outlines the processes and procedures involved in developing and implementing a clinical triage system through the perspectives of two sites. Issues addressed include how a mental health service moves to the utilization of a clinical triage system, the processes and components involved in the successful transition to a clinical triage system, the impact on the campus and a discussion of the risk management implications of implementing a clinical triage system. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website:<[http://www.Haworth Press.com](http://www.HaworthPress.com)> © 2006 by The Haworth Press, Inc. All rights reserved.]*

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Journal of College Student Psychotherapy, Vol. 20(4) 2006  
Available online at <http://www.haworthpress.com/web/JCSP>

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doi:10.1300/J035v20n04\_05

**KEYWORDS.** Clinical triage, mental health, university health services

Counseling centers and mental health services at colleges and universities continue to report an increase in the need for psychological and psychiatric services and an increase in the severity of the psychological and emotional difficulties with which students present. A thirteen-year longitudinal study involving 13,257 students seeking counseling at a large Midwestern University documented the increasing complexity of mental health concerns and increasing demand for services on campus. One of the most notable findings of this study was that increases were reported in 14 of 19 client problem areas. Also notable was that the number of students reporting with depression doubled, the number of suicidal students tripled, and the number of students seeking services after a sexual assault quadrupled (Benton, Robertson, Tseng & Benton, 2003). This trend is also addressed in the most recent National Survey of Counseling Center Directors, where 81.4% of directors report that they are seeing more students with serious psychological problems than they were 5 years ago (Gallagher, Zhang & Taylor, 2003). Of these same directors, this increase was cited as the primary service provision concern (77.2 %) as well as the primary administrative concern (49.5%). Consequently, this trend has placed considerable administrative pressure on counseling centers to devise the most innovative systems possible to respond to growing demands for services.

One system that has been developed and implemented at several institutions in the United States with some of the highest levels of acuity in psychological problems is a clinical triage system. Utilization of clinical triage systems within university settings was outlined at the 1999 and 2003 national meetings of the Association of University and College Counseling Center Directors (Rockland-Miller, 1999; Rockland-Miller, Hattauer, Hotelling & Eells, 2003). The relevance of the concept to the college and university population can be partially assessed by the large audience at each of these presentations (over 100 directors at each), together with the numerous inquiries subsequent to the presentations. A number of other colleges and Universities (e.g., Northeastern University, Northern Illinois University, Harvard University, MIT) have recently adopted systems building upon the concepts presented at these meetings. Despite this, a computerized literature search did not reveal any published papers describing mental health triage in a university context.

Originally used during World War I, the concept of triage has been widely adopted in disaster response and hospital emergency rooms. Utilization of triage systems allows for rapid sorting of patients/victims according to established criteria of acuity (Birch & Martin, 1985). While triage has been used in medical settings for decades it has only recently begun to be used in mental health settings. These systems in physical medicine are well developed and formulated while their implementation in mental health settings is still being explored (Everly, 1999).

A literature search resulted in a number of references to the introduction of mental triage systems in hospitals and community mental health centers (Birch & Martin, 1985; Broadbent, Jarman & Berk, 2002; Kevin, 2002; Smart, Pollard & Walpole, 1999; Wynaden, Chapman, McGowan, McDonough, Finn & Hood, 2003). They have a large focus upon the use by nursing staff in hospital emergency departments. A number of the descriptions are for programs in Australia (Broadbent et al., 2002; Kevin, 2002; Smart et al., 1999; Wynaden et al., 2003) where their 1998 National Mental Health Plan pointed to the need for improved training in mental health issues for Emergency Department staff and the development of triage guidelines (Broadbent et al., 2002).

The literature on the use of mental health triage in the hospital emergency room setting, commonly cite the significant advantages yielded subsequent to the introduction of the system. While there are variations in specifics of programs described, they share the concept of a rapid screening of patients into levels of care according to acuity of presentation. Uniformly, the authors report increased recognition of acuity, increased accuracy of screening, enhanced clinical care, more timely response, high patient and staff satisfaction and a more efficient utilization of limited resources (Birch & Martin, 1985; Broadbent et al., 2002; Kevin, 2002; Smart et al., 1999).

In outpatient settings, waiting lists are frequently used as means of responding to client demand going beyond service capacity. Informal discussions with other college and university mental health directors suggest that their use is widespread in university settings. Brown, Parker and Godding (2002) discuss the frequent use of waiting lists in outpatient mental health services as a function of demand outstripping capacity. The authors highlight the costs of waiting lists as including increased emotional distress, potential danger to self or others, a poor image of the service, loss of revenue and a missed opportunity for treatment. They conclude that a triage system is an alternative to a waiting list system, with multiple benefits.

The present article will draw upon the experiences of two directors of mental health services at two universities that have implemented clinical triage systems: the University of Massachusetts Amherst and Cornell University. The processes and procedures involved in implementing these systems will be explained by addressing how a mental health service moves to the utilization of a clinical triage system, the process used in the successful transition to a new clinical triage system, the components of a successful clinical triage system, the results within the service and the impact on campus, and a discussion of the risk management implications of implementing a clinical triage system.

### ***HOW A MENTAL HEALTH SERVICE MOVES TO THE UTILIZATION OF A CLINICAL TRIAGE SYSTEM***

The development and implementation of a clinical triage system usually occurs when the system in use is no longer efficient in meeting the demands of the students or other campus constituents. Increasingly, the primary mission for student mental health services in response to higher acuity levels in students is to provide more immediate access to care. The traditional entry point for a student into a university mental health system has been through scheduling a one-hour intake/assessment with a mental health professional after calling into the service. Any triage done is primarily limited to an office support staff member asking the potential client if their current difficulties are emergent. Office staff may take on a de facto clinical role in screening students. In settings where there is a high level of acuity in the student population this system often proves inefficient, and may lead to dissatisfaction with the service by the community.

One of the most common inefficiencies is that there is often a very high no show rate for an initial assessment. At times a student may arrive for an intake after a several week wait, only to need to be redirected to another university resource. Consequently, an hour of staff time is lost and a potential client who may need services more immediately will likely have to wait several weeks.

Data from earlier cited studies indicate that there are many students on university campuses in distress. It is our experience as directors that we have brief "windows of opportunity" when students are willing to access care, and if not available, may not return. Triage is an ideal way to provide access to services during this window. Via this system at UMASS-Amherst and Cornell we are able to provide same-day access

for virtually all students. Crisis situations can be followed up the same day and less urgent matters scheduled further out. It allows us to directly refer students to the appropriate provider or resource, maximizing utilization of our resources. With a triage system in place no shows now cost the system 15-20 minutes instead of an hour. At Cornell e-mail reminders of appointments to students are provided, further reducing the no show problem.

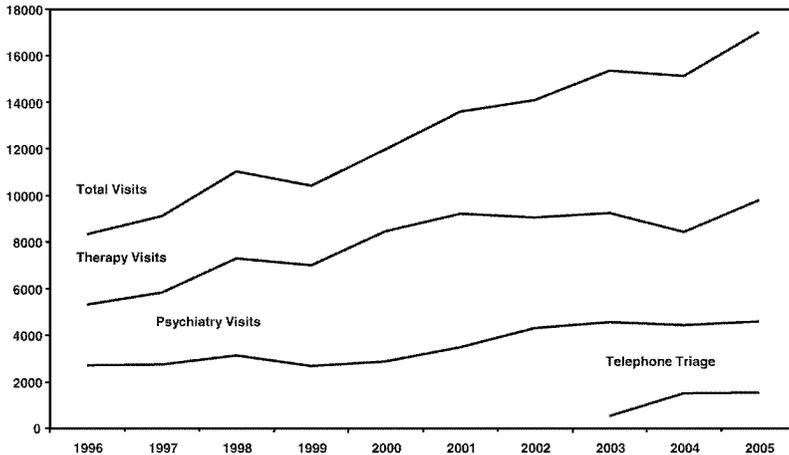
In designing a mental health triage system, several key concepts guided our thinking. We sought systems that provided clinically based decision making, have a customer friendly orientation, provided ease of use, maximized efficiency and promoted clinical discussion.

### ***THE PROCESS USED IN THE TRANSITION TO A NEW TRIAGE SYSTEM***

The first step in transitioning to a clinical triage system is to provide an effective rationale for the need for a triage system and then to build a foundation of significant support among the clinical and office staff at the mental health service. Achieving “buy-in” from staff is critical. Staff must embrace the system for it to be fully effective. Change in long-standing systems can be challenging for some. At UMASS-Amherst, after achieving a staff mandate, a multidisciplinary workgroup worked on implementation strategies. At Cornell, increase in client demand for services, a 104% increase over a ten year period of time displayed in Figure 1 in total visits, and a growing wait list prompted bringing in a consultant (Harry Rockland-Miller, PhD) to discuss the possibility of developing a triage system. Staff were very supportive of the concept and were looking for a more efficient way to manage client flow and respond to an increase in emergent situations. After the consultant’s visit a triage team was developed. Members of the team were strategically selected based on their ability to conduct brief assessments, their knowledge of the university community and its systems, and their knowledge of referral resources out in the community.

The next step is to construct a system that is a good fit within existing administrative structures that allows for the 15-30 minute triage appointments immediately available for students. Once this is accomplished, it is then essential to educate the community about the new service. Oftentimes, community members may have residual concerns about students who were unable to get access to mental health services in the past. This old myth must be dispelled and the advantages of the

FIGURE 1. Cornell University Counseling and Psychological Services: 10-Year Visit Trends



new system must be marketed. It is important that potential clients and community members are educated about what this assessment is and how it does not replace the existing more thorough assessment/intake process; rather it serves as the entry point into the system allowing for rapid access and matching with the appropriate level of care. Information from both Cornell and the University of Massachusetts Amherst indicate that it took about a year for the community to get used to the new system and for most first contacts to occur through the triage system.

Marketing strategies employed at Cornell included the director meeting with faculty and other campus partners to explain the shift in how students enter into the new system. It also included emphasizing the importance of students expressing their distress and the role faculty and staff could play in advocating for students that were of great concern. Other marketing strategies included changing the mental health service's web site to highlight and explain how students can access the system.

### ***THE COMPONENTS OF A SUCCESSFUL CLINICAL TRIAGE SYSTEM***

When students phone the clinic, it is explained to them that our system is to have them speak with a senior clinician, in a confidential

appointment, who will gather some basic information that will allow for a rapid matching of services, based upon their individual needs. Same-day appointments are set up at the front desk. If the student self-identifies at that point as being in an emergency, they are immediately referred to the on-call clinician, bypassing the standard triage system.

During the actual triage appointment, most often conducted by phone, students are given a brief description of confidentiality and told that we will be “gathering some basic information that will allow us to best match our services with your individual situation.” The conversation can be conceptualized as having 4 key components. Initially demographic information is gathered. Students are then asked to give an overview of what led them to call. Critical item questions are asked of all students, covering issues such as past and current treatment, suicidality, history of hospitalization, substance abuse, eating concerns, medical concerns, and current medications. Then a brief conversation takes place around follow-up, during which the clinician is assigning the student to an emergency (seen immediately by on-call clinician), urgent (appointment within 48-72 hours) or routine level of care.

A standardized triage form is completed, to carefully document the encounter. Common aspects of forms, from multiple sites, generally includes all of the following: client’s name, date, triage clinician’s name and signature, contact information (phone numbers, local address, e-mail address), basic demographics (gender, age, major, year in school), reasons for seeking service, how long the presenting difficulty has been going on, current and past outpatient treatment, any history of past psychiatric hospitalization, thoughts of harm to self or others, any history of suicide attempt, frequency of use of alcohol and other drugs, concerns about eating patterns, and current medications taken.

At Cornell the standardized form includes items that assist the triage clinician in making a decision about whether the student can be referred to a community provider or whether they are best served by receiving services at Cornell. If a student meets one or more of the following criteria they are maintained within the Counseling and Psychological Service: if the person is unstable or it is an urgent situation, if the potential client is a first year student or new to counseling, if the student is an international and/or minority student, if the student has been discharged from a psychiatric hospitalization, if the student has been on a medical leave of absence for psychological reasons, if there are concerns from other campus partners about the student, if the student has been involved with the campus judicial administrator, if there is concern from a parent, if there is a need to coordinate services with other university

health service providers or other campus partners, if the student prefers Cornell's service after an explanation of our brief care model, if the student has no resources to pay for care in the community, if the student is unlikely to follow through on a referral off campus, or if the student has tried other options for care and has been dissatisfied. Members of the triage team have found these criteria very helpful in making treatment recommendations. It was essential in developing these criteria to tie them to our overall sense of mission and philosophy about how we operate and the services we provide.

At Cornell the final section of the form allows the triage clinician to designate the student as either emergent (given a same-day appointment), urgent (given an appointment within 72 hours), or routine (given an appointment within 5-8 days depending on availability). Both UMASS-Amherst and Cornell have approximately 60-70 twenty-minute triage appointment slots available per week (14 per day, divided am/pm). An important adjunctive component to the triage system is making available emergency hour slots daily on other clinicians' schedules so triage clinicians have adequate resources to respond to emergent situations without overburdening the triage system. At Cornell, 27 emergency hours are allocated per week to respond to situations coming through triage and other campus partners.

Other components of a successful system include the use of regular follow-up through e-mail reminders and contacts. A potential difficulty with the triage system is that when a client is referred to a regular intake/assessment and they do not show there may be confusion about whether the triage clinician or the intake assessment clinician is responsible for follow-up. In the large mental health system at Cornell, the triage clinician is unlikely to be aware if a client they triaged attends a subsequent intake/assessment. Our solution to this difficulty is to send out standard e-mails to all no shows for intakes/assessments. This approach has provided adequate follow-up and allows clinicians to make any other contacts as needed.

A final component of a successful system is to develop a mechanism for quality improvement. One strategy is to have a team that meets weekly for 30 minutes to review the week and discuss any changes that need to be made to the system. This select team can keep abreast of changes in resources and staff in the University as well as the larger community and adjust referral processes in accordance with these changes. This team can also make presentations every semester to the entire staff and elicit feedback about any changes that need to be made.

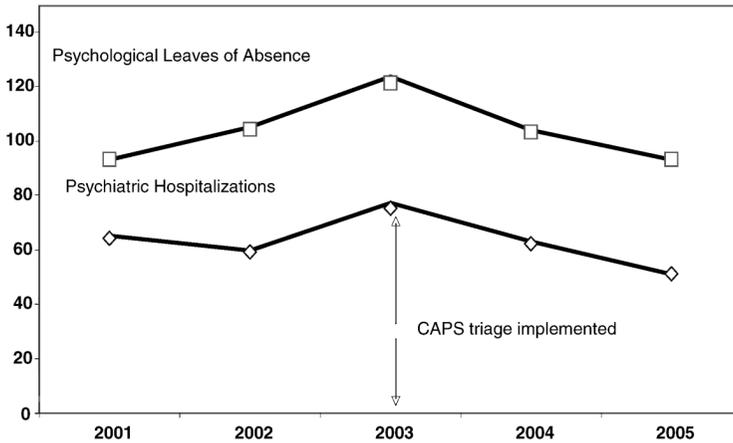
### ***THE RESULTS WITHIN THE MENTAL HEALTH SERVICE AND THE IMPACT ON CAMPUS***

The impact of the introduction of a clinical triage system has been overwhelmingly positive at both UMASS-Amherst and Cornell. First and foremost, we are able to offer all new referrals a clinical triage with a senior clinician on the day of the initial contact. In so doing, we are able to rapidly connect with the student, evaluate their needs, and route them to the correct service. At both of our institutions we are completing 45-60 triage assessments per week when school is in session. At Cornell in the first full year of the systems operation, this system translated into a total of 1495 triage appointments out of a total of 2314 students served.

As previously mentioned, urgent intake slots are available and are offered directly during triage. Prior to the implementation of the system UMASS-Amherst had a walk-in "urgent-care" clinic each afternoon. The spring semester of 1996, prior to implementation, there were 184 walk-ins to the clinic. By the spring semester of 1998 only 12 students walked in. Urgent cases are immediately screened and given full appointments, obviating the need for a walk-in urgent care clinic and eliminating all of the difficulties associated with its use. At Cornell during the first full year of the systems implementation, we observed a decline in psychiatric hospitalizations from 75 the previous year to 62 and a decline in requests for medical leaves of absences for psychological reasons from a record 121 the previous year down to 103. Additionally we were able to reach 7% more students while holding our number of visits stable. After two years we have been able to reduce these numbers further (See Figure 2). Though this data is correlational in nature and many other factors are likely to impact these variables, it does suggest the triage system is having a positive impact given that these variables had been trending upward for the five previous years.

The mental health service staff at both institutions are overwhelmingly supportive of the triage systems. Front office staff are happily removed from a quasi-clinical role. The system has reduced burnout and turnover among valuable front office staff and decreased confusion around responding to emergent situations. Clinical staff are relieved to have a system that reduces feelings of being overwhelmed during urgent-care times. Clinicians' schedules are more predictable, offering a sense of increased control over client flow during peak times. Clinicians who have elected to provide triage enjoy the rapid flow, the ability to develop skills where they must "think on your feet."

FIGURE 2. Cornell University, Psychological Leaves and Psychiatric Hospitalizations



Students' responses to the triage system have been quite positive as well. They appreciate the immediate access to a clinician. Even those who are triaged as routine (non-urgent), who may have some wait until the full intake, understand the system and have an initial sense of connection with the department. Client satisfaction surveys at Cornell have yielded positive results. In response to the question "I had a telephone screening that was helpful in starting the counseling process," 61% agreed. More impressively, the triage system has contributed to record high percentage agreement to items like "I feel better as a result of my counseling experience" (86%), "I would recommend CAPS to others" (94%), "I am satisfied with my experiences at CAPS" (92%). At UMASS-Amherst there has also been an overwhelming sense of satisfaction (95%), as measured by our patient satisfaction surveys, with the system.

Other key campus stakeholders, such as medical providers, the deans of students' office and faculty have also responded positively. While there were some initial concerns during the transition period, these offices have come to appreciate that they can reliably refer a student to our services and know that there will be an immediate response. Students who were not really interested in services could often use the excuse with a dean of students' office that they could not obtain service at the mental health service. The triage systems have been able to reduce the credibility of this response. Medical providers have also come to view the

service very positively. It is a system that they are already very familiar with and one that has allowed them more immediate access to mental health clinicians for patients that they are concerned about.

Difficulties have been few, but are worth noting. One concern is that with increased access to services comes increased client flow through the mental health service, which can lead to increased stress on the system as well as on the clinicians who provide the services. There is a possible increase in overall acuity within the department, given that all acute situations are immediately responded to and all acute cases are rapidly brought in to the clinic. For some staff, managing the shifting demands of triage is difficult—while others embrace the change. Those who find it challenging may require support during the transition.

Another concern expressed from a minority of students has been that the triage system adds another layer of assessment and that they have to tell their “story” to a triage clinician and conduct an intake/assessment before treatment commences. This is a very valid concern and ultimately is inherent in the triage system. From a cost/benefit perspective we believe the benefits previously outlined far outweigh the costs and concerns.

### ***RISK MANAGEMENT IMPLICATIONS OF IMPLEMENTING A CLINICAL TRIAGE SYSTEM***

Our review of the literature showed only one article addressing the potential risk management dangers of using a telephone triage for mental disorders (Erdman, 2001). This focused primarily on the use of these systems by health maintenance organizations (HMOs) but several of the authors’ concerns have implications for triage systems in higher education settings. The authors reported that the prominent difficulties in using a telephone triage system included: (1) the qualifications of the personnel; (2) special difficulties in diagnosis by telephone; (3) the attitudes of mental health patients and professionals toward managed care’s use of the type of treatment; (4) the liability of the HMO for incorrect diagnoses or recommended treatments; and (5) the question of what steps are necessary for mental health patients to receive the best possible treatment using a telephone triage system.

In response to these concerns, the systems at both Cornell and UMASS-Amherst use clinicians with the same qualifications for triage as for all other services. In both systems we avoid making any type of diagnosis on triage and focus on providing the next step in effective

treatment in as timely manner as possible, thus avoiding misdiagnosis at this stage. We also have addressed the importance of improving stakeholders' attitudes about the system and ways to make this type of system an important component to effective mental health treatment in general.

Overall, we believe that triage systems offer significant reductions in risk management concerns. Increasing access and capturing acute situations allow for more rapid intervention, thus potentially avoiding adverse outcomes such as harm to self or others, or avoidable hospitalizations.

### CONCLUSION

In expounding on the experiences of two university mental health services with triage systems we have attempted to outline the significant potential benefits of these systems to the mental health service and the university as a whole. These systems that allow for rapid clinical intervention at a time when it is likely that colleges and universities will be asked to respond effectively to more students presenting with severe depression, self-harm and sexual assault, among other concerns, will be essential to the mission of higher education. These systems have the potential to impact important variables such as number of medical leaves, psychiatric hospitalizations, and more broadly, student retention, and will allow key constituents to experience the university as a place that is more caring and responsive.

### REFERENCES

- Benton S.A., Robertson J.M., Tseng W., Newton F.B., & Benton S.L. (2003). Changes in counseling center client problems across 13 years. *Professional Psychology: Research and Practice*, 34(1), 66-72.
- Birch W.G., & Martin M. (1985). Emergency mental health triage: A multidisciplinary approach. *Social Work*, 30(4), 364-366.
- Broadbent M., Jarman H., & Berk M. (2002). Improving competence in emergency mental health triage. *Accident & Emergency Nursing*, 10(3), 155-162.
- Brown S.A., Parker J.D., & Godding P.R. (2002). Administrative, clinical, and ethical issues surrounding the use of waiting lists in the delivery of mental health services. *Journal of Behavioral Health Services Research*, 29(2), 217-228.
- Erdman C. (2001). The medical/legal dangers of telephone triage in mental health care. *Journal of Legal Medicine*, 22(4), 553-579.

- Everly G. S. Jr. (1999). Toward a model of psychological triage: Who will most need assistance? *International Journal of Emergency Mental Health*, 1(3), 151-154.
- Gallagher R.P., Zhang B., & Taylor R. (2003). *National Survey of counseling center directors*. Alexandria, VA: International Association of Counseling Service.
- Kevin J. (2002) An examination of telephone triage in a mental health context. *Issues in Mental Health Nursing*, 23(8), 757-769.
- Rockland-Miller H. (1999, October 31). Implementation of a clinical triage system in the university mental health clinic. *Workshop presented at the Annual Meeting of the Association for University and College Counseling Center Directors (AUCCCD)*, Miami Beach, Florida.
- Rockland-Miller H., Hattauer E., Hotelling K., & Eells G. (2003, November 11). Use of clinical triage in university mental health: A Multi-Site perspective. *Workshop presented at the Annual Meeting of the Association for University and College Counseling Center Directors (AUCCCD)*, Snowbird, Utah.
- Smart D., Pollard C., & Walpole B. (1999). Mental health triage in emergency medicine. *Australian and New Zealand Journal of Psychiatry*, 33(1), 57-66.
- Wynaden D., Chapman R., McGowan S., McDonough, Finn M., & Hood S. (2003). Emergency department mental health triage consultancy service: A Qualitative Evaluation. *Accident & Emergency Nursing*, 11(3), 158-165.

RECEIVED: 10/01/05

REVISED/ACCEPTED: 12/01/05