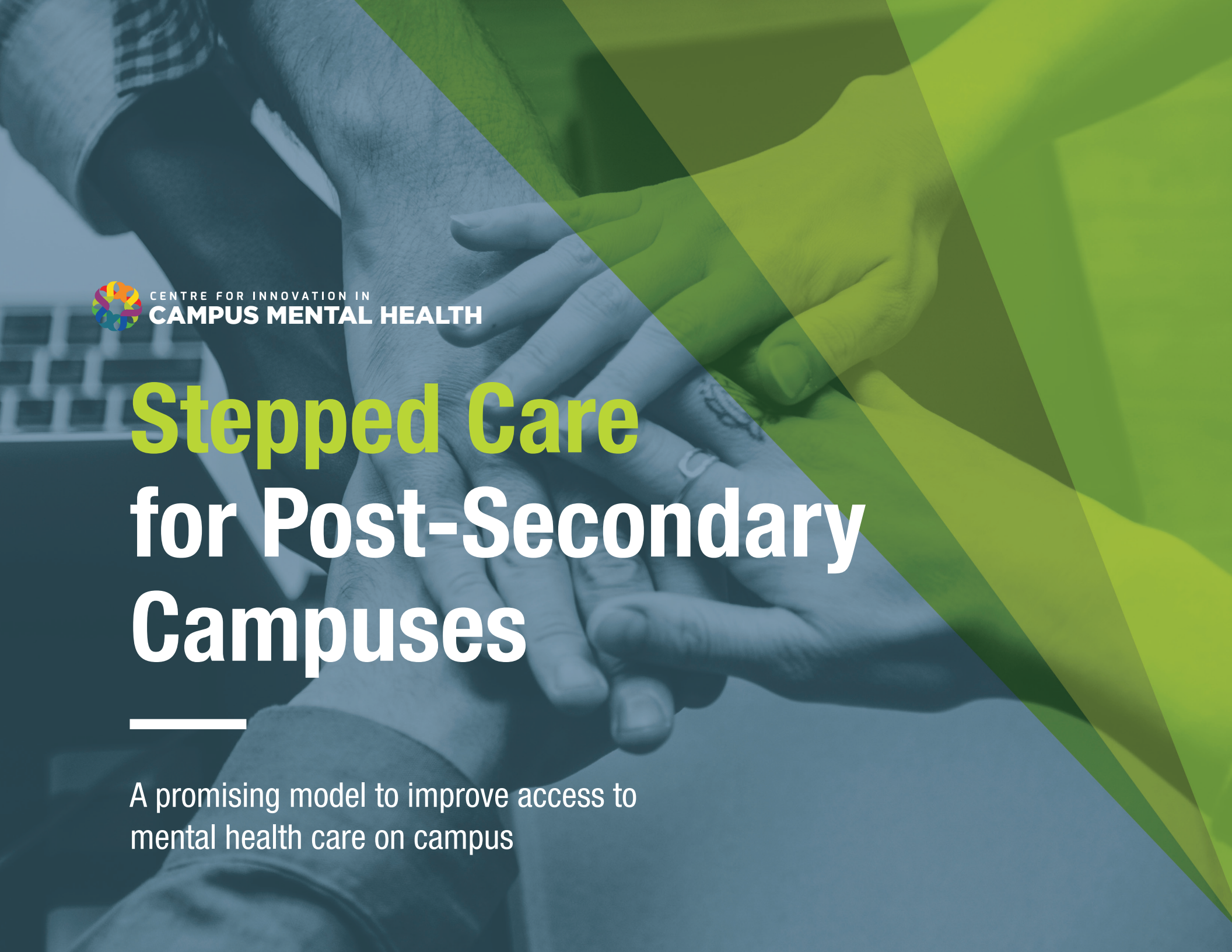

CENTRE FOR INNOVATION IN
CAMPUS MENTAL HEALTH

Stepped Care for Post-Secondary Campuses

A promising model to improve access to mental health care on campus

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Introduction

The Centre for Innovation in Campus Mental Health (CICMH) is a partnership project of Colleges Ontario, the Council of Ontario Universities, Ontario Undergraduate Student Alliance, College Student Alliance and the Canadian Mental Health Association, Ontario Division.

Our mission is to help Ontario's colleges and universities enhance their capacity to support student mental health and well-being. We do this by facilitating a campus mental health community of practice, co-ordinating access to expertise and fostering and supporting innovation. CICMH is funded by the Ministry of Training, Colleges and Universities.

In the past several years, universities and colleges across Canada have been moving towards the Stepped Care Model to enhance service delivery and support student well-being. This resource is a guide for front-line staff and leadership on campus – including counsellors, administrators and other decision makers at post-secondary institutions – considering the development of their own Stepped Care Model.

The guide provides:

- An overview of mental health service delivery on campus and how Stepped Care can help with increasing demands for support.

- The various steps for implementation of Stepped Care 2.0 – an updated, more client-centric version of the original Stepped Care Model – in three Ontario post-secondary institutions.
- A review of challenges that stakeholders may experience during the implementation of Stepped Care 2.0 and tips for a smoother transition.

Acknowledgements

We want to thank and acknowledge Dr. Peter Cornish (Memorial University of Newfoundland), Gregory Taylor (Georgian College), Dr. Sandra Yuen (University of Toronto) and Doug Stringer (Algonquin College), who each contributed to the creation of this guide. We also thank Justin Dickie, Joe Kim and Karen Alexiou of CMHA Ontario for editing and designing this guide.

Stepped Care

Context and Definition

The Current State of Mental Health Service Delivery on Campus

There are significant challenges facing mental health service providers/programs on campus. For instance, 70 per cent of post-secondary students report feeling overwhelming anxiety, leading to disproportionate demand for counselling centres. Other challenges to campus mental health programs include growing student diversity, ever-increasing symptom severity and cuts to funding.

Mental health concerns on campus have traditionally been treated by psychotherapy, delivered through 50-minute, one-on-one sessions between a client and counsellor, but this approach has become largely ineffective given the current landscape of post-secondary services. As one-on-one psychotherapy is time consuming and resource intensive, this current approach won't resolve supply and demand problems, is expensive, and often doesn't fit the lifestyles or needs of students today. Increasingly, campuses need to position themselves to pivot to a more sustainable model of care.

The current state of mental health service delivery on campus requires a creative solution: Stepped Care.

The Stepped Care Model prioritizes distribution of limited mental health resources in a way that maximizes effectiveness and best suits the needs of all students.

> ***Seventy per cent of post-secondary students report feeling overwhelming anxiety, leading to disproportionate demand for counselling centres.***

What is Stepped Care?

Stepped Care is a system of delivering and monitoring mental health treatment so the most effective, yet least resource-intensive treatment, is delivered first. Program intensity can then be either "stepped up" or "stepped down" depending on the level of client need. For example, less intensive treatments include self-help approaches or peer support, and more intensive treatments can include individual therapy or psychiatric consultation. Throughout the process, mental health indicators are monitored to give both the provider and client feedback on their progress and to empower the client to participate actively in care options, decisions and delivery.

The Stepped Care Model is founded on the beliefs that people shouldn't have to wait for psychological services, people require different levels of care, and finding the right level of care often depends on monitoring outcomes.

Stepped Care 2.0

Stepped Care 2.0, developed by Dr. Peter Cornish, re-imagines the original Stepped Care Model, with the main difference being that Stepped Care 2.0 is more client-centric. Therapists share responsibility of care with clients and, as a result, clients are more attentive to their needs and level of engagement.

Benefits to Stepped Care 2.0

- It promotes client responsibility, autonomy and resilience
- Steps are based in part on client readiness for change
- It includes face-to-face and/or online components to meet clients where they are
- It applies solutions-focused, strengths-based interventions first
- It ensures rapid access to prevent more serious health and mental health conditions

Monitoring: a key feature of Stepped Care 2.0

Prior to all sessions, clients complete an outcome monitoring survey (e.g., the ORS/SRS, OQ-45, CCAPS, BHM-20/43). The CelestHealth monitoring system, which includes the BHM-20/43, is particularly well suited to Stepped Care because, in addition to tracking mental health symptoms/deficits, it assesses capacities including readiness for change, wellness, functioning, and engagement with the health care professional. This assessment takes approximately 90 seconds to complete and is used to make collaborative decisions on treatment options. Stepping decisions are facilitated by this ongoing, session-by-session monitoring.

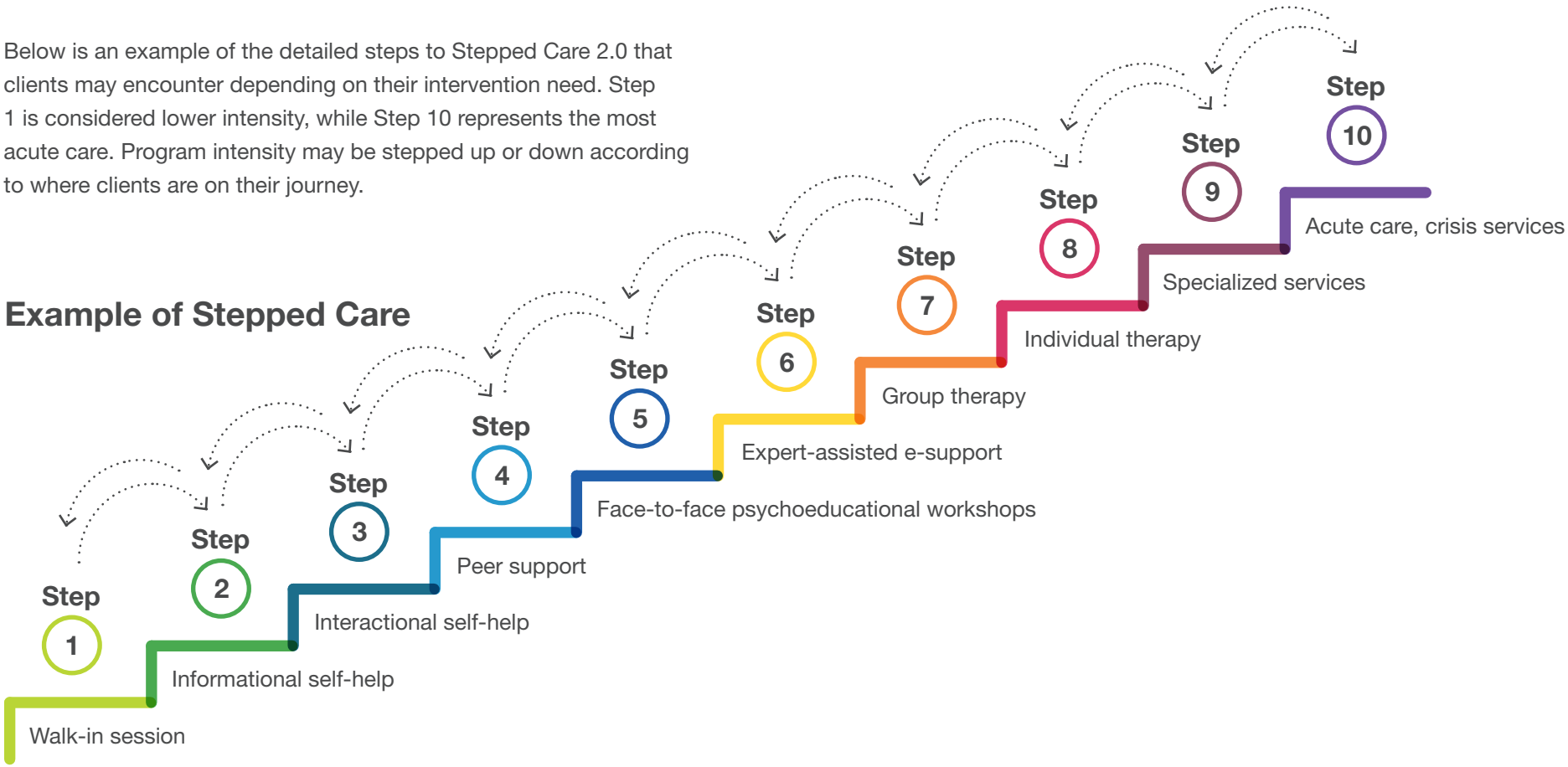
Note: In the following sections of this document, all references to "Stepped Care" will be referring to Stepped Care 2.0.

Steps Explained

Stepped Care Steps

Below is an example of the detailed steps to Stepped Care 2.0 that clients may encounter depending on their intervention need. Step 1 is considered lower intensity, while Step 10 represents the most acute care. Program intensity may be stepped up or down according to where clients are on their journey.

Example of Stepped Care



Note: the steps described are simply an example of the model. Stepped Care can take on different forms depending on an organization's size, needs and service delivery capacity.

[Step 1]

First client contact: Walk-in session

Clients making a first visit are seen on a walk-in basis. This rapid access is important since early intervention is key to preventing more serious health and mental health conditions. This walk-in consultation may include an intake assessment and initial solutions-focused intervention.

By the end of the initial session, a shared plan is developed and written on a behavioural prescription form based on step level. The plan is described to clients as tentative and flexible, and they're encouraged to make direct contact should they wish to alter the plan or miss a scheduled session. Timing and duration of a follow-up session are based on the severity of the client's needs.

[Step 2]

Informational self-help

This step involves educational self-help resources such as books, pamphlets and online media. This step aims to increase mental health literacy and engage the client in the change process when they first seek professional help.

Examples: More Feet on the Ground, JED Foundation, TED Talks, Half of Us

[Step 3]

Interactional self-help

This step involves the use of interactive self-help resources, such as workbooks or courses configured for online application. These tools can be useful for students who may not be ready to fully engage in the change process, but are ready to explore what might be involved in making small changes.

Examples: WellTrack, TAO Therapy Assistance Online, Big White Wall, Good2Talk, 7 Cups

[Step 4]

Peer support

This step involves the assistance of paid and/or unpaid peer workers and recovery coaches based on campus or within local community organizations. Students can benefit from the help of peer support programs, or be encouraged to become peer supporters themselves. For example, student peers can be trained by counselling staff to provide support to clients waiting at walk-in appointments or to coach e-mental health programming. Peer support can occur in-person, by phone or through online chat systems.

Examples: 7 Cups, Healthy Minds Healthy Campuses Guide, MHCC Guidelines for the Practice and Training of Peer Support, Peer Support Canada

[Step 5]

Face-to-face psychoeducational workshops

This step involves interactive, psychoeducational, professionally-facilitated, skill-building workshops. A variety of peer and professionally-led online chats and face-to-face interventions are offered on a drop-in, single-session basis or through a series of coaching workshops.

Examples: SMART Recovery, stress management, Canadian Mental Health Association workshops

[Step 6]

Expert-assisted e-support

This step involves therapist-assisted online mental health programming. Clients enrolled in therapist-assisted e-mental health programs are typically assigned to a provider who spends 15-20 minutes per week providing online or telephone coaching and support as participants work through care modules. Outcome monitoring is built into these programs.

Examples: BounceBack, TAO Therapist Assistance Online, keep.meSAFE, Sanvello

[Step 7]

Group therapy

This step involves intensive group programming and/or training sessions that are professionally led, and participating clients are initially referred by a clinician. Please note that this step is lower than Step 8 in terms of cost, but may be higher in terms of intensity and client readiness.

Examples: Group programs related to mindfulness, depression, anxiety, cognitive behavioural therapy (CBT)

[Step 8]

Individual therapy

This step involves more intensive one-on-one counselling sessions. Individual therapy is intense work during which clients are asked to set clear goals and work towards these with therapist guidance. Counsellors are encouraged to use time creatively and with some flexibility. Some clients with severe symptoms are seen weekly for sessions ranging from 20-50 minutes. Others are seen for brief check-ins on a bi-weekly basis. Clients who are in the recovery or maintenance stage may be seen only every three or four weeks with self-help resources assigned as homework.

Examples: Evidence-informed face-to-face counselling which includes but is not limited to CBT, dialectical behaviour therapy (DBT), interpersonal and brief psychodynamic therapy

[Step 9]

Specialized services

This step involves outpatient psychiatric consultation for individuals that don't show progress at Step 8 and/or specialized community-based services for clients with chronic mental health conditions that require long-term or prolonged intensive treatment.

Examples: Canadian Mental Health Association services, private psychotherapy, women's shelters, sexual assault clinics

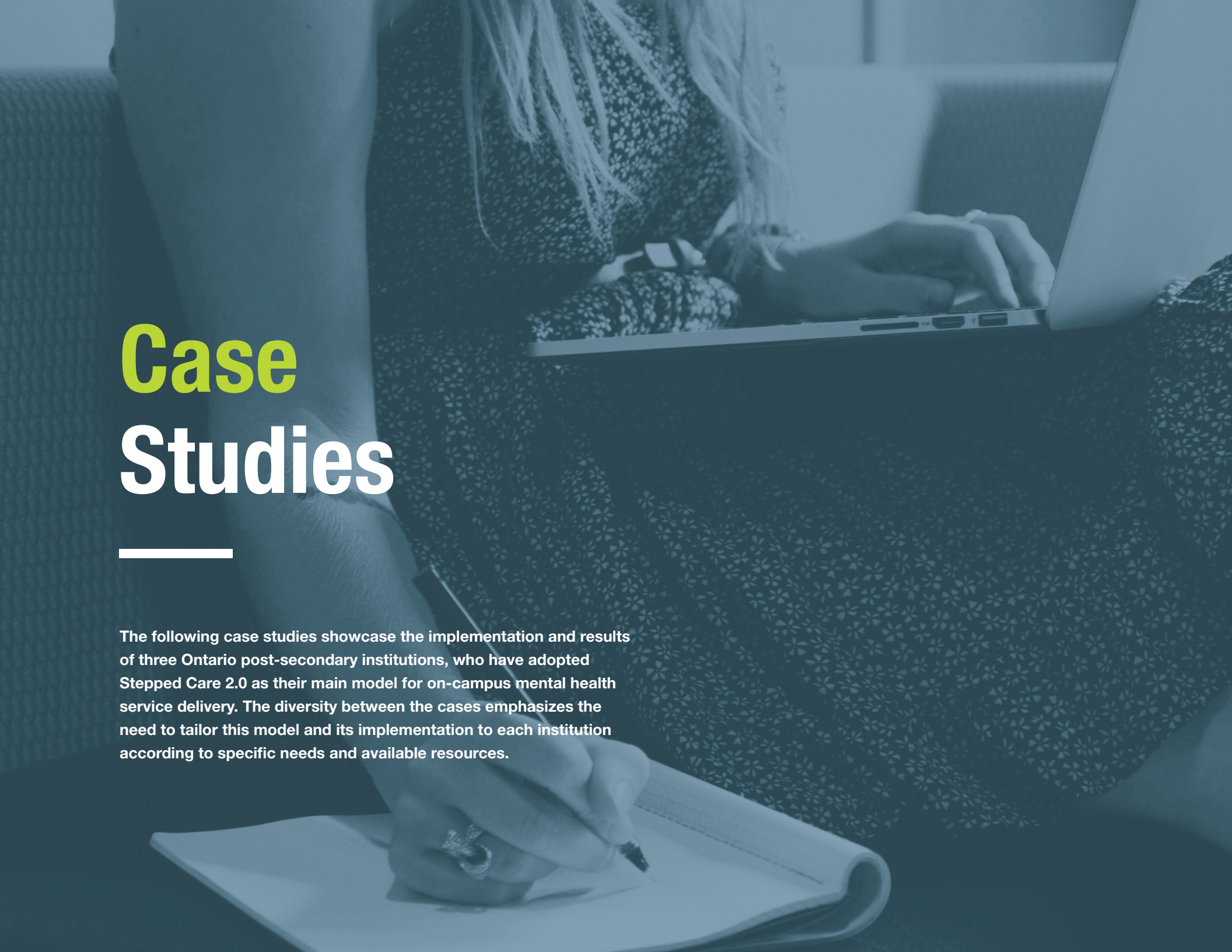
[Step 10]

Acute care, crisis services

This step involves intensive case management and crisis support for clients with chronic conditions, substance use and/or behavioural issues. This includes more intensive services such as admission to a hospital psychiatric ward.

Most Step 10 activities are co-ordinated by case managers who liaise between campus officials and community-based agencies to ensure continuity of care.

Examples: Campus safety and security, Canadian Mental Health Association crisis services, police, hospital emergency



Case Studies

The following case studies showcase the implementation and results of three Ontario post-secondary institutions, who have adopted Stepped Care 2.0 as their main model for on-campus mental health service delivery. The diversity between the cases emphasizes the need to tailor this model and its implementation to each institution according to specific needs and available resources.

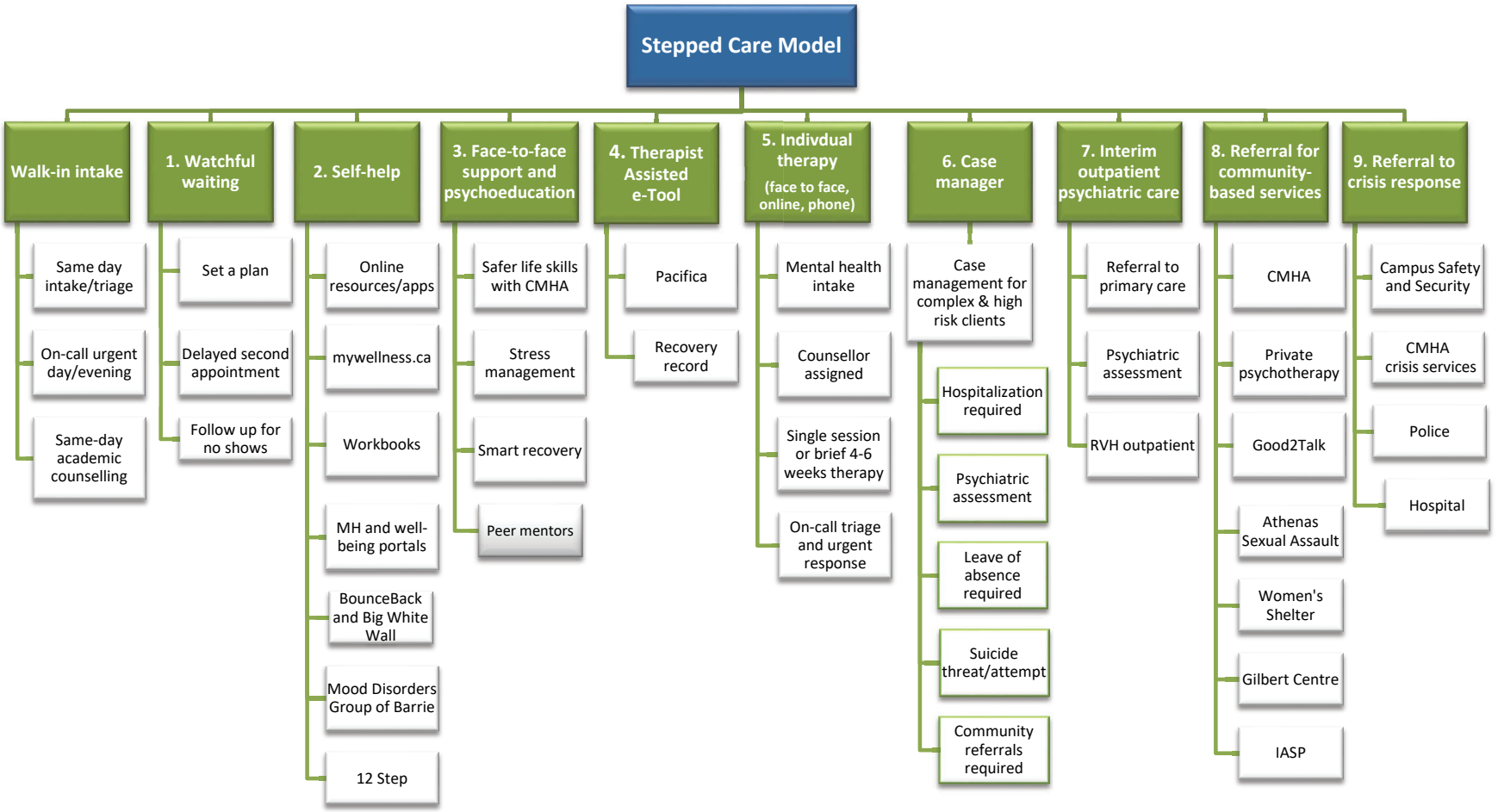
The Case of Georgian College

The Process

- A formal implementation of Stepped Care began when Georgian College received funding through the Ontario government's Mental Health Innovation Fund for two initiatives: Case Management Project (2013-15) and Case Management Project: Focus on Addictions and Transition (2015-17).
- Georgian College received funding for a part-time clinical case manager who was mentored by a case manager lead.
- Both the case manager lead and case manager developed new relationships and bolstered prior relationships with community partners (hospital in-patient and day programs, Canadian Mental Health Association, family service agencies and many more).
- Georgian College implemented walk-in and evening counselling services more than 10 years before implementation of the Case Management Project.
- In May 2018, Georgian College hired a mental health strategist responsible for developing a mental health strategy for both students and employees at all seven campuses.
- Collaboration with community partners is essential for Georgian College's Stepped Care Model. The mental health team and mental health strategist work together to ensure these relationships thrive.

The Results

- ✓ Stronger connection between on-campus counselling services, other campus services and community-based services (e.g. co-facilitated Skills for Safer Living with Canadian Mental Health Association staff, greater communication between the college and hospitals, participation on various community agency committees, shared expertise and collaboration between the college and other agencies).
- ✓ Wait times for appointments continue to be minimal (within 24 hours).
- ✓ Counsellors at Georgian College were generally very supportive of the changes. This was partly because walk-in and evening hours for counselling had already been implemented for several years.
- ✓ Students are increasingly aware of the flexible and accessible services available to them. New mental health and well-being student portals were launched in May 2019 to ensure more students are aware of these services and resources.



Based on model developed by Dr. Peter Cornish and Dr. Rice Fuller at Memorial University.

The Case of the University of Toronto

Background

Prior to fall 2015, Health and Wellness consisted of two distinct clinics, Health Services (HS) and Counselling & Psychological Services (CAPS). In September 2015, the two clinics were integrated into the Health & Wellness Centre (HWC) to provide an interdisciplinary collaborative care model for students. With that, a formalized Stepped Care Model was adopted for mental health services. The integration was a direct response to the University of Toronto Mental Health Framework, student feedback, and best practices to ensure students have quicker, direct access to health and mental health services.

The Process

- **Centralized intake:** Students can now access all services, including family physicians, nurses, psychologists, social workers, psychiatrists, a dietitian, and support staff through one single access point. Students are assessed through one intake process and receive interdisciplinary care based on their needs.
- **Triage:** Based on a mental health intake, students are matched to the most accessible, lowest intensity, and most autonomous mental health program, ranging from psychoeducational workshops, brief counselling, short-term group or individual psychotherapy, psychiatric care, case management, and urgent services.
- **Psychoeducational workshops:** A four-module, CBT-based coping skills workshop was developed in addition to wellness workshops focused on sleep and relaxation strategies. These workshops could be the recommended care pathway from triage or accessed during waits for more intensive services.
- **Embedded/on-location counselling:** Expansion of embedded counselling to over 20 faculties, colleges, and departments.
- **Group therapy:** Several evidence-based eight-week groups were developed, including a trans-diagnostic CBT group for depression and anxiety, DBT group for emotional dysregulation and low distress tolerance in the context of depression and anxiety, DBT group for personality issues with higher complexity (suicidality, self-harm), and a four-week mindfulness-based stress reduction group.
- **Shared care:** Psychiatrists are embedded within the medical team, providing psychiatric consultation and short episodes of care, with follow-up provided by the referring family physician.

- **Shared electronic medical record (EMR):** All clinicians utilize the same EMR, with one clinical chart for each student.
- **Training:** All clinical and administrative staff were provided with training sessions on the new model of care. Primary care physicians and nurses shadowed psychologists during mental health intakes and consulted on guidelines for determining urgency and disposition.
- **Collaborative care:**
  a. Interdisciplinary case conference teams are established each academic year. They meet monthly to discuss clinical cases.
  b. Interdisciplinary teams are established for specialized care (e.g., trans health care team).
  c. A complex care team was established to review treatment plans for students with complex needs. The team meets weekly or twice weekly and clinicians can join the meetings to discuss students of concern and treatment plans.
  d. Shared care consultations are hosted by a psychiatrist every afternoon for clinicians to consult on shared care cases, medication treatment, diagnostic issues, etc.

The Results

- ✓ Pathway approach: Single access point provides a more accountable, clear, and guided pathway to care.
- ✓ Centralized services reduce fractured care and duplication of services and provide an ongoing monitoring system rather than siloed care.
- ✓ Stepped Care Model matches severity of student concerns to intensity of mental health services.
- ✓ Promotes episodes of mental health care, with follow-up provided by primary care and opportunity for mental health consultation as needed.
- ✓ Promotes interdisciplinary care teams focused on specialized populations (e.g., trans health, eating disorders, trauma) and improves student experience and partnerships between service providers.
- ✓ Allows for psychiatry to adopt a more consultative role.
- ✓ Allows for nursing staff to operate as a “pivot” role and to bridge the two clinics by triaging to appropriate services, providing psychoeducational counselling and interim care for monitoring purposes.
- ✓ Inter-professional collaboration inherently contributes to professional development (e.g., improved medication treatment competency among family physicians and expanded nursing role in mental health.
- ✓ The combined service delivery changes resulted in an 80 per cent reduction in the number of students waiting for mental health services following intake.

UNIVERSITY OF TORONTO

	Health Promotion	Low Intensity	Medium Intensity	High Intensity	Severe Illness
Intensity	Step 0	Step 1	Step 2	Step 3	Step 4
Programs & Services	Health Promotion Prevention Resilience Self-Help	Guided Self-Help Self-Management Skills-Building Coping Access to Counselling	Skills-Building Coping Counselling Group Therapies Psychotherapy Primary Care	Collaborative/Shared Care Medical Treatment Interim Outpatient Psychiatric Treatment Case Management	Interim Outpatient Psychiatric Care Crisis Management Case Management Hospital/Community Care
	Health Promotion Programs Identify Assist Refer (IAR) Mindful Moments Psychoeducation Good2Talk Self-Help	Online Coping Workshops Coping Skills Workshops Wellness Workshops Mindfulness-Based Stress Reduction Group Same-Day Counselling (single-session) Embedded Counselling Brief Counselling Primary Care Good2Talk Mindful Moments MoveU|HappyU/SPARK Supported Education Big White Wall Bounce Back	Coping Skills Workshops Wellness Workshops Group Therapies (CBT, DBT, IPT) Embedded Counselling Brief Counselling Short-Term Psychotherapy Primary Care Medication Treatment Psychiatric Consultation MoveU|HappyU/SPARK Supported Education IASP CBT BounceBack	Group Therapies (CBT, DBT) Short-Term Psychotherapy Medication Treatment Shared Care Case Management Case Conference Outpatient Psychiatric Consultation Interim Outpatient Psychiatric Treatment On-Call Assessment LOFT	Short-Term Psychotherapy Shared Care Interim Outpatient Psychiatric Treatment Medication Treatment Case Management Crisis Management On-Call Assessment Case Conference Crisis & Student Progress and Support Hospital Admission LOFT

The Case of Algonquin College

The Process

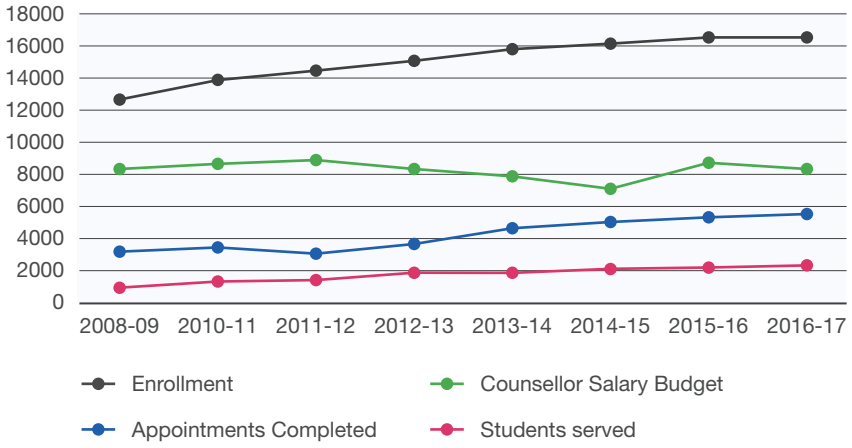
- Initial access to counselling was changed from an intake appointment to a walk-in model.
- The college hired a group counsellor that facilitates groups on anxiety, depression, mindfulness, sleep, relationships and emotional regulation.
- Counsellors were trained in single-session therapy and Stepped Care 2.0.
- A new page on the college's counselling services website was dedicated to online self-help apps and tools.
- The college purchased and implemented TAO Therapy Assistance Online technology.
- The college purchased and implemented Behavioral Health Monitor (BHM-20) outcome measurement technology, which all counsellors use on new tablets.
- The college continued to promote WellTrack interactive self-help therapy across all campuses.
- The college reviewed the whole service delivery model with Lean Six Sigma methodology in May 2018.
- Provincial tools such as BounceBack and Big White Wall were promoted.

The Results

Counselling budget hasn't increased since 2008. With the same budget, the college saw:

✓ Twice as many appointments completed
✓ Twice as many students served

This makes the case for the change.



Find more information at Algonquin College Counselling Services.

Pathways to Care

There are many pathways to access support. What paths will you choose?

Review Your Own Self-Care

How are the following present in your life?

- Exercise
- Healthy eating
- Healthy sleeping
- Fulfilling social activities
- Mindfulness practice
- Time management
- Other tools and strategies to deal with stress

Use Online Tools for Self-Directed Care

We have many online resources that you can access at any time:

- Essential Study Skills Guide:
  - Time management
  - Stress management
  - Studying and test-taking
  - Reading and note-taking
  - Presentation skills
  - Career and program choice
  - Resilience
  - Sleep
- Peer support with Big White Wall
- WellTrack
- BounceBack
- "Just As I Am" and "Your Best You" workbooks

See our website for more information and links.
algonquincollege.com/counselling/web-based

Walk-In

Access Counselling Services through a walk-in consultation, where a counsellor will meet with you and help you develop a plan to address your concern. Walk-ins are available Monday to Thursday from 9 a.m. to 4 p.m. and Friday from 9 a.m. to 3 p.m.

Workshops

Take your skills to the next level with workshops in the Digital Literacy Lab on:

- Time management
- Note-taking
- Motivation
- Study strategies
- Exam prep
- Stress management
- Group work

Sessions are held frequently. For dates, times, and locations, please visit the website.

Therapy Assistance Online

Use self-guided modules or workbooks combined with face-to-face support from a counsellor.

Community Referrals

If you need support outside of what Counselling Services provides, we will help connect you to resources in the community. In addition, if you are looking for 24/7 community support, you can call Good2Talk at 1-866-925-5454 or by dialing 2-1-1.

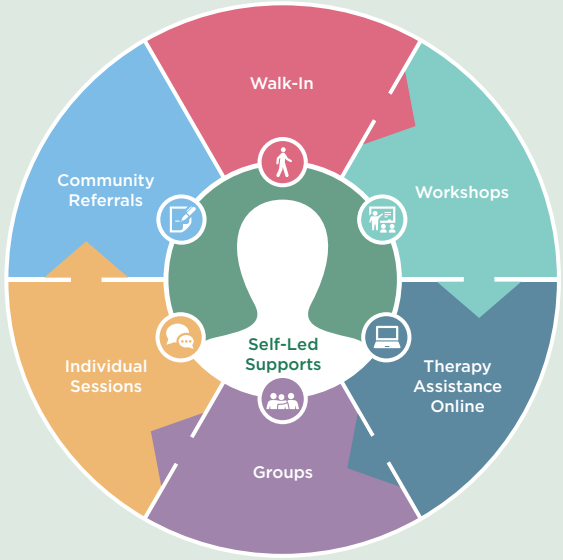
Individual Sessions

Talk to a counsellor for short-term support to help you thrive as a learner.

Groups

We offer a variety of groups to help you manage your mental health concerns and improve mental wellness. Our groups provide a safe, supportive space where you can connect with your peers and explore different perspectives, skills, and coping strategies for dealing with challenges. Most groups are led by one of our counsellors.

To find upcoming groups, visit
algonquincollege.com/counselling/group-counselling



Counselling Services | Student Support Services

Implementation Experiences

Any major changes to a service model may trigger varied reactions from the different stakeholders involved. As part of the change management process, it is essential to hear these voices, take into account the various perspectives and address potential concerns.

The following are examples of concerns, challenges and opportunities voiced by clients, service providers and administrators during the transition to Stepped Care. These testimonials are excerpts* from the publication by Peter Cornish et al. publication (2017). Meeting the needs of today's college student: Reinventing services through stepped care 2.0. *Psychological Services*. 14(4), 428-442.)

I Really Like Having This Plan

[A Client Perspective]

When students present at walk-in clinics, they are typically seen within two hours, and often within the first hour. Although most students prefer this same-day service, some opt for scheduling a slot in the first 30 minutes of a three-hour walk-in clinic with wait times typically of two to three weeks. At an initial session, student expectations about treatment are assessed and are sometimes adjusted by briefing them on the stepped care model. Based on a composite drawn from elements of two separate client presentations during a walk-in consultation period, the following is a description of a typical student experience:

Justine arrived at 10:15 on Monday morning requesting counseling services. She indicated that she had not been seen previously at the center and was informed of the walk-in consultation process. She decided to avail of the walk-in service. Justine was provided with an iPad walk-in assessment form which, along with demographic items, included an administration of the BHM-20 outcome tracking measure. She completed the forms within five minutes and at 10:25 a.m., a senior psychologist, Dr. G, serving in the role of primary care mental health consultant, greeted her in the waiting room.

Upon entering the consultation office, Dr. G reviewed the limits of confidentiality and outlined the stepped care model. She explained that the university had recently adopted an innovative system for improving service access, treatment effectiveness and empowerment of students seeking services. She showed a graphical representation of the model and indicated where they were in the process (i.e., walk-in consultation—step 1). Dr. G. said that prior to the adoption of stepped care, wait times were much longer with only two high intensity services available - group and individual therapy. Stepped care she explained, had expanded the options to fit better with wide ranging student needs. Dr. G added that some students, at least initially, prefer to "dip their toes into" the process of change with less intense programs that are educational in nature and self-directed.

Then Dr. G stated that outcome monitoring tools, such as the BHM-20 that Justine completed in the waiting room, are used to assess and reassess the impact and appropriateness of the programming offered. She added that by reviewing the results today, and on any future visits, they could decide together on treatment options best suited to her circumstances. Before discussing Justine's BHM-20 results, Dr. G asked if Justine had any questions. Justine replied, "No, it seems to make sense." Dr. G showed an iPad screen shot of the BHM-20 results to Justine. The results indicated that Justine's level of distress was moderate with elevations on general and social

anxiety. Justine responded “sometimes” to the critical item, “wanting to harm some-one.” When queried, Justine said that her stress was “getting so high” that she was afraid she might get the urge to “cut or scratch” herself like she did during her first year of high school. She clarified that her response was only in reference to harming herself not others.

At this point, Dr. G asked open-ended questions about Justine’s reasons for seeking services. Justine indicated that she had seen a counselor previously at another university and was taking 20 mg of Paxil for anxiety. However, over the past two weeks her symptoms had returned following an argument with her father. Dr. G asked about what had been helpful to her in her previous counseling and Justine said she liked being able to “just talk” but that it didn’t really change her symptoms much. Justine said she really wanted to learn about strategies for relaxing or dealing with her thinking which she said “gets messed up” whenever things get busy or there is conflict. She said that she also feels awkward and nervous in social situations and large spaces. Justine seemed eager for solutions but worried that with her part-time job, full course load and long commute time, she would have a hard time attending regular sessions.

Dr. G described three different online programs that are designed to introduce techniques for managing thoughts and feelings related to stress.

Dr. G described three different online programs that are designed to introduce techniques for managing thoughts and feelings related to stress. Both Dr. G and Justine decided that the low intensity self-help program, WellTrack, would not be enough because Justine expected she would procrastinate without any follow-up. They agreed to try the TAO (therapist assisted online) program because the weekly 15-min coaching sessions could easily fit into her tight schedule and would help motivate her to do the modules and exercises between sessions.

Dr. G said that she thought Justine may also benefit in the future from a therapy group for anxiety but wondered aloud if this might be too intensive and anxiety provoking for Justine right now. Justine agreed, saying, “I could never talk about this in front of a group of strangers.” Dr. G said, “The TAO program is a good choice right now and would likely reduce your anxiety.” She added, “The group might be an option once you pick up some of the basic CBT skills through TAO.” Justine seemed uncertain but agreed it was a possibility.

Dr. G wrote the plan out on a “behavioral prescription” pad checking off the box beside the midlevel TAO program as a first step and putting a question mark beside the high intensity group therapy box for the anxiety group as an option for the future. She showed Justine a copy and asked her how she felt about the plan. Justine said she was pleased with it. Dr. G informed Justine that an email invitation would come from TAO-connect later that day. Below her name on the plan, Dr. G wrote down her contact information and encouraged Justine to reconnect at any time if she wished to adjust the plan. She scheduled an appointment for the first 15-min TAO coaching session for the following week. Justine smiled, holding up the prescription, as she reached for the door and said, “I really like having this plan.”

But I Didn't Train for This

[A Post-Doc Perspective]

Provider experiences adapting to stepped care have generally been positive but varied. As with any major change, implementation may be met with initial reluctance or resistance. Given that many training programs do not prepare clinicians on flexible single-session therapy models (e.g., Hoyt & Talmon, 2014), professional development opportunities offered through a period for adjustment may be helpful. The following represents the experience of a postdoctoral counselor:

Today I discussed with my Director how I was feeling anxious, uneasy, and even unsure about the new stepped care model. I said to her that I felt unsure about seeing clients now because I feel the urge to follow stepped care in a perfect way; otherwise, I'm thinking to myself that I would be putting clients at risk. Moreover, following this model seems contrary to the best practices I learned so recently in graduate school. I was taught that the therapy process takes time, and that we need to be respectful of the client's pace. What I understood so far from this model was that I was supposed to prescribe something immediately to the client, and that, sadly in my opinion, only a small portion of my clients would receive actual therapy, simply because I was not going to have any time to see them.

I saw so many challenges to my accustomed practice: too much information, procedures to follow, and decisions to make for the client. I felt the pressure to grasp all this information in order to do what is now expected from me here. At first I was not sure exactly what was making me anxious since I had previously been pretty confident with my counseling approach. Then I realized with frustration I was losing the part of myself that trained so hard to be a good therapist!

In tears, I was able to share those feelings and uncertainties with my Director. After inquiring about where my anxiety was coming from, then learning that this feeling was new for me, my Director attributed it to normal anxiety associated with implementing a completely new service model. Then, abruptly she initiated a role play—by the way, I am not a fan of role plays, but I went there anyway because I was desperate and I trusted that she knew what she was doing. I was anxious as I played the role of therapist. I tried to assess the client's problems and offered options from the model. I tried so hard to do it right. As soon as I finished, I knew I missed some of the most important pieces—joining with the client, my presence in the room. I was too directive and cold. We reversed roles.

> ***If therapy is about empowering clients to make meaning and own decisions in their lives, now I can see that the stepped care model does just that.***

As the client, I was offered options. After listening to my (role-playing client's) concerns, the therapist (my Director), presented options for services using the metaphor of a food court. There are so many options, and it is up to me to choose what I will get. I did not feel like I was shopping for services, nor that I was denied the service I was seeking. In fact, as the client in this role, I felt I was gently supported to make a decision and to own it. I was told that here individual therapy is brief, yet intense and hard work. I somehow felt heard, and most importantly, I felt empowered. I was not sure quite why.

After a debrief, I realized I felt relieved by my role-playing- counselor's suggestion that therapeutic options come in a range of doses. Her invitation for me to be directly involved in treatment option decision making felt empowering. Finally, the frank admission that the therapy process itself is hard and that I have to take responsibility for doing the work led me to trust and feel confidence in her expertise and authority. A notable shift occurred. The powerful experience of being cared for sensitively, efficiently and honestly, rekindled my confidence. I was encouraged to draw on my own sensitivity and genuineness, qualities that I recognized in prior training made me a good therapist. I believe now I will figure out a way to be that same good therapist within the context of the new model.

I said to my Director that maybe notions of good therapy and of the good therapist need some rethinking. I had always been a firm believer that therapy is hard work, and that the client should be the one doing it. My job is simply to facilitate this process. If therapy is about empowering clients to make meaning and own decisions in their lives, now I can see that the stepped care model does just that.

I Cannot Do It That Way

[A Trainee Perspective]

In supervising trainees, we remind them to consider adjusting what is taught to fit with their own particular style and personality. One size does not fit all. As licensed practitioners in the field, we take our own advice on this by acknowledging that the stepped care model can be implemented in many different ways. A trainee describes her experience with discovering she needed to find her own way of "doing stepped care":

Having previously completed two practicum placements at the counseling center in the "pre-stepped care" era, I felt unprepared to work with this new model as I began my predoctoral internship. In my first week I attended a stepped care training seminar facilitated by my supervisor. I understood the model as presented. During the seminar I volunteered to role play a client at a walk-in consultation session. In the role of client, I was expecting to receive traditional weekly counseling for my social anxiety and to learn ways to deal with my father's verbal abuse. Despite my expectations, the walk-in counselor's explanation of the new model made sense and I actually felt the solutions offered were better than I had expected.

Later, as I practiced how I would introduce the model to clients at my first walk-in clinic, I had a hard time making it sound right. I lacked the confidence and credibility embodied by my supervisor (Dr. G.), who was also the Director of the Center. My first session was a flop. My client had years of experience of free counseling offered at another university and her scores on the BHM-20 indicated very little distress. She did not seem able to articulate any clear goals. Having just come from the stepped care seminar, I felt it would be a mistake to offer her intensive therapy. I did my best to play up the less traditional options, but no dice—she had come for individual therapy and that was what she was determined to get. I felt like I was being too pushy and so with some feelings of guilt and a little resentment I found space in my schedule to begin seeing her next week.

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In my next walk-in clinic, I convinced one student to accept an invitation to participate in the therapist assisted online program (step 5) and two others to join a group (step 6). I couldn't bring myself to offer the lowest intensity programs but at least I had avoided the dreaded step 7 (individual therapy)!

But my sense of accomplishment was short-lived. I soon learned that the student referred to the online program never completed the registration, one of the group referrals did not meet the group screening criteria and the other group client never showed up for any sessions. Clearly I didn't have the hang of it.

I decided to observe another therapist conducting stepped-care walk- ins. This therapist took a different approach—it began as I had been trained, with asking the client to say in her own words what issues she wanted to work on. This therapist explained the model after about five minutes and she tailored the message using some of the client's words and by focusing on the issues of importance to her. In this context the stepped care options seemed more natural and logical. Unlike my previous efforts, this therapist did not appear to be trying to sell a product or convince a reluctant buyer. In the end I found my own style which had a blend of both approaches—a much shorter explanation of the model at the beginning with details explained after hearing the client's story.

What Stepped Care 2.0 Looks Like

[A Parent Perspective]

Parents have also expressed reactions to the new service model. While it would be easy to dismiss overly involved parent interests as intrusive, it is possible to harness that energy by joining forces in support of improved care. Calls from parents range from polite inquiries on treatment access to advocating aggressively for unrealistic and unnecessary service levels. If the stepped care service model rationale is well described, stakeholders, including parents, may respond positively. The following is a composite of conversations the Director at The George Washington University has had with several parents:

I had been on the phone night after night for hours, trying to calm my daughter down. She was going over and over how she felt anxious and unmotivated. When I told her to go to the counseling center she was reluctant, but went eventually on my insistence. So many things went through my mind about whether the process would be useful or not and I considered alternatives such as paying out of pocket for a community provider. I was shocked when she reported back that she had been presented with a choice of several options and could "step up" depending on her "specific need." My initial thought was to call and complain, to demand that she be given a full course of psychotherapy, but when I heard her consider the options so thoughtfully, I could see her taking responsibility for her stress and anxiety with confidence and new optimism.

Of course, not all parents are as cooperative. Complaints range from: "why is a therapist telling my child to google it" to "this is not the service she was promised at orientation." Stepped Care 2.0 is not meant to duplicate comprehensive specialist services available elsewhere in the health system. Instead it aims to provide more realistic expectations of campus mental health supports by shifting away from a consumer model to a philosophy of empowerment, autonomy and shared responsibility. This philosophy, of course, is at the heart of academic teaching, learning and scholarship missions of colleges and universities.

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Final Thoughts

How to implement Stepped Care while leveraging partnerships and sharing resources with other institutions

Implementation

Implementation of a Stepped Care Model can be difficult. Keys to successful implementation include support through endorsement by senior administrators, including risk managers, as well as investment in technology, professional development and change management aimed at achieving efficiencies while improving overall care.

Partnerships

Instead of creating everything from scratch, it is good practice to invest more time in leveraging the capacities that already exist. Partnership building is especially important for community care and crisis management. When you engage in conversation with potential partners, start by asking them how they would like to play a role.

A good place to start would be to contact your local Canadian Mental Health Association branch to see what programs they already offer. Additionally, get in touch with other on-campus services, such as campus safety and security, and off-campus organizations such as community-based agencies, hospitals, local police and other specialized mental health services. Please refer to our Campus-Community Connection toolkit to help you through the creation of campus-community partnerships and circles of care.

Share and Exchange with Other Stepped Care Campuses

A community of practice (CoP) led by Dr. Peter Cornish includes campuses across North America. This is a place to share resources, develop innovative practices and provide staff training both on site and online via web conferencing and webinars. Since May 2015, this CoP has delivered on close to 30 requests for Stepped Care presentations and training across North America. The CoP is expected to grow and always welcomes the participation of additional colleges and universities.

Additional Resources

Stepped Care 2.0 by Dr. Peter Cornish

Peter Cornish keynote address – CICMH 2017 conference

Stepped Care in Ontario panel – CICMH 2018 conference