Stakeholder Investment

Overview

Implementation

Training to Shift the Risk Paradigm

Outcome Monitoring

Evidence

Step 1 - Watchful Waiting; informational self-directed

Step 2 - Interactional self-directed

Step 3 - Real-time peer support

Step 4 - Real-time psycho-educational Workshops

Step 5 - Expert-assisted e-support

Step 6 - Intensive group programming/training

Step 7 - Intensive flexible individual programming/consultation

Step 8 - Specialist consultation and/or chronic care

Step 9 - Acute care, system navigation & creative case management

Program Intensity & Client Readiness for Change

Autonomy / Empowerment
Overview

- Outline
- Basic Stepped Care
- Stepped Care 2.0
- e-Tools
- The steps
- Intersectoral Roles?
- 2.0 in action
- Model Variations
- 2.0 CoP
- Conclusions

Implementation

- Step 1 - Watchful Waiting; informational online self-directed

Training to Shift the Risk Paradigm

- Step 2 - Interactive online self-directed
- Step 3 - Real-time peer support
- Step 4 - Real-time psycho-educational Workshops
- Step 5 - Expert-assisted e-support
- Step 6 - Intensive group programming/training
- Step 7 - Intensive flexible individual programming/consultation
- Step 8 - Specialist consultation and/or chronic care
- Step 9 - Acute care, system navigation & creative case management

Outcome Monitoring

- Early Results

Conclusions
### SC2.0

**Learning Objectives**

I. List three features of SC2.0 that improve access & outcomes

II. Identify three applications for single session principles within SC2.0

III. Distinguish between *evidence-based practice* and *practice-based evidence*

**Medical model versus recovery model versions of stepped care**

- Principles of SC2.0
- The Steps
- The evidence at a glance
- Variations on SC2.0
- Implementation Science
- Implementation Checklist
- Learning outcomes revisited
Overview

Implementation

Training to Shift the Risk Paradigm

Outcome Monitoring

Early Results

► Overview

► Implementation

► Training to Shift the Risk Paradigm

► Outcome Monitoring

► Early Results

► Overview

► Basic Stepped Care

► Stepped Care 2.0

► e-Tools

► The steps

► Intersectoral Roles?

► 2.0 in action

► Model Variations

► 2.0 CoP

► Conclusions

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► Conclusions

► Outline

► Basic Stepped Care

► Stepped Care 2.0

► e-Tools

► The steps

► Intersectoral Roles?

► 2.0 in action

► Model Variations

► 2.0 CoP

► Conclusions
Western European Model
• Led by UK
• Goals: 1. Reduce the burden of mental illness in society; 2. Care system is self-corrective
• Most effective yet least resource intensive programming offered first
• Programming Intensity only stepped up to the next level with evidence or prediction of failure
• Pathways determined by symptom severity
• Better outcomes and more sustainable
Overview

- Outline
- Basic Stepped Care
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- 2.0 CoP
- Conclusions

Implementation

- Step 1 - Watchful Waiting; informational online self-directed

Training to Shift the Risk Paradigm

- Step 2 - Interactional online self-directed

Outcome Monitoring

- Step 3 - Real-time peer support

Early Results

- Step 4 - Real-time psycho-educational Workshops
- Step 5 - Expert-assisted e-support
- Step 6 - Intensive group programming/training
- Step 7 - Intensive flexible individual programming/consultation
- Step 8 - Specialist consultation and/or chronic care
- Step 9 - Acute care, system navigation & creative case management

Conclusions

- Outline
What’s New About 2.0? (Click for details below)

- Principles of SC2.0
- More rapid access to care
- Recovery oriented
- Assess both strengths & deficits
- Single session principles
- Based on readiness for change
- Maximizing outcomes
- Collaborative in 4 ways

What’s New About 2.0?

- No wait times
- Not a pathways or staging model
- More client-centric (shares responsibility with clients)
- More flexible and organic
- Incorporates natural community supports
- More attentive to patient engagement
What is Stepped Care 2.0?

- Collaborative system of delivering & monitoring recovery-oriented programs, while promoting client responsibility, autonomy & resilience.
- Steps based in part on readiness for change.
- Includes face-to-face and/or online components to meet clients “where they are.”
What is Stepped Care 2.0?

- Solution-focused, strengths-based interventions applied first.
- Trial and error approach is transparent so that clients and providers can fail forward together.
- Traditional 50-minute therapy is only offered mainly to those who are ready to engage in challenging work.
What is Stepped Care 2.0?

• Shares responsibility for wellness with entire community

• Not a pathways or staging model; minimal assessment unless necessary; instead flexible, adaptive / self-corrective.
What’s New About 2.0? (Click for details below)

- Principles of SC2.0
- More rapid access to care
- Recovery oriented
- Assess both strengths & deficits
- Single session principles
- Based on readiness for change
- Maximizing outcomes
- Collaborative in 4 ways

What’s New About 2.0?

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Rapid access through Stepped Care 2.0

Immediate Care Access Options in NL:
- Online (www.bridgethegapp.ca)
- Phone (Crisis phone/text; Central Intake; Warmline)
- Walk-in (Doorways Clinics)

Service users can walk in for a single-session to identify & address a targeted need. The outcome could be no further service, a return visit initiated by the service user, or suggestion / recommendation of services within stepped care system. The expectation is for a mutually agreed upon outcome.

Step 1 - Watchful waiting; informational self-directed
Step 2 - Interactional self-directed
Step 3 - Real-time peer support
Step 4 - Real-time psycho-educational Workshops
Step 5 - Expert-assisted e-support
Step 6 - Intensive group programming
Step 7 - Intensive flexible individual programming
Step 8 - Specialist consultation / chronic care
Step 9 - Acute care, system navigation & Advocacy

Stakeholder Investment

Program Intensity & Client Readiness for Change
Autonomy / Empowerment
What’s New About 2.0?

- No wait times
- Not a pathways or staging model
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- Incorporates natural community supports
- More attentive to patient engagement

What’s New About 2.0? (Click for details below)

- Principles of SC2.0
- More rapid access to care
- Recovery oriented
- Assess both strengths & deficits
- Single session principles
- Based on readiness for change
- Maximizing outcomes
- Collaborative in 4 ways
Mental Health Recovery

► Recovery Principles
► Clinical Staging vs. Recovery
Recovery Values (APA, 2012)

- Self-direction
- Individualized and person-centered
- Empowerment
- Holistic
- Nonlinear
- Strengths-based
- Peer Support
- Respect
- Responsibility
- Hope
Recovery Values (APA, 2012)

- Self-direction
  - Consumers determine their own path to recovery
  - Individualized and person-centered
  - Empowerment
  - Holistic
  - Nonlinear
  - Strengths-based
  - Peer Support
  - Respect
  - Responsibility
  - Hope
There are multiple pathways to recovery based on individuals’ unique strengths, needs, preferences, experiences and cultural backgrounds.
Recovery Values (APA, 2012)

- Self-direction
- Individualized and person-centered
- Empowerment
- Holistic
- Nonlinear
- Strengths-based
- Peer Support
- Respect
- Responsibility
- Hope

Consumers can choose among options and participate in all decisions that affect them.
Stepped Care Versions

Pathways/Staging Version

- UK, Europe, Australia
- Screening and thorough assessment upfront - purpose is to detect / address risk and conduct triage
- Decision tree - clear pathways
- Focus more on illness with priority to severe pathology
- Monitor symptoms
- Prescriptive, evidence-based, manualized treatments
- Fits in medically-based clinics and primary care fee-for-service context

Recovery Version

- Stepped Care 2.0 (Canada, US)
- Minimal upfront assessment, solution-focus + “fail forward” initially
- Deep assessment only when there is “a mystery”
- Flexible - no pre-determined pathways
- Population focus: prevention & treatment for all regardless of severity
- Monitor readiness, relationship capacities/recovery
- Collaborative, trial-and-error solutions based on practice-based evidence
- Fits multiple sectors - e.g., community clinics, educational settings, integrated service hubs, including when dx not required

Some tension exists between these versions
What’s New About 2.0? (Click for details below)

- Principles of SC2.0
- More rapid access to care
- Recovery oriented
- Assess both strengths & deficits
- Single session principles
- Based on readiness for change
- Maximizing outcomes
- Collaborative in 4 ways

What’s New About 2.0?

- No wait times
- Not a pathways or staging model
- More client-centric (shares responsibility with clients)
- More flexible and organic
- Incorporates natural community supports
- More attentive to patient engagement
Single Session Principles

Click on hyperlinks for details:

- What is single-session therapy?
- 30 year history; research is promising
- Hoyt & Talmon (2014)
- Narrative & solution focused assumptions, goals & interviewing style
- Walk-in access
- Strengths-based
- Capture the moment of opportunity afforded by client’s current hope-oriented inertia
What is Single-Session Therapy?

- **Walk-in access**
- **One-at-a-time** therapy
- Each session is self-contained
- Just like a visit to a physician
- **Rapid assessment**
- Targets a single issue
- A solution is generated
- Follow-up is an option but not the default
- Therapist works very hard to create an immediate success
- Client experiences it as their own solution
- **More on how SS fits in context of SC2.0...**
What’s New About 2.0?

• No wait times
• Not a pathways or staging model
• More client-centric (shares responsibility with clients)
• More flexible and organic
• Incorporates natural community supports
• More attentive to patient engagement

Stepped Care 2.0 ©
Readiness for Change

- Screening for severity?
- Stepping for readiness?
- Measures
Are you intending to change in the future?

In the next month?

PREPARATION

CONTEMPLATION

Are you actively working on: ________?

Yes

No

STEPS 2-3
- Peer consciousness-raising
- Apps & self-help for self-evaluation, self-discovery & monitoring
- “Dipping your toe in the waters of change”
- Chatbot could act as “Socratic teacher”

STEPS 4-5
- Learning in workshops
- Therapy-assisted eMH
- Coaching
- Small Changes

STEPS 6-9
- Expert as consultant
- Individual & group therapy
- Specialist treatment & consultation
- Case management
- Acute care

STEPS 2-9
- Expert as consultant
- Individual & group therapy
- Specialist treatment & consultation
- Case management
- Acute care

ACTION/MAINTENANCE

Program Intensity & Client Readiness for Change

Stakeholder Investment

Walk-in: The main concern is ________

Yes

No

No

STEPS 1
- Watchful waiting like a nurturing parent
- Information (about access to MH support opportunities) is there for when you need it

PRE-CONTEMPLATIVE
Explore the steps!
• Click on a step for details
**Bridge the gAPP:**
- Whole population
- Gov NL *mental health literacy* app
- Self help content
- Access to Province’s e-mental health tools
- Access to local resources

**TIP:**
Step 1, with its emphasis on mental health literacy, is appropriate for those at the precontemplation stage of change

**Step 1 - Watchful waiting; informational self-directed**

**Also:**
- Clinicians can prescribe other mental health literacy sites, as well as apps, YouTube videos and Ted talks.
Explore the steps!
• Click on a step for details
STEP 2: Interactional Self-Directed

**TAO**
Therapy Assistance Online
SELF-MANAGED

- Anxiety, depression, stress, substance abuse, anger, communication
- ACT, CBT, Behavioural Activation
- Online workbooks

**Step 2 - Interactional self-directed**

- Anxiety, depression, stress, phobias
- Online workbooks

**breathing room**

- 8 module self-help program
- Ages 12-24
- Stress, depression, anxiety
- Positive psychology approach

**CelesstHealth Solutions**

- Lifestyle coaching modules
- Based on stages of change

Also:
Clinicians can prescribe other self-help treatment programs in app or workbook form

**WellTrack**

- iCBT
- Relaxation
- Mood tracking
Explore the steps!
• Click on a step for details
**STEP 3: Real Time Peer Support**

**MindWell**
- 30-day online program
- 5-10 minutes per day
- Can choose a “buddy” to complete program together

**CHANNAL**
- Community-based peer support by phone
  - Warm Line
  - 1-855-755-2560

**7 Cups:**
- Online peer chat
- For non-crisis
- Brief training for global “listeners”
- Some questions on quality of global listeners
- Extensive training for local listeners

**MUN only:** Campus-based face-to-face peer support—volunteers provide bulk of 7 Cups peer support

**Pacifica**
- Peer support communities

**Big White Wall**
- Community-based peer support by phone
  - BHM-20/43

**CONSUMERS’ HEALTH AWARENESS NETWORK**
- Newfoundland and Labrador
- www.channal.ca

**CelestHealth Solutions**
- MINDWELL•U
Explore the steps!
- Click on a step for details
Step 4 - Real-time psychoeducational Workshops

Transdiagnostic Workshops - Distress
- Base psycho-education on Barlow’s Unified Protocol
- Dx is not relevant
- Focused on skills for coping with distress

Workshops – real-time
- Open to public or referred clients
- Drop-in classes
- Professionally led
- Mental health literacy
- E-mental health tool advice provided
- To increase viability of these workshops (i.e., ensure cost-effectiveness by maximizing attendance), these could be simulcast
Explore the steps!
• Click on a step for details
Anxiety, depression, stress, substance abuse, anger, communication

ACT, CBT, Behavioural Activation

Online workbooks

15-30 minute weekly expert coaching (not provided by TAO) online, phone, or in-person

Like flipped classroom (content and work online; consults live)

High ROI

Best in-class customer support

University of Central Florida (UCF)

TAO Calming Your Worry, Group Counseling

Christopher Nault, LMHC

Step 5 - Expert-assisted e-support

TAO coaching can be done individually or in groups.

Beacon

- iCBT content
- Email coaching
- Staging model: More assessment than other tools
Explore the steps!
• Click on a step for details
**Specialized Groups**
- Only if demand warrants (urban centres; large PSEs)
- High disclosure & exposure
- e.g., Eating Disorder, DBT or PTSD skills groups
- Professionally led
- Clinician referral required
- Lower than step 7 in terms of cost, but may higher than step 7 in terms of intensity and client readiness

**Transdiagnostic Groups**
- Barlow’s Unified Protocol
- When population density is lower
- Dx is not relevant
- Focused on skills for coping with distress

**Step 6 - Intensive group programming/training**
Explore the steps!
• Click on a step for details
• Only offer individual psychotherapy when clients are ready to be challenged
• Session length can be adjusted to fit with energy and pace
  • 10 minutes
  • 25 minutes
  • 50 minutes

Examples: Online tools used as adjunct to therapy

Step 7 - Intensive flexible individual programming / consultation

► See “Lisa” Video
Explore the steps!
• Click on a step for details
• In NL: 811 Health Line
• Medeo; Zoom
• Clinical psychology assessment, consultation for physicians or counsellors
• Psychiatric remote consult for physicians
• Residential or day-treatment

Step 8 - Specialist consultation and/or chronic care
Explore the steps!
- Click on a step for details
Step 9 - Acute care, system navigation & creative case management

Clinic-based
- Emergency Dept.
- Short Stay & Psychiatric Assessment Unit
- Case Management
- Peer support as O.T.
- Client Design Team (like O.T. with consumer input on design of services)

All ages

See “Scott” Videos

CRISIS TEXT LINE |
powered by Kids Help Phone 😊

ProtoCall

BHM-20/43

CelestHealth Solutions
Explore the steps!
• Click on a step for details
**Step 1** - Watchful Waiting; informational self-directed

**Step 2** - Interactional self-directed

**Step 3** - Real-time peer support

**Step 4** - Real-time psycho-educational Workshops

**Step 5** - Expert-assisted e-support

**Step 6** - Intensive group programming/training

**Step 7** - Intensive flexible individual programming/consultation

**Step 8** - Specialist consultation and/or case management

**Step 9** - Acute care navigation 

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**Evidence**

- Proj. Provider data
- Proj. Site visit data
- Proj. Client data
- Proj. Focus Groups
- NL Project Report
- SC2.0 Publication
- Related Literature
SC Literature Reviews & Meta-Analyses

- European SC & e-MH
- Recovery Principles
- Low Intensity
- Single Session
- Collaborative Care
- Common Factors & FIT
- Duration of Treatment
- Session Length
Evidence for e-Mental Health & European Stepped Care

The clinical effectiveness of stepped care systems for depression in working age adults: A systematic review

Nick Firth, Michael Barkham, Stephen Kellett

Abstract

Background: Stepped care service delivery models involve treatments that become increasingly intense through successive steps, with patients re-assessed via pre-defined decision criteria. This article reviews the clinical effectiveness of stepped care systems for depression in working age adults. A systematic literature review of quantitative clinical outcome evidence comparing stepped care with usual care identified 18 controlled trials meeting specified criteria. Principal outcomes were remission rates, defined as patients no longer meeting diagnostic criteria for an episode of depression, and a series of intermediate outcome measures ranging from remission to recovery. Treatment response rates, defined as a 50% decrease in outcome measures, were also considered.

Results: Stepped care systems had recovery rates ranging from 30% to 68%, compared to 18% to 43% for usual care. Remission rates were significantly higher for stepped care compared to usual care (43% to 83% vs. 13% to 35%). Intermediate outcome measures showed consistent benefits for stepped care versus usual care.

Conclusions: Stepped care systems have the potential to improve clinical outcomes for depression in working age adults, offering a range of benefits compared to usual care. Further research is needed to refine treatment protocols and enhance implementation in real-world settings.
Stepped Care Outcomes are Positive

**More Effective & Efficient:** Benchmarking studies suggest that the model is effective and cost-efficient in routine care but variability in performance across sites (Chatterton et al., 2019; Firth, Barkham & Kellett, 2014; Gyani, et al., 2011; Richards & Suckling, 2009; Gyani et al, 2011; Delgadillo et al, 2012; Ho, Feung, Ng & 2016)

**Increased Recovery:** An observational cohort study in the UK analyzed retrospective data (n = 16,723) over a 4 year period-patients in a progressive treatment stepped care context were 1.5 times more likely to reach recovery (Boyd, Baker, Rielly, 2019)

**Client Satisfaction:** Clients report satisfaction with stepped care greater or on par with treatment as usual (Brooks et al., 2007; Cornish et al., 2017; Hedrick et al., 2003; Katon et al., 1999)

**Stepping Process is Key:** ‘Holding’ non-improving clients in treatment may undermine stepped-care efficiency (Gellatly, 2011). Adherence to empirically supported treatments, adequate dose of therapy and proportions of patients stepped-up lead to better outcomes (Gyani et al, 2011)
Step 1 - Watchful Waiting; informational online self-directed

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Variations on SC2.0

► George Washington U
► McGill University
► Furman University
► UBC Vancouver
► UBC Okanagan
► University of Toronto
► Calvin College
► Brock (early draft)
► Algonquin College
► University of Ottawa
► Trent University
► University of Victoria
► Oregon State University
► Dalhousie University
► Southern Connecticut
► University of Dayton
► Variations in other contexts
Stepped Care Counseling

Our Stepped Care Model is designed to be personalized and relevant for each individual student.

We offer a wide array of services that take into account the type of concern, research evidence on best practices, student personality and preferences, and readiness for making difficult changes or engaging in complex therapeutic processes. By taking a personalized, stepped care approach we hope to provide rapid and flexible access to wellness and mental health resources. This approach is aimed at empowering you to maximize and manage your own mental health to the best of your ability.

To access counseling, come in to the Colonial Health Center, during business hours, and ask to speak with a counselor. No appointment is required.
If you are in crisis, or concerned about a GW student in crisis, please call us 24 hours a day, seven days a week at 202-994-5300 (option 2). Counselors are available 24 hours a day, everyday to speak with you. We also encourage concerned GW students, faculty, staff, or family members to call when needed.

Colonial Health Center
Marvin Center Ground Floor
800 21st Street, NW
Washington, DC 20052
Phone: 202-994-5300 (24/7)
Fax: 202-912-8488

Life-Threatening Emergencies
On Campus: Call GWPD at 202-994-6111.
Off Campus: Call 911, or go to the nearest emergency room.
Variations on SC2.0

- George Washington U
- McGill University
- Furman University
- UBC Vancouver
- UBC Okanagan
- University of Toronto
- Calvin College
- Brock (early draft)
- Algonquin College
- University of Ottawa
- Trent University
- University of Victoria
- Oregon State University
- Dalhousie University
- Southern Connecticut
- University of Dayton
- Variations in other contexts
UBC Collaborative Stepped Care

On-site full-day SC2.0 workshop 2017
Variations on SC2.0

- George Washington U
- McGill University
- Furman University
- UBC Vancouver
- UBC Okanagan
- University of Toronto
- Calvin College
- Brock (early draft)
- Algonquin College
- University of Ottawa
- Trent University
- University of Victoria
- Oregon State University
- Dalhousie University
- Southern Connecticut
- University of Dayton
- Variations in other contexts
A HOLISTIC APPROACH TO MENTAL HEALTH

The University of Dayton provides a variety of resources and support for individuals to build resilience and thrive at the University and beyond. Positive mental health requires ongoing commitment and work. Therefore, the elements outlined below build upon each other so individuals can create a foundation for resilience, demonstrate self-awareness, and seek out appropriate resources.

1. PRACTICE SELF-CARE
   - 30 minutes of moderate to vigorous physical activity daily
   - 7-8 hours of uninterrupted sleep
   - Eat a balanced diet including an appropriate amount of water based on individual characteristics such as sex and body weight
   - Educational resources and learning opportunities
   - Emotional Wellness Screener (online)

2. BUILD YOUR COMMUNITY
   - Active Minds, To Write Love on Her Arms, Mindful Living Movement, Club 6
   - Intramural Sports & Sport Clubs
   - Trainings (LGBTQ+/Ally, Green Dot)
   - UD Late Night events
   - Foster supportive relationships

3. DEVELOP YOUR SKILLS
   - Kognito: Mental Health Training Module (online)
   - Mental Health First Aid training
   - Anxiety Toolbox Seminar with the Counseling Center
   - Life Hacks workshop series
   - Other educational workshops

4. TALK ABOUT YOUR CONCERNS
   - Talk to a friend, family member, R.A., Neighborhood Fellow, mentor or other trusted individual
   - Peer mentor programs, PAVE, CMA Peer Educators
   - Group therapy sessions

5. UTILIZE CAMPUS RESOURCES
   - Campus Ministry
   - Center for Alcohol and Other Drug Resources and Education (CADRE) individual or group appointments
   - Counseling Center — individual session with therapist
   - Health Center
   - Seek support from a Fellow or R.A.

6. ACCEPT ASSISTANCE & SUPPORT
   - Dean of Students Office
   - CARE Team
   - Community Standards and Civility

7. SEEK IMMEDIATE HELP
   - Call Public Safety: 937-229-2121
   - Call 911 (UD campus phones)
   - Crisis Text Line: Text HOME to 741741
   - Suicide Prevention Lifeline: 1-800-273-8255
   - Seek care at the hospital

ACTIONS TO TAKE

- Autonomy
- Intervention

go.udayton.edu/mentalhealth
Step 1 - Watchful Waiting; Informational self-directed

Step 2 - Interactional self-directed

Step 3 - Real-time peer support

Step 4 - Real-time psycho-educational Workshops

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Step 8 - Specialist consultation and/or chronic care

Step 9 - Acute care, system navigation & creative case management
Implementation science can be 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).
IMPLEMENTATION SCIENCE (I.S.)
Implementation science can be 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)

Formula For Success

Effective Innovations  Effective Implementation  Enabling Contexts  Socially Significant Outcomes

IS Frameworks (Jaouich, 2019) CAMH
- Implementation Gap
- IS Impact
- Approaches to Change
- Active Implementation Framework
The Implementation Gap

- **EVIDENCE** → **NOT ADOPTED**
- **ADOPTED** → **NOT USED WITH FIDELITY**
- **USED WITH FIDELITY** → **NOT SUSTAINED**
- **SUSTAINED** → **NOT REPLICATED**

IMPLEMENTATION SCIENCE (I.S.)
Implementation science can be 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)

Formula For Success

- Effective Innovations
- Effective Implementation
- Enabling Contexts

= Socially Significant Outcomes

IS Frameworks (Jaouich, 2019) CAMH
- Implementation Gap
- IS Impact
- Approaches to Change
- Active Implementation Framework
Many Approaches to Change

Quality Improvement
- Lean
- Six Sigma
- Model for improvement (IHI)

Implementation Science
- Active Implementation Frameworks
- Getting to outcomes
- Consolidated Framework for Implementation

Change management
- Prosci
- Lewin’s model
- Kotter 8 step model

System design
- Human-centred design
- Co-design

Jaouich (Feb, 2019)
Stepped Care 2.0 ©

**What is SC2.0?**
- Implementation Sci.
- eMH Engagement
- Roadblocks
- Checklist

**Implementation**

**Training to Shift the Risk Paradigm**
- Step 1 - Watchful Waiting; informational self-directed
- Step 2 - Interactional self-directed
- Step 3 - Real-time peer support
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- Step 5 - Expert-assisted e-support
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- Step 9 - Acute care, system navigation & creative case management

**Outcome Monitoring**

**Early Results**
SC2.0 Implementation Checklist

- Same-day access
- One-at-a-time sessions
- Care first, assessment later
- Fail forward together (clients and clinicians)
- Therapeutic monitoring on every encounter
- Graphic representation of model
- Implementation science

These are the gold standard requirements for SC2.0
Overview

- Outline
- Basic Stepped Care
- Stepped Care 2.0
- e-Tools
- The steps
- Intersectoral Roles?
- 2.0 in action
- Model Variations
- 2.0 CoP
- Conclusions

Implementation

- Step 1 - Watchful Waiting; informational online self-directed

Training to Shift the Risk Paradigm

- Step 2 - Interactive online self-directed
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Outcome Monitoring

Early Results

- Step 9 - Acute care, system navigation & creative case management

Conclusions

Outline
## Conclusions

### List three features of SC2.0 that improve access & outcomes

1. Rapid access
2. Broader range of options
3. Stepping is collaborative & and based on monitoring

### Identify three applications for single session principles within SC2.0

1. Walk-in
2. Strengths-based assessment & monitoring
3. Shifts beyond client-centered to *client-centric*

### Distinguish between evidence-based practice and practice-based evidence

- EBP: derived from clinical trials, fidelity to model
- PBE: derived from practice, fidelity to relationship & context

### Conclusion: SC Checklist

- Same-day access
- One-at-a-time sessions
- Care first, assessment later
- Fail forward together (clients and clinicians)
- Therapeutic monitoring on every encounter
- Graphic representation of model
- Implementation science