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Meeting the Mental Health Needs of Today's College Student: Reinventing Services Through Stepped Care 2.0

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A new stepped care model developed in North America reimagines the original United Kingdom model for the modern university campus environment. It integrates a range of established and emerging online mental health programs systematically along dimensions of treatment intensity and associated student autonomy. Program intensity can be either stepped up or down depending on level of client need. Because monitoring is configured to give both provider and client feedback on progress, the model empowers clients to participate actively in care options, decisions, and delivery. Not only is stepped care designed to be more efficient than traditional counseling services, early observations suggest it improves outcomes and access, including the elimination of service waitlists. This paper describes the new model in detail and outlines implementation experiences at 3 North American universities. While the experiences implementing the model have been positive, there is a need for development of technology that would facilitate more thorough evaluation.

Keywords: stepped care, online mental health, service models, empowerment, change management

Despite valiant efforts, many university and college counseling centers are failing to meet the needs of their students. Counseling center directors report difficulties meeting the demand: 88% of directors report that students may not receive timely treatment, 79% report that students are not seen as often as optimal unless they are in crisis, 75% do not offer weekly appointments, 73% report that their clinical staff work overtime (usually without compensation), and 35% report having waitlists (Reetz, Barr, & Krylowicz, 2014). With growing media attention on campus mental health, questions are being raised about unacceptable wait times, convoluted procedures for accessing supports, ever increasing symptom severity, and cuts to funding—all within the context of growing student diversity and higher needs (Bishop, 1995, 2006). Rationing services is an inevitable result of increasing demand without a corresponding increase in resources. Strategies like spreading out sessions to once per 3 or 4 weeks or using waitlists can reduce treatment effectiveness and decrease retention rates (DiMino & Blau, 2012; Reese, Toland, & Hopkins, 2011). Stepped care represents a model for rationally distributing limited mental health resources to maximize the effectiveness of services based on the needs of all students. This article explores the historical context for current problems in college student mental health and proposes a model for improving service delivery through stepped care. This article also describes examples of implementation concerns and challenges from a variety of perspectives.

Therapy is difficult. It is not a simple process and disorders such as depression, posttraumatic stress disorder, or panic attacks are seldom resolved within the average 3–4 sessions utilized by students. Several sources of variability affect psychotherapy outcomes: the therapeutic alliance, the intervention strategies employed, and the therapist's clinical expertise, along with client variables such as culture, prefer-

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ences, and expectations (Hubble, Duncan, Miller, & Wampold, 2010). Treatment duration ranges from single sessions, to several meetings, to several years. Attendance can be weekly, biweekly, or monthly with session duration ranging from10 min to an hour.

These realities are often overlooked as university and college counseling centers strive, with limited resources, to be all things to students while somehow meeting professional, individual, administrative, familial, moral, societal, and legal obligations. Counseling centers are often charged with meeting unrealistic expectations of students, faculty, parents, and staff to "fix" students' problems. Students arrive in counseling offices often feeling overwhelmed by the various demands of university life. Despite the expectations for full service comprehensive mental health programming, counseling centers situated within the context of communities of higher learning are better suited for setting conditions that enable students to solve their own problems creatively and independently.

Historical Context

How did we arrive at this juncture of unprecedented interest in mental health and well-being without corresponding investment or innovation in programming? Historically, counseling centers focused on vocational and career counseling (Ogston, Altmann, & Conklin, 1969; Warman, 1961). A secondary role included handling traditional presenting problems of adjustment issues and individuation (Heppner & Neal, 1983). Students were predominately White males from upper-class communities. With the introduction of the postwar GI bill in the United States, colleges and universities welcomed more economically as well as racially diverse groups (Hodges, 2001). This expansion of the student body justified a nominal fee charged for mental health services.

By the 1980s, demand for mental health services increased, in part, due to the emergence of more effective medications that allowed students with psychiatric illnesses, who required ongoing support, to attend college (Benton, Robertson, Tseng, Newton, & Benton, 2003; Heppner et al., 1994; Johnson, Heikkinen, & Ellison, 1989; Pledge, Lapan, Heppner, Kivlighan, & Roehlke, 1998; Stone & Archer, 1990). Some postsecondary institutions attempted to curb the demand for services through the introduction of session limits while others increased student fees. More recently, mass media interest in college and university mental health has led to headlines like: "How Cambridge University Almost Killed Me" (Jones, 2014), "How Colleges Flunk Mental Health" (Baker, 2014), "Universities Failing on Mental Health" (Sanderson, 2015), and "Are Universities Doing Enough to Support Students with Mental Health Problems?" (Denham, 2013). With this increased scrutiny, growing consumer expectations, and extended administrative oversight, campus counseling and mental health centers have been urged to become more accountable to stakeholders. In this context, it has become increasingly important to clarify the service mission or model, to explain and justify the intervention strategies and set realistic and measurable outcomes (Bishop, 2006).

It is important to ground revised missions and models in solid epidemiological data. Youth (age 12–25 years) have the highest incidence and prevalence of mental illness. Most mental disorders have their peak age of onset within the second and third decades of life (Pedersen et al., 2014). Approximately 75% of mental health difficulties have their onset in childhood, adolescence, or young adulthood (Carver et al., 2015). Despite the high onset and prevalence, youth access to mental health programming is the poorest of all age groups (de Girolamo, Dagani, Purcell, Cocchi, & McGorry, 2012). It should not be surprising then that when young adults arrive on campus, there is considerable demand for a wide array of psychological services. University and college counseling services throughout North America are experiencing yearly increases of up to 15% in the demand for treatment, and students are increasingly waitlisted and/or experience long intervals between sessions (Mistler, Reetz, Krylowicz, & Barr, 2012).

Mental health issues are often first detected in educational settings or by primary care family physicians. Given that youth are not frequent users of primary health care and given that approximately 80% of youth access secondary or postsecondary institutions (Shaienks, Gluszynski, & Bayard, 2008), efficient and effective delivery of mental health programming in educational settings becomes crucial.

Any attempts to improve service accessibility or efficiencies should take into account the fact that youth spend much of their time *connected* or living online. Interventions should consider that young people now socialize, communicate, and discuss their fears, insecurities, and problems online. Youth are more likely to disclose mental health concerns online than anywhere else (Ivancic, Perrens, Fildes, Perry, & Christensen, 2014; Rice et al., 2014). While Internet-based mental health programming has been offered in Australia for more than a decade, very little online mental health programming is available in North America. This represents a missed opportunity for reaching a segment of the population most in need of mental health support. In addition, Internet services complement traditional therapy services which are expensive and in short supply.

In light of these trends, the Mental Health Commission of Canada (MHCC) has called for the development of a more efficient system—one that provides early and rapid assessment as well as systematic and monitored access to the most effective but least intensive treatment (MHCC, 2012). According to the MHCC, "a more systematic approach to the flow and efficiency of mental health-related services [is needed], so that people are able to access the most appropriate and least intensive services, treatments or supports required to meet their needs" (MHCC, 2012, p. 53). Such a system could not only reduce the chronicity of mental illness throughout the life span, but could also serve to prevent more serious mental health issues from developing. In the United States, increases in demand for service, as well as greater focus on the need for student retention and service provision for distance learners, nontraditional students, and students from varied cultures has led to interest in exploring new strategies, such as early alert programming aimed at preventing attrition due to the onset of mental illness (Balon, Beresin, Coverdale, Louie, & Roberts, 2015; Brunner, Wallace, Reymann, Sellers, & McCabe, 2014; Eisenberg, Hunt, & Speer, 2013; Meilman & Weatherford, 2016; Prevatt & Young, 2014; Shadick & Akhter, 2014; Tampke, 2013; Trenz, Ecklund-Flores, & Rapoza, 2015).

The Promise of Stepped Care

Traditionally, psychotherapy has been delivered through 50-min face-to-face, individual sessions with one counselor and one client. It has become increasingly clear to many college and university

counseling center directors that this model will not resolve supply and demand problems. The model is expensive and often does not fit the lifestyles or needs of today's students who live much of their lives online and expect immediate solutions. We will likely never be able to hire our way out of the service demand problem. The field could benefit from a paradigm shift that expands access to effective resources without a large corresponding increase in capital outlay. To this end, a more sustainable stepped care model that organizes programming in a systematic, yet flexible structure is recommended to meet the needs of students across the range of problems, personal preferences, and acuity. Both the implementation of the model and the programming itself described in this paper are rooted in stages of change and empowerment theory (Christens, Peterson, & Speer, 2014; Perkins & Zimmerman, 1995; Prochaska, Wright, & Velicer, 2008; Zimmerman, 2000). Changing to a stepped care model may be difficult for providers who have worked and trained predominantly in the traditional model. Effective change management in counseling center organizational structure and processes requires the same kind of sensitivity and focus characteristic of acceptance and commitment therapy (Hayes, Luoma, Bond, Masuda, & Lillis, 2006) that we provide to our clients.

Stepped care has been shown to be especially valuable in primary or secondary health care systems, such as university and college counseling centers and outpatient mental health clinics, where demand for service far outweighs supply (Reetz et al., 2014). Originally developed for primary care in the United Kingdom, stepped care has recently been reimagined (O'Donohue & Draper, 2011) for rapid access to mental health services in a wide range of settings. 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 client distress or need. Many promising online mental health tools that have been developed and are available for purchase or licensing can be applied at various levels within the stepped care model. Some of these have been evaluated with positive results for mild to severe client symptom severity (Benton, Heesacker, Snowden, & Lee, 2016; Hadjistavropoulos, Alberts, Nugent, & Marchildon, 2014; Hadjistavropoulos et al., 2016).

For the most part, mental health services are organized in a manner that is neither accessible nor enticing to youth most in need. While youth live much of their lives online, programs and providers are rarely accessible in this environment. Despite the fact that almost 80% of people experiencing mental health problems are not ready to take action toward change (Norcross, 2003) most mental health programs are designed as if clients are prepared to accept treatment recommendations immediately and make the difficult lifestyle changes prescribed by practitioners.

Traditional evidence-based mental health treatment interventions are designed to be intensive and offered one-on-one by highly paid specialists. Lower intensity and less expensive care that could address mental health concerns before they become acute or chronic are virtually nonexistent in North America. Such lower intensity care may be seen as more palatable to the large proportion of those in need who are not quite ready to accept all the challenges of ongoing psychotherapy or making needed lifestyle change. Less intensive online programs can also allow users to test the waters of change before embarking on more demanding tasks associated with mental health recovery. With such programs embedded in a system of care which can be rapidly adjusted according to continuously monitored outcome data, users of the service could receive the type of care they need when they most need it. Because monitoring is also configured to give continuous client feedback on progress, the approach empowers clients to become actively involved in care options and decisions.

The research on the United Kingdom model of stepped care has produced mixed results. While some studies indicate stepped care is superior to treatment as usual (Oosterbaan et al., 2013; van der Aa et al., 2015), others indicate that outcomes are no better than treatment as usual (Seekles, van Straten, Beekman, van Marwijk, & Cuijpers, 2011; van Straten, Tiemans, Hakkart, Nolen, & Donker, 2006). Meta-analyses which included a broad range of studies of varying step configuration drew similar conclusions (van Straten, Hill, Richards, & Cuijpers, 2015). In all of the studies, fewer steps were involved and none included online programming. What is most intriguing, however, is the implied conclusion that outcomes similar to treatment as usual would be considered failures. As long as the model can achieve efficiencies without compromising outcomes, outcomes similar to treatment as usual should be considered evidence of success.

Stepped Care 2.0

We have developed a nine-step model of mental health care (Figure 1) that we refer to as Stepped Care 2.0. In contrast to first generation programs (see reviews by Grochtdreis et al., 2015; Nordgreen et al., 2016; van Straten et al., 2006, 2015) which include fewer steps, little or no online programming, and/or no community-based interventions, this new version includes same day access and multiple levels of Internet-based programming. It also organizes clinical and healthy campus (American College Health Association, 2012) promotion and prevention activities on dimensions of intervention intensity and stakeholder autonomy/responsibility. This last feature—healthy campus activity—has been described elsewhere (Cornish & Fuller, 2014).

At Step 1, client walk-ins are handled through a decentralized primary care case management system in which all providers assume responsibility for at least one half day of scheduled and walk-in consultations. Prior to all sessions, clients complete the Behavioral Health Measure (BHM-20/43) on tablets in the waiting room Kopta and Lowry (2002). In accordance with a phase model of psychotherapy change, the BHM assesses suicidal risk, well-being, symptom severity, and life functioning. It is offered through the CelestHealth system which includes both psychotherapy readiness and therapeutic bond scales (Bryan, Kopta, & Lowes, 2012). The CelestHealth system was adopted because if its capacity to monitor outcome trajectories associated with three phases of change (increase in well-being, decreased symptoms, improved life functioning), readiness for change, and the therapeutic alliance.

Single-session psychotherapy theory (Hoyt & Talmon, 2014), based for the most part in solution-focused therapy principles, forms the basis for the primary care walk-in approach. The term "single session therapy" is somewhat misleading because unlike brief therapy or long-term therapy, consultation is open-ended and flexible as is the case with visits to a primary care physician. Further mirroring primary medical care, Stepped Care 2.0 providers are highly skilled generalists who conduct brief focused as-

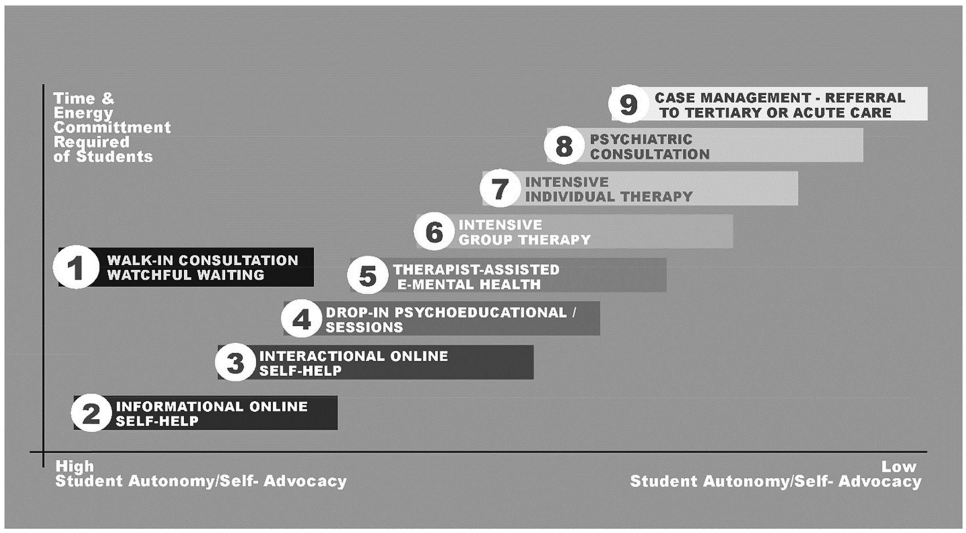

Figure 1. Stepped Care 2.0 step levels in relation to intervention intensity and student autonomy/self-advocacy.

sessments and deliver an initial intervention often involving a behavioral prescription. Each provider is responsible for managing all cases that present during their scheduled walk-in consultation coverage times. Referrals to other providers or trainees are permitted but typically provider availability is scarce. As such, providers are motivated to refer clients to lower steps of care unless client presentation complexity warrants "stepping up." Lowering treatment intensity can simply involve using time more judiciously (e.g., 5-, 15-, 30-, or 50-min sessions either weekly, biweekly, monthly, etc.) or could involve referrals to online programming, self-help books, drop-in programs, or some combination thereof. Suggested interventions and guidelines for step assignment are presented in Table 1. More objective step assignment guidelines will follow the development and implementation of an analytics technology platform currently in the design phase.

Responsibility for step decisions is a collaborative process between the client and counselor. By the end of the initial (Step 1) session, a shared plan is developed and written on a behavioral prescription form demarcated by step level. The plan is described to clients as tentative and flexible. Provider email addresses or phone numbers are written on the bottom of the form and clients are encouraged to make direct contact should they wish to alter the plan or they miss a scheduled session. Providers openly acknowledge that with a brief intake assessment and initial solution-focused interventions, important underlying issues could be missed and that follow-up may be necessary. Risk is mitigated through this transparent open-ended process by shifting responsibility to the client to make contact as needed.

Step 2 involves providing access to self-help materials in the form of educational resources including books, pamphlets, and online media. Although research on the effectiveness of informational self-help for mental health reveals mixed results, most studies indicate that it can be effective when used in combination with some therapeutic support (Gould & Clum, 1993). According to Norcross, Krebs, and Prochaska (2011), up to 80% of clients are not ready to engage in the change process when they first seek professional help. Both motivational interviewing methods and psychoeducation are often employed by counselors in an effort to prepare clients for taking more active responsibility for change. Providers at this step prescribe educational materials aimed at increasing mental health literacy and outlining the costs and benefits associated with either avoiding or committing to the change process.

Step 3 involves the use of *interactive* online self-help resources, which are essentially workbooks configured for Internet application. There is currently considerable private sector development of online interactive programming in the self-help field, but access can be expensive and, until recently, it has been mostly geared to institutional users such as employee assistance firms. Several free or inexpensive smartphone apps are available; however, they have less sophisticated interactive capabilities. WellTrack is a tool, with combined web- and app-based technology, that has been adopted by approximately 50 campuses. It has both clinic-based and outreach/healthy campus applications. Clinical tools include basic cognitive-behavioral therapy (CBT) and mindfulness modules. Counselors have found this tool to 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. In such cases, counselors simply provide a card that includes instructions and a code for accessing the online tool. Depending on the presenting issues, counselors may or may not schedule a follow up session to review the WellTrack experience.

Step 4 involves interactive psychoeducational, professionally facilitated, skill-building workshops. A variety of peer and professionally led online chat and face-to-face interventions (both mental health and academic skill-building) are offered on a drop-in, single-session basis or through short rolling series of coaching workshops. Psychoeducational coaching sessions have been found to improve coping for clients with mild to moderate symptoms (Van Daele, Hermans, Van Audenhove, & Van den Bergh, 2012). For clients 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 et al., 2007).

Table 1
Stepped Care 2.0 Clinical Interventions

Step number	Description (and associated BHM20/43 assessment criteria)	Clinical intervention examples
1	Walk-in consultation/watchful waiting	Administer BHM43 at walk-in (and BHM20 at subsequent steps when appropriate) Informed consent on stepped care treatment model 30-min intake/consultation Formulate and prescribe treatment or watchful waiting with a one to two-week follow-up
2	Informational self-help (for low to moderate symptom complexity, low readiness, low risk)	Books; pamphlets AnxietyBC.com resources Center for Clinical Interventions (cci.health.wa.gov.au) Counseling Center Village (ccvillage.buffalo.edu) Mindfulness resource list with links Bridge the gApp (bridgethegapp.ca) Transitions app (teenmentalhealth.org)
3	Interactional self-help (for low to moderate symptom complexity, low to moderate readiness, low risk)	MoodCheck (iOS) WellTrack (mywelltrack.com) without counselor involvement Breathing Room positive psychology online depression treatment (breathingroom.me) e-CHECKUP TO GO (echeckuptogo.com) MoodGym CBT and interpersonal treatment for mood disorders (moodgym.anu.edu.au) 6 ACT Conversations (emedia.rmit.edu.au/communication) MoodKit iOS app (thriveport.com)
4	Coaching/drop-in educational sessions (for moderate symptom complexity, low to moderate readiness, low risk)	Academic skills drop-in clinic Life coaching Career orientation and interpretation sessions Daily mindfulness drop-in sessions Thought Helper web program (thoughthelper.com) Relationship support group Green Mindfulness (mindful indoor gardening) DBT Diary app (diarycard.net) coaching sessions Online peer chat (local program built into 7 Cups of Tea platform - www.7cups.com)
5	Therapist assisted online (for moderate to high symptom complexity, low to moderate readiness, low to moderate risk)	TAO-Connect for anxiety and depression (taoconnect.org) WellTrack with counselor coaching (mywelltrack.com)
6	Intensive group therapy (for moderate to high symptom complexity, high readiness, low to moderate risk)	Anxiety and depression group Yalom-style interpersonal therapy group Healthy lifestyles group Relationship skills group Mindfulness group
7	Intensive individual therapy (for high symptom complexity, low to high readiness, moderate to high risk)	Single session Brief sessions (5, 15, or 30 min) 50-min sessions Weekly, biweekly, monthly sessions With junior, senior trainees With experienced counselors
8	Psychiatric consultation (for high symptom complexity, low to high readiness, high risk, nonresponsiveness to therapy)	90-mi initial assessment Referral back to GP Consultation with GP, case managers, and/or counselors Follow-up only when justified
9	Case management—Referral to tertiary or acute care (for high symptom complexity, low readiness, high risk, nonresponsiveness to outpatient care)	Case management and systems navigation assistance by university-based case managers on Students of Concern (SOC) Committee Supervised intensive paid student peer support for students of concern (including autism spectrum, addictions, code violations) Supervised intensive paid student peer support for students of concern (including autism spectrum, addictions, code violations) "Red Folders" support and referral tool in faculty offices Community outpatient referrals Referrals to private practitioner Referrals to specialist treatment programs (eating disorders, trauma, DBT) Inpatient hospitalization

Note. BHM = Behavioral Health Measure; CBT = cognitive-behavioral therapy; ACT = acceptance and commitment therapy; DBT = dialectical behavior therapy; TAO = therapist assisted online; GP = general practitioner.

Step 5 involves therapist-assisted e-mental health programming. Cognitive-behavioral and interpersonal therapy modules have long been available in Australia (e.g., Mewton, Wong, & Andrews, 2012) and more recently in Canada (Hadjistavropoulos et al., 2011). In the United States, therapist assisted online (TAO) treatment was originally developed for treatment of anxiety but has been expanded, applying more sophisticated evidence-based transtheoretical treatments for both anxiety and depression. Clinical trials indicate that therapist-assisted e-mental health is effective in primary and secondary health care settings (e.g., Kessler et al., 2009; Hedman et al., 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, & Lindefors, 2011). Clients enrolled in therapist assisted e-mental health programs are typically assigned to a provider who spends 15 to 20 min per client, per week providing online web coaching and support as participants work through the modules. Outcome monitoring is built into these programs. Therapist-assisted ICBT studies have demonstrated superior outcomes for clients with wide-ranging symptom severity in comparison with traditional therapy (Benton et al., 2016; Hadjistavropoulos et al., 2016).

Step 6 involves the provision of traditional face-to-face group counseling designed to respond to the trending needs observed at walk-ins or on therapist caseloads. For example, when more clients present with depression, additional sections of a depression group are offered. Mindfulness group sections are expanded when stress or anxiety become more prevalent at walk-in. 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 clients and providers seem reluctant to make use of this efficient service modality (Strauss, Spangenberg, Brähler, & Bormann, 2014). We have found that successful referrals to group therapy improve within a stepped care framework which reduces risk of referral error, given the systematic monitoring and capacity to step up or down the intensity of care as needed. When describing the stepped care model to clients at the walk-in consultations, we say that group therapy is *intensive*. By referring to group work as intensive a clear message is delivered to clients that group therapy is challenging and that to feel comfortable and benefit they would need to be ready to take full advantage of the power of this level of intervention. Sometimes the effect is reminiscent of paradoxical interventions (Erickson, 1964) insofar as clients that might otherwise balk at the prospect of expressing vulnerability in a group environment, openly rise to the challenge.

Step 7 involves one-on-one counseling or therapy. As is the case with Step 6, we state explicitly at walk-in consultations that one-on-one therapy is intensive and that clients need to be ready to take on challenges associated with difficult change processes. Session duration and frequency is determined by clinical judgment and ongoing outcome monitoring. Counselors are encouraged to use time creatively and with some flexibility. Some clients with severe symptomatology are seen weekly for sessions ranging from 20 to 50 min. Others are seen for brief check-ins on a biweekly basis. Clients who are in the recovery or maintenance stage may be seen only every 3 or 4 weeks with self-help resources (typical of Step 2) assigned as homework. Clients with chronic mental health conditions requiring longer-term or prolonged intensive treatment are referred to more specialized community-based services.

Step 8 involves outpatient psychiatric consultation (with follow-up care provided by family physicians) for those clients who fail to show progress by Step 7. A thorough psychiatric assessment is conducted and follow-up consultation is provided to the primary care physician and individual therapist.

The highest level of intervention, Step 9, involves health system navigation, intensive case management, crisis support for clients with chronic conditions, support for students with substance use and behavioral conduct violations, as well as help accessing more intensive external community services such as admission to a hospital psychiatric ward. Some students receiving support at this level, such as those on the autism spectrum, respond well to support from paid student peers (often 2–3 times per week). Peers operating at this step assist students on the autism spectrum to navigate daily campus life by mitigating potential disruptive social interactions. Most Step 9 activities are coordinated by case managers who liaise with campus officials, staff, and faculty as well as community-based agencies to ensure continuity of care.

Implementation Experiences

Stepped Care 2.0 is currently being piloted at our counseling centers and the change management process is well under way. Training has been provided in shorter-term models of care, including single session therapy, shortened sessions, and mental health coaching approaches to counseling. The more rapid walk-in consultation process along with greater expertise with brief interventions, including use of online tools, has allowed for the elimination of waitlists. Providers have received group and online therapy training and assume responsibility for implementing programming in both areas.

The additional group and online programming introduced as we adopted stepped care has produced the service capacity needed to accommodate the increased number of clients served through daily walk-in clinics. Providers are in full control of managing their own caseloads and they decide when to use traditional intensive one-on-one interventions or refer to the less intensive group programs, problem-solving coaching sessions, or online programming. The following are examples of concerns, challenges, and opportunities voiced by clients, service providers, and administrators during the transition to stepped care.

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 min of a 3-hr walk-in clinic with wait times typically of 2 to 3 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 someone." 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. 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.
>
> 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.

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.

I Can Work Fast: A Counselor Perspective

Sometimes clients present in tears at the reception desk when there is no walk-in counselor available. With the stepped care model, we avoid putting support staff in the role of gatekeepers. As such, we encourage them to seek out a professional staff member to connect with students in distress even when it appears initially that no such staff are available. The key principles are access, care, and efficiency. We have found that it is possible to support clients through a rapid "touch point"—a brief connection which includes listening and a successful microintervention. The following is a composite case example of an unscheduled 10-min microintervention:

I was not scheduled for walk-in consultations on Friday morning, as this time is reserved for administrative meetings and case conference. While in the midst of discussing a complex case of a student in need of case management services, a knock came on the conference room door. Ms. B, the administrative assistant who manages the reception desk, said "I know that we don't offer walk-in coverage on Friday mornings, but I think this student really needs to be seen now. She's quite upset and crying. I took her down to the group room so she could have some privacy." I agreed to see her.

Lucy entered my office red-eyed and holding a small wad of used tissues. She was silent, she stared at the floor, one leg trembling. Her anxiety was evident. I gently asked her, "what brings you in to the Counseling Center today Lucy?" Lucy looked up from her boots and said, "I'm sorry, I have anxiety and I just had to leave class because I was overwhelmed." I thought about our stepped care model and how I've come to enjoy working in 15, 20, 30 min increments rather than the traditional 50-min session. I immediately got to work.

I reflected to Lucy how it must have felt to flee from class and commended her for seeking support. I asked Lucy to reset both feet on the ground and to rest both hands on her thighs palms down. I followed suit, so that Lucy could follow my movements. I then asked Lucy to turn her attention inward and to focus on any thoughts or feelings that she was experiencing. A scaled question followed, "Lucy, on a scale of 0–10 with ten being the most anxious and 1 being the least, where is your anxiety right now. Lucy responded quickly, saying "9." I nodded to acknowledge her answer.

I felt my energy pick up because I had a plan. I could deliver a quick intervention! I am a mindfulness teacher and believe in the power of the breath as a way to settle the mind and the body. I explained to Lucy that we would be doing a breathing exercise called "take five." Lucy watched as I took five long breaths. I immediately felt more relaxed, grounded and focused. I invited Lucy to close her eyes if she was comfortable, if not she could simply lower her eyes to the floor. Lucy closed her eyes. My breath was audible and I encouraged Lucy to place her hand on her stomach so she could feel her diaphragm while it expanded and slowly deflated. At first her breath was shallow throat breathing however, by breath three I noticed her hand on her stomach gently moving in and out with her breath. Lucy looked more relaxed, her

face softening and shoulders dropping. We were breathing in unison and I decided we could go for eight breaths rather than five.

The eighth breath came to a close and Lucy opened her eyes, "That was amazing, I feel so calm." I smiled and said, "You have all you need to settle yourself; it's right here, it's always with you." Lucy smiled and said, "My breath?" I nodded and inquired about the scale she had done earlier, "Where are you now Lucy on that scale from 0–10?" "I'm a two!" she said. Breathing a sigh of relief and smiling, I wondered if Lucy was ready to move on with her day. Before I was able to inquire Lucy said, "I think I'm ready to go back to class." In less than 10 min Lucy learned a new skill, one that she can take with her wherever she goes.

You Should Ask for Real Therapy: A Colleague's Perspective

Interventions at counseling centers represent a broad spectrum of theoretical orientations. Typically, in our application of CBT, for instance, we instruct clients on challenging myths and faulty beliefs or assumptions. This is particularly important when implementing a new model because many will assume that the old model is the only one that works when, in fact, it is failing us. Some university stakeholders were initially skeptical but concerns were quickly assuaged by dispelling myths and informing them about the model.

In my role as Chief Physician, I informed the Director of the Counseling Center that student union representatives were concerned that students were waiting too long for counseling follow-up sessions. Physicians working with me in the University Health Clinic had expressed similar concerns.

The Director met with our physician group and the student representatives separately. We told the Director that we had been recommending to students *weekly* cognitive–behavioral therapy for depression or anxiety because that is "what the evidence-base says works best." The students replied that the Counseling Center did not offer weekly sessions but rather that students were often assigned online programming or might only see counselors every two or three weeks and sometimes just briefly. When the Director asked us if the students themselves were unhappy with the supports offered, we noted that students had not actually complained.

At this point, the Director asked if we would like to know more about the new stepped care model at our next staff meeting. We said yes. We were particularly impressed by the evidence he presented on the effectiveness of low intensity CBT (Bennett-Levy et al., 2010). The Director told us that he had already met with student union leaders who had expressed concerns about the perceived wait time for follow up visits. He said that he delivered a similar presentation and that the student leaders expressed no concerns after learning about the new model. We left the presentation intrigued and relieved, feeling confident that the model was appropriate. A few weeks later, the student newspaper published an article outlining the uniqueness and effectiveness of the model.

Breaking out of the "Black Box"—An Administrator Perspective

While senior administrators typically value the mental health support provided by staff at counseling centers, they sometimes express frustration with the fact that communication often travels only in one direction in compliance with privacy laws (Behnke, 2008). Counseling centers have been accused of operating in a black box where no one, including administrators, are able to assess operations. Decisions for hiring more counselors are often made following a rash of suicides. Requests for additional staff are sometimes backed up by opinion surveys of counseling directors who perceive a spiraling mental illness epidemic (Reetz et al., 2014). In such cases, neither the reports nor decisions are based on epidemiological mental health data (Varlotta, 2012). Greater transparency and rigor in reporting is needed to ensure counseling centers are well aligned with the academic mission of universities. A more collaborative, data-driven administrative decision- making process (Varlotta, 2012) would be welcomed by senior administrators and counseling directors alike. We argue that opening up the black box for redesign should include participation of nonclinical administrators. Redesign of the service model, whether stepped care or some other model, should be collaborative. The associate dean of students stated:

After struggling with the growing number of students needing access to our mental health services for years, we came to the realization that our model was not sustainable. When the management of our counseling center brought the stepped care model to my attention, it was easy to see the many ways it would benefit our students and move our services forward. Reducing our waiting list, easy access to appointments, continuity of care, and providing a larger array of "tools" to assist today's college student are goals that the stepped care model helps us to reach. The response from various stakeholders including students, colleagues around campus, parents and senior leadership at the university continues to be positive. From an administrative perspective, the financial impact of the model is still unknown. However, it seems unlikely to cost more. On the contrary, the investment in online tools, apps, and other 24/7 resources for students to use and for clinicians to recommend has the possibility of making the model cost-effective.

We Are Struggling With This New Model: It Clashes With Our Values

At the Stepped Care 2.0 piloting universities, some counselors continue to struggle with the new model, the emphasis on rapid access, flexible session length, reduced emphasis on pretreatment assessment, and changes in workload. These struggles are to be expected and should be welcomed as a natural part of a healthy transformation process. Stepped Care 2.0 deviates from traditional graduate training models and standard treatment guidelines. Initial assessments are more focused on presenting concerns, with less attention to client history, diagnosis, or case formulation. The following represents the views expressed by three counselors:

Our own differences, values and approaches as counselors are just as important to consider as client variables when implementing stepped care. Clients who have a chronic mental health history or a high level of symptom complexity on intake may require longer and more frequent face-to-face sessions. Without flexible implementation procedures, we worry that we will disappoint, short-change, or provide insufficient care to such clients. In addition, we are not trained in conducting single session interventions and have little experience with 15 or 30-min appointment lengths. We need time to familiarize ourselves with the theory and philosophy underlying the model as well as unfamiliar program content associated with the various steps. We feel uncomfortable with the videoconferencing component of

therapist-assisted online therapy, and are struggling to manage the technology.

We need opportunities to explore how our values, philosophies, and theoretical orientations relate to the stepped care model. We continue to experience strain associated with psychologically "holding" larger caseloads. To help us adjust and learn new skills, nonclinical duties need to be reduced. The time freed up could be used for training in single session assessment approaches (e.g., Hoyt & Talmon, 2014) and low-intensity step interventions. We also need time and support to develop our own solutions through trial and error. As our caseloads increase we need more administrative support and templates for streamlining documentation procedures. In place of current technology that is sometimes cumbersome and comes with a steep learning curve, we need more user-friendly technology that is seamless, that facilitates, rather than hinders the transition to the new model.

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.

Transitioning to Stepped Care

The piloting universities are at different stages of implementing and evaluating stepped care. Memorial University of Newfoundland developed the Stepped Care 2.0 model and implemented it in 2014. The George Washington University received training in the model in 2015 and implemented that fall. McGill University has undergone initial training and began implementation in 2016. Memorial University managed without waiting lists for years, initially with a combined scheduled/walk-in intake system and more recently (beginning in 2014) a walk-in-only intake system. In contrast, both McGill and George Washington Universities had waiting lists prior to the implementation of stepped care.

With an unyielding waitlist—one that had survived several administrations and various fruitless attempts to reduce wait times (i.e., by recruiting additional contract staff, reorganizing the management structure)—the counseling management team at The George Washington University was ready to consider more radical service model change. In the winter of 2015, The George Washington University had a waiting list of 266 students with a 14 business-day lag before an intake session could be scheduled. The change process began with an environmental scan of comparable universities, as well as informal consultations with colleagues willing to share service model innovations and procedures. The stepped care model was selected for its "no waitlist" claim and the expanded range of service intensity tailored for the diverse mental health needs of students.

After the stepped care model was customized to fit The George Washington context, it was presented to and approved by the senior university leadership. The model was then presented to counseling staff during a 3-day training event in May, 2015 and a description was circulated shortly afterward for input from the wider university campus community. Counseling staff were fully involved with the implementation process including the development of protocols in June through August, 2015. A nonnegotiable launch date for the stepped care model, along with the new same-day intake process was set for the first day of classes in the Fall Semester 2015. Staff anxiety was ameliorated with administrative assurances that the impact of the change would be closely monitored and that adjustments would be made to the model as necessary. The waitlist was eliminated immediately with the introduction of a walk-in-only intake system. Few adjustments were needed and through the first year of stepped care there was no waitlist, some staff turnover and a higher student counseling attendance rate.

Memorial University has committed approximately $30,000 per year to fund online programming and monitoring technology. In contrast, The George Washington University implemented the model with minimal cost (i.e., by providing some professional development to staff, launching a series of rolling educational workshops and self-help packets containing YouTube video links to serve as low-intensity (Steps 2–5; programming). While all three piloting institutions continue to seek additional funding to support expanded online programming, the model can be implemented at low cost.

Preliminary Data

We will undertake a systematic evaluation of the model following the development of a technology platform designed specifically for monitoring and informing stepping decisions. While preliminary, the available evaluation data are encouraging.

Efficiencies Pre- and Post-Stepped Care

As is the case with most universities, the number of clients seen at our counseling centers has been increasing each year. With tightening budgets and resulting instability of staffing levels we determined that simply reporting total clients or appointments over the implementation period would not give an accurate indication of efficiency. Instead we calculated the number of clients, appointments, and counseling hours per full-time equivalent staff members at both Memorial University and George Washington University prior to and following stepped care implementation. We also calculated the attendance rates prior to and following implementation. Percentage changes in clients per counselor, appointments per counselor, session attendance, and counseling hours per counselor after implementation of stepped care are illustrated in Figure 2. The number of clients and appointments per counselor increased as did the attendance rate. In contrast, the counselor time per client decreased slightly. These results suggest that stepped care implementation was associated with more rapid care and increased counselor productivity.

Client Satisfaction Pre- and Post-Stepped Care

Service satisfaction surveys were administered at Memorial University of Newfoundland over a 3-year period to clients at all first and third visits using an in-house questionnaire with items keyed on a 5-point Likert scale. Scores ranged from 1 (*very dissatisfied*) to 5 (*very satisfied*). Completion of the forms upon presentation to the reception desk was voluntary. Given counselor and predoctoral resident turnover of 38% during the 3-year observation period, the effect of counselor was controlled in the analysis.

Adjusted mean satisfaction scores are summarized in Table 2. A series of one-way analysis of covariance (ANCOVA) tests (controlling for counselor) revealed that assumptions of homogeneity of variance were violated (Levine's test of equality of error variance) for Items 3, 4, 5, and 6 ($p < .05$). Kruskal-Wallis nonparametric H tests conducted on these items (including a pairwise post hoc comparison) revealed that the "time spent with counselor" (Item 3) mean score distribution during the postlaunch year was significantly lower than that of the launch year, $\chi^2(2, N = 481) = 6.94$, $p < .05$. Similarly, a one-way ANCOVA and Fisher's least significant difference post hoc comparison revealed that the "extent to which counseling helped me deal with my concerns" (Item 7) mean score was significantly lower postlaunch in comparison to the launch year $F(2, n = 481) = 3.04$, $p < .05$. It is not clear why the launch year scores were higher than the postlaunch scores. There were no observed significant differences between prelaunch and postlaunch groups for any of the eight satisfaction items. Notwithstanding the differences between launch and postlaunch years, client satisfaction, including "time spent with counselor," remained high and unchanged postlaunch compared with prelaunch of the stepped care model.

Step 5 TAO Outcomes

TAO is typically offered at Step 5 in the stepped care model. TAO was developed and first implemented at the University of Florida in 2013. It was introduced to Memorial University of Newfoundland in 2015 and will be implemented soon at George Washington and McGill Universities.

We compared outcomes for students receiving TAO treatment with those of students receiving traditional face-to-face psychotherapy. The benchmarking data included 13,664 clients who were seen at 46 different college and university counseling centers and one community mental health center for eight or fewer sessions (Owen, Adelson, Budge, Kopta, & Reece, 2016). The Owen et al. (2016) sample clients were administered the BHM-20 by the

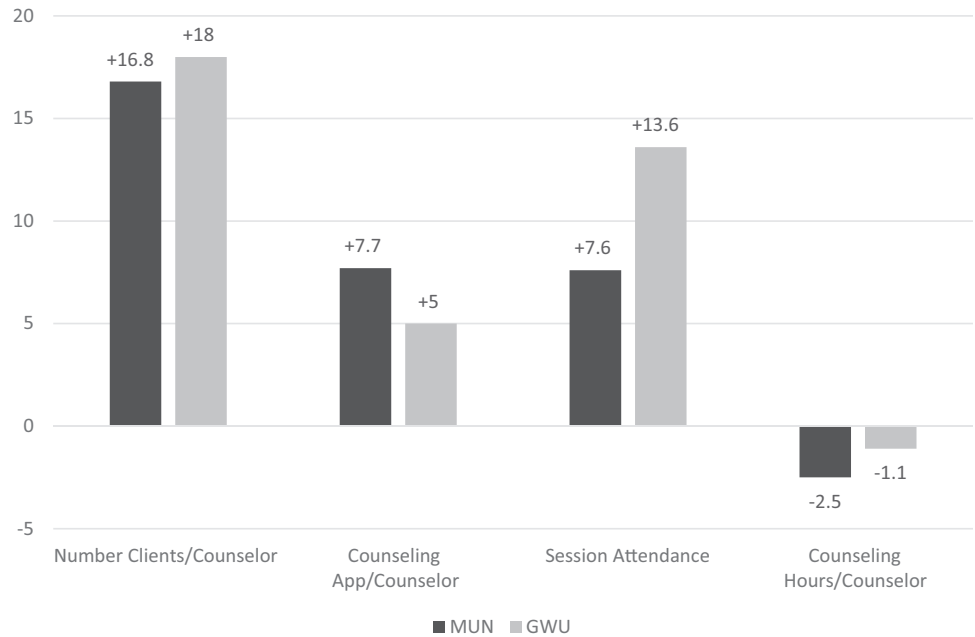

Figure 2. Percentage change in caseloads and attendance after implementation of stepped care.

Table 2
Contrast Prelaunch, Launch, and Launch Year Client Satisfaction Controlling for Counselor

Satisfaction survey items	*H* and *F* tests (n = 481)	*p*	Prelaunch *M* (*SE*)	Launch *M* (*SE*)	Postlaunch *M* (*SE*)
1. Length of time waited to be seen	$F(2) = 1.67$	.19	4.23 (.104)	4.25 (.078)	4.07 (.067)
2. Length of time in waiting room before the appointment	$F(2) = 1.75$	.17	4.18 (.114)	4.12 (.086)	3.95 (.074)
3. Total amount of time spent with the counselor	$\chi^2(2) = 6.94$	<.05	4.45 (.085)	4.64* (.063)	4.40* (.071)
4. Technical skills of the counselor	$\chi^2(2) = .18$	.91	4.45 (.086)	4.59 (.065)	4.52 (.056)
5. Extent to which I felt understood	$\chi^2(2) = 4.53$	.10	4.33 (.088)	4.63 (.066)	4.51 (.057)
6. The personal manner of the person I saw	$\chi^2(2) = 2.09$	.35	4.58 (.076)	4.79 (.057)	4.79 (.063)
7. Extent to which the counseling helped me deal with my concerns	$F(2) = 3.04$	<.05	4.14 (.104)	4.36* (.078)	4.15* (.067)
8. Overall evaluation of my visit(s)	$F(2) = 3.06$	.13	4.28 (.060)	4.51 (.069)	4.39 (.060)

* Post-hoc analyses revealed that "total amount of time spent with the counselor" and "extent to which the counseling helped me deal with my concerns" were only significant between the launch and post-launch years.

computer-based CelestHealth system—Mental health (Bryan, Kopta, & Lowes, 2012) prior to each session.

The TAO treatment group included 785 clients from 24 college and university counseling centers who were seen for eight or fewer sessions. TAO clients completed the BHM-20 on the TAO online platform prior to each session. High scores on the BHM-20 reflect good mental health; the lower the score, the more severe the symptoms. We calculated means and standard deviations at Sessions 1 and 8 for each group, then calculated Cohen's *d* effect size and effect size *r* for each group. Table 3 illustrates the means, standard deviations, Cohen's *d* effect size, and effect size *r* for the two treatment groups.

Treatment with TAO had slightly higher effect sizes compared with the Owen et al. (2016) sample on the Global Mental Health, Well-Being, and Life-Functioning scales. TAO had a significantly higher effect size than the Owen et al. (2016) sample on the Symptom scale primarily because the sample had lower scores, indicating greater acuity at intake. The effect sizes were somewhat lower (i.e., d = 0.49 – 0.73) for TAO at Memorial University due to higher variance and less regular use by clients and counselors in the early launch days when data were collected. Nevertheless, the effect sizes are comparable in terms of explained variance if not better than that of 50-min therapy. The results support the use of lower intensity treatment in the stepped care model. They suggest that treatment with shorter sessions supplemented with online educational resources are at least as beneficial as traditional 50-min face-to-face therapy.

Stepped Care Community of Practice

Our three universities have established a community of practice through which we share resources, develop innovative practices, and provide staff training both onsite and online via web conferencing and webinars. Since May of 2015, our team has delivered on close to 30 requests for stepped care presentations and training across North America. We expect this community of practice to grow and would welcome participation of additional colleges and universities.

Discussion

Based as it is in a primary care mental health philosophy (Frank, McDaniel, Bray, & Heldring, 2004), Stepped Care 2.0

Table 3
Contrast of Step 5 (TAO Aggregate and TAO Memorial University) and Step 7 (50-Minute Therapy) Treatment Effectiveness

BHM Scale	Mean at intake	*SD* at intake	Mean at session 8	*SD* at session 8	Cohen's effect size	Effect size (*R*)
Global Mental Health						
Owen et al. (2016)	2.56	.65	2.92	.63	.562	.27
TAO aggr.	2.46	.57	2.94	.6	.82	.379
TAO MUN	2.23	.63	2.56	.77	.49	.24
Symptoms						
Owen et al. (2016)	2.82	.67	3.15	.65	.499	.242
TAO aggr	2.17	.58	3.17	.59	1.57	.617
TAO MUN	2.5	.64	2.8	.67	.61	.29
Well-Being						
Owen et al.	1.76	.86	2.24	.78	.554	.267
TAO aggr.	1.79	.78	2.38	.73	.73	.343
TAO MUN	1.46	.86	2.56	.86	.63	.3
Life Functioning						
Owen et al. (2016)	2.16	.82	2.49	.84	.2	.1
TAO aggr.	2.18	.75	2.63	.83	.55	.273
TAO MUN	1.92	.39	2.16	.25	.73	.34

Note. TAO = therapist assisted online; BHM = Behavioral Health Measure; aggr. = aggregate; MUN = Memorial University of Newfoundland.

represents a substantial departure from typical college mental health services and established best practices. Early evidence and anecdotal observations outlined in this paper suggest the model has potential; however, implementation comes with challenges and more systematic evaluation is needed. Innovation is sometimes disruptive (Christensen, Grossman, & Hwang, 2009), and requires professional risk taking which increases real or perceived liability. The model may be at odds with mainstream counseling theoretical orientations and could disrupt traditional professional identities and ethical values. Stepped Care 2.0 can be seen as challenging existing ethical guidelines that focus exclusively on clients who have already accessed care. On the contrary, by focusing only on clients who have been assigned to professionals, licensing bodies are silent on the ethical implications of sessions limits, waitlists, and other gate-keeping practices on those who cannot access care. While the stepped care model is not yet supported by an extensive body of evidence, access is less restricted and practice-based monitoring processes guiding decision making and care ensure that outcomes are maximized.

According to the directors at all three piloting universities, energy and morale of providers seems to have improved for most staff members with the introduction of stepped care, but a minority of providers have struggled to adapt. At The George Washington University, staff turnover was high, and while the move to stepped care was a contributing factor, turnover had been high previously for a variety of unrelated reasons.

The innovative nature of the model can serve as a catalyst for sites experiencing low morale or awaiting overdue organizational change. In such cases, high level institutional support and investment are important. Implementation can be supported through endorsement by senior administrators, including risk managers, as well as by investment in technology, professional development, and change management strategies aimed at achieving efficiencies while improving overall care. Counseling centers considering adoption of the model will benefit by designing and implementing changes in collaboration with all campus stakeholders, including trainee feeder programs. Finally, such partnerships could allow access to research funding and the wide ranging expertise needed for designing and evaluating the emerging practices.

Conclusion

Traditional models of counseling are not meeting the needs of our college and university students. Stepped Care 2.0 has been proposed as a system for rationally distributing limited mental health resources to maximize the effectiveness of services for all students. Unlike models evaluated with equivocal results in Europe (Seekles et al., 2011; van Straten et al., 2015), this version of stepped care includes online programming, rapid access, and an empowering process for collaborative client-counselor treatment-option decision making. For both clients and providers, attention to readiness for change is an important factor to consider during implementation of the model. One of the most rewarding aspects of the model for providers, clients, and stakeholders in our three universities is that stepped care is eliminating waitlists and allowing much more rapid access to programming. Early data indicate high levels of efficiency and client satisfaction with this reimagined version of stepped care and superior outcomes for therapist assisted online programming. Although the model is showing promise, more research is needed. Future research may consider the possibility that counseling centers vary in the extent to which stepped care is adopted or online resources are integrated into service models. There is a need for developing a more sophisticated technology platform to monitor outcomes and ensure more objective treatment level decision making. Such a platform could also enable further student empowerment through the development of personal health record monitoring.

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