

# Innovating Online with Stepped Care:

## *A Research-Based Stepped Care Mental Health Community of Practice Proposal*

by Dr. Peter Cornish

**I**nnovative service delivery models are needed by outpatient mental health clinics and university and college counselling services, as these settings face increasing demand for treatment within a context of limited resources. Wait times for secondary, outpatient mental health care in Canada exceed international norms, and Newfoundland and Labrador is no exception (Esmail, 2009; Newfoundland and Labrador Medical Association, 2011). University and college counselling services throughout North America are experiencing yearly increases of up to 15% in the demand for treatment, and students are increasingly waitlisted or must experience longer intervals between sessions (Mistler, Reetz, Kyrowicz & Barr, 2012).

A stepped care model (O'Donohue & Draper, 2011) has been developed in the United Kingdom. It promises rapid access for face-to-face intake from mental health services within a primary care setting, followed by a systematic triage and monitoring system. The model offers the lowest level of intervention intensity warranted by the initial and ongoing assessments. Treatment intensity can be either stepped up or down depending on the level of patient distress or need.

Clinical trials conducted in primary care settings in Europe indicate that stepped care is at least as effective as traditional care (e.g., van Straten, Tiemens, Hakkaart, Nolen & Donker, 2006) and has the potential for health system efficiencies (Bower & Gilbody, 2005). No research has been published on the use of stepped care in secondary health care settings such as community mental health clinics or university and college counselling services. A stepped care model has not yet been implemented or evaluated in North America nor has it been employed in a university or college system. Identifying a safe, efficient, and effective system of care in college and university counselling services is crucial given that most students attending these institutions fall within the vulnerable age range where early signs of mental illness typically emerge.

The Mental Health Commission of Canada has concluded that this country has no accessible, organized, or effective mental health *system* (Mental Health Commission of Canada, 2013). An efficient system is needed that can provide early and rapid assessment as well as systematic and monitored access to the

most effective, but least intensive, treatment (Mental Health Commission of Canada, 2013). Such a system promises to reduce the chronicity of mental illness in Canada throughout the lifespan. We propose that stepped care would be especially valuable in secondary care systems, such as university and college counselling centres and outpatient mental health clinics where demand for service far outweighs supply (Reetz, Barr & Krylowicz, 2014).

### **A Stepped Care Model for Mental Health in Secondary Health Care Settings**

We have developed a unique but untested model of stepped care for secondary mental health care settings (see Figure 1 on page ). Patient intake is handled through a decentralized case management approach in which all providers assume responsibility for at least one half-day of scheduled and walk-in intakes. Each provider is responsible for managing all cases that present during their coverage times. Referrals to other providers or trainees are permitted, but typically provider availability is scarce. As such, providers are motivated to refer patients to lower steps of care unless patient presentation severity warrants "stepping up."

Given that up to approximately 20 percent of people seeking mental health services experience a spontaneous recovery within the first week of initial contact (Patten, 2006), the proposed first step in this care model is "watchful waiting" during which service providers simply monitor the mental health of patients through the use of screening instruments without delivering an intervention. The OQ-45 outcome monitoring system (Lambert, et al., 2004) is first administered at intake on computer tablets in the waiting room and then accessible online so that students can complete these when prompted through email reminders at various points in treatment.

The second step involves providing access to self-help materials in the form of books, pamphlets, or online resources. Although research on the effectiveness of self-help for mental health reveals mixed results, most studies indicate that it can be effective when used within a treatment context (Gould & Clum, 1993). There is currently considerable private sector development of online programming in the self-help field, but access is often expensive and geared to institutional users such as EAP firms. Free or inexpensive smartphone apps have less sophisticated mood management capabilities. With additional funding, some of the more comprehensive online mental health educational self-help resources will be made available to patients who do not recover spontaneously during the watchful waiting period.

Step three involves face-to-face, interactive, psychoeducational skill-building workshops. A wide variety of face-to-face programs (both mental health and academic skill-building) will be offered on a drop-in, single-session basis or through a short, rolling series of workshops (see Figure 1 on page 11). Psychoeducational sessions have been found to improve coping for patients with mild to moderate symptoms (Van Deale, Hermans, Audenhove & Van den Bergh, 2012). For patients with higher levels of stress, the increased mental health literacy afforded by such sessions has been found to improve treatment adherence and outcomes (Greenberg, Constantino & Bruce, 2006; Swartz, Zuckoff, Grote, Spielvogel, Bledsoe, Shear & Frank, 2007).

Like several other universities across the country, Memorial University is planning to implement a campus-wide, community-development approach to wellness promotion (e.g., Budgen, Callaghan, Gamble, Wiebe, Reimer, Feddersen, Dunn, Johnson, McHugh, Morrison, Sullivan, Cull & Abd-El-Aziz, 2011; Burwell, Dewald, & Grizzell, 2010), which may include mental health first

aid training, a wellness audit of University policies and processes, and a review of curriculum design practices with the aim of integrating universal course design across campus. Psychoeducation in the stepped care model would be an integral component of this proposed healthy-campus direction. The Counselling Centre will participate fully in the healthy-campus activities in order to build capacity across campus for delivery of mental health psychoeducation beyond the walls of our clinic space.

Step four involves therapist-assisted, e-mental health programming. Cognitive behavioural and Interpersonal therapy modules have been developed in Australia (e.g., Mewton, Wong & Andrews, 2012) and are being modified for use in the United States (e.g., Therapist Assisted Online Treatment for Anxiety (TAO-anxiety), 2013) and Canada (Hadjistavropoulos, Thompson, Ivanov, Drost, Butz, Klein, & Austin, 2011). Clinical trials indicate that therapist-assisted, e-mental health is effective in primary and secondary health care settings (e.g., Kessler, Lewis, Wiles, King, Weich, Sharp, Araya, Hollinghurst & Peters, 2009; Hedman, Ljotsson, Kaldo, Hesser, El Alaoui, Andersson & Lindefors, 2014). A Swedish study employing a randomized controlled trial of therapist-assisted, internet-based cognitive behavioral therapy (ICBT) concluded that ICBT is more cost-effective than face-to-face therapy (Hedman, Andersson, Ljotsson, Andersson, Ruck & Lindefors, 2011).

Patients enrolled in e-mental health programs are typically assigned to a provider who spends up to twenty minutes per patient per week providing online (email) coaching and support as participants work through the modules. Outcome monitoring is built into these programs. Although therapist-assisted online programs have been evaluated with favourable results in Australia, Europe, and Saskatchewan (Hivert-Bruce, Rossouw, Wong, Sunderland & Andrews, 2012; Kessler et al., 2009; Pugh, Hadjistavropoulos, Klein & Austin, 2014), a fully integrated stepped care model (as proposed by O'Donohue & Draper, 2011) has yet to be tested anywhere in the world.

Step five involves the provision of traditional face-to-face group psychotherapy designed to respond to the trending needs observed at intake or on therapist caseloads. For example, when more patients present with depression, additional sections of a depression group are offered. Mindfulness group sections are expanded when stress or anxiety become more prevalent at intake. When relationship conflict and family of origin issues prevail, additional Yalom-style interpersonal process groups are offered (Yalom, 1995). Although research on group therapy over the past 50 years has consistently indicated outcomes on par with, or exceeding, one-on-one treatment (Fuhriman & Burlingame, 1994), both patients and providers seem reluctant to make use of this efficient service modality (Strauss, Spangenberg, Brähler & Bromann, 2014). We argue that successful referrals to group therapy will improve within a stepped care framework, which reduces risk of referral error given the systematic monitoring and capacity to step up the intensity of care.

Step six involves one-on-one therapy. Session duration and frequency is a matter of clinical judgment and ongoing outcome monitoring. Counsellors are encouraged to use time creatively and with some flexibility. Some patients with severe symptomatology will be seen weekly for 30-minute sessions. Others are seen for brief check-ins on a bi-weekly basis. Patients who are stabilized may be seen only every three or four weeks with self-help resources (typical of Step 2) assigned as homework. Students with chronic mental health conditions requiring longer-term or prolonged intensive treatment are referred to community-based services, which typically have a 12-to-16-month waiting list. Limited ongoing support is provided to students on this community waitlist.

Step seven involves limited outpatient psychiatric consultation with follow-up care provided by family physicians for those patients who fail to show progress by step six. A thorough psychiatric assessment is conducted, and follow-up consultation is provided to the primary care physician.

The highest level of intervention, step eight, involves inpatient admission to a hospital psychiatric ward. This is coordinated by the in-house consulting psychiatrist with support from a case manager who together liaise with the local psychiatric ward to ensure appropriate community or campus-based follow-up upon discharge. A key function of both the psychiatrist and case manager is to ensure a smooth hospital admission process and appropriate follow-up care upon discharge. Coordinated case management is key to risk management for patients in crisis and/or with severe psychopathology.

## Proposed Methodology

An examination of the literature shows that stepped care often involves randomized clinical trials. The relevant control group in such cases is the currently provided standard treatment, sometimes referred to in the literature as *treatment as usual*. This study will be conducted in two phases. In phase 1, the stepped care program described above will be delivered at Memorial University of Newfoundland's Counselling Centre and evaluated through a clinical trial comparing stepped care to treatment as usual. Also in phase 1, additional funding will be sought through both corporate sponsorship and federal granting agencies to support clinical trials in other treatment settings during phase 2. In phase 2, programming informed by the first phase and adapted to other colleges, universities, or community clinic sites will be evaluated through similar trials.

In phase 1, patients (i.e., university students) who agree to participate will be randomly assigned to either stepped care (as described in detail above) or treatment as usual conditions. Patients in both conditions will be assessed through a 30-minute walk-in intake session with an individual therapist. Continuing care in the treatment as usual control condition will involve 50-minute, one-on-one, face-to-face counselling sessions as availability permits (typically within two to four weeks after the initial intake). Continuing care in the stepped care condition will be provided at the lowest level of treatment intensity appropriate to the student's needs. In order to ensure patient wellness, all students participating in the research trial (in both treatment as usual and stepped care conditions) will be monitored weekly using sensitive, reliable, and valid mental health progress measures. These measures include critical items that identify suicidality and risk of harm to others. Students in either condition who endorse these items would be stepped up to the appropriate level of care (typically steps 6, 7, or 8).

## A Research-Based Stepped Care Community of Practice

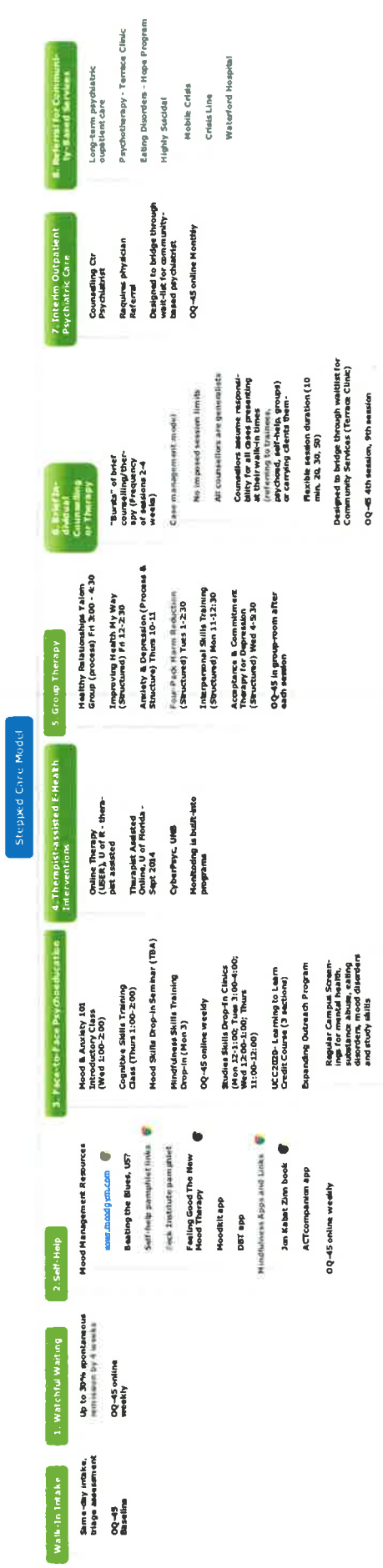
Consumers of mental health services, representatives of the Canadian Mental Health Association, mental health policy specialists, and student service professionals will be active participants on the research team. Program, research, and funding partners are currently being sought to launch phase 1 of the project. If phase 1 of this project is successful (i.e., stepped care achieves better outcomes than treatment as usual, or it achieves comparable outcomes with cost efficiencies) we will use additional funding from other sources to launch, evaluate, and sustain stepped care in other primary and secondary care settings in the province and the Atlantic region. We envision the emergence of a research-based stepped care community of practice that could extend through

Atlantic Canada and possibly across Canada. We invite interested practitioners, student service administrators, and researchers from across the country to join with us as we form a stepped care community of practice.

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2013 Literature Review  
2005 Trial  
2011 Trial  
O'Donohue & Draper Ch. 1  
Lucas et al Ch. 2

**Stepped Care Initiatives**

(Figure 1. Stepped Care Model for Counselling Centre)