Chapter 7
Adapting for Unique Settings

Contents

Why Change

"But isn't stepped care meant for clinics with inadequate resources?" A head-hunter for an Ivy League school expressed interest in my candidacy for Director of an integrated wellness and counselling centre. "With a multi-billion-dollar endowment, this school is not afraid to chart bold paths through innovation. Your approach might be just what they are looking for". I was impressed. My ego inflated. An Ivey League school might be interested in me? Not so, though, in the end. While the head-hunter was intrigued, she could not sway the committee. "We have lots of resources. We don't need stepped care", the Committee Chair reportedly said to the head-hunter. I had originally assumed as much. It had started as a model for an impoverished, remote Canadian province and our own under-resourced university counselling centre. But ever since I gave that 10-minute conference presentation in Chicago in 2015, I have been inundated with requests for consultation on our model from some of the unlikeliest places. One of the first is known by many as Canada's "Ivey league" leader. Initially, I had been invited to co-lead an administrative review of their mental health programming. I mentioned my work on stepped care during that visit and was invited back to present the model. At the time, this university had about 50 clinicians for 40,000 students. It has since increased the number of staff dramatically. Somehow, they still struggled with a long waitlist. They had an abundance of resources. The students were unhappy. The staff were unhappy.

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Change was necessary. While the change process was complex and not without storming and controversy, the model was adapted to the unique culture of the institution and its commitment to be the best of the best.

7.1 Adaptation Stories and Processes

Our small consulting team, Cornish & Associates Stepped Care Solutions Ltd., has worked with over 100 colleges and universities across North America who have expressed interest in SC2.0. Recently, Provincial and Territorial Governments in Canada have contracted with us to introduce the model more broadly through the country's publicly funded healthcare system. A core feature of SC2.0 is its flexibility and adaptability. Some have remarked that it is more of a recovery care design process than a treatment model. It is certainly not a manualized program. In keeping with the principles of distributed co-design, it looks different in every location. The case study presented below describes co-design stories across all six stages of the implementation cycle. These have been drawn from experiences on our own campus and work we have done with a variety of institutions in both Canada and the United States. Many details have been changed to preserve anonymity.

7.2 Case Study: Large Mid-Western Public University

One of the first institutions we worked with is well known for its highly competitive admission standards and has solid reputation globally. Over the years this university had invested more in mental health than comparable institutions but the concerns about access had been raised by students. Was there duplication, were there inefficiencies, could we do better? A senior administrator asked me to serve on an external administrative review panel. We visited the campus and met with a variety of stakeholders internal and external to the department. We discovered about midway through the first day of consultations that representation from one key department responsible for addressing a large proportion of mental health programming was missing. We were surprised initially and then discovered that relationships between three student wellness service departments were strained. With a little initial resistance, we managed to arrange meetings with all parties.

At the end of the first day, during a break, I described our stepped care model to my fellow administrative review panellists. They were intrigued expressing interest in learning more. I said, maybe we could meet after our consultations are finished and I could share with both of you a presentation I delivered elsewhere. We asked one of the senior members of the department under review if we could get access to a room where I would have AV technology to present on my new model. Of course, the answer was yes. But, curious, this administrator asked if others would be welcome. We discussed privately as a panel and agreed to open it up to others. Four

representatives of two of the three wellness departments attended. It was hard to read the interest of participants. The atmosphere in the room was somewhat guarded. Within a month our report was delivered. Among the recommendations, we suggested some steps be taken to improve collaboration among the units.

7.2.1 Stage 1: Initial Consultation—Getting to Why and Wow

I thought that was the end of my work with the University. However, about 1 year later, I was invited to present on the stepped care model to all clinical and administrative staff in the three wellness departments. I worked in advance with leaders of two wellness departments (the only two who were intrigued), to plan the agenda. The leadership teams of the two departments sat at the same table as me near the front of the room. I thought this was a good sign; the leaders were in this together. Collaboration was happening. There was both excitement and apprehension throughout the day of the workshop. Many were intrigued, however, a handful of very vocal critics held sway. These clinicians, some from each department were sceptical. Their questions at times bordered on hostility. It was, it turned out, the beginning of a period of significant storming.

Some of the clinicians filed grievances with their union. Others consulted with their professional organizations. SC2.0 was considered a potential threat to their professional autonomy, ethical practices and even their livelihoods. The model was perceived as prescriptive – mandating low-intensity, low-quality programming, some of which they feared would be facilitated by other professions, paraprofessionals or peer supporters.

I soon discovered that all was not well between two of the three leadership teams. One leader expressed serious concerns about SC2.0 and dropped out of the consultation process with us. Another leader, while not hostile to the SC2.0 model, did not see it as relevant at the time. Her department was not slated for amalgamation like the other two. The third leader continued to work with us, convinced that stepped care held promise. Despite the internal conflict, the University administration decided to go ahead with adapting the model. They invited me to visit again, this time to work with a smaller design team. The group on this team were enthusiastic and committed. This group knew *why* they were working on transformation and were *wowed* by SC2.0. However, one of the two departments had completely disengaged. The *why* did not seem clear to them. As such, collaboration between the units deteriorated. The one department that decided to go it alone received some institutional support. Lower intensity programs were launched including e-mental health tools and a rapid access system. The departmental leadership seemed pleased and I was too, but the transformation process was on shaky ground.

Our SC2.0 consulting team offered to help resolve some of the conflict between leaders of the two separate units that were to be merged at a future date. The unit that was more engaged with us was comprised of counsellors, psychologists and social workers. They identified as non-medical. The disengaged unit was more

medically oriented; the mental health counsellors worked alongside health clinic staff, including physicians, psychiatrists, nurses and nurse practitioners. I was surprised initially that the medically oriented unit was not as interested in the model. Stepped care was initially developed for medical settings to improve coordination and transfer of care between primary care physicians and psychiatrists. But the drive for change had historically come from primary care practitioners who were frustrated with challenges accessing psychiatric care or consultation for their patients. At this University, psychiatrists were the majority among the staff of physicians, nurses, and nurse practitioners. The unit was led by a psychiatrist. All the staff psychiatrists worked fee-for-service which was covered by students' insurance. It was a private practice model of care. They did not receive benefits from the University and their allegiance was to their patients rather than the institution.

First, we met with the leaders separately to gauge their interest in mediation. They agreed only if the sessions would be structured according to an agenda developed in advance with their input. Over the course of 5 months, we met four times via web conference with the two leaders. An agenda was developed collaboratively prior to the first meeting and notes were "flip-charted" using the screen share feature. We carried forward the same agenda across all meetings, adjusting as we went along. Common goals were identified which include developing recommendations for:

(a) The relationship between the two leaders.
(b) More consistent revenue structures.
(c) Campus-wide consultations on mental health service reform and possible restructuring.
(d) How they envisioned their roles adapting through restructuring.
(e) Full implementation of an adapted version of SC2.0.

While the relationship between the two leaders had been strained, we got a sense that they liked each other. They recognized how their different styles were complementary. One was thoughtful and cautious, whereas the other was passionate and eager to act. Early on we also named 'the elephant in the room"—one of them might be vulnerable. Was one of their positions at risk with restructuring? We agreed after some discussion that it would be useful to explore the kinds of roles they envisioned with restructuring. It turned out that the administration was not in a rush to complete restructuring. Instead, they were interested in what both leaders would recommend following campus-wide consultations that had begun prior to our first contact with them. The University had a reputation for consulting widely and repeatedly on many issues. The focus of the consultation was vague. It was intended to gather all and any input on mental health experiences and ideas. After 5 months of consultation, and support from our team, the two leaders completed their report. It recommended a flatter organizational structure with a variety of adjacent lead roles. To facilitate development of the new care model (yet to be designed), the following lead roles were adopted: Healthy Campus Lead, Primary Care Lead, Mental Health Lead, Collaborative Lead and Stepped Care Lead. The report also recommended that the merger would ensure that all staff would be funded by a blend of insurance

and operating revenue and that all would be eligible for benefits. The new money and matching central funds would allow for this.

7.2.2 *Stage 2: Public Relations Crisis—People with Lived Experience Lash Out*

In hindsight we had attempted to move too quickly to solutions. We had only gotten to the first step in the distributive design cycle—working at the inner circle with leaders. While we had made strides with the internal leadership team, we had underestimated conflict among staff. We thought we had solved some problems to their satisfaction. Low-intensity programming, including e-mental health tools, was helping to curb student demand already. Aligning revenue streams would bring clinical staff on board. And flatter leadership roles would ensure meaningful roles or existing leaders following restructuring. But the buy-in was not there. The two leaders had heard a number of complaints, but collectively we assumed we already had answers: low-intensity programming and stepped care. Yes, consultation had happened. Broad input had been obtained. But not true co-design. While all stakeholders agreed that demand for care had been exceeding supply, there was no shared perspective on why this was the case. Disregarding Sinek's appeal to always with "why" (Sinek, 2009), we had moved directly to "what". And we were nowhere near a well thought out implementation method (how).

A public relations crisis made the false start obvious. Although never proven, rumours circulated that some disaffected staff had warned the student union that the stepped care program was a threat to good service. In an effort to save money and decrease wait times, service quality would be compromised. Some clinical staff left the University. They were uncomfortable with the prospect of altering their practices in alignment with the model that was already being adopted. Highly critical articles were published in the student newspaper.

The University communications team became involved. Senior Administration officials had no desire to reverse the course on stepped care—after all, early indications were (contrary to the press reports) that it was working. Secondly, funders were very interested in the model. However, with input from the public relations office, a decision was made to rebrand the change. Instead of stepped care, the new approach was labelled "Cooperative Care". This was a brilliant move because not only would there be a commitment to stepped care principles, but in addition, the issue that had derailed implementation (internal and inter-department conflict) could be addressed with a focus on relationship-building. The crisis became an opportunity to implement a formal process of working through storming at two levels: Level 1 among clinicians and leadership and Level 2 with persons with lived experience (students and the student union leadership).

After the dust settled, it became clear through deliberate engagement with clinicians, student union representatives, as well peer helpers what the problem areas

were. The "why change" became more obvious. Students found the current organization of programming confusing. Why were there two departments offering similar services? Which one do I go to? Why do I have to wait so long when we have more funding and more staff than many other colleges and universities? Do we really have quality programming? Can't we do better? By pausing implementation and asking stakeholders whether and/or why anything (whether it be programming, clinical roles or leadership structures) should change, motivation to participate in the design process increased. When the clinicians learned that changes would address inequities in funding between the two units, preserve their professional principles and values through horizontally organized process leadership roles, and that the decisions on how and what to implement would involve them directly, buy-in further increased. Likewise, when the students learned that access to care would be streamlined and the new model would only *add* programming, not remove anything they valued, they were on board. Finally, both groups were reassured that future steps would include consideration of a wide range of possible solutions and that they would be involved in the process. They were invited to search for and create innovations that addressed the issues of importance to them. The fact that staff and students were supported to engage in blue-sky thinking to address their own needs, indicated a shift from why to wow. We had completed Stage 2, identifying *why* change and inspiring some *wow* among the leadership team, clinical staff and the students (persons with lived experience).

7.2.3 Stage 3: Multi-Sectoral Consultations on the Need for Change and Inspiration

We could have stopped at Stage 2. The core stakeholders were engaged. Why do we need to keep moving outward? The University leaders had researched innovations, contracted with us as thought leaders for innovative practice. Students and clinicians were part of the co-design process. Should this not be enough? A wide range of expertise and experience had been tapped. But as Gino cautions, accumulated expertise and experience can be restrictive. In her NPR interview, she referred to a study she conducted on cardiac surgeons who had been notified by the Food and Drug Administration that a routine technique was no longer considered safe. The results indicated that the more experience a surgeon had, the less likely they were to change their practices in response to the FDA warning (Gino, 2018).

The clinicians, managers and students at the University we had worked with thus far had considerable experience. As a result of this experience we wondered if they might be too deep in the forest to recognize out-of-the-box ideas. Compared to outsiders, would their collective years of experience with established practices make them less receptive to novel, experimental ideas? Outsider perspectives, according to Gino, are crucial for innovation.

Following the two suicides at Memorial University (Chap. 3), it was conversations with residence leaders, not counsellors, managers or students attending counselling, that led us to recalibrate what needed to be changed. Before these conversations, the suicide prevention strategy had created an atmosphere of high tension and fear. The risk paradigm had not been challenged. We had not even recognized its presence. The protesting residence leaders alerted me to its presence. And the conversations that followed inspired a vision of a more engaging, vibrant residence community that could be cultivated in the very space occupied by postvention puppies. The idea of bringing fun and games back to that multipurpose room was a *wow* moment. The residence leaders who helped us to see where we were going wrong with the risk paradigm would not have been invited at a Stage 2 level had the distributive design cycle method been in place at Memorial University. But they might be considered for participation as external stakeholders at Stage 3.

At Memorial University, group counselling programming had been poorly attended for years. The student peer network at Memorial could not attract interest in their activities. They had helped to market the groups with us, but with no success. The experts and students with the most experience were stumped. Given the increasing demand and the full waiting rooms, why was there no uptake? We had no answers. But when a new Director of the Botanical Gardens approached me expressing interest in mental health, we discovered an alternative. He had a background working in psychiatric hospitals as a horticultural therapist. He wondered if there might be opportunities for collaborating with the Counselling Centre. He came to a staff meeting and presented on his work. One of our counsellors had expertise in mindfulness. The concept of Green Mindfulness was hatched at this meeting. Together they launched a 90-min weekly walk-in event in a high traffic area of campus. It quickly became known as a place to get a new houseplant. When students wandered in they were invited by students from the peer network to take a cutting and plant it mindfully in a small pot. They were encouraged to feel the texture of soil, its temperature. They could take a mint leaf and absorb the aroma of fresh mint tea. An average of 100 students attended each week. It took an outsider, the Director of the Botanical Gardens, to solve the problem of failed group work and the lack of uptake from peer mentors. Before his appearance, we kept offering the same kind of groups somehow continuing to think people might start coming. The peer mentors, determined to build a successful peer counselling program, continued to host drop-in hours for 2 years despite few takers. None of us considered that we should stop doing this or try something different.

While undoubtedly success stories (bringing fun back to residence and green mindfulness), the prompt for change was random and could easily have been missed. What would have happened if the resident assistant, the director of the Botanical Gardens and all kinds of other outsiders had been deliberately invited to answer the question "why change?" Maybe innovation would have happened more smoothly and rapidly.

Returning to our mid-sized public university, what might the broader community think about change? Would extending the "why change your practices" question be of interest to academic advisors, to the fitness centre, to the student residences, to

faculty partners? And then what about the city beyond the campus? Are there no other influential organizations asking questions about change? Could we engage in a broader conversation about change in policies with potential external partners? Who else wants change? Are others being inspired by new ideas? Can we share our "wow" blue sky ideas?

Not surprisingly, conflict also emerged when we got to Stage 3—external stakeholders. Campus staff and faculty invited to participate in the discussion were divided. Some said the problem was that the clinicians were not seeing students fast enough and did not have time to consult with them when they called. Others simply wanted the clinicians to take the mental health problems off their hands; they did not want to learn more about how to support students because that was not part of their job. It appeared that at least one common problem among all stakeholders (clinicians, managers, students, staff and faculty) was the sense of being overloaded with no room to do anything new or more. What were their needs? All stakeholders needed something to make their experiences easier, more manageable and more comfortable. How could *wow* be facilitated for external partners? We already learned that moving too quickly to *how* or *what* will fall flat. Resolving tensions cannot happen without some consensus on the question "why change".

Some tensions were traced to conflicting opinions about what constitutes best practices in mental health care. About a year after implementing Cooperative Care, the Manager of Counselling Services received a complaint from a Student Union Board Member. The Board Member said that students were complaining about the new model. The Manager called the Board Member to suggest they host a joint meeting with all who might have concerns. Several board members attended along with a representative from a student society group focused on mental health awareness programming. The student society representative complained about the quality of care they received at the counselling centre. "What did they say about the quality? Did they have negative experiences?" asked the Counselling Manager. "No", replied the student, "But they both see Dr. X at the health clinic operated by the Faculty of Medicine, and he said to them that they should be getting weekly CBT treatment, with hour-long sessions for up to three months. That is best practice and their symptoms warrant this". The Manager thought for a few moments and then said, "Sometimes care providers on our own teams disagree about what constitutes quality care. If you are interested, I can show you part of a presentation I give frequently which shows how we are both right. CBT is evidence-based but so is our model. Would you like to see what I have been presenting to my colleagues at conferences about our Cooperative Care model?" The students agreed. They asked pointed questions and seemed to leave the meeting both satisfied and intrigued. The Counselling Servicer Manager made a note to set up a meeting with the Chair of Family Medicine.

As external consultations at Stage 3 continued, it turned out there were several philanthropic organizations interested in participating. When they joined, we learned of their concerns about current practices, and more importantly, how eager they were to fund change. For years, these organizations had been funding regional and national projects gathering data in support of innovation. They hinted that some

of their funders were now ready to donate large sums of money to support change. Their *raison d'etre* was to fund broad systemic innovations aimed at serving all stakeholders.

They were committed to well thought out strategies based on implementation science. A one-day forum was hosted by one of the philanthropic groups with a focus on implementation science. An expert facilitated the workshop. Participants learned about the drivers of successful design and implementation. They were introduced to tools that would help focus the work at Stages 4, 5 and 6 of the multisectoral design cycle. They agreed to engage the implementation science expert again at later stages to support their work.

Prior to the engaging stakeholders on the *why* and *wow* process at Stages 2 and 3, consultations had been reactive and unfocused. Previously, when students or other campus stakeholders complained, or worse, published scathing reports in social media or the campus newspaper, administrators and public relations staff were only able to work on putting out the fires. By the end of Stage 3, however, all parties (the SC2.0 leads, clinicians, managers, persons with lived experience, and external stakeholders) agreed on the *why* of change and were more inspired (*wow*ed) by what could be.

7.2.4 Stage 4: Identify the External Partnerships Their Resources and How to Operationalize Them

With agreement that change was needed and shared understanding of issues to be addressed, all stakeholders were ready to begin identifying solutions. They had been inspired enough by opportunities but there was no agreed upon process for building solutions or a clear sense of what those solutions might look like. It was time for an environmental scan. Field trips were organized. Representatives of the mental health strategy committee arranged visits to three campus that were a little further along in their transformation process. In their visits they asked about their process, the changes, what did and did not work and why. Following the visits, a workshop was held to debrief. Stakeholders at all levels were asked to think about how to move forward. One of the lessons learned by an institution they had visited was to resist the allure of the "shiny object". The Manager of Counselling at one campus they had visited admitted to having a reputation for saying yes to every new and exciting e-mental health program that promised to solve the challenge of increased service demands. While programs were evidence-based or evidence-informed, little attention had been paid to implementation strategy. The utilization rates had been low.

The committee agreed that they did not want to fall into the shiny object trap. One of the members had recently attended a conference where a psychiatrist, now a Canadian Senator, warned that "the bloom will eventually fade and fall off the rose" of e-mental health. While this committee member was not so pessimistic, she was wary of the promise of technology. The hype can be overblown.

The committee struggled with a common implementation tension. One side cried for bold action now, "Mental health reform here is long overdue: we've been working on this forever! One more study will sit on the shelf gathering dust and nothing will change!" While perhaps less passionate, but equally pointed, another committee member countered "Shiny-object syndrome will lead us down blind alleys, we should proceed carefully and cautiously". In the end, they agreed that balance was needed. There might be some things that can be actioned immediately—initiatives that have already been researched and subjected to broad consultation.

Politicians, for better or worse, are masters at balancing quick wins with carefully planned, drawn-out strategies requiring exhaustive consultation. A few carefully selected immediate actions can satisfy pent up demand and inspire others to commit to change. Was there anything in line with their Cooperative Care model that could be implemented without further delay? What needed more careful consideration? A representative from the University's Marketing and Communications department spoke up, "I think what we need is a good communications strategy so that we can leverage anticipation the way Apple does, but of course within an academic values frame". A counsellor on the committee added that managing expectations is very important in mental health treatment; expectations are key to positive outcomes. But she admitted that this was not part of her skillset, and cautioned that, "Our licensing board actually prohibits any type of promotion of psychological services". Due to the potential for manipulating vulnerable persons, advertising is considered unethical.

Another counsellor countered this caution, "We are masters of persuasion. Our practices sell hope. Some psychotherapy schools are explicit in this respect". Ericksonian Hypnotherapy, for example, has influenced many contemporary methods, including solution-focused, narrative, and positive psychology approaches. Has the ethical code proscription on promotion been interpreted too broadly? Other committee members were intrigued. "This could work on so many levels", one said. "The transparency about our process is in keeping with recovery principles. And a more proactive approach could stimulate feelings of anticipation and hope". Perhaps promotion aimed at the principles underlying the system of care would be considered outside the scope of the profession, especially, if it is guided by external partners and administrators and not the practitioners alone. A ripple of excitement spread through the room. The first clear action-step (an example of *what*) was emerging—communications. The committee would work out a full implementation strategy with input from the communications experts sitting on the panel. A communication strategy would roll in tandem with implementation steps.

The committee prepared a report with recommendations organized along six guiding principles: (1) access to care needed to be streamlined—there should be a clear point of entry; (2) options for care need to be expanded since one size does not fit all; (3) the care system needs to be nimble and informed by continuous co-design by all stakeholders; (4) The care system needs to be accountable with its mission to improve outcomes; (5) implementation should follow best practices informed by implementation science; (6) a communications strategy is needed to stimulate hopeful help-seeking.

7.2.5 *Stage 5: Identify Unmet Needs of Students and Adjust Existing Programming and Consider New Ones*

At Stage 5, the work was transferred back to *internal* stakeholders—clinic managers, clinical staff, representatives from Student Affairs and students with lived experience. One of the first tasks was to re-engage with the implementation science consultant. This was deemed essential to ensure the "what" would not get ahead of the "how". Implementation science has been defined as "the scientific study of methods to promote the systematic uptake of research findings and other evidence-based practices into routine practice, and, hence, to improve the quality and effectiveness of health services" (Eccles & Mittman, 2006). The practice has evolved to address what is referred to as "the implementation gap" that exists between research and practice. While evidence may exist to support care practices, the practices are often not adopted. If they are adopted, they may not be used with fidelity to the intervention originally tested. And even if they are used with fidelity to the originally tested intervention, the practices may not be sustained. And if they are sustained in one setting, they may not be scaled up or replicated in other settings. Multiple gaps may interfere with impactful knowledge mobilization.

Our six-stage SC2.0 distributive design cycle is an example of an "active implementation framework" (Metz & Bartley, 2012). In addition to organizing the process through phases that extend across 2–4 years, an active implementation framework specifies useable interventions, drivers for successful implementation, processes for improvement and composition of teams.

An initial step in developing an implementation framework is to articulate a clear description of the program. Second, the essential and gold standard features of a program or model are identified. Third, core interventions are clearly operationalized in line with underlying principles. Finally, practice guidelines and standards are developed to allow for performance and fidelity assessment. Typically, few programs are implemented with attention to all these features of implementation science. While most programs are clearly described, few identify the core or essential components and most fail to operationalize or test for fidelity in practice settings. Our team recently compiled standards for Stepped Care 2.0 in collaboration with the Mental Health Commission of Canada (MHCC, in press). The standards are currently being applied through the implementation of a digital platform that extends SC2.0 to all Canadians as part of the Government of Canada's COVID-19 mental health response (Wellness Together Canada, 2020). The platform provides the technological infrastructure for not only tracking and enhancing outcomes, but also treatment fidelity to the new SC2.0 standards.

As indicated in Fig. 7.1, meaningful outcomes for any new program depend on the efficacy of the intervention, how it is implemented and the context in which implementation occurs. In our six-stage implementation model, enabling contexts are nurtured first by asking *why* change is needed and by inspiring blue-sky *wow* thinking. This nurturing happens long before effective interventions are selected (the *what*) and before application of implementation science (the *how*).

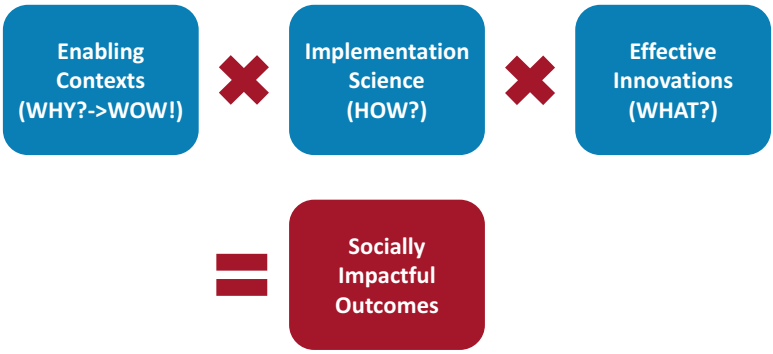

Fig. 7.1 Implementation science outcomes, adapted from National Implementation Research Network (2019)

The Implementation Science consultant met several times with the team. The goal was to develop "useable cooperative" interventions. The University wanted a clear description of what Cooperative Care *really* is. But first the team worked through another full-day workshop aimed at developing Cooperative Care Practice Profiles. Practice profiles were developed using a toolkit designed to operationalize care principles. The toolkit ensured that treatment protocols were based on research and information about best practices. It also ensured that competencies aligned with innovations, and that the innovations would be phased in gradually. It was important that the incremental process of adoption met the expectations of all stakeholders. The facilitator began the day by asking, "What are the critical, non-negotiable components of your cooperative care model? To know if a component is critical, ask yourself, if it were to be missing, would you no longer be able to think of it as Cooperative Care". The team defined cooperative care and came up with five critical components (see Table 7.1).

Then, for each of the five components, workshop participants operationalized, in turn, what ideal implementation, acceptable variations and unacceptable variations might look like. Beside each, they also specified what outcomes could be expected if acceptable variations were applied with fidelity. For example, the first component (flexible approaches) was operationalized first by deciding the number of step categories and then populating them with existing programs. The team decided on a 10-step model ranging from prevention at the lower end to psychiatric consultation at the higher end. But because of the sensitivity to hierarchy, and the long-standing discomfort with the word "stepped care", the category list on their graphic was unnumbered. In the prevention category, four programs were specified: orientation events, outreach/distress activities, training for professors and other campus staff, and departmental talks for the various faculties.

Table 7.1 The core components of "Cooperative Care"

Cooperative Care means that our healthcare professionals work with students and explore various services to find the best kind of care for their needs. This means using one or multiple treatment options, both traditional and holistic. Our staff collaborates with campus colleagues, other care providers, peers and community services to support students and meet their individual needs. Cooperative Care includes:
1. **Flexible** approaches that match students with the right resource at the right time to help students feel better—fast.
2. **Treatment that gives students choices**, building on their existing strengths and autonomy.
3. **Community-based care** that pulls together resources on-campus, off-campus and online, depending on what best fits students' needs.
4. **A holistic wellness approach** that targets all of the factors that contribute to overall student wellness.
5. **Goal-oriented care** that builds resiliency and focuses on what makes them well rather than only discussing what makes them unwell.

The second component (treatment that gives students choices) was operationalized in several ways. One stemmed from a mock webpage storyboard created by participants to map out the envisioned help-seeker experience. They drafted a Counselling Services webpage with the title: "What kind of support are you looking for?" Four top-level options were drafted (1) mental health support; (2) support for a physical health condition; (3) academic support; (4) I want to learn more about mental health and self-care. If the student were to click on the first option (mental health support), three options would appear: (a) I need to speak with someone right now; (b) It's not a crisis but I still need to talk; (c) I am not in immediate distress or I am open to online resources. Then if the student were to choose option 2 (it's not a crisis but I still need to talk), they would see four options: speaking to a professional right now, speaking to a professional in person, speak to a peer, or speak to an academic advisor.

By the end of the day, practice profiles were completed for all five components of the Cooperative Care Model. Participants were cautioned that none of these operationalized care components would succeed without careful attention to enabling factors. What needed to be in place to support implementation? What were the implementation drivers for their campus? These were identified at the next meeting. As indicated in Fig. 7.2, several drivers were specified on organizational, leadership and competency dimensions. On the organizational level, support was needed to adapt policy, fund new initiatives, support the implementation process, and develop technological infrastructure. Managers had to develop new procedures for operations, and strategies for anticipating and mitigating team dysfunction that might arise through the transformation process. Clinical and organizational training was needed to adapt practices and develop new competencies. A system of coaching or mentoring was needed to support ongoing adjustments to care.

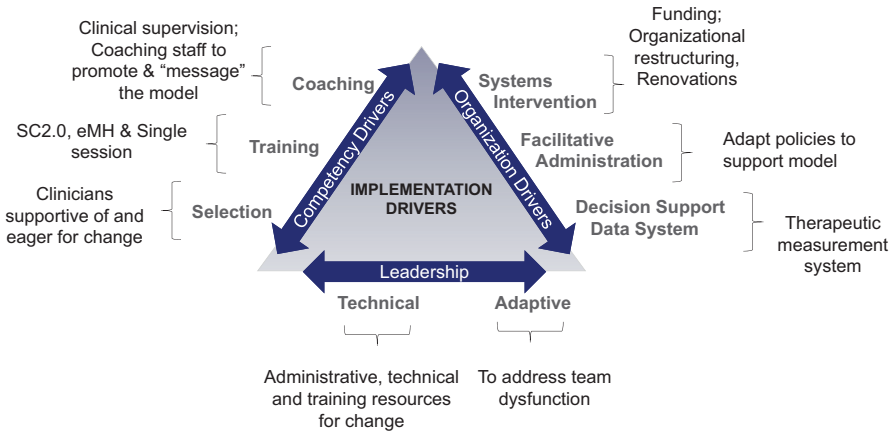

Fig. 7.2 Implementation drivers, adapted from National Implementation Research Network (2019)

7.2.6 Stage 6: Re-allocate Resources to Support Adjustments and Procure New Programs

At Stage 6, the co-design process was complete. The Implementation Team was in full operation, useable interventions had been defined and enabling structures were in place. Funding from donors had been received and matched by the University. Architects and contractors were hired to redesign and renovate the space to facilitate smooth, integrated, cooperative care. Technological infrastructure for self-check-ins, shared record-keeping, therapeutic monitoring and web-page improvements was developed. Policies and procedures were adapted or created anew.

New staff with experience in walk-in, single-session counselling, and e-mental health care were recruited and hired. None of these new staff were hired within the existing counsellor collective bargaining unit. This decision was made in collaboration with the union representing counsellors. Vacancies within the bargaining unit would continue to be filled for the next 3 years and hiring outside of the bargaining unit could only be made with new funds. This agreement helped resolve some of the anxiety expressed by existing staff about the future of their roles. On the other hand, it meant that some of the existing staff no longer felt obligated to adjust their practices in line with the new Cooperative Care model, since this new way of practicing was only required by the new hires outside of the bargaining unit. We reminded the managers of the units to use the same approach to change management as counsellors use with their clients in the context SC2.0. Rather than urging staff to become more ready for change, the job of managers was to connect with staff where they were already.

This pivot to where people are ready did not mean that any staff would be isolated from the new model. Training was provided to all staff on recovery principles, stepped care decision-making, collaborative care, walk-in care interviewing

techniques, case management and e-mental health tool use. Weekly meeting agenda structures were adapted to facilitate modified operations. For example, case conferences shifted focus to sharing successes and failures with single session care, stepping decisions, therapeutic monitoring and using time more flexibly. Staff were supported to join community of practice webinars on stepped care, attend relevant conferences and conduct research on topics related to the new model.

At the time of writing, Stage 6 implementation had just begun. The renovations were complete, and a more centralized, collaborative care hub was in operation. A flatter organizational structure was in place with six leads reporting to a new Assistant Dean of Campus Wellness. The two mental health managers, as well as the manager of primary care services, had received promotions to campus lead roles. There was still a lot of work to do before the new Wellness Hub would be truly integrated. The physicians were still operating in isolation and there was no unified health record. A new cycle of design would be needed to move to fully collaborative care.

7.3 Adaptations at Other Sites

There are infinite ways to develop stepped care. Some of the earliest adopters of SC2.0 organize their programming in a non-hierarchical pattern. The University of British Columbia was one of the first Canadian institutions to adapt the model from our campus. As indicated in Fig. 7.3, programming is still arranged in linear fashion but there is no implied hierarchy. Arranged horizontally, there is no suggestion that one program is better than the other. In consultations following introduction to

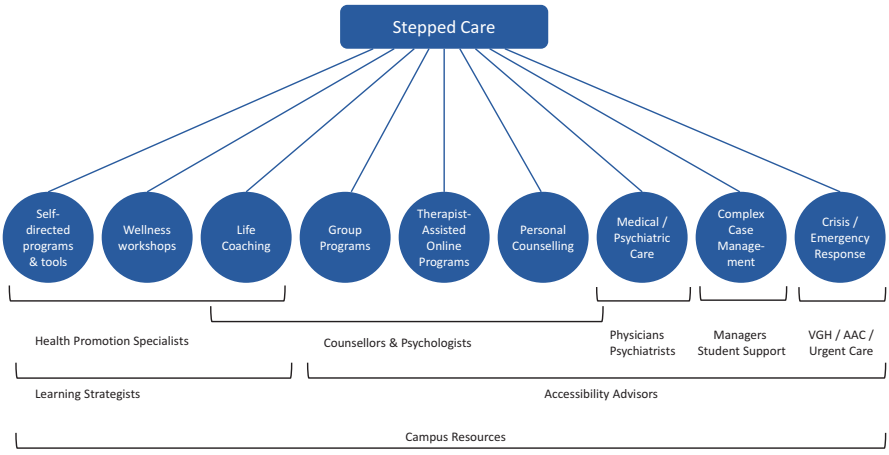

Fig. 7.3 University of British Columbia's adaptation of SC2.0 (Cornish, 2019)

SC2.0, some stakeholders expressed discomfort with the values associated with the three dimensions (i.e. on the *x*, *y*, and *z* axes). One worry was that help-seekers might feel cheated with lower intensity programs or with programs requiring less investment. The arrangement along the continuums might reinforce the prevailing assumption that psychiatric care or face-to-face intensive psychotherapy is more valuable or more effective. If this were the case, help-seekers might be less inclined to consider low-intensity program offerings.

Other non-linear versions of SC2.0 are more explicit. Instead of arranging steps perpendicularly along the *x* or *y* axes, interventions are positioned around a circle. The Province of Newfoundland and Labrador now organizes publicly funded mental healthcare for adults into seven categories which are arranged in a circle around the help-seeker. This emphasizes their commitment to client-centric care, in which the help-seeker preferences are accommodated as much as possible. Following consultation with us, The George Washington University in Washington DC and Algonquin College in Ottawa have also developed circular versions of SC2.0. The Newfoundland and Labrador version is still under development. The two other circular versions are illustrated in Fig. 7.4.

The importance of client-centricity cannot be overstated. Helen (a pseudonym), is a local hero in my mind. She is the the CEO of Newfoundland and Labrador's only Province-wide peer network (CHANNAL), literally lives recovery principles. Helen is a person with lived experience who continues to struggle from time to time, but somehow manages to break new ground on multiple fronts. Amber's story in Chap. 4 is a testament to Helen's impact. Helen coined one of my favourite recovery phrases: "ATP, ask the person first!" she exclaims with the broadest of smiles. This refrain is a constant reminder to all of us working on mental health reform. Before making any prescriptions based expert opinion why not simply "ask the person"

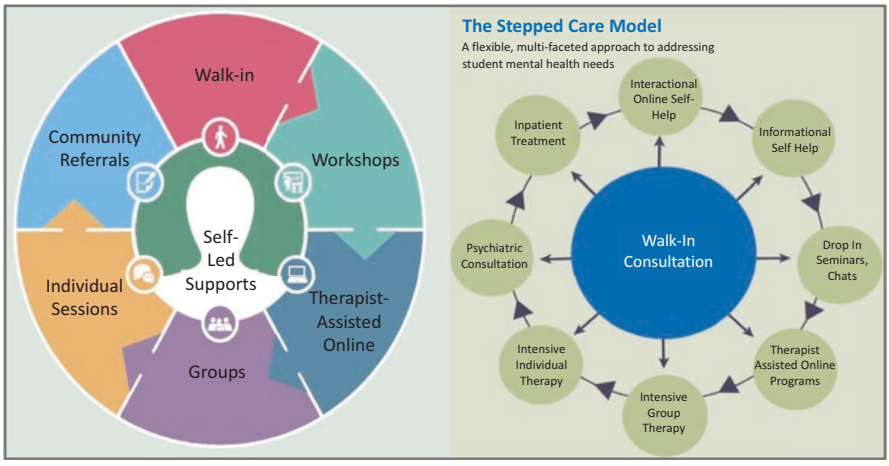

Fig. 7.4 Variations on SC2.0 (from left to right): Algonquin College, the George Washington University (Cornish, 2019)

first? Helen says this with such good humour, and so often, that the acronym, ATP is now common parlance in the Province's mental health sector.

Circles are ancient features of healing practices. Sacred circles have a long tradition throughout the world. When people gather in a circle, they are practicing connection, equality, sustainability and unity. If there is power expressed, it is not a power-*over* anyone or anything. Instead it is power-*with*. The Medicine Wheel, a term coined by people of European descent, is a common structure for organizing knowledge in North American Indigenous populations. The Earth's resources and habitats, if preserved in their natural state, have healing power. The resource configuration across the four quadrants (North, East, South and West) of the wheel represents the natural order of our planet, Mother Earth (Fig. 7.5). Order is not forced. It is what was there to begin with. Wellness and harmony are achieved by aligning with the balancing forces of nature, the elements, the four directions and the cycle of life. While sacred circles bear some resemblance to our SC2.0 circular stepped care models, we are careful to avoid cultural appropriation. We aspire to anti-oppressive and anti-colonial values and avoid making firm assumptions of relevance to Indigenous peoples and their communities. If invited, however, we would welcome opportunities for co-design.

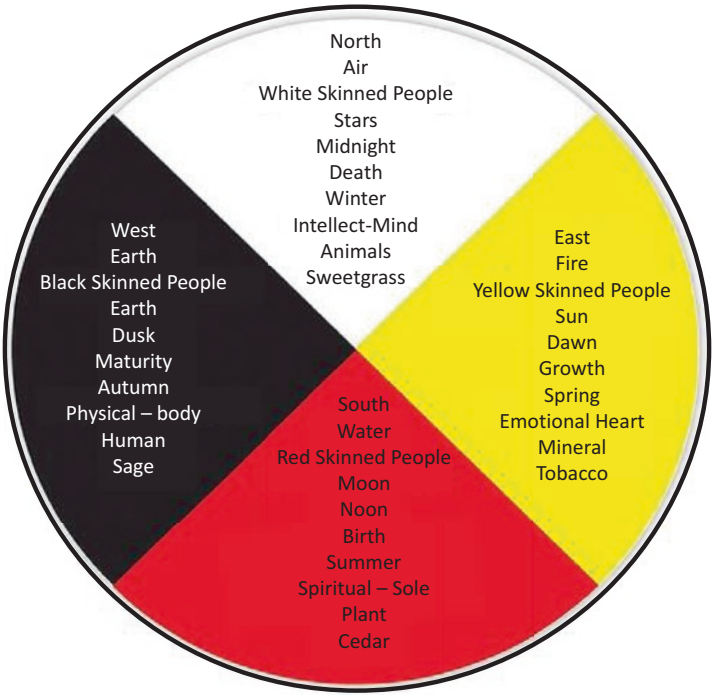

Fig. 7.5 The medicine wheel (Indigenous Corportate Training Inc., 2019)

Foxes and Hedgehogs

Francesca Gino might consider me an aspiring rebel leader. I still have a lot to learn though. My humble attempts to lead have yielded mixed results. I broke the rules and while I did attract a following, I left my team behind. Good rebel leaders practice humility. They make themselves vulnerable through risk-taking. And with the right balance of positive deviance, good judgement, tact and empathy, they manage to bring others with them. There is a tension between disruption, collaboration and nurturing. Effective rebel leadership requires the right mix of bold action and patience. Perhaps a more reasonable approach is to assemble a flat rebel leadership team with complementary collegial roles. I am good at positive deviance but not so good at nurturing. Our Stepped Care Solutions social enterprise has some of these qualities. We have systems thinkers and concrete thinkers. We have peacemakers and disruptors. We have salespeople and we have deviants. I am reminded of a conversation many years ago with my doctoral thesis supervisor who spoke of foxes and hedgehogs. He identified with the fox and wondered if I did too. According to the Ancient Greek poet, Archilochus, "The fox knows many things, but the hedgehog knows one big thing". Hedgehogs burrow down, espousing a single, grand idea to explain everything, while foxes run around on the surface coming up with new ideas to fit every separate encounter. Isiah Berlin popularized this distinction, but later regretted the overly simple dichotomous interpretations of his 1953 essay. I still don't know which I am. I think it is a dialectic. I strive for the grand idea—SC2.0, but the idea itself is amorphous. It slips and slides through co-design, a built-in disruptive process.

We need bold thinking. We need humility. We need risk-takers. We need caretakers. The fable of the fox and the cat (Aesop, 1893) *is a variation on the fox/hedgehog dichotomy. The fox and the cat discuss their varied talents, namely their tricks and dodges in the face of danger. The fox has many, whereas the cat admits to just one plan. When hunters arrive, the cat immediately flees to the safety of high tree branches. The fox can't decide, thinks of many options, and tries a few but none with commitment. The fox is caught by the hounds. In this perilous context, the fox fails and pays with its life. Mass media reports warn that we are in the midst of a mental health crisis. Risk managers, in efforts to maintain reputations of insurers, insist on a cat-like, focused and rigid protocol. Professional associations for the most part follow suit. Does the cat plan save lives? While the cat survives, we can't all hide in trees. A risk averse approach to mental healthcare protects providers more than those they serve. Help seekers are frustrated by this overly cautious approach. Do they want only foxes? Probably not. Isiah Berlin wouldn't either. Why not dispel with dichotomies. We need cats, hedgehogs, and foxes. Cats climb up to watch out for danger. Hedgehogs focus on details. Foxes run around practicing sly deviance and disruption. Let's make room for all three.*

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