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Mental Health Commission of Canada / Commission de la santé mentale du Canada

Stepped Care 2.0 Where we have been, where we will go: A quality improvement workshop

Summary report

Mental Health Commission of Canada
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Contents

Introduction

On November 20, 2018, the Mental Health Commission of Canada convened representatives from provincial and territorial governments, post- secondary institutions, non-profit organizations, and other stakeholder groups to:

> *"We don't need the perfect solution to start. Small steps lead to bigger ones. So let's get going."*
>
> Workshop participant

- Increase awareness of the Stepped Care 2.0 Demonstration Project in Newfoundland and Labrador, Stepped Care generally, and other implementation procedures that promote rapid access to mental health services
- Identify barriers, facilitators, and best practices for Stepped Care and e-mental health service adoption
- Explore recommendations for development, implementation, and evaluation of current e-mental health projects and future opportunities.

Kickoff: Transforming mental health and addictions care

E-mental health solutions use technology to broaden and accelerate access to care and complement existing services. It is an important area for the MHCC, said Nicholas Watters, who welcomed participants to the event. A number of Canadian jurisdictions are using e-mental health solutions to improve mental health care, including Newfoundland and Labrador.

SPEAKERS

Nicholas Watters, Director, Knowledge Exchange Centre, Mental Health Commission of Canada

Justin Garrett, Project Manager, Mental Health and Addictions Division, Department of Health and Community Services, Government of Newfoundland and Labrador

In June 2017, the Government of Newfoundland and Labrador launched Towards Recovery, a comprehensive mental health and addictions action plan with e-mental health elements. As Justin Garrett explained, the plan also included 54 recommendations, completion timelines, and a governance oversight and accountability model. With all of the 18 short-term recommendations and two medium-term recommendations now implemented, the province has seen a 68 per cent reduction in wait times for counselling services. "We're changing how we operate," said Garrett.

Among those changes are new single-session walk-in clinics across the province. For many clients, one session is enough and, for those who need more, the clinics serve as access points to long-term care.

Work is underway to implement the 34 recommendations that remain — including the introduction of Stepped Care with e-mental health components provincewide.

> *"We're not in the business of fortune telling. We have experience that might lead us to a good first guess of what might help someone, but that's all it is. With Stepped Care we say to the client, 'You're the expert; try this out, let me know how it works for you, and we'll go from there.'"*
>
> Peter Cornish, PhD

Stepped Care Overview: The right care at the right time

The Stepped Care 2.0 service delivery model promotes fast access to mental health care while connecting clients to the right care at the right time. Peter Cornish walked workshop participants through the model's key features and shared a number of key lessons from Memorial University of Newfoundland's (MUN's) demonstration project experience:

SPEAKER

Peter Cornish, Associate Professor and former Director, Student Wellness and Counselling Centre, Memorial University and Stepped Care 2.0

- Stepped Care 2.0 is "scaffolding you can hang any kind of program on", including self-guided e-mental health apps, tools, and resources as well as face- to-face counselling, peer support, and other traditional forms of care.
- Rapid, same-day access is the goal with emphasis on single-session care that lets clients move into long-term care if they need it. This departure from traditional care models has helped eliminate wait-lists at MUN, but success requires that clinicians also change how they work.
- Client readiness determines interventions — in other words, what a client feels capable of doing *today*.
- CelestHealth Solutions' Behavioral Health Measure (BHM-20) generates data after each clinical encounter to inform further treatment decisions. This isn't about micromanaging or quality control; it's a therapeutic tool for clinicians and their clients.
- Monitoring is critical because it lets stakeholders experiment and "fail forward" — a shift away from risk adverse mental health and psychology research.

Q&A

One participant asked if anything in the model aligns a client's immediate needs with the best available resource. Cornish said there are several ways to do this. At MUN, clients have an email contact they can use if their current plan isn't working. Single- session walk-in clinics like N.L.'s Doorways also help by offering rapid access to a professional who can help clients navigate services and supports.

> *"We are incredibly risk averse — and sometimes we underplay the risk of not doing something."*
>
> Lori Wozney, PhD

Another participant wondered whether the *step* metaphor was misleading, since the services in the program are complementary rather than sequential. Cornish explained that the idea of steps comes from the original, more rigid U.K. model, which doesn't allow users to skip steps or access multiple interventions as they can with Stepped Care 2.0. The new model also differs in its interventions, which are based on readiness rather than severity. That said, Cornish added, the steps are useful because they show the amount of work a client needs to put in for each intervention. Some jurisdictions that have adopted Stepped Care have changed to circular or linear imagery.

Panel: Quality improvement of e-mental health solutions

The panelists reflected on the Stepped Care 2.0 model, its e-mental health tools and outcome measures, and the best approach to implementation and change management. Two clear themes emerged from the discussion:

- Co-design is critical
- Change management is key

Alicia Raimundo said online forums provided vital support when people in need couldn't access it elsewhere, but in the "wild west" of early e-mental health not all experiences were positive, since technology isn't inherently good or bad but can be a platform for both. The good is that e-mental health tools can make supports more accessible, depending on where people are at and what they're comfortable with. What's critical in avoiding the bad is to involve users in co-design. Even the most evidence-based app has limited value when it's hard to use.

Justin Scaini suggested we need to understand what Stepped Care 2.0 does best and who it helps most. Also important is knowing which skills and capabilities are needed for great delivery (to measure provider performance). He then noted that setting user expectations could improve the perceived effectiveness of e-mental health apps, since people are used to high-end technologies and not all e-mental health apps are that sophisticated. Lastly, he pointed out that driving and managing change demands its own set of non-clinical skills from sectors such as sales and customer service.

Lori Wozney added to the discussion by saying that the traditional risk paradigm needed to be challenged: things don't have to be perfect before launching Stepped Care 2.0. She then posed three questions: How many resources are needed for critical mass? What are the reasons for choosing one intervention over another? How does the monitoring backbone work? Noting that e-mental health is about system transformation, not just adding to the existing system, she underscored the importance of setting clear goals so that change can be deliberate and strategic. She also mentioned that jobs and roles may need to be redefined in the transformed system to provide new skills and functions.

Cassie Jararuse spoke about being a support counsellor in a remote Inuit community and how valuable e-mental health tools can be in that context. She was enthusiastic about the Stepped Care 2.0 monitoring tool because it lets care providers see how clients are being helped and provides continuity when there is counselling staff turnover. She stressed the importance of involving Inuit and other Indigenous peoples at every stage when developing any model, approach, or tool they might use — from the start of planning to the monitoring of implementation — not just getting feedback once something is built.

PANELISTS

Alicia Raimundo, Mental Health Super Hero, Project Coordinator, Foundry

Justin Scaini, Director, Consulting, Capitalize for Kids

Lori Wozney, Health Outcomes Scientist, Nova Scotia Health Authority/Mental Health and Addictions

Cassie Jararuse, Regional Youth Services Program Coordinator, Department of Health and Social Development, Nunatsiavut government

MODERATOR

Nicholas Watters, Director, Knowledge Exchange Centre, MHCC

PRESENTATION

Justin Scaini, Director, Consulting, Capitalize for Kids

Q&A

One participant suggested that the next frontiers will involve integrating Stepped Care and e-mental health into providers' practices and then into the overall service delivery model.[1] Scaini, in response, said that understanding how providers work today is crucial to knowing what to change. Wozney acknowledged that "normalization is going to be bumpy," and that changing culture requires a lot of support. Raimundo advocated promoting Stepped Care and e-mental health to people who aren't being reached today, noting

[1]See the MHCC's *Toolkit for e-Mental Health Implementation*.

that co-design sheds light on how people truly perceive the use of services — in ways traditional evaluations don't.

Other comments included the need to align Stepped Care work with reconciliation and to tap into Indigenous knowledge. In responding, Jararuse said reconciliation must be pursued in all areas, not just e-mental health. Lastly, one participant mentioned that organizations might find Canada Health Infoway's change management toolkit a useful resource.

> *"Training can't be so rigid that people providing support can't put themselves into the interaction. We don't want humans to seem like chatbots. Andwe need to remember that peer support isn't just putting people with livedexperiencetogether ina room.Peer supporters are trainedpeople."*
>
> Alicia Raimundo

Group Discussion: Implementation barriers, facilitators, and best practices

Participants worked together at their tables to identify barriers, facilitators, and best practices for implementing Stepped Care, e-mental health services, and other rapid-access solutions.

BARRIERS

- Lack of leadership, stakeholder buy-in and capacity, and data to inform action
- Limited internet access in rural areas that may make some services or solutions unavailable
- No one-stop shop for services and a potentially confusing multitude of options
- Hard-to-track patient journey due to self- direction
- Fragmentation of Canada's health system
- Risk-averse culture and providers; unwillingness to change
- High cost of implementing and maintaining change
- Need for clinician education and training
- Lack of fee structures that support non- traditional models
- Restrictive organizational structures or policies

FACILITATORS

- Increased awareness of mental illness and mental health problems; reduced stigma
- Early adopters and trailblazers
- Rapid change management capacity
- Lots of momentum among stakeholders
- Medical will, user will
- Seeking access to services through multiple channels is becoming more widespread
- International experiences that provide direction
- Local community, innovators
- Partnerships with technology firms and innovators
- Government involvement and strategy
- Conceiving the project as a long-term investment
- Ability to show evidence that these solutions work
- Collaboration to avoid the duplication of effort
- Motivated service users, especially youth
- Post-secondary faculty involved in advocacy
- Word of mouth, social media

BEST PRACTICES

- Involve stakeholders from the beginning using co-design processes
- Incorporate performance management of the professionals offering services; fidelity checklist
- Apply change management principles, drawing on knowledge from sales, business, and other sectors
- Focus on mental health and wellness, not just illness
- Collaborate and respond collaboratively
- Know what we're delivering, to whom, when, and why
- Trace outcomes with routine monitoring, adapt as needed
- Tap into the knowledge of people with lived and living experience, Indigenous people, and other important groups.
- Ensure continuity with other developments, e.g., electronic medical records
- Partner with primary care
- In some cases, build a new system rather than trying to fix a broken one

Panel: Scaling up e-mental health solutions

The afternoon panel highlighted key ingredients for success in scaling up — echoing the call in the morning sessions to use co-designed, evidence-based solutions and find ways to avoid getting stuck in "pilot mode."

> *"Co-design is key. Almost everything we build is wrong unless we do it in partnership with people who have lived experience. Without that, really beautiful things become pilots because they fail."*
>
> Alisa Simon

Patricia Lingley-Pottie described the Strongest Families Institute's experience with the IRIS system. Her advice:

- Use client-centered co-design
- Shift from pilot projects to ongoing iteration
- Automate for efficiency
- Load-test to scale up with reliable performance
- Confirm the availability of the data you want to extract and export
- Design for flexibility and build in APIs[2] (hardwiring is tough to undo)
- Embed security, including keeping data in Canada and complying with the *Personal Information Protection and Electronic Documents* Act (PIPEDA)
- Be prepared to invest (IRIS cost $2 million over 20 years)

Alisa Simon shared learning from 30 years of experience with Kids Help Phone:

- Banish the words *pilot* and *trial* — think instead of *test* and *scale*
- Create a technology platform people want to use: co-design everything
- Use AI[3] and machine learning, both to understand who benefits most from which services and to help navigate
- Train users (e.g., Kids Help Phone volunteers) — gamify training if it helps
- Learn from your data: it may challenge assumptions
- Keep and protect your data
- Give users the right to scrub their data if they want; it's theirs

PANELISTS

Patricia Lingley-Pottie, President and CEO, Strongest Families Institute

Alisa Simon, Vice-President, Service Innovation and Chief Youth Officer, Kids Help Phone

Karen Tee, Director, Service Innovation, Foundry and Frayme Stepped Care member

Lori Wozney, Health Outcomes Scientist, Nova Scotia Health Authority/Mental Health and Addictions

MODERATOR

Nicholas Watters, Director, Knowledge Exchange Centre, MHCC

Karen Tee talked about her experience at Foundry and her perspective as a Frayme Stepped Care member:

- Make sure your leaders buy in, share purpose, and can lead change: change leadership is key
- Use co-creation and co-design to get buy-in
- Make sure you have the capacity to implement (e.g., using coordinators to apply implementation science and build trust)
- Time your scale-up process smartly (e.g., set up walk-in counselling before stepped care)
- Align measures with users (you may need multiple measures, e.g., if serving a broad age range)

Lori Wozney offered advice from an implementation science perspective:

- Focus on what's driving change (e.g., user demand, cost savings, quality goals, equity, co-design/co-creation, legal or political mandates)

[2]Application programming interfaces
[3]Artificial intelligence

- Know how you're scaling up — spreading out or growing up (horizontal or vertical)
- Think long-term investment, not running little projects
- Seek quick wins even while pursuing long-term goals
- Incent early adopters and celebrate progress
- Think about workforce development and training: what are the competencies, how will you train for them, and what will future jobs look like?

Q&A

Asked what incentives Kids Help Phone uses for training, Simon said that so far it has been small things like "levelling-up" stickers, although next year's budget will include real swag. She also noted that an incentive can be community building: bringing volunteers together to foster collegiality and a sense of being part of something.

Lingley-Pottie answered a question about data compliance silos across Canada by explaining how the

> *"If we could standardize data collection, we could compare and learn. I'd also like to see research and satisfaction surveys on people who don't come back."*
>
> Karen Tee

Strongest Families Institute addresses data compliance: through its (lengthy) contracting process, which involves multiple privacy impact assessments. Simon added that Kids Help Phone starts from its own principles on such questions — "What's right for youth and data (twelve-year-olds can't consent)?" — and takes best practice advice to privacy commissioners, demonstrating good thinking and research.

Group Discussion: Scaling up barriers, facilitators, and best practices

The afternoon's discussions focused on the barriers, facilitators, and best practices for scaling up rapid-access mental health care. Participants also explored ways to extend the project or other rapid-access solutions to different populations and sectors.

BARRIERS

- Fiscal-year timelines and four-year political cycles
- Aversion to risk and change
- Lack of buy-in among stakeholders
- Legal frameworks developed in the pre- internet era
- Not enough time for capacity planning
- Competing priorities

FACILITATORS

- Funding
- Capacity of clients to propose creative solutions
- Stakeholder input
- Co-design, transparency in communications, and consistency in language
- Meaningful value propositions for all stakeholders
- Identifying and pursuing quick wins to demonstrate success

WAYS TO EXTEND THE PROCESS

- Expand services in post-secondary schools
- Engage Indigenous people, newcomers to Canada, people with lived experience, and other communities
- Take the project to a higher level, e.g., the conference of federal/provincial/territorial deputy ministers
- Introduce technology hubs in house and share local resources; add to resources through crowdfunding
- Convene stakeholders to discuss Stepped Care design and changes to scope of practice
- Define the project's core features; identify what might be contextually important
- Conduct data analysis of subpopulations and jurisdictions
- Develop minimum data set and core data measures
- Tie investments to outcome improvements
- Remove silos to look at return on investment

BEST PRACTICES AND RECOMMENDATIONS

- Assign people to work on the project and lead it
- Focus on change management
- Involve all disciplines, including primary care
- Get commitment from all political parties to ensure sustainability and continuity
- Let people or organizations tweak aspects of the model so they don't feel dictated to
- Pilot to scale, not pilot to end
- Increase buy-in on core values to avoid slowing momentum if champions drop out

Final Remarks: Moving forward

To close the workshop, Peter Cornish returned to the podium to reflect on what he took away from the day's presentations and discussions:

SPEAKER

Peter Cornish, Associate Professor and former Director, Student Wellness and Counselling Centre, Memorial University and Stepped Care 2.0

- Co-design needs to be built into Stepped Care from day one. Every voice must be included in the process. We need to listen to those that aren't included and bring them in as soon as we hear them.
- Design and consultation processes are continuous. A month ago, there were eight steps. Then someone in central Newfoundland suggested breaking one step into two. This kind of rethinking is crucial for honing the model so it's as effective as can be.

> *"What can we learn from today that will allowus to move forward together and share the wisdom that comes from our diverse communities?*
>
> Peter Cornish, PhD

- We need to correct the idea that the only mental health care processesworth investing in are primary care or hospital-based. There's a huge amount of capacity in our communities that we're not capitalizing on, for example through collaborative care — Stepped Care aims to correct that.
- Data is critical for scaling up. We need to define minimal data sets and outcome measures and identify or develop tools that can measure results along theway.

Cornish thanked participants for sharing their feedback and invited further thoughts by phone or email. "The more we talk to people," he said, "the more we discover great ideas that we've missed." "We're constantly revisiting and rethinking the model, and we encourage others to do the same."

Appendix A: Meeting at a glance

Tuesday, November 20th, 2018

Hyatt Regency | Toronto, Ontario

TIME	ITEM	SPEAKER(S)
8:45-9:15 a.m.	Opening remarks	Nicholas Watters, Director, Knowledge Exchange Centre, MHCC Justin Garrett, Project Manager, Mental Health and Addictions Division, Department of Health and Community Services, Government of N.L.
9:15-10:00 a.m.	Overview of Stepped Care principles and the N.L. demonstration project, with Q&A	Peter Cornish, Associate Professor and Former Director, Student Wellness and Counselling Centre, Memorial University and Stepped Care 2.0
10-10:30 a.m.	*Networking break*	
10:30-11:30 a.m.	Quality improvement panel, with Q&A	Moderator: Nicholas Watters, MHCC Panelists: Alicia Raimundo, Mental Health Super Hero, Project Coordinator, Foundry Justin Scaini, Director, Consulting, Capitalize for Kids Lori Wozney, Health Outcomes Scientist, Nova Scotia Health Authority/Mental Health and Addictions Cassie Jararuse, Regional Youth Services Program Coordinator, Department of Health and Social Development, Nunatsiavut government
11:30 a.m.-12:15 p.m.	*Lunch and networking*	
12:15- 1:15 p.m.	Table discussions: Barriers and facilitators	All
1:15-2:15 p.m.	Scaling-up panel, with Q&A	Moderator: Nicholas Watters, MHCC Panelists: Patricia Lingley-Pottie, President and CEO, Strongest Families Institute Alisa Simon, Vice-President, Service Innovation and Chief Youth Officer, Kids Help Phone Karen Tee, Director, Service Innovation, Foundry and Frayme Stepped Care member Lori Wozney, Nova Scotia Health Authority
2:15-2:30 p.m.	*Health break*	

TIME	ITEM	SPEAKER(S)
2:30-3:30 p.m.	Next steps: Implementation and scaling-up discussions	All
3:30-4:00 p.m.	Final remarks and closing	Nicholas Watters, MHCC Peter Cornish, Memorial University, Stepped Care 2.0

Appendix B: List of participants

NAME	TITLE/ORGANIZATION
Alexia Jaouich	Director of Implementation and Innovation, Provincial System Support Program, Centre for Addiction and Mental Health (CAMH)
Allison Bichel	Senior Provincial Director, Alberta Health Services
Andrea Brown	Territorial Manager, Mental Health and Addiction Services, Northwest Territories Health and Social Services Authority
Annmarie Churchill	Assistant Professor/Project Coordinator, Memorial University of Newfoundland (MUN)
Austin Mardon	Assistant Adjunct Professor, University of Alberta Psychiatry Department
Benjamin Fortin- Langelier	Psychiatrist, Royal Ottawa Health Care Group
Branka Agic	Director of Knowledge Exchange, CAMH
Cassie Jararuse	Regional Youth Services Program Coordinator, Department of Health and Social Development, Nunatsiavut Government
Cheryl Washburn	Director, Counselling Services, UBC
Deanne Simms	Psychologist, IWK Health Centre
Fraser Ratchford	ACCESS e-Services Group Director, Canada Health Infoway
Heather Hair	Associate Professor, School of Social Work, MUN
Heather Thomas	Executive Director, CINIM
Jenna MacQueen	Consultant, Nova Scotia Health Authority, Mental Health and Addictions
Justin Garrett	Project Manager, Mental Health and Addictions Division, Department of Health and Community Services, Government of Newfoundland and Labrador
Justin Scaini	Director of Consulting, Capitalize for Kids
Karen Cohen	Chief Executive Officer, Canadian Psychological Association
Karen Tee	Director, Service Innovation, Foundry
Kimberley Korf-Uzan	Director, e-Mental Health and Special Projects, B.C. Mental Health and Substance Use Services
Lisa Crawley	Nurse Manager, University Health Network, Toronto General Hospital
Lori Wozney	Health Outcomes Scientist, Nova Scotia Health Authority, Mental Health and Addictions
Mark Embrett	Health System Impact Fellow, Canada Health Infoway
Nadiya Sunderji	Psychiatrist and Medical Director, Quality, Mental Health and Addictions Service, St. Michael's Hospital and University of Toronto
Neil Drimer	Director, Programs, Canadian Foundation for Healthcare Improvement (CFHI)

NAME	TITLE/ORGANIZATION
Nora Bressette	Curriculum Coordinator, Thunderbird Partnership Foundation
Patricia Lingley-Pottie	President and CEO, Strongest Families Institute
Paula Robeson	Director of Operations, Frayme
Peter Cornish	Associate Professor, Memorial University and Stepped Care 2.0
Peter Farvolden	Senior Clinical Director, Beacon
Samantha Hodder	Senior Director, Mental Health and Addictions, Nova Scotia Health Authority
Sara Chorostkowski	Manager Mental Health and Addictions, Government of the Northwest Territories, Department of Health and Social Services
Sarah Joynt	Royal Ottawa Health Care Group
Sarah Olver	Senior Improvement Lead, CFHI
Stacy Taylor	Health Consultant, New Brunswick Department of Health
Stephanie Loewen	Director, Mental Health and Addictions, Manitoba Health, Seniors and Active Living
Steve Mathew	Provincial Lead, Mental Health and Addictions, Ontario Telemedicine Network
Vera Romano	Director, Rossy Student Wellness Hub, McGill University

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