Chapter 4
Expanding the Options Through Nine Steps

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Amber’s Recovery Pathway
I had just delivered my speech on the results of our SC2.0 Demonstration Project. The Minister of Health had opened the event by describing the Province’s recently adopted “Towards Recovery” mental health strategy. The CEO of the Mental Health Commission of Canada spoke prior to me, sharing comments about how the project fits within a pan-Canadian context. Amber was invited up right after me. I had never met Amber and had no idea what she was planning to say. It turns out that I couldn’t have scripted a better testimonial to the value of our nine-step model of care. She began by saying that she was a 23-year-old recent graduate from Memorial University and that this was the first time she had ever talked publicly about her mental illness. Despite this, she showed no signs of anxiety and the audience was soon riveted by her story. Amber recalled having severe bouts of anxiety and panic symptoms since in kindergarten. Years later, with her mental health deteriorating, she frequently cried herself to sleep. During the day she masked her panic with lies. One time a teacher asked why she was so out of breath, “Oh, I just went for a run on my lunch break”. Ashamed and embarrassed, she was afraid to tell anyone about her weakness. In grade 11, Amber called Canada’s Kids Help Phone. This was her first contact with the mental health system. The staff at Kids Help Phone were supportive, “They gave me the courage to finally tell my parents”, she said. Amber’s parents helped her connect with their family physician. Amber remembers her physician as kind, gentle and reassuring: “Amber, we’re going to get you some help. It
was really good that you decided to talk about this with me and your parents”. Amber replied sharply, “I don’t want any meds!” She wasn’t sure why at the time, just knew that they were a no-go. Much later, after a lot of self-reflection and support from CHANNAL (a local community-based peer network), she understood that it had to do with her values and personality. “I guess I have always been a stubborn person. I wanted to tackle the problem myself. I didn’t want to change who I am or see myself as someone with a mental illness. I wanted to fight the problem myself”. But at the time, neither Amber nor her physician knew quite how to proceed. She was referred for counselling. Amber was reluctant and nervous, Amber fought through the anxiety and doubts. She went for the counselling appointment. She was asked questions about her symptoms, her experiences of panic and the frequent night-time crying. Then, somewhat stunned, she heard the counsellor say something that threw her off, “Amber, you are being a dramatic teenager and you will get over it”.

Amber was crushed. She retreated, gave up on help-seeking. There were no other options for counselling in her small community. Depression took over. “Depression”, she said, “it was sort of like having four or five of those blackout curtains wrapped tightly around my whole body. I couldn’t see a thing. I couldn’t move. What was happening? I would feel hot and clammy, followed by chills. I couldn’t move. I was alone and trapped with my negative, despairing thoughts”.

There wasn’t a dry eye in the room at this point. I heard someone crying softly behind me. Amber’s speech, I noticed turning my head to the left, was being recorded. The young woman holding up the smart phone just behind me had tears streaming down her face. Later while watching the recording, I could hear the suppressed sobs and a few sniffles from Amber’s younger sister. At that moment in her speech, Amber acknowledged her sister and said if it wasn’t for her, she may not be alive.

Both family and peer support were essential for Amber’s recovery, “I was in my third year of university when I got placed at CNIB (Canadian Institute for the Blind) for my first work term. CNIB works out of the same building as CHANNAL (the province-wide peer support network), just upstairs. At this time in my life, I was not very open about my mental illness and was not yet diagnosed with depression—only an anxiety disorder. I had never heard of CHANNAL before and was curious. My coworkers at CNIB told me it was a mental health and addictions organization. Living with mental illness myself, I was intrigued. I decided to look up CHANNAL’s Facebook page and do a little research. It sounded like an amazing place, but I was not in a healthy mindset to use their services - I still had a lot of shame. I kept tabs on their Facebook page”.

Amber’s mood worsened. Suicidal thoughts became more frequent and graphic. She imagined herself jumping off a familiar cliff at the top of Signal Hill. The urge became overwhelming when she and her boyfriend parked one day at the top of the hill. But, “It was the love I feel for my sister that stopped me from acting on the impulse to jump. It was the thought of my sister that led me to my Dad. Mom was away. I told Dad about my scare on Signal Hill, and then I went back to my Doctor”. Again, with genuine compassion, her physician said, “Amber, we’re going to get you help” and once more she gently, yet firmly, recommended counselling and medication. Amber was ready now to consider a variety of options including counselling
and medication. Her physician had recently learned about some new resources that had been implemented through our project and suggested that Amber check out the Bridge the gApp online mental health services directory/portal.

Amber valued autonomy. She speculated that, “It was probably my shyness, my shame and stubbornness, along with my do-it-myself attitude, that attracted me first to the online tools on the website. I tried the mindfulness app, but I couldn’t concentrate at the time. I found the “Art Room” where other kids had posted photos of drawings. There were so many other young people posting anonymously about their own feelings of panic and despair. I was shocked. I guess I’m not really alone. My confidence boosted, I explored some of the other tools. Breathing Room inspired me, building my confidence further. I tried some online therapy modules and eventually returned to the mindfulness app. With some of these skills and growing confidence, I reached out to CHANNAL. I had started opening up more about my mental illness and was ready to get the help I needed and to let go of the shame I was holding”.

Recovery and resilience depend on the availability of timely opportunities, “CHANNAL had posted a job. I couldn’t believe the timing; it was almost like fate. I decided to apply and just give it my best shot. If I didn’t get the job, at least I took a step forward in my recovery and a step towards CHANNAL. Fortunately, I got the job along with six other amazing people. I became part of a family with the 12-plus people that were already working there. The support and respect were incredible, and I knew I had found the job that was for me. I have been there for almost a year now and am so thankful for CHANNAL and its role in my recovery”. Amber paused and said with a wry smile, “You know at CHANNAL they try to break you!” A few knowing chuckles across the room. “The peer training is very intensive. They challenge you to do so much self-reflection”.

At the news conference, Amber emerged as a valued spokesperson for the power of peer support. Her speech has since been adapted into a video explaining the importance of co-design, peer support and lived experience for our recovery-oriented SC2.0 Model.

4.1 Recovery Step by Step

In true recovery fashion, Amber entered the care system in her own way. I wonder what would have happened to her if the Province of Newfoundland and Labrador had not adopted the Towards Recovery strategy. The SC.0 model in Newfoundland and Labrador allowed Amber to access the help she was ready for, right at the time she sought help. Unfortunately, the model was not in place the first time she went looking and her condition had worsened. At the beginning, the anxiety she experienced had been unpleasant and restricted her social functioning. The only services available at that time were counselling and medication. Neither proved a good match for her. When the counselling backfired, there was no opportunity to fail forward. Towards Recovery had not been conceived. SC2.0 did not exist. Amber became severely depressed and suicidal. Luckily, according to Amber herself,
“Having a much wider selection of options available to me the second time I went to my doctor probably saved my life!” Amber’s recovery could now proceed step by step.

### 4.2 How Many Steps Should There Be?

A review of published studies on stepped care reveals wide variability in the number of step categories. We were surprised to discover that the most common number of steps was only two. Our version, SC2.0 has the greatest number of steps. This is deliberate. We were interested in breaking care down into its most basic, elemental components. To our knowledge, the categories are exhausted at nine steps. Originally, we specified eight steps, but stakeholder input from one of our co-design implementation workshops led us to break psychoeducational and family/peer support into separate categories. Psychoeducation, we were told, could be delivered by either peers or professionals, or even both at the same time, in the form of workshops.

We believe that a high specificity of step levels maximizes the potential of stepped care. It encourages the discovery of ever more mental health resource options. With more options, comes greater potential for accommodating help seeker preference and maximizing treatment fit.

The most basic two-step model, formerly known as “shared care”, has been around for decades. It typically involves transitioning back and forth between physician and psychiatric care. A more recent two-step model involves stepping between e-mental health and traditional face-to-face psychotherapy. Neither of these stepped care approaches would have worked for Amber. Face-to-face counselling, poorly timed for the state Amber was in at the time, was a setback for her. It was unhelpful and Amber lacked the confidence at the time to give this feedback to her physician. She dropped out of that treatment.

In the context of our SC2.0 model, Amber made use of five of the nine steps, only one of which existed several years ago. And while research suggests that individual psychotherapy and pharmacotherapy are highly effective for treating anxiety or depression (Cuijpers et al., 2013), it fails to account for barriers to access. Barriers to access for Amber included internalized stigma and lack of readiness to engage fully in the therapeutic process. Another barrier stemmed from the one-size-fits-all approach to psychotherapy referrals. The counsellor she had been referred to was not a good fit. There was no alignment or connection. Amber experienced the counsellor as dismissive. In a recovery-based SC2.0 context, Amber would have had more choice. She could have attended the same-day walk-in clinic. She would have known from the information in the waiting room, that choice was paramount. She would have known that if she didn’t feel comfortable with her first experience, she could walk in another day and try someone else.

Amber’s journey began with a Step-9 consultation. She reached out to Kids Help Phone; a crisis line staffed by professional counsellors. This worked for Amber because it removed an access barrier. It was easy for Amber to connect without
anyone knowing. She made the call in the safety and privacy of her own bedroom. The help-line counsellor recommended a Step-3 resource—family support. She was nudged to open up to a loved one. Perhaps this worked because Amber made the call from a safe and relaxed place. She was ready to receive this recommendation. Family support was key to Amber’s recovery. Her parents supported her to reach out to their family physician. This is a Step-7 resource—flexible individual professional support.

In Canada, physicians and psychiatrists are the only professionals that can bill directly the publicly funded Medicare system for counselling. This was the only accessible option known to Amber and her family at the time. The compassionate mental healthcare she received from her physician was critically important, but it was not enough. Amber needed more options. There were only two to choose from the first time—medication, or “talk therapy” with the one and only counsellor in her small community. There was no system aimed at empowering help-seekers. There was no encouragement to engage in trial and error among a variety of options. There was no buffet to sample from.

4.3  Step 1: Watchful Waiting; Informational Self-Directed

The second time she reached out, again through a Step-3 resource—family support, the mental health system in the Province had evolved. The Provincial *Towards Recovery* strategy had being launched (Government of Newfoundland and Labrador, 2017). There was a new mind-set among providers. Help-seeker preference was now emphasized and many more options were available. Amber’s physician told her about the new and powerful Step-1 resource, Bridge the gApp. Step 1 focuses on information. It is aimed at supporting mental health literacy. Mental health literacy includes knowing the difference between distress and mental illness. Bridge the gApp is a mental health literacy site designed to educate. In order to be effective, the information at Step 1 must be evidence-informed and practical. It must include up-to-date resources, including a directory of programs available locally. It also should include details on how to access evidence-informed online resources. Bridge the gApp is such a resource. It is managed by mental health professionals and meets the highest privacy standards. It includes a directory of services organized by region. The directory includes both (1) formal, professionally and peer-led, publicly funded programs and (2) informal programs available in the community. Formal programs include counselling, psychological and psychiatric services as well as programming offered by paid, trained peer support workers. Formal programming also includes online tools funded by the government and available to all citizens free of charge. Informal programs include community-based programs and support groups such as AA, NA, Big Sisters and Brothers and Survivors of Suicide.

Step 1 also includes the notion of “watchful waiting”. Amber’s physician referred her to *Bridge the gApp* after learning of Amber’s bad experience with counselling and she already knew that Amber did not want medication. She wasn’t sure if Amber
was ready to try the new walk-in, single-session counselling program called “Doorways”. Amber’s preference and/or readiness for engaging in intensive programming was unclear. As such, her physician simply prescribed Step 1: Self-directed informational resources and watchful waiting. Step 1 can be a good option when readiness is low or preferences hard to determine. Watchful waiting in the context of SC2.0 involves no specific recommendation, but instead an agreement to keep an eye on things through continued wellness monitoring. Research suggests this, alone, can be an effective intervention with at least 20% of help-seekers recovering after making an initial contact and receiving no specific treatment (Whiteford et al., 2012). When watchful waiting is prescribed along with access to solid, accessible mental health literacy tools, this percentage may well increase.

Amber spent a lot of time at Step 1. She discovered and experimented with a variety of resources available through the Bridge the gApp portal. From that vantage point, she moved up and down from Step 2 (interactional self-directed resources) and Step 3 (peer support). Step 1 proved to be a safe harbour for Amber. It laid the foundation for her to experiment with options, to sample the buffet, to risk trial and error. Her first attempt at the Step-2 MindWell app was a failure. It required too much concentration. She was too easily distracted at that time. No matter; the Art Wall was there. Colouring calmed her. Reading what peers posted helped her to fight internal stigma. She felt less alone with her symptoms. She kept exploring and trying out the various Step-1 options and, as her mental health literacy grew, she made progress with recovery.

4.4  Step 2: Interactive Self-Directed

Step 2 requires a little more commitment and energy than Step 1. The assumption at this step is that a help-seeker will become a more active and committed learner. Programming at Step 2 moves beyond mental health literacy. It calls for sustained participation. The participation at Step 2 is private. It typically involves completing workbooks or worksheets. These can be paper-based or online. Prior to the internet, this was referred to as bibliotherapy—self-help treatment with a book or workbook. One popular example of bibliotherapy is David Burn’s book, Feeling Good: The New Mood Therapy (Burns, 1981). This is a cognitive behavioural therapy self-help manual. Ironically, this was the text we had proposed to use in our failed self-help study described in the preface to this book. We estimated that the book had been written at a grade six reading level, but we underestimated the extent to which reading books had become unpopular. In hindsight, I wonder if the study may have succeeded were Bridge the gApp and some online Step-2 programs had been available? After all, online reading is now the preferred medium.

Amber accessed several Step-2 resources. The first one she tried was MindWell U. This is a 30-day mindfulness course. It requires a minimum of 3–5 min of work per day. Each day, participants receive an email from MindWell with a link to the day’s unique content, along reminders and tips on how to practice the Take-5
meditation (see Fig. 4.1 for description of the Take-5 exercise). The programming is
dynamic and has a well-designed user-interface. In other words, it is attractive,
eticing and easy to use. To encourage commitment, users can select a “buddy”—a
friend or family member—who they can invite to register for the program. Users are
couraged to connect with their buddies to share experiences, encourage each
other or engage in some friendly competition around participation goals. With this
buddy feature, MindWell has an element of a Step-3 program (peer support).

Although intrigued by the program—she had set herself a goal of becoming
more relaxed through mindfulness meditation—Amber decided the program was
not right for her at the time. She couldn’t concentrate enough to follow the Take-5
meditation exercise, which was central to the program. Instead, she found the TAO
program, with its more basic relaxation tools, a better fit with her capacities.
Whereas, MindWell prescribed scheduled fixed content for each of the 30 days of
the program, the TAO self-managed program allowed more flexibility. Amber was
able to browse the modules, picking and choosing programming corresponding
with her readiness. She found that the simple relaxation training exercises in TAO
required less concentration than the Take-5 mindfulness protocol. A screenshot for
one of the TAO modules on relaxation is illustrated in Fig. 4.2.

Fig. 4.1 Mindwell U’s Take-5 mediation exercise (Mindwell, 2020)
4.5 Step 3: Family and Peer Support

When Amber contacted Kids Help Phone line (Step 9), the crisis counsellor listened to her concerns and encouraged her to reach out to her parents for support. This was a good example of an effective stepping down intervention. The help-line counsellor sensed Amber was not ready or unable to access professional care but had a good relationship with her parents. Reaching out to her parents was a simple, elegant option. She was ready and willing to do this. Family support was the home base for Amber’s attempts to access formal professional care. Without Step 3, Amber would not have accessed the range of resources she needed.

While not understood as such, Amber already had engaged in Step-3 support. Specifically, her connection with her younger sister and her parents are examples of informal, unpaid community-based peer support. Formal peer support, in contrast, is typically paid work which requires standardized training, supervision and certification. The type of informal family and peer support offered through organizations like AA is voluntary and includes little or no training or oversight. Both are valuable. Amber said that she probably would not be alive if it wasn’t for her love for her younger sister.

After her failed attempt with professional counselling and her successful work with self-managed e-mental health tools (at Steps 1 and 2), Amber discovered the formal peer support network, CHANNAL. Amber certainly valued her autonomy and the informal supports extended by her family. It is perhaps no surprise then that formal peer support was a logical step up when she became ready. She needed more
than informal support but found professional care (talk therapy and medication) too intense initially, the dosage of care was too high. Formal peer support was skill-based (the peers who supported her had received certified paraprofessional training). It also included access to a community of peers, as well as a welcoming physical space (like a clubhouse). This formal peer support enabled stable connection that was also empowering. Amber initially felt uncomfortable being in the passive position of simply receiving treatment. She saw herself as strong, a fighter and someone who finds meaning and purpose through giving to others. Amber probably does not realize how much she has already given to others. By sharing her story publicly, in front of television cameras, the Minister of Health and other local and national dignitaries, Amber has proven the untapped power and potential for peer support to empower people while also reforming our mental health system.

### 4.6 Step 4: Workshops

Step 4 is the first point on the care continuum where professionals may enter the picture. Unlike group counselling or therapy, the focus in Step-4 workshops is mainly educational; it does not typically involve disclosure or much interaction among attendees. The format is akin to a class or presentation. While there are some similarities to Step 1, insofar as the aim is increasing mental health literacy, the commitment and energy required by both attendees and presenters are typically greater. For an attendee, there is a social commitment to stay for at least an entire session. It involves some public exposure. Others will know of the attendee’s interest, thereby compromising privacy. However, unlike group therapy, participants will not learn much more than that. There is little chance of sensitive information being revealed. This can make it feel safe.

In a few of the communities where we implemented SC2.0, workshops were the most popular option. For example, on the Burin Peninsula, a region experiencing a rash of suicides a few years ago, workshops on mood and anxiety fill to capacity. This may be a logical extension of the successful community lobbying efforts that fast-tracked the Provincial *Towards Recovery* rollout (Government of Newfoundland and Labrador, 2017). Community members had already discovered power in numbers. They had achieved much through town hall meetings following the suicides. That attending workshops together might continue to foster mental health was a no-brainer; they already knew the healing power of community.

### 4.7 Step 5: Guided Self-Help

Guided self-help is a little like the so-called “flipped classroom”. A flipped classroom is a post-secondary course modality that blends human contact with web-based content. High-quality content is procured and offered asynchronously through
web-based video and interactive programming. Presentations by some of the world’s most gifted educators can be recorded and accessed online anytime by students. Typically, weekly interaction with a tutor or instructor is scheduled. This face-to-face, classroom-based, interaction focuses on problem-solving, answering questions and motivating task completion. While flipped classrooms have demonstrated proof of concept (i.e. learning does occur), widespread implementation has not happened (O’Flaherty & Phillips, 2015). They account for a very small percentage of post-secondary curriculum delivery (McPherson & Bacow, 2015).

With Step-5 mental healthcare, the guided sessions can be in person, online or in group format. The focus may include technology troubleshooting, motivational interviewing to maximize module engagement, or addressing gaps arising from other mental health needs. Guided self-help has demonstrated very impressive results through clinical trials—almost always matching the outcomes achieved by traditional face-to-face 50-min weekly psychotherapy sessions but using far less professional time and expense (Andersson et al., 2014). However, much like flipped classrooms, guided self-help just hasn’t caught on. In both cases, practitioners are unmotivated, or perhaps not well enough prepared, to adopt the new practice. Very little training is available to supply educators or therapists with knowledge or skills for successfully implementing web-based learning.

Rather than waiting for practitioners to adapt their practices to include technology, some clinic decision-makers are contracting out the work. A growing number of online psychotherapy platform developers have begun recruiting their own clinicians. Only those with interest in e-therapy work and grounding in recovery principles are considered for the positions. They are expected to specialize in this modality. Although there are no clear signs yet, this could mark the beginning of disruption in the mental health field akin to Uber’s influence on the Taxi industry. Will therapists and their professions adapt or might they fall prey to some more massive, as yet unforeseen e-mental health disruption?

Currently, there are two types of vendors operating in the expert-assisted e-mental health space. Therapy-Assisted Online (known as TAO-Connect) was one of the first commercially available platforms. It is a social enterprise aimed at having a significant positive impact on campus mental health. Priced aggressively, it is easily absorbed through the limited budgets of college and university counselling centres. TAO provides the platform, a video conferencing function, a wide variety of trans-diagnostic modules, and practice-based therapeutic measurement tools. TAO does not provide any labour. Clinics use their own professional staff. As such, counselling centres must somehow prepare and convince existing staff to adapt practices. This is proving to be very challenging. Few psychotherapists have shown interest. As such, companies like TAO Connect are adapting their business models by reaching outside clinic settings where there are more willing coaching partners. The shift means moving away from expert clinician guidance to peer or paraprofessional coaching. On campuses, residence leaders, athletics staff and judicial affairs officers have started to take this on. Some are prescribing the programming regularly now to the students they serve.

Mind Beacon is a Canadian startup that is succeeding with the expert-assisted e-mental health model. They recruit and train both psychologists and wellness advi-
sors to support customers using their CBT platform which is designed to treat both anxiety and depression. While easier to implement because the therapists are supplied by the vendor, the program is expensive. Therapists are hired and trained specifically to support clients using the platform. This model addresses the key obstacle to implementing therapist-assisted e-mental health: professional change management. However, therapist involvement is not the only challenge. Purchasers of the solution still need to establish referral pathways and market the innovation to clients. While clinician training would not be required, stakeholder buy-in is needed to facilitate appropriate referrals and stepping decisions. Unfortunately, even with a strong evidence base supporting both guided (Andersson, Cuijpers, Riper, & Heidman, 2014) and self-guided (Karyotaki et al., 2017) e-mental health programming, providers remain largely unconvinced. That is, many believe few clients would either choose or benefit from anything other than face-to-face traditional 50-min weekly psychotherapy. However, since the onset of COVID-19 early in 2020, interest in these programs has increased. The pandemic is accelerating the shift to digital mental health.

A carefully designed change management program is needed to ensure Step-5 success. Training might include increasing provider technical proficiency, developing a coaching mind-set, and encouraging treatment adherence. Some clinics have succeeded by seconding early adopters to specialized implementation roles. With release from regular duties, they are able to focus energy on championing the program and mentoring colleagues. Some of these innovators found success in delivering the e-mental health client coaching component through a group counselling format. This has worked especially well in settings that routinely deploy two facilitators to lead groups. Such cases afford an opportunity for mentoring less enthusiastic colleagues. This apprenticeship approach could be a vehicle for gently nudging buy-in from therapists otherwise reluctant to offer guided e-mental health programming on their own.

### 4.8 Step 6: Intensive Group Programming

Group psychotherapy is a powerful and effective treatment modality; however, group has long played second fiddle to individual psychotherapy. Many mental health professionals see individual face-to-face psychotherapy as the gold standard treatment. Anything else short changes help-seekers. Like guided e-mental health programming, group psychotherapy is proven effective but underutilized. There are several explanations for this tendency to undervalue group psychotherapy. One is that therapists themselves say they would not opt for group therapy given a choice. Perhaps, this is because it is a high dosage treatment largely due to the social exposure element. Opening up to peers and being challenged by both peers and therapists in a closed environment is not for the faint of heart. From a client perspective, group therapy might better be thought of as a higher intensity treatment than individual therapy. Currently, we situate group therapy at Step 6 just below individual
therapy because from a funding perspective group requires less investment. Perhaps the order of the steps should be reversed for client-facing depictions of the model. Understandably, help-seekers may feel some trepidation when offered group psychotherapy. Consider a person struggling with social anxiety. Theoretically, we might argue group therapy is the treatment of choice. The group setting affords a safe place to fully experience, understand and develop skills for coping with anxiety. But client readiness and preference almost always trump theory. As such, it may not be the best place to start treatment.

The underutilization of group psychotherapy is also related to inadequate training. Typically, training in group therapy is limited by a relatively thin curriculum and sparse practicum site opportunities. Under such conditions, we cannot expect to develop a critical mass of confident group therapists needed to raise the profile, legitimacy and availability of this powerful modality.

Nevertheless, SC2.0 training and implementation help motivated providers to develop a variety of alternatives to the Step-7 gold standard. An incremental approach to group program development, in the context of this larger transformation process, holds promise. Without a lot of previous experience or training in group work, it is fair to assume inexperienced practitioners would not begin by facilitating open-ended process groups. Nor would they cut their teeth working with populations likely to challenge authority. Starting with highly structured groups makes a lot more sense. The structure allows leaders to maintain control. This is important for building confidence. Lecture and workshop psycho-educational formats, like those outlined above at Step 4, are the most structured types of groups. Just as Amber needed to begin with low-intensity programming, therapists might need to begin with Step-4 practices before attempting the more intensive Step-6 work. At Step 4, communication is unidirectional, thereby precluding any need to manage interactions. In contrast, group psychotherapy at Step 6 is by nature more unpredictable. Group psychotherapy participants are often expected to display their maladaptive interpersonal patterns in vivo. Not a good experience for neophyte therapists. Quite often the most valuable learning for clients comes from working through authority issues by challenging the leadership. Few therapists are ready for this straight out of the gate. Some may never choose it.

For agencies and clinics that have decided to adopt SC2.0, not all steps are populated at once. Implementing a group therapy program in the context of SC2.0 is best done incrementally. If group work has not been a key part of the treatment continuum at a clinic, it would make sense to begin with structured educational approaches focusing on mental health literacy in Step 4. Perhaps the next step in implementation would be to move to semi-structured psychotherapy groups. These groups have well-developed curricula and are more akin to teaching a class. There is some interaction but the interaction is limited to the parameters of pre-set exercises. While there may be some open-ended disclosure and unstructured interactions, these are usually restricted by returning to the pre-set agenda of the sessions.

I suggest that the most highly structured therapy groups be classified as Step-4 interventions, whereas semi-structured psychotherapy groups are best categorized
as either Step-6 or Step-8 interventions, depending on the client population. Groups specifically targeting clients with highly sensitive and interpersonally volatile presentations should be considered Step-8 specialist level interventions. A basic Yalom-style interpersonal process psychotherapy group is highly unstructured and as such it fits the category of intensive group work. This is by design. The lack of structure creates space, a social microcosm, whereby clients’ maladaptive patterns can play out safely within the context of skilled group leadership. And depending on the volatility of the clients attending, this could be classified as either Step 6 or 8. In an outpatient clinic context, a Yalom-style group would be considered a Step 6 level intervention. Trauma groups or DBT groups in residential or inpatient settings would be classified as Step 8. Readiness for exposure and being challenged are key factors when considering referrals to groups at Steps 6 and 8.

Developing group programming can be frustrating. Groups require considerable upfront planning and some risk that this time will not pay off. Why put all the work into planning when participant recruitment is so challenging? Many practitioners report attempts at planning groups only to discover few people accept referrals. Scheduling is naturally more complicated by the fact that, even if willing and eligible clients were to be identified, it is likely that a time would not be found to accommodate all. Even if these challenges are met, repeated reluctance expressed by clients can be enough to discourage all attempts. This is understandable, particularly if groups offered never fill or have to be cancelled due to low numbers. Some providers, those with high caseloads or increasing demand, may persevere. Growing frustration may lead them to a hard sell approach, “I won’t see you unless you go to group first”. I do not expect much success with this approach unless the programming is well-matched to client readiness. Offering choices might help especially if a series of groups, with varying levels of structure or exposure intensity, are available.

Some theorists have emphasized the importance of group therapy preparation sessions or workshops. There is evidence that this increases attendance and outcomes (Piper & Perrault, 2015). There is certainly room in SC2.0 to offer group preparation at a lower level within the continuum of care. After all, readiness is a core variable in stepping decisions. If a clinic setting has a long wait time for individual therapy, clients may be open to attending a workshop entitled “Everything you would like to know about group therapy”. Some may be enticed by this one-time information session and enrol in group therapy. Others might decide to wait. In both cases, offering the choice is empowering.

While readiness is a key factor in SC2.0, the goal of preparing people for higher level programming conflicts with a key principle of our model. Instead of moving people to a level that practitioners would like to practice, the goal in SC2.0 is to move the treatment to where the person is ready without any assumption that more is needed. Of course, a help-seeker may wish to strive for more and this is fine. But it is more empowering and less burdensome on the care system to leave the question of “Is this enough or should there be more” up to the help-seeker.
4.9 Step 7: Flexible Intensive Individual Programming

Step 7 is undoubtedly where most work currently happens in mental healthcare. While the demand can be reduced with the implementation of SC2.0, social workers, psychologists, counsellors, physicians, nurses and psychiatrists will continue to deliver some form of talk therapy on a routine basis. Often the style, complexity, duration and interval of treatment are different depending on the provider or discipline. This is a good thing, as one size does not fit all. Client preference and choice are core principles of SC2.0. However, there is considerable debate among providers and uncertainty among help-seekers about what to expect from whom.

In SC2.0, informed consent is especially important. This is partly because the model and approaches are new. It is also because having clear expectations improves outcomes. Equally important to informed consent is role clarity. This includes the expectations and roles of both client and provider, but increasingly in our more collaborative care networks, we need to do more to develop interprofessional role clarity. What should a nurse do in the SC2.0 system? What about the family physician, a psychiatrist or a psychologist? While we have not yet worked this out, the model does provide a kind of scaffolding for exploring and testing out role differentiation. This is detailed more in Chap. 6.

Have you ever wondered why psychotherapists typically work in the context of the 50-min hour? This has been the case for more than a century. An hour is a useful period of time for costing. An hourly rate is easily understood and remains the most common unit for pricing all wages in our economy. The extra 10 min afforded by the 50-min hour, of course, ensures that time spent with record keeping and other administrative tasks are factored into the pricing. But what does science say about this? Is this unit of time any better than others for improving mental health? And then, what about weekly intervals, why do we practice psychotherapy at one-week intervals? Is there evidence to support this? Is the weekly 50-min session in the best interest of help-seekers or is it really for providers? Of course, we do need a system that is sustainable. The needs of providers are important, but they should not preclude innovation.

Very little research has addressed these questions. That in itself is interesting. Why hasn’t this been studied more? The research that has been conducted suggests that there is nothing particularly beneficial or important about intervals and session duration (Erickson, Lambert, & Eggett, 2015; Turner, Valtierra, Talken, Miller, & DeAnda, 1996). While it is true that much more study is warranted before drawing firm conclusions, proponents of SC2.0 encourage more experimentation in general and this also applies to the use of time. In the context of continuous therapeutic measurement, client preference and a trial and error philosophy, therapists operating at Step 7 can become much more creative with time. Sometimes we ask our clients at the beginning of Step-7 sessions, “What would you prefer today, a targeted brief 15-min skill-building session or a longer meeting to explore and dig deeper? Do you want to get something done today or delve into understanding the complexity of your life?”
With a client who is exhausted due to lack of sleep, or one with low energy levels associated with depression, maybe a briefer session is in order. With what little energy there is, a shorter, more focused session could be more productive. For someone who finds the sessions highly anxiety provoking, a small dosage might be more tolerable. My colleagues who work with indigenous peoples sometimes suggest a day-long session on the land makes far more sense than seven or eight 50-min meetings.

My life partner, Karen, is an experienced psychologist who owns and operates a small private practice. She is known in the community for her experience in treating complex cases, including clients with Borderline Personality Disorder, Bipolar Disorder and Complex PTSD. She sees her clients more regularly and for longer periods than I do. As I was finishing writing this book, we were beginning preparations for an international move. This meant that Karen was considering how to terminate treatment with her clients. She received an email request for therapy from a person with a long and complex history of mental illness. She was working on a response and asked me for advice on what to say in the email. I asked what her concern was. She replied, “I am not sure how I should indicate that I will only be practicing here for the next six months”. I asked her why she thought that was necessary. She answered, “Well, if I don’t tell the client then she won’t be able to make an informed choice about whether to see me for such a short time”. I said, “But if you do tell her in advance, aren’t you subtly implying that six months might not be enough for her? How does that instill hope?”

Some colleagues, including my partner Karen, say to me, “Surely there is value in a course of 10–20 (or more) 50-min sessions for those people with complex needs, such as complex PTSD”. I agree that this might be helpful but suggest it need not be the default. Why not be more flexible? Why not ask the help-seeker? “But”, say my colleagues, “It can take a long time for someone who has been abused for years to build up trust in a therapist. Having briefer and fewer sessions would further delay this process”. This may be true for some, but then I question aren’t there many ways to build trust? Colleagues sometimes counter with, “You can’t rush the development of the therapeutic bond. This happens very slowly”. While there is a large and robust body of research underscoring the value of the therapeutic alliance in driving mental health outcomes, the alliance does not necessitate a deep and lasting bond. Our goal is not to replicate friendship. Such an effort would be considered unethical for a variety of reasons—creation of dependency, profiting through the dependency, doing more harm than good. Instead the alliance is about alignment. Alignment can happen within a matter of seconds. A gifted health practitioner does this frequently. Think of a talented and beloved rural family physician. With kind eyes and a warm, gentle smile, such a physician aligns swiftly and smoothly with patients. I call this “flash empathy”. Unfortunately, we have not given enough attention to teaching alignment. Without adequate training, we are left waiting patiently with our clients for it to develop slowly and naturally over the course of many sessions.

With SC2.0, we do not dawdle when it comes to connecting. Professional development on forming rapid connection is a must. The model requires swift
alignment with a therapeutic success in every encounter. With SC2.0, we remind ourselves of the fact that an initial encounter is likely to be the one and only. Even if a course of sessions is contracted at Step 7, we work hard to align anew each time, just in case it may be the last.

I now practice most of my psychotherapy one-session-at-a-time. I have many clients, most of whom I see infrequently. While not nearly the same number, this is akin to a typical family physician who has a large roster of patients, most of whom do not need medical attention. Some clients I see only once or twice. I believe they get what they came for. Because I have shared with them principles of the SC2.0 model, including start-strong/start-simple, trial and error, fail forward and come back if/when needed, clients begin feeling empowered and reassured that care is there when they need it. This produces rapid alignment. Sometimes I say, “I will work really hard today to make sure that you walk away feeling like this was helpful, that we did something useful and that something has already been achieved. But if, tomorrow, you think we might have missed something or got it wrong today, I really would like you to come back”. This does two things related to alignment. The fact that I promise to work really hard to make sure that something therapeutic happens right away instills hope, optimism and faith in me as a dedicated helper. Secondly, a help-seeker does not feel pressured to get everything right, to solve all their problems right now, because they know they can come back. I often invite clients to think of visiting me in the same way they visit their family physician. Come when you need to. I will be available. Because my dominant form of practice is therapy one-at-a-time, I can usually accommodate requests for sessions within a week or two. Sometimes, when there is energy and substantial momentum, we may commit to a run of weekly sessions. Regardless of the pace or frequency, we review progress using therapeutic measurement at every session to guide treatment planning. If the data indicate deterioration or flattening of progress, we might decide together to experiment with adjusting the modality, frequency or duration of contacts.

Sometimes with people whom I have followed for longer than average, I make use of the traditional assessment, diagnostic and therapeutic techniques I was trained in. But I do this only when we are both feeling puzzled or stuck. The results can be spectacular and the outcome rewarding for both me and the client. In other cases, we discover through the use of therapeutic measurement and the successful reapplication of solution-focused interviewing, that a return (or stepping down) to periodic, one-at-a-time sessions is preferred. In a case where outcomes are flat or deteriorating, we will re-examine the treatment plan and consider the many other options available along the SC2.0 continuum. Some clients do initially experience stepping down as a threat to the connection we have established. If so, I liken it to a family physician’s responsibility to find allied care options, to refer to specialists, to recommend strategies for lifestyle changes. In other words, I remind clients that I am still available to them, but I will not see myself as the only healer. I can be your touchpoint, your mental health go-to-consultant in the way that a family physician considers their clinic as the patients’ medical home. In similar fashion, at Step 7, in SC2.0, the provider takes on the role of mental health treatment coordinator, or their mental healthcare treatment home.
Consultation is an area for growth within the context of SC2.0. There is a need for our most highly trained, expensive mental health practitioners to work to their full scope of practice. While there are decades of research supporting the efficacy of talk psychotherapy, there is very little evidence indicating that level of training, discipline or years of practice reliably influence outcomes (Boswell, Castonguay, & Wasserman, 2010; Stein & Lambert, 1995). In other words, a social worker with a year of post-graduate training is typically about as effective as a psychologist or psychiatrist with 6 years of post-graduate training. There is a perception that professions with more years of training provide better psychotherapy. This has led funders (insurance companies and government funded Medicare plans) to authorize payments to providers that are the most expensive and potentially no more effective. Secondly, it allows specialists to do basic psychotherapy work that less costly providers could do. Not only is this inefficient, but it also means that specialists are not working to full scope. Both psychiatrists and psychologists working to full scope would prioritize more consultation and assessment for complex cases by either treating the complex cases themselves or advising generalist practitioners on treatment plans.

If mental health specialists were working to full scope, their practices would have greater resemblance to those of medical specialists such as urologists, oncologists and internists. For these specialty groups, the ongoing “contract” is with the general practitioner who receives their reports. The patient is only a client to the specialist for the one episode of care. The primary care physician is the specialist’s true client. Unlike other medical specialists, mental health specialists (including psychiatrists and psychologists) often carry cases for long periods of time without discharging back to their medical home—the primary care physician. Without evidence suggesting that long-term care by mental health specialists is any better than support by lower intensity providers, this type of expensive practice is both inefficient and unethical.

Some of my psychiatrist and psychologist colleagues are reluctant to move completely into consultation roles. This is understandable. They were trained to work long-term directly with help-seekers and to value the development of a therapeutic bond. Part of what makes the work rewarding is the maintenance of these bonds over time and the fact that work with patients tends to become easier as they become known to providers. Both the patients and the providers become more relaxed through familiarity. My colleagues argue that burnout could increase if they only worked with the most complex cases or lost opportunities to form more comfortable alliances with patients. This is possible, but only if other rewards are not in place. I can think of two possible incentives. First a consulting role should be valued more, and payments should be higher. Secondly, practices should be set up so that the relationships formed are with the other professionals benefitting from their consultation.
One simple way to cultivate these relationships is through the development of integrated wellness hubs. These hubs could exist in both primary and tertiary care settings. Currently, specialists are not usually aligned with either primary or tertiary care settings. Most often, specialists work in private practice or acute care settings. Neither of these settings allow for specialists to maximize the impact of their consultation expertise. While specialist work may be essential for treatment of complex disorders, private practice care tends to prolong care longer than is necessary. The impact of specialist care in acute care settings is limited by the restricted healing capacity of patients that are in hospital mainly to be stabilized. Complex treatments that have the potential to impact recovery do not usually begin until after stabilization.

4.11 Step 9: Acute Care, Systems Navigation, Case Management and Advocacy

In the context of SC2.0, treatment at Step 9 expands to include more meaningful partnerships with both formal and informal community-based organizations. This is needed to improve care transitions, ensure follow-up by the right provider, and reduce frustrations and inefficiencies associated with the emergency department revolving door syndrome. Many people in crisis attend emergency departments when in high distress because there are no other real or perceived options. As a result, those in high distress who are not acutely ill (i.e. do not require psychiatric stabilization) are either not admitted or are discharged quickly. This is reasonable, given that the purpose of acute care is to save lives and stabilize. It is not aimed at recovery work or complex treatment.

With the development of lower step programming, including open access modalities on first contact, inappropriate mental health presentations at the emergency department can be reduced substantially. When peer support programming is available for people in distress (but not suicidal), emergency visits are also decreased. In Newfoundland and Labrador, CHANNAL operates clubhouse drop-in centres in various locations across the province. They also staff a peer-supported “Warmline”. In contrast to crisis help lines, the Warmline offers supportive, active listening to people who are not in crisis. It is staffed by persons with lived experience of mental illness who have received intensive, certified peer-support training. Included in the Warmline brief assessment protocol is a question asked at the end of the phone call, “If this service were not available, what would you have done today?” In many cases callers indicate that they would have visited the emergency department.

Trained peer support workers are increasingly valued on hospital wards for their discharge planning and facilitation work. Not only is this work being done in psychiatric wards, but increasingly people with lived experience are facilitating social and mental health adjustment for patients discharged from oncology and cardiology words. They are also helping with adjustment in chronic disease management, faci-
Itating early discharge without risking rebound admissions attributed to inadequate community supports.

Case management teams are becoming more common at various levels throughout the care continuum. Nurses or social workers are typically tasked with managing or coordinating the teamwork. These teams often include community stakeholders and trained peer supporters. Coordinators offer supervision and advice to team members. The coordinators likewise develop community-wide networks with counterparts operating at various levels of care. For example, almost every post-secondary institution now has a case management team. The case managers may operate within wellness clinics or independently. Team members include heads of counseling, the health clinic, accessibility services, campus police, residence life, the international students’ office and academic advising. The coordinator’s job is twofold: (1) to support team members in making appropriate care referrals and (2) in cases where referrals are not needed, to advise on how to maintain informal community support. For example, an accessibility advisor may get direction at a team meeting on coaching a student’s supervisor in active listening techniques for moments when their student is in distress.

Case managers function as both system navigators and healthy community development advisors. This dual role has the potential to reduce or reverse the hot-potato referral tendency that has arisen within the context of the risk paradigm dominating both our care and judicial processes.

Within acute care settings, case managers coordinate care transitions required upon discharge. In the context of SC2.0 hospital-based case managers form partnerships with community-based case managers and care navigators. For example, in the City of Halifax in Nova Scotia, case managers in hospital settings have formed an alliance with the city’s ten post-secondary institutions through a program called “Stay Connected”. They rotate regular meeting locations across institutions so that case managers become familiar with the types of care offered along the stepped care continuum at the various sites. This has allowed them to develop efficient referral pathways and maintain coordinated care without duplication and while minimizing loss of continuity in care.

SC2.0 can only work if all parties are familiar with the whole system of care. Given that the system is dynamic—always in a state of evolution or improvement—it is difficult to see the forest for the trees. System navigators and case managers attend to this dialectic. They have eyes on the moving parts, can help with treatment planning and life-transitions on the micro level, but are also crucial partners, at the macro level, in system design and adjustment. They focus in and out on parts and system. Increasingly, people with lived experience with mental illness participate in this design work under supervision of case managers. In some cases, client design teams dedicated to system adjustment are established. For example, at Memorial University in 2017 we launched our first client design team. As described in the story at the end of Chap. 5, our design team was comprised of students with either lived experience of mental illness or an interest in improving care at the University. The team was led by a graduate student in educational psychology who, in turn, was supervised by our case manager. They worked over the course of a year to research,
report and recommend feasible improvements and adjustments to our stepped care model. They presented this to the wellness clinic operations manager at the end of the academic year. Almost all recommendations were implemented. This design work, involving people familiar with various levels of the care continuum and supervised by case managers who can see the forest for the trees, ensures that care coordination and innovation are one and the same. It also elevates the recovery principle of empowerment through all levels of SC2.0.

**Knit and Talk**

When we made our first SC2.0 training site visit to the small Newfoundland coastal community of Lewisporte, we invited the clinicians and mangers in attendance to populate the nine steps in our model with existing programs available in their region. Using a white board, we began by drawing the x- and y-axes to represent the two dimensions of the model: Stakeholder investment on the y-axis and program intensity/client autonomy on the x-axis. We then created boxes and labelled each along the diagonal. The task for the group exercise was to “populate the steps” above and below the boxes. By this we explained that programs existing within clinic settings should be arranged under the appropriate step boxes and resources existing external to the clinic (both formal and informal) should be listed above the boxes. Programs below the diagonal included “Doorways” walk-in appointments at Step 1, “choice appointments” at Step 7, TAO programming at Steps 2 (self-managed TAO) and 5 (therapist assisted). Formal programs external to the clinic included, Strongest Families anxiety treatment program at Step 5 (this is delivered through contracting out telephone counselling to therapists located in another province), the Warmline (at Step 3) operated by the Province’s peer support network and the Crisis Text Line (Step 9) operated by a non-profit national peer support network based in Toronto. We asked if there were any informal community supports that could be included above the line. Without delay we heard three voices in unison: “Knit and Talk”. This women’s support group had existed in the community for more than 20 years. While none of the clinicians had first-hand experience with the group, the reputation was positive. We asked if it should be included on the white board as a possible referral destination. Without hesitation the clinicians agreed. I asked, “What about liability, what if something goes wrong at Knit and Talk and someone you refer has a negative experience?” One of the more eager participants replied, “We are so past that now, Peter. We are not so risk averse. Besides we empower our clients to take managed risks, to fail forward when necessary, and we monitor outcomes regularly to ensure care is adjusted when necessary”.

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