Waiting for the Great Leap Forward

Ideas for Change in University Mental Health Systems

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My Experience

- Counseling Psychologist
- Counseling Center Leadership
  - Brown University - Director (2017- current)
  - University of Portland - Asst. Director (2012-2017
  - WSU Vancouver - Lead Psychologist (2008-2012)
    - One person counseling center
- Education
  - PhD: University of Missouri - Kansas City
  - Internship & Post Doc: University of Delaware

My Experience

Much of what follows really has its origin in my time as a one-person counseling center at WSUV. I was the first full time clinician on campus and built the program to be able to have one person handle mental health care for 4000 students, many of which did not have resources to afford care in the community.

This, combined with doing pilot programs, in-house experiments around access and clinical outcomes, and applying research to our practice over the years at different universities paved the way for what we are doing now.

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Health Care Systems & Clinical Models

Primary Care

- Outpatient home-base for care
  - **Services**: Treat a wide range of needs
  - **Scheduling**: Appointment based, mostly in advance
  - **Wait**: Days or weeks depending on availability
  - **Pros**: Continuity of care with one provider
  - **Cons**: Challenges meeting urgent needs, wait time, capacity issues

This is the core of what most university counseling centers are modeled on

Urgent Care

- Easy access to routine and urgent care
  - **Services**: Treat a wide range of needs
  - **Scheduling**: Mostly walk-in or same-day scheduled
  - **Wait**: No time to 8 hours
  - **Pros**: Efficient, easy to access, immediate treatment
  - **Cons**: Not usually scheduled in advance, continuity of care with same provider can be more of a challenge

Most university counseling centers have some urgent care style services, usually for managing crises

Common Clinical Models

- **Traditional Model**
  - 50min intake assessment →
  - Psychotherapy / Wait list / Referral
- **Triage Model**
  - 15-30min triage assessment →
  - Urgent session / 50min intake assessment / Wait list / Referral→
  - Psychotherapy
- **Stepped Care** (trending)
  - 15-30min triage assessment →
  - Wide range of levels of intervention based on need

Current College Mental Health Landscape

National Campus Trends

- Increased demand for care
- Increased acuity
- Increased suicideality
- Increased anxiety presentation
- Demand for immediate care
- Demand for longer term care
- Greater student diversity
- Access challenges
- Integration with health centers
- Destigmatization campaigns
- Media attention
- Whole campus approaches
- Staff morale issues
- Student activism

New Era Realities

1. Students in college now have different needs and interests in receiving mental health care.

2. Increasing counseling staff is an important but temporary solution; the approach to the work itself needs to evolve.

3. Outside forces will determine the path forward if counseling centers aren't proactive and take the lead.

History of Evolving

- Counseling centers have a history of evolving as organizations based on changing student and university landscapes, although we are often slow to do so.
- Common context for change
  - Innovations in treatment (medications, mindfulness, telehealth)
  - Outside pressure (student needs, discontent, lawsuits)
  - Structural changes (mergers, new leadership, outsourcing)
- Common approaches to change
  - Increasing staff and resources
  - Expanding menu or model (triage, single session, Let's Talk)
  - Limiting access (session limits, scope of practice, wait list)
  - Referrals and reliance on community providers

Proposal / Thesis

Counseling centers have been operating as primary care clinics, and should evolve into mental health urgent care centers to better meet current student needs.

Most university counseling centers have operated as appointment based primary care-style clinics. Over the decades, many centers evolved to meet increasing demand by adding staff, expanding services, limiting access, and relying on community resources. Most now typically function as hybrid primary / urgent / case management / referral centers that have generally maintained some level of a comprehensive / community mental health orientation.

However, student needs and demands on counseling centers are different now than even a decade ago, and the ways counseling centers have typically evolved has not delivered a sustainable path forward this time. My view is that efforts to maintain the primary care foundation (advanced scheduling, thorough assessment, 50 minute counseling sessions, clinician expectation of ongoing follow up sessions) is the largest barrier to meeting current student needs. An alternative that has been revolutionary in medicine are urgent care centers, which have exploded in number since the 1990s and are very popular with younger adults.

I’m proposing that counseling centers, at their core, should embrace the principles and practices of urgent care centers (same-day scheduling, concise sessions, parallel assessment, immediate treatment, as-needed follow up) over those of primary care, to better match the needs of the current college student population. In short, *urgent care style services should be the default*, with primary care as the adjunct, an inverse of the current model on most campuses. This effort will honor student preferences for access and result in more students receiving treatment quickly. It also establishes a sustainable foundation and identity for our centers to operate from into the future.

Our Story

CAPS History

- Founded in 1983. Previously, mental health care was provided at Health Services starting in the early-70s
- Session limit (5, then 7) in early 1990s, ended in 2016
- Steady growth in demand since 2007-08
- Early 2010s access crisis
- 2014 formation of Mental Health Community Council
- 2014 founding of Project LET'S @ Brown
- 2015 high profile on-campus suicide
- 2017 beginning of integration with Health & Wellness

CAPS Facts

- Enrollment 9,900ish (1/3 are grad students)
  - Has increased by about 2000 students since 2007-2008 (20%)
- Last year 22% of students saw us for counseling
  - Was 15% in 2007-2008
  - 1165 students seen in ‘07-08, 2154 in ‘17-18
- CAPS Staff/student ratio is about 1:750
- Providing mostly individual care and a few groups
- Mission: help students engage in the academic, social, and extracurricular opportunities at the university; suicide prevention

Our Good Stuff in 2016-2017

- Very talented and diverse staff, open to change
- Good staffing ratio (even better now)
- Reliable and significant financial resources
- Committed and supportive upper administration
- Student activist groups (e.g. Project LET'S) with great ideas and energy, and interest in partnership

All of this is still true

Our Challenges in 2016-2017

- Access
  - 14-21 day wait for intake after triage assessment
  - Limited follow up appointments with substantial waits
  - Referred about 35% of students off campus at some point
  - Relying heavily on private practice clinicians
- Campus negativity
  - Negative reputation among students
  - Community pressure to change
  - People started working around us
  - Staff were stressed and unhappy
- Some good things were happening, but we weren't addressing the larger systemic problems.

My Approach

1. Deeply listen to what students want and find a way to try it, even if it’s counter-intuitive.

2. Provide care that is in accord with our mission

3. Dedicate as much time as possible to *treatment*, and provide it as fast as possible.

4. Be at peace with people who don’t like our evolution because it's ultimately in service of our students.

Our Evolution

Our Model

We provide care in a culturally-informed clinical framework that has the following defining features, which were inspired by urgent care centers.

1. Same day access
2. 25 minute sessions
3. Parallel assessment
4. Immediate treatment
5. Flexible follow-ups

Same Day Access

- Same day appointments available every day for *anyone*
  - First time / returning / routine follow up / crisis
  - Use as the primary entry point into the system
- Dedicate full days/weeks to all same-day scheduling
  - We do the first two weeks and last three of each term, and don't book follow ups in those weeks except for severe situations.
- Each clinician has one or two of these per day, everyday, during the main part of the semester.
  - This about 15-20/day overall, and they typically sell out by 1pm.
  - Afternoon times are much more popular than mornings

25 Minute Sessions

- The default counseling session length at the center
  - Everyone begins with this, and it is also the follow up length for a majority of students. 50 minute sessions are the exception and reserved for students when 25 minutes is not enough.
- A smaller ‘dose’
  - A 25-minute immediate dose of counseling is potent enough for a significant number of students, and this creates more time in the schedule for students that need a regular 50-minute doses.
- Already practiced at many centers
  - 25 minute (or less) services are already provided at many centers as triage assessments, Let’s Talk, drop-in support, psychiatry follow ups, case management, behavioral health sessions, late clients, etc

Parallel Assessment

- Assessment is done on forms before the first session, then as-needed as the session and treatment progresses.
  - We don't have any special forms
  - We assess for safety at every visit
- Eliminate emphasis on diagnosis for most clients
  - We strive for a diagnosis before referral to psychiatry, but providers are generally encouraged to think less about diagnosis, and more about having the client take something meaningful from the session.
- No formal intake interviews except in rare circumstances
  - These are typically only done with students that have the most complex histories, or when determining a diagnosis is important.

Immediate Treatment

- We call our approach “goal-focused counseling”
- Spend the majority of time on the client’s immediate needs
  - Provide something clinically meaningful as quickly as possible in the process, ideally in the first session
  - Approach the session as if it may be the only/last time they will come to the center (our modal number of visits is 1)
  - Set counseling goals and start every session with them
  - Deliver what the client wants for each session
- This approach can work *for all theoretical orientations*
  - The same skills, interventions, principles, and practices of each therapy style can be applied in this format

Flexible Follow Ups

- Provide multiple follow up options
  - Future same-day session, 25m counseling, 50m counseling
  - In practice for us, those are usually equally utilized
  - Revisit these options after very session
- Collaborate with the student in creating the right type of follow up plan for their specific needs.
  - Stay mindful of the mission of the center in making follow up plans and the level of care being offered.
- Connect healthy/stable/higher functioning students who want regular sessions to community care

Urgent Care Model Services

ACCESS POINTS

- Same Day
- Advanced
- Returner
- One Time

FOLLOW UPS

- Same Day
- 25m Counseling
- 50m Counseling

EXTRAS

- Crisis Appt
- Psychiatry
- Referral
- Group

Other Changes That Helped

Other Changes That Helped

- No post-entry case assignment process. Whoever is on the clinician's schedule is their client.
- 'Paced reservation' method for advanced scheduling
- 'Fast Track': Move students with brief needs into open clinical time, including moving them up after the next week's schedule is set.
- Ask students how many sessions they are interested in having at the time of scheduling.

Other Changes That Helped

- Create new names for what you do that fit your campus
- Hire dedicated crisis clinicians and eliminate rotating or ‘white space’ crisis scheduling
- Automate after hours systems as much as possible to prevent staff burnout
- Allow for flexibility on clinical documentation style
- Allow students to choose different clinicians for each visit if they want to (almost all pick the same person, but some will see a variety of providers for same day sessions out of their own needs and interest)

Other Changes That Helped

- Maximized clinical time
  - Stop providing lower impact programs that don't require our specific expertise if it can be done well by others.
  - Eliminate unnecessary clinical appointments (check ups, pre-med leave, pre-study abroad, mandated, students with off campus therapists, returns to campus, etc).
  - Condense staff meetings, planning, and professional development into less clinically heavy times.
- Allow non-clinical staff (deans, advisors, other services) to be the follow up rather than just counseling staff.

Our Outcomes & Implementation

Outcomes

- 3 day wait average for first session, down from 14-21
  - Many get in the same day
  - Spring ‘19: Longest new client wait time for a student open to seeing anyone on staff and declining same day sessions is 7 days
- Wait between sessions reduced from two weeks to one.
- No show rate significantly reduced (11-6-%)
- Off campus referrals significantly reduced (35-19-?%)
- Staff morale has increased
- Improved reputation on campus

Providing treatment faster, and in smaller doses is enough for many students, which has allowed for more long-term, 50-min, weekly counseling to happen with students with greater needs.

In Practice

- Choose Your Own Adventure: There are many different paths through the center based on how the student wants to use the service, and it's hard to predict how they will want to use it.
- This model relies substantially on therapist instincts and clinical judgment earlier in the process
- Students begin to trust the access, and start using counseling and the service differently because of it
- Some students really want sessions set up in advance, so we accommodate that

Implementation

1. We did almost all of this in one semester
2. Staff needed to see results first hand to believe in it
3. Offer training on shorter session / single session / walk-in counseling approaches
4. It was a very cost effective solution since it was a reallocation of existing staffing resources

All of these ideas can be used individually or as a package, and they should be adapted to fit each university's unique needs, context, and culture.

Starter Pack

The biggest impact moves and suggested starting points are:

1. Change triage assessments into brief counseling sessions
2. Do all same-day scheduling for the last two weeks
3. Offer non-urgent same-day sessions every day
4. Make the standard counseling appointment 25 minutes
5. Allow for and encourage as-needed follow up sessions

Thank You

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Common Questions

How do you get staff buy in?

My perspective is that each center is different based on staffing levels, theoretical orientation, university context, center mission, and internal dynamics, so there's no easy answer for this. My approach was for us to have staff collectively acknowledge that the current system was not working (for both students or themselves), that many students were hurting that couldn't get care, and that we needed to do something different together.

How do you manage crisis needs in the 25min sessions?

Since we do all same day scheduling for anything, there is a chance a more serious crisis situation could land on a counselor's schedule in a 25 minute spot. In those cases if they can't resolve it in that span of time, they do a warm handoff to our crisis clinician, or they just take longer and manage the rest of their day with that delay. We build in 30min admin blocks when we do a lot of same day sessions to buffer it and allow for catching up.

Is there a specific method for doing the 25min sessions?

The shorter sessions, especially earlier in treatment, rely on clinician instincts and learning what to ask as you go, than if they did traditional counseling after an intake. There isn't a specific method or system, it's just therapy in a smaller package. We have found that *all staff already have the skills necessary to do this well*, it just requires practice and willingness to try something new. Ultimately all of our staff learned a rhythm and way of doing this that works for each of them that is now just a part of their daily work.

Empirical support for 25min counseling sessions?

All of our clinicians practice from mainstream counseling orientations, typically integrating various approaches (relational, dynamic, cognitive, behavioral, multicultural, etc). The short sessions are just a repackaging of the same empirically supported approaches and techniques, they don't represent a new clinical orientation. The dose effect literature is important to us in these pursuits, and this model aims to provide the right dose of care whether that is one 25min session, or a lot more.

No intake assessment?

Counseling intakes are often done more to satisfy the center's needs rather than the client's. Doing an intake interview, when it's possible to offer a meaningful and effective counseling session, is an unnecessary delay in providing care. Furthermore, the vast majority of gathered information from intakes will not be relevant for the rest of treatment, and can also be gathered in other ways. Ending the process of doing these also means that staff don't write long intake reports that are typically never read, and that time can be dedicated to providing more care.

Reducing outreach to increase clinical time?

We were able to maintain most of our outreach programming, but did reduce programs that hadn't been effective, or that our wellness office or student groups did very well. However, many centers do face a reality of fewer resources on campus than we have, and do have a more legitimate dilemma. My perspective is that clinical care is the main service we offer, and we are the *only* people who offer it. If we cannot meet demand for that, than we should reduce secondary services like outreach, especially during clinically heavy time frames.

What other data do you have?

We do not have data on these changes yet beyond the access numbers, no show rates, and similar metrics that are common for counseling centers to report. We have anecdotal information from students, faculty, and staff and their positivity and self-reported improvement in this format. We are gathering more student satisfaction data, and are interested in collaborating on research. Given this, it's important to note that each student has their own route through the system and use it differently from one another, so apples to apples model comparisons are very difficult.

What about the CCMH report?

The 2018 CCMH report said systems doing traditional counseling produced more symptom reduction than those offering “rapid access” approaches, possibly due to dose effect (fewer sessions and longer waits between for rapid access). The Urgent Care Model is a balance of access and traditional treatment that offers flexibility based on student need. Our wait times between sessions are excellent, and our average number of sessions have increased in this model, although the total time with the therapist on average is less. We also appreciate that many students, perhaps more in this cohort, will not follow through with, or are not interested in traditional structures of treatment, and greatly prefer this system. Finally, when faced with the dilemma of helping fewer students more intensively while others get nothing, or helping larger numbers more modestly, we chose the latter given the mission of the center.

“Treatment” vs. “Consultation”

In the counseling world, definitions of consultation, counseling, and treatment vary, and do not represent discrete concepts. Given whatever the local nomenclature is, our clinical work is providing empathic listening in relationship, insight, education and skills, crisis stabilization, symptom assessment / explanation / relief, behavioral plans, case management, and suggestions for life improvement as early in the process as possible, and within an ethical, boundaried, and culturally informed clinic context. We consider that ‘treatment / counseling / psychotherapy.’

How has long term care also increased?

This was a hoped for but unexpected development in our implementation. The smaller and faster ‘dose’ of care at the outset, plus students also electing for 25 minute counseling sessions or as needed follow up, creates a lot of new clinical space on the backend that we have used for more long term, hour long, weekly care. This has also been a huge part of what staff have appreciated about the system, since many of them, especially those hired before this change, find a lot of meaning in that part of their work, and we are also able to serve higher needs students more completely on campus.

How did you change student narratives about the office?

The prevailing student narrative about us when I started was definitely negative, with frequent complaints about wait times, quick referrals off campus, staff not being diverse, and CAPS being generally "unhelpful." I approached changing the story by letting as many people know about our new system as possible; focusing all efforts on creating a critical mass of students that had positive experiences so that the actual grassroots would change because their experiences were actually different; and encouraging students who believed in us to speak up when they were in conversation with their peers. Right now there is a generational difference on campus where juniors and seniors report continued negative comments in their social spaces (mostly from students that haven't followed our progress or given us a second chance), while first and second year students report hearing generally positive things.

Slides From Previous Versions of this Presentation

Origins: Two Parallel Tracks

- Track 1: Mental hygiene / primary health care / psychiatry / pathology-treatment focused approaches
  - **Holistic Health Centers**: providing integrated physical and mental health care including med management, behavioral health, etc

- Track 2: Community mental health / vocational counseling / developmental psychology
  - **Comprehensive Counseling Centers**: provide a range of treatment services, and also offer a significant prevention program, systems advocacy, counselor training, and broad leadership across the campus on mental health.

Counseling Center Missions

- Most centers exist for a combination of these reasons:
  - Student retention & graduation
  - Suicide prevention & risk management
  - Help students engage and succeed in the academic, social, and extracurricular opportunities at the university

- The services we offer are the tools to accomplish this:
  - Counseling, psychiatry, group, outreach, etc

Additional Systems

- **Emergency Department**
- **Inpatient Treatment**
- **Partial Hospital**
- **Intensive Outpatient**
- **Specialty Care**
- **“Retail” Care**

Only some university counseling centers have these options as part of their campus mental health system.